

Personal Care Assistance Services - A Report to the 2011 Minnesota Legislature

Disability Services Division

February 2011



Legislative Report

Minnesota Department of **Human Services**

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I. Executive Summary

Personal care assistance (PCA) is a home care service administered by the Minnesota Department of Human Services (DHS). Personal care assistants provide services and support to help people who need assistance in activities of daily living (ADL), health-related procedures and tasks, observation and redirection of behaviors and instrumental activities of daily living (IADL) for adults. PCA services are funded by Medical Assistance (MA), MinnesotaCare expanded benefits and Alternative Care (AC).

PCA service grew as eligibility expanded from serving only adults with physical disabilities to serving all Medical Assistance populations based on functional need.

The complexity of the program has also increased over time. The 2009 and 2010 Minnesota Legislature enacted comprehensive reform of PCA services to help people who need the service most get it in a cost-effective, quality-conscious manner. Changes were made to:

- Improve consumer protection and assure consumer health and safety
- Increase accountability
- Simplify and clarify requirements
- Strengthen provider standards
- Produce cost savings

DHS was directed by the 2009 Minnesota Legislature to make changes, including the following major initiatives:

- Modify the access, assessment and service authorization process, improving statewide consistency
- Require DHS-administered training for provider agencies, qualified professionals and personal care assistants
- Strengthen PCA Provider initial and annual enrollment requirements

Highlighted activities during 2010 include:

- Completed the six-month PCA reassessment project in May 2010, a phased rollout of the new assessment and authorization process
- Revised the Medicaid Management Information System (MMIS) to reflect assessment and service authorization changes, new service denial reason codes and changes to prevent improper payments
- Revised multiple policies and procedures to reflect legal changes
- Trained over 21,743 staff representing lead agencies (counties, tribal agencies and health plans), provider agencies, stakeholders and others involved in PCA services

DHS was also directed in 2009 to develop alternative services to personal care assistance services for persons with mental health and other behavioral challenges who can benefit from other services that more appropriately meet their needs and assist them in living independently in the community. This report includes DHS's recommendation for serving the approximately 2,789 state plan consumers who are anticipated to lose access to PCA services in 2011 with the legislated change in access criteria.

II. Background

Personal care assistance (PCA) is a home care service administered by the Minnesota Department of Human Services. Between January 1, 2010 and December 10, 2010, PCA services were authorized for 21,408 fee-for-service¹ recipients who need assistance in activities of daily living, health-related procedures and tasks, observation and redirection of behaviors and instrumental activities of daily living (for adults). The 21,408 fee-for-service recipients include 14,970 people on state plan² services and 5,427 people receiving PCA services as part of their waiver services. An additional 4,354 non-waiver MA recipients are currently receiving PCA services from their managed care plan.³ Activities of daily living include dressing, grooming, bathing, eating, transfers, mobility, positioning and toileting. Instrumental activities of daily living include tasks like accompanying someone into the community, paying bills, making appointments, household tasks like cooking and laundry. PCA services are funded by Medical Assistance (MA), MinnesotaCare expanded benefits and Alternative Care.⁴

There are currently 786 Personal Care Provider Organizations (PCPOs) that offer traditional PCA services and 500 of those are also PCA Choice agencies that serve as fiscal intermediaries for recipients that select the PCA Choice option. There are 26 PCA Choice only agencies. Through the PCA Choice option, the consumer is responsible for hiring, training, scheduling and terminating their personal care assistants. As of December 31, 2010, there are 66,490 enrolled personal care assistants.

PCA services had grown in number of people served as the services expanded across all Medical Assistance populations. The complexity of the program has also increased over time. The 2009 Minnesota Legislature enacted comprehensive reform of PCA services, which introduced changes to help people who need the service most get it in a cost-effective, quality-conscious manner.

This report fulfills the legislative requirement under 2009 Laws of Minnesota, Chapter 79, Article 8, Section 80 (2):

report data on the training developed and delivered for all types of participants in the personal care assistance program, audit and financial

¹ There are two types of payments for PCA services. Payments are either direct billed to DHS as fee-for-service claims or covered by a prepaid medical assistance managed care plan.

² State plan services refers to the standard benefit set available to all MA recipients who meet functional need access criteria. Home and community-based (HCBS) waiver programs offer service options beyond the state plan benefit set.

³ 2010 data on the number of Elderly Waiver recipients on managed care using PCA services is not available at this time. In 2009 4,439 people on the Elderly Waiver received PCA services from managed care.

⁴ Medical Assistance is Minnesota's Medicaid program. It is jointly funded by state and federal government to provide health care services to people with low incomes. MinnesotaCare is a publicly subsidized health plan for people who do not have access to affordable health care coverage. Alternative Care assists Minnesotans 65 years and older who meet income and asset requirements to receive community services instead of moving into a nursing home.

integrity measures and results, information developed for consumers and responsible parties, available demographic, health care service use, and housing information about individuals who no longer qualify for personal care assistance, and quality assurance measures and results to the legislative committees with jurisdiction over health and human services policy and finance by January 15, 2010, and January 15, 2011.

This report also fulfills the legislative requirement under 2009 Laws of Minnesota, Chapter 79, Article 8, Section 76:

The commissioner of human services, in consultation with advocates, consumers and legislators, shall develop alternative services to personal care assistance services for persons with mental health and other behavioral challenges who can benefit from other services that more appropriately meet their needs and assist them in living independently in the community. In the development of these services, the commissioner shall: (1) take into consideration ways in which these alternative services will qualify for federal financial participation; and (2) analyze a variety of alternatives, including but not limited to a 1915(i) state plan option.

The commissioner shall report to the legislature by January 15, 2011, with plans for implementation of these services by July 1, 2011.

This report was prepared by the staff of the Minnesota Department of Human Services, Continuing Care Administration, Disability Services Division.

This report provides an overview of the recent legislatively mandated changes to PCA services. It reports on the progress of implementing the PCA reform efforts, including the following topics mandated by 2009 Laws of Minnesota, Chapter 79, Art. 8, Sec. 76 and 80 (2):

- Training initiatives
- Audit and financial integrity measures
- Consumer and responsible party information
- Available demographic, health care service use and housing information about individuals who no longer qualify for personal care assistance
- Quality assurance measures
- Alternative services for persons with mental health and other behavioral challenges

III. 2009 and 2010 Legislative Changes

The 2009 Minnesota Legislature enacted comprehensive reform of PCA services. DHS was directed to make several changes, including the following major initiatives:

- Modify the access, assessment and service authorization process, improving statewide consistency
- Require DHS-administered training for provider agencies, qualified professionals and personal care assistants
- Strengthen PCA Provider initial and annual enrollment requirements

There were three main implementation dates identified in the legislation.

Effective July 1, 2009:

- Assessors must provide referrals to the consumer and responsible party for other services as part of the assessment (Appendix F)
- Lead agencies must send a copy of the completed PCA Assessment and Service Plan (Appendix F) to consumers, responsible parties and providers within 10 working days
- New PCA provider agencies must complete the new enrollment process and meet all new requirements prior to providing PCA services
- New PCA provider agency owners, operators, managing parties, qualified professionals, and billing staff must complete required training prior to providing PCA services
- New provider agency owners, operators and managing parties, qualified professionals, and individual PCAs must pass a background study prior to providing PCA services
- Provider agencies and responsible parties must enter into written agreements with each other

Effective January 1, 2010:

- Access to PCA services is limited to people with at least one dependency in an activity of daily living (ADL) or who exhibit Level 1 behavior. A dependency means a person requires hands on assistance or constant cuing and supervision to begin and complete one or more activities of daily living. Level 1 behavior is physical aggression towards self, others or destruction of property that requires the immediate response of another person
- Lead agencies must assess people using a new assessment tool and revised home care rating and authorization requirements
- PCA provider agencies must complete annual re-enrollment to continue providing PCA services
- PCA provider agencies must use 72.5 percent of PCA revenue towards PCA salary and benefits
- PCA provider agencies must have qualified professional supervision of PCA staff
- PCA provider agencies cannot both control someone's housing and provide PCA services
- PCAs cannot assist children under age 18 with instrumental activities of daily living (amended in 2010 – see below)
- Previously enrolled PCA provider agencies, qualified professionals and individual PCAs must complete DHS required training
- Stepparents cannot provide PCA services

Effective July 1, 2011:

- Access to PCA services is limited to people with at least two dependencies in activities of daily living
- DHS must implement an alternative service for persons with mental health and other behavioral challenges who can benefit from other services that more appropriately meet their needs and assist them in living independently in the community

The 2010 Minnesota Legislature made additional changes to PCA services. Chapter 351 from the regular session and Chapter 1 from the special session included the following non-technical changes:

- PCA provider agencies must provide recipients a copy of the home care bill of rights and 30-day notice prior to terminating services

- Individual PCA training and PCA provider organization training must be provided in languages other than English and in an accessible format for people with disabilities
- Owners, operators, managing parties, supervisors and qualified professionals must pass competency testing
- Owners, operators, managing parties, supervisors and qualified professionals with Medicare-certified home health agencies are exempt from training requirements
- PCAs from closed agencies may immediately enroll with a new provider agency to provide a continuity of care for recipients. They must complete a new background study as soon as possible
- PCAs may assist with IADLs for children under 18 “when immediate attention is needed for health or hygiene reasons integral to the personal care services and the need is listed in the service plan by the assessor”
- Visits to supervise overall PCA services may alternate between face-to-face and phone or Web visits, after the first 180 days of service; however, the 2010 Minnesota Legislature did not authorize payment for phone or Web visits
- PCA provider agencies may not use restrictive employment contracts
- PCAs are limited to working 275 hours a month

IV. Reform Implementation

During 2010, DHS engaged staff and stakeholders to continue to implement changes to PCA services.

This section of the report reviews the training developed and delivered, audit and financial integrity measures, consumer and responsible party information, quality assurance measures and other relevant information in 2010.

a. Training initiatives

The following training occurred between January 1, 2010, and December 30, 2010.

Target Audience	Title	Mode	Frequency	Attendance
Provider agency owners, managers, supervisors and qualified professionals (QPs)	Steps for Success	Three-day (one day for QPs); face-to-face or Webinar	20 sessions	1,264
Provider agency billing staff	PCA Billing Lab	One day; face-to-face computer lab or Webinar	54 sessions	443
Individual PCAs	Individual personal care	Online module	anytime	19,486

Target Audience	Title	Mode	Frequency	Attendance
	assistant training	and competency test		passed test
Lead agency assessors	PCA Refresher Training	Half-day; face-to-face	10 sessions statewide	550
Total				21,743

Ongoing training activity

DHS continues to offer both mandatory and voluntary training opportunities related to PCA services.

Provider agency owners, managing employees and supervisors

DHS has offered voluntary PCA provider agency training since 2008. Effective with the 2009 legislation, each owner and managing employee of every new PCA provider agency must attend and successfully complete Steps for Success training before providing services. In 2010, the training requirement was added for supervisors and exempted for Medicare-certified home health agencies.

Each owner, managing employee and supervisor of already enrolled PCA provider agencies must attend and successfully complete training by January 1, 2011. DHS extended the deadline through March 2011 since the Webinar opportunity was not available until September 2010. Managing employees who solely manage non-PCA areas of the business and board of director members who are not owners, managing employees, qualified professionals or designated billing staff do not have to complete Steps-for-Success. The 2010 Minnesota Legislature waived the training for owners, managers and supervisors who work for Medicare-certified home health agencies.

DHS offered Steps for Success twice a month through October 2010 and monthly since October 2010. Up to 100 participants can attend in person in St. Paul and hundreds more can attend via Webinar. Online learning modules and an accompanying competency test are under development.

Post training evaluations were very positive. Comments include:

- “The training was very informative and educative for providers like me. Because of the continuous changes and sometimes misunderstanding regarding applications of the new statutes and laws, I believe it is better for providers to take advantage of all.”
- “I thought all of the presenters were very knowledgeable about the rules and regulations and it was obvious that they were trying to present the material in as easy and clear a manner as possible. They took the time to thoughtfully answer questions.”
- “I heard it was quite boring and just loads you with information. I didn’t think it was boring at all. I really enjoyed it. There was so much information that will help me with my everyday tasks. Thank you for having this.”

DHS regularly evaluates PCA provider agency training and responds to meet the needs of providers. For example, DSD reorganized the curriculum for the three day Steps for Success training and moved all policy information to day one so qualified professionals could shorten their participation to one day of content that was directly relevant to their roles.

Qualified professionals

Effective March 2010, qualified professionals had the option of attending one day of Steps-for-Success rather than the full three days, at the direction of their provider agency. Effective September 2010, the training is available via Webinar. New qualified professionals must attend Steps for Success within six months of the date hired by a PCA provider agency. The 2010 Minnesota Legislature waived the training for qualified professionals who work for Medicare-certified home health agencies.

In 2011, online learning and an accompanying competency test will provide qualified professionals another way to complete the required training.

PCA provider agency billing staff

DHS offered PCA billing lab training 55 times in 2010. The one-day training was attended face-to-face or via Webinar by 443 PCA provider agency billers.

Personal care assistants

The 2009 legislation created a training requirement for personal care assistants. A nine part online module and accompanying competency test was available beginning in March 2010.

The nine parts of the online training include:

- Overview
- Emergencies
- Infection Control and Standard Precautions
- Body Mechanics
- Understanding Behaviors
- Boundaries and Protection
- Timesheet Documentation
- Fraud
- Self Care

The online training modules and the accompanying test are available in English. Hmong, Russian, Somali, Spanish and Vietnamese translations will be available spring 2011. One thousand, nine hundred eighty nine (1,989) non-native English speakers have already passed the competency test in English.

When the training is available in six languages, enforcement of this requirement will begin. Each new PCA must successfully pass the PCA competency test before providing services. Current PCAs must meet the PCA training requirement within a year of it being available. Viewing the online modules is optional. Passing the test is required. Between March and December 2010 19,486 PCAs have passed the competency test.

Lead Agencies

While no legislative mandate exists, DHS provides periodic training for lead agency (county, tribal agency and health plan) staff on PCA services.

In 2009, 18 sessions of “PCA - A New Assessment” were voluntarily attended by 1,192 lead agency staff. In 2010, 550 assessors attended ten sessions of PCA Refresher Training across the state.

Post training evaluations were very positive. Evaluation results indicated:

- 89% found the information very relevant or relevant
- 87% found the material helpful

Comments included:

- “All of the updates were helpful. The examples were especially helpful to see real case information.”
- “It was a good experience to new and experienced PCA assessors to attend in this time of confusion with the changes.”
- “Presenter was knowledgeable, was able to give answer to people's questions. Presented examples which helped to clarify understanding of data. Provided info on expected upcoming changes to programs. Provided info on contacts to get answer to questions.”

DHS is developing a comprehensive assessment, called MnCHOICES. Eligibility review for several long-term care programs including Home and Community Based Services (HCBS) waiver programs, Private Duty Nursing private duty nursing and PCA services will be conducted through this new process. Beginning January 1, 2012, lead agencies must use certified assessors in preparation for MnCHOICES. There will be required training to become a certified assessor.

b. Audit and Financial Integrity Measures

DHS has expanded its auditing efforts to assure the financial integrity of PCA services. DHS database systems have built-in edits to validate PCA data and claims. DHS has also implemented several changes to increase the financial integrity of PCA services.

DHS uses the Medicaid Management Information Systems (MMIS) to manage fee-for-service authorizations and expenditures. In late 2009 and early 2010, MMIS updates included:

- Programed MMIS with new PCA access requirements, at least 1 ADL and/or Level 1 behavior
- Programed to determine Home Care Rating
- Programed to determine daily PCA units authorized
- Programed appropriate edits to assure the above

In May 2010, previously implemented edits to deny payment for claims where an individual personal care assistant exceeded 24 hours a day and 275 hours a month, were revised and underwent rigorous testing to assure they were working as intended. The following monthly compliance reports are reviewed:

- 24 hour limit – reports if any PCA provider claims over 24 hours of PCA services for one individual personal care assistant in one day were denied

- 24-hour limit – reports if any PCA recipient is receiving over 24 hours of PCA services in one day. Current policy does allow some recipients to receive more than 24 hours per day of PCA services
- 275 hour limit – reports if any PCA provider is claiming over 275 hours for one individual personal care assistant in a calendar month for Fee For Service PCA

The enhanced enrollment and annual re-enrollment requirements for PCA provider agencies include new requirements and audit procedures. Some of the new requirements and audit procedures include:

- Verification that owners, managers, or qualified professionals are in good standing with the U.S. Department of Health and Human Services Office of Inspector General
- All owners, managers, qualified professionals and personal care assistants must pass a background study prior to providing services
- All qualified professionals licensure is verified
- Copies of bank statements, insurance policies, bonds and Secretary of State’s registration are required

Seventy-seven new PCA provider agencies have completed the initial enrollment under the requirements mandated by the 2009 legislation. As of January 2011, another 73 potential agencies are in the process of enrolling as PCA provider agencies.

PCA provider agencies must complete annual re-enrollment. Re-enrollment is being phased in as PCA provider agencies complete the new training requirements. During 2010, 96 re-enrollments were completed. One PCA provider agency failed to meet the annual review requirements and was terminated by DHS. This action is currently under appeal.

c. Consumer and Responsible Party Information

DHS has developed and improved several information tools for consumers and responsible parties.⁵

- Direct mailed 2,471 current fee-for-service consumers regarding access changes to PCA services effective July 2011. The January 2011 letters went to individuals most likely to be affected by the access changes. Consumers have several months before their reassessment to seek assistance, talk to families and friends, find alternate services, increase use of more appropriate services available under Medical Assistance and generally prepare for life without PCA services, if they lose access to PCA services.
- Centralized information about PCA services on the DHS public Web site at www.dhs.state.mn.us/pca

⁵ Responsible parties are required for recipients under age 18, those with a court-appointed guardian and those unable to direct their own care.

d. Available demographic, health care service use and housing information about individuals who no longer qualify for personal care assistance

As of December 10, 2010, 165 former fee-for-service state plan PCA recipients no longer have access to PCA services.⁶ As of January 1, 2011, 12 people have in-process appeals to service termination and continue to receive PCA services at their previous rate. This data includes all fee-for-service state plan recipients; it does not include people on waivers or managed care participants. People receiving waiver services who no longer qualify for PCA services continue to have a menu of services choices and several alternatives to PCA.

There were 107 new applicants assessed between December 1, 2009 and December 10, 2010 who failed to meet the access criteria for PCA services. They had no dependencies in an activity of daily living and did not have Level 1 behavior.

The Consumer Support Grant (CSG) is a state-funded alternative to personal care assistance. CSG grants are based on PCA assessments. Fifteen former grant recipients did not meet the January 2010 PCA access criteria and are no longer eligible for a CSG grant.

The following demographic information applies to the 165 former fee-for-service state plan PCA recipients.

Characteristic	Number of people	Percent of 165 fee-for-service state plan people
Age		
18 – 64	135	82%
Under 18	21	12.7%
65+	9	5.5%
Race		
People of color	122	73.9%
White	40	24.2%
Unknown	3	1.8%
Gender		
Female	94	57%

⁶ No data was available at the time this report was produced for fee-for-service waiver recipients or state plan and waiver recipients on managed care who did not meet the January 1, 2010 access criteria.

Male	71	43%
County of residence		
Hennepin County	98	59.4%
Dakota County	20	12.1%
Ramsey County	19	11.5%
16 other counties	28	17%
Primary diagnosis		
Mental disorder	80	48%
Circulatory disease	14	8%
Musculoskeletal disease	14	8%
Endocrine, nutritional, metabolic disease	14	8%
Other	43	26%

While these 165 people are no longer eligible for PCA services, they continue to qualify and receive other Medical Assistance benefits. Select 2010 claims information is in Appendix D. There is no data showing any nursing facility admissions for the people who lost PCA services.

DHS has contracted with the University of Minnesota and Indiana University to design an evaluation of several initiatives to promote more effective and efficient use of long-term care services, including PCA services and the impact of PCA reform. This is a 5 year longitudinal evaluation. The evaluation will look at the following questions:

- Did the initiative achieve Medicaid savings?
- Were services provided more efficiently?
- Were personal health, functioning, family support, and other individual outcomes maintained or improved by the initiative?
- Were unintended adverse outcomes avoided?

e. Quality assurance measures

Provider enrollment standards

The new PCA provider enrollment standards are designed to increase quality. Seventy-seven new PCA provider agencies have enrolled under the requirements mandated by the 2009 legislation. Another 73 potential agencies are in the process of enrolling as PCA provider agencies.

PCA provider agencies must complete annual re-enrollment. In 2010, DHS completed 96 annual reviews. One PCA provider agency failed to meet the annual review requirements and was terminated by DHS. This action is currently under appeal.

The DHS Surveillance and Integrity Review division took action that resulted in termination for 23 PCA provider agencies in 2010. Another three agencies voluntarily dis-enrolled in 2010.

Participant experience survey

Legislation enacted in 2007 (Minnesota Statutes 256B.096, Subdivision 3) required DHS to develop a survey for individuals receiving waiver and PCA services.

Through a RFP process, DHS selected Vital Research to interview 825 randomly selected individuals receiving Community Alternative Care (CAC), Developmental Disabilities (DD), and Traumatic Brain Injury (TBI) waiver services as well as persons receiving PCA services. Interviews were completed in November 2010.

The interview surveys included questions in the following ten domains:

- Case Management and Service Plan Development
- Living Arrangement (Home)
- Experience with Congregate Housing
- Self-Direction
- Experience with Direct Care Staff
- Daily Activities/Employment
- Health, Welfare and Safety
- Community Membership
- Important Long-Term Relationships
- Quality of Life

Data, obtained from the 83 PCA recipients interviewed, generally reflected strong support for the services received.

The three domain areas that scored lower for PCA recipients as compared to the other seven domains were in the following areas:

- Important Long Term Relationships
- Living Arrangement
- Daily Activities/Employment

PCA recipients indicated that they often rely on paid staff to interact with them versus family or friends. Persons receiving PCA services also scored lower than waiver recipients did in the ability to select where to live and who lives with them. Over 54% of those PCA recipients who currently do not work wanted more options to obtain a paying job. Most PCA recipients identified a health condition as a reason for their lack of success in obtaining a job.

It should be noted that PCA recipients responded that their health and safety was being addressed and that they felt safe in their homes and in their communities. They felt staff treated them with dignity and respect. One area of concern, however, is those PCA recipients who indicated that they have gone without a meal when they needed to eat (22%). DHS will follow-up on this concern.

PCA provider database

A PCA provider database was developed and has been in use the last four months. The database tracks both current and historical PCA provider information which includes: service agreement history, enrolled PCA staff, billing history, claims history and other provider/recipient demographics which are updated at least on a monthly basis. DHS has completed incorporating

quality assurance outcome measures from 2009 legislation as well as recommendations from the 2009 Office of the Legislative Auditor report and the Lewin and Associates Report into the PCA provider database. Information obtained from the database will be incorporated into easily retrievable reports that can also be used by DHS staff to generate public reports on a regular basis. The PCA provider database provides an efficient and effective tool for department staff to communicate and coordinate work and create a standardized reporting system for on-going quality assurance.

PCA provider data request

DHS has explored additional discovery options to provide a more complete overview of PCA provider compliance with standards, policy, state statute and best practice efforts. DHS reviewed past onsite auditing efforts as well as other states' processes to determine quality outcomes. DHS is gathering data on:

- Service delivery
- Policies, procedures and business practices
- Enrollment, affiliation and contracting
- Recruitment, wages and benefits
- Agency program integrity
- Challenges and successes

Quality dashboards

The internal DHS PCA Integrity workgroup is overseeing the collection of quality measures. Once the workgroup selects the final indicators, implementation and continuous improvement will progress.

f. Other relevant information

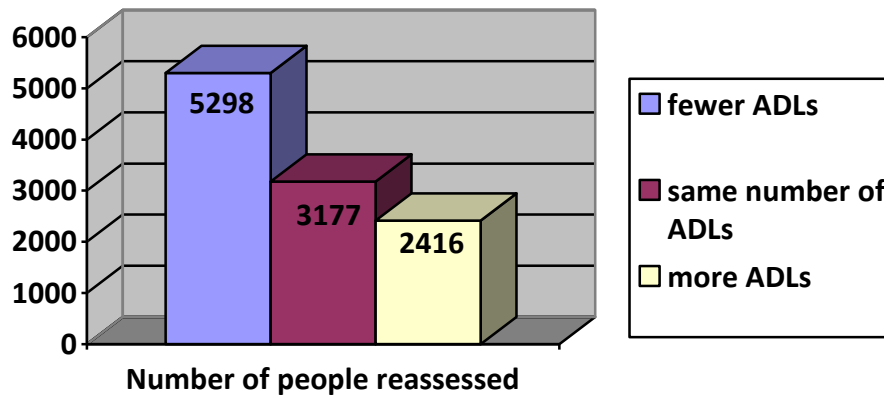
Assessment

Lead agencies conducted 21,622 PCA assessments for fee-for-service state plan consumers between January 1, 2010 and December 10, 2010. Several people had more than one assessment in 2010 due to changes in condition and the implementation of 2010 access changes to PCA services.

The 2009 legislation tightened the definition of a dependency. For some, the new assessment criteria and process resulted in changed service levels. Out of 10,891 fee-for-service state plan assessments done between December 1, 2009 and October 31, 2010:

Change in ADLs at reassessment	Number of fee-for-service state plan people reassessed	Percent of 10,891 fee-for-service state plan people reassessed
fewer ADLs	5298	49 %
same number of ADLs	3177	29%
more ADLs	2416	22%

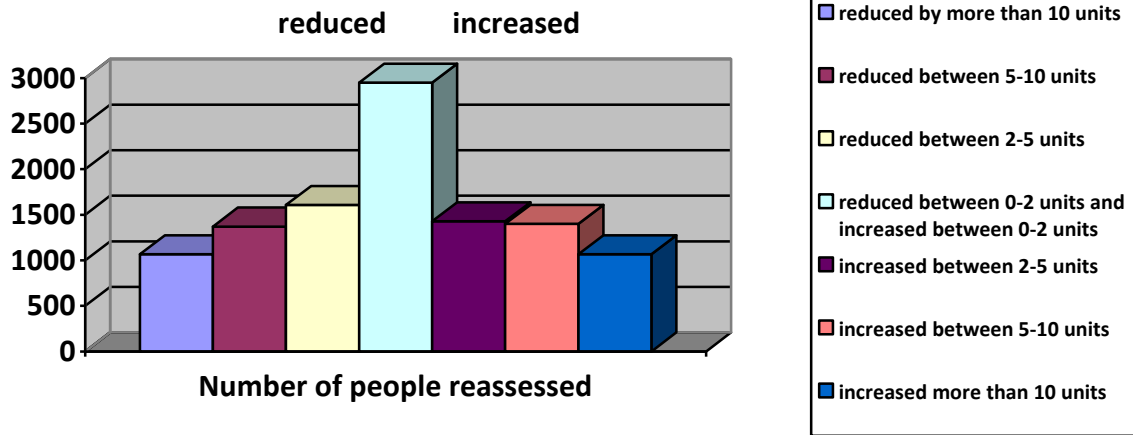
Changes in ADL Dependencies at Reassessment (12/1/09-10/31/10)



Out of 10,887 of the 10,891⁷ fee-for-service state plan assessments done between December 1, 2009 and October 31, 2010:

Change in 15-minute units authorized at reassessment	Number of fee-for-service state plan people reassessed	Percent of 10,887 fee-for-service state plan people reassessed
reduced by more than 10 units	1066	10%
reduced between 5-10 units	1370	13%
reduced between 2-5 units	1608	15%
reduced between 0-2 units and increased between 0-2 units	2948	27%
increased between 2-5 units	1427	13%
increased between 5-10 units	1401	13%
increased more than 10 units	1067	10%

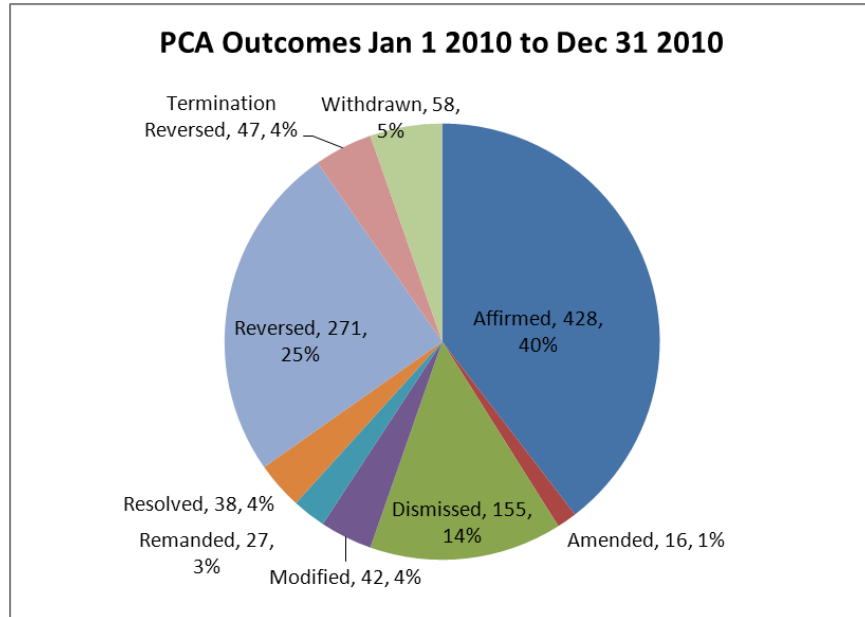
Change in authorized PCA units at reassessment (12/1/09-10/31/10)



⁷ ADL data is missing for four people.

Appeals

Between January 1, 2010, and December 31, 2010, 1,261 PCA appeals were filed with DHS by fee-for-service state plan recipients.⁸ This does not include any appeals filed by waiver recipients or recipients on managed care. One hundred seventy nine (179) appeals are in process. Thirty-four (34%) percent of appeals were decided at least in part in the appellants favor. Forty-seven (47) had their termination of PCA services reversed. The remaining appeals affirmed the PCA assessment or were withdrawn or dismissed. During 2009, only 534 appeals were filed, indicating a 136% growth rate in the number of appeals filed. DHS expects appeals growth with the new access changes beginning July 1, 2011.



Communication

DHS has used a variety of methods to communicate changes to PCA services. Target audiences include consumers, responsible parties and families; lead agencies, including counties, tribes and health plans; assessors; provider agency owners, operators, managing parties, billing staff, qualified professionals and PCAs; DHS colleagues; stakeholders and advocates. Communication methods include direct mail, telephone, Web pages, electronic mailings, videoconferences, regional meetings and presentations, individual and small group meetings and others.

In 2010, DHS developed and implemented a new system to notify the recipient's physician of the results of the assessment.

⁸ Counties and tribes handle appeals for fee-for-service waiver services. Managed care processes appeals from their members.

V. Alternative Service

a. Background

2009 Laws of Minnesota, Chapter 79, Article 8, Section 76 require:

The commissioner of human services, in consultation with advocates, consumers and legislators, shall develop alternative services to personal care assistance services for persons with mental health and other behavioral challenges who can benefit from other services that more appropriately meet their needs and assist them in living independently in the community. In the development of these services, the commissioner shall: (1) take into consideration ways in which these alternative services will qualify for federal financial participation; and (2) analyze a variety of alternatives, including but not limited to a 1915(i) state plan option.

The second phase of PCA access changes begins July 1, 2011. All new consumers assessed beginning July 1, 2011, must have dependencies in two ADLs to receive PCA services. Current fee-for-service state plan PCA recipients who have one dependency in only one activity of daily living, Level 1 behavior, or both will be reassessed between June 1, 2011 and November 30, 2011. The 2009 Minnesota Legislature charged DHS with recommending an alternative service, with a \$3,237,000 appropriation in FY12 and a \$4,856,000 appropriation in FY13, to support those with mental health or behavioral issues who no longer have access to PCA services. After conversations with authors of the original legislation related to the alternative to PCA services, they requested that the alternative be available to people who have one dependency in an activity of daily living and/or Level 1 behavior.

b. Characteristics of consumers

DHS examined the characteristics of those fee-for-service state plan consumers who are likely to lose access to PCA services in 2011. At the completion of this second phase of assessment, DHS estimates that approximately 2,789 recipients of state plan PCA services will no longer meet access criteria. This includes 2,214 fee-for-service state plan recipients and an estimated 386 state plan managed care recipients. Also expected to lose services are 189 Consumer Support Grant (CSG) recipients. The following demographic information from December 10, 2010 compares the 2,214 fee-for-service state plan recipients likely to lose services to the 12,756 fee-for-service state plan recipients who have two or more dependencies in activities of daily living and are likely to continue receiving PCA services.⁹

⁹ DHS estimates that 2,214 fee-for-service state plan recipients are likely to lose services based on a past assessment. DHS estimates that 12,756 fee-for-service state plan recipients are likely to continue receiving PCA services based on a past assessment. These figures are estimates as individual eligibility is determined by a PCA assessment and recipients whose health status has changed will continue to receive or not receive PCA services based upon a reassessment.

Characteristic	Number of people who do not meet the 7/11 access criteria	Percent of 2,214 people who do not meet the 7/11 access criteria	Number of people with 2+ ADLs	Percent of 12,756 people with 2+ ADLs
2010 access criteria				
1 ADL	791	36%		
Level 1 behavior	815	37%		
1 ADL and Level 1	608	28%		
2 ADLs			12,756	100%
Age				
18-64	1144	52%	4685	37%
Under 18	1031	47%	7513	59%
65+	39	2%	557	4%
Race				
People of color	1103	50%	7105	56%
White	1052	48%	5,198	41%
Unknown	59	3%	453	4%
Gender				
Male	1220	55%	6387	50%
Female	994	45%	6369	50%

County of Residence

An estimated 80% of persons who are likely to lose access to PCA services in 2011 live in 13 counties. They include Anoka, Becker, Beltrami, Crow Wing, Dakota, Hennepin, Itasca, Olmsted, Ramsey, St. Louis, Stearns, Washington and Wright Counties. These counties have received data on these recipients so they can help these recipients find alternatives to PCA.

Primary diagnosis	Number of fee-for-service state plan people who do not meet the 7/11 access criteria	Percent of 2,214 fee-for-service state plan people who do not meet the 7/11 access criteria	Number of fee-for-service state plan people with 2+ ADLs	Percent of 12,756 fee-for-service state plan people with 2+ ADLs
Mental disorder	1385	63%	4842	38%
Musculoskeletal disease	164	7%	1427	11%
Perinatal condition	95	4%	283	2%
Nervous system disease	87	4%	1783	14%
Endocrine, nutritional, metabolic disease	83	4%	881	7%
Circulatory disease	68	3%	719	6%
Congenital anomalies	53	2%	815	6%
Other	279	13%	2006	16%

While these 2,214 fee-for-service state plan consumers may no longer be eligible for PCA services, they may continue to qualify and receive mental health benefits. The following 2010 claims information applies to these 2,214 fee-for-service state plan recipients. It compares the mental health service use between those who are likely to lose PCA services and the 12,756 fee-for-service state plan PCA service recipients with two or more dependencies in activities of daily living.

Mental health service	Number of fee-for-service state plan people who do not meet the 7/11 access criteria	Percent of 2,214 fee-for-service state plan people who do not meet the 7/11 access criteria	Number of fee-for-service state plan people with 2+ ADLs	Percent of 12,756 fee-for-service state plan people with 2+ ADLs
Psychotherapy	746	34%	2345	18%
General mental health	625	28%	2235	18%
Children’s therapeutic supports	379	17%	1033	8%
Mental health case management	170	8%	375	3%
Adult rehabilitative mental health services (ARMHS)	143	7%	362	3%
Crisis response and emergency	77	4%	159	1%
Adult crisis response	35	2%	77	<1%
Neuropsychological	23	1%	126	1%
Adult day treatment	18	1%	24	<1%
Children’s crisis response	14	<1%	22	<1%
Partial hospitalization	15	<1%	17	<1%
Intensive residential rehab	16	<1%	44	<1%
Assertive community treatment	19	<1%	35	<1%
Children’s residential treatment	3	<1%	15	<1%
Certified peer specialist	2	<1%	0	0%

Earlier 2010 data divided the group of fee-for-service state plan recipients who, based on their 2010 reassessment, do not meet the new July 2011 access criteria. Group A includes people who received PCA services in 2010 because they had Level 1 behavior. Group B includes people who received PCA services in 2010 because they had a dependency in one activity of daily living. Group C includes people who received PCA services in 2010 because they had one dependency in an activity of daily living and Level 1 behavior. This August 2010 data is located in Appendix E.

Waiver services

Minnesotans with disabilities or chronic illnesses who need certain levels of care may qualify for the state's home and community-based (HCBS) waiver programs. HCBS waivers afford states the flexibility to develop and implement creative alternatives to placing Medicaid-eligible persons in hospitals, nursing facilities or Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/MR).

People receiving waiver services have various service options that are not available under regular MA. These service options are available to persons in addition to PCA and other state plan services covered by MA.

People receiving CAC, CADI, TBI, EW waiver services and AC are assessed annually using the Long Term Care Consultation (LTCC). Assessors also complete the Supplemental Waiver PCA Assessment and Service Plan in Appendix H. DD Waiver recipients are assessed using the PCA Assessment and Service Plan. The waiver recipient and their case manager develop a waiver plan that can include both waiver and state plan home care services. Some people receiving waiver services may be eligible for PCA services, but choose to use other services to meet their needs.

Because PCA service eligibility for people receiving waiver services is integrated into the broader LTCC, detailed data on ADL dependencies is not available. DHS estimates that approximately 379 fee-for-service waiver recipients and 285 waiver recipients on managed care will lose access to PCA services with the 2011 access changes. People receiving waiver services who no longer qualify for PCA services continue to have a menu of waiver services as alternatives to PCA.

Managed care organizations

As of February 1, 2011, 4,354 non-waiver MA recipients are currently receiving PCA services from their managed care plan. Non-waiver managed care recipients who received PCA services in 2010 because they had one dependency in an activity of daily living and/or Level 1 behavior, will be reassessed between January 1 and June 30, 2011. Those managed care recipients who do not have two dependencies in activities of daily living will lose access to PCA services based on each health plan's policy for implementing the 2011 access changes. DHS estimates that approximately 671 state plan and waiver recipients on managed care will lose access to PCA services with the 2011 access changes. People receiving waiver services who no longer qualify for PCA services continue to have a menu of waiver services as alternatives to PCA.

Consumer Support Grant

The Consumer Support Grant (CSG) is a state-funded alternative to personal care assistance, home health aide and private duty nursing. CSG allows a recipient to convert a portion of the state funds that would have gone towards PCA services into a monthly cash grant. CSG recipients can then manage and pay for a variety of home and community based services. CSG provides recipients with greater flexibility and choice. As of October 2010, 189 people who currently receive CSG via PCA eligibility do not have two dependencies in activities of daily living. When these 189 recipients no longer qualify for PCA services, they will no longer qualify for a Consumer Support Grant under current requirements.

Characteristic	Number CSG recipients who do not meet the 7/11 access criteria	Percent of 189 CSG recipients who do not meet the 7/11 access criteria
2010 access criteria		
Level 1 behavior	94	50%
1 ADL and Level 1	70	37%
1 ADL	25	13%
Age		
Under 18	168	89%
18-64	21	11%
Race		
White	138	73%
People of color	32	17%
Unknown	19	10%
Gender		
Male	135	71%
Female	54	29%

Individualized Education Program Services (IEP) services

Minnesota Health Care Programs (MHCP) covers certain health-related services provided to children under age 21 when the services are included on an IEP, Individualized Family Service Plan (IFSP), or Individual Interagency Intervention Plan (IIIP). Only schools or school districts can be IEP services providers. IEP services providers are reimbursed the federal share and are responsible for the non-federal share of MA payments.

All reimbursement rates for covered IEP services are cost-based. In state funding year 2009, IEP services providers provided covered personal care assistance services to 5,185 children enrolled in MA and MinnesotaCare and were reimbursed \$19,397,797. DHS does not have access to data to determine how many children will not meet the new criteria to qualify for MA reimbursement of PCA services at school.

Schools and districts are responsible under federal law for providing education and health-related services to children in special education. Medicaid reimbursement cannot be a deciding factor in determining services children receive through IEPs, IFSPs or IIPs.

c. Alternative service stakeholder group feedback

DHS developed an alternative service stakeholder group. Their charge was to:

- Identify support needs of people likely to lose PCA
- Review existing services that could meet some needs and identify barriers
- Identify service gaps
- Make recommendations to fill gaps

The stakeholder group met monthly, July to December 2010, to discuss the affected populations, review existing services, and consider new ideas. A list of participants is in Appendix B.

The stakeholder group reviewed the following existing services and new ideas as possible alternatives to PCA services.

- Family Support Grants (FSG)
- Semi-Independent Living Skills (SILS)
- Adult and Children's Mental Health Services
- Home and Community Based Services (HCBS) Waivers
- Home Health Aide
- Medicaid funded options for home and community based services including:
 - 1915 (c) HCBS
 - 1915 (i) state plan for HCBS services
 - 1915 (j) self-directed personal assistance option
 - 1915 (k) Community First Choice Option

The stakeholder group spent a considerable amount of its time discussing the impact of the cuts to service and in identifying problem issues and obstacles to creating alternatives.

The stakeholder group expressed concerns about the availability of culturally competent mental health services in languages other than English, noting that PCA services are available in the person's own language and culture.

After examining the data, the group noted that there are waiting lists for FSG, SILS, and the Community Alternative for Disabled Individuals (CADI) and Developmental Disabilities (DD) waivers. The group also expressed concerns about the timely availability of some mental health services, especially diagnostic assessments and children's behavioral aides. Stakeholders also raised concerns about the availability of occupational therapy assessments.

Children's mental health behavioral aides (MHBA) are one service available under Children's Therapeutic Support Services (CTSS). In 2009, 192 children received MHBA services from 14 provider agencies. More than half, 55% of these children had a diagnosis of disruptive behavior disorders, 19% had a diagnosis of pervasive developmental disorders and the remaining 26% had several other diagnoses. MHBA services are broken into two different levels and rates. Level I

has a rate of \$6.03 per 15-minute unit and Level II has a rate of \$7.89 per 15-minute unit. MHBA expenditures in 2009 were \$231,522.

The stakeholder group expressed concerns about the availability of mental health services to children with a primary diagnosis of fetal alcohol spectrum disorder (FAS). According to August 2010 data, eight percent of people who accessed PCA services in 2010 due to Level 1 behavior have a primary diagnosis of FAS. Children with FAS who have a history of Level 1 behavior are quite likely to have a dual diagnosis that gives these recipients eligibility for the full range of MA mental health services.

The National Alliance on Mental Illness (NAMI) Minnesota surveyed PCA recipients and currently has preliminary data available from 69 people. Interested parties may contact NAMI at www.namihelps.org for their completed report when available.

After examining the demographic data and existing mental health services, the stakeholder group unanimously agreed that PCA is an appropriate service for this population. While important, clinical mental health services do not provide daily functional support at home. The group was also concerned about both the lack of adequate numbers of mental health service providers and the lack of timely access across the state.

In addition to the stakeholder-expressed preference for restoring PCA services, recommendations include:

- Develop a 1915 (k) Community First Choice Option state plan service
- Develop a universal worker state plan service that could provide both assistance with ADLs, IADLs and mental health issues
- Occupational therapy assessments followed by use of adaptive or monitoring technology that replace the need for human assistance
- Training to increase access to children's mental health behavioral aides, a service available under Children's Therapeutic Support Services (CTSS.) Mental health behavioral aides are not available statewide and long wait times exist due to a shortage of providers with trained aides
- Navigator service to assist recipients in finding possible alternatives. Most consumers of state plan services do not receive case management. Navigators could help consumers through the transition to alternate services
- Homemaker services for state plan consumers
- Respite services

d. County feedback

Additional information was gathered by DHS from the 13 counties most effected by the 2011 access changes. An online meeting was followed up with a survey. A list of participants is in Appendix C. The service recommendations from this group, in alphabetical order, included:

- Increase availability of children's behavioral aides
- Encourage informal supports
- Increase extended day care/respite care
- Increase family skills training

- Fund homemaking as non-waiver service
- Increase waiver capacity

e. DHS recommendation

DHS examined the stakeholder workgroup's leading recommendation of developing a 1915 (k) Community First Choice Option state plan service. The 1915 (k) Community First Choice Option appears to be an option for capturing federal matching funding to provide services that are more flexible. However, CMS has not released any guidance to states on this option and the option is not available until October 2011. Once more information is available, DHS can resume analysis for consideration of this option in Minnesota.

DHS recommends a two-pronged approach to providing alternative services to those who will no longer qualify for PCA services or the Consumer Support Grant: a new PCA home care rating and improved referrals to existing services.

DHS recommends implementing a new PCA home care rating for recipients who have a dependency in one ADL and/or Level 1 behavior. This new rating would authorize two 15-minute units of PCA service a day for a total of three and one half hours a week. Recipients can use their PCA units flexibly over a six-month period. The PCA service allows the recipient to choose a personal care assistant from their cultural community to assure the service is culturally sensitive and appropriate.

The new PCA home care rating would bring a federal financial match and essentially double the funding made available to provide an alternative service. If implemented, the commissioner will monitor the use of this home care rating and will inform the Minnesota Legislature if the forecasted use exceeds the appropriations made available.

Given the data on this group's primary ADL need, primary diagnosis and current service usage, lead agency assessors are expected to increase referrals to other available services. Two current MA services that may be appropriate for those with one ADL include home health aide services and occupational therapy, in the home. Both of these services are provided by Medicare-certified home health agencies and any MA recipient can contact a provider agency for an assessment. Lead agency assessors will also be encouraged to refer people for a mental health diagnostic assessment, as appropriate.

Home health aides provide assistance similar to PCA. Both adults and children can receive home health aide services. The primary differences are:

- Home health aides can only assist in the home while PCAs can accompany into the community
- PCA is a daily service and the service frequency for home health aides is determined by the assessment
- Home health aides can only visit once per day. For example, a person who is dependent only in bathing is no longer eligible for PCA services; however periodic home health aides visits can assist them with bathing and other personal cares

MA also covers several home therapies designed to improve or maintain a person's functioning. Occupational therapists can visit a person's home to assess the environment, identify needs and

problems and recommend assistive technology or other process solutions. Occupational therapists provide interventions to increase independence, improve safety, and improve a person's ability to live at home. For example, a person who is dependent only in dressing may be unaware of techniques, tools and adaptations that would allow them to dress independently.

Mental health diagnostic assessments are a covered benefit for both adults and children enrolled in a MA or other Minnesota Health Care Programs and they are available statewide. Fewer than 28% of the 2,214 fee-for-service state plan recipients have a 2010 claim for a mental health diagnostic assessment. During a diagnostic assessment, a mental health professional conducts a face-to-face interview, reviews medical history, considers the person's need for additional mental health assessments and services and makes appropriate referrals. Assessments in the home are available for homebound people.

Given that two-thirds of the people who will no longer have access to PCA services have Level 1 behaviors, the array of mental health benefits covered by MA may be appropriate to meet many needs. The majority of the 2,214 fee-for-service state plan consumers identified as no longer eligible for PCA do not have claims for mental health benefits.

DHS recommends the development of a new PCA home care rating. DHS's substitute recommendation for alternative services for those people who have one dependency in an activity of daily living and/or Level 1 behavior is an individual grant program.

If unable to implement a new home care rating, DHS's recommendation would then be to create individual grants for those who do not receive state plan home care services, home and community based waiver services, Consumer Support Grant, Family Support Grant, Semi-Independent Living Services or mental health services. Applicants must maintain MA eligibility and cannot live in a registered or licensed setting. Grant funds must be used for items and services directly attributable to the person's disability, over and above costs incurred by a person without a disability, and delay or prevent placement in a registered or licensed setting. A fiscal support entity will administer the grant for a cost deducted from the allocation.

As part of the substitute recommendation, DHS also proposes that state appropriations be used to improve access to children's behavioral aides. CTSS is one of the rehabilitative mental health packages covered by MA. It includes a spectrum of services to address the conditions of emotional disturbance that impair and interfere with children's abilities to function. These rehabilitative services offer a broad range of medical and remedial services and skills to restore a child's functional abilities as much as possible. These services include children's mental health behavioral aides. Behavioral aides have training requirements prior to providing services. DHS recommends that \$50,000 annually go towards DHS sponsored training to increase statewide access to behavioral aides.

VI. Conclusion

Full implementation of the 2009 and 2010 PCA reform legislation is ongoing. As identified in statute, DHS has implemented in phases several key components of the reform.

The first phase of the new access requirement (at least one activity of daily living or Level 1 behavior) was applied during the six-month reassessment process in early 2010. All new consumers in 2010 had to meet new access requirements.

DHS recommends implementing a new PCA home care rating for recipients who have a dependency in one ADL and/or Level 1 behavior. This new rating would provide two 15-minute units of PCA service a day for a total of three and one half hours a week. Recipients can use their PCA units flexibly over a six-month period.

If the DHS recommended alternative isn't approved by the Minnesota Legislature, the second phase of access requirement changes (at least 2 ADLs) begins July 1, 2011. All new consumers assessed beginning July 1, 2011, must have dependencies in two ADLs to receive PCA services. Current fee-for-service state plan PCA recipients who have one dependency in only one activity of daily living, Level 1 behavior, or both will be reassessed between June 1, 2011 and November 30, 2011. Any recipient who no longer meets the criteria for PCA services will have 30-day notice before the termination of services. Consumers continue to have appeal rights and their former benefit level continues until the completion of the appeal process. DHS would initiate a grant program with appropriated funds for those no longer receiving PCA within established criteria.

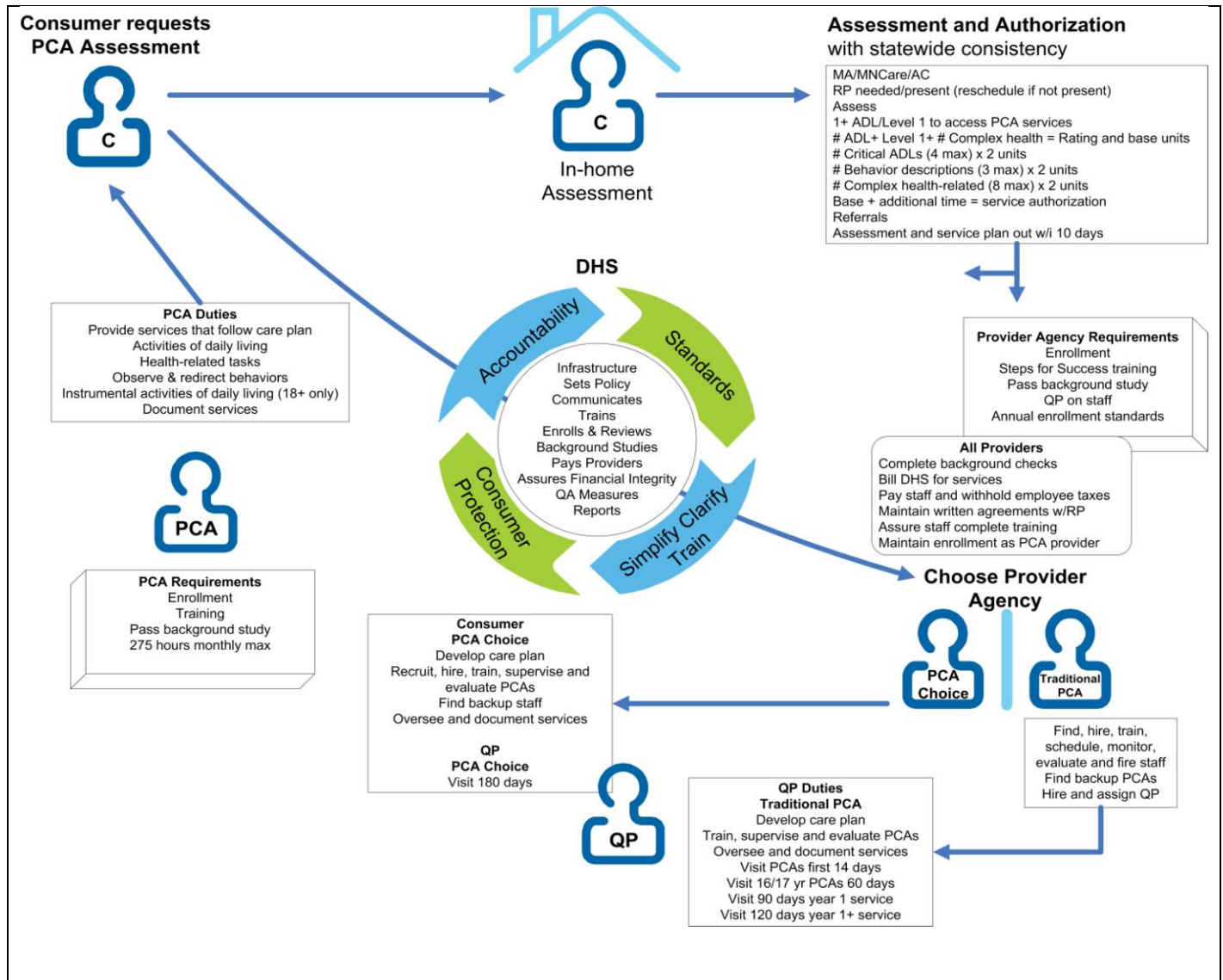
Ongoing implementation activities include:

- Reassess 2,214 fee-for-service state plan PCA recipients who had either one ADL or Level 1 behavior, or both to apply new two ADL access criteria
- Reassess waiver and managed care recipients who had either one ADL or Level 1 behavior, or both to apply new two ADL access criteria
- Refer people who no longer qualify for PCA to other services
- Develop a new home care rating for those who no longer meet access criteria for PCA services when authorized by 2011 legislation
- Continue annual re-enrollment of provider agencies
- Implement quality assurance project plan
- Obtain necessary approval for waiver and state plan amendments from the Centers for Medicare and Medicaid Services for changes effective July 1, 2011, and beyond
- Continue implementing training requirements
- Continue developing communication tools to support all parties involved with PCA services

VII. Appendices

a. Overview of PCA Services

The diagram below illustrates the PCA service and highlights key requirements and duties.



Acronym key

AC – Alternative Care
 ADL – activities of daily living
 C – consumer
 DHS – Minnesota Department of Human Services
 Level 1 – behavior rating

MA – Medical Assistance
 MNCare – MinnesotaCare
 PCA – personal care assistance or assistant
 QA – quality assurance
 QP – qualified professional
 RP – responsible party

This is a narrative description of the diagram that visually illustrates the personal care assistance service. The diagram also provides some of the key requirements and duties different entities play.

At the center of the diagram is the Minnesota Department of Human Services. DHS's role includes infrastructure, sets policy, communicates, trains, enrolls and reviews, background studies, pays providers, assures financial integrity, quality assurance measures and reports. Directly surrounding DHS are the key principles of the PCA reform effort, including accountability, standards, simplify, clarify, train and consumer protection.

In the upper left corner is a stick figure of the PCA consumer and the consumer requests a PCA assessment. An arrow points to the right at a stick figure under a roof. This illustrates the consumer having an in-home assessment. The new assessment and authorization process has statewide consistency.

The items under the assessment and authorization heading include:

- Medical Assistance, MinnesotaCare, Alternative Care
- Responsible party needed/present (reschedule if not present)
- Assess
- 1 plus ADL/Level 1 to access PCA services (changes to 2 ADLs July 2011)
- # ADLs plus Level 1 plus Complex health equals Rating and base units
- # Critical ADLs (4 max) times 2 units
- # Behavior descriptions (3 max) times 2 units
- # Complex health-related (8 max) times 2 units
- Base plus additional time equals service authorization
- Referrals

Arrows indicate that the assessment and service plan is sent out to consumer and provider agency within 10 days.

Boxes below the assessment and authorization section list information about the role of PCA provider agencies.

Provider agency Requirements:

- Enrollment
- Steps for Success training
- Pass background study
- Qualified professional on staff
- Annual enrollment standards

All providers must:

- Complete background checks
- Bill DHS for services
- Pay staff and withhold employee taxes
- Maintain written agreements with the responsible party
- Assure staff complete training

- Maintain enrollment as PCA provider

An arrow from the consumer in the upper left of the diagram flows to the lower right corner of the diagram where the consumer chooses their provider agency. Consumers have two choices, traditional PCA and PCA Choice.

Under traditional PCA, the provider agency is responsible to find, hire, train, schedule, monitor, evaluate and fire staff; find backup PCAs; hire and assign qualified professional. An arrow points from the stick figure of a traditional PCA provider agency to the role of the QP under traditional PCA.

The qualified professional duties under traditional PCA include:

- Develop care plan
- Train, supervise and evaluate PCAs
- Oversee and document services
- Visit PCAs first 14 days
- Visit 16/17 year old PCAs 60 days
- Visit 90 days year 1 service
- Visit 120 days year 1 plus service

A stick figure of a qualified professional is surrounded by the lists of the QP duties under traditional PCA and PCA Choice.

An arrow points from a stick figure of a PCA Choice provider agency to the consumer and QP roles under the PCA Choice option. Under PCA Choice option, the consumer must:

- Develop care plan
- Recruit, hire, train, supervise and evaluate PCAs
- Find backup staff
- Oversee and document services

Under the PCA Choice option, the qualified professional visits every 180 days.

A stick figure of the PCA is in the lower left of the diagram. PCA requirements include:

- Enrollment
- Training
- Pass background study
- 275 hour monthly max

An arrow from the list of PCA duties points to the stick figure of the consumer in the upper left corner. The PCA duties include:

- Provide services that follow care plan
- Activities of daily living
- Health-related tasks
- Observe and redirect behaviors
- Instrumental activities of daily living (18 years plus)
- Document services

b. Alternative service stakeholder group

Sue Abderholden, NAMI MN	Kathy Kelly, DHS Disability Services
Kim Anderson, DHS Continuing Care	Sherrie Kunkel, DHS Disability Services
Sharon Autio, DHS Adult Mental Health	Greg Marita, Legal Aid Society
Karen Conrath, ARC	Jacki McCormack, ARC
Lori Dablow, DHS Disability Services	Nancy Noetzelman, Hennepin County
Glenace Edwall, DHS Children's Mental Health	Kongmo Nsameluh, Olmsted County
Cynthia Fashaw, NAMI MN	Lorraine Pierce, DHS Adult Mental Health
Audrey Fischer, DHS Disability Services	Mary Regan, Minnesota Council of Child Caring Agencies
Karen Goedken, Hennepin County	Susan Renfroe, Hennepin County Children's Mental Health Collaborative
Michelle Gray, Brain Injury Association	Kathy Rogers, Hennepin County
Kathy Hendrickson, Accura Care	Erica Tennessen, St. David's Center
Anne Henry, MN Disability Law Center	Antonia Wilcoxson, DHS Management Support and Development
Dwight Heil, DHS Children's Mental Health	Jeanine Wilson, Hennepin County
Deb Holtz, DHS Long-term Care Ombudsman	Cary Zahrbock, Medica
Lori Jensen, Beltrami County	

c. County stakeholder group

Kristin Bausman, Becker

Angela Bicknese, Olmsted

Diane Boben, Beltrami

Ben Byker, Stearns

Alicia Collins, Olmsted

Constance Comford, Ramsey

Carol Fish, Dakota

Patricia Gerber, Olmsted

Karen Goedken, Hennepin

Barbara Hayes, Itasca

Nancy Hints, St. Louis

Cheryl Irwin, Anoka

Lori Jensen, Beltrami

Pamela Maurelli, Anoka

Susan Mezzenga, Crow Wing

Nancy Nelson, Becker

Kongmo Nsameluh, Olmsted

Margaret Patterson, Ramsey

Jeanie Porter, Beltrami

Tamara Sukohl, Dakota

Deborah Tulloch Magee, Washington

Mary Voss, Beltrami

Connie Waldera, Washington

d. Claims data for people who lost PCA service in 2010

Select claims data for the 165 fee-for-service state plan people who lost PCA services in 2010. PCA providers have 12 months after the date of service to file claims, causing this following data to be incomplete.

Service	Number of people	Percent of 165
Targeted Case Management	15	9%
Private Duty Nursing	0	0%
Home Health Aide	0	0%
Skilled Nurse Visits	14	8%
Home Therapies	1	6%
Nursing Facilities	0	0%
ICF/MRs	1	<1%
Hospitalizations	3	2%
Waiver services	3	2%
Mental Health		
Psychotherapy	30	18%
General Mental Health	31	18%
Mental Health Case Management	15	9%
ARMHS	15	9%
Neuropsychological	3	2%
Children's Therapeutic Supports	4	2%
Adult Crisis Response	3	2%
Assertive Community Treatment	2	1%
Adult Day Treatment	1	<1%
Children's Crisis Response	1	<1%

e. August 2010 data on people expected to lose PCA access in 2011

Characteristic or Service	Group A Level 1 behavior	Group B 1 ADL	Group C 1 ADL and Level 1 behavior
PCA Recipients	749	695	510
Consumer Support Grant (CSG)	100	22	77
Age	67% <18 77% <22	14% <18 82% 23-64	65% <18 73% <22
Race	41% people of color	66% people of color	47% people of color
Gender	61% male	61% female	61% female
County	63 counties	51 counties	55 counties
Primary diagnosis	28 % ADD 25% schizophrenia, psychoses, mood, delusional disorders 13% autism 11% emotional disturbances of childhood 9% developmental delay 8% fetal alcohol syndrome	17% musculoskeletal 16% mental illness 11% endocrine or metabolic 11% nervous system 5% developmental delay	26% ADD 19% schizophrenia, psychoses, mood, delusional disorders 19% autism 12% emotional disturbances of childhood 10% developmental delay
ADL dependency	n/a	Age 0-12 – eating Age 13-22 – bathing and grooming Age 23+ – bathing	Age 2-22 – grooming Age 25-64 – bathing Age 65+ – bathing
Receiving mental health services	36% of children 33% of adults		37% of children 23% of adults
Adoption assistance	16% of children		14% of children
MA children’s eligibility group	17% of children		12% of children
Title IVE foster care eligible			3%

- f. Personal Care Assistance (PCA) Assessment and Service Plan (DHS-3244) (PDF)**
- g. PCA Assessment and Service Plan Instructions and Guidelines (DHS-3244A) (PDF)**
- h. Supplemental Waiver PCA Assessment and Service Plan (DHS-3428D) (PDF)**
- i. PCA Decision Tree (DHS-4201) (PDF)**
- j. Authorization for PCA Services (PDF)**