DHS-8346-ENG 04-25

DEPARTMENT OF HUMAN SERVICES

Legislative Report

Development of Direct Care Services:

Providing Direct Care Services During Acute Hospital Stays

Prepared with information provided by Newman and Associates

April 2025

For more information contact:
Minnesota Department of Human Services
Disability Services Division
P.O. Box 64967
St. Paul, MN 55164-0967

651-431-4300

NO ENGLISH  **651-431-4300 or 866-267-7655 (toll free)**

Attention. If you need free help interpreting this document, call the number in the box above.

ማሳሰቢያ፦ ስለ ዶክሜንቱ ነፃ ገለፃ ከፈለጉ፣ ሠራተኛዎን ያነጋግሩ። Amharic

انتباه. إذا احتجت الى مساعدة مجانية في ترجمة هذه الوثيقة، اتصل بالرقم الموجود في المربع أعلاه. Arabic

মেনাযোগ দিন। যিদ আপিন বিনামূলেয এই নিথটির বযাযার জেনয সহায় চান তাহেল উপেরাকত বাকেস থাকা নমবরটিতে কল করুন। Bengali

သတိပြုရန်။ ကျွန်ုတော်တို့ကိုဘာသာပြန်ဆိုရန်အတွက် အခမဲ့အကူအညီ လိုအပ်ပါက, အထက်ဖော်ပြပါ အကွက်ရှိ နံပါတ်ကို ခေါ်ဆိုပါ။ Burmese

ការយកចិត្តទុកដាក់។ ប្រសិនបើអ្នកត្រូវការជំនួយឥតគិតថ្លៃក្នុងការ បកស្រាយឯកសារនេះ សូ មេហៅទូរសព្ទទៅលេខក្នុងប្រអប់ខាងលើ។ Cambodian

注意！如果您需要免費的口譯支持，請撥打上方方框中的電話號碼。
Cantonese (Traditional Chinese)

wáŋ. héčiŋhaŋ niyé wačhíŋyAŋ wayúiyeska ki de wówapi sutá, ečíyA kiŋ wóiyawa ed ophíye waŋ. Dakota

Paunawa. Kung kailangan mo ng libreng tulong sa pag-unawa sa kahulugan ng dokumentong ito, tawagan ang numero sa kahon sa itaas. Filipino (Tagalog)

Attention. Si vous avez besoin d’aide gratuite pour interpréter ce document, appelez le numéro indiqué dans la case ci-dessus. French

સાવધાન. જો તમને આ દસ્તાવેજને સમજવા માટે નિ:શુલ્ક મદદની જરૂર હોય, તો ઉપરના બોક્સ પૈકીના નંબર પર કોલ કરો. Gujarati

ध्यान दें। यदि आपको इस दस्तावेज़ की व्याख्या में निशुल्क सहायता की आवश्यकता है, तो ऊपर बॉक्स में दिए गए नंबर पर कॉल करें। Hindi

NO ENGLISH  **651-431-4300 or 866-267-7655 (toll free)**

Lus Ceeb Toom. Yog tias koj xav tau kev pab txhais lus dawb ntawm cov ntaub ntawv no, ces hu rau tus nab npawb xov tooj nyob hauv lub npov plaub fab saum toj no. Hmong

ဟ်သူဉ်ဟ်သး. နမ့ၢ်လိဉ်ဘဉ် တၢ်မၤစၢၤကလီလၢ ကကျိုးထံလံာ်တီလံာ်မီတဖဉ်အဃိ, ကိးနီဉ်ဂံၢ်လၢ အအိဉ်ဖဲတၢ်လွံၢ်နၢဉ် လၢတၢ်ဖိခိဉ်အပူၤတက့ၢ်. Karen

이 문서의 내용을 이해하는 데 도움이 필요하시면 위에 있는 전화번호로 연락해 무료 통역 서비스를 받으실 سەرنج بدە. ئەگەر بۆ وەرگێڕانی ئەمەنامەیە پێویستت بە یارمەتی بەبەرامبەرە، ئەوا پەیوەندی بەو ژمارەیەوە بکە کە لە بۆکسەکەی سەرەوەدایە. Kurdish Sorani

Baldarî. Ger ji bo wergerandina vê belgeyê hewcedariya we bi alîkariya belaş hebe, ji kerema xwe bi hejmara li qutiya jorîn re telefon bikin. Kurdish Kurmanji

Hoȟpíŋ. Tóháŋ waŋží thí wíyukčaŋpi kiŋ yuhá níyuŋspe héčha čhéya, lé tkíčhuŋ kiŋ k'é náŋpa opáwiŋyaŋ. Lakota

ເອົາໃຈໃສ່. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອຟຣີໃນການຕີຄວາມເອກະສານນີ້, ໃຫ້ໂທຫາເບີທີ່ຢູ່ໃນປ່ອງຂ້າງເທິງ. Lao

注意！如果您需要免费的口译帮助，请拨打上方方框中的电话号码。
Mandarin (Simplified Chinese)

Pa̱lɛ rɔ piny: Mi gööri luäk lɔrä kɛ luɔ̱c kä mɛmɛ, yɔtni nämbär ɛmɔ tëë nhial guäth ɛmɛ. Nuer

Mah Biz'sin'dan.
Keesh'pin nan'deh'dam'mun chi'wee'chi'goo'yan chi'nis'too'ta'man oo'weh ooshii'be'kan.
Ishi'kidoon ah'kin'das'soon ka'ooshi'bee'kadehk ish'peh'mik ka'shi ka'ka'kak. Ojibwe

NO ENGLISH  **651-431-4300 or 866-267-7655 (toll free)**

Hubachiisa:-Yoo barreeffama kana hiikuuf gargaarsa bilisaa barbaaddan, lakkoofsa saanduqa armaan olii keessa jirun bilbilaa Oromo

Atenção. Se você precisar de ajuda gratuita para interpretar este documento, ligue para o número na caixa acima. Portuguese

Внимание! Если Вам нужна бесплатная помощь в переводе этого документа, позвоните по телефону, указанному в рамке выше. Russian

Pažnja. Ukoliko vam je potrebna besplatna pomoć u tumačenju ovog dokumenta, pozovite broj naveden u kvadratu iznad. Serbian

Fiiro gaar ah. Haddii aad u baahan tahay caawimo bilaash si laguugu turjumo dukumiintigan, wac lambarka ku jira sanduuqa sare. Somali

Atención. Si necesita ayuda gratuita para interpretar este documento, llame al número que aparece en el recuadro superior. Spanish

Zingatia. Iwapo unahitaji msaada usio na malipo wa kutafsiri hati hii, piga simu kwa namba iliyo kwenye kisanduku hapo juu. Swahili

ልቢ በሉ፡ ነዚ ሰነድ ንምትርጓም ነፃ ሓገዝ እንተ ደልዮም፣ በቲ ኣብ ላዕሊ ኣብ ውሽጢ ሰደቓ ተቐሚጡ ዘሎ ቁጽሪ ይደውሉ። Tigrinya

Увага! Якщо Вам потрібна безкоштовна допомога в перекладі цього документа, зателефонуйте за номером, вказаним у рамці вище. Ukrainian

Xin lưu ý: Hãy liên hệ theo số điện thoại trong ô trên nếu bạn cần bất kỳ sự hỗ trợ miễn phí nào để hiểu rõ về tài liệu này. Vietnamese

Àkíyèsí. Tí o bá nílò ìrànlówọ́ pẹ̀lú tí tú mọ̀ àkọ́ọ́lẹ̀ yìí, pe nọ́mbà tó wà nínú àpótí tí wà ló kè. Yoruba

LB (7-24)

ADA Advisory

For accessible formats of this information or assistance with additional equal access to human services, email us at dhs.info@state.mn.us, call 651-431-4300, or use your preferred relay service. ADA1 (3-24)

Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $75,000.

Printed with a minimum of 10 percent post-consumer material. Please recycle.

Table of contents

I. Executive summary 8

Applicability 8

Consultation with stakeholders 8

Recommendations 8

II. Legislation 10

2021 legislation 10

United States Code, title 42, section 1396a(h) 10

III. Introduction 11

Purpose of report 11

Consultation with stakeholders 11

IV. Findings 13

Services eligible to be provided in an acute hospital setting 13

Role distinction between hospital and direct care staff 13

Comparison to other states 14

Status of direct care staff in the acute hospital setting 14

Meeting service plan requirements stated in the federal statute 15

Budget considerations 15

PCA/CFSS 15

Waivers 15

VI. Recommendations 16

Service development 16

PCA/CFSS 16

Waivers 16

Direct care staff and liability concerns 16

Service planning 17

I. Executive summary

In 2020, United States Code, title 42, section 1396(h) was amended to allow delivery of some home and community-based services (HCBS) in an acute hospital setting. Minnesota Laws 2021, 1st Special Session, Chapter 7, Article 13, Section 68 required the Department of Human Services (DHS) to develop modifications to existing services in a manner consistent with the change to United States Code and provide any draft legislation needed to Minnesota Legislature by Aug. 31, 2022. The Minnesota DHS partnered with a vendor to research options, engage stakeholders and produce this report to review the feasibility of implementing this change in Minnesota.

Applicability

DHS determined this change is applicable to:

- Personal care assistance (PCA)/Community First Services and Supports (CFSS).[1]
- Brain Injury (BI) Waiver.
- Community Access for Disability Inclusion (CADI) Waiver.
- Community Alternative Care (CAC) Waiver.
- Developmental Disabilities (DD) Waiver.

Consultation with partners

DHS consulted with external partners, internal DHS divisions and other state administrations to identify all possible areas of conflict, as well as strategies to implement this service change. During these discussions, DHS identified the following concerns and process-related issues:

- Services eligible to be provided in an acute hospital setting.
- Role distinction between hospital staff and direct care staff.
- Status of direct care staff in an acute hospital setting.
- Meeting the service plan requirements stated in the federal statute.
- Budget considerations.

Recommendations

Due to the federal limitations on the specific supports that can be offered through home and community-based services delivered in an acute hospital setting, a two-prong approach would be required: one service option for PCA/CFSS, and one service option for waiver services.

[1] DHS is in the process of transitioning PCA to CFSS.

As a result of the findings of this report, DHS developed recommendations specific to:

- Service development.
- Direct care staff and liability concerns.
- Service planning.
- Implementation language for the state plan and waiver plan.

II. Legislation

2021 legislation

Sec. 68. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**

DIRECT CARE SERVICES DURING SHORT-TERM ACUTE HOSPITAL VISITS.

> The commissioner of human services, in consultation with stakeholders, shall develop a new covered service under Minnesota Statutes, chapter 256B, or develop modifications to existing covered services, that permits receipt of direct care services in an acute care hospital in a manner consistent with the requirements of United States Code, title 42, section 1396a(h). By August 31, 2022, the commissioner must provide to the chairs and ranking minority members of the House of Representatives and Senate committees and divisions with jurisdiction over direct care services any draft legislation as may be necessary to implement the new or modified covered service.

United States Code, title 42, section 1396a(h)

(h) Payments for hospitals serving disproportionate number of low-income patients and for home and community care

(1) Nothing in this subchapter (including subsections (a)(13) and (a)(30) of this section) shall be construed as authorizing the Secretary to limit the amount of payment that may be made under a plan under this subchapter for home and community care, home and community-based services provided under subsection (c), (d), or (i) of section 1396n of this title or under a waiver or demonstration project under section 1315 of this title, self-directed personal assistance services provided pursuant to a written plan of care under section 1396n(j) of this title, and home and community-based attendant services and supports under section 1396n(k) of this title.

(2) Nothing in this subchapter, subchapter XVIII, or subchapter XI shall be construed as prohibiting receipt of any care or services specified in paragraph (1) in an acute care hospital that are-

(A) identified in an individual's person-centered service plan (or comparable plan of care);

(B) provided to meet needs of the individual that are not met through the provision of hospital services;

(C) not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and

(D) designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

III. Introduction

This report addresses a proposal to allow delivery of direct care services to a person during an acute hospital stay. The proposal applies to people who receive:

- Personal care assistance (PCA)/Community First Services and Supports (CFSS).
- Brain Injury (BI) Waiver.
- Community Access for Disability Inclusion (CADI) Waiver.
- Community Alternative Care (CAC) Waiver.
- Developmental Disabilities (DD) Waiver.

Purpose of report

Historically, federal code prohibited the provision of home and community-based services (HCBS) to people while they were in an acute care setting. In 2020, Congress amended the code to allow states to pay for HCBS in an acute care hospital when specific conditions are met.

In 2021, the Minnesota Legislature directed DHS to consult with partners and develop a new service or modify existing services to allow people to receive direct care services in an acute care hospital, consistent with federal requirements. The Legislature also required DHS to develop draft legislation necessary to implement the new or modified services by Aug. 31, 2022.

Consultation with partners

DHS consulted with the following associations that deliver direct care services and/or represent acute care hospitals[2]:

- Home Care Association.
- ARRM.
- First Provider Alliance.
- Care Providers.
- Minnesota Organization for Habilitation and Rehabilitation (MOHR).
- Minnesota Medical Association.
- Minnesota Hospital Association.

DHS also consulted with the Department of Commerce and internal DHS staff in the areas of health care programs, licensing and disability services administrations.

[2] Not all partners invited chose to participate.

Consultation questions focused on possible impacts of delivering direct care in acute care settings, along with possible legislative changes that may be needed to allow the service. These questions included:

- What functions and practices of our current system would be impacted, from both the acute care and community care perspectives?
- What functions and practices may need to change?
- What statutes and rules govern these functions and practices?
- How will those statutes and rules need to change?

Additionally, the DHS Federal Relations unit researched approaches other states have taken due to the federal code changes.

IV. Findings

During consultation with external partners and internal DHS staff, DHS identified the following concerns and process-related issues:

- Services eligible to be provided in an acute hospital setting.
- Role distinction between hospital staff and direct care staff.
- Status of direct care staff in an acute hospital setting.
- Meeting the service plan requirements stated in the federal statute.
- Budget considerations.

The following sections discuss these concerns and process-related issues in detail.

Services eligible to be provided in an acute hospital setting

Many concerns about the changes are related to services the hospital is obligated to provide that are prohibited from being delivered by the direct care provider. Partners and internal staff expressed concerns about proper delivery of activities of daily living support (e.g., bathing, eating, walking, etc.), monitoring of ongoing medical issues and proper use of medical equipment. However, these concerns are outside the scope of this report. Those services are the responsibility of the hospital, and federal language prohibits direct care providers from delivering services that are the responsibility of the hospital.

Additional concerns centered on responsibilities not specifically assigned to hospital staff, which can be delivered by direct care providers. These responsibilities include:

1. Interpreting verbal and non-verbal communications.
2. Managing challenging behaviors (including dementia).
3. Providing companionship and reassurance.
4. Assisting with transitions to and from the hospital setting.

During the evaluation process, DHS determined it would not be possible for one service to cover people on PCA/CFSS and people on a waiver. All four areas of support identified above can be provided under at least one existing waiver service. However, only item #4 can be provided under PCA/CFSS. Therefore, it is necessary for DHS to create a state plan option (for people on PCA/CFSS only) and a waiver plan option.

Role distinction between hospital and direct care staff

It is important to have clear distinction between services the hospital is responsible to provide and services the direct care staff is responsible to provide. Most partners that participated in the consultation process shared the desire for clear role distinction.

Additionally, direct care providers that historically had staff present during hospitalizations (without reimbursement) found it important that all parties understand direct care services are for the person, not the hospital or hospital staff. This means the direct care staff are not there to supplement hospital staffing. They are present to support the person, and their support role may change as the person moves from admission, to treatment, to discharge.

The person's support plan largely determines the roles of direct care staff during hospitalization. The support plan includes information about the services that must continue during hospitalization. The content of the support plan must be clear and clearly communicated. All stakeholders consulted agreed that successful implementation would require development of policies and procedures to support clear definition of roles.

Partners suggested the following ideas:

- Provide templates or formats to help with assessment and planning.
- Include a checkbox of issues to address.
- Provide examples of support plan and support plan addendum language.
- Provide sample instructions for staff.
- Have an explanation of roles posted in the hospital room.
- Provide instruction for assessors about how to include service needs during hospitalizations in the assessment process.

Comparison to other states

To address this issue, Illinois described the allowable services in its CMS-approved waiver plan as follows:

> "Personal Support is being expanded to include supports provided to a participant while hospitalized to foster communication, provide intensive personal care, and/or promote behavioral stabilization for the purpose of smooth transitions or preserve functional abilities. These are services in the plan of care that cannot be provided by facility staff and are not a substitute for services the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement. Services in the plan of care that cannot be provided by facility staff will be provided by the Personal Support Worker."

Status of direct care staff in the acute hospital setting

Associations representing acute hospitals and direct care providers both identified issues about the status of the direct care staff while at the hospital, specifically in terms of liability. They raised the following questions:

- Liability: Who is responsible if something happens to the direct care staff?
- Service plan: Does the direct care staff follow orders from the hospital or the direct care provider?
- Paying for services: Does direct care staff providing services affect the hospital rate?

Refer to the Direct care staff and liability concerns section for recommendations to address these issues.

Meeting service plan requirements stated in the federal statute

Direct care services provided in acute care hospitals must be identified in the person-centered service plan (or comparable plan of care), per the federal statute.

For both people on PCA/CFSS and people on waivers, the need for transitional support must be identified during the assessment and consultation process and described in the plan of care.

For people on waivers, the support plan must identify which services must continue during an acute hospital stay and the aspects of the service that are not duplicative of what the hospital is obligated to provide. This information can be part of a support plan addendum, as well as part of the annual person-centered planning process. If a person not currently using a qualifying service has an expected need for services in the event of a hospitalization, the lead agency can authorize those services so they are available if needed.

Many people receiving PCA/CFSS also receive waiver services. The availability of direct care services in acute care hospitals through both PCA/CFSS and waivers will raise issues about which provider is doing what and why. Service planning must address coordination among providers during hospitalizations.

Budget considerations

PCA/CFSS

People on PCA/CFSS would receive transition support through a new state plan service. Upon implementation of CFSS, this transition support would not be part of the CFSS budget.

HCBS waivers

Generally, DHS expects a person's waiver service needs while in the hospital will not be substantially greater than what is provided outside the hospital. If a person's service needs increase during or after hospitalization, those needs would be addressed through current practices and procedures for adjusting budgets.

VI. Recommendations

As a result of this report's findings, DHS recommends a two-pronged approach to allow direct care service delivery in an acute care hospital:

- A state plan option for PCA/CFSS.
- A waiver plan option.

Service development

PCA/CFSS

DHS recommends developing a new state plan service that is specifically for the purpose of transition to and from acute hospital stays for people receiving PCA/CFSS. All other supports provided by PCA/CFSS (i.e., medical services, activities of daily living supports and instrumental activities of daily living supports) are the hospital's responsibility.

Waivers

DHS recommends allowing only non-residential, unit-based services during acute hospital stays. A person usually receives these services in their home or in the community. The rate factors do not include any cost categories that do not apply in a hospital or in other community locations, so no rate adjustments will be needed.

Direct care staff and liability concerns

DHS recommends the following approach to address concerns about the presence of direct care staff in an acute hospital setting.

The direct care staff will remain an employee of the direct care provider, be covered by their insurances and be subject to the same licensing (if applicable) and job performance requirements.

When in the hospital setting, the direct care staff will be subject to any requirements the hospital sets. The best analogy for the role of direct care staff in the hospital is that of a visitor. Like a friend or family member, they are there to provide care and support that is not the obligation of the acute hospital. They must follow procedures set by the hospital.

This approach does not change documentation and accountability processes and standards because the roles of the direct care provider and the hospital are not duplicative, and the direct care staff's employment status does not change.

There is no need to adjust hospital payment rates because the direct care services are not duplicative of what the hospital is obligated to provide.

Service planning

A person's person-centered service plan (or comparable plan of care) must identify the service and supports that are allowed to be delivered by a direct care staff in an acute hospital setting, per federal statute. DHS recommends documenting this information during a person's initial or annual service planning process.