OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

EVALUATION REPORT

Personal Care Assistance

JANUARY 2009

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OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA • James Nobles, Legislative Auditor

January 2009

Members of the Legislative Audit Commission:

People enrolled in Minnesota's publicly funded health care programs may be eligible to receive certain personal care assistance in their homes and communities. In response to legislative concerns, the commission directed OLA to evaluate how well the services are being administered.

We found that the services have been subject to minimal state regulation and oversight, even though expenditures have grown significantly and the program is vulnerable to fraud and abuse. Administration of the services needs to be improved, and we offer several recommendations.

Our evaluation was conducted by Joel Alter (manager), Carrie Meyerhoff, and Lolyann Connor. We received the full cooperation of the Department of Human Services, and we also received helpful advice from the Department of Health, counties, health plans, consumer advocates, and service recipients.

Sincerely,

James Nobles
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Table of Contents

		Page
	SUMMARY	**ix**
	INTRODUCTION	**1**
1.	**BACKGROUND**	**3**
	PCA Services	3
	Administration and Regulation	6
	Individual Eligibility and Access	10
	Spending	16
2.	**RECIPIENT CHARACTERISTICS, PCA USE, AND ASSESSMENT**	**21**
	Recipient Characteristics and PCA Use	21
	Assessments for PCA Services	29
3.	**FISCAL INTEGRITY**	**41**
	Background	41
	Nature and Extent of Fiscal Integrity Issues	42
	State Efforts to Address Problems	49
	Recommendations	55
4.	**SERVICE QUALITY**	**59**
	Outcomes	59
	Quality Assurance Plan	61
	Quality Assurance Reviews	64
	Supervision of PCA Services	66
	Protection of Vulnerable PCA Recipients	72
	Adequacy of Consumer Information	79
	Personal Care Assistant Work Hours	83
	Personal Care Assistant Training and Compensation	85
5.	**OTHER ISSUES**	**89**
	Use of Family Members as Personal Care Assistants	89
	Adequacy of Services for People with Behavior Issues	91
	Standards for PCA Agencies	91
	Judges' Decisions in PCA Appeals	94
	LIST OF RECOMMENDATIONS	**97**
	APPENDIX	**101**
	AGENCY RESPONSE	**103**
	RECENT PROGRAM EVALUATIONS	**105**

List of Tables and Figures

Tables | Page

1.1 Categories of Personal Care Assistance Services Authorized by Minnesota Law 5
1.2 Responsibilities of Personal Care Provider Agencies 7
1.3 Selected Requirements for Personal Care Assistance Providers 9
1.4 Minnesota Health Care Programs Offering Personal Care Assistance Services 11
1.5 PCA Spending, Medical Assistance State Plan Participants, Fiscal Years 2002-07 18
1.6 Minnesota's Rank Among States on Medicaid Personal Care Expenditures 19
2.1 Characteristics of Medicaid Fee-for-Service Personal Care Assistance Recipients, Fiscal Year 2007 23
2.2 Use of Fee-for-Service PCA Services in Selected Counties, Fiscal Year 2007 28
2.3 Variation in Identification of Behavior Issues Among Fee-for-Service PCA Recipients, Selected Counties 33
2.4 Participant-Hours of Training in DHS's Courses on PCA Assessment, 2000-07 36
2.5 PCA Appeal Outcomes by Type of Issue, 2007 Cases 37
3.1 Federal Medicaid Definitions of Fraud and Abuse 41
3.2 Examples of Cases Investigated by DHS's Surveillance and Integrity Review Section (SIRS) 45
3.3 Amounts of Improper PCA Payments Identified by SIRS for Recovery, 2002-07 46
3.4 Provider Agencies by Number of Fee-for-Service PCA Recipients Served, Fiscal Year 2007 53
4.1 Quality Assurance Activities for Personal Care Assistance Services, 2001 to Present 63
4.2 Supervision Duties of a "Qualified Professional" 67
4.3 Agency Compliance with Requirements for Investigations of Maltreatment Allegations Involving PCA Recipients 73
4.4 Personal Care Assistant Workweeks, May 2008 84
4.5 Personal Care Assistant Claimed Work Hours, May 2008 85
4.6 Personal Care Assistant Training Requirements in Minnesota Law 86

Figures

1.1 Process for Accessing Personal Care Services 13
1.2 Minnesota Spending on Personal Care Assistance, Fiscal Years 2002-07 17
2.1 Changes in the MA State Plan PCA Recipient Population, Fiscal Years 2002-07 25
4.1 Percentage of Medical Assistance Fee-for-Service PCA Recipients Without Paid Supervision, Fiscal Years 2002-07 69

Summary

Personal care assistance is an important service to many Minnesotans, but it lacks sufficient state oversight and accountability.

Major Findings:

- Between fiscal years 2002 and 2007, estimated publicly funded personal care assistance (PCA) expenditures grew by 164 percent, from $153 million to just over $400 million annually (p. 16).
- Personal care services remain unacceptably vulnerable to fraud and abuse (p. 43).
- Provider agencies are allowed to administer PCA services without demonstrating their understanding of state requirements (pp. 51-54).
- Many recipients strongly value the PCA services they receive, although there has been little systematic analysis of outcomes (pp. 59-60).
- The Department of Human Services (DHS) has implemented a weak quality assurance review program for PCA services (p. 65).
- Minnesota has not implemented sufficient controls and guidance to ensure that assessments of individuals' need for PCA services are reasonably consistent around the state (p. 31).
- DHS protects vulnerable recipients by screening providers for records of criminal offenses, but many adult recipients do not have the abuse prevention plans required by state law (p. 76).
- Supervision of personal care assistants is sometimes inadequate (p. 68).

Recommendations:

- DHS should promptly and regularly analyze claims data to identify improper payments (p. 55). It should also conduct more quality assurance reviews and investigations of PCA agencies (pp. 66, 56).
- The Legislature should establish mandatory training requirements for PCA assessors and the provider agencies that administer PCA services (pp. 38, 56).
- The Legislature should require that all Medical Assistance State Plan PCA recipients have their services periodically supervised by a "qualified professional" (p. 70).
- The Legislature should amend statutes to give DHS responsibility for investigating all maltreatment reports involving unlicensed personal care provider agencies (p. 75).
- DHS should identify topics that all personal care assistants need to understand. PCA agencies and service recipients should arrange for training in these topics, as needed (p. 87).

Report Summary

Personal care assistance (PCA) helps individuals living in non-institutional settings who are unable to care for themselves. It can include assistance with daily living activities, behavior issues, or other health-related tasks. Minnesota offers PCA as a benefit through several publicly funded health care programs. Most PCA services are funded by Medical Assistance, Minnesota's Medicaid program.

Total annual spending for Minnesota's PCA services exceeds $400 million.

The Minnesota Department of Human Services (DHS) has overall administrative responsibility for the state's health care programs. However, since the late 1980s, personal care provider agencies have played a major role in day-to-day administration of PCA services. In fiscal year 2008, over 500 provider agencies were paid to administer PCA services. These agencies are not required to have state licenses, and most are unlicensed.

PCA spending has grown significantly.

Between fiscal years 2002 and 2007, Minnesota's estimated total annual spending for PCA services grew from $153 million to just over $400 million. This represented growth of about 21 percent per year. The spending growth occurred because of increases in the number of recipients, not increases in spending per recipient. Possible reasons for growth in PCA use include the state's move away from institutional forms of care, limited amounts of other types of community-based services, and expansions of PCA eligibility and service options.

The state should provide more guidance to ensure that individuals have relatively equal access to PCA services.

There are large differences in the rates of PCA use among Minnesota counties. For example, the number of fee-for-service PCA recipients per 1,000 Medical Assistance-eligible persons with disabilities ranges from less than 50 in several counties to more than 300 in others. These differences suggest that residents have unequal access to PCA services.

Inconsistencies in assessment practices are one plausible reason for these differences. Counties differ in the extent to which they have assessed individuals as having certain disabilities, such as behavior issues. DHS provides voluntary training for assessors, but some assessors have not taken DHS's comprehensive or advanced courses. We recommend that the Legislature mandate minimum training levels for assessors.

Assessors need more state guidance for determining who should get PCA services and how much. DHS should start with guidance for assessing behavior issues, an area that accounts for some of the recent growth in PCA enrollment. Many assessment agencies would welcome additional guidance in this area, although some people believe the widespread use of PCA for behavior issues largely reflects the lack of better alternatives. Assessment guidelines should not be too rigid, given the need to take into account individual circumstances.

We also recommend that DHS periodically review samples of assessments. This would help ensure consistency in decisions that have large state fiscal impacts.

PCA services remain too vulnerable to fraud and abuse.

The Legislature should require PCA agencies to complete state training before they can provide services.

Improper payments for PCA services have been a significant problem.

DHS is responsible for ensuring the overall fiscal integrity of the state's publicly funded health care programs. There is not definitive information about the total amount and nature of improper payments for Minnesota's PCA services, but these services are unacceptably vulnerable to fraud and abuse.

Investigations of possible improper PCA payments consume a disproportionately large share of the state's Medicaid fraud investigation resources. Although PCA accounts for less than 10 percent of Minnesota's total Medicaid spending, PCA cases account for an estimated 65 percent of DHS fraud investigators' time and half of the Attorney General's Medicaid prosecutions. Nevertheless, most PCA fraud investigations have been narrow in scope, usually done in response to complaints and focusing on an individual caregiver or recipient. DHS should reallocate existing resources to conduct more PCA-related investigations, especially given the recent increase in the number of new PCA agencies.

DHS has taken some steps to address past problems with improper payments. For instance, DHS assigned unique numbers to PCA caregivers starting in 2005 to help identify implausible claims for payment. But, through 2008, DHS had not established controls to prevent payment for clearly inappropriate claims. For one month, we identified more than 400 cases in which DHS paid claims for personal care assistants who allegedly worked more than 24 hours in a day. There were also 152 cases in which caregivers reportedly worked consecutive 24-hour workdays. DHS's failure to prevent payment of these improper claims raises questions about its ability to detect less obvious problems.

In addition, PCA agencies have often provided services without the documentation required by the state for reimbursement. During on-site reviews of PCA agencies' records, we were unable to fully reconcile paid claims and timesheets for 23 percent of a sample of recipients. Also, 26 percent of a sample of recipient files did not have up-to-date care plans for the period of services we reviewed, and 28 percent lacked a current statement attesting to the recipient's medical need for services.

To help foster better compliance, DHS implemented a voluntary, three-day training program in January 2008 for key PCA agency staff. Through 2008, 31 percent of personal care provider agencies have had at least one staff person complete the training. We recommend that the Legislature mandate completion of this training by all PCA agencies. Also, clearer state policies about which PCA services will be covered by the state might improve agency compliance.

The state has not taken sufficient steps to ensure high quality services and protect vulnerable recipients.

The state has conducted one statewide survey of PCA recipients (in 2003). That survey indicated that most recipients rated their services as "excellent" or "good," and current recipients told us about the importance of PCA services in helping them lead fuller lives.

DHS has been working to develop a quality assurance system for a broad range of community-based services

There has been limited state review of provider agencies, and many personal care assistants lack sufficient supervision by professionals.

(including PCA), but it never completed a PCA quality assurance plan required by the Legislature in 2001. Despite the state's large investment in PCA services, there is little information on service outcomes or cost-effectiveness.

DHS started conducting quality assurance reviews of PCA agencies in 2006. But this program has had limited impact, due partly to inadequate staffing. Nearly all quality assurance reviews have been initiated by complaints, leaving little time for potentially valuable reviews of randomly selected agencies. Also, we saw little evidence of follow-up by quality assurance staff after initial reviews, contrary to DHS policy.

Ongoing supervision is another way to help ensure the quality of PCA services. Currently, Minnesota statutes have contradictory provisions about whether PCA services must be subject to professional supervision. In practice, however, DHS allows recipients to forgo this type of supervision. In fiscal year 2007, 22 percent of recipients had no paid supervision. Among recipients with paid supervision, one-third received an average of 30 minutes or less of paid supervision per month. In our view, supervision not only helps ensure that recipients are being well served but also provides accountability to the state. Thus, we recommend amending statutes to ensure that all Medical Assistance State Plan recipients have their PCA services professionally supervised.

There has been longstanding discussion about whether PCA agencies should be licensed by the state. In our view, implementing effective quality assurance reviews and supervision (in combination with some other recommendations in this report) would be a better use of scarce resources than requiring PCA agency licensure at this time.

State law's designation of which state and local agencies are responsible for investigating maltreatment allegations involving PCA agencies is overly complicated. We recommend that DHS be given sole responsibility to investigate allegations involving unlicensed agencies. Also, DHS should ensure that recipients have clearer information about whom to contact about maltreatment or other service-related concerns. Furthermore, many PCA agencies have not developed individual abuse prevention plans for adult recipients, contrary to statutory requirements, and DHS should monitor this.

Finally, many personal care assistants have minimal training and excessive work hours. Statutes do not require formal training for personal care assistants. We recommend that DHS more clearly define which topics must be addressed by PCA agencies and service recipients in their caregiver training. In addition, we found that about 25 percent of personal care assistant workweeks exceeded 40 hours, raising questions about the quality of care provided.

Introduction

Personal care assistance (PCA) is an important service for many low-income and disabled individuals in Minnesota. Effective services delivered to people in their homes can enable them to live independent, productive lives and avoid expensive institutional services. The Legislature has recognized this by authorizing personal care services as a benefit in some of the state's publicly funded health care programs.

But Minnesota, like other states, faces challenges in overseeing the delivery and quality of home-based services. With that in mind, we focused our evaluation on the "integrity" of personal care services by addressing the following questions:

- **Who uses PCA, and how does its use vary around the state? Have sufficient steps been taken to ensure a consistent, sound process for assessing potential service recipients?**
- **Has the state taken sufficient steps to prevent fraud, abuse, and other types of improper payments for PCA services?**
- **Does the state have effective ways of ensuring the quality of PCA services and protecting recipients from harm?**

We examined personal care services paid for by publicly funded health care programs, primarily Medical Assistance. These included services the state paid for on a "fee-for-service" basis, as well as those paid for through the state's payments to managed care organizations. We devoted more of our analysis to fee-for-service care because (1) it accounts for a significant majority of the state's PCA expenditures and (2) the state collects more data on services funded through fee-for-service than services funded through managed care.

We used several sources of data from the Minnesota Department of Human Services (DHS). To better understand recent trends, we analyzed the department's data on PCA recipients, services, and expenditures for fiscal years 2002 through 2007. We also used DHS data to analyze assessments of PCA recipients, training records of assessors and PCA agencies, and appeals filed by PCA recipients.

In addition, we examined the nature and scope of oversight provided by state agencies. We reviewed investigations of fraud and abuse conducted by DHS's Surveillance and Integrity Review Section, quality assurance reviews conducted by DHS's disability services staff, and cases prosecuted by the Minnesota Office of the Attorney General.

We also visited 26 PCA agencies, selected at random from agencies across the state. During these visits, we reviewed samples of recipient and employee files,

interviewed agency owners and administrators, and collected information on employee training and wages.

Finally, we talked with a wide variety of people to get perspectives on PCA services. We interviewed officials from the departments of Human Services and Health, service recipients and family members, disability advocates, managed care administrators, and county staff.

Our report offers some recommendations regarding the state's standards for personal care provider agencies. However, the 2008 Legislature required the Minnesota Department of Health to prepare recommendations on personal care provider standards by February 15, 2009, so we limited our analysis in this area.[1] Also, we did not evaluate the "Self-Directed Supports Option," a type of personal assistance authorized by the 2007 Legislature.[2]

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[1] *Laws of Minnesota* 2008, chapter 230, secs. 6 and 7.

[2] *Minnesota Statutes* 2008, 256B.0657. The self-directed supports option allows recipients to purchase services under an approved budget plan. The services can include PCA, as well as "items, related services, and supports, including assistive technology, that increase independence or substitute for human assistance" (subd. 6).

1 Background

Due to health concerns, some people need help caring for themselves. Assistance may be needed for short or long periods of time. Most long-term care in the U.S. is unpaid care provided informally by family, friends, and community members. For example, an adult child might help an aging parent grocery shop and prepare meals.

Government health care programs can provide assistance, too. Personal care assistance (PCA) services provided through government health care programs help certain individuals who are unable to fully care for themselves. PCA services may help people stay in their homes and communities, rather than spending time in hospitals or other institutional settings. Personal care assistants provide a range of services—from assistance with activities of daily living (such as eating, bathing, and dressing) to more specialized tasks (such as applying and maintaining prosthetics).

In this chapter, we provide an overview of PCA services. We examine federal and state regulations, how PCA services are administered, and how individuals access services. We also review trends in Minnesota spending for PCA services over the past several years.

PCA SERVICES

Minnesota offers PCA services as a benefit through several publicly funded health care programs, but the majority of PCA services are provided through Medical Assistance (the state's Medicaid program) and Medicaid waiver programs. Therefore, it is useful to review federal guidance for PCA services funded by Medicaid before examining how PCA services have been implemented in Minnesota.

Federal guidelines for Medicaid PCA are broad, giving states the ability to design services that meet their needs. To be eligible for Medicaid funding, personal care services must be: (1) authorized by a physician in accordance with a plan of treatment, or otherwise authorized in accordance with a service plan approved by the state; (2) provided by a qualified individual who is not a member of the individual's family; and (3) delivered to an individual at home or in another location.[1]

The U.S. Department of Health and Human Services (DHHS) has provided states with additional guidance on what "personal care services" includes and which

[1] *42 U.S. Code*, sec. 1396d(a)(24) (2008). Federal law also specifies that personal care services cannot be provided to an individual who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease.

family members can be compensated for providing the services. According to DHHS, personal care assistance may include:

> hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/her self. Such assistance most often relates to performance of ADLs [activities of daily living] and IADLs [instrumental activities of daily living]. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.[2]

DHHS also clarified that spouses of recipients and parents of minor recipients are family members who cannot be compensated by Medicaid for providing PCA services.[3] Other family members may be compensated for providing PCA services.[4]

Within federal guidelines, Minnesota offers a broad range of personal care assistance (PCA) services.

As Table 1.1 shows, PCA services in Minnesota fall into four categories: (1) activities of daily living; (2) instrumental activities of daily living; (3) health-related functions; and (4) redirection and intervention for behavior.[5] For example, a personal care assistant might remind a person to bathe, help her dress, or prepare a meal. PCA services may be delivered in a one-to-one ratio (i.e., one assistant and one recipient) or in a "shared care" arrangement. An example of shared care is two children in the same child care program receiving personal care assistance from the same person at the same time.[6]

In addition to PCA services that involve direct assistance to individuals at home or in their communities, Minnesota's publicly funded PCA activities include: (1) assessments of individuals' service needs and (2) supervision of personal care assistants by "qualified professionals." Assessments determine whether PCA is an appropriate service for enrollees in publicly funded health care programs—and, if so, the amount of personal care time needed.[7] Supervision by a qualified

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[2] U.S. Department of Health and Human Services, *State Medicaid Manual*, part 4, sec. 4480, part C.

[3] U.S. Department of Health and Human Services, *State Medicaid Manual*, part 4, sec. 4480, part D.

[4] *Ibid*. According to the *State Medicaid Manual*, family members are "legally responsible relatives." Thus, the enumeration of family members who may be compensated for providing care "will vary based on the responsibilities imposed under State law or under custody or guardianship arrangements."

[5] *Minnesota Statutes* 2008, 256B.0655, subds. 1a, 1d, 1e, and 2.

[6] "Shared care" may be provided in a one-to-two or one-to-three ratio. *Minnesota Statutes* 2008, 256B.0655, subd. 5(b) and (c).

[7] As described later, assessments generally are completed by public health nurses.

professional is an option available to recipients of PCA services.[8] The qualified professional's role is to help develop a care plan that addresses the recipient's needs, train the personal care assistant, and provide ongoing monitoring of the PCA services.

Table 1.1: Categories of Personal Care Assistance Services Authorized by Minnesota Law

Activities of Daily Living

- Eating
- Toileting
- Grooming
- Dressing
- Bathing
- Transferring[a]
- Mobility[b]
- Positioning[c]

Instrumental Activities of Daily Living[d]

- Meal planning and preparation
- Shopping for food, clothing, and other essential items
- Getting around and participating in the community
- Managing finances
- Performing essential household chores
- Communicating by telephone and other media

Health-Related Functions

- Functions that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care assistant

Redirection and Intervention for Behavior

- Includes observation and monitoring

[a] Transferring is the process of moving from one seating/reclining area or position to another.

[b] Mobility is the process of moving from one place to another, including with use of a wheelchair.

[c] Positioning is the process of moving a person's body for necessary care and comfort or to relieve any pressure areas.

[d] Personal care assistance services may be used for instrumental activities of daily living if a person has a need for assistance with one or more activities of daily living, health-related functions, or behavior.

SOURCES: *Minnesota Statutes* 2008, 256B.0655, subds. 1a, 1d, 1e, and 2.

Minnesota pays for PCA services on either a fee-for-service or managed care basis.

Minnesota pays for PCA services on either a fee-for-service or managed care basis, depending on the approach used to pay for an individual's overall public health care program benefits. Under fee-for-service, health care providers submit bills to the Department of Human Services (DHS) for reimbursement after

[8] A qualified professional is a registered nurse, mental health professional, or licensed social worker. Personal care assistants performing health-related functions must do so under the direction of a qualified professional or doctor. *Minnesota Statutes* 2008, 256B.0625, subd. 19c, and 256B.0655, subd. 2(e).

services have been provided. DHS pays for eligible costs, and there are no caps on the state's cumulative spending for fee-for-service health care.[9] In contrast, DHS pays managed care organizations at a predetermined, fixed rate that covers a wide variety of services. Managed care organizations administer the services on behalf of DHS, and they bear responsibility for enrollee costs that exceed the predetermined payment amounts. As we discuss in Chapter 2, most PCA recipients get services on a fee-for-service basis.[10]

ADMINISTRATION AND REGULATION

The Department of Human Services has overall administrative responsibility for publicly funded PCA services in Minnesota.

DHS has responsibility for the overall administration of the state's publicly funded health care programs. State law directs DHS to "plan and implement a unified, accountable, comprehensive health services system."[11] In addition to these broad responsibilities, the law assigns DHS some important duties that are specific to PCA services. Of particular note, the law requires DHS to (1) have an ongoing PCA audit process for potential fraud and abuse, (2) authorize PCA services before they are provided to recipients, and (3) establish a PCA quality assurance plan for the state.[12] The law also authorizes DHS to oversee service providers' compliance with PCA-related laws, rules, and policies.[13]

Prior to 1987, DHS played a fairly direct role in the day-to-day administration of Minnesota's PCA service delivery. For example, personal care assistants could submit bills directly to DHS, and DHS made direct payments to these caregivers. However,

- **Since the late 1980s, state law has authorized provider agencies to play a major role in the day-to-day administration of PCA services.**

The 1987 Legislature authorized DHS to select agencies to carry out detailed PCA administrative duties for the state. The law said that these agencies must "contract with or employ and train staff to provide and supervise the provision of personal care services."[14] Today, these agencies submit claims for services provided by their personal care assistants, and DHS makes payments for PCA services to these agencies.

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[9] As we discuss in Chapter 2, generally there is a cap on the fee-for-service dollar amount of PCA services an individual can receive.

[10] In Medical Assistance, seniors are required to receive services through managed care, while people with disabilities can choose between fee-for-service and managed care. One of Minnesota's managed care programs for people with disabilities—Special Needs Basic Care—does not cover PCA services.

[11] *Minnesota Statutes* 2008, 256B.04, subd. 1a.

[12] *Minnesota Statutes* 2008, 256B.0655, subds. 2(g), 4, and 9.

[13] *Minnesota Statutes* 2008, 256B.0655, subd. 10.

[14] *Laws of Minnesota* 1987, chapter 378, sec. 15.

Personal Care Provider Agencies

There are two varieties of PCA provider agencies: Personal Care Provider Organizations (PCPOs) and PCA Choice agencies.[15] The agencies' roles and responsibilities differ, as shown in Table 1.2. A recipient's responsibilities also differ, depending on the type of agency with which he or she chooses to work.

Table 1.2: Responsibilities of Personal Care Provider Agencies

	Personal Care Provider Organization	PCA Choice Agency	Recipient or Responsible Party
Staffing Responsibilities			
Recruit and hire personal care assistant and qualified professional	X		X
Enroll personal care assistant with the Department of Human Services	X	X	
Initiate criminal background check for personal care assistant	X	X	
Train the personal care assistant	X		X
Schedule personal care services	X		X
Provide for back-up assistant	X		X
Monitor personal care assistant and fire if necessary	X		X
Responsibilities Specific to Individual Recipients			
Verify recipient eligibility for public health benefits	X	X	
Obtain initial and annual Physician's Statement of Need	X	X	
Maintain care plan	X	X	
Notify county public health nurse when a new assessment is needed	X	X	
Implement and document responsible party requirements when recipient cannot direct his or her own care	X	X	
Maintain documentation of services	X	X	

NOTE: This list of responsibilities is not exhaustive. It highlights some of the distinctions between responsibilities of Personal Care Provider Organizations and PCA Choice agencies.

SOURCE: Department of Human Services, "Comparison Chart: Personal Care Provider Organization and PCA Choice Agency," January 2007; abridged by Office of the Legislative Auditor.

PCPOs have a fairly traditional employer-employee relationship with the personal care assistants they employ. PCPOs are responsible for recruiting, hiring, and training individuals to work as personal care assistants.[16] Additional responsibilities include monitoring assistants' work and firing them, if necessary. PCPOs also employ a qualified professional to provide supervision for recipients who elect it.

[15] Besides personal care provider agencies, DHS authorizes some other types of health care agencies to provide PCA services. For example, Medicare-certified home health agencies and private duty nursing agencies can provide PCA services. The agencies that provide direct PCA services have typically been nongovernmental organizations.

[16] A PCPO must hire a personal care assistant selected by a recipient as long as the person meets the organization's employment requirements.

In contrast, PCA Choice agencies have a more limited role. Recipients who opt for PCA Choice are selecting a more consumer-directed approach, in which the agency acts largely as a "fiscal intermediary." In essence, PCA Choice agencies share employment responsibilities with the recipients of PCA services. Recipients who choose to work with a PCA Choice agency are responsible for recruiting, training, monitoring, and firing their assistants. The recipients are also responsible for finding a qualified professional and scheduling supervision if they have chosen to receive qualified professional supervision. Recipients might elect PCA Choice for the greater control it affords them. In addition, the reduced administrative responsibilities of PCA Choice agencies might allow the agencies to provide higher compensation to personal care assistants than PCPOs can afford.

The two types of agencies have some responsibilities in common. Both are responsible for enrolling personal care assistants with DHS, initiating background checks, submitting claims to DHS for services and supervision, and paying personal care assistants and qualified professionals. In addition, PCPOs and PCA Choice agencies are required to: (1) verify a recipient's eligibility for publicly funded health care benefits monthly, (2) obtain and keep updated the Physician Statement of Need that asserts an individual's medical need for PCA services, and (3) maintain documentation of services on timesheet forms created or approved by DHS.

Regulation of PCA Providers

Over 39,000 personal care assistants provide PCA services in Minnesota.

Personal care provider agencies must meet certain state requirements before they can provide publicly funded PCA. For example, as listed in Table 1.3, agencies must demonstrate financial solvency and maintain a fidelity/dishonesty bond.[17] Table 1.3 also lists requirements for personal care assistants. For example, personal care assistants usually must be 18 or older and, consistent with federal law, cannot be the spouse of the recipient or a parent of a recipient who is a minor child.[18] Owners and managers of personal care provider agencies and personal care assistants must pass a criminal background check. Provider agencies and assistants that meet all of the requirements can be enrolled with DHS. As of the beginning of fiscal year 2008, over 39,000 personal care assistants were enrolled with and considered active by DHS.[19]

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[17] A fidelity/dishonesty bond covers work-related activities of employees who have access to a recipient's personal property. For example, it provides insurance against theft of a recipient's property by a personal care assistant.

[18] *Minnesota Statutes* 2008, 256B.0655, subd. 1f, and 256B.0625, subd. 19a. Individuals who are at least age 16 and have completed related job training or a certified home health aide competency evaluation may serve as personal care assistants.

[19] This count excludes personal care assistants who were only active with managed care organizations.

Although personal care providers must meet some state requirements, they are not required to obtain a state license.

Table 1.3: Selected Requirements for Personal Care Assistance Providers

Personal Care Assistants	
Must:	Must Not:
• Be at least age 18 (or at least 16 and completed a related training program or competency evaluation) • Have acquired through training or experience the necessary skills to provide personal care assistance • Be able to communicate with a recipient and deliver care consistent with the recipient's needs • Pass a criminal background check	• Be the recipient's spouse or parent of a recipient who is a minor • Be a recipient of personal care assistance • Be the recipient's responsible party
Personal Care Provider Agencies[a]	
Must:	
• Use generally accepted accounting principles • Demonstrate financial solvency • Be owned and managed by individuals who have passed a criminal background check • Maintain fidelity/dishonesty bond • Maintain liability insurance	

NOTE: Health care providers in general, and personal care assistance providers in particular, must meet many requirements. This table focuses on requirements for enrollment with the Department of Human Services as a personal care provider agency or personal care assistant.

[a] Personal care provider agencies employ personal care assistants. Agencies include Personal Care Provider Organizations and PCA Choice agencies. Some other types of health care providers, such as home health agencies and private duty nursing agencies, may also provide PCA. If they offer PCA, these agencies must meet the requirements for personal care provider agencies, in addition to any requirements specific to their agency type.

SOURCES: *Minnesota Statutes* 2008, 256B.0625, subd. 19a, and 256B.0655, subds. 1f and 1g; and *Minnesota Rules* 2008, 9505.0335, subd. 5.

State regulation of PCA provider agencies is fairly limited. Unlike many agencies that provide home care services in Minnesota,

- **State law currently exempts PCA agencies that provide Medicaid-funded services from licensure by the Minnesota Department of Health.**

The Minnesota Department of Health licenses many types of agencies that provide home care services. On several occasions, the Legislature has considered whether PCA provider agencies should be licensed by a state agency. However, the 2008 Legislature exempted all providers of Medicaid-funded PCA

services from licensure requirements, pending implementation of provider standards recommended by the Department of Health.[20]

Some agencies that provide PCA services have state licenses. For example, some home health agencies provide PCA services, and they are licensed by the Department of Health and certified by the federal government to provide Medicare services. But, while agencies must enroll with DHS to provide personal care services, they are not required to obtain a license.

In fiscal year 2007, unlicensed personal care provider agencies delivered over three-quarters of the state's fee-for-service PCA services. DHS paid 417 unlicensed personal care provider agencies $234 million for PCA services delivered in 2007. In contrast, DHS paid 78 licensed home health agencies just over $41 million for PCA services that year.

INDIVIDUAL ELIGIBILITY AND ACCESS

Minnesota is one of 36 states that offer personal care services as a standard benefit for Medicaid recipients.

To receive PCA services in Minnesota, an individual must be eligible for one of the government-funded health care programs that include these services as a benefit and meet additional eligibility criteria specific to PCA. Table 1.4 lists Minnesota's health care programs that include PCA and general information about the programs' eligibility requirements. For example, Medical Assistance (MA) is a health care program funded by the federal and state governments that provides health care to low-income families, children, pregnant women, and people who are elderly or disabled. Eligibility for MA is based on income, residency, and citizenship status. Since 1977, Minnesota has included PCA services as a standard benefit in its MA State Plan, and it is one of 36 states that do so.[21]

Individuals who are eligible for a Medicaid Home and Community-Based Services waiver program can access extra quantities of PCA services beyond those provided as a standard benefit through the MA State Plan. For these waiver programs, the U.S. Department of Health and Human Services waives certain requirements that apply to state plans, allowing states to provide benefits unavailable to the Medicaid population as a whole to individuals who meet eligibility criteria for care in an institutional setting.[22] For example, individuals

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[20] *Laws of Minnesota* 2008, chapter 230, secs. 6 and 7, codified in *Minnesota Statutes* 2008, 144A.46, subds. 1 and 2. The Legislature required the department to make recommendations in consultation with DHS by February 15, 2009. We discuss the issue of PCA provider agency licensure further in Chapter 5.

[21] For states offering personal care assistance, see: U.S. Department of Health and Human Services, *Medicaid At-a-Glance 2005: A Medicaid Information Source* (Washington, DC, 2005), 10. The federal government requires that states include certain benefits in their Medicaid state plan, but it also gives states the option of including others. Since the mid-1970s, the federal government has allowed states to offer personal care assistance as an optional benefit under their Medicaid state plan.

[22] Home and Community-Based Services waiver programs provide an alternative to institutional care. Therefore, an individual must have health needs that would qualify them for care in an institutional setting in order to be eligible for one of these waiver programs.

Table 1.4: Minnesota Health Care Programs Offering Personal Care Assistance Services

Program	To be Eligible, Individuals Must:
MEDICAL ASSISTANCE (MA)	• Meet income and asset limits • Be a Minnesota resident • Be a U.S. citizen or qualified noncitizen • Be under age 21, a parent of a minor child, pregnant, age 65 or older, or blind or disabled
MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVERS	
Community Alternative Care Waiver	• Be MA-eligible • Need hospital level of care • Be disabled • Be chronically ill/medically fragile • Be under age 65
Community Alternatives for Disabled Individuals Waiver	• Be MA-eligible • Need nursing facility level of care • Be disabled • Be under age 65
Developmentally Disabled Waiver	• Be MA-eligible based on disability diagnosis • Need intermediate care facility for persons with mental retardation level of care • Be diagnosed with mental retardation or a related condition
Elderly Waiver	• Be MA-eligible • Need nursing facility level of care • Be age 65 or older
Traumatic Brain Injury Waiver	• Be MA-eligible • Need specialized nursing facility or neurobehavioral hospital level of care • Be diagnosed with traumatic or acquired brain injury • Experience significant behavior and cognitive deficits related to injury • Be under age 65
MINNESOTACARE	• Meet income limits (higher than under MA) • Be a Minnesota resident • Be a U.S. citizen or qualified noncitizen • Have no health insurance or Medicare for four months • Be younger than age 21 or pregnant[a]
ALTERNATIVE CARE	• Have insufficient income and assets for more than 135 days of nursing home care • Need nursing facility level of care • Be age 65 or older

NOTE: To receive personal care assistance (PCA), individuals must meet specific criteria for PCA in addition to the program eligibility criteria. For PCA, individuals must: (1) be in stable health, (2) be able to direct their own care (or have a responsible party who can), and (3) have a medical need for services.

[a] In the MinnesotaCare program, PCA is available only to persons under age 21 and women who are pregnant. There are no asset limits for these participants.

SOURCES: Department of Human Services, *Disability Services Program Manual*, "Waivers;" Department of Human Services, "Minnesota Health Care Programs," July 2008; Department of Human Services, "Alternative Care Program," February 2008; and Department of Human Services, *Personal Care Assistance (PCA) Program Consumer Guidebook* (St. Paul, May 2007), 7-9.

in the Elderly Waiver program must qualify for MA, need a level of care that would otherwise be provided in a nursing facility, and be age 65 or older. Most states offer personal care assistance services through at least one waiver program.

Finally, Minnesota has chosen to offer PCA services through MinnesotaCare and Alternative Care. PCA through MinnesotaCare is available only to pregnant women and children. The Alternative Care program is for elderly individuals whose income and assets are too high to qualify for MA.

Individuals who meet health care program eligibility criteria must meet additional conditions before receiving PCA. Individuals must: (1) be in stable health, (2) be able to direct their own care (or have a responsible party who can direct their care), and (3) have a medical need for services. Figure 1.1 illustrates the process Minnesota follows to determine whether fee-for-service recipients in the MA State Plan meet these conditions.

To receive PCA services, individuals must have documentation of their medical need for these services.

The first step in accessing PCA is an independent assessment of a person's eligibility and need for services. Most PCA assessments are conducted by public health nurses (PHNs). Assessments are available to all MA individuals upon request and are required at least annually for people already receiving PCA services.[23] The initial assessment is completed face-to-face, generally in a potential recipient's home.[24] During an assessment, the nurse (1) documents the person's health status, (2) makes a judgment about the person's ability to direct his or her care, and (3) determines whether the individual needs assistance in the four categories shown in Table 1.1.

If the nurse determines that a person cannot direct his or her own care, a "responsible party" must be present during the assessment. Responsible parties participate in decisions about and supervision of PCA services for recipients who are unable to fulfill these responsibilities.[25] If, after the assessment, the PHN concludes that the individual needs assistance, the nurse determines an appropriate amount of time to fulfill the individual's needs.[26]

The PHN also explains four choices that the recipient or responsible party must make. First, the recipient must decide whether supervision of the personal care assistant will be done by the recipient/responsible party or a qualified professional.[27] Second, the PHN explains the difference between a traditional Personal Care Provider Organization and a PCA Choice agency, and the

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[23] *Minnesota Statutes* 2008, 256B.0655, subd. 1b.

[24] An initial assessment can be completed in a nursing home or hospital in anticipation of a person's release from the institution, but PCA services cannot be delivered in these settings. Assessments of PCA recipients are repeated when there is a change in condition and at least annually. Not all follow-up assessments must be conducted face-to-face.

[25] If a responsible party is not present, the nurse must stop the assessment.

[26] Assessors recommend the number of minutes of assistance a person needs. For example, an assessor might determine that a person needs 10 minutes of assistance per day to bathe.

[27] As noted earlier, a qualified professional is a registered nurse, mental health professional, or licensed social worker.

Figure 1.1: Process for Accessing Personal Care Services

ASSESSMENT

County Public Health Nurse (PHN) conducts an independent assessment.
An assessment of an individual includes:
- documentation of health status and
- determination of need for personal care assistance.

PHN determines the person's ability to direct care.
If person is incapable of directing his or her own care, a responsible party must be designated. The responsible party must be present during the assessment.

The recipient or responsible party decides:
- if he or she will supervise the personal care assistant or whether a qualified professional will supervise the services;
- whether to work with a traditional Personal Care Provider Organization or a PCA Choice agency;
- whether "flexible use" of personal care assistance services would best meet his or her needs; and
- with the PHN, whether "shared care" is appropriate.

↓

SERVICE PLAN

PHN develops a service plan.
The service plan:
- summarizes the assessment results about the need for care;
- documents the decisions the recipient or responsible party has made regarding supervision, flexible use, shared care, and provider agency; and
- drives the care plan (see below).

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SERVICE AGREEMENT

The Department of Human Services (DHS) authorizes services.
DHS sends a service agreement to the recipient and provider agency indicating the amount of personal care assistance and supervision authorized by the department.

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PHYSICIAN STATEMENT OF NEED

The provider agency obtains a statement of "medical necessity."
The provider agency obtains the physician statement of need from a physician, physician's assistant, or nurse practitioner. The statement asserts that personal care assistance services are medically necessary.

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CARE PLAN

Relevant parties develop a care plan.
The recipient or responsible party must be involved in developing the care plan. Other relevant parties may include:
- the provider agency,
- personal care assistant, and
- qualified professional (if applicable) or physician.

A care plan specifies the types and schedule of services that the assistant will provide and is based on the service plan (see above).

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The personal care assistant provides services consistent with the care plan.

NOTE: This figure shows the process for accessing personal care assistance services provided on a fee-for-service basis through Minnesota's Medical Assistance State Plan.

SOURCE: Office of the Legislative Auditor.

recipient chooses an agency with which to work from among those enrolled with DHS. Third, the recipient indicates a preference for standard or "flexible use" of the assessed PCA time. PCA time is generally authorized through service agreements lasting one year.[28] Standard use is a fairly equal distribution of PCA services over the course of the service agreement, while flexible use allows recipients to vary their PCA use within six-month time periods. For example, flexible use would allow a school-aged child to receive more PCA during the summer months, and less during the school year. Finally, the recipient and PHN determine whether services should be provided one-to-one or through shared care.

Assessments by public health nurses play a key role in determining the PCA services individuals will receive.

The assessment results in a "service plan" and a "service agreement." The service plan includes the nurse's recommendation for the amount of PCA time and qualified professional supervision needed, and it records the individual's decisions in the four areas described above. DHS directs the public health nurse to send a copy of the service plan to the recipient and the personal care provider agency with which the recipient has chosen to work.[29] The service agreement documents DHS's authorization of a certain amount of PCA time and supervision. Until 1997, DHS had nurse consultants review PCA assessments and decide how many hours of services should be authorized. Since then, however, DHS has typically authorized services without second-guessing assessors' judgments.

After the assessment, the recipient arranges for services with the chosen PCA agency. It is the agency's responsibility to obtain a statement from a medical professional that services are medically necessary. The statement must be made using a form created by DHS called the "physician statement of need."[30] The agency also works with the recipient to develop a care plan that outlines the specific services that the personal care assistant will provide. The care plan and physician statement of need must be updated at least annually.[31]

The process for managed care recipients is quite similar to the process by which fee-for-service recipients access services. The main difference is that managed care organizations—not DHS—authorize PCA services for managed care enrollees. Managed care organizations may authorize different amounts of service than those recommended by the assessor. However, DHS has directed

[28] Authorizations can cover shorter periods of time.

[29] As we discuss in Chapter 4, some personal care provider agencies have said that they do not receive copies of service plans. Service plans contain important information about recipients' needs for PCA and are useful when developing care plans.

[30] A physician, physician's assistant, or nurse practitioner determines whether PCA services are medically necessary.

[31] Department of Human Services, *MHCP Provider Manual*, Chapter 24, and *Minnesota Statutes* 2008, 256B.0625, subd. 19c.

managed care organizations to clearly document and explain differences in the assessed and authorized service amounts in the recipient's service plan.[32]

Since Minnesota first authorized PCA services in the 1970s, there have been many changes in the regulations that govern them. We found that:

- **Changes in Minnesota laws and rules have broadened PCA eligibility, access, and consumer choice.**

Minnesota's PCA services are quite different now from when they were first authorized in the 1970s.

Some changes expanded the population of individuals eligible to receive PCA services. Initially, PCA services in Minnesota were restricted to people with physical disabilities who could direct their own care. Definitions of "responsible party" were enacted in state rules in 1987 and in state law in 1992, thus authorizing PCA services for people who could not direct their own care.[33] In 1991, the Legislature authorized the use of PCA services for behavior-related problems.[34]

In addition, some changes may have broadened the appeal of PCA services to persons who would not have used them previously. For instance, in the early years of Minnesota's PCA program, family members were not allowed to provide PCA services.[35] In 1991, the Legislature placed criteria in statute for DHS-authorized "hardship waivers," which allowed certain family members to provide PCA services.[36] For potential recipients who preferred care provided by a relative, this statutory change authorized an alternative approach. In 2003, the Legislature repealed the requirement for hardship waivers, making it easier for certain family members to serve as personal care assistants.[37] The 2003

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[32] Department of Human Services, *Clarification of Policy for Personal Care Assistant (PCA) Services for Managed Care Enrollees*, Bulletin #08-25-06 (September 2, 2008), 4, 6-7. In addition, managed care organizations must give an individual a notice of denial, termination, or reduction that outlines the individual's right to appeal the authorized amount when it is different from the assessed amount.

[33] *Minnesota Rules* 9505.0335, subp. 1, adopted October 5, 1987, and *Laws of Minnesota* 1992, chapter 391, sec. 3.

[34] *Laws of Minnesota* 1991, chapter 292, art. 4, sec. 12, authorized PCA for people exhibiting "complex behavior" on a daily basis. This included self-injurious behavior, unusual or repetitious habits, withdrawal behavior, hurtful behavior to others, socially offensive behavior, destruction of property, or a need for constant one-on-one supervision for self-preservation. Also, *Laws of Minnesota* 1993, First Special Session, chapter 1, art. 5, sec. 52, added "redirection and intervention for behavior" to Minnesota law's list of PCA services eligible for payment.

[35] *Laws of Minnesota* 1977, chapter 453, sec. 2, subd. 3, limited personal care assistants to non-family members, reflecting a federal prohibition on the use of Medicaid funds for caregivers who were family members of recipients.

[36] *Laws of Minnesota* 1991, chapter 292, art. 7, sec. 12.

[37] *Laws of Minnesota* First Special Session 2003, chapter 14, art. 3, sec. 27. This repealed the statute that had prohibited provision of PCA services without a waiver by (1) parents of adult recipients, (2) adult children of recipients, or (3) siblings of recipients.

Legislature also gave recipients the option of naming a responsible party who did not live with the recipient; previously, this was not allowed.[38]

The Legislature has also made many changes that increase consumer choices. Most notably, the 1999 Legislature authorized PCA Choice agencies as alternatives to PCPOs.[39] As noted earlier, working with a PCA Choice agency allows recipients to fulfill many responsibilities that would otherwise be performed by traditional provider agencies. For example, recipients under PCA Choice recruit, monitor, and fire their own personal care assistants. In addition, the 1999 Legislature authorized the flexible use of authorized PCA hours.[40]

SPENDING

We examined how Minnesota's total spending for PCA has changed over time and how Minnesota's spending compares with that of other states. We found that:

- **Minnesota's expenditures for personal care services increased by an estimated 164 percent between fiscal years 2002 and 2007.**

Minnesota spent over $400 million for PCA services in fiscal year 2007.

As Figure 1.2 shows, we estimated that Minnesota spent just over $400 million for PCA services in fiscal year 2007, up from $153 million in 2002.[41] This represents growth of roughly 21 percent per year.

There was significant growth in both the managed care and fee-for-service components of overall PCA spending. Managed care costs for PCA grew at an annual rate of 35 percent between 2001 and 2007 (from $15 million to $92 million). However, the majority of PCA spending growth occurred in the fee-for-service area. Minnesota spent almost $316 million on fee-for-service PCA delivered in fiscal year 2007, up from $135 million in 2002. This $181 million increase in spending represented growth of over 18 percent a year, although rates of increase were lower in 2006 and 2007 than in earlier years.[42]

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[38] *Laws of Minnesota* First Special Session 2003, chapter 14, art. 3, sec. 26.

[39] *Laws of Minnesota* 1999, chapter 245, art. 4, sec. 56.

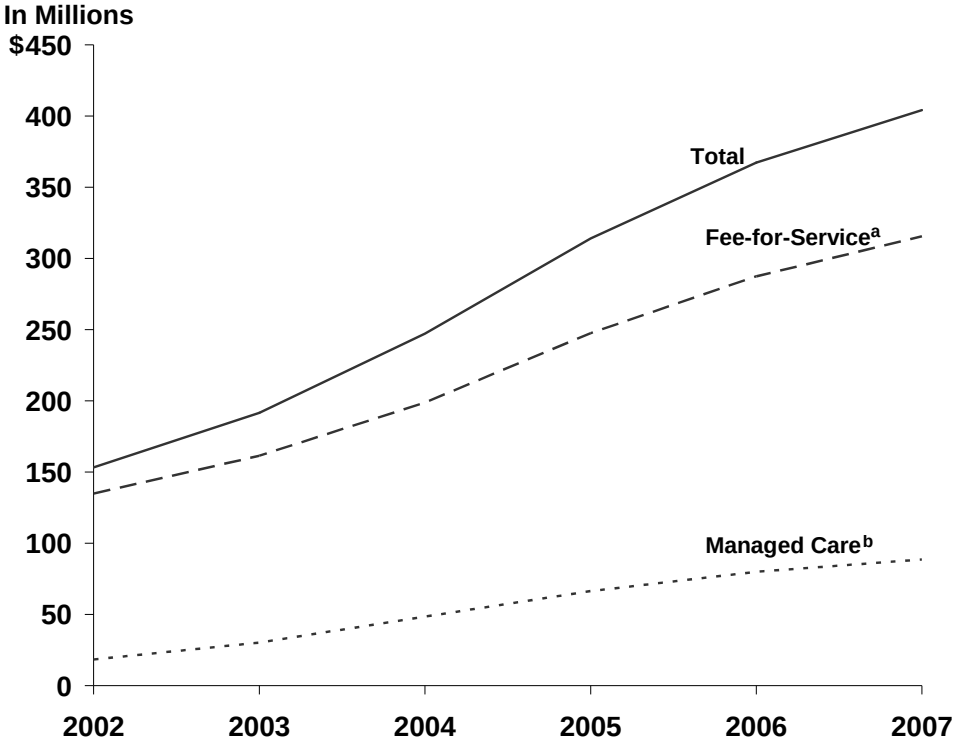
[40] *Laws of Minnesota* 1999, chapter 245, art. 4, sec. 55.

[41] Our spending estimates do not include expenditures by Minnesota's three county-based purchasing organizations, due to incomplete data. In calendar year 2007, two of these organizations spent a total of $1.63 million on PCA services; the county-based purchasing organization serving the largest number of counties (South Country Health Alliance) was unable to provide us with comparable data in a timely manner. The managed care fiscal year figures are estimates based on calendar year data. The data reflect spending funded by MA and MinnesotaCare. However, spending for Minnesota Disability Health Options, a managed care program for certain people with disabilities, is excluded.

[42] Data include fee-for-service PCA delivered through all of Minnesota's publicly funded health care programs, not just Medicaid. Costs reflect PCA services, assessments, and qualified professional supervision. The federal government pays for half of Minnesota's Medicaid costs.

Between 2002 and 2007, Minnesota's total spending on PCA services increased by about $250 million.

Figure 1.2: Minnesota Spending on Personal Care Assistance, Fiscal Years 2002-07



[a] Fee-for-service data reflect spending for personal care services delivered in each fiscal year.

[b] Fiscal year spending through managed care is an estimate based on calendar year data.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data and Minnesota Council of Health Plans data.

Between 2002 and 2007, most fee-for-service PCA spending was for services to MA State Plan and Medicaid waiver participants. Growth in spending for these participants appears to be related to an increase in the number of persons receiving care, while service use per recipient decreased. The decline in service use per recipient was particularly pronounced for MA State Plan participants.[43] As Table 1.5 shows, the number of MA State Plan recipients of PCA services increased by 170 percent between 2002 and 2007, while PCA units of service per recipient decreased by almost 14 percent.

[43] We defined "MA State Plan participants" as individuals who received PCA during the year only as state plan participants. They do not include individuals who participated in a waiver program for any part of the year. For this analysis, we also excluded individuals who were assessed for services but did not receive a service agreement for PCA services.

While Minnesota's number of PCA recipients has increased, cost per recipient has declined.

Table 1.5: PCA Spending, Medical Assistance State Plan Participants, Fiscal Years 2002-07

Year	Recipients[a]	Spending[b]	Spending Per Recipient	Units Per Recipient[c]
2002	4,314	$ 88,343,222	$20,478	5,594
2003	5,120	102,377,352	19,996	5,292
2004	7,047	129,962,476	18,442	4,876
2005	8,926	169,337,648	18,971	5,023
2006	10,425	198,373,911	19,029	4,984
2007	11,652	219,221,808	18,814	4,822
Percentage change	170%	148%	-8%	-14%

NOTE: Table includes fee-for-service spending only.

[a] Recipients include nonwaiver recipients of MA State Plan personal care assistance who had a service agreement with the Department of Human Services that included direct services and/or qualified professional supervision.

[b] Spending includes personal care assistance, assessment for PCA needs, and qualified professional supervision.

[c] Units reflect only direct PCA services, not assessments or qualified professional supervision. One unit of PCA equals 15 minutes.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

Recent growth in PCA expenditures could be related to the changes in program eligibility and access discussed in the previous section, but it could also be related to Minnesota's efforts to deinstitutionalize services for MA recipients. For instance, from fiscal years 2002 to 2007, Minnesota's average monthly number of MA recipients in nursing facilities declined by 18 percent, and its average monthly number of MA recipients in intermediate care facilities for people with mental retardation declined by 25 percent. In addition, Minnesota downsized several regional treatment centers in recent years, and "Rule 36" facilities for adults with mental illness have been limited to 90-day stays since 2001.[44] Also, enrollment limitations or reductions in some types of community-based services—such as Medicaid waiver programs—may have contributed to increased reliance on PCA services.[45]

[44] In Minnesota, community-based residential facilities for adults with mental illness have commonly been called "Rule 36" facilities.

[45] For example, a 2008 DHS report showed 4,893 people on waiting lists for services through Minnesota's Developmental Disabilities Waiver. Nearly 1,300 of these people were receiving home care services (such as PCA) while waiting for waiver services, although PCA is also a service people can receive once they qualify for waiver services. See Department of Human Services, *Annual Report on the Use and Availability of Home and Community-Based Waivers for Persons with Disabilities* (St. Paul, February 2008), 21-22.

Other states have also been transitioning many Medicaid recipients from institutional services to community-based services.[46] We examined Minnesota's ranking among states on several recent measures of PCA spending and found that:

- **Minnesota's Medicaid spending for PCA services has been higher than that of most states.**

As shown in Table 1.6, Minnesota spent 5 percent of its MA State Plan dollars on PCA services in 2007, more than twice the median of other states with PCA expenditures under their state plans.[47] Minnesota also had per capita and per recipient PCA expenditures well above the national medians. Among the 12 states that spent more than $100 million for Medicaid state plan personal care services in fiscal year 2002, Minnesota had the largest 2002-07 growth rate in these expenditures.

Table 1.6: Minnesota's Rank Among States on Medicaid Personal Care Expenditures

Measures of Personal Care Spending	Minnesota	Median	Minnesota Rank
Personal Care Spending, as a Percentage of Total Medicaid Spending, 2007	5.1%	2.3%	7 out of 35
Personal Care Spending per Capita, 2007	$60.44	$23.41	7 out of 35
Personal Care Spending per Participant, 2004	$14,620	$5,968	6 out of 30

NOTES: Measures are based on Medicaid state plan expenditures for fee-for-service health care. For each measure, a ranking of 1 represented the state with the highest spending or percentage. The 2007 measures are from the Thomson Reuters Healthcare report; the 2004 data are from the Kaiser report.

SOURCES: Office of the Legislative Auditor, analysis of Brian Burwell, Kate Sredl, and Steve Eiken, *Medicaid Long-Term Care Expenditures in FY 2007* (Thomas Reuters Healthcare, September 26, 2008); and Kaiser Commission on Medicaid and the Uninsured, *Medicaid Home and Community-Based Service Programs: Data Update* (Washington, DC, December 2007).

[46] One impetus toward deinstitutionalization was a 1999 U.S. Supreme Court decision (Olmstead v. L.C. [98-536] 527 U.S. 581 [1999]) that required states to provide community-based services to people with mental disabilities when (1) the state's treatment professionals recommend this, (2) the affected persons do not oppose this, and (3) the placement can be reasonably accommodated.

[47] Minnesota's PCA spending as a percentage of total Medicaid state plan spending (5.1 percent) ranked behind California, New Mexico, Alaska, New York, Washington, and Nevada. More generally, Minnesota ranks high among states in the percentage of Medicaid long-term care dollars spent on community-based services, rather than institutional care. For example, Minnesota spent 63 percent of its Medicaid long-term care dollars on community-based services in 2007, which was fourth highest among the 50 states.

2 Recipient Characteristics, PCA Use, and Assessment

As discussed in Chapter 1, Minnesota's spending on personal care assistance (PCA) services increased greatly over the past several years. This spending growth resulted largely from increases in the number of PCA recipients, not from increases in the amount of services used per person.

In this chapter, we present information on the growth in the number of people receiving PCA services, their characteristics, and their choices about the personal care services they receive. We examine how PCA use varies around the state, giving particular attention to one possible explanation for this variation—assessment practices—over which the state has some influence.

RECIPIENT CHARACTERISTICS AND PCA USE

Personal care services address the diverse service needs of a wide variety of individuals. Before looking at the characteristics of users and their services in detail, we begin with two observations about Minnesota's overall use of PCA services:

- **About 25,000 people—or about 1 of every 200 Minnesotans—received publicly funded PCA services in calendar year 2007.**
- **There was large growth in the number of Minnesotans who received PCA services in the past several years.**

Most recipients obtain personal care services through fee-for-service rather than managed care.

As we noted in Chapter 1, the Minnesota Department of Human Services (DHS) pays for health care services in two main ways: (1) on a fee-for-service basis, or (2) through payments to a managed care organization. In calendar year 2007, about 71 percent of PCA recipients were served through a fee-for-service approach, and the rest were served through managed care.[1]

Our analysis of DHS Medical Assistance (MA) data showed that the number of fee-for-service PCA recipients grew by 124 percent between fiscal years 2002 and 2007.[2] This included 170 percent growth in the number of persons receiving

[1] An undetermined number of PCA recipients receive services through both fee-for-service and managed care.

[2] These numbers exclude recipients who were assessed for services but did not receive a service agreement for PCA during the fiscal year.

PCA services under the MA State Plan, as well as 60 percent growth in the number of waiver participants receiving PCA.[3]

In addition, a recent DHS analysis indicated that the size of Minnesota's managed care PCA population grew by an even larger percentage over a similar period.[4] Between calendar years 2002 and 2007, the number of managed care participants receiving PCA grew by 270 percent, with seniors accounting for three-fourths of this growth.

The number of people receiving personal care assistance (PCA) services has grown much more quickly than Minnesota's population overall.

These increases in PCA enrollment occurred during a time when there was a more modest increase in Minnesota's total population, including its numbers of seniors and MA recipients.[5] It is likely that the number of people needing PCA services will increase in coming years as Minnesota's population ages. The state demographer projects that the size of Minnesota's population age 65 and older will increase by 92 percent between 2010 and 2030.

Characteristics

The fee-for-service and managed care PCA populations showed two notable differences in 2007. First, PCA recipients served by managed care tended to be older than PCA recipients served by fee-for-service care. About 76 percent of the PCA recipients served by managed care were age 65 or older, compared with just 10 percent of the PCA recipients in fee-for-service care.[6] Second, the average PCA recipient in managed care tended to receive fewer hours of PCA services than the average fee-for-service PCA recipient.[7] DHS staff believe this reflected a greater predominance of people with serious disabilities in the fee-for-service population than in the managed care population.

The rest of this section focuses on the characteristics of the Medicaid fee-for-service PCA population. Table 2.1 summarizes the characteristics of this population overall plus its two components: (1) MA State Plan participants and (2) Medicaid waiver program participants. In general, MA State Plan PCA recipients were more likely than PCA recipients in a waiver program to be children (41 percent vs. 22 percent), nonwhite (50 percent vs. 22 percent), and residents of the Twin Cities metropolitan area (63 percent vs. 50 percent).

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[3] Chapter 1 explained the difference between the MA State Plan and waivers. We defined "MA State Plan recipients" as individuals who received PCA only as state plan participants. They do not include individuals who participated in a waiver program for any part of the year.

[4] Vicki Kunerth, Director, DHS Performance Measurement and Quality Improvement, memorandum to Joel Alter, Office of the Legislative Auditor, and Anne Henry, Minnesota Disability Law Center, *Data on PCAs and Home Health Aides Services to MHCP*, October 2, 2008.

[5] Minnesota's total population increased by less than 5 percent between 2002 and 2007. The state's number of seniors increased by 15 percent during this period, and the number of MA-eligible persons increased by 25 percent.

[6] The percentage of all fee-for-service PCA recipients age 65 or older (10 percent) is somewhat higher than the percentage of MA-funded fee-for-service recipients age 65 or older (7 percent, as shown in Table 2.1).

[7] An analysis by DHS indicated that the average fee-for-service PCA recipient received about 105 hours of service per month, compared with 73 hours per month for the average managed care recipient.

Table 2.1: Characteristics of Medicaid Fee-for-Service Personal Care Assistance Recipients, Fiscal Year 2007

	All Recipients		PCA Recipients in Medical Assistance State Plan[a]		PCA Recipients in Waiver Programs	
	Number	Percentage	Number	Percentage	Number	Percentage
Age						
5 years old or younger	1,312	8.0%	1,168	10.0%	144	3.0%
6 to 17 years old	4,519	27.4	3,594	30.8	925	19.1
18 to 22 years old	1,003	6.1	669	5.7	334	6.9
23 to 64 years old	8,458	51.3	5,621	48.2	2,837	58.5
65 years old or older	1,208	7.3	599	5.1	609	12.6
Total	16,500		11,651		4,849	
Sex						
Female	8,448	51.2	5,675	48.7	2,773	57.2
Male	8,053	48.8	5,977	51.3	2,076	42.8
Total	16,501		11,652		4,849	
Race						
White	9,042	58.5	5,420	50.2	3,622	77.7
Black or African American	3,954	25.6	3,273	30.3	681	14.6
Asian	1,542	10.0	1,360	12.6	182	3.9
Other[b]	930	6.0	752	7.0	178	3.8
Total	15,468		10,805		4,663	
Interpreter Needed						
No	14,016	86.7	9,454	83.2	4,562	95.0
Yes	2,148	13.3	1,908	16.8	240	5.0
Total	16,164		11,362		4,802	
Residence						
Twin Cities Metropolitan Area	9,767	59.3	7,335	63.0	2,432	50.4
Central	1,786	10.8	1,163	10.0	623	12.9
Northeast	1,262	7.7	896	7.7	366	7.6
Northwest	1,955	11.9	1,374	11.8	581	12.0
Southeast	903	5.5	448	3.8	455	9.4
Southwest	795	4.8	424	3.6	371	7.7
Total	16,468		11,640		4,828	

NOTES: Includes recipients of PCA direct services or supervision. For most characteristics, some recipients were missing information. Missing values are not included in the totals, so totals vary by characteristic. Overall, there were 16,501 recipients in 2007: 11,652 State Plan recipients and 4,849 waiver recipients.

[a] Includes recipients who received PCA services as a participant in the Medical Assistance State Plan, not a Medicaid waiver program.

[b] Includes American Indians, Alaskan Natives, Pacific Islanders, and Native Hawaiians.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

Recipients of PCA services have a wide range of disabilities. The most frequent categories of diagnoses cited in fiscal year 2007 assessments of MA State Plan PCA recipients were various types of mental disorders, such as attention deficit disorder; autism; and schizophrenic, bipolar, manic, and depressive disorders. Diabetes, infantile cerebral palsy, and “other paralytic syndromes” (such as

paraplegia and quadriplegia) were other categories of diagnoses among those most commonly cited.[8]

We also examined the "home care rating" that is the result of each MA State Plan recipient's assessment for PCA services. The rating is based on an individual's need for assistance with activities of daily living, behavior issues, and complex medical needs. Among fiscal year 2007 State Plan PCA recipients, 56 percent had a home care rating that indicated the presence of behavior issues.[9] The proportion of recipients with behavior issues varied considerably by age. In 2007, 79 percent of recipients under the age of 18 had a behavior-related home care rating, compared with 40 percent of recipients age 18 or older.

Figure 2.1 highlights changes that occurred in the composition of the MA State Plan PCA population in recent years. In particular,

- **Between fiscal years 2002 and 2007, there were sizable increases in the percentage of MA State Plan PCA recipients who had behavior issues or lived outside the Twin Cities metropolitan area.**

A majority of fee-for-service PCA recipients have behavior-related issues.

Recipients assessed as having behavior issues now account for a larger share of the PCA population than they did several years ago. Among fee-for-service recipients served under the MA State Plan, the percentage of recipients with behavior issues grew from 42 to 56 percent between fiscal years 2002 and 2007.

In addition, there has been a shift in the geographic distribution of PCA recipients served under the MA State Plan. The percentage of State Plan recipients living outside the seven-county Twin Cities area increased from 27 percent in fiscal year 2002 to 37 percent in 2007. The number of Twin Cities PCA recipients grew significantly during this period, but the number of outstate recipients grew even faster (especially in northern Minnesota). Later in this chapter, we discuss inter-county variation in service use in more detail.

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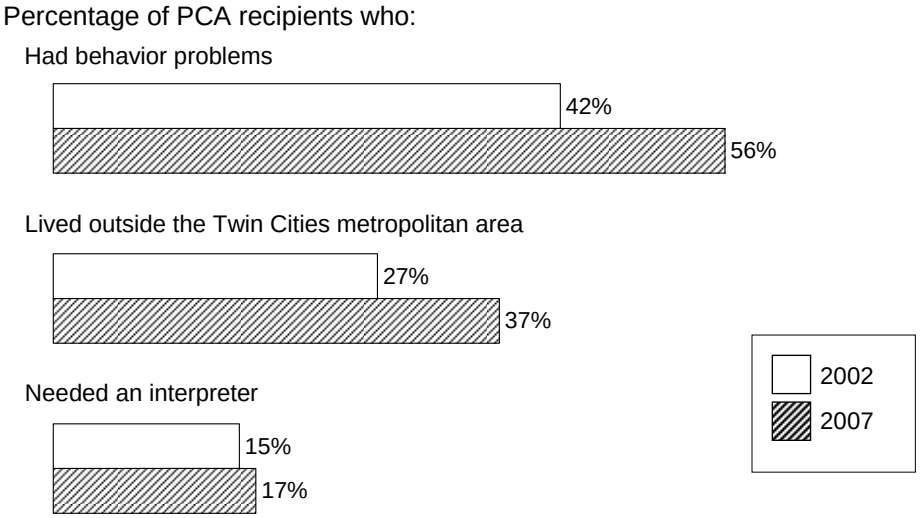
[8] Diagnoses categories reflect the U.S. Department of Health and Human Services ICD-9-CM codes for October 2007 through September 2008, as published in: Ingenix, *ICD-9-CM Expert for Hospitals Volumes 1, 2, and 3: International Classification of Diseases, 9th Revision, Clinical Modification, Sixth Edition* (2007). During an assessment for MA State Plan PCA, a nurse indicates up to three diagnoses for the individual being assessed. We counted only the most recent assessment for individuals who received multiple assessments related to their 2007 use of PCA services. The diagnoses might be self-reported by the individual or based on the nurse's previous experience with the individual. Nurses are not required to indicate more than one diagnosis, even if more than one has been made. Our analysis included all diagnoses categories indicated for each individual, but it did not count multiple diagnoses from within the same category. For example, a person diagnosed with both "expressive language disorder" and "unspecified delay in development" was counted only once in the category "specific delays in development."

[9] For the most part, individuals with behavior issues included those whose assessments for State Plan PCA services indicated a regional treatment center level of care or Level I or Level II behavior. For less than 2 percent of State Plan PCA recipients, we determined the presence of behavior issues based on assessments for a waiver program. Level I behavior causes, or could cause, self-injury, injury to others, or destruction of property. Examples of Level I behavior include head banging, hitting others, and fire setting. Level I behaviors must be documented by a mental health professional or physician. Level II behavior includes unusual or repetitive habits, withdrawn behavior, and offensive behavior. Examples of Level II behavior include repetitive hand washing, avoiding personal interactions, and bullying.

Figure 2.1: Changes in the MA State Plan PCA Recipient Population, Fiscal Years 2002-07



NOTE: Figure reflects fee-for-service PCA recipients only.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

The number of fee-for-service PCA recipients who needed an interpreter almost tripled between 2002 and 2007.

Increases in the number of non-English speaking PCA recipients have presented new challenges. The percentage of MA State Plan recipients who identified themselves as needing an interpreter grew from 15 to 17 percent between fiscal years 2002 and 2007, but the actual number needing an interpreter grew from 643 to 1,908 during this period. Recipients often arrange to get PCA services from someone who speaks their language, but language and cultural differences sometimes complicate the PCA assessment process because an interpreter is needed. Representatives of a nursing organization that conducts assessments mostly in the Twin Cities area told us that it needs interpreters for 60 percent of its PCA assessments.

Service Use

We also examined the nature of the PCA services received by participants in the MA State Plan. These service characteristics are determined during the assessment process. During the assessment, the nurse determines whether an individual can direct his or her own care or if a responsible party is needed. In 2007, about 57 percent of MA State Plan PCA recipients had a designated responsible party. Over 90 percent of the recipients under age 18 had a responsible party, compared with an estimated 23 to 34 percent of adult recipients.[10]

[10] We are unable to be more precise in our estimate of the percentage of adult recipients who had a responsible party due to missing information for 11 percent of the cases.

During the assessment, recipients also decide whether they want shared care, supervision, and flexible use. According to 2007 paid claims, 6 percent of MA State Plan PCA recipients received at least some shared care (in which one personal care assistant works with two or three recipients at the same time). Data on paid claims also reveal that 81 percent of State Plan PCA recipients received qualified professional supervision in 2007, down from 92 percent in 2002.[11] In addition, the vast majority of recipients (98 percent) chose flexible use of PCA services. The flexible use option allows an individual to use varying amounts of PCA services during six-month periods.[12]

There is considerable variation in the quantity of PCA services received by individuals. Among MA State Plan recipients who used PCA services in each month of fiscal year 2007, 17 percent received an average of over 8 hours of assistance per day, while 3 percent received an average of 1 hour or less.[13] Overall, the average full-year MA State Plan PCA recipient received 5.0 hours of PCA services per day in fiscal year 2007, down from 5.8 hours in fiscal year 2002.

The median annual cost of PCA for Medical Assistance State Plan participants who received services throughout 2007 was $23,783.

We also examined the annual cost of MA State Plan PCA services for individuals who received these services during each month of fiscal year 2007. The median cost per recipient was $23,783, and 87 percent of these recipients had annual costs under $50,000. Individuals with costs of $50,000 or more accounted for 13 percent of full-year recipients, but their services accounted for 31 percent of the total cost of PCA services to full-year recipients.

Finally, we looked at a recent six-year period to determine how long 2007 recipients had been receiving PCA services. Among individuals who received MA State Plan PCA services in fiscal year 2007, 16 percent received some form of PCA services in every year of the fiscal year 2002-07 period. In fact, about 7 percent used PCA services in each of the 72 months during the 2002-07 time period. On the other hand, about 32 percent of fiscal year 2007 State Plan PCA recipients used PCA services in 12 or fewer months during the six-year period.[14]

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[11] It is possible that some individuals who opted in their assessments for shared care or supervision by a qualified professional did not actually receive these types of services during the year.

[12] During the assessment, recipients also decide whether they want to use a PCA Choice agency or a traditional Personal Care Provider Organization (PCPO). A PCA Choice agency acts as a fiscal intermediary for recipients and allows for more consumer direction than is available through a PCPO. We found that DHS does not have reliable information about the extent to which recipients chose a PCA Choice agency over a PCPO.

[13] This measure understates the number of PCA hours per day people actually received on the days they received care. We calculated the measure based on total units of PCA paid during the fiscal year divided by 365 days.

[14] Services include PCA, assessments, and supervision. Although recipients were MA State Plan participants in 2007, they may have received services as a Medicaid waiver participant or non-MA participant in earlier years.

Variation in Service Use Across Minnesota

Ideally, individuals' access to PCA services should not depend on where in Minnesota they live. Some differences in service use across the state are inevitable, but significant variation may indicate inequitable access to services.

We examined inter-county differences in PCA use among fee-for-service MA recipients. To help us account for differences in counties' poverty and disability rates, we compared each county's number of PCA recipients for a given year to the county's total number of MA-eligible persons with disabilities. We found that:

- **Large differences in the rates of PCA use among Minnesota counties suggest that Minnesota residents do not have equal access to PCA services.**

Access to PCA services appears to vary significantly across Minnesota.

Table 2.2 shows fee-for-service PCA utilization rates in selected counties for fiscal year 2007. In aggregate, there was a greater rate of use of PCA services in the seven-county Twin Cities metropolitan area (159 PCA recipients per 1,000 MA-eligible persons with disabilities) than in the rest of Minnesota (129 PCA recipients per 1,000 MA-eligible persons with disabilities). Of particular significance, there were sizable variations in the rates of PCA use among individual counties, especially outside the Twin Cities metropolitan area. Among all 87 counties, the number of residents receiving PCA services per 1,000 MA-eligible persons with disabilities ranged from 10 (Cook County) to 313 (Beltrami County). Among counties with populations exceeding 50,000, rates of PCA use ranged from 80 recipients per 1,000 MA-eligible persons with disabilities (Blue Earth County) to 234 (Chisago County). There was less variation among Twin Cities metropolitan counties in rates of PCA use, ranging from 127 recipients per 1,000 MA-eligible persons with disabilities (Ramsey County) to 192 (Washington County).

In addition, there was wide variation in counties' recent rates of growth in the number of PCA recipients. Between fiscal years 2002 and 2007, the number of PCA recipients living in the Twin Cities metropolitan area grew by 112 percent, compared with a 151 percent increase in the rest of Minnesota. The largest percentage growth during this period was in northwestern Minnesota (275 percent), followed by northeastern Minnesota (149 percent). Beltrami County—which we noted above had the highest PCA utilization rate of any county in 2007—experienced 573 percent growth in its PCA recipient population between 2002 and 2007. In contrast, there were lower growth rates in southwestern Minnesota (85 percent) and southeastern Minnesota (97 percent).[15]

[15] For the most part, the percentage increases in the number of PCA recipients in individual counties and regions far exceeded recent increases in the state's general population and number of MA-eligible persons. Thus, most increases in counties' number of PCA recipients appear to be due to increased PCA utilization rates, not population increases.

Table 2.2: Use of Fee-for-Service PCA Services in Selected Counties, Fiscal Year 2007

	PCA Recipients	Total MA-Eligible Persons with Disabilities	PCA Recipients per 1,000 MA-Eligible Persons with Disabilities
Statewide	16,336	112,385	145
Twin Cities Metropolitan Area	9,699	61,082	159
Washington	441	2,300	192
Hennepin	5,128	29,025	177
Anoka	881	5,068	174
Carver	127	758	168
Scott	195	1,227	159
Dakota	790	5,859	135
Ramsey	2,137	16,845	127
Outstate Counties	6,637	51,303	129
Highest Rates			
Beltrami	417	1,333	313
Mahnomen	56	182	308
Isanti	139	532	261
Kanabec	90	374	241
Cass	162	676	240
Lowest Rates			
Pipestone	10	222	45
Lake of the Woods	3	79	38
Big Stone	5	162	31
Lincoln	3	111	27
Cook	1	100	10
Counties with Over 50,000 Population			
Chisago	163	698	234
Wright	232	1,310	177
Crow Wing	225	1,330	169
St. Louis	764	7,026	109
Olmsted	277	2,560	108
Stearns	290	2,737	106
Rice	95	908	105
Otter Tail	120	1,204	100
Clay	137	1,442	95
Blue Earth	101	1,255	80

NOTE: The number of recipients includes any recipient who received fee-for-service Medicaid PCA services during the fiscal year, excluding those whose only paid services were assessment or supervision.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data and U.S. Census 2007 county population estimates.

Several factors could contribute to variation in the use and growth of PCA services around the state. First, some local officials we interviewed partly attributed their counties' high PCA utilization rates to increased consumer information about PCA services. Specifically, these officials mentioned

promotion of services by parents and advocacy groups, marketing by provider agencies, or outreach by the counties. Second, high PCA utilization rates might reflect unusual concentrations of people with challenging service needs. For example, some local public health officials told us that counties that used to have regional treatment centers are home to many former residents of these centers.[16]

There are several possible explanations for county variation in PCA use.

Third, the limited availability of PCA providers in some counties may contribute to those counties' relatively low use of these services. For instance, the director of a public health agency in southwestern Minnesota told us his region's low rates of PCA use partly reflect the fact that only one personal care provider agency is based in his agency's service area. Finally, the availability of alternatives to PCA services may affect demand for PCA services. For example, some counties may have more extensive resources than others for providing home and community-based services besides PCA to disabled recipients.[17]

The next section discusses assessment, which is another possible explanation for differences in counties' PCA utilization and growth rates. Counties play the lead role in assessments that determine individuals' initial and ongoing need for PCA services. Inconsistencies among counties in this "gate-keeping" role could affect whether (and how much) PCA services are provided to their residents.

ASSESSMENTS FOR PCA SERVICES

Minnesota law defines a PCA assessment as "a review and evaluation of a recipient's need for home care services conducted in person."[18] After a person begins to receive PCA services following an initial assessment, subsequent assessments must occur at least annually. The law requires a new assessment when there is a significant change in a recipient's condition or need for PCA services.[19]

Most PCA assessments are conducted by a county public health nurse or a certified public health nurse under contract with the county. For recipients of certain Medicaid waiver services, assessments may be conducted by a county case manager or service coordinator. DHS's *PCA Consumer Guidebook* informs

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[16] Our analysis of PCA utilization rates took into account differences in counties' total numbers of MA-eligible persons with disabilities—that is, individuals who qualified for Supplemental Security Income or Retirement Survivors Disability Insurance, or whose disability had been determined by a state medical review team. We did not consider differences in the *types* of disabilities counties' residents had.

[17] MA recipients in all 87 counties can receive services through either fee-for-service or managed care. We did not examine the extent of differences among counties in use of fee-for-service versus managed care, but such differences could also affect counties' fee-for-service PCA use rates.

[18] *Minnesota Statutes* 2008, 256B.0655, subd. 1b.

[19] A "service update"—which may be completed by telephone—can substitute for the annual face-to-face assessment for two consecutive assessments in cases where there is no significant change in the recipient's condition or need for increased services.

potential recipients that an assessment "should take about one hour to complete."[20]

All MA participants are entitled to an assessment for PCA services, upon request. Individuals or their responsible parties may contact the county directly to request an assessment, or another person or agency (such as a personal care provider agency) may request an assessment on behalf of a potential PCA recipient. An assessment must be completed within 30 days of a request.

An assessment determines the amount of PCA services an individual needs.

Assessors use one of two standard instruments to help determine individuals' need for services. Assessors complete the *MA Health Status Assessment* for MA State Plan participants and participants in the Developmental Disabilities Waiver program. The *Long-Term Care Consultation* is used for participants of other waiver programs. Both assessment instruments guide assessors through a determination of an individual's health status and ability to complete various activities independently to arrive at a recommendation for needed services. The remainder of this section describes the *MA Health Status Assessment*, which is used for most PCA assessments.[21]

The *MA Health Status Assessment* is a 17-page document used by assessors to record individuals' need for assistance to (1) accomplish activities of daily living and instrumental activities of daily living, (2) complete health-related tasks (such as dressing a wound), and (3) address behavior-related issues. Assessors ask individuals about their need for assistance in each of these areas, and they observe accomplishment of tasks, if appropriate. For example, to determine time needed to assist with medications, an assessor might ask an individual to get his or her medications and bring them to the area where the assessment is occurring.[22] The assessor determines the daily number of minutes of assistance the individual needs for the three areas listed above. The assessor also determines whether the individual has a "dependency" in each of eight activities of daily living.[23]

After completing the assessment instrument, the assessor has the information needed to determine the individual's "home care rating." The home care rating determines the maximum amount of PCA time an individual can receive. The

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[20] Department of Human Services, *Personal Care Assistance (PCA) Program Consumer Guidebook* (St. Paul, May 2007), 11.

[21] The *Long-Term Care Consultation* has more detailed questions about individuals' health issues, abilities to complete various tasks, and support systems. It is used to determine the appropriateness and need for various waiver services, not just personal care assistance.

[22] The assessor obtains detailed information about the medications, the frequency with which they are taken, and assistance needed to take them. Also, by asking the recipient to retrieve the medications, the assessor can observe the person's ability to move about.

[23] "Activities of daily living" include dressing, grooming, bathing, eating, transferring, mobility, positioning, and toileting. To determine the individual's level of dependence, the assessor considers how much help the person needs from others. A child's need for assistance in activities of daily living takes into account the child's age, usual milestones in child development, and typical parental responsibilities. For example, a child up to one year old cannot be found "dependent" in the area of mobility.

home care rating is based on the individual's: (1) number of dependencies; (2) behavior-related needs; and (3) complex medical needs. For example, an individual with two dependencies, no behavior-related issues, and no complex medical needs would have a home care rating that allows a maximum of just over 2.5 hours of PCA a day. The actual amount of PCA time the person receives depends on the number of minutes the assessor calculated that the person needs across all of the areas covered by the assessment.

Assessment Consistency and Accuracy

Inconsistent assessment practices are a possible explanation for variation in counties' PCA service use.

It is important to have reasonably consistent practices throughout Minnesota for assessing recipient needs for personal care services. This is because (1) the assessment process gives local agencies an important role in decisions that have direct fiscal consequences for the state, and (2) for simple fairness reasons, people should have similar access to state-funded services regardless of where in Minnesota they live. To help us consider the issue of assessment consistency, we analyzed statewide data and interviewed representatives of DHS, organizations that conduct assessments, health plans, and consumer advocacy groups.[24] We concluded that:

- **Minnesota has not established sufficient guidance and controls to ensure reasonably consistent, sound assessments of individuals' need for PCA services.**

In this section, we highlight reasons why the Legislature and DHS should take additional steps. First, our analysis of assessment-related data suggests that assessment inconsistencies are a plausible explanation for some of the wide variation in PCA use around the state. Second, the state's oversight of assessment decisions has been limited. DHS has not provided guidance to help translate assessment findings into decisions about how much care individuals should receive, nor has it systematically monitored the reasonableness of assessment decisions. This is one reason that people from agencies that conduct or contract for assessments expressed concern about inconsistencies in assessment decisions. Third, the state has not mandated specialized training for PCA assessors, and intensive training courses have not always been available from the state. However, even with training, assessors sometimes reach different conclusions about individuals' need for services when presented with the same facts.

Inconsistencies Among Counties

In the previous section, we noted that rates of PCA use vary widely around the state. Assessment inconsistencies are one of several possible reasons for these

[24] We could not conclusively determine from the PCA utilization data how much of the inter-county differences in PCA use is due to assessor inconsistency. Each assessment is conducted by one assessor, so there is no opportunity to compare assessors' judgments about a recipient. Also, the needs of individual clients can be affected by unique circumstances. Thus, we supplemented our data analysis with other sources of information (such as interviews and reviews of appeals cases) to draw conclusions.

differences. To supplement the earlier analysis, we looked at inter-county differences in PCA use for certain subcategories of recipients. These subcategories were based on assessors' home care ratings of individual recipients. We found that:

- **Counties differed in the extent to which individuals were assessed as having certain disability issues needing PCA services.**

We examined data on PCA recipients who were assessed with behavior issues. This is a subcategory that experienced significant recent growth in its number of recipients. Table 2.3 shows two measures of PCA service use, focusing on counties with at least 100 PCA recipients in fiscal year 2007. First, the table shows wide county variation in the percentage of PCA recipients that had behavior issues. For example, 77 percent of Douglas County's PCA recipients were assessed as having behavior issues, compared with only 34 percent of recipients in Beltrami County. Second, the table shows wide variation in each county's PCA recipients with behavior issues as a percentage of the county's total number of Medicaid-eligible people with disabilities. Percentages ranged from 3 percent (Blue Earth County) to 18 percent (Isanti County).[25] This suggests that some counties were more likely than others to assess people as having behavior issues.

Differences in assessment practices can have significant cost impacts.

We also looked at statewide assessment data for PCA recipients with "Level I behaviors," the largest subgroup of persons with behavior issues.[26] Specifically, we examined differences among counties in the average hours of service recommended by PCA assessors for these individuals. We focused on the 11 counties that conducted at least 100 PCA health status assessments resulting in this home care rating during fiscal year 2007. Among these counties, the average hours of service recommended per recipient with Level I behaviors varied considerably. At the low end, assessors in Stearns and Ramsey counties recommended an average of 3.6 hours and 4.3 hours per day, respectively. In contrast, assessors in Kandiyohi, Crow Wing, and Washington counties recommended an average of 9.2, 7.8, and 7.5 hours per day, respectively.[27] The difference in average recipient hours between the highest and lowest counties above represented a cost difference of more than $30,000 annually per recipient.

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[25] In addition, we found considerable variation among counties in the number of PCA recipients assessed as *not* having behavior problems. Focusing on counties with more than 100 total PCA recipients in fiscal year 2007, we looked at the number of recipients served for non-behavior problems as a percentage of those counties' total MA-eligible people with disabilities. This percentage ranged from 3 percent (Benton County) to 20 percent (Beltrami County).

[26] "Level I behaviors" cause or have the potential to cause (1) injury to self, (2) injury to others, or (3) destruction of property.

[27] Among the 11 counties, differences in these recipients' average number of dependencies in activities of daily living did not explain variation in the hours recommended by the assessors. For recipients with Level I behaviors, these counties' average total minutes recommended by the assessor was highly correlated both with (1) time recommended for addressing Level I behaviors ($r = +0.92$) and (2) time recommended for service needs other than Level I behaviors ($r = +0.74$).

Individuals within the same disability subgroup can have unique circumstances that affect their need for PCA services. Undoubtedly, some variation in assessors' decisions reflects these case-by-case differences. However, by focusing on counties with relatively larger numbers of cases, we think our analysis reflects assessment inconsistencies among counties more than differences in the counties' recipient characteristics.

Table 2.3: Variation in Identification of Behavior Issues Among Fee-for-Service PCA Recipients, Selected Counties

	County PCA Recipients Assessed as Having Behavior Issues as a Percentage of:	
County	All PCA Recipients in the County[a]	The County's MA-Eligible Population with Disabilities
Douglas	77	10
Wright	76	13
Benton	74	8
Sherburne	72	12
Carver	71	11
Isanti	71	18
St. Louis	71	7
Crow Wing	69	11
Anoka	67	11
Washington	67	12
Otter Tail	65	6
Kandiyohi	64	10
Carlton	62	12
Chisago	62	13
Becker	61	9
Itasca	59	8
Scott	57	9
Dakota	57	7
Clay	56	5
Stearns	53	5
Ramsey	50	6
Hennepin	48	8
Winona	47	5
Polk	47	5
Blue Earth	47	3
Olmsted	46	5
Cass	34	8
Beltrami	34	10

NOTE: The table only includes counties that had at least 100 total Medicaid-funded PCA recipients in fiscal year 2007.

[a] Percentages are based on the total number of Medicaid-funded PCA recipients who were given a case mix rating or home care rating during the assessment process.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

State Guidance and Oversight for Assessors

The state has taken some important steps to bring uniformity to assessment decisions. Nearly 20 years ago, DHS developed a "decision tree" that limits the cost of services an individual PCA recipient can receive, depending on the individual's specific assessed needs. Also, DHS has developed instruments that are used by assessors throughout Minnesota to determine individuals' need for PCA services. Despite these efforts:

- **Many agencies that conduct PCA assessments would like DHS to provide more guidance and oversight to ensure assessment consistency.**

There has been considerable debate among DHS, managed care organizations, consumer advocacy groups, and others on the merits of statewide guidelines for assessors. In 2006, some of Minnesota's managed care organizations drafted a set of guidelines to help their assessors recommend amounts of time for seniors assessed as needing PCA services. Recipient advocates expressed concern that the guidelines would cause assessors to overlook individuals' unique needs. DHS prohibited the use of such guidelines in 2006, and it recently stated:

> It is DHS policy that lead agencies (counties, managed care organizations, tribes) cannot use their own tools or guidelines that assign specific ranges and/or amounts of time for PCA service components.[28]

This prohibition on guidelines developed by individual organizations does not rule out the possibility of state-authorized assessment guidelines. Minnesota has caps on the amount that can be spent to serve individuals with various home care ratings, but there are no state guidelines for determining the amounts of time that should be allocated to PCA tasks. DHS trainers have generally advised assessors to use their best judgment. Sixteen states have developed guidelines that address the amount of time to assign to specific PCA tasks, according to a 2005 study.[29] This study noted considerable variation among states in the time guidelines adopted for particular tasks, perhaps reflecting differences in their processes for developing the guidelines and their existing levels of social supports for people with disabilities.

Assessment of PCA service needs for individuals with behavior issues is particularly challenging for assessors.

Many officials from Minnesota agencies that conduct assessments told us they would welcome state guidance, especially in the area of behavioral health. They told us that the state's existing PCA assessment instruments do not adequately assess behavior issues for adults or children. They said it can be especially difficult to distinguish severe behavior problems in children from behaviors that might be considered normal for a particular age. In addition, they said it is

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[28] Department of Human Services, *Clarification of Policy for Personal Care Assistant (PCA) Services for Managed Care Enrollees*, Bulletin #08-25-06 (September 2, 2008), 6.

[29] Ernest L. Cowles and Robert Chiles, *Time per Task for In-Home Personal Care: A Cross-State Perspective* (Sacramento, CA: Institute for Social Research, California State University, September 6, 2005).

challenging for assessors to determine the right amount of time to recommend for PCA services related to behavior issues. For example, if an assessor is told that a child exhibits aggressive behavior an average of nine times a day, the assessor might decide to allocate 90 minutes of PCA time per day (10 minutes per incident) for "redirection" of the child's behavior. However, there is no guarantee that the PCA will be on the job at those times during the day when the child's behavior needs attention.

More generally, representatives of agencies that conduct or contract for assessments expressed concern to us about assessment inconsistencies—among individual nurses, public and private assessment agencies, and individual health plans. For example, they described some assessors as "soft-hearted" or "thick-skinned," reflecting the amount of PCA service time the assessors recommended. Public health agency directors said recipients sometimes seek assessments from nurses they perceive to be more generous in granting service hours. One public health director said that PCA recipients have grown increasingly assertive about the services they want, resulting in some assessors finding it difficult to refuse recipients' requests. Because of these concerns, directors of some public health agencies told us they would welcome DHS oversight of local assessment decisions. DHS does not systematically review the reasonableness of PCA assessment decisions or the adequacy of the documentation presented by assessors to support their recommendations. Also, aside from the training exercise cited in the next section, DHS has not examined the extent to which assessors reach similar conclusions when assessing the same PCA recipients.

Assessor Training

Uniform training could help ensure that assessors use sound, consistent assessment practices, but:

- **There has been insufficient training of PCA assessors, reflecting uneven availability of state training courses over time and the absence of state requirements for minimum training levels.**

The Department of Human Services has offered training courses for PCA assessors sporadically.

The training opportunities DHS has offered to PCA assessors have been sporadic. We examined records of courses offered by DHS on PCA assessment since mid-1999. Participation levels in DHS training varied considerably from year to year, as shown in Table 2.4. In 2002 and 2003, for example, DHS offered no PCA assessment training courses due to budget constraints. Today, DHS's main PCA assessment course provides 20 hours of instruction over three days, covering a wide variety of assessment-related topics. DHS also offers short courses (two to four hours) on specific topics of interest to assessors. On one occasion, DHS offered a half-day course specifically for experienced assessors.

We examined the extent to which assessors of MA State Plan recipients have participated since 1999 in the more comprehensive or advanced assessment training courses offered by DHS. Specifically, we focused on participation in (1) courses of 12 hours or more in duration, or (2) the advanced training course

specifically designed for experienced assessors.[30] Based on a review of state records, we found that 35 percent of PCA assessments conducted during the first half of 2008 were done by assessors who had not completed a comprehensive or advanced PCA assessment training course from DHS since at least 1999.[31]

Table 2.4: Participant-Hours of Training in DHS's Courses on PCA Assessment, 2000-07

Year	Total Participant-Hours of Training[a]
2000	1,212
2001	300
2002	0
2003	0
2004	7,198
2005	978
2006	8,587
2007	1,238

[a] A "participant-hour" is one hour of training taken by one individual. A four-hour class attended by 20 individuals would result in 80 participant-hours of training. Some of the participants whose hours of training are included in this table were DHS employees.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services training records.

Training alone has not eliminated differences in assessors' recommendations for PCA services.

Even with training, assessors may reach differing conclusions about individuals' need for PCA services. We observed evidence of this at one of DHS's assessor training courses. After instructing assessors on how to conduct assessments and recommend hours of service, DHS trainers conducted an exercise in which the training participants watched an enactment of a hypothetical assessment and decided how much service time to recommend. In the course we attended, three groups of assessors separately reached consensus on the hours the hypothetical recipient should receive. The groups reached different conclusions on the individual's dependencies and made recommendations for time ranging from 3.5 hours to 5.5 hours per day.[32] Thus, even trained assessors can reach different conclusions from the same set of information.

Appeals of PCA assessment decisions also highlight the different conclusions sometimes reached by human services professionals. Individuals have a right to

[30] Our selection of a 12-hour threshold was intended to identify individual courses that were reasonably comprehensive, in light of DHS's current 20-hour training course. DHS offered assessment-related courses of 12 hours or more in 2000, 2001, and 2005-08. During 2004, DHS's main assessment course was only six hours long, so these training sessions did not meet the 12-hour threshold we used. DHS offered its course for experienced assessors in 2007.

[31] Among nurses who completed at least five MA State Plan PCA assessments in the first half of 2008, 31 percent had not completed at least a 12-hour training course or the advanced course for experienced assessors.

[32] As mentioned earlier, the number of dependencies is a critical factor in determining an individual's home care rating and, therefore, the dollar caps on PCA services. The ranges in recommended PCA time for this exercise have been even larger in some of the DHS training sessions we did not observe, according to past participants.

appeal if they disagree with service-related decisions by DHS or managed care organizations.[33] This process allows individuals to seek a hearing before a state human services judge. We reviewed the results of all 2007 PCA-related state hearings. Our analysis indicated that 97 percent of the PCA-related appeals cases involved disputes about the amount of time authorized for services by DHS or a managed care organization. Table 2.5 shows the outcomes of the 2007 appeals. In the most common type of PCA case—appeals of reductions in services from amounts previously authorized—judges reversed or modified the reductions 65 percent of the time.[34] On average, individuals who appealed reductions in services were granted a 24 percent increase in service time as a result of the

Table 2.5: PCA Appeal Outcomes by Type of Issue, 2007 Cases

		Percentage of Cases in Which the Human Services Judge:			
Main Issue Raised by the Appellant	Number of Cases	Affirmed Agency Position	Modified Agency Position	Reversed Agency Position	Other[a]
Agency's Initial Assessment Led to Denial of PCA Services	15	47%	N/A	40%	13%
Agency's Initial Assessment Did Not Result in Sufficient Amount of PCA Services	36	58	33%	3	6
Agency Reduced the Recipient's Amount of PCA Services	227	33	41	24	2
Agency Terminated PCA Services	40	55	N/A	43	3
Other Issue Related to Amount of PCA Time Authorized[b]	12	58	33	8	0
There Was a Gap in the Recipient's Periods of Authorized PCA Services	8	38	0	63	0
Other[c]	3	67	0	0	33
Total	341	40	32	25	3

NOTES: Table reflects only one issue for each appeal. Ten appeals involved multiple issues, such as a reduction in services and a gap in service periods; in these cases we categorized the appeal under the time-related issue. "Agency" in column headers refers to the Department of Human Services or the managed care organization. "N/A" indicates that modifications were not applicable; in cases involving denial or termination of services, there is no middle ground between the agency's position and the appellant's position.

[a] An example of an "other" decision is a judge requiring a new assessment and determination of time by a public health nurse.

[b] An example of "other issue related to amount of PCA time authorized" is an appellant who was awarded additional time after a reassessment but thought even more time was needed.

[c] Examples of "other" issues include whether the appellant should be allowed to use a fiscal intermediary or choose flexible use PCA.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services PCA-related appeals closed in 2007.

[33] Managed care organizations are required by state contracts to have internal grievance and appeals processes. Fee-for-service recipients—as well as managed care recipients who have already pursued managed care internal grievance procedures—have the option of filing an appeal under the state's "fair hearing" process.

[34] In cases involving reductions in recipients' hours, we defined a "reversal" to mean that the judge restored the number of hours the recipient received prior to the most recent assessment. A "modification" in such a case meant that the judge ordered a smaller reduction of hours than DHS or the managed care organization had authorized. Important information that was not available to the assessor, such as documentation of Level I behavior, sometimes informs judges' decisions.

appeal. When the judge reversed the reduction in services, an average of almost two hours was added to the individual's PCA time. Although just a small fraction of PCA assessments are appealed to the state, these cases indicate that judges and assessors sometimes reach very different conclusions when reviewing similar information about a recipient.

Recommendations

Minnesota's number of PCA recipients has grown significantly in recent years. Some parts of Minnesota use PCA services at much higher rates than others, and it is important to ensure that assessments are reasonably consistent. Assessments are not the only reasons for variations in PCA use, but they are a service the state can influence.

We recognize that PCA assessors have a very difficult job. Assessors are expected to accurately determine individuals' health status based on a single home visit, with limited time for direct observation. Potential service recipients sometimes try to persuade the assessor that a condition is more disabling than it really is, or they ask for assistance that is not authorized by state PCA policy. The assessor is expected to translate observations about individuals' unique circumstances into recommendations on the exact number of service minutes that should be authorized.

Assessors need increased training, guidance, and oversight.

Perhaps relying on 87 individual counties to conduct or arrange for PCA assessments invites inconsistencies in this process. However, we are not convinced that a more centralized approach, such as using DHS-employed assessors, would be cost-effective. Rather, we think DHS and the Legislature should bring greater standardization into the existing assessment process through increased training, guidance, and oversight.

RECOMMENDATIONS

The Legislature should require the Minnesota Department of Human Services to:

- ***Implement mandatory training requirements for persons conducting assessments of individuals' need for PCA services.***
- ***Develop additional guidance to help assessors determine the PCA service needs of persons with behavior issues.***
- ***Develop a process for periodically reviewing samples of PCA assessments for the purpose of ensuring reasonable levels of consistency.***

We think that new PCA assessors should be required to successfully complete a comprehensive DHS course in assessment, such as the three-day training course now offered. Also, because policies and practices change over time, there should be requirements for periodic training of experienced assessors. During the DHS

assessor training, we heard assessors ask many relevant questions about topics that required interpretation of existing laws or DHS policies. For example, one person asked whether an assessor should allocate time for recipients to receive PCA assistance for multiple baths in one day, noting that "ritual bathing" is a part of some religious practices.[35] DHS should also consider ways other than formal training to inform assessors throughout the state about how to apply state assessment policies to specific situations. Perhaps DHS could do this by using its web site to answer questions or provide guidance.

Also, we think PCA assessors need more state guidance. Guidelines can help ensure that judgments are fair and reasonably consistent. Guidelines are used in many areas of medicine to encourage the use of "best practices" or improve cost-effectiveness. In criminal justice, Minnesota requires judges to use advisory guidelines when sentencing offenders, while allowing judges to deviate from the guidelines.[36] Developing reasonable guidelines is a large undertaking, and we suggest starting with guidelines in the behavior area. This would address an area in which assessment agencies expressed particular frustration. Such guidelines could (1) identify ranges of time that may be appropriate to recommend for certain activities and (2) clarify circumstances that may justify deviation from guidelines. DHS should also consider recommending specialized behavioral health assessment instruments to supplement, where appropriate, the state's general assessment instruments. In our view, it is possible to have stronger state guidance on PCA assessments while still allowing assessors to make judgments based on individuals' unique needs.[37]

Finally, we recommend that DHS periodically review samples of PCA assessments. DHS could look at the adequacy of assessment documentation, or it could explore instances in which assessors' recommended amounts of time appear to be unusually large or small. Assessment decisions have important impacts on the services people receive and the costs borne by the state, so these decisions deserve careful state scrutiny.

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[35] In response to the question, DHS staff said that bathing multiple times in one day for religious reasons is not covered. According to *Minnesota Statutes* 2008, 256B.0655, subd. 2(c)(6), PCA services cover bathing necessary for personal hygiene.

[36] *Minnesota Statutes* 2008, 244.09.

[37] DHS is developing a computerized comprehensive assessment instrument that would replace the *MA Health Status Assessment* and the *Long-Term Care Consultation*. The department hopes this instrument could provide nurses with guidance on individuals' time needs based on recipients' specific conditions and the experience of recipients in similar situations. At this time, it is unclear exactly what form this guidance would take and when such an instrument might be implemented.

3 Fiscal Integrity

In 2002, the U.S. Department of Health and Human Services conducted an audit of Minnesota's personal care assistance (PCA) services. The audit concluded: "Based on our sample results, the State had no assurance that payments for personal care service claims during [federal fiscal year 1999] were proper and that compliance requirements were fully met."[1]

Since that report was issued, the state's fee-for-service expenditures for PCA services have nearly tripled. The Minnesota Department of Human Services (DHS) has made changes in its administration of PCA services in an effort to address fraud, abuse, and payment-related compliance problems, but concerns about these issues persist. In this chapter, we discuss the nature and extent of these issues, evaluate the state's efforts to address them, and offer recommendations.

BACKGROUND

Traditionally, efforts to ensure the "integrity" of the Medicaid program have focused on ways to identify and control improper payments. Improper health care payments result from fraud, abuse, and unintentional errors. Table 3.1 shows the federal Medicaid definitions of fraud and abuse. Improper payments can involve inappropriate actions of agencies that bill or pay for services, personal care assistants who provide services, or recipients who access services.

Table 3.1: Federal Medicaid Definitions of Fraud and Abuse

Fraud	"[A]n intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person."
Abuse	"[P]rovider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care."

SOURCE: *42 CFR* sec. 433.304 (2007).

[1] U.S. Department of Health and Human Services, Office of Inspector General, *Audit of Medicaid Costs Claimed for Personal Care Services by the Minnesota Department of Human Services, October 1, 1998 Through September 30, 1999* (Chicago, April 23, 2002), 3.

State laws provide a general framework for assuring fiscal integrity in PCA services. The law requires criminal history checks for PCA agency managers, personal care assistants, and persons with more than 5 percent ownership of a PCA agency.[2] PCA agencies must maintain surety bonds and liability insurance.[3] To be paid for services, PCA agencies are required to maintain up-to-date records for individual recipients, including physician statements of need, service plans, care plans, and PCA timesheets.[4] PCA agencies must provide DHS with any requested information demonstrating compliance with laws, rules, or other policies; failure to do so can result in sanctions.[5] In addition, DHS is required to have an ongoing audit process to identify potential fraud and abuse in PCA services.[6]

Minnesota law requires the Commissioner of Human Services to establish procedures for identifying and investigating "suspected medical assistance fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statement or representation of material facts by a vendor of medical care."[7] The commissioner may impose sanctions against health care vendors and refer cases to the Minnesota Attorney General for criminal or civil prosecution.[8]

Personal care assistance (PCA) services are susceptible to fraud, although the total amount of improper payments is unclear.

DHS contracts with managed care organizations to administer some publicly funded health care services, and DHS requires each of these organizations to have its own "integrity program." Each organization must have administrative arrangements or procedures to "guard against fraud, abuse and improper payments."[9] Also, each organization must annually report to DHS on its efforts to investigate, correct, and prevent fraud and abuse.

NATURE AND EXTENT OF FISCAL INTEGRITY ISSUES

There is not definitive information about the total amount and nature of improper payments for Minnesota's PCA services.[10] However, based on our evaluation

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[2] *Minnesota Statutes* 2008, 256B.0655, subds. 1f and 1g.

[3] *Ibid.*

[4] *Minnesota Statutes* 2008, 256B.0655, subd. 2(f).

[5] *Minnesota Statutes* 2008, 256B.0655, subd. 10.

[6] *Minnesota Statutes* 2008, 256B.0655, subd. 2(g).

[7] *Minnesota Statutes* 2008, 256B.04, subd. 10.

[8] *Ibid.*, and *Minnesota Statutes* 2008, 256B.064.

[9] Department of Human Services contract with managed care organizations, section 9.15.1.

[10] A 2003 report by our office said there was inadequate information on the overall extent of improper payments in Minnesota's Medical Assistance program—see Office of the Legislative Auditor, *Controlling Improper Payments in the Medical Assistance Program* (St. Paul, August 2003), 19. DHS reviewed a representative sample of PCA claims in 2005, partly in response to that report, but it did not provide a dollar estimate of total improper payments in the PCA program.

and the work of Medicaid investigative units within DHS and the Office of the Attorney General, we concluded:

- **Minnesota's PCA services remain unacceptably vulnerable to fraud and abuse.**

The sections below discuss these vulnerabilities in more detail. The types of problems uncovered in investigations by DHS and the Attorney General's Office are significant, but usually these investigations have been undertaken in response to a complaint or referral. Thus, the problems documented by these units might not be representative of practices in all PCA agencies. To get a more balanced picture of problems with PCA services, we reviewed one month of PCA claims and conducted site visits to a random sample of PCA provider agencies. These efforts reinforced our concerns with the fiscal integrity of PCA services. We were not always able to conclude whether the problems we identified met the criteria for fraud or abuse, but the prevalence and nature of the issues we found indicate unaddressed risks to the financial integrity of PCA services.

Our concerns echo those of others who have closely examined PCA financial integrity issues. According to a 2005 report, the Office of the Attorney General considered PCA services to be "the most problematic of all of the state's health care programs in terms of fraud and abuse."[11] Also in 2005, the Medicaid investigative unit in DHS examined a representative sample of PCA claims and documented significant compliance problems.[12] In a more recent report, key administrators of publicly funded health care services in Minnesota concluded: "The common and individual interests of the PCA agencies, their PCA employees, and PCA clients has led to the unintended consequence of increasing fraudulent and abusive practices while in some cases placing vulnerable recipients at risk."[13]

Work and Findings of State Investigative Units

Minnesota's Department of Human Services (DHS) and Attorney General investigate allegations of Medicaid fraud.

The two primary state investigators of improper Medicaid payments are the Surveillance and Integrity Review Section (SIRS) of DHS and the Medicaid Fraud Control Unit of the Attorney General's Office. SIRS conducts post-payment reviews of PCA services to determine whether payments for the services were appropriate. Most SIRS investigations begin in response to a complaint from a provider, recipient, county agency, or other source. If SIRS finds evidence that a provider has committed fraud or abuse, it refers the case to the Attorney General's Office for further investigation and possible prosecution.

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[11] Department of Human Services, *Health Care Services Study: Findings and Strategies for Savings* (St. Paul, January 2005), 40.

[12] Department of Human Services, Surveillance and Integrity Review Unit, *PCA Program Study: Compliance with DHS Policies* (St. Paul, September 2005).

[13] Program Integrity Subcommittee of the DHS PCA Workgroup, *Program Integrity and the PCA Program* (draft), July 2008, 3. The subcommittee included DHS staff plus officials from the private and public health plans that contract to administer health care services on behalf of the state.

The Attorney General also has the authority to pursue civil cases to recoup improper payments that do not involve fraud.

We found that:

- **Minnesota's state fraud investigators have devoted a disproportionately large share of their resources to PCA services due to concerns about financial integrity, and they have found a variety of problems.**

DHS fraud staff spend a majority of their time investigating PCA issues.

According to SIRS staff, PCA-related complaints make up the largest share of complaints they receive. Staff estimated that 65 percent of their time is spent on PCA issues. This is noteworthy, given that the state's total expenditures for PCA services account for less than 10 percent of Minnesota's total Medicaid spending. PCA cases also make up a large share of the Attorney General's Medicaid fraud caseload. Between January 2005 and December 2007, PCA cases accounted for 51 percent of the Medicaid cases opened by the Attorney General's Office.[14] In addition, PCA-related cases accounted for 29 of the 60 Medicaid cases (48 percent) prosecuted by the Attorney General from 2005 to 2007.

SIRS and Attorney General findings have documented many vulnerabilities with PCA services. Table 3.2 shows examples of cases investigated by SIRS staff. A majority of recent PCA investigations by SIRS involved cases in which PCA agencies billed the state for services not provided (or not documented). SIRS investigations typically identify improper payments for recovery by DHS.

The 2005 DHS study mentioned above reported significant compliance problems with agencies maintaining the documents that DHS requires for reimbursement for PCA services. Based on a statewide sample, the DHS study found that 42 percent of recipient files did not contain current, signed physician orders at the time of service. Furthermore, 52 percent of files did not contain a current, signed care plan at the time of service.[15]

In addition, a DHS committee that included key administrators of Minnesota's publicly funded health care programs noted that past investigations by DHS and health plans have identified the following problems: (1) personal care assistants who report hours worked in excess of actual hours worked; (2) agencies that do not keep sufficient records documenting services billed; (3) caregivers that discourage recipients from reporting when the caregiver does not show up for work; (4) agencies that tell recipients they are eligible for fewer hours of service than had actually been approved, and then bill the state for services not performed; and (5) recipients who sign blank time cards.[16]

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[14] The Office of the Attorney General opened a total of 152 Medicaid cases during this three-year period. As a percentage of total cases opened, PCA cases grew from 42 percent in 2005 to 59 percent in 2007.

[15] Department of Human Services, Surveillance and Integrity Review Unit, *PCA Program Study*, 2.

[16] Program Integrity Subcommittee of the DHS PCA Workgroup, *Program Integrity*, 3-8.

Recent DHS investigations illustrate risks to the fiscal integrity of personal care services.

Table 3.2: Examples of Cases Investigated by DHS's Surveillance and Integrity Review Section (SIRS)

Claims for services not provided

- A recipient complained that she had not received services from her PCA agency for more than three months, although the agency had been paid for more than 700 hours of services during that time. The recipient said she had signed blank timecards on some occasions.
- A recipient learned she had used up her authorized PCA hours, even though she had not used PCA for several months. In a subsequent investigation of this agency, SIRS discovered that the agency had submitted claims for PCA services provided to seven recipients while they were in the hospital.

No statement of medical need for services

- SIRS reviewed records for ten recipients at a PCA agency. SIRS recovered more than $91,000, mostly due to evidence that recipients did not have proper "physician statements of need" certifying that PCA services were medically necessary.

Services provided by ineligible personal care assistants

- SIRS found that one agency allowed (1) two personal care assistants to continue providing services after their authorization to do so had been removed by DHS, (2) a personal care assistant to work before a criminal history study was initiated, and (3) four "responsible parties" of recipients to serve as those recipients' personal care assistants.

Inadequate documentation of hours worked

- Upon learning that the owner of a PCA agency was scheduled for deportation, SIRS conducted an on-site review of the agency's records. It found PCA timesheets that were not completed and did not reconcile to the amount of time claimed for state payment. SIRS determined that the agency should repay more than $113,000.

Kickback to parent

- The mother of a child receiving personal care assistance admitted to SIRS that she proposed an arrangement in which she and the personal care assistant shared the state's payments for services. The mother signed timesheets even when the assistant provided no services. The PCA agency agreed to repay the state $4,662.

Personal care assistant using two identification numbers

- During an investigation of a personal care assistant, SIRS discovered that she had a second personal care assistant identification number. Multiple numbers assigned to one person might allow for duplicate billing and inhibits DHS's ability to analyze all payments made on behalf of a caregiver. DHS sent letters to the assistant and PCA agency informing them of the termination of the two identification numbers.

SOURCE: Office of the Legislative Auditor, review of cases closed by SIRS in 2007 and early 2008.

The outcomes of state investigations indicate that financial integrity problems in PCA services are sometimes extensive. Table 3.3 shows the amounts of improper payments identified by SIRS for recovery in recent years, peaking at $544,000 in 2007.[17] In addition, DHS has suspended a number of PCA agencies and individual personal care assistants as a result of SIRS investigations. For example, between January 2006 and July 2008, SIRS suspended the operations of 21 PCA agencies. Also, between November 2007 and November 2008, SIRS suspended 52 individual personal care assistants.

DHS investigators identified over half a million dollars in improper payments to PCA agencies in 2007.

Table 3.3: Amounts of Improper PCA Payments Identified by SIRS for Recovery, 2002-07

Year	Amount
2002	$201,031
2003	90,281
2004	253,972
2005	87,814
2006	224,955
2007	543,721

SOURCE: Minnesota Department of Human Services, Surveillance and Integrity Review Section.

The Attorney General has obtained many criminal convictions in PCA-related prosecutions, often involving restitution to the state. There was an acquittal in only 1 of the 29 PCA-related cases prosecuted by the Attorney General in 2005-07; the rest resulted in convictions or plea agreements involving employees or owners of PCA agencies.[18] The amount of restitution ordered in cases over this three-year period totaled nearly $420,000.

OLA Review of PCA Claims

To provide balance to the complaint-based work of the state's investigative units, we reviewed all DHS-paid claims for PCA services provided during May 2008. We found:

- **DHS paid PCA service claims that asserted impossible or implausible work hours.**

In our review of claims, we found hundreds of instances of payments for impossible or implausible work hours. Our analysis of PCA claims data revealed 423 instances in which DHS paid claims for personal care assistants who

[17] The repayment amounts sought in individual cases are quite variable. In the 2007-08 cases we reviewed, SIRS sought recoveries ranging from $94 in one case to $154,000 in another.

[18] Most of the convictions were for theft by false representation or theft by swindle.

reportedly worked more than 24 hours a day.[19] In one instance, DHS paid for 254 hours of service by one personal care assistant on a single day.[20]

Some claims for PCA services indicated that assistants worked more than 24 hours a day or consecutive 24-hour workdays.

We also found 314 instances in which claims reflected a 24-hour workday. DHS staff indicated that such claims are questionable because DHS does not pay personal care assistants to sleep. Because there might be rare cases in which a 24-hour workday cannot be avoided, we looked for instances of caregivers with consecutive 24-hour workdays. These instances might indicate fraud. At a minimum, if the hours were accurately reported, they would represent a safety risk for the personal care assistant and recipient. We found that 152 of the 24-hour workdays represented consecutive 24-hour workdays. Based on paid claims, one PCA worked 24 hours each day of the month.

In total, we identified 575 personal care assistant workdays that represented either (1) workdays for which the personal care assistant reportedly worked more than 24 hours or (2) consecutive 24-hour workdays. These workdays accounted for less than 0.2 percent of total days worked in May 2008.[21] Still, these cases represented claims totaling about $308,000.[22]

OLA File Reviews at PCA Agencies

We also conducted site visits at 26 PCA agencies in August and September 2008, partly to examine fiscal integrity issues. During the site visits, we reviewed agency records for samples of recipients and their personal care assistants. In all, we reviewed files for 185 recipients and 238 personal care assistants. Specifically, we reviewed agencies' supporting documentation for claims covering April 13-19, 2008, and we reviewed compliance with documentation requirements agencies must meet to receive state payments. Our sample was too small for us to draw general conclusions about all PCA provider agencies. However, because we selected the agencies at random, the extent of the problems we found was striking. We found:

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[19] Claims for PCA services indicate the person who received services, the personal care assistant who provided them, and the date of service. Most of the cases we identified were based on multiple claims for individual personal care assistants, not single claims. Also, for most of these assistants, a single agency submitted all of the claims.

[20] A recent federal report examined PCA claims data from five states, including Minnesota, for possible payment errors—see U.S. Department of Health and Human Services, Office of Inspector General (OIG), "Memorandum Report: Medicaid-Funded Personal Care Services in Excess of 24 Hours per Day" (Washington, DC, 2008). Using data for Minnesota claims from the last three months of 2005, the OIG found claims in which PCA services exceeded 24 hours a day per recipient, amounting to 35,751 hours. Our analysis focused mainly on claims exceeding 24 hours per day *per personal care assistant* because there is no defensible explanation for such claims. In contrast, claims might legitimately reflect over 24 hours of care in a day for a recipient. For example, a person might require the services of more than one personal care assistant at a time. We also looked for claims exceeding 24 hours of PCA in a day *per recipient*. May 2008 claims indicating that an individual received more than 24 hours of assistance in a day totaled 11,900 hours.

[21] The 130 personal care assistants involved in these cases represented about 0.7 percent of the roughly 18,000 personal care assistants for whom claims were submitted for May 2008.

[22] We did not determine whether all or just a portion of each claim was questionable.

- **PCA agencies provided services to many recipients without the documentation required by DHS for reimbursement for PCA services.**

As discussed below, we found problems with the timesheets, care plans, and physician statements of need that providers are required to keep on file in order to be reimbursed for PCA services.

Files at some provider agencies indicated lax administration of PCA services.

Our comparison of paid claims to agency timesheets found mismatches in a minority of cases, but the problems were concerning. For 23 percent of recipients whose files we examined, there was at least one day during the week we reviewed for which timesheets and claims did not reconcile.[23] Typically, these cases were characterized by (1) more hours claimed by the agency than the personal care assistant reported on the timesheet, (2) a claim submitted on behalf of a different personal care assistant than the one who completed the timesheet, or (3) the absence of valid timesheets for the date(s) in question.[24] At one PCA agency we visited, timesheets for individual recipients covering extended periods were repeatedly photocopied, with changes in only the dates of service. In two cases at this agency, we observed timesheets with apparently forged recipient signatures (as indicated by misspellings of the recipients' names).[25]

Also, we often found minimal documentation by PCA agencies to verify that qualified professionals provided the hours of supervision for which the state paid. Some agencies submitted single claims to the state for several weeks of supervision, covering multiple qualified professionals and multiple recipients. Qualified professionals usually did not have timesheets indicating the exact hours they spent supervising individual personal care assistants.

Minnesota law requires that PCA agencies have an individual recipient's care plan (signed by the recipient) and physician statement of need on file "[i]n order to be paid for personal care assistant services."[26] Thus, these documents are considered essential under Minnesota law for ensuring the integrity of PCA services. As we described in Chapter 1, a care plan is a written description of the PCA services an individual is supposed to receive. DHS's health care program provider manual requires PCA agencies to update the care plan annually. Without a current care plan for reference, it is impossible to determine if personal care assistants are providing the services an individual needs and for which they are being paid. The physician statement of need reflects a medical professional's

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[23] Some recipients had multiple personal care assistants during the week we examined. The 23 percent figure was calculated based on a total of 259 unduplicated recipient-caregiver combinations for which we reviewed claims documentation during site visits.

[24] In addition, 3 percent of the recipients whose files we reviewed had a timesheet-claim mismatch that did not work to the agency's financial advantage. In other words, the timesheet reported more time than the agency claimed for state billing purposes.

[25] Beyond the 23 percent of cases in which we found significant timesheet-related issues, there were numerous minor problems with timesheets that suggested carelessness by the PCA agencies. For example, many timesheets did not have the personal care assistant's provider number or the recipient's birth date or Medical Assistance number.

[26] *Minnesota Statutes* 2008, 256B.0655, subd. 2(f).

judgment that a recipient has a medical need for PCA services. As explained earlier, Medicaid-funded PCA services must be medically necessary. Minnesota law requires that physician statements of need be updated annually.[27]

Agencies did not have up-to-date care plans in 26 percent of recipient files we reviewed. An additional 43 percent of files included a care plan, but it was not signed by the service recipient or responsible party. Unsigned care plans do not comply with statutory requirements, and they provide no clear documentation of consumer participation in the development of the plan. In our view, DHS bears some responsibility for the absence of recipient signatures on these plans. DHS has distributed a template for a care plan that agencies may use, but it does not include a place for the signatures of the recipient (or responsible party) or qualified professional.

Over one-fourth of files we reviewed did not contain appropriate documentation of a recipient's medical need for PCA services.

We found similar problems with the physician statements of need. Twenty-eight percent of recipient files we examined did not have a current physician statement of need at the time the claimed services were provided. In some cases, it appeared that doctors were not timely in completing these documents and returning them to the PCA agency. In other cases, there was no evidence that the PCA agency sought a physician statement of need in a timely manner.

We did not determine whether the problems cited above represented intentional efforts by PCA agencies, personal care assistants, or recipients to obtain unauthorized financial benefits. If the compliance problems we observed do not indicate fraud, however, they certainly reflect laxity in the administration of PCA services. A lapse of several days or months without a current care plan or physician statement of need might not have an adverse impact on the services actually provided to recipients. However, violations of payment rules established by the Legislature and DHS undermine the fiscal integrity of PCA services and should not be taken lightly.

STATE EFFORTS TO ADDRESS PROBLEMS

The state relies on several approaches to foster financial integrity in PCA services. These include (1) investigations by state fraud units, (2) controls on agencies' claims for payment, (3) screening agencies during the provider enrollment process, and (4) providing agencies with training and information. Below, we describe these efforts and identify areas still needing attention.

State PCA-Related Investigations

As noted earlier, the state has two units that investigate fraud and abuse in the Medicaid program, and each has devoted significant resources to PCA issues. Investigations by SIRS and the Attorney General have led to suspensions of providers, recoveries of improper payments, and even criminal convictions. Concerns expressed by these units have contributed to DHS's efforts to

[27] *Minnesota Statutes* 2008, 256B.0625, subd. 19c.

implement stronger financial controls and procedures. Still, it is important to note that:

- **The scope and breadth of the state's PCA-related investigations have often been limited.**

Due to resource constraints, state fraud investigations have often had a narrow focus.

First, SIRS staff have rarely had the time or resources to conduct audits of randomly-selected PCA agencies. The main exception was a 2005 compliance review of a statewide sample of PCA claims, selected at random. Second, SIRS usually conducts investigations in a somewhat limited number of PCA agencies in a given year. In 2006, SIRS investigated 31 personal care provider agencies; in 2007, it investigated 34 of these organizations.[28] The questionable claims we discussed earlier were associated with personal care assistants working for 70 agencies. At its 2006-07 rate, SIRS would need over two years to investigate these agencies, especially if it continued to conduct investigations in response to complaints.[29] Third, SIRS investigations most often focus on the actions of a single person, rather than looking more broadly at practices throughout an agency. We reviewed 41 cases closed in 2007 and early 2008, and more than 60 percent focused on a single personal care assistant or a single recipient. There were exceptions, such as a case in which SIRS expanded its investigation of an agency to review state payments made on behalf of all of the agency's personal care assistants over the course of a year. SIRS staff said they would prefer to look in more depth at more agencies, if resources allowed.

Limits on the scope of SIRS investigations also limit the volume of cases referred for prosecution to the Attorney General. Still, staff in the Attorney General's Office have implemented their own limits, restricting their investigation of PCA-related referrals to cases with potential recoveries exceeding $5,000. Attorney General staff welcomed the Minnesota U.S. Attorney's Office's creation in 2008 of a multi-agency task force to focus on investigation of PCA services. This task force includes staff from the U.S. Attorney, Minnesota Attorney General, U.S. Department of Health and Human Services Office of the Inspector General, Federal Bureau of Investigation, and Internal Revenue Service. Attorney General staff told us the involvement of federal agencies is providing resources for surveillance and investigation that were not previously available.

Controls on PCA Claims

DHS has instituted some important policies and procedures to improve accountability for PCA claims. In 2005, DHS established an enrollment process to assign provider identification numbers to individual personal care assistants,

[28] SIRS investigated 101 personal care provider agencies in 2005, mainly during its compliance review of a random sample of claims.

[29] It is likely that not all 70 agencies require investigation, but this example reinforces the inability of SIRS to respond to anything but complaints at its current rate of investigations.

enhancing its ability to monitor the hours worked by individual caregivers.[30] Also, effective April 1, 2008, DHS policy required PCA agencies to submit separate payment claims for each day of service by each personal care assistant. Previously, PCA agencies could submit individual claims that covered multiple days of service by a personal care assistant. This change made it possible for state investigators to identify actual hours of work claimed for an individual personal care assistant per day. SIRS staff can now directly compare the claimed work hours on a date with the hours reported for that date on personal care assistants' timesheets.

DHS has changed some procedures to improve fiscal integrity, but it needs to do more.

In addition, DHS announced a policy that it would not pay for more than 24 hours of service per day per personal care assistant, effective May 1, 2008. However, as our earlier discussion illustrates, we found:

- **Through late 2008, DHS had not implemented an effective way to stop payments in cases that involved reports of impossible or excessive work hours.**

In fall 2008, DHS staff confirmed that they had not yet implemented a way to systematically identify and prevent payment of claims for more than 24 hours per day per personal care assistant. DHS officials told us that the agency intends to implement a way to flag these excessive claims by early 2009.

DHS's failure to prevent payment of these clearly improper claims through improvements in its claims processing procedures raises questions about its ability to detect less obvious problems. Detecting improprieties in cases involving more limited work hours would involve, at a minimum, some review of agencies' documentation supporting the claims. But even with on-site visits, it might be difficult to detect cases in which a recipient and a personal care assistant have colluded to defraud the state—especially if the fraudulent claims submitted to the state matched the timesheets signed by the recipient and caregiver. Such fraud might only be detected with on-site surveillance of recipients and personal care assistants.

PCA Agency Enrollment

Since 1988, Minnesota has relied on provider agencies to administer personal care services on behalf of the state. DHS enrolls organizations that perform key administrative tasks: submitting claims to the state, paying caregivers, and sometimes recruiting and supervising personal care assistants. We found that:

- **Current state requirements for PCA provider agencies are insufficient to prevent enrollment of agencies with questionable management skills.**

[30] In our review of personal care assistants' provider numbers, we identified a relatively small number of personal care assistants who had more than one provider number. Multiple provider numbers could prevent DHS from easily identifying individuals with excessive work hours.

It is relatively easy in Minnesota to establish an agency authorized to administer PCA services. State law sets relatively few requirements for an agency to enroll with the Department of Human Services as a "personal care provider organization." As discussed in Chapter 1, there is no requirement for such agencies to obtain a license from the state. The law specifies that: (1) agency managers and primary owners must pass criminal background checks, and (2) the agency must maintain a surety bond and liability insurance.[31]

There is too little scrutiny of agencies seeking to provide PCA services.

State rules set forth additional requirements for agencies seeking to provide PCA services, but DHS's scrutiny of compliance with these requirements has been limited. For example, the rules require applicants to demonstrate that their services will be cost-effective, they follow generally accepted accounting principles, they have a system of personnel management, and they have a quality assurance mechanism.[32] DHS staff told us they review the applying agency's bank balance and verify the credentials of the agency's "qualified professionals," but they do not independently verify agency compliance during the enrollment process with many of the other enrollment requirements in state rules. For some agency enrollment requirements—such as having a grievance process—DHS officials told us they monitor compliance through quality assurance reviews (which would only be conducted after agencies have started providing services).

Both DHS and the Attorney General have voiced concern that it is too easy for former owners of fraudulent PCA agencies and owners without necessary management skills to enroll new PCA provider agencies in Minnesota. In several cases, DHS has suspended payments to certain PCA agencies, only to find later that the agency's owners have started a new PCA agency with a different name. In addition, DHS officials told us that basic management issues are the topic of many of the calls PCA agencies make to DHS's call center for health care providers.

DHS has developed a process to ensure that enrolled PCA agencies continue to meet certain enrollment requirements. The process calls for DHS to annually send a letter to PCA agencies to verify and update information about the agencies' liability insurance, surety bond, qualified professional, and ownership. As of late 2008, however, DHS placed implementation on hold due to reallocation of resources to other projects. When the project is complete, the letter will be sent automatically, based on a PCA agency's liability insurance expiration date.

PCA Agency Training

One way to prevent improper payments for PCA services is to ensure that agency officials are knowledgeable about state PCA requirements and billing practices. Many PCA agencies are relatively new, and health care officials have raised

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[31] *Minnesota Statutes* 2008, 256B.0655, subd. 1g. As part of the provider enrollment process, DHS does some additional tasks, such as determining whether the agency appears on a federal list of businesses excluded from eligibility for health care program payments.

[32] *Minnesota Rules* 2008, 9505.0335, subp. 5.

questions about their management capabilities. From the beginning of 2007 through July 2008, DHS newly enrolled an average of nearly 12 unlicensed personal care provider agencies per month, compared with 7.6 per month from 2003 through 2006. Overall, the number of unlicensed personal care provider agencies paid by the state for PCA services increased from 167 in fiscal year 2002 to 417 in fiscal year 2007, an increase of 150 percent. During this period, the number of licensed home health agencies paid to provide PCA services was more stable, declining slightly from 82 in fiscal year 2002 to 78 in fiscal year 2007.

Many agencies that administer PCA services are also relatively small. Table 3.4 shows that more than half of all PCA agencies served 15 or fewer fee-for-service recipients in fiscal year 2007. In fact, 31 percent of agencies served five or fewer fee-for-service recipients. Between 2002 and 2007, there was particular growth—174 percent—in the number of unlicensed personal care provider agencies serving 15 or fewer fee-for-service recipients.[33] The increase in the number of relatively small PCA agencies has raised questions about whether these agencies have the required management skills to comply with PCA requirements.[34]

Table 3.4: Provider Agencies by Number of Fee-For-Service PCA Recipients Served, Fiscal Year 2007

	Number of Agencies in These Size Categories			Percentage of Agencies in These Size Categories		
Number of Recipients	Unlicensed Personal Care Provider Agencies	Licensed Home Health Agencies[a]	Total	Unlicensed Personal Care Provider Agencies	Licensed Home Health Agencies	Total
1 to 15 recipients	225	37	262	54.0%	47.4%	52.9%
16 to 50 recipients	110	16	126	26.4	20.5	25.4
51 to 100 recipients	51	18	69	12.2	23.1	13.9
Over 100 recipients	31	7	38	7.4	9.0	7.7
Total	417	78	495	100.0%	100.0%	100.0%

[a] The number of home health agencies includes only the agencies that submitted claims for PCA services.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

[33] Aside from the fiscal integrity issues raised by the increase in new PCA agencies, we also heard concerns that the larger number of small PCA agencies may have increased statewide PCA administrative costs, due to diseconomies of scale. We could not readily determine whether this has occurred because PCA agencies do not report their administrative costs to the state.

[34] Recently, a working group of DHS and health plan officials said that some PCA agencies trying to compete in this market "increase their profit margin by minimizing client support, record keeping, and PCA oversight." See Program Integrity Subcommittee of the DHS PCA Workgroup, *Program Integrity*, 3.

In an effort to help the increasing number of new PCA agencies, DHS has taken some important steps to increase training opportunities. Most notably, DHS started in January 2008 to offer a three-day training program for PCA agency owners and administrators.[35] Key topics covered during this program include how recipients obtain PCA services, eligibility of services for state reimbursement, statutory requirements affecting PCA agencies, and how to bill DHS for services provided. However:

- **Training for administrators of PCA agencies is voluntary, and most agencies have not yet had a staff person attend it.**

We examined DHS records showing which PCA agencies have had owners or staff who attended the three-day training sessions. We focused on unlicensed personal care provider agencies because these agencies are subject to fewer state requirements and have less experience billing the state for services than licensed home health agencies. Through the end of 2008, only 31 percent of the personal care provider agencies enrolled with DHS had at least one staff member who had completed the training.

Policies on Services Eligible for Payment

Without clearer state policies, PCA provider agencies may misunderstand the types of services their employees can deliver.

It is important for DHS to have clear state policies about which types of services are eligible for state payment. Such policies help PCA agencies comply with the law; they also help state investigators enforce the law. State law lists activities that are eligible and ineligible for state PCA payments.[36] Nevertheless, we concluded that:

- **There is too much ambiguity in state policy about the specific types of PCA services that may be covered by state payments.**

In training sessions, DHS staff have provided guidance to supplement the provisions in law. Presumably, DHS has offered this guidance to help agencies apply broad policies to real circumstances that PCA agencies may encounter. For instance, DHS trainers have said that non-covered services include: mentoring, educational training or support for recipients, daycare or babysitting, helping recipients with homework, providing vocational or recreational skills training, providing or supporting independent living skills, and respite care for parents or other family members. However, we are not aware of written policies that explicitly prohibit payment for these activities.

During our study, we observed and heard varying notions about what PCA services include. In an appeals case, a state human services judge ruled in favor of limiting certain aspects of a recipient's PCA services, noting that "companionship is not a service that is medically necessary." Yet we also reviewed records indicating that some personal care assistants played games,

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[35] In addition, DHS started offering half-day "labs" for PCA agencies in mid-2007, focusing largely on proper billing.

[36] Most of these provisions are in *Minnesota Statutes* 2008, 256B.0655, subd. 2.

watched TV, or did homework with recipients or walked recipients' dogs. In addition, recent increases in the number of PCA recipients assessed as having behavioral problems may raise questions about what specific services personal care assistants can provide to these recipients without providing "therapy."[37] Finally, state fraud investigators told us it is sometimes difficult to determine agency compliance due to ambiguities about which PCA activities are allowable. In general, we think there is room for state policy to more clearly specify which services can be reimbursed with federal and state funds for health care services.

RECOMMENDATIONS

The vulnerability of PCA services to fiscal integrity problems and our evaluation of the state's efforts in this area lead us to make several recommendations to the Department of Human Services and the Legislature.

RECOMMENDATION

DHS should regularly and promptly analyze its data on paid claims for PCA services to identify and recoup payment of improper claims.

Analyzing claims data should be a first step in identifying questionable payments for PCA services.

Analysis of claims data is a relatively low-resource approach to identifying agencies that may be submitting erroneous or fraudulent claims.[38] In light of the resource constraints under which the state's fraud units operate, strategic analysis of claims data could help focus limited resources on clear problems. Although the questionable claims we identified represented a small percentage of all claims, we think this type of data analysis is important. The claims we identified were associated with personal care assistants working for over 10 percent of the agencies with paid claims in May (70 of 514 agencies). Additional analysis of data would allow DHS to focus on the agencies with a greater number or frequency of problem claims. For example, one agency was responsible for the seven instances in which a personal care assistant allegedly provided over 100 hours of care in a day. According to DHS, SIRS has started doing more post-payment reviews of this type in recent months.

We think there is a strong need for the state to increase its oversight of PCA agency compliance. SIRS has conducted useful, well-documented reviews of PCA agencies, and the state would benefit from more frequent reviews of this sort.

[37] According to a "resource document" in DHS's Disability Services Policy Manual: "PCA staff are not trained or paid to do mental health or behavioral therapy following a behavioral plan written by a mental health professional. [Personal care assistants] may be oriented to a behavior/treatment plan including if and where their role in observation, monitoring, intervention and redirecting fits into the overall behavior/treatment plan."

[38] In some cases, analysis of data alone would not definitively identify improper claims. For personal care assistants whose excessive work hours were accumulated over numerous agencies, additional investigation might be required to determine which specific claims were valid and which were not.

Risks to the fiscal integrity of PCA services suggest the need for sustained attention from state fraud investigators.

RECOMMENDATION

To the extent possible, DHS should reallocate existing resources to conduct more PCA-related investigations.

PCA services already consume a disproportionate share of DHS's investigative resources. Also, we recognize that DHS operates within financial constraints, and PCA is only one part of the Medicaid program it administers. However, it is important for DHS to aggressively review PCA agencies, for several reasons. First, there are many relatively new agencies administering PCA services, and these types of agencies may pose a greater risk for improper payments than well-established agencies. Second, state investigators generally believe that there are greater vulnerabilities in PCA services than in most other Medicaid services. DHS officials told us that the state may be obligated to repay the federal government for improper payments even in cases where the state is unable to recoup money owed by the provider agency, so the state bears an important financial risk. Third, past PCA investigations have led to constructive procedural changes to improve integrity, such as requirements for the enrollment of personal care assistants and for single-day claims. Therefore, we think that expenditures on PCA investigations have been a sound investment.

The 2009 Legislature should have discussions with DHS officials about the potential for increased PCA agency oversight within existing resources and authority. If legislators subsequently want to consider *additional* ways to increase oversight, we think two options should be considered. First, the Legislature could authorize annual enrollment fees for PCA agencies to help offset the costs of state regulation and oversight. The Legislature has often authorized fees for this purpose for licensed facilities, but it has not done so for unlicensed personal care provider agencies. Second, the Legislature could require PCA agencies to submit additional information to the state, perhaps allowing DHS to conduct improved oversight even in cases where it cannot conduct compliance reviews in the field. For example, if PCA agencies were required to provide DHS with copies of each PCA recipient's most recent physician statement of need, DHS might be able to audit agency compliance more efficiently.

There should be stricter enrollment standards for PCA provider agencies.

RECOMMENDATION

The Legislature should require representatives of new and existing personal care provider agencies to periodically complete comprehensive state training on PCA standards and practices.

In our view, new PCA agencies should not be allowed to enroll with DHS until key staff have completed a course such as the three-day course implemented by DHS in 2008. In addition, agencies already serving PCA recipients should be required to have staff periodically complete this training.

RECOMMENDATION

The Legislature should amend state law to explicitly authorize DHS to reject agency applications for PCA enrollment in cases where the agency's owners or administrators have previous violations of federal or state regulations.

Stricter enrollment standards—such as requiring new PCA agencies to complete a DHS training course—might dissuade some owners of questionable agencies from trying to restart their businesses. However, we also think the law should clarify that DHS may consider the track record of agencies' owners and administrators when determining whether to authorize the agencies' enrollment in the PCA program. Minnesota law has this type of provision for some other types of service providers. For instance, the law authorizes the Department of Health to deny home care licenses to agency owners or managers whose licenses have previously been revoked.[39]

RECOMMENDATION

The Legislature should direct DHS to propose more specific policies regarding which PCA activities are (and are not) reimbursable.

PCA agencies should be able to get clear, detailed descriptions in easily-accessible state policies about which services are reimbursable. For example, someone who has not attended a DHS training session might not understand that helping a PCA recipient with homework is not considered by DHS to be a reimbursable activity. The Legislature should consider whether clarifications of policies on reimbursable activities should be developed through amendments to state laws or rules rather than less formal processes, such as amendment by DHS of its administrative policies and manuals.

[39] *Minnesota Statutes* 2008, 144A.46, subd. 3.

4 Service Quality

State oversight of service quality is important in personal care assistance (PCA) for several reasons. PCA services are provided to potentially vulnerable individuals in their homes. Unlicensed individuals, most often employed by unlicensed agencies, provide the care. Professional supervision of the care is done at the recipient's or responsible party's option. In this environment, it is important for the state to ensure that providers understand and follow the policies and procedures designed to result in appropriate care.

In this chapter, we discuss various topics that affect the quality of PCA services: (1) measurement of service outcomes, (2) statewide quality assurance planning, (3) periodic quality assurance reviews of provider agencies, (4) ongoing supervision of PCA services, (5) protection of service recipients from maltreatment, (6) the adequacy of information consumers receive, (7) the reasonableness of caregivers' work hours, and (8) caregiver training and compensation. Weaknesses in these areas place service recipients at risk, and we highlight needed improvements that merit the attention of the Legislature and Department of Human Services (DHS).

OUTCOMES

Given Minnesota's large investment of public dollars in personal care services, it would be useful to have information demonstrating the impact of these expenditures. However, it is unclear what measures should be used to evaluate these services. This is because:

- **Minnesota statutes do not clearly define the intended outcome of personal care services.**

Minnesota law lists various activities that qualify for state payment, but it does not state an ultimate purpose for PCA services. DHS's *PCA Consumer Guidebook* says these services are "designed to support people of all ages with disabilities to live independently in the community."[1]

To better understand the impact of PCA services, we talked with consumer advocates and several groups of service recipients, and we reviewed previous research. We found:

- **There has been little systematic analysis of PCA outcomes or cost-effectiveness, in Minnesota or elsewhere, but many recipients strongly value the PCA services they receive.**

[1] Department of Human Services, *Personal Care Assistance (PCA) Program Consumer Guidebook* (St. Paul, May 2007), 7.

We are not aware of any formal evaluations of the cost-effectiveness of PCA services in Minnesota, so we examined research conducted elsewhere.[2] Researchers have evaluated various types of home and community-based services, but few carefully controlled studies have specifically examined personal care services.[3] For example, a 2008 research summary on personal care services for children with intellectual impairments found hundreds of articles from many countries discussing personal care services, but only one study met the authors' criteria for scope and methodological rigor.[4]

Personal care assistance (PCA) recipients expressed considerable satisfaction with their services in Minnesota's only statewide user survey.

In Minnesota, there has been one statewide survey of PCA consumers. That survey, conducted in 2003, found that: "In general, PCA consumers express strong satisfaction with the quality of care they receive through the PCA program, PCA workers, and their provider agencies."[5] Overall, 69 percent of the surveyed consumers rated quality of care as "excellent," 25 percent "good," 5 percent "fair," and 1 percent "poor." The survey asked recipients to name the most valuable aspect of PCA services, and "most consumers described how it helps them and their families to lead a more active, less stressful life."[6] In addition, recipients generally said they liked being able to choose their own personal care assistants and schedule services when needed.[7]

The 2007 Legislature directed DHS to conduct an annual survey of recipients served by various disability programs "to determine the effectiveness and quality" of these services.[8] It specified that "[t]he survey shall analyze whether desired outcomes have been achieved for persons with different demographic,

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[2] *Minnesota Statutes* 2008, 256B.0655, subd. 1b, requires individual client assessments to include an "evaluation of service effectiveness." In practice, however, PCA assessments do not involve measurement of service impacts on clients' health or well-being. Rather, the "cost-effectiveness" portion of the assessment requires an assessor to determine that the estimated cost of PCA and other home care services does not exceed a dollar limit established by DHS for the individual's assessed needs. Also, *Minnesota Rules* 2008, 9505.0335, subp. 5, requires each PCA agency applying to enroll with DHS to "demonstrate the cost effectiveness of its proposal for the provision of personal care services," but DHS does not have criteria for evaluating this. DHS recently hired a consulting firm to study PCA services, including an analysis of cost-effectiveness.

[3] Some useful reviews of past research include: David C. Grabowski, "The Cost-Effectiveness of Noninstitutional Long-Term Care Services: Review and Synthesis of the Most Recent Evidence," *Medical Care Research and Review* (February 2006), 3-28; National Council on Disability, *Consumer-Directed Health Care: How Well Does It Work?* (Washington, DC, October 26, 2004); and Paul Montgomery, Evan Mayo-Wilson, and Jane A. Dennis, "Personal Assistance for Children and Adolescents (0-18) with Intellectual Impairments," *Cochrane Database of Systematic Reviews*, Issue 3 (2008), 1-25.

[4] Montgomery, Mayo-Wilson, and Dennis, "Personal Assistance for Children and Adolescents (0-18) with Intellectual Impairments."

[5] Cara L. Bailey, *Minnesota's 2003 PCA Consumer Survey* (St. Paul: Wilder Research Center, for the Minnesota Department of Human Services, May 2004), 1. The survey was based on responses from 455 randomly selected PCA recipients.

[6] *Ibid.*, 4.

[7] *Ibid.*, 44-45.

[8] *Laws of Minnesota* 2007, chapter 147, art. 7, sec. 18, subd. 3. The law required the survey for home and community-based waiver service programs, but DHS staff told us it will be conducted for Medical Assistance State Plan recipients, too. The law required field testing of the survey in 2008.

diagnostic, health, and functional needs receiving different types of services, in different settings, with different costs." Although this survey will cover a broad range of service recipients when it is implemented, it has the potential to provide useful information about PCA services.

During our evaluation, we talked with many PCA recipients, family members, and consumer advocates who emphasized the valuable role that PCA services play. Recipients emphasized that PCA services increase their ability to lead a normal life. For instance, one recipient told us he would be in a nursing home without PCA services, due to physical disabilities that prevent him from getting out of bed on his own and doing daily personal tasks. With PCA, he runs his own business and participates regularly in community activities. We also heard from a mother of twin five-year-olds who have intellectual disabilities, autism disorders, and speech impairments. Before getting PCA services, it was difficult for the woman and her disabled husband to protect the children from harm. For example, the children sometimes ran away or played with knives. PCA services have enabled the mother to focus on the needs of one child at a time, without placing the safety of the other child at risk.

Based on our interviews, it also seemed to us that many PCA owners and administrators have a sincere desire to serve the best interests of their recipients. For example, one agency owner told us she went into the home health care business to help recipients avoid the fate of her grandfather, who was beaten to death in a nursing facility. Another agency's first PCA recipient needed a kidney transplant, and the agency's owner donated one of hers when the recipient had difficulty finding a compatible donor. Some owners started their PCA agencies following years of experience in nursing or home health care.

It is difficult to measure the cost-effectiveness of personal care services.

Even if consumers are generally satisfied with the personal care services they receive, it is difficult to conclusively measure the cost-effectiveness of these services. In part, this is because it is hard to quantify the extent to which consumers of home-based services would otherwise be living in more expensive institutional settings.[9] In addition, there are long-standing concerns that expansions of home and community-based service options may have contributed to higher aggregate long-term care expenditures, due to some substitution of publicly funded care for informal, unsubsidized care.[10]

QUALITY ASSURANCE PLAN

The 2001 Minnesota Legislature required DHS to develop a quality assurance plan for PCA services. According to the law, the plan should include:

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[9] Medicaid waivers for home and community-based services are specifically targeted to persons who would otherwise qualify for institutional care. However, non-waiver recipients account for most of Minnesota's PCA recipients, and it is unclear what their needs for institutional care would be if PCA services were not available.

[10] For example, see Pamela Doty, U.S. Department of Health and Human Services, *Cost-Effectiveness of Home and Community-Based Long-Term Care Services* (Washington, DC, June 2000). According to this report, a review of research indicated that a so-called "woodwork effect" "seriously impedes the cost-effectiveness of home and community-based services."

> (1) performance-based provider agreements; (2) meaningful consumer input, which may include consumer surveys, that measure the extent to which participants receive the services and supports described in the individual plan and participant satisfaction with such services and supports; (3) ongoing monitoring of consumer health and well-being; and (4) an ongoing public process for development, implementation, and review of the quality assurance plan.[11]

We found that:

- **The Department of Human Services has not completed the personal care assistance quality assurance plan required by law.**

DHS has done some work on quality assurance, but it has not completed the plan required by the 2001 Legislature. DHS addressed one component of the plan through a PCA consumer satisfaction survey in 2003. The survey gathered information on satisfaction with various aspects of PCA services, including assessments, service quality, and assistants' training.[12] DHS has not conducted another statewide consumer survey since that time.

Over the years, the department has pursued some additional quality assurance initiatives. For example, as Table 4.1 shows, DHS developed a guidebook for PCA consumers in 2003.[13] In 2006, the department started conducting on-site reviews of PCA agencies. Two years later, DHS started offering training for personal care provider agencies.

In addition, DHS has engaged in broad quality assurance planning for home and community-based care, including PCA. For example, in response to 2005 legislation, a group convened by DHS studied and recommended a quality assurance model for disability services, including PCA.[14] The resulting report recommended: a state quality commission; regional quality councils to identify, design, and implement initiatives to improve services; annual surveys of service recipients; outcome-based quality assessment; and an effective system of reporting abuse, neglect, and exploitation. The Legislature included some of these recommendations in legislation requiring development of a "quality management, assurance, and improvement system" for individuals receiving

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[11] *Laws of Minnesota* First Special Session 2001, chapter 9, art. 3, sec. 41, codified in *Minnesota Statutes* 2008, 256B.0655, subd. 9.

[12] Bailey, *Minnesota's 2003 PCA Consumer Survey*.

[13] Department of Human Services, *Personal Care Assistance (PCA) Program Consumer Guidebook*, 5.

[14] *Laws of Minnesota* First Special Session 2005, chapter 4, art. 7, sec. 57, and Minnesota Quality Assurance Panel, *Quality Assurance 2007: Findings and Recommendations of the Legislatively-Mandated Quality Assurance Panel, Final Report* (Minneapolis: University of Minnesota, Research and Training Center on Community Living, February 2007).

disability services.[15] Although the legislation focuses on waiver programs, DHS intends to also apply it to PCA provided through the Medical Assistance (MA) State Plan.

The Department of Human Services (DHS) has undertaken some quality assurance initiatives, but it has not developed a quality assurance plan for PCA services.

Table 4.1: Quality Assurance Activities for Personal Care Assistance Services, 2001 to Present

2001	Minnesota Legislature requires the Minnesota Department of Human Services (DHS) to develop a quality assurance plan for personal care assistance (PCA). The plan is never completed.
2003	DHS contracts for a survey of PCA consumers. DHS produces a PCA Consumer Guidebook.[a]
2005	The Legislature mandates that DHS study and recommend a quality assurance system for disability services. The Commissioner of DHS creates a quality assurance panel to complete the study.
2006	DHS begins conducting quality assurance reviews of personal care provider agencies.
2007	The quality assurance panel recommends: (1) a state "quality commission;" (2) regional "quality councils" to identify, design, and implement initiatives to improve services; (3) annual surveys of service recipients; (4) outcome-based quality assessment; and (5) an effective system of reporting abuse, neglect, and exploitation. The Legislature passes a law requiring a quality management, assurance, and improvement system for individuals receiving disability services through waiver programs. DHS decides to incorporate home-based services delivered outside of waivers, including PCA.
2008	DHS begins offering a voluntary three-day training program for personal care provider agencies.

NOTES: Some DHS activities that are not specific to personal care assistance could affect the quality of PCA services. For example, fiscal accountability is addressed by the Surveillance Integrity and Review Section (SIRS) through its post-payment reviews and investigations of Medicaid programs. SIRS is discussed in Chapter 3. Also, consumer choice can help ensure quality, and some choice is built into PCA services. For example, recipients (or their responsible parties) can choose their PCA and whether they want qualified professional supervision.

[a] DHS updates the consumer guidebook periodically so that it stays current.

SOURCES: *Laws of Minnesota* First Special Session 2001, chapter 9, art. 3, sec. 41; Cara L. Bailey, *Minnesota's 2003 PCA Consumer Survey* (St. Paul: Wilder Research Center, for the Minnesota Department of Human Services, May 2004); Department of Human Services, *Personal Care Assistance (PCA) Program Consumer Guidebook* (St. Paul, May 2007); *Laws of Minnesota* First Special Session 2005, chapter 4, art. 7, sec. 57; Minnesota Quality Assurance Panel, *Quality Assurance 2007: Findings and Recommendations of the Legislatively-Mandated Quality Assurance Panel, Final Report* (Minneapolis: University of Minnesota, Research and Training Center on Community Living, February 2007); and *Laws of Minnesota* 2007, chapter 147, art. 7, sec. 18.

[15] *Laws of Minnesota* 2007, chapter 147, art. 7, sec. 18, codified in *Minnesota Statutes* 2008, 256B.096.

Overall, DHS's plan to develop a quality assurance system that focuses on a broad array of services, not just PCA, seems like a reasonable approach. But most of these activities are awaiting implementation, eight years after the Legislature mandated a PCA quality assurance plan.

QUALITY ASSURANCE REVIEWS

DHS started conducting quality assurance reviews of PCA agencies in 2006.

In 2002, the Office of the Inspector General for the U.S. Department of Health and Human Services completed an audit of Minnesota's claims for Medicaid PCA costs. Having found improper payments and provider noncompliance that could negatively affect quality of care, the Inspector General recommended that Minnesota "develop oversight mechanisms that would ensure compliance with [PCA] program rules."[16] Four years later, another Inspector General report noted that Minnesota was one of three states that did not conduct reviews or audits to ensure that personal care assistants meet program requirements.[17] The 2005 Minnesota Legislature authorized DHS to monitor PCA agencies for compliance with laws and rules.[18] The following year, DHS created a Quality Assurance Review program and began conducting reviews of PCA agencies. The program's mission is "to build better providers through education, training, and compliance."[19]

In our view, DHS's Quality Assurance Review program contains elements that could contribute to an effective program. These elements include a mission statement that clarifies and focuses the intended purpose of the program, and an investigative process and procedures that could help ensure that staff conduct reviews in a consistent manner.

The process that DHS has developed to fulfill its quality assurance mission includes: (1) procedures for receiving and assigning complaints for review; (2) procedures and a timeline for scheduling and conducting site visits or desk audits; and (3) a schedule for follow-up with providers.[20] Upon receiving a PCA-related complaint, staff determine whether it raises an issue that needs investigation by quality assurance staff or the Surveillance Integrity and Review Section (SIRS). Quality assurance staff address issues regarding service quality and recipient health and safety. In contrast, SIRS, discussed in Chapter 3, addresses complaints involving money, such as investigating alleged improper payments.

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[16] U.S. Department of Health and Human Services, Office of Inspector General, *Audit of Medicaid Costs Claimed for Personal Care Services by the Minnesota Department of Human Services, October 1, 1998 through September 30, 1999* (Washington, DC, April 2002), 6.

[17] U.S. Department of Health and Human Services, Office of Inspector General, *States' Requirements for Medicaid-Funded Personal Care Service Attendants* (Washington, DC, December 2006 revision), 18.

[18] *Laws of Minnesota* First Special Session 2005, chapter 4, art. 7, sec. 19, codified in *Minnesota Statutes* 2008, 256B.0655, subd. 10.

[19] Department of Human Services, "[PCA Quality Assurance] Investigative Process," April 13, 2007.

[20] For desk audits, providers send requested documentation to DHS.

During quality assurance site visits, staff review recipient and personal care assistant files to determine whether all necessary documents are in place. Staff also interview the owner or manager of the personal care provider agency. Staff inform the provider of their findings and follow up with a letter indicating deficiencies and whether a corrective action plan is needed. As appropriate, staff also give the provider educational materials. DHS policy calls for follow-up site visits to agencies 3, 6, and 12 months after the initial review. The process also directs staff to fully document each quality assurance review.

In spite of the process outlined above, we found that:

- **The Department of Human Services has implemented a weak Quality Assurance Review program with limited impact.**

Evidence of this is seen in: (1) the amount of staff and other resources the department has devoted to this area, (2) the breadth of program coverage, and (3) documentation of completed reviews.

DHS has not adequately staffed its PCA quality assurance program.

The number of staff and level of other resources assigned to the quality assurance program are too low to maintain a strong presence. At one time, four staff conducted reviews, with one person focused on desk audits and three conducting field audits. Although the number of PCA providers has grown, currently fewer than two full-time staff conduct reviews for the entire state. In fiscal year 2007, 495 personal care provider and home health agencies were paid for providing PCA services.[21] A full-time equivalent of fewer than two staff cannot provide sufficient attention to this number of agencies.

In addition, DHS suspended work on a database for the Quality Assurance Review program when it reassigned the staff developing it to other tasks. According to the program's lead staff person, the database would have assisted with fieldwork documentation and allowed her to generate summary reports and statistics on review findings. In late 2008, DHS officials told us that work has resumed on this database and it will soon be operational.

Further undermining a strong and proactive Quality Assurance Review program, the breadth of coverage provided by the program is inadequate. Evidence of inadequate coverage is seen in the number of and impetus for quality assurance reviews. We found documentation of 34 quality assurance reviews completed between the program's start in 2006 and mid-2008. Even if DHS conducted 34 reviews a year, it would take staff over 14 years to review all of the personal care and home health agencies that provided services in fiscal year 2007. Furthermore, evidence of follow-up by DHS with providers who have been

[21] This figure includes personal care and home health agencies that were paid through Medical Assistance for providing fee-for-service PCA services in fiscal year 2007.

reviewed is virtually nonexistent. We found evidence of follow-up in only 2 of the 26 quality assurance files we reviewed.[22]

Complaints were the impetus for most of the quality assurance reviews. Reviewing agencies based on complaints may be a sound strategy for prioritizing the use of scarce resources, but ideally a Quality Assurance Review program should include some random and "preemptive" reviews. Reviews of randomly selected agencies would give the department and other interested parties a better sense of the overall quality of personal care provider agencies and the issues that need attention. Preemptive reviews—that is, reviews conducted shortly after a provider's enrollment—would provide initial assurance that personal care provider agencies understand and comply with program requirements. Given concerns voiced by DHS and the Attorney General about the management capabilities of some providers, preemptive reviews seem like a wise idea.

Better documentation of quality assurance reviews could help DHS ensure that they are timely, consistent, and effective.

Finally, DHS quality assurance reviews were poorly documented, contributing to a weak Quality Assurance Review program. We were unable to evaluate the actual work completed by staff because of poor documentation. For example, we could not establish the timeliness of reviews or the extent to which staff adhered to the quality assurance process and procedures. Thorough and clear documentation of reviews could provide management with information on the extent of PCA agencies' compliance and areas of noncompliance. This knowledge could help the department identify topics to include in training or other communication with provider agencies. In addition, documentation could help management ensure that reviews are timely, consistent, and effective.

RECOMMENDATION

The Department of Human Services should strengthen its Quality Assurance Review program by: (1) increasing resources devoted to it; (2) expanding the number and types of reviews; and (3) improving documentation.

DHS needs to closely oversee the agencies that administer PCA services on its behalf. These agencies are not required to go through a licensing process, so it is especially important for them to be reviewed periodically.

SUPERVISION OF PCA SERVICES

From the time that publicly funded personal care services started in Minnesota in the late 1970s, there have been statutory provisions addressing supervision of these services. In 1977, the Legislature authorized Medical Assistance payment

[22] As mentioned above, DHS's investigative process says that follow-up site visits should be conducted after 3, 6, and 12 months. Although we found evidence of 34 completed reviews, we focused our evaluation of program files on site visits instead of desk audits. The eight files that we did not evaluate documented desk audits.

of PCA services "supervised by a registered nurse."[23] In 1999, the Legislature amended PCA supervision requirements in state law by substituting the term "qualified professional" for "registered nurse."[24] Today, for purposes of PCA supervision, "qualified professionals" are defined as registered nurses, mental health professionals, and licensed social workers, and they have the duties outlined in Table 4.2.[25] However, our review of existing statutes also indicated that:

- **Minnesota laws have contradictory provisions governing the requirements for supervision of PCA services.**

Recipients decide whether they want their PCA services supervised by a qualified professional.

Table 4.2: Supervision Duties of a "Qualified Professional"

- Through direct observation or consultation with the recipient, ensure that the personal care assistant is capable of providing the required personal care services.
- Ensure that the personal care assistant is knowledgeable about the care plan before providing personal care services.
- Ensure that the personal care assistant is knowledgeable about the recipient's health conditions and health-related observations that need to be made.
- Through direct observation or consultation with the recipient, conduct written evaluations of PCA services (1) within 14 days after placement of a personal care assistant with the recipient, (2) at least once every 30 days during the first 90 days of PCA services, and (3) at least once every 120 days after the first 90 days of PCA services.
- Review the care plan with the recipient and make necessary revisions at least once every 120 days following development of the plan. Ensure that the personal care assistant and recipient know about any changes in this plan.
- Ensure that records are kept showing the PCA services provided and the time spent doing so.
- Determine that a recipient is still capable of directing his or her own care (or, alternatively, that the recipient has a responsible party).
- Determine with a physician that a recipient is a qualified recipient.

SOURCE: *Minnesota Statutes* 2008, 256B.0655, subd. 13.

[23] *Laws of Minnesota* 1977, chapter 453, sec. 2, subd. 3.

[24] *Laws of Minnesota* 1999, chapter 245, art. 4, secs. 44, 50, 51, 53, and 54.

[25] *Minnesota Statutes* 2008, 256B.0625, subd. 19c.

One part of statutes specifies that PCA recipients (or their responsible parties) "may choose to supervise the personal care assistant or to have a qualified professional…provide the supervision."[26] In contrast, another part of statutes says that "personal care service to a qualified recipient…shall be under the supervision of a qualified professional."[27] Thus, the statutes are at odds regarding whether supervision by a qualified professional is required in all cases or only in cases where the recipient chooses it. But, in practice:

- **DHS allows PCA recipients to forgo ongoing supervision by a qualified professional.**

According to DHS, nurses conducting PCA assessments should offer recipients three supervision options: (1) the recipient will conduct all supervision of the personal care assistant, (2) a qualified professional will conduct all supervision, or (3) the recipient and qualified professional will share supervision tasks. A form developed by DHS requires the assessing nurse and recipient to specify one of these arrangements for each of several supervision tasks.

For certain recipients, DHS supervision requirements are less stringent than those required by state law.

DHS has also authorized supervision responsibilities for some qualified professionals that are less stringent than those in state law. Table 4.2 showed that the law requires qualified professionals to conduct written evaluations of individuals' PCA services at least every 120 days (and more frequently in the early weeks of service). But, for recipients who have opted to get services and qualified professional supervision from a "PCA Choice" agency, the supervision requirements adopted by DHS differ from those in statute. DHS's policies only require a qualified professional who supervises a PCA Choice recipient to visit the recipient "at least once a year."[28] Also, DHS policies do not specify whether the qualified professional must prepare a written evaluation of services in these cases.

To assess the actual extent to which qualified professionals supervise PCA services, we looked at two sources of data. First, we analyzed statewide MA payments to PCA agencies for supervision of fee-for-service recipients.[29] Second, during site visits to 26 PCA agencies, we reviewed documentation of supervision in recipient files. We found that:

- **Most PCA recipients have their services supervised by qualified professionals, but supervision frequency and documentation is sometimes inadequate.**

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[26] *Minnesota Statutes* 2008, 256B.0655, subd. 2(e). This supervision provision was passed by the Legislature in 2001. This section of the law also requires that any health-related tasks delegated to a personal care assistant by a licensed health care professional must be supervised by a qualified professional or under the direction of the recipient's physician.

[27] *Minnesota Statutes* 2008, 256B.0655, subd. 13. This subdivision was added by the 2007 Legislature.

[28] Department of Human Services, *Disability Services Program Manual*, Personal Care Assistance Choice Option.

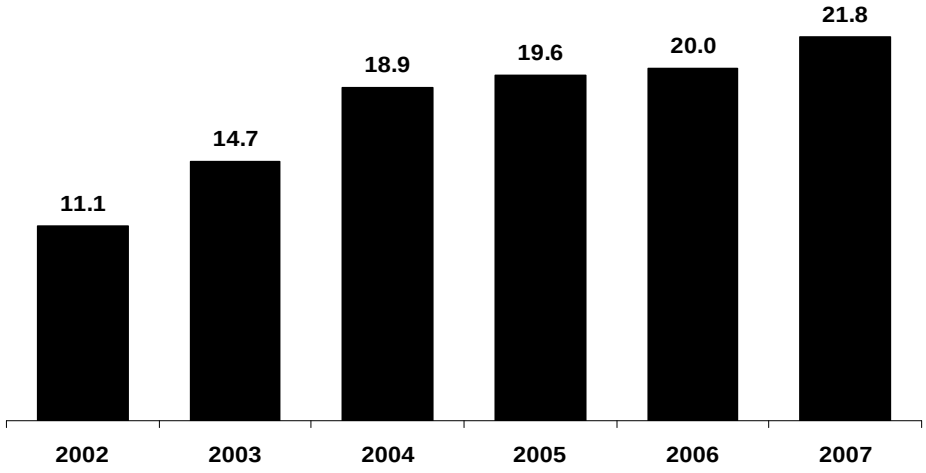
[29] Effective October 2008, the state pays for PCA supervision at a rate of $28.56 per hour.

Our review of statewide payment data indicated that 78 percent of fee-for-service PCA recipients in fiscal year 2007 received paid supervision from a qualified professional. However, Figure 4.1 shows that the percentage of recipients with no paid supervision on their behalf increased from 11 percent in fiscal year 2002 to 22 percent in fiscal year 2007. Furthermore, there were many cases in which the supervision provided by qualified professionals was for modest amounts of time. In fiscal year 2007, one-third of the individuals who received qualified professional supervision received a half hour or less per month, on average.

During our site visits, we examined the extent and nature of supervision by qualified professionals, based on documents in recipient files. We first determined which recipients had elected to receive their supervision from a qualified professional.[30] Of those who had, we found that 82 percent of these recipients had documentation of at least one written evaluation of PCA services in their files. However, only 57 percent of recipients had evaluations of PCA services that complied with the frequencies specified by state law and DHS. Also, many of the written evaluations of PCA services consisted only of checklists, with few or no narrative comments by the qualified professional.

Increasingly, PCA recipients have not had professional supervision of their services.

Figure 4.1: Percentage of Medical Assistance Fee-for-Service PCA Recipients Without Paid Supervision, Fiscal Years 2002-07



SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

[30] Most often, we relied on the recipient's service plan to specify whether the recipient had elected to have supervision by a qualified professional. For files without service plans, we looked for other documentation or talked with the PCA agency's staff to determine supervision arrangements for the recipients. Of the 185 recipients whose files we reviewed, we saw evidence that 151 elected to have supervision by a qualified professional.

In addition, we observed one problem that does not appear to be specifically addressed by statutes, rules, or other state policies. In 2 of the 26 agencies we visited, we saw cases in which a recipient's personal care assistant also served as the recipient's qualified professional. Such an arrangement would not allow for independent supervision of the recipient's PCA services.

We heard significant disagreements from PCA agency directors about the need for ongoing supervision by qualified professionals. On one hand, the director of a PCA agency told us that all of his 90 recipients were capable of supervising their own services. He said his agency has not arranged for qualified professional supervision of any of his recipients during the past year. Recipient files we reviewed at this agency had no documentation about the adequacy of services provided to recipients.

On the other hand, some agency directors told us that all PCA recipients should have ongoing, external supervision. In fact, some directors said they only enroll recipients who are willing to accept periodic supervision of their services by a nurse. They cautioned that even family members and friends who are serving as personal care assistants do not always act with the recipient's best interests in mind.

Supervision by qualified professionals helps protect recipients and provides some accountability to the state for its expenditures.

In our view, ongoing supervision of recipients by qualified professionals serves important purposes. First, supervision helps ensure that vulnerable persons are receiving appropriate services and that their health and safety are being protected. Some service recipients (or their responsible parties) may be capable of judging for themselves—without the assistance of a qualified professional—whether PCA services are meeting recipient needs. But supervision also serves a second purpose, for which the role of the qualified professional seems less dispensable. Supervision by qualified professionals helps provide accountability to the state that its public expenditures have been used wisely—specifically, that services were actually provided, and the caregivers delivered satisfactory care. For this reason, we have serious concerns about state policies that allow recipients to "opt out" of supervision by a qualified professional from their first day of PCA service.

RECOMMENDATIONS

The Legislature should clarify state statutes to ensure that all MA State Plan PCA recipients have their services periodically supervised by a qualified professional.

The Legislature should amend state law to prohibit the same person from serving as both the qualified professional and personal care assistant for a recipient on an ongoing basis.

Individuals who receive PCA services through Medicaid waivers have case managers who help to coordinate and oversee their services. In contrast, recipients who receive services through the Medical Assistance State Plan typically do not have case managers. Thus, while it might be useful for all PCA recipients to have supervision by a qualified professional, it seems especially

important for the Legislature to require ongoing supervision of services for State Plan recipients.

In our view, all PCA recipients should receive some supervision from a qualified professional, although reductions in this supervision should be available when a personal care assistant has served a recipient for an extended period. For instance, perhaps statutes should require PCA services to be evaluated at least every 120 days by a qualified professional during a personal care assistant's fourth through twenty-fourth month of service to a recipient. Subsequently, there could be opportunities for reduction of supervision for those recipients who would prefer this, subject to approval by DHS or the managed care organization that administers the case on behalf of DHS.

Responsible parties and provider agencies could play stronger roles in supervision of PCA services.

In addition, we think that DHS should do more to encourage effective supervision of PCA services by persons other than qualified professionals. For example, DHS should help to ensure that "responsible parties" (where they have been designated) are aware of their duties. State law requires responsible parties to "monitor the services at least weekly according to the plan of care."[31] But, if weekly monitoring by responsible parties occurs, our site visits did not find that it is systematically documented in PCA agency records. Also, some PCA agency directors expressed concern about the lack of active involvement by responsible parties. We liked the approach of one PCA agency that provides its responsible parties with a "contract" that spells out their duties in detail.

RECOMMENDATION

DHS should develop a stand-alone document for PCA assessors and PCA agencies to distribute that clearly and concisely states the duties of a responsible party.

There is a list of responsible party duties in DHS's *PCA Consumer Guidebook*.[32] However, this guidebook is a lengthy document, and it would be useful to have a document focused solely on responsible party duties that could be readily distributed to these parties at the time a recipient is assessed or begins services. Until recently, DHS listed the duties of responsible parties on the standard form used by assessors to develop recipients' service plans. DHS staff told us they would like to develop a "fact sheet" on responsible party roles and a tool that would demonstrate responsible parties' understanding of these roles.

Also, we think that problems with service quality and fiscal integrity are less likely to occur if DHS encourages PCA agency administrators to maintain regular contact with recipients.

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[31] *Minnesota Statutes* 2008, 256B.0655, subd. 1h.

[32] Department of Human Services, *Personal Care Assistance (PCA) Program Consumer Guidebook*, 16.

RECOMMENDATION

DHS should amend its provider manual to require Personal Care Provider Organizations to periodically make visits or phone calls to recipients' residences to verify that scheduled services are actually being provided.

Some PCA agencies periodically make phone calls or unannounced visits to recipients' homes to verify that the personal care assistant is working the scheduled shift. We think this is a good practice, and DHS should provide guidance to agencies about how to do this.

PROTECTION OF VULNERABLE PCA RECIPIENTS

Recipients of publicly funded PCA services are considered vulnerable to maltreatment. According to Minnesota law, individuals age 18 or older who receive services "from a person or organization that exclusively offers, provides, or arranges for personal care assistant services under the medical assistance program" are considered to be "vulnerable adults."[33] In addition, state law considers children under 18 to be potentially vulnerable to physical abuse, neglect, or sexual abuse, and it has specific provisions for reporting and investigating allegations involving children served by unlicensed Personal Care Provider Organizations.[34]

Responsibility for Maltreatment Investigations

As shown in Table 4.3, Minnesota law has a complicated set of provisions regarding agency responsibility for maltreatment investigations. The agencies with investigative responsibilities differ, depending on whether the alleged victims are (1) adults or children, and (2) served by licensed or unlicensed PCA agencies. We found that:

- **It is unclear whether alleged maltreatment of PCA recipients has been adequately investigated, partly reflecting confusion about which agencies are required to conduct the investigations.**

For allegations of child maltreatment, Minnesota law gives the Department of Health responsibility for investigations involving unlicensed home care agencies.[35] However, as of late 2008, the Department of Health web site said the

[33] *Minnesota Statutes* 2008, 626.5572, subd. 21. This law also says adults with "a physical or mental infirmity or other physical, mental, or emotional dysfunction" are vulnerable adults. Thus, it is reasonable to assume that adults whose need for PCA services has been documented by a physician would be considered vulnerable, even if they are served by organizations that do not *exclusively* provide PCA services under Medical Assistance.

[34] *Minnesota Statutes* 2008, 626.556, subds. 1, 2(b), 2(i), and 3(c).

[35] *Minnesota Statutes* 2008, 626.556, subd. 3c(c).

Table 4.3: Agency Compliance with Requirements for Investigations of Maltreatment Allegations Involving PCA Recipients

Investigations of Alleged Maltreatment of Adults	
Statutory Assignment of Responsibility[a]	Compliance With This Requirement
Licensed home care providers: State law designates the Minnesota Department of Health (MDH) as the lead investigative agency for licensed home care providers. *Minnesota Statutes* 2008, 144A.46 specifies which agencies must be licensed as "home care providers."	MDH complies with the requirement to conduct maltreatment investigations of the agencies it licenses as home care providers.
Licensed Personal Care Provider Organizations: State law designates the Minnesota Department of Human Services (DHS) as the lead investigative agency for providers licensed as Personal Care Provider Organizations.	There are no organizations licensed as Personal Care Provider Organizations, despite requirements for provider licensure in *Minnesota Statutes* 256B.04, subd. 16. Thus, there are no licensed Personal Care Provider Organizations at which DHS can conduct investigations.
Unlicensed PCA agencies: **MDH:** State law designates MDH as the lead investigative agency for programs "required to be licensed" as home care providers. From 1997 to 2008, *Minnesota Statutes* chapter 144A said that the only Personal Care Provider Organizations exempt from MDH's home care provider licensure were those serving just one person. In 2008, the Legislature exempted all Personal Care Provider Organizations from licensure pending implementation of new provider standards.	Due to lack of legislative funding, MDH did not implement licensure of Personal Care Provider Organizations between 1997 and 2008. During this time, MDH also did not investigate maltreatment involving Personal Care Provider Organizations that were subject to home care provider licensing requirements.
DHS: State law designates DHS as the lead investigative agency for providers "required to be licensed" as Personal Care Provider Organizations.	DHS staff said they have not done investigations involving Personal Care Provider Organizations because there are no requirements for DHS licensure of these agencies.
Counties: State law says that county social service agencies (or their designees) are the lead investigative agencies for "all other reports." This would include reports involving personal care provider agencies not required to be licensed.	DHS did not have a comprehensive system for tracking county adult protection investigations until 2008, so county compliance with statutory investigative requirements is unclear.

Investigations of Alleged Maltreatment of Children	
Statutory Assignment of Responsibility	Compliance With This Requirement
State law says MDH is responsible for investigating allegations of child maltreatment in unlicensed home health care.[b] The law does not specify which agency shall investigate maltreatment cases involving licensed home care agencies, although MDH has general authority to investigate complaints involving home care providers, as defined in *Minnesota Statutes* 2008, 144A.43, subd. 4.[c]	MDH's web site says that MDH's Office of Health Facility Complaints only investigates complaints related to "licensed facilities."

[a] *Minnesota Statutes* 2008, 626.5572, subd. 13.

[b] *Minnesota Statutes* 2008, 626.556, subd. 3c.

[c] *Minnesota Statutes* 2008, 144A.51-144A.53.

SOURCE: Office of the Legislative Auditor, review of statutes and Department of Health web site, and interviews with agency officials.

department only handled complaints involving *licensed* agencies.[36] This inaccurate description of the department's authority may have discouraged reporting of PCA-related complaints to the department, given that the majority of agencies administering PCA services are unlicensed. In addition, Minnesota's child maltreatment law does not specify which agency is required to investigate cases involving home care providers licensed by the Department of Health.[37] The Department of Health told us it received only six PCA-related child maltreatment allegations during a recent 30-month period. Four involved unlicensed agencies and two involved licensed agencies.

State agencies have played a limited role in investigation of PCA-related maltreatment allegations.

For allegations of adult maltreatment, the Department of Human Services is supposed to investigate maltreatment in agencies "licensed or required [by law] to be licensed" as Personal Care Provider Organizations.[38] However, the law does not specifically require licensure of Personal Care Provider Organizations, so DHS has not conducted PCA-related maltreatment investigations.[39] The law also requires the Department of Health to investigate maltreatment in agencies "which are licensed or are required to be licensed" as home care providers. Between 1997 and 2008, *Minnesota Statutes* chapter 144A required that certain Personal Care Provider Organizations be licensed by the Department of Health as home care providers, although the Legislature did not fund implementation of licensure.[40] The Department of Health has not conducted investigations of adult maltreatment in unlicensed PCA agencies.

Table 4.3 also shows that county agencies are supposed to investigate adult maltreatment allegations that are not within the purview of the departments of Health or Human Services. Unfortunately, it is difficult to know the extent of

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[36] Department of Health, http://www.health.state.mn.us/divs/fpc/ohfcinfo/contohfc.htm, accessed December 8, 2008. Department of Health officials told us they will clarify on the web site that the department does, in fact, conduct child maltreatment investigations in unlicensed PCA agencies.

[37] *Minnesota Statutes* 2008, 626.556, subd. 3c, gives the Department of Health responsibility for investigating child maltreatment in facilities licensed under *Minnesota Statutes* 144.50 to 144.58. However, it does not address providers licensed as home care providers under *Minnesota Statutes* 144A.46.

[38] *Minnesota Statutes* 2008, 626.5572, subd. 13(b).

[39] *Minnesota Statutes* 2008, 256B.04, subd. 16, requires the departments of Human Services and Health to jointly develop rules "to be applied to the licensure of personal care services provided under the medical assistance program." The law does not specify whether this requirement pertains to licensure of agencies or individuals, although DHS is given responsibility for determining which standards are appropriate. Rules for licensing Personal Care Provider Organizations have never been implemented, and DHS officials told us that the Legislature has not communicated a desire for DHS to expand its maltreatment investigation duties to include unlicensed PCA agencies.

[40] From 1997 to 2008, *Minnesota Statutes* 144A.46, subd. 2, exempted from home care provider licensure "a person or organization that exclusively offers, provides, or arranges for personal care services to only one individual under the medical assistance program." Other personal care organizations were not exempt. However, *Laws of Minnesota* 2008, chapter 230, sec. 7, applied the exemption to all personal care organizations until new provider standards are implemented.

county investigations involving PCA because DHS did not implement a comprehensive case tracking system for county investigations until 2008.[41]

Disagreements about agencies' investigative authority can impede timely maltreatment investigations.

Agency disagreements about how to interpret state maltreatment statutes have sometimes been an impediment to timely, effective investigations. In a 2006 report about the death of a PCA recipient, Minnesota's Ombudsman for Mental Health and Mental Retardation said: "For a period of time, it appeared that no one was going to investigate this case."[42] Eventually, a county agency conducted an investigation at the ombudsman's urging.[43] But, because of the jurisdictional disputes in this case, the ombudsman recommended that the Legislature amend vulnerable adult laws to specify one entity to be the lead investigative agency in cases involving PCA services. The Legislature has not taken this action.

RECOMMENDATIONS

The Legislature should amend statutes to give the Department of Human Services responsibility to investigate all reports of maltreatment involving unlicensed personal care provider agencies paid through DHS-administered health care programs.

The Legislature should amend Minnesota Statutes 626.556 so that the Department of Health is responsible for investigating alleged child maltreatment involving personal care services provided by agencies licensed by the department as home care providers.

We think it would be best for the Legislature to give DHS the responsibility to conduct maltreatment investigations involving all unlicensed personal care provider agencies. DHS already has authority to enroll these agencies to deliver PCA services and monitor their compliance with state requirements. For licensed provider agencies, we think it makes sense for the licensing agency to conduct maltreatment investigations, although the statutes regarding the Department of Health's authority in this area need clarification.[44]

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[41] Counties were asked to enter information into the tracking system from January 2008 forward. DHS staff told us that, as of late 2008, all counties except Hennepin had entered their 2008 information.

[42] Office of Ombudsman for Mental Health and Mental Retardation, *In Re the Death of Jesse David Anderson* (St. Paul, January 13, 2006), 19. This office is now called the Office of the Ombudsman for Mental Health and Developmental Disabilities.

[43] The administering agency provided some of its PCA services as a Personal Care Provider Organization and some as a Department of Health-licensed home health agency. The Department of Health reviewed the case's compliance with Minnesota's "Home Care Bill of Rights" but later forwarded the case to the county because department staff believed they lacked jurisdiction to act.

[44] Sometimes a PCA agency is a licensed provider of some services and an unlicensed provider of others, further complicating the issue of which state agency should investigate maltreatment allegations. For such cases, the Legislature should consider ways to ensure continuity in the investigative process—for example, by authorizing a single state agency to investigate all issues related to a provider's licensed or unlicensed operations, or by authorizing joint investigations by the departments of Health and Human Services.

In addition, we observed that:

- **For children served by unlicensed personal care provider agencies, Minnesota law does not require that allegations of maltreatment be reported to independent agencies.**

When persons who are mandated by law to report abuse or neglect become aware of possible maltreatment in a *licensed* facility, they are required by law to make a report to the agency responsible for the facility's licensure.[45] But in cases of alleged child maltreatment in *unlicensed* personal care agencies, this law appears to require reporting to the unlicensed provider agency.[46] In our view, this does not provide adequate assurance that the report will be investigated, particularly if employees of the unlicensed agency are the alleged perpetrators.

RECOMMENDATION

The Legislature should amend Minnesota Statutes 626.556, subd. 1, to require that reports of maltreatment involving children served by unlicensed personal care provider agencies be made to the Department of Human Services.

Individual Abuse Prevention Plans

We also examined the extent to which PCA agencies take steps to prevent maltreatment of the recipients they are serving. State law requires all licensed and unlicensed personal care providers to develop an individual abuse prevention plan for each adult recipient. According to the law, this plan must include:

> [A]n individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.[47]

We found that:

- **There is noncompliance with the state requirement for PCA agencies to develop individual abuse prevention plans for their adult recipients.**

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[45] *Minnesota Statutes* 2008, 626.556, subd. 3. For children, this statute defines a "mandated reporter" as a professional (or a professional's delegate) who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, correctional supervision, probation and correctional services, or law enforcement.

[46] *Ibid.*

[47] *Minnesota Statutes* 2008, 626.557, subd. 14(b).

DHS should monitor PCA providers' compliance with state requirements for individual abuse prevention plans.

During our visits to 26 PCA agencies, we examined whether the files of 144 adult service recipients contained individual abuse prevention plans. We found that only 29 percent of these recipients had such plans in their files. In addition, it is worth noting that there is no requirement in state law for personal care provider agencies to develop abuse prevention plans for the *children* they serve.

RECOMMENDATIONS

The Department of Human Services should (1) remind PCA agencies about their obligation to develop individual abuse prevention plans and (2) monitor compliance with this requirement during quality assurance reviews.

The Legislature should consider whether to require PCA agencies to develop individual abuse prevention plans for children, as the law requires for adults.

Criminal Background Checks

Another way that PCA agencies help ensure the safety of their recipients is by initiating criminal background checks on their employees. We found that:

- **DHS has taken important steps in recent years to ensure that the individuals providing PCA services have the required criminal background checks.**

For more than a decade, state law has required criminal background checks for all personal care assistants. However, a 2005 DHS study found that 19 percent of personal care assistants statewide did not have a completed background check on file at the time the person provided services to recipients.[48] In 2005, DHS adopted a policy requiring the state enrollment of individual personal care assistants before PCA agencies could be reimbursed for their services.[49] When a personal care assistant enrolls with DHS, the provider agency that will employ the assistant initiates a background check by DHS. Probably because of this requirement, we found documentation of background checks in nearly all employee files we reviewed at PCA agencies. We reviewed the files of personal care assistants at 26 agencies. In 97 percent of these cases, we found documentation that a background check had been completed at the time the personal care assistant provided services in April 2008.[50]

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[48] Department of Human Services, Surveillance and Integrity Review Unit, *PCA Program Study: Compliance with DHS Policies* (St. Paul, September 2005), 2.

[49] Department of Human Services, "Individual Personal Care Assistant Enrollment," MHCP Provider Update PCA-05-01 (June 28, 2005).

[50] There were 225 personal care assistants for whom we collected information on background checks.

State background checks have screened out many potentially risky caregivers, but they do not guarantee the safety of service recipients.

Existing background check practices do not guarantee the safety of PCA recipients. As with employees of other types of human services and health care agencies, a personal care assistant can begin providing services to a recipient once a state background check has been *initiated* but before it has been *completed*.[51] In addition, a background check is done when a personal care assistant first seeks employment with a PCA agency, but there is no requirement for the agency to subsequently obtain updated background checks of the employee. Thus, it is possible that PCA agencies may be unaware of offenses by employees since the time of their most recent background checks.[52] Also, most background checks do not examine whether an individual has prior criminal offenses in states other than Minnesota.[53] Despite these limitations, background checks provide an important method of screening out individuals who might pose a risk to vulnerable recipients. Between January 2006 and June 2008, DHS conducted nearly 59,000 background checks on people seeking to work for unlicensed personal care provider agencies, and more than 3,100 people (5.3 percent) were disqualified from serving as a personal care assistant on the basis of these checks.[54]

Although background checks help to safeguard recipients from personal care assistants with criminal histories:

- **Minnesota law does not require that DHS conduct background checks of all qualified professionals who supervise PCA services.**

For recipients who receive services from a PCA Choice agency, statutes specify that one of the agency's duties is to "request and secure background checks [from DHS] on personal care assistants and qualified professionals."[55] But for other recipients, there is no requirement for agencies to obtain background checks on qualified professionals.

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[51] *Minnesota Statutes* 2008, 245C.04, subd. 3. *Minnesota Statutes* 2008, 245C.13, subd. 2, requires such individuals to be under "continuous direct supervision."

[52] In our review of personal care assistants' files during site visits, 77 percent of the most recent background checks for PCAs we reviewed were conducted since January 2006. One personal care assistant's most recent background check was from 1996; this was the oldest "current" background check we saw. *Minnesota Statutes* 2008, 245C.05, subd. 7, requires probation officers to notify DHS of an individual's criminal conviction if the person is affiliated with a DHS-regulated program. The extent to which these notifications occur is unclear.

[53] *Minnesota Statutes* 2008, 144.057, subd. 1, requires that background checks of individuals who work for licensed home care agencies must include a search of criminal history records in the state where the person resides. This is not a requirement for unlicensed PCA agencies, although *Minnesota Statutes* 2008, 245C.02, subd. 15, authorizes DHS to search records from other states if DHS has "reasonable cause" to believe the subject has a history that would disqualify the individual or pose a risk to others. In 2007, DHS requested fingerprints from individuals (for purposes of a multi-state background check) in 1.4 percent of its 22,940 background checks related to personal care provider agencies.

[54] DHS disqualified a higher percentage of potential personal care assistants due to failed background checks than it disqualified for most other types of services for which it conducted background checks.

[55] *Minnesota Statutes* 2008, 256B.0655, subd. 7.

RECOMMENDATION

The Legislature should amend Minnesota statutes to require all agencies providing personal care services to obtain background checks on their qualified professionals.

In our view, the statutes should be amended so that qualified professionals are subject to background checks, regardless of the type of agency for which they work.

ADEQUACY OF CONSUMER INFORMATION

Service recipients need good information to make informed choices.

Users of PCA services should have the information needed to make informed choices and report problems when they arise. During our evaluation, we heard various concerns from consumer advocates, DHS staff, and others about the adequacy of consumer information. Our review of these issues was not exhaustive, but this section discusses selected problems that need attention.

Information on Maltreatment Reporting

Because of the complicated provisions in state law for investigation of maltreatment allegations involving PCA recipients, we wondered whether individual recipients get clear, consistent information about whom to contact with complaints or concerns. Each PCA agency determines the types of information its recipients need when they begin services. DHS has distributed thousands of copies of its *PCA Consumer Guidebook* over the past several years, although there is no requirement that recipients receive a copy. We examined the "Consumer Safeguards" portion of DHS's guidebook to see what advice it offers to potential victims of maltreatment. We found:

- **DHS has not provided PCA recipients and responsible parties with adequate information about which agencies to contact with concerns about abuse or neglect.**

The DHS guidebook gives examples of physical abuse, sexual abuse, and financial exploitation; it does not give examples of neglect. The guidebook then says: "If any of these types of abuse are happening to you, you need to report this immediately to someone who can help you. This could be your case manager, a friend or family member, or your PCA agency. If you are in immediate danger, call 911."[56]

In our view, the information provided in the DHS guidebook is not sufficiently helpful. Most PCA recipients do not have a "case manager," and some may be

[56] Department of Human Services, *Personal Care Assistance (PCA) Program Consumer Guidebook*, 17.

DHS should provide recipients with better information for reporting abuse and neglect.

uncomfortable disclosing a concern to a friend, family member, or PCA agency (especially if a PCA agency's employee is the source of the concerns). Also, each county is required by law to have a "common entry point" for reports of suspected maltreatment, but the DHS guidebook does not mention this. In addition, DHS quality assurance staff investigate quality-related consumer complaints, but the guidebook does not indicate how to contact these staff. Furthermore, the guidebook provides minimal explanation of the roles played by three state ombudsman offices on behalf of recipients. The guidebook has only a brief mention of the Ombudsman for Mental Health and Developmental Disabilities, and it does not mention the Ombudsman for Managed Care. The guidebook lists issues the Ombudsman for Long-Term Care can address, including "abuse or neglect issues." But staff with the Ombudsman for Long-Term Care office told us that consumers often do not know whom to contact with concerns, and even the ombudsman staff sometimes struggle to advise recipients about where to report their concerns.

RECOMMENDATION

The Department of Human Services should develop a concise, useful document that indicates whom PCA recipients can contact with service-related concerns. The department should require all PCA agencies to distribute this to recipients.

Information to Help Consumers Select Providers

We also observed that:

- **DHS provides consumers (and the agencies that help consumers select providers) with little information to help them make informed choices of personal care provider agencies.**

DHS has a provider directory on its web site. Under "Personal Care Services," the directory lists nearly 1,000 PCA agencies. The agencies can be sorted by location, but other information to distinguish the agencies is very limited.

RECOMMENDATION

DHS should post relevant documents from its quality assurance reviews of PCA agencies on its public web site.

At a minimum, we think that DHS should give consumers access to information from its recent quality assurance reviews. For example, it might be helpful for consumers (or agencies that help consumers find appropriate services) to see (1) the DHS letter summarizing the findings of a quality assurance review and (2) the provider's corrective action plan. This will be more useful once DHS conducts reviews of a larger number of PCA agencies. In general, however, we

think that well-done quality assurance reviews could provide some insights for consumers seeking a reputable PCA agency.

Copies of PCA Assessments

The information collected during a PCA assessment could be helpful to the PCA agency that eventually must oversee services for this individual. However:

- **Agencies that conduct or arrange for PCA assessments do not always send copies of the assessments to the PCA agencies that will provide services to the recipient.**

Staff at several PCA agencies told us this has been a problem for both fee-for-service and managed care service recipients. Agency staff prefer to know as much as possible about the individuals they will be serving. Although PCA recipients may develop their own care plan, they may also develop it with assistance from the PCA agency's qualified professional or the recipient's doctor.

Provider agencies should be able to obtain copies of their service recipients' assessments.

RECOMMENDATION

The Legislature should require counties and managed care agencies that arrange for PCA assessments to provide timely copies of the assessment reports to PCA agencies that will be providing services, if they request them.

A copy of the assessment findings can be a useful resource during development of the care plan. Currently, state law does not specifically require the counties or managed care organizations responsible for assessments to send copies of the assessment reports to the relevant provider agencies.

Some PCA agencies also said they have not received copies of PCA recipients' service plans from counties or managed care organizations. Existing law and state policy already require timely provision of service plans to recipients and providers, so we offer no recommendation for statutory change.[57] However, PCA agencies should inform DHS of noncompliance so that DHS can enforce this requirement.

Home Care Bill of Rights

In our discussions with PCA recipients, recipient advocates, PCA agencies, and others, we heard a variety of other concerns regarding the quality of services provided to recipients. We did not independently confirm most of these reports, but many of the concerns were credible and should be taken seriously. For example, we heard reports of: personal care assistants who exploited recipients through unauthorized use of bank or long-distance calling cards; personal care

[57] *Minnesota Statutes* 2008, 256B.0655, subd. 1i, and Department of Human Services, *Clarification of Policy for Personal Care Assistant Services for Managed Care Enrollees*, Bulletin #08-25-06 (September 2, 2008), 7.

assistants who reportedly borrowed money from recipients or stole items from a recipient's household; and PCA agencies that have served as landlords to their recipients, potentially restricting the ability of the recipients to move to other locations. We saw an example of a "noncompete agreement" that personal care assistants employed by one PCA agency were asked to sign, potentially limiting the ability of recipients to use a personal care assistant who chose to seek employment at a different PCA agency. We also saw examples of service reduction notices sent to recipients that were poorly worded or did not carefully explain the changes in the recipient's services.

Minnesota state law contains a "Home Care Bill of Rights" to help protect people receiving home care services.[58] This law establishes 21 rights that home care consumers have, such as the right to refuse services and the right to choose freely among service providers. However:

- **The extent to which PCA recipients have been made aware of Minnesota's Home Care Bill of Rights is unclear.**

State law establishes protections for home care recipients, but these have not always been communicated to PCA recipients.

The law says the Home Care Bill of Rights is established "for the benefit of persons who receive home care services," apparently including personal care services.[59] Also, the law says: "A copy of these rights must be provided to an individual at the time home care services are initiated."[60] But the bill of rights posted on the Department of Health's web site as of late 2008 declared that it only pertains to licensed facilities.[61] We are not aware of specific DHS policies or instructions regarding the distribution of the bill of rights to PCA recipients. In 2008, a DHS work group's meeting minutes said: "Most PCA agencies do not provide [information on the bill of rights] nor are they required to unless they have licensure from the Minnesota Department of Health."[62]

RECOMMENDATION

The Legislature should amend statutes to explicitly require unlicensed personal care provider agencies to provide Minnesota's Home Care Bill of Rights to the recipients they serve. The Department of Human Services should incorporate discussion of the bill of rights into its training program for PCA agencies.

We think the applicability of the Home Care Bill of Rights to unlicensed personal care provider agencies needs to be explicitly addressed in statute. The bill of rights might not prevent service problems from arising. However, if these rights

[58] *Minnesota Statutes* 2008, 144A.44.

[59] *Minnesota Statutes* 2008, 144A.44, subd. 1, and 144A.43, subd. 3.

[60] *Minnesota Statutes* 2008, 144A.44, subd. 2.

[61] In December 2008, the Department of Health told us that it intends to clarify on its web site that the bill of rights applies to all PCA provider agencies.

[62] Department of Human Services, Consumer Health and Safety/Quality Assurance Topic Team, June 24, 2008, meeting minutes.

are given to service recipients in a clear, understandable way, they might help consumers determine whether to initiate a complaint or an appeal.

PERSONAL CARE ASSISTANT WORK HOURS

In Chapter 3, we noted that DHS has made payments to PCA agencies for some personal care assistants whose reported workdays or workweeks were very lengthy. In some cases, DHS paid for amounts of services by personal care assistants that we said were implausible, apparently reflecting improper payments by DHS. In addition:

- **Long work hours claimed for some personal care assistants raise questions about the quality of services provided.**

Frequently, personal care assistants work hours in excess of those recommended by Minnesota's Ombudsman for Mental Health and Mental Retardation. In a 2006 report, the ombudsman offered the following opinion: "No PCA should be allowed to work more than 40 hours per week except for extraordinary or emergency situation[s]."[63]

We reviewed claims for PCA services provided in May 2008 to determine the extent to which personal care assistants' workweeks fell within the ombudsman's recommendation. One-fifth of the weeks that personal care assistants worked in May 2008 exceeded 40 hours per week (13,208 of 63,163). Ten percent of the workweeks (6,460) included 50 hours or more of PCA services, and 6 percent (3,837) included 60 hours or more.[64]

Table 4.4 shows that almost 4,500 personal care assistants worked more than 40 hours at least one week in May 2008. These workers represented almost 25 percent of the personal care assistants who worked at least one week during the month. Almost 13 percent of the personal care assistants worked all four weeks in excess of 40 hours. Of more concern, claims data show that almost 4 percent of personal care assistants worked four workweeks of 60 hours or more.

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[63] Office of Ombudsman for Mental Health and Mental Retardation, *In Re the Death of Jesse David Anderson*, 20. This office is now called the Office of the Ombudsman for Mental Health and Developmental Disabilities.

[64] We counted weeks as Sunday through Saturday, beginning Sunday, May 4, 2008. If a personal care assistant worked any hours during the week, we counted the week as a workweek. The claims we reviewed are described in Chapter 3 and include those with implausible work hours.

Excessive work hours raise questions about service quality and safety.

Table 4.4: Personal Care Assistant Workweeks, May 2008

Personal Care Assistants Whose Claimed Work Included:	Number	Percentage of PCAs who Worked in May 2008 (N=18,143)
Any workweeks over 40 hours	4,499	24.8%
Four workweeks over 40 hours	2,274	12.5
Any 50-plus hour workweeks	2,279	12.6%
Four 50-plus hour workweeks	1,101	6.1
Any 60-plus hour workweeks	1,350	7.4%
Four 60-plus hour workweeks	645	3.6

NOTES: Includes personal care assistants who worked at least one week in May 2008. Weeks are measured Sunday through Saturday, beginning Sunday, May 4, 2008. Some assistants worked fewer than all four weeks. Claims include those reflecting implausible workdays, such as those exceeding 24 hours a day.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

We also looked at the length of personal care assistants' workdays, as reported in the claims of the personal care provider agencies. As Table 4.5 shows, a small percentage of personal care assistants provided care for very long hours, day after day. For example, according to claims data, 469 personal care assistants provided 10 or more hours of care a day for 16 or more days in a row. In fact, according to claims, 288 personal care assistants provided 10 or more hours of care every day of the month.

If the excessive claimed work hours were actually worked, they raise real concerns about the quality and safety of care that recipients are getting from fatigued personal care assistants. If the assistants identified in the claims did not actually work the hours attributed to them, it raises two additional concerns about the quality of care. One concern is that some recipients may not be getting the reported care. Second, if people other than the staff identified in the claims are providing the hours of care claimed, DHS has no way of knowing who is actually providing the care and whether these staff meet the requirements for being a personal care assistant. For example, it is not known whether the person providing the care would pass a criminal background check.[65]

[65] It is clear that some personal care provider agencies are submitting claims that do not reflect who is actually providing the personal care services. For example, our review of claims across all provider agencies indicated that some personal care assistants were reported to have provided more than 24 hours of care in a day.

Table 4.5: Personal Care Assistant Claimed Work Hours, May 2008

Personal Care Assistants Whose Claimed Work Included:	Number	Percentage of PCAs who Worked in May 2008 (N=18,330)
16 or more consecutive workdays lasting:		
8 hours or more	908	5.0%
10 hours or more	469	2.6
12 hours or more	227	1.2
16 hours or more	57	0.3
20 hours or more	19	0.1
31 consecutive workdays lasting:		
8 hours or more	594	3.2%
10 hours or more	288	1.6
12 hours or more	118	0.6
16 hours or more	27	0.1
20 hours or more	10	0.1

NOTE: Claims include those reflecting implausible workdays, such as those exceeding 24 hours a day.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

PERSONAL CARE ASSISTANT TRAINING AND COMPENSATION

Some recipients want their caregivers to have better training.

Personal care assistants should provide reliable, competent services consistent with recipients' care plans. In a state-sponsored survey of PCA recipients in 2003, 80 percent said their personal care assistants did not need more training.[66] But, when asked to identify one thing they would change about their PCA services, the survey respondents most often cited issues related to PCA wages, training, and recruiting.[67] We heard concerns from some recipients and their family members about caregivers who did not have sufficient understanding of the recipient's disability or failed to show up on time to provide services. Thus, we looked at statutory provisions regarding training and talked with PCA agencies about how they train their employees.

State law requires personal care assistants to meet at least one of the five training options shown in Table 4.6. Four of the options involve formal training programs, such as a program that trains nursing assistants. The fifth option does not involve a formal training program. Rather, under this option, the PCA agency makes a determination that the personal care assistant has appropriate skills, whether through training or experience. During our site visits to PCA agencies, we asked agency directors to provide us with information on how a

[66] Bailey, *Minnesota's 2003 PCA Consumer Survey*, 26.

[67] *Ibid*., 22.

sample of their employees met the statutory training requirements.[68] We found that:

- **Staff with limited amounts of formal training provided most PCA services, and PCA agencies varied significantly in the way they trained their employees.**

Of 306 personal care assistants on whom agencies provided information to us, 84 percent met the state training requirements solely through the PCA agency's determination of competence, not a formal training program.

Many personal care assistants have not completed a formal training program.

Table 4.6: Personal Care Assistant Training Requirements in Minnesota Law

Personal care assistant training must include successful completion of one or more of the following:

1. A nursing assistant training program or its equivalent, for which competency is determined by a statewide test.
2. A homemaker home health aide pre-service training program, using a curriculum recommended by the Department of Health.
3. An accredited education program for registered nurses or licensed practical nurses.
4. A training program that provides the skills required to perform PCA services specified in law.
5. A determination by the personal care provider that the personal care assistant has, through training or experience, the skills required to perform the PCA services specified in law.

SOURCE: *Minnesota Statutes* 2008, 256B.0655, subd. 1f(b).

During our site visits to 26 PCA agencies, we asked agency administrators to explain how they train their personal care assistants. State policies do not address the content of agencies' in-house training, and we found that agencies' training practices varied considerably. Some agencies had detailed training curricula. For example, one agency requires all personal care assistants to complete 18 hours of training on general policies and procedures, first aid, and medication supervision within their first six months of employment. This agency also requires employees to annually complete courses on topics such as suicide prevention and vulnerable adult policies. Other agencies handled training more informally—through one-on-one instruction at the agency or the recipient's

[68] At each agency, we selected a sample of 15 recipients who received services during April 13-19, 2008. We reviewed the files of up to 16 personal care assistants associated with these recipients. If the recipients had more than 16 assistants during this period, we selected a sample of 16.

home. DHS does not offer in-person training courses for caregivers, but many agency directors told us they would welcome any training DHS could offer.[69]

Except in cases where the recipients choose to train their own personal care assistants, we think it makes sense for PCA agencies to retain primary responsibility for employee training. PCA services are scattered around the state, and it would be expensive and logistically difficult for DHS to provide timely training to personal care assistants throughout the state. However, we think DHS could provide stronger guidance on training.

DHS should provide more guidance about the training caregivers need.

RECOMMENDATION

The Department of Human Services should define a set of topics on which personal care assistants should receive training.

While it would not make sense for DHS to train caregivers on how to meet the needs of particular individuals, DHS should identify general policies and procedures that all personal care assistants need to understand. The training topics identified by DHS could address various issues, ranging from proper timesheet reporting to practices for preventing the spread of infections. DHS should monitor compliance with training requirements during quality assurance reviews. Also, DHS should consider ways it could help recipients and PCA agencies to train their employees—perhaps by: (1) directing them to useful training resources, (2) developing training materials or videos that recipients and PCA agencies could use, or (3) contracting with vendors that offer meaningful online training.

In addition to wanting well-trained personal care assistants, PCA recipients told us they would like to have adequately compensated caregivers. Some recipients said that low wages contribute to staff turnover. Agency directors told us that wage levels can be an important factor in their ability to attract (or retain) recipients or personal care assistants.

At the time of our site visits, the state paid PCA agencies $15.92 per hour of direct care services provided. From this amount, agencies paid for payroll taxes, workers compensation, unemployment insurance, liability insurance, and bonding (altogether, an estimated $1.36 per hour, according to one agency). In addition, agencies paid for general overhead expenses, such as rent and utilities, billing costs, administrative and support staff, and employee background checks.

We obtained data on personal care assistant wages from 25 of the PCA agencies we visited.[70] Our sample is not necessarily representative of all personal care assistants, but it provides an indication of wages at a group of randomly selected

[69] DHS has a contract with the College of Direct Support, which provides online training in topics related to personal care assistance. The cost of this contract has been about $70,000 per year. However, use of the training by provider agencies and individuals has been very limited, and the online training information has not been customized to address Minnesota-specific requirements.

[70] We requested wage data for the personal care assistants whose training credentials we reviewed.

agencies. The median wages at individual PCA agencies ranged from a low of $9.00 an hour at an agency in southeastern Minnesota to $12.25 an hour at an agency in a western Twin Cities suburb. Among the 299 employees on whom we collected wage data, the median wage was $10.45 an hour. Two agencies that mainly served PCA Choice recipients had higher median salaries than other agencies, probably because they did not have to recruit, train, and supervise employees as extensively as other agencies.

5 Other Issues

The earlier chapters of this report have addressed issues that affect the overall integrity of personal care assistance (PCA) services—particularly assessment of recipients, financial oversight, and quality assurance. This chapter addresses several additional PCA issues that deserve the Legislature's consideration. These issues include: (1) the use of family members as personal care assistants, (2) the adequacy of PCA services for people with behavioral health issues, (3) standards for PCA provider agencies, and (4) the basis of judges' decisions in PCA appeals.

USE OF FAMILY MEMBERS AS PERSONAL CARE ASSISTANTS

Over the years, there has been significant change in the state's policy about who can serve as a personal care assistant. When the Legislature first authorized Medical Assistance expenditures for PCA services in 1977, the law specified that services could not be provided by a family member of the recipient.[1] In 1990, the Legislature enacted narrower restrictions, stating that PCA services could not be provided by the recipient's spouse or legal guardian, nor could parents serve as personal care assistants for their children under age 18.[2] In 1991, the Legislature also prohibited the provision of PCA services by (1) parents of adult recipients, (2) adult children of recipients, or (3) adult siblings of recipients, unless the relative met one of the "hardship criteria" specified in law and received a waiver from the Department of Human Services (DHS).[3] The 2003 Legislature repealed the requirement for hardship waivers, making it easier for certain relatives to provide PCA services.[4] Since then, Minnesota law has allowed relatives to serve as personal care assistants, with two major exceptions: people may not serve as personal care assistants for their spouses or minor children. According to a 2004 survey, 18 of 24 responding states that offered PCA services to adults under a

[1] *Laws of Minnesota* 1977, chapter 453, sec. 2, subd. 3.

[2] *Laws of Minnesota* 1990, chapter 568, art. 3, sec. 51.

[3] *Laws of Minnesota* 1991, chapter 292, art. 7, secs. 11-12. The hardship criteria adopted into law in 1991 included relatives who: (1) resigned from a job to provide PCA services for the recipient, (2) went from a full-time job to a part-time job to allow time to provide personal care, (3) took a leave of absence without pay to provide personal care, (4) incurred substantial expenses to provide personal care, or (5) must provide personal care due to labor shortages of qualified personal care assistants.

[4] *Laws of Minnesota* First Special Session 2003, chapter 14, art. 3, sec. 27.

Medicaid state plan said they allowed family members other than spouses and minor children to be personal care assistants.[5]

Some people expressed concerns to us about the state's reduced restrictions on people serving as personal care assistants to family members. First, they suggested that repeal of the hardship waiver may have been a factor in recent growth in the size of Minnesota's PCA recipient population. Unfortunately, DHS does not collect information on familial connections between PCA recipients and providers. Thus, we were unable to determine how many recipients have a relative as a personal care assistant, nor could we examine trends in this over time.

Second, some people expressed concern that paid care by relatives of recipients might sometimes encourage fraud or weaken the quality of care. For example, some PCA assessment agencies told us that family members have tried to convince assessors that recipients' service needs are greater than they really are. One PCA agency told us it does not hire family members to serve as personal care assistants because it prefers to have clear "professional boundaries" between recipients and their personal care assistants. Some people suggested that recipients may be less inclined to report problems with the amount or quality of services actually provided when the personal care assistant is a family member.

Allowing certain family members to be paid as caregivers can be beneficial.

On the other hand, many people told us that it is important to preserve the option of using family members as caregivers. Some PCA agencies mostly use family members as caregivers for immigrants or other recipients with limited English skills. Staff at these agencies said that, in many cases, family members can communicate with recipients and win their trust more effectively than others. Also, some people told us that family members may have a stronger incentive to provide reliable, high-quality care to recipients than people who have no ongoing connections with the recipients.

Overall, we concluded that:

- **Minnesota's existing policies about the use of family members as personal care assistants are reasonable, and we offer no recommendations for changes.**

For the most part, people who expressed concerns about family members serving as personal care assistants did not favor eliminating this option or reinstating past restrictions such as the hardship waiver. In our view, the potential benefits of using family members as personal care assistants are significant. We think that any risks of relying on family members as caregivers can be mitigated through

[5] Laura L. Summer and Emily S. Ihara, *The Medicaid Personal Care Services Benefit: Practices in States That Offer the Optional State Plan Benefit* (Washington, DC: Georgetown University Health Policy Institute, 2005), Table 12. The authors identified 26 states and the District of Columbia that offered the personal care services benefit to adults under their Medicaid state plans. Three states did not respond to the survey question about state restrictions on family members as service providers.

general improvements in the supervision and oversight of PCA services, as recommended elsewhere in our report.

ADEQUACY OF SERVICES FOR PEOPLE WITH BEHAVIOR ISSUES

Since 1993, Minnesota law has authorized the use of PCA services for "redirection and intervention for behavior, including observation and monitoring."[6] There has been a large, recent increase in the number of PCA recipients assessed as having behavior issues or mental health issues, as discussed in Chapter 2. Some people attributed the increase to reductions in other types of institutional or community-based services for individuals. In addition, assessors expressed frustration about the difficulties they have experienced in trying to accurately assess and determine services for people with behavior issues.

Some people with behavior issues need more help than personal care assistants can provide.

We did not evaluate whether Minnesotans with behavior issues are being adequately served by PCA or other services. This is a large, complex issue. Personal care assistance may play an important role in the lives of people with behavior issues. However, some persons with significant behavior issues need more help than personal care assistants with minimal training can provide. This additional help could include specialized interventions or treatment, perhaps by trained mental health professionals or behavior aides.

Earlier, we recommended that DHS provide additional guidance to PCA assessors to help ensure consistent, sound recommendations about the nature and quantity of PCA services for people with behavior problems. In addition, we think DHS should continue to examine broader issues about the adequacy and quality of services—PCA and others—for people with behavior problems and mental health issues. We offer no specific recommendations because this is already an ongoing responsibility of DHS. However, DHS should consider ways to evaluate existing services and recommend any necessary improvements.

STANDARDS FOR PCA AGENCIES

Regulation of PCA agencies has been a recurring issue for the Legislature. Most of Minnesota's personal care services are provided by unlicensed staff who work for unlicensed agencies. The 1991 Legislature required the departments of Human Services and Health to jointly promulgate licensing rules for personal care services funded by Medical Assistance.[7] In 1992, DHS issued a report stating that "minimum safety and quality of care standards can be attained most efficiently and cost effectively through licensure of agencies, rather than through

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[6] *Minnesota Statutes* 2008, 256B.0655, subd. 2(c)(16).

[7] *Laws of Minnesota* 1991, chapter 292, art. 7, sec. 8, as codified in *Minnesota Statutes* 2008, 256B.04, subd. 16.

licensure of individuals."[8] DHS recommended licensure of agencies that provide up to 75 percent of their personal care services through Medical Assistance. DHS staff told us that, largely because of cost concerns, legislation to implement these recommendations did not pass.

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

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

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

Personal care provider agencies need more standards and state oversight.

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

PCA agencies need greater oversight, and their key staff should be well trained in state policies. Toward this end, chapters 3 and 4 recommended (1) more investigations and quality assurance reviews of PCA agencies and (2) mandatory participation by PCA agencies in DHS's intensive training courses for agency officials. We think these would be good starting points for improving compliance and accountability. At a time when the state faces significant budget constraints, it would be more cost-effective to build on existing DHS

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[8] Department of Human Services, *A Report to the Legislature on Recommendations for a Personal Care Services Licensure Rule* (St. Paul, 1992), ii.

[9] *Laws of Minnesota* 1997, chapter 195, sec. 5.

[10] Minnesota Department of Health, *A Report to the Minnesota Legislature on a Draft of Proposed Rules for a Unique Licensure Category for Providers of Personal Care Assistant Services* (St. Paul, January 1999), 10.

[11] *Laws of Minnesota* 1997, chapter 195, sec. 1.

[12] *Laws of Minnesota* 2008, chapter 230, secs. 6 and 7.

mechanisms for improving compliance—namely, the PCA provider enrollment process, training courses for PCA agencies, and quality assurance reviews of PCA agencies—than by beginning a new licensing process. If DHS's initial steps do not have the intended effects, however, legislators should consider requiring PCA agencies to be licensed or obtain some type of certification.

Another issue related to provider standards is the financial liability of PCA agencies. We found that:

- **State law does not explicitly address the financial liability of PCA Choice agencies for improper payments.**

The Legislature should clarify the financial liability of certain provider agencies.

The law authorizes DHS to deny, revoke, or suspend individual recipients' authorization to use PCA Choice agencies if the use of the option has led to abusive or fraudulent billing.[13] However, DHS financial integrity staff expressed concern to us that PCA Choice agencies might not bear legal liability for improper payments, limiting DHS's ability for recoveries.[14] DHS staff said that, unless they have clear evidence that a PCA Choice agency was aware of improprieties by a recipient or personal care assistant, DHS may have little basis for pursuing recoveries. Because of this, DHS sometimes gives lower priority to investigating complaints involving PCA Choice agencies (to the extent that it knows this). Some PCA Choice agencies disagree with DHS's characterization of their liability. For example, one agency director told us that the PCA Choice agency "is the employer of record and is liable for all financial aspects of the PCA Choice program."

In addition, we found that DHS's Medicaid information system often lacks reliable information to indicate which recipients have elected to receive services under the PCA Choice option. Without information on the total number of PCA Choice cases in the state, it is impossible to estimate the magnitude of the financial risks resulting from the state's inability to recover improper payments in these cases.

RECOMMENDATIONS

The Legislature should amend Minnesota Statutes 256B.0655, subd. 7, to clarify the financial liability of PCA fiscal intermediaries for improper payments involving their recipients or employees.

DHS should ensure that its Medicaid Management Information System contains accurate reporting about which PCA recipients have elected to get services under Minnesota's PCA Choice option.

[13] *Minnesota Statutes* 2008, 256B.0655, subd. 7(i).

[14] PCA Choice agencies act as fiscal intermediaries for PCA Choice recipients, processing claims from the personal care assistant and receiving payments from the state. PCA Choice recipients recruit, train, and supervise their personal care assistants.

In our view, the statutes should explicitly address the liability of PCA Choice agencies for improper payments. PCA Choice agencies play a more limited role in PCA services than other PCA provider agencies, but PCA Choice agencies should still bear some responsibility for the personal care assistants they employ. Also, it is important for DHS to have accurate information about how many PCA recipients have opted for services under the PCA Choice model.

JUDGES' DECISIONS IN PCA APPEALS

In Chapter 2, we expressed concern about possible inconsistencies in PCA assessment practices. Individuals have the option of challenging assessment and other service decisions through the state's "fair hearing" appeals process. In this process, state human services judges consider evidence from the appellant and relevant administrative agency (DHS or a managed care organization) before rendering a judgment. Nearly all PCA-related appeals are filed by recipients in response to the outcomes of PCA assessments.

We reviewed all of the 2007 fair hearing decisions related to PCA appeals. During the course of our review, we observed that:

- **The outcomes of appeals appeared to depend partly on which judge heard the case.**

There were significant differences among judges in their likelihood of siding with appellants in personal care cases.

We observed that individual judges differed considerably in the extent to which they ruled for or against the appellants in the PCA cases. For example, among the eight judges who issued decisions on at least 18 PCA-related cases in 2007, the percentage of cases in which the position of DHS or the managed care agency was completely affirmed ranged from 11 percent for one judge to 68 percent for another. One judge who reversed a larger share of his cases than other judges appeared to apply a standard that other judges did not. Specifically, this judge expressed a preference for testimonial evidence provided during hearings over documentary evidence (such as the completed assessment form). For instance, in one case the judge said the following:

> Although the sworn testimony of a [public health nurse] might be accorded more weight than that of the appellant and his son if both sides were present to testify, mere unsworn assertions on a form do not receive as much weight as appellant's sworn testimony. I do recognize the potential bias in appellant's testimony and that of his son; however, where the [public health nurse] is not present to challenge the appellant's corrections of the record in this hearing, it is difficult for the [human services judge] to sustain the [public health nurse's reduction in services].

State law offers general guidance to human services judges regarding which party bears the "burden of persuasion" in appeals decisions. The law says:

> The burden of persuasion is governed by specific state or federal law and regulations that apply to the subject of the hearing. If there is no specific law, then the participant in the hearing who

> asserts the truth of a claim is under the burden to persuade the appeals referee that the claim is true.[15]

This language applies to a wide range of human services cases, not just PCA appeals. Based on our review of appeals cases and an interview with an assistant chief human services judge, we concluded that:

- **In practice, the statutory language defining which party has the "burden of persuasion" in appeals cases has provided limited guidance to judges.**

In the appeals decisions we reviewed, it appeared that judges required the party proposing a change in PCA services to bear the burden of proof. A majority of the cases we reviewed involved recipient appeals of service reductions, and judges in these cases placed the burden of proof on the agency (DHS or a managed care organization) that had reduced the recipient's PCA services in response to a new assessment.

We asked one of the state's assistant chief human services judges to clarify how the statutory language regarding the burden of persuasion is applied by the appeals judges. He said the statutory language is "not practical" and that judges usually follow other rules not formally established in state policy. Specifically, he said that case law and legal treatises have established that parties seeking changes in the status quo bear the burden of proof. For example, he said, if an agency's assessment of a PCA recipient leads to a reduction in the recipient's services, the agency would bear the burden to show that the reduction was reasonable.[16] Or, he said, if a recipient wants authorization for more PCA services than the recipient currently receives, the recipient would bear the burden of proof. Also, the assistant chief human services judge said that the overall quality and weight of the evidence presented by both sides in an appeal has an important impact on a judge's decision.

RECOMMENDATION

The state's chief human services judge should periodically review summary data showing the outcomes of PCA appeals for individual judges. Where appropriate, the chief judge should take steps to reduce inconsistencies—for example, through the development of increased training or clearer guidelines for judges.

We think decisions by human services judges should show a reasonable level of consistency. Judges exercise discretion as they consider the unique circumstances of cases, and this is appropriate. However, the chief human

[15] *Minnesota Statutes* 2008, 256.0451, subd. 17.

[16] In such a case, however, there could still be debate about which party is seeking to change the status quo (and thus bears the burden of proof): the administrative agency that has reduced a person's PCA services, or the recipient who is seeking to overturn an action implemented by the administrative agency in response to a new assessment of the recipient's circumstances.

services judge should ensure that individual judges use similar standards to assess evidence and have consistent interpretations of how to apply the "burden of persuasion." Also, the chief judge should ensure that judges have sufficient knowledge of the human services policies relevant to their cases.[17] If DHS officials believe that existing statutory language on the "burden of persuasion" is inappropriate or unclear, they should seek changes.

[17] DHS staff told us there were five occasions from 2005 through 2008 when they provided information and answered questions on PCA-related topics at staff meetings of the human services judges. Typically, the judges devote one hour of their monthly staff meetings to discussion of a specific human services topic area.

List of Recommendations

- The Legislature should require the Minnesota Department of Human Services to:

  - ✓ Implement mandatory training requirements for persons conducting assessments of individuals' need for PCA services.

  - ✓ Develop additional guidance to help assessors determine the PCA service needs of persons with behavior issues.

  - ✓ Develop a process for periodically reviewing samples of PCA assessments for the purpose of ensuring reasonable levels of consistency (p. 38).

- DHS should regularly and promptly analyze its data on paid claims for PCA services to identify and recoup payment of improper claims (p. 55).

- To the extent possible, DHS should reallocate existing resources to conduct more PCA-related investigations (p. 56).

- The Legislature should require representatives of new and existing personal care provider agencies to periodically complete comprehensive state training on PCA standards and practices (p. 56).

- The Legislature should amend state law to explicitly authorize DHS to reject agency applications for PCA enrollment in cases where the agency's owners or administrators have previously documented violations of federal or state regulations (p. 57).

- The Legislature should direct DHS to propose more specific policies regarding which PCA activities are (and are not) reimbursable (p. 57).

- The Department of Human Services should strengthen its Quality Assurance Review program by: (1) increasing resources devoted to it; (2) expanding the number and types of reviews; and (3) improving documentation (p. 66).

- The Legislature should clarify state statutes to ensure that all MA State Plan PCA recipients have their services periodically supervised by a qualified professional (p. 70).

- The Legislature should amend state law to prohibit the same person from serving as both the qualified professional and personal care assistant for a recipient on an ongoing basis (p. 70).

- DHS should develop a stand-alone document for PCA assessors and PCA agencies to distribute that clearly and concisely states the duties of a responsible party (p. 71).

- DHS should amend its provider manual to require Personal Care Provider Organizations to periodically make visits or phone calls to recipients' residences to verify that scheduled services are actually being provided (p. 71).

- The Legislature should amend statutes to give the Department of Human Services responsibility to investigate all reports of maltreatment involving unlicensed personal care provider agencies paid through DHS-administered health care programs (p. 75).

- The Legislature should amend *Minnesota Statutes* 626.556 so that the Department of Health is responsible for investigating alleged child maltreatment involving personal care services provided by agencies licensed by the department as home care providers (p. 75).

- The Legislature should amend *Minnesota Statutes*, 626.556, subd. 1, to require that reports of maltreatment involving children served by unlicensed personal care provider agencies be made to the Minnesota Department of Human Services (p. 76).

- The Department of Human Services should (1) remind PCA agencies about their obligation to develop individual abuse prevention plans and (2) monitor compliance with this requirement during quality assurance reviews (p. 77).

- The Legislature should consider whether to require PCA agencies to develop individual abuse prevention plans for children, as the law requires for adults (p. 77).

- The Legislature should amend Minnesota statutes to require all agencies providing personal care services to obtain background checks on their qualified professionals (p. 78).

- The Department of Human Services should develop a concise, useful document that indicates whom PCA recipients can contact with service-related concerns. The department should require all PCA agencies to distribute this to recipients (p. 80).

- DHS should post relevant documents from its quality assurance reviews of PCA agencies on its public web site (p. 80).

- The Legislature should require counties and managed care agencies that arrange for PCA assessments to provide timely copies of the assessment reports to PCA agencies that will be providing services, if they request them (p. 81).

- The Legislature should amend statutes to explicitly require unlicensed personal care provider agencies to provide Minnesota's Home Care Bill of

Rights to the recipients they serve. The Department of Human Services should incorporate discussion of the bill of rights into its training program for PCA agencies (p. 82).

- The Department of Human Services should define a set of topics on which personal care assistants should receive training (p. 87).

- The Legislature should amend *Minnesota Statutes* 256B.0655, subd. 7, to clarify the financial liability of PCA fiscal intermediaries for improper payments involving their recipients or employees (p. 93).

- DHS should ensure that its Medicaid Management Information System contains accurate reporting about which PCA recipients have elected to get services under Minnesota's PCA Choice option (p. 93).

- The state's chief human services judge should periodically review summary data showing the outcomes of PCA appeals for individual judges. Where appropriate, the chief judge should take steps to reduce inconsistencies—for example, through the development of increased training or clearer guidelines for judges (p. 95).

List of Key Terms

APPENDIX

Assessment. An evaluation of an individual's need for personal care assistance (PCA) services, conducted by a public health nurse, case manager, or service coordinator. Assessments must occur at least annually, or when there is a significant change in a recipient's condition or need for PCA services.

Care plan. A written description of specific PCA services to be provided to a recipient, as developed by the qualified professional or recipient's physician with the recipient or responsible party.

Fee-for-service. An approach the state uses to pay for health care services in which providers submit bills to the Department of Human Services (DHS) for reimbursement after services have been provided. Most PCA recipients in Minnesota participate in fee-for-service health care.

Flexible use. PCA recipients may opt for "flexible use" (rather than "standard use") of their authorized hours of PCA services. This option allows for variation in the pattern of service use within a period of time not exceeding six months.

Managed care. An alternative approach to fee-for-service payment of health care. Under this approach, DHS pays managed care organizations at a predetermined, fixed rate that covers a wide variety of health-related services. Managed care organizations administer the services on behalf of DHS, and they bear responsibility for enrollee costs that exceed the predetermined payment amounts.

Medicaid waivers. States may apply to the U.S. Department of Health and Human Services for waiver of certain requirements that apply to Medicaid "state plans." Medicaid Home and Community-Based Services waivers allow states to provide benefits unavailable to the Medicaid population as a whole to individuals who meet eligibility criteria for care in an institutional setting.

Medical Assistance State Plan. Minnesota's Medicaid program is known as "Medical Assistance." Each state's Medicaid program operates under a state plan that identifies the standard benefits the state will provide to its qualified recipients. Most PCA services in Minnesota are provided under the Medical Assistance State Plan.

PCA Choice agency. Recipients may opt to have their PCA services administered by a PCA Choice agency. This agency acts largely as a "fiscal intermediary." In essence, PCA Choice agencies share employment responsibilities with the recipients of PCA services. Recipients who choose to work with a PCA Choice agency are responsible for recruiting, training,

monitoring, and firing their assistants. The recipients are also responsible for finding a qualified professional and scheduling supervision if they have chosen to receive qualified professional supervision.

Personal care assistant. A person who provides services to a PCA recipient according to the recipient's care plan.

Personal Care Provider Organization. A PCA recipient may choose to have PCA services administered by a Personal Care Provider Organization (PCPO). This type of organization is responsible for recruiting, hiring, and training individuals to work as personal care assistants. Additional responsibilities include monitoring assistants' work and firing them, if necessary. PCPOs also employ a qualified professional for recipients who elect this type of supervision.

Physician statement of need. Required by state law, this document attests to an individual's medical need for PCA services.

Qualified professional. A mental health professional, registered nurse, or licensed social worker who supervises the personal care assistant if the PCA recipient chooses this type of supervision.

Responsible party. An individual who directs the PCA services of an individual who is not capable of doing so. The responsible party must be capable of providing the support necessary to assist the recipient to live in the community, be at least 18 years old, actively participate in planning and directing the PCA services, and not be the personal care assistant.

Service agreement. A document that states DHS's (or a managed care organization's) authorization of a certain amount of PCA time and supervision.

Service plan. This document includes the nurse's recommendation (based on the assessment) for the amount of PCA time and qualified professional supervision needed, and it records the individual's decisions regarding (1) who will supervise the personal care assistant, (2) the type of PCA agency to be used, (3) standard or flexible use of authorized hours, and (4) the use of one-to-one or shared care.

Shared care. PCA services provided by a personal care assistant to two or three individuals simultaneously.

Minnesota Department of **Human Services**

January 9, 2009

James R. Nobles, Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

Thank you for the opportunity to review and respond to your report "Personal Care Assistance." The Department of Human Services (DHS) appreciates the time and effort of the Office of the Legislative Auditor in reviewing the Personal Care Assistance (PCA) program. This report confirms the importance of the PCA program as a source of support in the community for many Minnesotans who are elderly or have a disability.

We support the key recommendations of the report, which are consistent with our current goals and objectives. The development and implementation of some of these changes is already underway. We plan to bring a number of these proposed changes to the Legislature this year.

We do have concerns about the recommendation that the Legislature amend statutes to give DHS responsibility for both investigating all maltreatment reports and enforcing the Home Care Bill of Rights involving state-funded personal care services. Currently, the Minnesota Department of Health completes vulnerable adult investigations and investigates complaints under the Home Care Bill of Rights when related to a licensed home care service provider.

We believe that consolidating both the responsibility for investigating alleged maltreatment and enforcing the Home Care Bill of Rights with one agency would be more effective and efficient.

Thank you again for the work of your office in conducting this evaluation and addressing important issues regarding the availability, effectiveness, and management of personal care assistance services.

Sincerely,

Cal R. Ludeman
Commissioner

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