

DEPT. OF
HUMAN SERVICES
MINNESOTA
1995

Recommendations of the Home Care Services Task Force

Alternatives to the Pending July 1, 1996, PCA Program Changes

Prepared for the 1996 Minnesota Legislature

December 28, 1995

Upon request, this information will be made available in an alternative format, such as Braille, large print or audiotape.

The estimated cost of preparing this report is \$69,500, including any costs incurred by another agency or another level of government.

Acknowledgments

The Home Care Task Force wishes to thank all the individuals and organizations who generously invested their time, shared their experience and wisdom, and employed their talents to make the Task Force a successful endeavor. The recommendations represent the consensus, from a variety of perspectives, on how Minnesota may provide better and more cost-effective services to disabled individuals.

In particular the Home Care Services Task Force wishes to thank the following:

Meeting Facilitators

Barbara Burke
Doris Jane Conway
Barbara Deming
Russell Goodman
Jolene Kohn

Minnesota Consortium for Citizens with Disabilities

The Task Force also wishes to thank members of the public who provided input by attending task force meetings, responding to informal surveys, and submitting written statements, and the Department of Human Services who provided information and documentation.

Table of Contents

Title	Page
The Legislation	i
Executive Summary	ii
Final Recommendations	1
Fiscal Summary of Final Recommendations	12
Background	
Program History	13
July 1, 1996 Changes	16
Organization and Structure of the Task Force	17
Steering Committee	18
Subcommittee Work	
Alternative Service Models Subcommittee	20
Nursing & Assessment Processes Subcommittee (Phase I)	23
Fiscal Proposal Subcommittee	31
Appendices	
Appendix A: Glossary of Acronyms	33
Appendix B: Task Force Members	35
Appendix C: Minority Report	39
Appendix D: Recommendations of Minnesota Health Care Commission, <i>Consumer Incentives and Prevention Report</i> , February 16, 1994	50
Appendix E: Recommendations of Minnesota Consortium for Citizens with Disabilities, <i>Cost Savings to Public Programs through Private Sector Reforms</i> ...	51
Appendix F: MA Health Status Assessment	53
Appendix G: MA Home Care Service Plan	62
Appendix H: Prior Authorization Process Flow Chart	64
Appendix I: Proposal Review Tool	65

The Legislation

The 1995 Legislature mandated the establishment of a Home Care Services Task Force as provided by Laws of Minnesota 1995, chapter 207, article 6, section 121:

“The commissioner shall appoint a home care services task force to recommend changes to medical assistance home care services as alternatives to the home care changes to take effect July 1, 1996, Minnesota Statutes, sections 256B.0625, subdivisions 6a, 7, and 19a; 256B.0627; and 256B.0628, which will reduce projected growth for the 1996-1997 biennium to no more than five percent over 1995 projected expenditures as described in the November 1994 medical assistance forecast, department of human services. The recommendations shall include: proposals for independent delivery models for personal care assistant services; county assessment, service plan, and care plan development; coordination, including coordination with mental health services; streamlining of assessment and reporting process to achieve administrative cost efficiencies; and alternative ways to serve segments of this population with needed services.”

This language was interpreted to mean that recommendations should limit spending for each year of the biennium to no more than five percent over the fiscal year (FY) 1995 forecast. Since changes the Task Force recommends cannot affect FY 1996, the reduction target must be for FY 1997.

This mandate referenced all medical assistance (MA) home care services including home health agency services, personal care services, and private duty nursing services. However, since the only service with changes to take effect on July 1, 1996, is the personal care service, this was the focus of Task Force efforts.

Executive Summary

Overview

Following the introduction of the 1996-1997 Biennial Budget, the Department of Human Services was directed to evaluate program expenditures and submit recommendations for curbing growth in long term care expenditures. Although consistent growth was noted across all home and community based programs, a continued steep growth was noted in the Personal Care program. This program, originated in 1977, has experienced a 1450 percent increase since fiscal year (FY) 1987 when expenditures reached \$7.7 million. Actual expenditures in FY 1995 were \$119.5 million.* In response, the Department proposed a variety of program revisions targeted toward reducing the expenditure level of \$147.1 million projected for FY 97.

Subsequent legislative proposals generated intense concern, questions and debate related to who would be impacted by the proposed changes as well as the quality, appropriateness, abuse/misuse and essential nature of this mostly unregulated service. Consumers of all ages and disabilities/diagnosis had come to rely on this service; children under 18 years of age represented the fastest growing segment of users.

In response to the controversy surrounding the growth limiting measures, the 1995 Legislature directed the Department to establish a Task Force to recommend alternatives to those legislated by statute. To address this directive, the Department solicited participation from a variety of advocacy, consumer and provider groups. Interest was high; over one hundred applications were received. Nearly three hundred individuals/organizations asked to be placed on a mailing list.

Department appointments to the Task Force were aimed at achieving both broad and statewide representation, as well as, meeting legislative directives. Task Force membership included: Senate and House Democrats and Republicans; home care and personal care providers; consumers and/or parents and responsible parties; county public health and social service agencies; advocates for the developmentally disabled, for adults and children with mental health needs and for the physically disabled; as well as staff from the Departments of Finance; Children, Families and Learning; Human Services; Health; and the Attorney General's Office.

Sixty-three persons served on one or more of the committees. The Task Force committee's included the Steering Committee, and three subcommittees; Alternative Service Models; Nursing and Assessment Processes; or, Fiscal Proposal (See Schema, page 18). The Steering Committee provided overall

direction to the Task Force; the subcommittees responsibilities were to collect information, analyze issues, generate alternatives and develop recommendations. The Task Force met between August 16, 1995, and December 21, 1995. Twenty-nine Steering and/or subcommittee meetings were held.

Twenty-five recommendations were formalized for legislative consideration. The goal of the recommendations was to off-set the \$15.6 million fiscal impact should the Personal Care program changes slated to take effect on July 1, 1996, be repealed.

The Task Force's recommendations addressed both short-term and long-term efforts. Recommendations included initiatives targeted toward personal responsibility such as upgrading the primary seat belt laws and mandating safety helmet use. Several called for health care system changes. These initiatives targeted increased private sector responsibility including mandates for increased service provision, the use of a capitated menu program and single point of entry with eligibility determination based on a functional assessment.

The Task Force proposed to decrease service hours for all personal care recipients up to seven percent if necessary to meet the mandated target. The Task Force recommends the committee continue to meet to discuss alternative delivery models for home and community based services.

This report presents a summary of the Task Force's work and final recommendations. Following the legislative language, a background of the Personal Care program and an overview of the Task Force's organization and structure are provided; subcommittee work is summarized. The Appendix provides documents developed by the Task Force, support materials and a Minority Report. The Task Force reviewed, suggested revisions and approved a major draft of this report at the last meeting, December 21, 1995. The Minority Report, included in Appendix C, was not discussed, reviewed or approved by the Task Force.

***Based on November 1995 DHS Forecast**

(Actual and projected expenditures for personal care and private duty nursing services are specified as a combined, single value. Approximately 90 percent of this figure is for personal care services and 10 percent is for private duty nursing services.)

Fiscal Information

The 1995 Legislature mandated significant changes to the Personal Care program to slow the rate of program growth. These changes will affect access, scope, and maximum service hour limits of personal care services.

Although the mandate of the Home Care Services Task Force was limited to the Personal Care program, the changes were part of a restructure plan which included the Tax Equity and Fiscal Responsibility Act (TEFRA) option. TEFRA provides Medical Assistance (MA) eligibility for qualified, disabled children who live at home with their families.

As part of the restructure plan, a portion of the savings from the TEFRA/PCA restructuring (\$700,000 for FY 96 and \$4.0 million for FY 97) was transferred to state mental health grants. The funds are to provide services for:

1. Children with severe emotional disturbances who will not meet eligibility requirements for medical assistance through the TEFRA option; and
2. Children with severe emotional disturbance and adults with serious and persistent mental illness, who will continue to be eligible for medical assistance, but will not receive personal care services because they do not meet program criteria.

The 1995 Legislature mandated the Department to apply for additional Medicaid waiver slots to accommodate recipients at risk of institutional placement who no longer meet the criteria for personal care services. No fiscal impact was projected in these transfers between programs.

The projected savings for the restructure initiatives for FY 97 outlined above was \$19.6 million. The initiatives were assumed to impact children and adults who could not direct their own care, especially the developmentally disabled, and those with mental health diagnoses.

As noted in the legislative language preceding the executive summary, the charge of the Task Force was to recommend changes to MA home care services as alternatives to the changes to take effect July 1, 1996. The interpretation of the fiscal impact for the Task Force was to limit spending for each year of the biennium to no more than five percent over the FY 1994 forecast. Because the work of the Task Force could not have an impact on expenditures for FY 96, the reduction would begin in FY 97.

The Department's November 1994 forecast (in total MA dollars) estimated combined personal care and private duty nursing (PDN) service expenditures at \$122.6 million for FY 1995 and \$147.1 million for FY 1997. The Department approximates that 90 percent of these figures are personal care service expenditures (\$110 million for FY 1995 and \$132 million for FY 1997). By increasing the estimated personal care expenditures for FY 1995 by 10 percent (5 percent for FY 1996 and another 5 percent for FY 1997), and subtracting this amount from estimated personal care expenditures for FY 1997, a reduction target of \$11 million for FY 1997 is estimated.

Personal Care Services Reduction Target (Total MA Dollars)			
FY 1995 Projected Expenditures	FY 1997 Projected Expenditures	FY 1995 Increased 10%	Reduction Needed
\$110,000,000	\$132,000,000	\$121,000,000	\$11,000,000

The \$11 million does not consider the \$4.7 million dollars the Legislature allocated to state mental health grants nor additional waiver slots for Medicaid waivers.

One of the guiding principles adopted by the Task Force was that all people, regardless of diagnosis, should have equal access to support services needed to live in the community. The Task Force drew no distinction between people who could or could not direct their own care. The assumption by the Task Force was that the changes that were mandated by the Legislature would not take place.

The Task Force did not identify direct fiscal exchanges between their recommendations and current legislative initiatives. Any legislation directed at revising the changes mandated for implementation on July 1, 1996, must take these variables into consideration.

Final Recommendations

The Task Force recommends repeal of the following personal care program changes to take effect on July 1, 1996: limiting personal care services to those who can direct their own care, eliminating certain covered services, and reducing maximum service hours. These recommendations are brought forward to assure that no one loses personal care services.

Prevention

The most cost-effective approach to reducing the need for publicly funded long term care is through illness and injury prevention. Seventy percent of health care expenditures are spent on preventable conditions, while only three percent are invested in prevention.

Reducing the growth in publicly funded acute and long term care programs, while continuing to meet the needs of our State's most vulnerable citizens, can be accomplished through injury prevention and promoting healthy lifestyles. In a 1993 report to Governor Carlson and the Minnesota Legislature, *Containing Costs in Minnesota's Health Care System*, the Minnesota Health Care Commission gave a broad strategy toward containing costs in the health care system. In a 1994 report, *Consumer Incentives and Prevention Report*, the Commission recommended specific methods through which significant improvement could be made to achieve cost containment and quality outcomes. (See Appendix D)

Although prevention components are outside the scope of the legislative charge to the Task Force, if Minnesota proposes to reduce the growth in publicly funded health care (both acute care and long term care), it also must enact legislation that includes personal responsibility for lifestyle.

- 1. Upgrade the Minnesota seat belt law to require universal (everyone in the vehicle) seat belt usage with primary enforcement.**

This recommendation is estimated to achieve savings from reduced brain and spinal cord injuries of \$2.1 million in Medicare and Medicaid for acute care and new waiver level services. Additional savings in rehabilitation and long term care could be achieved, however cost figures are not available. The potential cost savings are calculated as follows.

In 1994 in Minnesota, 1,343 individuals with brain injury and 60 individuals with spinal cord injuries were admitted to hospitals due to a motor vehicle accident.¹ Half of the unbelted drivers in police reported crashes would not have been injured had they been belted.²

In 1995 Minnesota had a seat belt usage rate of 65 percent.³ States with a primary enforcement law have a 10 - 20 percent higher usage rate.⁴

Approximately \$2 million could have been saved in Medicare and Medicaid acute care alone as follows:

Of 1403 persons hospitalized from motor vehicle accidents:

66% (926) did not wear seat belt⁵

38% (352) were Medicare/Medicaid recipients⁶

50% (176) would not have been injured

The average acute cost per injury is \$55,000. (Acute costs run from \$35,000 - \$75,000 per injury per Minnesota Department of Health.) Increasing seat belt usage by 20 percent could have resulted in saving Medicare and Medicaid \$1,936,000 in acute care costs.

$$(\$55,000 \times 176) \times .20 = \$1,936,000$$

There could also have been long term care savings of approximately \$209,880 as follows:

DHS estimated 120 nursing level and 25 hospital level traumatic brain injury (TBI) waiver clients annually.

120 nursing waivers averaging \$38,000 each =	\$4,560,000
---	-------------

25 hospital waivers averaging \$72,000 each =	1,800,000
---	-----------

Total New Waivers in given year	\$6,360,000
---------------------------------	-------------

50% (\$3,180,000) TBIs, vehicle related⁷

66% (\$2,098,800) did not wear seat belt⁸

50% (\$1,049,400) would not have been injured

Increasing seat belt usage by 20 percent could have resulted in savings of \$209,880. (This does not include people with traumatic brain injury on MA or other waiver programs.)

Total savings for one year that could have been realized had there been enforcement of universal seat belt usage are estimated at \$2,145,880.

2. Mandate safety helmets on anyone operating (and passengers of) bicycles or in-line skates on public property or right-of-way.

The estimated potential savings of this recommendation from reduced brain and spinal cord injuries is \$704,000 in publicly funded acute care costs and waiver level of services. Additional savings in rehabilitation and long term care could be achieved, however cost figures are not available.

Bicycles are a sharply increasing cause of significant injuries, resulting in 227 brain or spinal cord injuries in 1994. This is an increase of 50 percent over 1993.⁹

In cases documented through the Minnesota Traumatic Brain and Spinal Cord Injury Registry (Trauma Registry) of the people known to use or not to use helmets, Minnesota has a bicycle helmet usage rate of 15 percent.¹⁰

Of 227 persons hospitalized from bicycle collisions:

85% (193) did not wear helmets

38% (73) were Medicare/Medicaid recipients¹¹

88% (64) would not have received the brain injury if they had been wearing a helmet¹²

Average acute cost per injury is \$55,000. If helmet usage is increased by 20 percent it could potentially save Minnesota \$704,000 in publicly funded acute care costs.

$$(\$55,000 \times 64) \times .20 = \$704,000$$

3. Institute mandatory helmet law for anyone operating (and passengers of) motorcycles, all terrain vehicles (ATVs), or snowmobiles on public property or right-of-way.

Savings from reduced brain and spinal cord injuries of approximately \$385,000 in publicly funded acute care costs and waiver level of services could result. Additional savings from rehabilitation and long term care could be achieved, however cost

figures are not available.

Motorcycles, ATVs, and snowmobile collisions hospitalized 209 individuals in Minnesota in 1994 with brain injury and/or spinal cord injury.¹³

In cases documented through the Trauma Registry of persons known to use helmets, Minnesota has a helmet usage rate of 33 percent (23 percent motorcycle and 54 percent snowmobile and ATV).

Of 209 persons hospitalized from motorcycles, ATV, and snowmobile collisions:

66% (138) did not wear helmets¹⁴

38% (52) were Medicare/Medicaid recipients¹⁵

67% (35) would not have received the brain injury if they had been wearing a helmet

Average acute cost per injury \$55,000. **If helmet usage had been increased by 20 percent, it could have resulted in saving Minnesota \$385,000 in publicly funded acute care costs.**

$$(\$55,000 \times 35) \times .20 = \$385,000$$

4. **Implement the recommendations from the Minnesota Health Care Commission, *Consumer Incentives and Prevention Report*, February 16, 1994. (See Appendix D)**

Private Sector Reform

5. **Hold private health insurance and health maintenance organizations (HMOs) responsible for the first 90 days of long term care services annually.**

There is no incentive and/or consequence for private health insurers and HMOs to provide long term care options. There is an incentive for them to provide prevention programs as it reduces acute and emergency costs. But since insurers and HMOs do not pay for long term care, they and may not take the most prudent approach toward it. Incentives must be explored for private health plans and HMOs to provide intensive acute and primary services that can help

individuals with disabilities reduce their dependency on public programs.

DHS estimates personal care expenditures will reach \$132.4 million in FY 1997. (This is 90 percent of projected personal care and PDN expenditures for FY 1997 taken from the DHS February 1995 forecast.)

DHS also estimates that approximately 32 percent of personal care service recipients have health insurance coverage other than Medicare. This was based on Medicaid Management Information System (MMIS) II data for recipients with an authorization for personal care service with a begin date of July 1, 1994, through June 30, 1995.

Savings to MA would be approximately \$10.6 million if this recommendation was adopted.

$(\$132.4 \text{ million} / 12 \text{ months}) \times .32 \times 3 \text{ months} = \10.6 million

6. **Implement a statutory definition of the word "treatment" that would expand private health coverage beyond to "effect a cure."**

This would allow individuals to access services through their own private health plan or HMO, rather than being denied access and needing MA for long term care.

7. **Implement the following recommendations of the Minnesota Consortium for Citizens with Disabilities outlined in *Cost Savings to Public Programs through Private Sector Reforms*. (See Appendix E)**

- To control costs across the entire health care system, the paradigm must be shifted away from a short term, purely restorative focus, to emphasize cost-effective, long term maintenance and prevention. Arbitrary limits on the quantity and type of services must be removed, with the focus shifted to health outcomes and cost efficiency.
- Explore incentives for private health plans to provide intensive acute and primary services that can help

individuals with disabilities reduce dependency on public programs.

- Remove arbitrary annual maximums for disability related services and/or establish maximums that are more realistic and more consistent with the annual maximums for other types of medical services. Health plans would retain control over the costs of these services since they would still only be required to provide them in situations where they were medically necessary and cost-effective.
- Require health plans to reimburse covered specialty care needed by people with disabilities that is only available through out-of-network providers, as if it were provided within the network.
- Broaden the definition of “medical necessity” to include “establishment of function.”
- Develop standard exclusions to be used by all health plans to prevent enrollees from being surprised by complexly worded limitations in the fine print of their insurance policies.

Eligibility

8. **Use a functional assessment to determine eligibility for services for all disabilities.**

Alternative Services

9. **Develop a Self Determination project utilizing vouchers and grants.**

Vouchers or grants empower consumers to determine how their needs can best be met. Current total spending on behalf of the consumer is computed. The consumer then has the option to continue current services or create an individual budget. This model assumes that consumers will find cost savings when they exercise control over services. Some portion of savings are set

aside for the consumer if their support needs change. Spending is based on a per diem, not service by service. This model is similar to programs offered in New Hampshire and Rhode Island.

The Self Determination project would be an option to the existing PCA program and not a mandate, since all consumers are not willing or able to make long term plans for their care. This model is based on a menu of services from which the consumer could choose.

Per the DHS February 1995 forecast the projected average monthly payment per recipient for personal care and PDN services is \$1,508 and the average monthly caseload is estimated at 7,359 for FY 1996. **If 10 percent of the caseload chose this model, assuming a 20 percent cut in total service dollars, savings of approximately \$2.7 million could result.**

$$(7,359 \times .10) \times (\$1,508 \times .20) \times 12 \text{ months} = \$2,663,369$$

Based on existing pilots, this project will take several years to reach 10 percent participation.

10. Create a non-mandated consumer option to share personal care services.

Individuals needing personal care services would forego a portion of their monthly dollar cap to gain additional units of service by sharing some portion of personal care services with other consumers.

Consumers must be in geographic proximity, allowing services to be provided simultaneously. Shared services should be available in a variety of settings and be included in existing programs. Providers would be reimbursed at higher rates proportionate to the number of consumers sharing services. (The provider receives more payment per personal care assistant [PCA] staff hour, less per consumer.)

This model would be an option on a menu of services. Shared personal services should not be a mandate since shared services are not appropriate for all consumers.

DHS estimates personal care expenditures to be \$119.8 million for FY 1996. (This is 90 percent of projected personal care and PDN expenditures for FY 1996 taken from the DHS February 1995 forecast.) **If 10 percent of the consumers choose this option at an assumed 30 percent savings, roughly \$3.6 million could be saved.**

$$(\$119.8 \text{ million} \times .10) \times .30 = \$3.59 \text{ million}$$

- 11. Institute multi-year assessments when a consumer's condition is not expected to change.**

Some consumers' conditions do not change over time.

Approximately \$200,000 could be saved if the interval between assessments is extended to three years for consumers whose conditions are not expected to change.

Currently, Home Care Screening Forms (HCSFs) are used to request reauthorization of service when the consumer has had no change in condition or functional status, and no change in the amount of service is requested. DHS reported that 807 HCSFs were received from December 1994 through September 1995. This number was annualized to get 968 (807 / 10 months X 12 months).

The MA maximum reimbursement rate for an initial assessment of personal care services is \$102.18.

$$968 \text{ consumers} \times 2 \text{ years} \times \$102.18/\text{assessment} = \$197,820$$

- 12. Institute a Capitated Menu program with a single point of entry through a functional assessment.**

A functional assessment provides a single point of entry for consumers and leads to a capitated level of spending for the individual. Similar to current MA waiver programs, consumers choose from a menu of services. The total pool of resources is reduced thus reducing total program spending.

In the first phase, this model would include all MA recipients. Later phases would include all recipients of home and residential waivers in the same assessment and assigned service budget process.

The Capitated Menu program could act as a transition to new programs if federal reform funding takes the form of a block grant.

The menu of services would at minimum include: PCA services (shared and non-shared), shared child care, active treatment, weekend or hourly respite care, and community alternatives.

Assuming a 3.5 percent cut in total service dollars, savings are estimated at approximately \$4.2 million.

DHS estimates personal care expenditures to be \$119.8 million for FY 1996. (This is 90 percent of projected personal care and PDN expenditures for FY 1996 taken from the DHS February 1995 forecast.)

$(\$119.8 \text{ million} \times .035) = \4.19 million

13. **Require providers not certified by Medicare to develop relationships with Medicare certified providers to ensure that Medicare resources are used whenever possible. Vendors, providers, county public health nurses, and other professionals conducting assessments and developing care plans should be trained to ascertain Medicare eligibility.**
14. **The Home Care Services Task Force should continue to meet and work.**
15. **Adopt the personal care assessment tool and service plan developed by the Nursing & Assessment Processes Subcommittee.**

Refer to pages 25-26. Also see Appendices F and G.

16. **Adopt legislative language to indicate that the service plan is developed by the county public health nurse (PHN).**

Since the *MA Home Care Service Plan* (Appendix G) is a new document, legislative language is needed to indicate responsibility for its use.

17. **Adopt legislative language to clarify that an RN or PHN must assess the need for private duty nursing (PDN) services.**

Currently, a private duty nurse (including a licensed practical nurse [LPN]) assesses the need for PDN services. LPNs can provide PDN services, however, it is outside their scope of practice to conduct assessments. Legislative language is needed to indicate that an RN or PHN must assess the need for PDN services.

- 18. Implement the personal care assessment process developed by the Nursing & Assessment Processes Subcommittee.**

This process is described on pages 26-27. Also see Appendix H.

- 19. Adopt the care plan distinctions developed by the Nursing & Assessment Processes Subcommittee.**

Refer to page 28.

- 20. Consider professional nursing issues related to the personal care assessment legislation.**

These issues are outlined on pages 28-29.

- 21. Require the physician's order to be submitted to DHS in order to receive prior authorization of personal care services.**

- 22. Require all personal care providers to hold a modified Class A license from the Minnesota Department of Health (MDH).**

Currently personal care providers are not required to be licensed. Providers of personal care services only would be licensed under specially created licensing criteria.

- 23. Review the MA program and all MA waiver programs, including dollars to provide services and dollars to administer.**

Review of personal care services has provided valuable information and opportunities for cost savings. A similar review of other programs may suggest additional savings.

- 24. Support the detection and elimination of fraud and abuse.**

The Task Force recognizes that the Federal Office of Management and Budget (OMB) estimates fraud and abuse within the Medicaid

Program to be 10 percent of total program expenditures.

The experience of the Medicaid Fraud Division of the Minnesota Attorney General's Office indicates this estimate is consistent with fraud and abuse within the personal care program.

25. Reduce utilized hours of personal care service by no more than seven percent.

This recommendation is not intended to be implemented with other recommendations. It is to be used only as a fall back in the event that program expenditures are more than five percent growth and other recommendations are not effective, requiring more savings.

Independent PCA Model

As required in statute, the Task Force considered an independent PCA delivery model. This model optimizes consumer control. The consumer is responsible to recruit, hire, train, schedule, pay, and fire PCAs. The Task Force did not have enough time to review all the issues involved with such a model and recommends further study and development. However, an independent PCA service would probably be included in the menu of services under the Capitated Menu program.

Fiscal Summary of Final Recommendations

No.	Recommendation	Vote*	Potential Savings this biennium (in millions)	Budget Impact
1	Require universal seat belt usage	Yes	\$ 2.1	This biennium
2	Bicycle/in-line skate helmet law	Yes	.7	This biennium
3	Motorcycle/ATV/snowmobile helmet law	Yes	.3	Long term
4	Recommendations of MHCC	Yes	—	Long term
5	Private insurance & HMOs responsible for first 90 days of LTC services annually	Yes	10.6	Policy impact
6	Statutory definition of "treatment"	Yes	—	Policy impact
7	Recommendations of MCCD	Mixed	—	Policy impact
8	Functional assessment for all disabilities	Yes	—	Long term
9	Self Determination project	Yes	2.7	Long term
10	Option to share PCA services	Yes	3.6	Long term
11	Multi-year assessments	Yes	.2	Long term
12	Capitated Menu program	Mixed	4.2	Policy impact
13	Medicare maximization	Mixed	—	This biennium
14	Continue the Task Force	Yes	Admin. costs	Future impact
15	Adopt PCA assessment tool & service plan	Mixed	—	This biennium
16	Clarify that co. PHN develops service plan	Yes	—	This biennium
17	RN or PHN must assess for PDN services	Yes	—	This biennium
18	Implement PCA assessment process	Yes	—	This biennium
19	Adopt care plan distinctions	Yes	—	Policy impact
20	Consider professional nursing issues	Mixed	—	This biennium
21	Require physician's orders	Yes	—	This biennium
22	PCPOs hold a modified Class A license	Mixed	Possible costs	Policy impact
23	Review MA & MA waiver programs	Mixed	—	—
24	Support detection/elimination of fraud/abuse	Yes	—	—
TOTAL ESTIMATED SAVINGS			\$ 24.4	
25	Reduce utilized hours by no more than 7%	Mixed	FY 97 = \$ 10.4	This biennium

* "Yes" represents a unanimous vote in favor of the recommendation by Steering Committee members present at the time the vote was taken. "Mixed" represents some dissenting votes on the recommendation, however, the majority of the members present at the time the vote was taken voted in favor of the recommendation.

"Long term" means more than two years.

Background

Program History

On July 1, 1977, the category of services called “personal care services” (often referred to as “PCA services”) was added to the Medical Assistance (MA) Program administered by the Minnesota Department of Human Services (DHS). Personal care services are a distinct category of home care services under state statutes (Minnesota Statutes, section 256B.0625, subdivision 19a) and rules.

Personal care services are noninstitutional, medically oriented tasks that are required because of a consumer’s physical or mental impairment. The purpose of personal care services is to accommodate the need for relatively unskilled maintenance or supportive nursing care furnished in the home.

Minnesota’s program of personal care services originally served the physically disabled non-elderly adult who could direct their own care, such as consumers with paraplegia and quadriplegia. The amount of service was generally limited to 200 hours per month.

Over the years access to the program has been expanded to include consumers who cannot direct their own care and to consumers with behavioral or mental health diagnoses. In addition, the list of covered personal care services has been expanded and the amount of service is no longer limited to 200 hours per month. Under some circumstances, technology dependent consumers may receive up to 24 hours per day of personal care service.

On July 1, 1995, all children under 21 and pregnant women who are enrolled in MinnesotaCare became eligible for full MA benefits including PCA services. It is expected that few enrollees require and qualify for PCA services. This expansion is expected to have minimal impact on the PCA program but will be monitored.

The present PCA program serves consumers of all ages and all disabilities/diagnoses. Consumers have physical disabilities, chronic diseases, behavioral diagnoses, and mental illness. Those under 18 years of age represent the fastest growing segment of users.

Personal care services covered by MA include assistance with: activities of daily living (ADLs) such as dressing, grooming, bathing, eating, and toileting; maintenance exercises; respiration; normally self-administered medications; prosthetics/orthotics; cleaning medical equipment; accompanying to medical appointments; redirection and monitoring for behavior; seizure intervention; and

incidental household services if an integral part of a covered personal care service. Personal care services covered by MA are considered a maintenance level of service to meet the medical needs of consumers in a stable condition.

The PCA program has grown beyond original projections of both the number of persons needing personal care services and the scope of services as an outcome of Minnesota's efforts to assist consumers to live independently in the community.

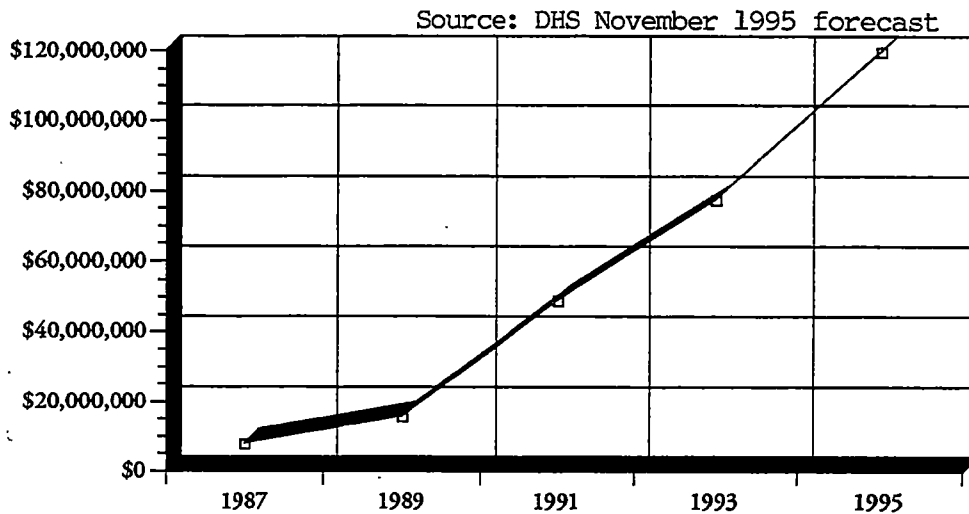
The increases in program expenditures and caseload size are attributed to:

- growth of the disabled population
- Minnesota's deinstitutionalization efforts
- expanded access to PCA services
- limits on the number of individuals who can be served on MA waivers
- expansion of covered services
- increase in the maximum service hour limits
- change from independent personal care assistants to provider organizations
- lack of funding for services which may be more appropriate

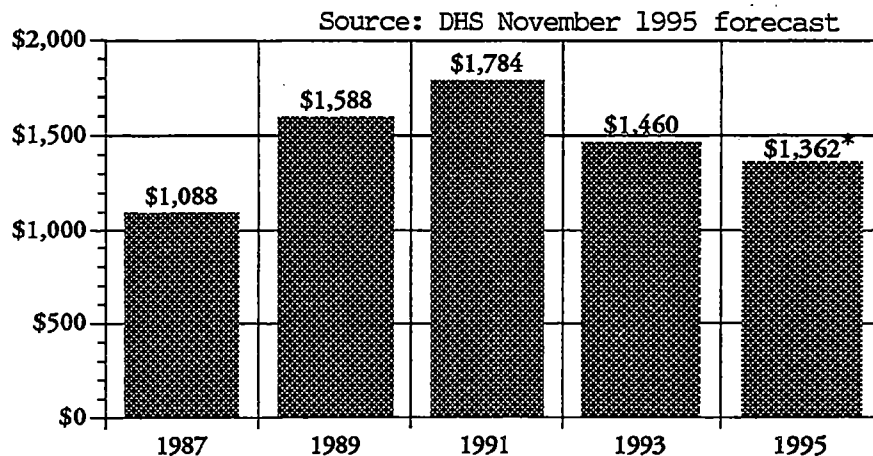
Despite the concerns over rapid program growth, PCA services often provide a less costly alternative to institutional care and are essential to many consumers to maintain independence in the community.

Data for the following charts was taken from the DHS November 1995 forecast. It should be noted that the data includes both MA recipients and MA waiver program recipients whose PCA services are paid by MA. The Task Force questioned the accuracy of data.

MA expenditures for personal care and private duty nursing services for FY 1995 totaled \$119.5 million. This represents a growth of approximately 1450% since FY 1987 when expenditures totaled \$7.7 million. *(Note: Actual and projected expenditures for personal care and private duty nursing services are specified as a combined, single value. Approximately 90% of this figure is for PCA services and 10% is for private duty nursing services.)*

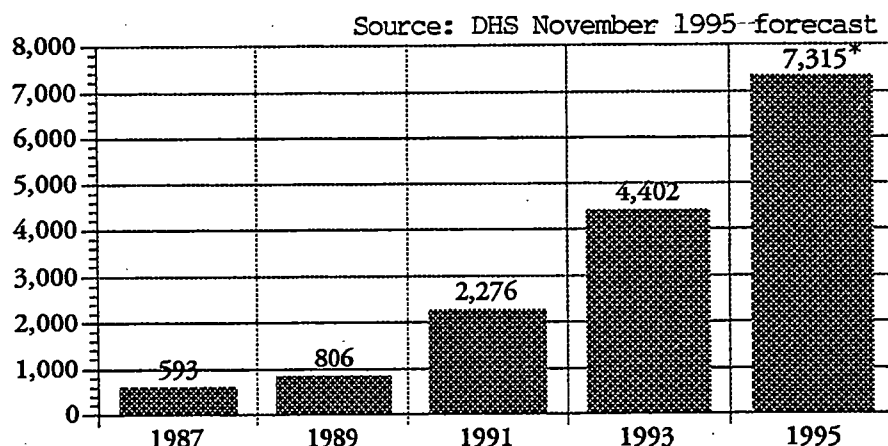


Prior authorization of PCA services has reduced the rate of growth of program expenditures. When prior authorization was implemented in October 1991, the monthly average payment per consumer for personal care and private duty nursing services for the preceding fiscal year (FY 1991) was \$1,784. In FY 1995 the monthly average payment per consumer was \$1,362.



* Average payment for FY 1995 is estimated at 3% above FY 1994.

While program expenditures have risen, so too have the number of consumers. The monthly average caseload has risen from 593 consumers in FY 1987 to 7,315 in FY 1995, an increase of approximately 1133%.



* Recipients for FY 1995 are calculated based on the estimated average payment.

July 1, 1996 Changes

The 1995 Legislature mandated significant changes to the PCA program in order to slow the rate of program growth. Unless repealed, the changes will affect access, scope, and maximum service hour limits of PCA services. No program savings were projected as a result of these changes in FY 1996; for FY 1997 \$19.6 million was projected in savings from these changes.

The legislative changes effective July 1, 1996, are:

* Revised qualifying criteria for PCA services

Starting July 1, 1996, to qualify for PCA services consumers must be able to identify their needs, direct and evaluate task accomplishment, and assure their health and safety.

Currently, consumers who cannot direct their own care qualify for services if they reside with a "responsible party." Consumers who cannot meet the new qualifying criteria will be referred to alternative programs such as waivers or mental health grants. Not all of the current consumers will continue to receive service.

* Deletion of language and references to "responsible party"

*** Ineligibility of certain services for payment**

The following services will not be eligible for payment starting July 1, 1996:

- A. Assisting, monitoring, or prompting the consumer to complete covered personal care services specified in Minnesota Statutes, section 256B.0627, subdivision 4, paragraph (a);
- B. Redirection, monitoring, and observation that are medically necessary and an integral part of completing covered personal care services specified in Minnesota Statutes, section 256B.0627, subdivision 4, paragraph (a);
- C. Redirection and intervention for behavior including observation and monitoring; and
- D. Interventions for seizure disorders including monitoring and observation.

*** Reduction in maximum service hour limits**

Currently, the maximum amount of personal care service hours that may be authorized ranges from 2.5 to 14.5 hours per day. Effective July 1, 1996, maximum hour limits will be reduced to 2.25 to 11.25 hours per day.

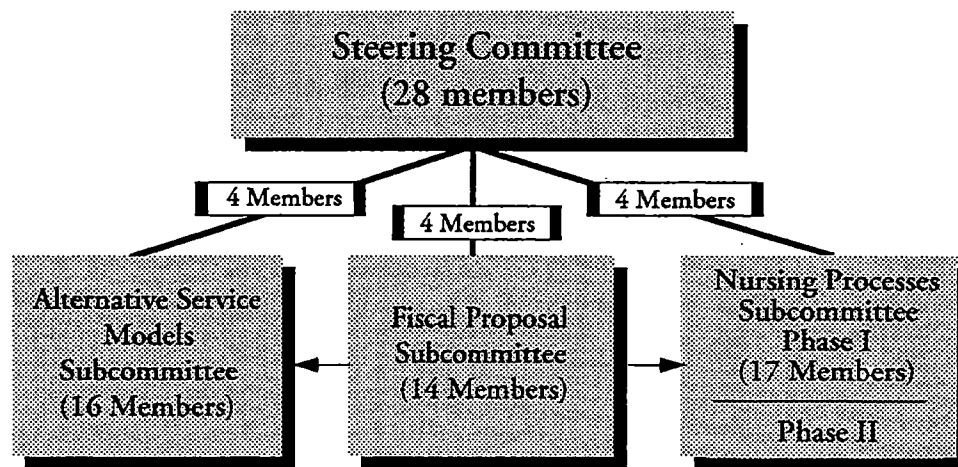
Organization and Structure of the Task Force

Members of the Home Care Services Task Force represented a broad range of perspectives as mandated by statute. Representation on the Task Force included: home care service consumers, family members, providers, counties, advocates, state departments, and legislators. Sixty-three people served as members of the Task Force. Appendix B is a listing of Task Force members.

The Task Force was structured to include a Steering Committee and three subcommittees to assist the Steering Committee with specific tasks. The subcommittees were: Alternative Service Models, Nursing & Assessment Processes (Phase I), and Fiscal Proposal. Each subcommittee had members who served on the Steering Committee and functioned as liaisons between the Steering Committee and subcommittees.

The Steering Committee provided direction to the Task Force, reviewed subcommittee proposals, and made final recommendations to the Legislature.

The subcommittees served a design function. Each subcommittee was responsible for collecting information, analyzing issues, brainstorming and generating alternatives, developing recommendations, and reporting results to the Steering Committee.



Steering Committee

The Steering Committee was composed of twenty-eight members representing consumers, family members, providers, counties, advocates, state departments, and legislators. A list of Steering Committee members is in Appendix B.

The Steering Committee was responsible for:

- providing direction to the Task Force
- reviewing subcommittee proposals
- providing final recommendations to the Legislature

Guiding Principles

The Steering Committee developed a set of principles to guide the work of the subcommittees. The principles were grouped into three areas: fiscal, individual issues, and system issues.

Fiscal Principles:

Recommendations need to:

1. Meet fiscal targets based on accurate financial data.
2. Identify shifting cost to other programs.
3. Achieve consensus by all stakeholders.

Individual Issue Principles:

Recommendations need to:

1. Be guided by respect for human dignity, the legal rights of individuals, and recognize the need to provide an opportunity to be useful to society.
2. Include a system of providing flexibility of home based service to meet the varying needs of individuals while assuring quality and consistency across regions.

System Issues Principles:

Recommendations need to:

1. Be based on a review of current programs and resources provided by state, county, and private programs with plans to coordinate not duplicate services.
2. Address new models of services with partnerships between the government and private sectors, with the goal of simplifying administration, eliminating fraud, and coordinating services.
3. Be creative, practical, and flexible.

4. Assure the legal and ethical aspects of professional nursing are not violated.
5. Include incentives to provide quality care and disincentives for providers to provide inappropriate or unnecessary care.
6. Address alternatives that appropriately support recipients and their families in the least restrictive environment.

Steering Committee Concerns

The Steering Committee had concerns about the ambiguity of data from DHS records that was used to project potential fiscal savings. The fiscal target seemed unclear and varied during the course of the Committee's work.

The Steering Committee supported the final recommendations *in concept*. However, it reserved the right of future review of the details to determine final extent of support.

Subcommittee Work

Alternative Service Models Subcommittee

The Alternative Service Models Subcommittee was composed of sixteen members representing consumers, families, providers, advocates, counties, and DHS. A list of subcommittee members is in Appendix B.

The legislative charge of the Alternative Service Models Subcommittee was to:

- identify different populations utilizing MA home care services
- identify basic service needs of those populations
- identify barriers to meeting those basic service needs
- design alternative models of care for the identified populations while considering the relationships and impacts on other programs, services, and agencies

The Alternative Service Models Subcommittee recommended alternatives to the legislative changes to be effective July 1, 1996, that would help people live independently, support families, and care for children. The following set of assumptions was developed as a basis of their work.

- Assumption I:** All people regardless of diagnosis should have equal access to the support services needed to live in the community. The recommendations developed by this subcommittee are based on this assumption and do not draw a distinction between people who can direct their own care and people who cannot.
- Assumption II:** To provide future savings this subcommittee looked at reducing MA costs as a single unit, not program by program. There should be no pet programs. All MA funded services are included in these recommendations.
- Assumption III:** Recommendations are medically and socially intertwined options, which are an appropriate alternative to the otherwise necessary long term care institutional options.
- Assumption IV:** Consumers or their responsible party should have a choice of services, PCA, waivers, etc. Frequently the consumer will choose the less expensive option because it better meets their personal situation.
- Assumption V:** The issue is not just the benefits being provided, it is the increasing number of people needing the service. We need to find ways so that people do not need publicly funded services.

Strategies to Reduce Dependency on Publicly Funded Long Term Care

The strategies to reduce the dependency on publicly funded long term care are: 1) to reduce the number of people who need services, and 2) to meet the needs of people already needing services.

Illness and injury prevention is the most cost-effective approach to reducing the need for publicly funded long term care. Prevention includes taking personal responsibility for one's lifestyle.

Private sector reform of health insurance (including HMOs) also reduces the need for publicly funded long term care. Inadequate health insurance coverage is a cost savings to employers, however the result is a cost shift

to the State of Minnesota. Insurers should extend policy lifetime maximums, and include long term care prevention and maintenance components. A paradigm shift changing the emphasis from a short term restorative focus to a cost-effective, long term maintenance and prevention focus based on outcome and long term cost efficiency is necessary.

Cost saving incentives must be built into the system for consumers, providers, and gatekeepers to meet the needs of consumers currently using services. Consumers need assurance that a full range of appropriate services will be accessible.

Ideas to meet present system needs were generated by separate adult and children subgroups of the Alternative Service Models Subcommittee. These subgroups considered the needs, barriers, and resources by age group. While not a formal recommendation, subcommittee members recognized that there are limited services to assist adolescent consumers in the transition to adult life.

Recommendations of the Minnesota Health Care Commission (*Consumer Incentives and Prevention Report*, February 16, 1994) and the Minnesota Consortium for Citizens with Disabilities (*Cost Savings to Public Programs through Private Sector Reforms*), were included (refer to Appendices D and E). Models used in other states were identified and modified.

Multiple alternatives were considered by the subcommittee. Using the format developed by the Fiscal Proposal Subcommittee, alternative service models were compared to the current service model in: method of delivery, the providers, the consumers, and program operational costs.

Recommendations were categorized as having budget impact this biennium, long term budget impact, policy impact, or requiring future study. Estimated cost savings were assigned to each proposal whenever reasonable supporting information was available. Proposals from this subcommittee were forwarded to the Fiscal Proposal Subcommittee for review, and forwarded to the Steering Committee for consideration.

Nursing & Assessment Processes Subcommittee (Phase I)

The 1995 Legislature mandated a significant change in the PCA assessment process. According to Minnesota Statutes, section 256B.0627, subdivision 1, paragraph (d):

“Assessments for personal care services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.”

Legislative Charge

In response to the legislation, the Steering Committee identified the following tasks for the Nursing & Assessment Processes Subcommittee. The Subcommittee was assigned the responsibility to:

- develop a new assessment tool and service plan for PCA services
- design the new assessment process
- make distinct the service plan and the care plan
- make recommendations on professional nursing issues related to this legislation

Background

Currently, the supervising registered nurse (RN) of the PCPO conducts the assessment or reassessment for PCA services, develops a care plan, and submits a request for prior authorization of services to the Department of Human Services.

This process creates a significant financial conflict of interest; the PCPO, which is reimbursed to provide the consumer's care, also conducts the assessment of need that is the basis for a service authorization. Reimbursement is tied directly to the number of hours of care a PCPO provides. The greater the number of hours of care provided, the greater

the reimbursement to the PCPO. Supervising RNs may be incented to add additional time to the care plan, which may not be medically necessary, in an effort to obtain a maximum service authorization.

Legislative Change

To eliminate this conflict of interest, the Legislature mandated moving the PCA service assessment process from PCPOs to county public health nursing (PHN) agencies. Effective January 1, 1996, assessments and reassessments of a consumer's need for PCA service must be conducted by a county PHN or a certified PHN under contract with the county. The Legislature supported the objectivity inherent in separating assessment from financial interest, and utilizing PHNs who are aware of community resources and other payment sources as a way to decrease the need for MA personal care services.

Process Overview

1. In addition assessing consumer needs, the county PHN will develop a service plan with the consumer or responsible party which describes the services needed, frequency and duration of services, and expected outcomes and goals.
2. Within 30 days of the request for services, the county PHN will complete and submit the assessment, the service plan, and any other information required to determine medical need to the consumer, the PCPO, and DHS.
3. Home Care Nurse Consultants (HCNCs) will review the assessment, service plan, and other information and authorize the amount and type of service. This authorization will follow the consumer if the consumer chooses to change providers.
4. The supervising RN from the PCPO, together with the consumer or responsible party, will develop a care plan that is to be used by the personal care assistant (PCA). The plan will describe the personal care services to be provided.

The Nursing & Assessment Processes Subcommittee (Phase I) was composed of seventeen members representing consumers, families, providers, advocates, counties, and state agencies. A list of subcommittee

members is in Appendix B.

PCA Service Assessment Tool

A copy of the new assessment tool, the *MA Health Status Assessment*, is in Appendix F. The design of the assessment tool targeted the characteristics of:

- flexibility*: as required for the utilization of professional judgement
- objectivity*: to prevent rater bias
- standardization*: evaluation for inter-rater reliability is planned
- compatibility*: with current PCA maximum service limits
- adaptability*: to program alternatives and modifications

The tool currently being used, *Medical Assistance (MA) Home Care Assessment / Care Plan*, was used as a reference for development of the new assessment tool. A sample of authorization for activities of daily living (ADLs) was reviewed to determine whether a numerical average for PCA services should be included. The *mode* was selected as the measure to be used to indicate the “typical” time for each ADL by dependency level. The mode is the daily time value occurring most frequently for each ADL by dependency level based on data compiled from the Medicaid Management Information System (MMIS) II of what the PCPO requested and what DHS authorized. The mode is intended only as a guide for the county PHN. The county PHN may recommend authorization above or below the mode based on actual consumer needs.

PCA Service Plan

A copy of the *MA Home Care Service Plan* is in Appendix G. The subcommittee developed and recommended a service plan which:

- is developed with the participation of the consumer or responsible party
- is signed by the PHN as “recommended”
- allows a 30 day pending authorization for the consumer to acquire an agency*

- considers the availability of other community supports and resources
- includes referrals to non-PCA agencies and programs
- limits the obligation of the PHN to completing the service plan and informing consumers of other possible sources of support
- holds the PHN accountable for referrals to skilled services within 12 working days of the assessment

* If the consumer fails to contact an agency within 30 days, the PHN will determine if a reassessment is needed.

PCA Assessment Process

A flow chart of the new assessment process is in Appendix H. The Subcommittee recommended the following regarding the assessment process.

1. The assessment process should be the least intrusive and most respectful of consumer privacy and choice-making, yet sufficiently comprehensive to determine medical need and identify required services.
2. A PCA service assessment must be based on the *MA Health Status Assessment* form.
3. PCA assessments must be completed within 30 days beginning with the date the request for assessment is received by the county PHN agency.
4. Initial data for temporary authorizations may be collected while the person is in a facility such as a hospital or nursing facility to accommodate discharge planning. The *MA Health Status Assessment* must be finalized on a home visit.
5. The county where the consumer resides is the county responsible for conducting PCA assessments and reassessments.

6. The PCA consumer or responsible party must notify both the old and the new county when moving from one county to another.
7. The county PHN conducting the assessment cannot be working with a PCPO providing care for the consumer or have an agency to agency contract with the PCPO.
8. An "emergency" provision of PCA services without a county PHN assessment is limited to weekends and holidays. Under these conditions, the PCPO can begin PCA services based on an assessment performed by the supervising RN. This "operational" service at no time replaces the county PHN assessment. The provider must obtain the physician's orders for PCA services prior to initiating them.
9. A county PHN may utilize a telephone determination to make a recommendation for a temporary increase in PCA services based upon a request from the provider or the consumer. A short-term increase may not necessarily require a complete reassessment.
10. The PCPO is responsible to complete and submit relative hardship waiver requests to DHS.
11. DHS may increase or decrease service levels recommended by the county PHN.
12. County intake staff must hold a broad program knowledge base to assure an appropriate intake process.
13. The consumer appeals process remains unchanged.
14. Training materials, including a bulletin developed by DHS, must clearly outline all aspects of the new process, including initial assessment, reassessments, changes in needed levels of services, and emergency requests.

Care Plan

The subcommittee developed the following distinctions between the service plan and the care plan.

1. The PCPO is responsible for developing an appropriate care plan utilizing appropriate staff. The county PHN will recommend supervisory nursing time on the service plan.
2. PCA services cannot be delivered without a physician's order.
3. Development of the care plan with the consumer or responsible party will include a description/clarification of the activities which a PCA can perform.

Professional Nursing Issues Related to Legislation

The subcommittee made the following recommendations on professional nursing issues related to legislation addressing the PCA assessment process.

1. Delay implementation of county PHN agency responsibility for PCA service assessments to no sooner than March 1, 1996.

This would allow the subcommittee to gain more information from the Alternative Service Models Subcommittee, gain a better understanding of the impact of federal reform, provide sufficient time to fully train the county PHNs, permit a transition period for consumers and providers, and allow a "field test" period of the tool and process. This test period would be followed by a meeting to redesign the tool and/or process as needed.

If this recommendation is rejected, the subcommittee further recommends that implementation occur in a "phased-in" manner until March 1, 1996. This would permit the field testing of both process and assessment tool, with an opportunity for feedback and adjustment.

2. Most subcommittee members requested to continue as members on the Nursing & Assessment Processes Subcommittee (Phase II). This phase should include two subgroups: one to address county prior authorization of MA home care services, and a second to address the nursing issues in relation to legislative changes.
3. A nursing subcommittee should continue to meet: to discuss final recommendations from other subcommittees, to act as a "transition" committee to monitor the implementation of the new assessment tool and process, and to discuss other nursing issues.
4. The adequacy of the PCA assessment reimbursement rate should be evaluated to avoid cost-shifting to local governments. The evaluation should be completed by DHS and county public health agencies; data will be provided by county PHN agencies.
5. A second reimbursement concern is related to referral follow-through. If a consumer or responsible party is unable to pursue referrals, the county PHN agency needs compensation for referral follow-through.
6. The subcommittee recommends that no population should be targeted for elimination of PCA services.
7. There should be actual potential to affect the legislative process and time lines when committees are required to report to the Legislature. The subcommittee had implementation deadlines which did not permit any legislative "window" for pursuing alternatives to the current legislation.

Reassessment: Proposed Alternative Schedule

In addition to the legislative charges of this subcommittee, this subcommittee was also asked by other subcommittees of the task force to consider an alternative schedule for reassessment of PCA services and to develop criteria for any alternative schedule recommended. Current law requires annual reassessment of the need for PCA services.

Recommendation:

The subcommittee recommended limiting the length of time between assessments to two years and further recommends that:

1. All consumers should receive their next scheduled annual reassessment.
2. The county PHN should decide whether future assessments need to be annual or biennial at the consumer's next scheduled reassessment.
3. The subcommittee further recommends that the following groups continue with annual assessment:
 - children 18 years or younger
 - persons with behavioral complications
 - persons with fragile medical conditions
 - "new" consumers (persons with no home care history) must have two annual assessments, then, if stable, biennially

The county PHN will consider the consumer's stability in medical condition and service usage in the previous two years when determining that biennial assessment is an alternative.

DHS can provide county PHN agencies with information on previous usage of PCA services, as well as utilization of other health care services (e.g., emergency admissions for acute care services). This information will assist the county PHN in determining the appropriate frequency interval of reassessments for a consumer.

If a permanent change in the level of service is approved through a reassessment, this reassessment "resets" future reassessment dates.

For consumers who require a reauthorization of PCA service and have not had significant changes in condition, the supervising RN of the PCPO completes the *Home Care Screening Form (DHS-3069)* and forwards it to the county PHN agency no more than 45 days before the consumer's current service authorization ends.

Fiscal Proposal Subcommittee

The Fiscal Proposal Subcommittee was composed of fourteen members representing consumers, families, providers, advocates, counties, state agencies, and tax payers. A list of subcommittee members is in Appendix B.

The charge of the Fiscal Proposal Subcommittee was to:

- develop a process and instrument to measure and review subcommittee proposals
- assure that recommendations forwarded to the Steering Committee met the fiscal target
- produce fiscal report for submission to the Legislature

Proposal Review Tool and Process

The tool developed to evaluate subcommittee proposals, compared the current system to the proposed system on the following aspects: service description, method of delivery, providers, recipients (including age, impairment, level of dependency, eligibility, and number served), and program operating costs (both DHS and service costs). The tool included a section to describe the impact of the proposal and cost savings (including fund transfers). It also included a section for additional comments/recommendations, and an estimated implementation date. A copy of the tool and related definitions are in Appendix I.

The tool was to be completed by the subcommittee submitting the proposal, with one tool completed per proposal. If necessary an additional narrative on the proposal was also to be submitted.

Subcommittee proposals would be received and reviewed by the Fiscal Proposal Subcommittee then forwarded to the Steering Committee. (Although this review process was established, not every proposal reached the Steering Committee through this process.)

Fraud Subgroup

The subcommittee also considered tightening rules, as cost saving measures, in the following areas: physician's orders, changing the frequency of assessment from annual to every five years, auditing insurance

denials, educating providers and consumers, definition of medical necessity, and fraud.

A fraud subgroup was formed to consider fraud concerns. They concluded that fraud is a legitimate task force issue. Through discussions with the Attorney General's office and with Surveillance and Integrity Review Section (SIRS) staff from DHS, it was determined that a significant amount of the MA home care budget is lost due to intentional and unintentional fraud.

The Attorney General's office estimates that 20-30 percent of PCA billings are fraudulent, including deliberate criminal fraud and fraud resulting from misunderstanding or misuse of the system. Identifying a specific annual fraud recovery amount (which can't be accurately estimated) should not be a precondition to recognizing that two state enforcement agencies have identified fraud as a significant problem, and have recommended specific actions to reduce fraud.

This subgroup recommended the following actions to reduce fraud:

1. Require physician's orders to be submitted to DHS with prior authorization requests.
2. Require PCPOs to hold a modified Class A home care license from the Minnesota Department of Health (MDH) in order to provide PCA services. DHS and MDH should proceed with the development of a licensure standard for PCPOs.
3. The budget for SIRS should be increased by \$170,000 on a two year test basis to allow for the addition of 3.4 staff conduct compliance audits of all agencies at a minimum of once per year.
4. All PCAs should be required to be registered at a central data base maintained by DHS. (Similar to the nursing assistant registry maintained by MDH.)

Glossary of Acronyms

ADL	Activities of Daily Living. These are the self-care, communication, and mobility skills required for independence in everyday living. The distinction is made between basic activities of daily living and ancillary but very important activities, such as telephone use, preparing meals, laundry, house cleaning, taking medicines, and handling finances.
DHS	Minnesota Department of Human Services. This is the state agency responsible for the MA program. The DHS is also responsible for the supervision of 87 county human services agencies and the many programs and services that are funded at the federal and state level.
HCNC	Home Care Nurse Consultant. This is a registered nurse with at least two years of experience in home care employed by DHS to authorize home care services that meet the requirements of the MA program. In addition, the HCNC provides technical assistance to providers and consumers.
LPN	Licensed Practical Nurse. This is an individual licensed by the Board of Nursing to practice practical nursing. LPNs usually work under the direction of a licensed physician or a registered nurse. LPNs administer care which requires specialized knowledge and skill such as are taught or acquired in an approved school of practical nursing, but which does not require the specialized education, knowledge, and skill of a registered nurse.
LTC	Long Term Care. This includes nursing home care, home health care, preventative care, day care, assistance with tasks of daily living, transportation, various forms of supportive housing, and help with cooking, cleaning, laundry, and shopping-and it includes many instances of physician care and rehabilitation service. Long term care is interdependent with hospital care and other acute care services.
MA	Medical Assistance. This is Minnesota's Medicaid program. Medicaid is funded by federal, state, and county dollars. It is available in each state, but each state designs its own program within federal regulations. MA helps people who meet certain eligibility criteria to pay for their medical care.
MCCD	Minnesota Consortium for Citizens with Disabilities. This is a broad-based coalition of consumers, providers and advocacy organizations concerned about health care and related issues for Minnesotans with disabilities.
MHCC	Minnesota Health Care Commission. The commission was established in the 1992 legislation known as "Health Right" and was charged with the responsibility to develop a cost containment plan that would slow the rate of growth in health care spending by at least ten percent a year over five years.

MMIS	Medicaid Information System. This is the computer system that is utilized for claims processing and payment, and information retrieval.
PCA	Personal Care Assistant. This is a person who assists, prompts, monitors, or completes activities of daily living for an individual who is unable to do so for him or her self. The activities that a PCA would perform are: bowel and bladder care including catheterization that is not sterile and ostomy care, skin care including wound and decubiti care that is not sterile, range of motion, muscle exercises, respiratory assistance including postural drainage, percussion, nebulizer treatments, suctioning, tracheotomy care, oxygen, and mechanical ventilation, transfers, ambulation, bathing, grooming, turning, positioning, assistance with self-administered medications, assistance with prosthetics and orthotics, cleaning and maintaining medical equipment, dressing and undressing, assistance with nutritional activities including tube feedings, accompanying recipients to medical appointments, supervision and observations, redirection and intervention for behavior, interventions for seizures. A PCA is not a licensed health care professional and is an employee of a PCPO or has enrolled independently to provide personal care services under MA. The PCA is under the supervision of an RN, who generally is <u>not</u> on-site.
PCPO	Personal Care Provider Organization. This is an entity that is enrolled in the MA program to provide personal care services to MA recipients and agrees to follow the rules and policies established under the MA program for personal care services. The PCPO must also employ or contract with RNs to supervise the PCAs.
PDN	Private Duty Nurse. This is an LPN or RN who provides extended hours of nursing in the home of the recipient. These hours are beyond the limits of a skilled nurse visit. This service is for recipients who need care that is also beyond the scope of that which can be provided by a PCA or home health aide.
PHN	Public Health Nurse. This is a registered nurse who meets the voluntary registration requirements established by the Board of Nursing.
RN	Registered Nurse. An RN is an individual licensed by the Board of Nursing to practice professional nursing. RNs supervise a PCA or a home health aide. In addition, RNs provide private duty nursing and skilled visits. Skilled visits monitor the health of recipients who may have changing health care needs and allow the nurse to teach recipients how to provide their own daily health care needs.
SIRS	Surveillance and Integrity Review Section. The SIRS unit of DHS provides a post payment review process to insure compliance with MA requirements by monitoring both the use of health services by recipients and the delivery of health services by providers.
TEFRA	Tax Equity and Fiscal Responsibility Act. TEFRA provides MA eligibility for certain disabled children who live at home with their families.

Steering Committee Membership

The Honorable Bob Anderson Minnesota House of Representatives	Mr. Jeff Bangsberg Consumer/Health Care Commission
The Honorable Linda Berglin The Minnesota Senate	Mr. Jeff Betchwars Parent
Mr. Robert J. Brick Arc Minnesota	Ms. Jane Dietzman Goodhue/Wabasha Public Health Service
Mr. Mike Dreier Minnesota Independent Living Services, Inc.	Ms. Pam Erkel Department of Human Services
Mr. Robert Fischer Department of Children, Families, and Learning	Mr. Luther A. Granquist Minnesota Disability Law Center
The Honorable Lee Greenfield Minnesota House of Representatives	Ms. Jan Harrington Department of Finance
Ms. Nancy Hylden Minnesota Chamber of Commerce	Mr. Lester Kachinske Minnesota Association of County Social Service Administrators (MACSSA)
The Honorable Sheila M. Kiscaden The Minnesota Senate	Ms. Jeanelle Lahr Department of Health
Ms. Jeanette Mefford, RN, MPH Mefford, Knutson & Associates	Ms. Jane Norbin Ramsey County Department of Public Health
The Honorable Tony Onnen Minnesota House of Representatives	Ms. Rene Panelli, RN JD State of Minnesota Board of Nursing
Ms. Eloise Porterfield Dobbs RN, JD Medica	Ms. Suzanne M. Renfroe Parent
The Honorable Don Samuelson The Minnesota Senate	Ms. Sharon Schmid Office of the Attorney General
Ms. Pat Shafer, RN, BSN Minnesota Home Care Association	Ms. Susan Stout, RN Minnesota Nurses Association
Ms. Marilyn Viehl Unity Home Health Services	Mr. Gerald J. Waldholm Consumer

Alternative Service Models Subcommittee Membership

Ms. Louise Brown Family & Children's Services	Ms. Jane Dietzman* Goodhue/Wabasha Public Health Service
Ms. Barbara Donaghy Children's Health Care	Ms. Pam Erkel* Department of Human Services
Ms. Chris Foss-Hausske, PHS Minnesota Home Care Association	Mr. Thomas C. Gode Brain Injury Association of Minnesota
Mr. Ronald S. Goldstein Parent	Ms. Kristin Hays St. David's School
Mr. Thom Johnson Ramsey County Community Human Services	Mr. Lester Kachinske* Minnesota Association of County Social Service Administrators (MACSSA)
Mr. Dan Klint Consumer	Ms. Judy Miller, MBA, CCC Gillette Children's Hospital
Mr. Frederick A. Olsen St. Ann's Residence	Ms. Suzanne M. Renfroe* Parent
Ms. Jamie Slattery Consumer	Ms. Leah Welch Consumer/Independence Crossroads, Inc

* denotes member is also on Steering Committee

Nursing & Assessment Processes Subcommittee (Phase I) Membership

Mr. Rick Cardenas Consumer	Mr. Stephen Carpenter, RN, PHN Becklund Home Health Care, Inc
Ms. Tania France Parent/Legal Aid Society of Minneapolis	Mr. Gerry Huerth, RN Mental Health Advocate
Ms. Patricia Jump, RN, MA Minnesota Home Care Association	Ms. Jeanelle Lahr, RN, C* Department of Health
Ms. Jeanette Mefford, RN, MPH* Mefford, Knutson, and Associates	Ms. Jane Norbin, RN, MS* Ramsey County Department of Public Health
Ms. Rene Panelli, RN, JD* State of Minnesota Board of Nursing	Ms. Ruth Riley, RN, BSN Home Life Personal Care Services, Inc
Ms. Pat Rudie, PHN Morrison County PHN Service	Ms. Becky Schultz-McDermott Consumer/Metropolitan Center for Independent Living
Mr. Charlie Smith Consumer/Access Press	Ms. Karen Swanson, RN, MS Department of Human Services
Ms. Jane Vujovich, BSN, PHN Department of Human Services	Ms. Kathy Wick, PHN Dakota County Public Health Department
Ms. Carolyn S. Williams, RN, BSN Lake Region Hospital & Nursing Home	

* denote member is also on the Steering Committee

Fiscal Proposal Subcommittee Membership

Ms. Rhoda Becklund Becklund Home Health Care, Inc	Mr. Jeff Betchwars* Parent
Ms. Mary Ann Blade Metropolitan Visiting Nurse Association	Ms. Mary Beth Davidson Parent
Mr. Mike Dreier* Minnesota Independent Living Services, Inc.	Mr. Ted Dunaski Parent
Mr. Robert Fischer* Department of Children, Families, and Learning	Mr. Alvin Ghylin Parent
Ms. Jan Harrington* Department of Finance	Ms. Cathy McCarty, BSN, RN A Chance to Grow, Inc
Ms. Kathleen Murphy RN, MSN St. Cloud Hospital Home Care	Mr. Eric H. Sandrock Minnesota Chamber of Commerce
Mr. Gregg Saunders Student Experience, Inc	Ms. Judy Soderberg, MSW, LSW Fairview MS Achievement Center

* denotes member is also on Steering Committee

HOME CARE SERVICES TASK FORCE

MINORITY REPORT

This Minority Report is submitted on behalf of Jeff Bangsberg, Bob Brick, Mike Dreier, Luther Granquist, and Gerald Waldholm, members of the Steering Committee, and Tania France and Charles Smith, members of the Nursing and Assessment Process Subcommittee. With regard to the comments on the assessment instrument and the assessment process, this Minority Report has the support of Steering Committee member, Pat Shafer, RN, representing the Minnesota Home Care Association.

I. Positive accomplishments of the Home Care Services Task Force

For reasons noted below, we disagree, in part, with the report of the Recommendations of the Home Care Task Force. Our disagreement is limited to particular issues. We emphasize that the Task Force report includes a number of excellent recommendations which would, if implemented, provide both short-term and long-term reduction in spending for the personal care services program as well as Medical Assistance in general.

Prevention. It is imperative for the Legislature to consider the long-term ramifications of mandatory seat belt and helmet requirements. These measures would both prevent harm and save money.

Reform of private insurance. Persons with disabilities need Medical Assistance coverage because most private insurance policies do not cover many needed services, including PCA services. Medical Assistance expenditures in general, not just for PCA services, increase because private insurance coverage discriminates against persons with disabilities. The short-term and long-term ramifications for the publicly supported Medical Assistance program of requiring private insurance to meet the unique needs of persons with disabilities should be addressed in this and subsequent legislative sessions.

Multi-year assessments. Many persons who receive PCA services have conditions which have not changed and will not change. There is no reason to spend money on repetitive assessments of conditions which do not change. The time period allowed should extend up to five years for adults.

Optional flexible benefits. Prompt action should be taken to flesh out the details of proposals for shared PCAs and for optional programs which would provide an alternative menu of services with more flexibility in the scope of services. Such programs would enable recipients to obtain greater benefit for themselves and their families, even with fewer service hours.

II. The Proposed July 1, 1996 changes must be repealed.

The initial draft of the Task Force Recommendations did not include the recommendation included in the final report that the changes made by the 1995 Legislature in the PCA program which are to be effective July 1, 1996 must be repealed. While this recommendation is included in the present report, it is so understated at the beginning of the "Final Recommendations" section that it could easily be missed. Also, the fundamental human reasons for taking such action have not been adequately emphasized. The issues are critical, for hundreds of persons will be hurt if corrective action is not taken.

A. Persons who cannot direct their own care should continue to be entitled to personal care services.

In the 1995 session, the Legislature repealed, effective July 1, 1996, those provisions of the statute which allow persons who cannot direct their own care to receive PCA services. Based on the information the Department provided the Legislature in the May 5, 1995 fiscal note, on July 1, 1996 3,078 persons will no longer be receiving PCA services. This figure includes 1,251 children who presumably would be receiving services under managed care, 908 persons who would be on waiver programs, and 919 persons who would not be eligible for waivers or PCA services at all. Of the latter group, some may be eligible for some form of mental health grant.

The sad fact, however, is that alternatives for most of these persons are simply not going to be available on July 1, 1996. There is no managed care service established for TEFRA PCA recipients. The waivers involved have yet to be requested, much less approved by HCFA. PCA services will continue under a rider to the appropriations bill for some of these persons, but eligibility for the program on past terms would have ended. A serious question is posed by reducing what the Department could calculate as \$16,000,000 for the 919 persons cut off entirely to the possibility of receiving part of a \$4,000,000 mental health grant program.

The result is not revision of a program or cutting its growth; it is slashing the program in half. Cutting half the persons off the PCA program in these circumstances cannot be tolerated.

B. The changes in covered services under the PCA Program to be effective July 1, 1996 should be reinstated.

Along with elimination of persons who cannot direct their own care from the PCA program, the 1995 Legislature repealed, effective July 1, 1996, certain of the covered services in the PCA program. The services to be eliminated involve assisting, monitoring, or prompting a consumer to complete personal care services, redirection and intervention for behavior, and intervention for seizure disorders. According to DHS statements made to the Task Force, these services were eliminated because they were generally provided to persons who cannot direct their own care who

would no longer be on the program. Indeed, such services are provided to persons who cannot direct their own care, as well as others. *They are essential services for the well-being of these individuals. These services should be reinstated as covered services.*

C. Reduction in maximum service hour limits must be rolled back.

Also effective July 1, 1996, the 1995 Legislature amended several portions of the statute to reduce the maximum amount of personal care service hours that may be authorized. Some of the provisions eliminated particularly affect persons with significant behavioral problems. Other changes involved the multiplier used with regard to direct care service in nursing homes and the imposition of a limitation based on the average per diem for the persons' case mix in a nursing facility.

These changes affect the maximum number of hours of service that may be authorized in each category or for each home care case mix classification. *Most of the persons in each of those categories actually have fewer hours of service authorized than the maximum available. It follows, of course, that the persons who will be adversely affected by the reduction in maximum service hours will be those persons who have already established that it is medically necessary to receive service at or close to the maximum limitation. This change in the program will hurt the people who need the services the most. This outcome is intolerable.*

The Department's own projection in the May, 1995 fiscal note was that this change would "save" only \$289,000 in FY 1997. Such "savings" should never have been suggested at the expense of the persons who demonstrably require the services the most.

Slashing a program in half, failing to provide alternative services for persons cut off the program, and cutting hours of the persons who need them most is unjustifiable at any juncture, but particularly at a time when major changes are likely at the federal level. These cuts, for they are really cuts, not simply changes or a restriction in growth, should not be allowed to happen at a time when the state projects a budget surplus of \$800 million.

III. Task Force Recommendations which should not be implemented.

A. Recommendation 25 of the Task Force to reduce utilized hours of PCA services by no more than 7 percent should not be adopted by the Legislature.

Recommendation 25 of the Task Force is to "reduce utilized hours of PCA service by no more than seven percent." While this proposal modifies an earlier proposal to reduce utilized hours by seven percent if a capitated menu program is not established July 1, 1996, it is still a proposal which would hurt most the people who need the services the most. The Steering Committee

purported to adopt the principle that the recommendations made should reflect respect for human dignity. This recommendation does not. To impose a reduction in service, even if not the full seven percent, on persons who need help the most is inappropriate at a time when the state projects a budget surplus.

B. Recommendation 15 to adopt new PCA assessment tool.

The Task Force recommends adopting the personal care assessment tool and service plan developed by the Nursing and Assessment Process Subcommittee. We disagree.

The new form headed the MA Health Status Assessment is, in large part, simply a reworking of the Home Care Assessment/Care Plan which the Department has been using for the last several years. Many of the questions are the same. The form is shorter only because smaller type is used. There should be no misunderstanding; this document is not a "streamlined" assessment.

1. Misleading "direct your own care" standard.

The first section of the new form includes questions the Department proposes to ask after July 1, 1996 to determine whether a person can direct his or her own care. According to the statement on the form, if any of three questions is answered "No" the person will not be eligible for PCA services and must be referred to a waived services program. The third question reads as follows:

Can this client assure their own health and safety?

Many persons who are quite capable of stating what they want and where with regard to a caregiver cannot, by virtue of their physical disabilities, assure their own health and safety. Many persons who have championed this program for years and influenced the legislation which created it are paraplegic or quadriplegic. They cannot move their bodies to protect their own health or safety. Yet they are totally capable of telling PCAs and Department bureaucrats what they need and whether those needs are being served.

These persons were receiving PCA services before the responsible party language was added to the statute. Yet, in terms of the question quoted above, they would not be eligible for the program. The Department's language amending the PCA statute to exclude persons who cannot direct their own care did include the phrase "assure their health and safety." Why the Legislature approved such a provision is not clear. With regard to other amendments to the PCA statute which raised problems, such as the age and English language requirement, the Department wisely found a way to interpret the language to lessen the harm done. Yet here the Department highlights a question which begs misuse and misapplication in the assessment process. Then the

Department provides no guidance for application of that language to avoid the absurd result of cutting off eligibility for service for persons who have been on the PCA program for years.

2. Lack of standards for using instrument.

The new form contains no standards for use by county public health nurses who have not been involved in the prior authorization process for PCA services in the past few years using the various forms of the Home Care Assessment/Care Plan. There are no directions for the county public health nurses to follow to determine what amount of services the recipient is to receive.

According to the report of the Assessment Subcommittee, based on a sample of times authorized by the Department for activities of daily living, the "mode" was selected as the measure to be used for the "typical" time for each activity of daily living. There are no directions for the public health nurse to follow to determine whether and how to deviate from the "mode."

The form requires the public health nurse completing this assessment to note severity ratings (page 1 of the form) and "factors impacting level of function with regard to the various activities of daily living." There are no directions for how these criteria are to be applied.

With regard to the activities of daily living, the form includes some boxes to check whether a service is met, partially met, unmet, and the time. How these little boxes are to be used is not clarified in anything the Department has provided.

There is no standard articulated anywhere regarding how all these considerations are to be applied in making the ultimate determination which is of importance to the recipient, the number of hours that will be authorized. Neither recipients nor personal care provider organizations will be well served when decisions regarding hours of service are made without defined standards.

3. The form is not "objective."

The Department is likely to state that this form was developed by a group of professionals who considered the issues presented and that it, therefore, provides a basis for an objective determination of recipients' needs. Even with the present Home Care Assessment/Care Plan the Department staff have asserted that it provides an "objective" presentation of recipient needs, as opposed, apparently, to the subjective judgment of physicians and nurses who know the recipient and care for her or him.

The form does ask a number of relevant questions in a structured manner. To that extent, it assists in the process of identifying a recipient's needs. It is not, however, an objective form. Personal predilections with regard to client performance may enter into the judgment of the

public health nurse. Personal predilections with regard to what family members do or ought to do for someone will enter into this process.

III. The Department's numbers game.

A. What was the Task Force's task?

Readers of the Task Force report should know that the Department did not state how much savings the Task Force was required to report in order to comply with the statutory directive until the final version of the Task Force Report, prepared after the last meeting of the Steering Committee. Only after the Task Force had completed its work did the Department state that the fiscal target for savings was \$11 million.

Throughout the course of the Task Force's proceedings, the amount of savings required to be identified varied from \$12 million to \$19 million. As the minutes of the organizational meeting of the task force held on August 16, 1995 indicate (page 3), Mr. Hoffman of the Department was not clear whether the 5 percent legislative mandate is an annual rate of increase or a simple increase. The minutes go on to record that "we need to find savings of \$19 million or \$13 million based upon the value placed on the PCA changes to take effect one year from now."

This uncertainty continued throughout the course of the Task Force deliberation. Indeed, at the November 20, 1995 meeting of the Steering Committee, Marge Brchan, Director of the DHS Home and Community-Based Services Division, handed out a short document headed Fiscal Charge for Home Care Services Task Force. According to Ms. Brchan, that handout gave two options to the committee with regard to the financial target. Exactly what those two options were, was not clarified. A copy of the document is attached to this report. As is evident, even at that late stage in the process the Department did not identify what it considered the fiscal target for the Task Force deliberation.

B. Are the Department's PCA participation figures misleading?

Members of the Steering Committee repeatedly questioned the Department's data regarding PCA program. One issue, still not clarified by the Department in the final report, is whether the increase in the number of persons receiving PCA service which is emphasized in the Task Force Report (page 14) is misleading, in part, because persons on waived services receiving PCA services are not included in figures for earlier years but are now. Even in the final report the Department admits (page 13) that the numbers are being "worked on."

C. DHS failure to respond to requests for data.

The Task Force consistently requested the necessary financial information from the Department of Human Services in order to have a basis for proposing reasonable alternatives to the July 1, 1996 changes. At the task force meeting on September 21, 1995, the Department's representatives acknowledged the need for clear numbers. The minutes of the Steering Committee meeting of that date include the following statements:

Marge Brchan, Home & Community-Based Services Division Director, DHS, stated that the Department is cognizant that people want clear numbers. The commissioner has prioritized information requests for groups with Medicaid Management Information System (MMIS II). We will reconvene the data group from the last legislative session. This is twelve people from various program areas to put best read on data. MMIS II is vendor driven; it is for provider payment. The priority on the table is to give you the best projection we can.

Senator Berglin noted that the numbers from last legislative session were corrected (fiscal note numbers). George Hoffman, DHS, admitted that the numbers were not correct.

Marge Brchan stated that the May 5, 1995, fiscal note is the finalized one that we are told to be using. Senator Berglin stated that those numbers are not correct.

At the September 21st meeting, the Minnesota Consortium For Citizens with Disabilities specifically requested detailed fiscal information. At the next meeting of the Steering Committee held on October 6, 1995, the Department provided a response to data requested by the Steering Committee. This response was based upon the May 5, 1995 fiscal note discussed at the previous meeting. There was not, however, in that response, an articulation of the process or procedure by which the Department's projections were reached.

Requests for clarification of the Department's method of calculating PCA participation and cost continued at the November 20 meeting. The minutes for that meeting include the following statements:

Members of the committee requested clarification on previous information given out on the dollar savings that had been projected pertaining to July 1, 1996 legislation. George Hoffman, DHS, stated that the figures the members have need to be elaborated upon in order to come up with the reconciliation projected. George did not have all the numbers with him but said they would be available to the group. He reminded the committee members that some of the money projected in the savings was shifted to state mental health grants and waivers and did produce a savings of federal funding. George did elaborate that the committee members must remember that this forecast was only a rough forecast and not an exact measure.

George did indicate the calculation was possibly affected by artifact. However roughly done the projections are coming up close to accurate.

Mr. Hoffman, in his brief presentation at that meeting, indicated that projections for expenditures in the home care program, PCA and PDN, were made from the "top down" by allocation of expenditures to this program and extrapolation based upon the judgments relating to increased participation and the like.

Previously he had provided to the Fiscal Committee a document dated September 19, 1995 which includes the following statement as an explanation of how the Department reaches its projections:

Projected expenditures are aggregated by fiscal year, combining expenditures for all eligibility categories.

Each year's expenditures are distributed to service categories used in the forecast, based on previous year's proportion for each service, adjusted for enrollment changes in different eligibility categories, changes in rates, in business expected to be shifted to Managed Care.

Dollar projections for each service category are adjusted for effects of legislative changes not included in previous calculations.

Final projections are displayed in forecast tables.

Projections for home health agencies and personal care & private duty nursing display average monthly recipient and average monthly payments. Monthly average payment is estimated from the FY1994 average monthly payment, increased by 3 percent. Monthly average recipients are calculated from the expenditure projection and the average payment projection (expenditures divided by average monthly payment divided by 12 months).

At the meeting of the Steering Committee held on November 27, 1995, Ms. Brchan, as part of her report on the basis for the Department's projections in this program, distributed three charts that had been prepared in March, 1995. These charts obviously provided no new information to the Task Force. She also passed around certain documents which apparently had been reviewed within the Department. Her conclusion with regard to the question on data needs is recorded in the minutes as follows:

Marge Brchan, DHS Home and Community-Based Division Director, addressed the committee on data needs and availability. The Medicaid Management Information System (MMIS) II is a complex, newly implemented payment system. It is not a data system. Its priority is to provide timely, accurate payment to providers.

The information provided to the legislature on the committee was a multi-disciplinary, continuously refined data analysis effort. DHS used a process based upon professional judgment. Professional judgment uses an individual's expertise gained from experience and education. The process is not flawless, but the results of this process usually hold up well. The fiscal reports are coming in on target; they are following the projections we expected them to follow.

At no point during the course of the discussions of the Steering Committee was any representative of the Department able to describe how professional judgment was actually used in coming up with the projections and the data the Department presented both to the Legislature in 1995 and to the Steering Committee during the past several months.

D. The Department's projection for 1995.

The Department stated that, despite some uncertainty regarding the data, their projections were coming in "on target." Consider as an example of the Department's performance the figures provided for FY1995. At the first meeting of the Steering Committee, a document headed Reduction Target for Home Care Task Force was provided to the members of the committee. It included the November 1994 forecast of expenditures in FY1995 for personal care and PDN of \$122,613,000. That projection stated that monthly average payments would be \$1,508 for an average of 6,774 recipients each month. Similar figures were used in forecasts dated February 4, 1995 and June 16, 1995.

Despite repeated requests for actual FY1995 data, only in the draft report of the task force prepared by Department personnel and distributed prior to the December 21, 1995 meeting of the task force, did the Department provide written information with regard to FY1995. According to that document, Medical Assistance expenditures for personal care and private duty nursing services for FY1995 totaled \$119.5 million. There was no explanation whether this figure reflected an actual total of payments made in those categories or an extrapolation from a larger, aggregate figure.

According to the information first presented in the draft report, the average payment for fiscal year 1995 was estimated at 3 percent above the FY1994 figure, or \$1,362, which is 9.7% lower than the \$1,508 monthly average used in the November projections. The number of recipients was increased, according to the Department's report, to 7,315 persons, a figure which was said to be "calculated based on the estimated average payment." This number is 8% higher than the 6774 persons included in the Department's previous projection. That higher level of participation is then used in the Report (page 14) as the basis to calculate the continued increase in the number of recipients in the program.

What figure is to be believed? A reduction of expense of 2.5%? A 9.7% reduction in the average monthly payment? An 8% increase in the participation rate? The Department provided no reasoned justification for any of these figures.

IV. The Composition of the Committees.

The Legislature mandated consumer representation on the Task Force. An adequate number of consumer representatives were not, in fact, appointed by the Department of the Task Force. The Steering Committee included only three persons who are consumers of PCA services, two of whom were also employed by a personal care provider organization. The Steering Committee included two persons identified as parents of persons receiving PCA services.

The Nursing and Assessment Process Subcommittee initially included nobody who was a consumer of PCA services. A parent of a person receiving PCA services was added, but three direct consumers of PCA services were added only after protests were lodged by the Minnesota Consortium for Citizens with Disabilities. By that time, much of the work of this subcommittee had been completed.

Direct consumers of services have a great deal to offer agency representatives, professionals in the field, and professional advocates regarding the way in which services should be delivered. The Department could have benefitted from greater consumer participation in this important effort and should have arranged initially for that representation.

Fiscal Charge for Home Care Services Task Force

A. Fiscal Requirements Applied to Program Changes for Clients

Changes for Clients	FY 1996	FY 1997
<ul style="list-style-type: none"> •New Definition for PCA Svs •Movement to waivers and other programs •Growth limit due to eligibility 	\$0	(\$19,342,840)
Change in hour limits	0	(289,049)
PHN assessment	(218,220)	(2,774,870)
State Mental Health Grants	700,000	4,000,000
Total	\$481,780	(\$18,406,759)

B. Limit Growth to 5% over 1995 projected expenditures for 1996-1997 biennium

		Total Expenditures
FY 1995 Projected Expenditure	\$110,000,000	\$110,000,000
+5% growth for FY 1996	5,500,000	\$115,500,000
+5% growth for FY 1997	5,500,000	\$121,000,000

Home and Community-Based Services Division
11/20/95

Recommendations from the Minnesota Health Care Commission

- **Increase Tobacco Taxes to decrease smoking-related diseases, with revenues dedicated to universal coverage and specific prevention initiatives, including smoking prevention and cessation, violence prevention, and improving birth outcomes.**
- **Make nonuse of vehicle restraints a primary offense, punishable by a fine of \$100, with revenues going to seat belt educational initiatives.**
- **Make nonuse of motorcycle, snowmobile, and all-terrain-vehicle (ATV) helmets a misdemeanor punishable by a fine of \$25, with revenues dedicated to education programs for helmet use.**
- **Increase alcohol taxes to decrease alcohol abuse and adverse effects.**
- **Study and provide a report on consumer incentives that would enable consumers to make "the healthy choice the easy choice."**
- **Establish a stable, streamlined funding mechanism to effectively deliver core public health functions.**
- **Identify incentives and relationships for advancing Integrated Service Network (ISN) contributions to public health goals in an accountable and flexible manner.**

*Consumer Incentives and Prevention Report
February 16, 1994*

MINNESOTA CONSORTIUM FOR CITIZENS WITH DISABILITIES

c/o Arc Minnesota, Attn: Bob Brick, 3225 Lyndale Avenue, South, Minneapolis, MN 55408, (612) 827-5641

COST SAVINGS TO PUBLIC PROGRAMS THROUGH PRIVATE SECTOR REFORMS

OVERVIEW

A key opportunity to address the growth in public health care programs is to pursue further reforms in the private sector. A large share of Medicaid expenditures labeled "long term care" consists of acute and primary care costs that are not assumed by private insurance. While it may never be reasonable to expect the private sector to pay for some of the ongoing services needed by persons with disabilities, it does seem appropriate to expect private coverage of acute and primary services that can prevent complications and reduce the need for long term care.

It is critical to recognize that people with disabilities are not just using Medicaid because they can't afford or can't qualify for private insurance; rather, their health needs are not met by private sector health plans. Not only are the *types* of benefits that Medicaid offers important, but also the fact that those benefits are allowed under broader circumstances than private insurance. Key gaps to which Medicaid has had to respond include:

- arbitrary limits and exclusions governing private insurance benefits;
- services unavailable in the variety of settings needed by individuals with disabilities;
- a narrow view of "medical necessity" with a short term, episodic view of prevention; and
- no private sector incentives to reduce dependency on long term care.

If Medicaid is no longer able to fill these gaps and the needs of people with disabilities are not better addressed by the private sector, costs to our community will grow in areas such as:

- increased acute care costs due to complications that could have been prevented;
- higher rates of institutionalization due to increased dependency that could have been avoided with proper care;
- increased crime because we have not managed the impulsivity and judgment problems of people with behavioral disorders;
- increased property taxes as responsibility for addressing unmet needs is shifted to the local level;
- higher special education costs because children with disabilities are more dependent than necessary; and
- caregiver burnout, family disintegration and income loss.

SPECIFIC ISSUES TO BE ADDRESSED:

A) Problem: Short term focus on long term needs increases both acute and long term care costs

Under most health plans, limits on the quantity of care are generally set with the average enrollee in mind (reflecting, for example, the amount of therapy, follow-up doctor visits, medication or home care needed by someone recovering from a knee operation). For more serious impairments, the intensity and duration of treatment most appropriate to meet the needs of an individual may vary, depending on factors such as severity of the disability, age of onset, length of time post-onset, and secondary diagnoses. The private sector's short term focus often leads to decisions whereby a plan's refusal to pay for needed care or equipment ultimately results in increased dependency and complications that are costly for both the acute and long term care systems. As a result, people with disabilities may require more frequent doctor visits, hospitalization, medication and/or institutionalization that could have been prevented.

Example: An insurance company denied a \$200 seat cushion needed to prevent pressure ulcers for an individual in a wheelchair. As a result, this individual developed serious pressure sores requiring surgery and a lengthy institutional stay, costing both the acute and long term care systems thousands of additional dollars.

Recommendation: To control costs across the entire health care system, the paradigm must be shifted away from a short-term, purely restorative focus, to emphasize cost effective, long term maintenance and prevention. Arbitrary limits on the quantity and type of services must be removed, with the focus shifted to health outcomes and cost efficiency.

B) Problem: Lack of incentives to prevent long term dependency

Since health plans are typically not responsible for long term care, they have little incentive to provide aggressive therapy and other services that can reduce dependency on community-based, long term care programs and/or prevent institutionalization.

Example: Private plans do not cover personal care services, so they have little incentive to provide sufficient therapy to reduce a person from a two-person transfer to a one-person transfer. Under the current system, doing so would save the public sector money, but would have no effect on the private plan's costs.

Recommendation: Explore incentives for private health plans to provide intensive acute and primary services that can help individuals with disabilities reduce dependency on public programs.

C) Problem: Unrealistic annual maximum limits on disability-related services

Example: Sally is a child with cerebral palsy who has medical needs for occupational therapy, physical therapy and speech therapy in order to grow and develop properly. Her family's private insurance pays a maximum of \$750 per year for rehabilitation services—only a fraction of the cost of the services Sally needs. As a result, Sally's family must resort to Medicaid's TEFRA program to obtain these services.

Recommendation: Remove arbitrary annual maximums for disability-related services and/or establish maximums that are more realistic and more consistent with the annual maximums for other types of medical services. Health plans would retain control over the costs of these services since they would still only be required to provide them in situations where they were medically necessary and cost effective.

D) Problem: Unique services needed to address disability labeled as "out of network"

Example: Nicholas is a 6 year old child with cerebral palsy whose parents both work and have private insurance coverage. Nicholas required Post Selective Posterior Rhizotomy surgery to alleviate spasticity in his legs. Few local hospitals have experience in performing this surgery, even though its effectiveness is well documented. Since Gillette Hospital, where Nicholas needed to have the surgery, was not considered "in network" by the family's private health plan, the plan was only willing to pay for 70% of the cost of this surgery. As a result, the other 30% was covered by Medicaid's TEFRA program, for which Nicholas' parents pay a monthly fee, based on their income. Without the rhizotomy surgery, Nicholas would have had to go through 15 to 20 more traditional surgeries (muscle lengthenings and bone structure repairs) over the next several years. The rhizotomy surgery avoided the need for all of these surgeries and, by giving Nicholas increased use of his legs, will make him less dependent on special education and long term care services over the course of his lifetime.

Recommendation: In cases where specialty care needed by people with disabilities is a covered benefit, but can only be obtained through an out-of-network provider, require private plans to cover that care as if it were provided within the network.

E) Problem: Narrow definition of medical necessity discriminates against persons with disabilities

The current HMO definition of "medical necessity" requires care to "restore, maintain or prevent deterioration in a member's condition." This definition has often resulted in denial of care for individuals with congenital disabilities who need care to "establish function."

Example: John is a child with cerebral palsy whose parents have private insurance that includes coverage for therapy services. Even though health care professionals agreed that these services would be very successful in enabling John to walk and talk, treatment was denied by the private health plan on the grounds that it was not possible to "restore, maintain or prevent deterioration" functions that John was born without. As a result, John's family had to turn to Medicaid's TEFRA program to obtain services they thought they had paid for with their premium dollars.

Recommendation: Broaden the definition of medical necessity to include "establishment of function."

F) Problem: Policy exclusions discriminate against persons with disabilities

Private health plans typically exclude anything considered "custodial". While this appears appropriate on the surface, some plans have defined extended therapy services needed by people with disabilities as "custodial", again leaving people with disabilities with no choice, but to seek these needed services through Medicaid. Plans also exclude "educational services," and some have defined all speech therapy as "educational," even though a trained and certified health care professional must provide these services, not a teacher.

Recommendation: Standard exclusions to be used by all health plans should be developed to prevent enrollees from being surprised by complexly-worded limitations in the "fine print" of their insurance policies.

DHS-3245 (11-95)

MA HEALTH STATUS ASSESSMENT

☐ Initial Assessment

☐ Reassessment

Date of Referral _____

Date of Assessment _____

SOCIAL SECURITY NO. OPTIONAL	PMI NUMBER	CLIENT LAST NAME	FIRST	MI
MEDICARE NUMBER/PRIVATE INSURANCE		STREET ADDRESS	CITY, STATE	ZIP
PRIMARY SPOKEN LANGUAGE		COUNTY OF RESIDENCE	(AREA CODE) TELEPHONE NUMBER	
DATE OF BIRTH	SEX: <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	LEGAL GUARDIAN/PRIMARY CONTACT:	TELEPHONE	
CURRENT CLIENT LOCATION	STREET ADDRESS	CITY, STATE	ZIP	

1. DIRECTING OWN CARE DETERMINATION:

A. Effective through June 30, 1996

1. Is this client oriented to person, time, and place? ☐ YES ☐ NO
2. Does this client have an understanding of the plan of care including medications and medication schedule? ☐ YES ☐ NO
3. Does this client have an understanding of his/her needs? ☐ YES ☐ NO
4. Does this client have an understanding of safety issues, including how to access emergency help? ☐ YES ☐ NO

B. Effective July 1, 1996

1. Can this client identify their own needs? ☐ YES ☐ NO
2. Can this client evaluate task accomplishment (in relationship to a caregiver)? ☐ YES ☐ NO
3. Can this client assure their own health and safety? ☐ YES ☐ NO

If all questions under "A" were answered "yes", client is determined to be capable of directing their own care. If any question under "A" was answered "no", client must have a responsible party. If all questions under "B" were answered "yes", client is determined to be capable of directing their own care. If any questions under "B" were answered "no", client must be referred to an HCBS waiver.

For Reassessments only (check each item below which has changed since the initial screening/assessment and explain the change.)

Reassessment 1 Reassessment 2

2. DIAGNOSIS : List each diagnosis and ICD-9 code. Rate them using the following severity index. Choose one value for each diagnosis with level 4 as most severe. Specify the date of onset or exacerbation.

Severity Index:

- 0- Asymptomatic; no treatment at this time
- 1- Symptoms well controlled with current therapy
- 2- Symptoms controlled with difficulty; needs on-going monitoring and affects daily functioning

- 3- Symptoms poorly controlled; needs frequent adjustment
- 4- Symptoms poorly controlled; re-hospitalizations

Diagnosis	Date of Onset or Exacerbation	ICD-9	Severity Rating
a. _____	_____	_____	___ 0 ___ 1 ___ 2 ___ 3 ___ 4
b. _____	_____	_____	___ 0 ___ 1 ___ 2 ___ 3 ___ 4
c. _____	_____	_____	___ 0 ___ 1 ___ 2 ___ 3 ___ 4
d. _____	_____	_____	___ 0 ___ 1 ___ 2 ___ 3 ___ 4

Has there been a change? _____

Reassessment 1 Reassessment 2

3. LIST MEDICATIONS (Including oxygen and PRN meds)

Meds	Route/Dosages/Frequency
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Medication Management

- ☐ Needs no assistance
- ☐ Needs help of another person
- ☐ Uses pill caddy: assist with filling
- ☐ Needs help obtaining prescriptions
- ☐ Unable to do

Time: _____

Reassessment 1 Reassessment 2

4. ENVIRONMENT

A. Living Arrangements: ✓ Check who the client lives with:

- ☐ 1 Lives alone
☐ 2 Lives with spouse or friend
☐ 3 Lives with family
☐ 4 Lives with paid help (PCA, aide, etc.)
☐ 5 Foster Home (☐ Family ☐ Corporate)
 Total No. Foster Residents: _____
 Total Monthly Rate: _____
 Monthly Room/Board Rate: _____
☐ 6 Shares PCA with other recipient

B. Current Residence: ✓ Check where the client resides:

- ☐ 1 Owned/rented house, apt., trailer
☐ 2 Family member's residence
☐ 3 Boarding care home
☐ 4 Assisted Living
☐ 5 Other (specify): _____

C. Structural Barriers: ✓ Check all structural barriers in the client's environment that restrict independent mobility:

- ☐ 0 None
☐ 1 Stairs inside home which must be used for daily living (e.g. toilet, sleep)
☐ 2 Stairs inside home optional use (e.g. laundry)
☐ 3 Stairs leading from inside house to outside
☐ 4 Narrow or obstructed doorways

D. Safety Hazards: ✓ Check all safety hazards found in the client's place of residence:

- ☐ 0 None
☐ 1 Inadequate floor, roof, windows
☐ 2 Inadequate lighting
☐ 3 Unsafe gas, electric appliance
☐ 4 Inadequate heating/cooling
☐ 5 Unsafe floor coverings
☐ 6 Inadequate stair railings
☐ 7 Hazardous materials exposed
☐ 8 Lead-based paint
☐ 9 Other (specify): _____

E. Sanitation Hazards: ✓ Check all sanitation hazards found in the client's current place of residence:

- ☐ 0 None
☐ 1 No running water or contaminated
☐ 2 No toileting facilities
☐ 3 Inadequate sewage disposal
☐ 4 Inadequate food storage/refrigeration
☐ 5 Inadequate cooking facilities
☐ 6 Insects/rodents present
☐ 7 Other (specify): _____

Reassessment 1	Reassessment 2

Reassessment 1	Reassessment 2

Reassessment 1	Reassessment 2

Reassessment 1	Reassessment 2

Reassessment 1	Reassessment 2

5. SENSORY STATUS

A. Language Expression: ✓ Check the item that best describes the client's ability to effectively express herself/himself through speech and verbal (oral) expression of language.

- ☐ 0 Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
☐ 1 Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice; grammar or speech intelligibility; needs minimal prompting/assistance).
☐ 2 Expresses simple ideas or needs with moderate difficulty (needs prompting/assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
☐ 3 Has severe difficulty expressing basic ideas or needs and requires maximal assistance/guessing by listener. Speech limited to single words or short phrases.
☐ 4 Unable to express basic needs even with maximal prompting/assistance but is not comatose/unresponsive (e.g., speech is nonsensical or unintelligible).
☐ 5 Patient unresponsive, unable to speak.
☐ 6 Age appropriate.

B. Hearing and Auditory Comprehension of Language: ✓ Check client's ability to hear and understand spoken language (with hearing aid if used).

- ☐ 0 No observable impairment. Able to hear and understand complex or detailed instructions and extended or abstract conversation.
☐ 1 With minimal difficulty, able to hear and understand most multi-step instructions and ordinary conversation. May need occasional repetition, extra time, or louder voice.
☐ 2 Has moderate difficulty hearing and understanding simple, one-step instructions and brief conversation; needs frequent prompting/assistance.
☐ 3 Has severe difficulty hearing and understanding simple greetings and short comments. Requires multiple repetitions, restatements, demonstrations, additional time.
☐ 4 Unable to hear and understand familiar words/common expressions consistently.
☐ 5 Not determined.

C. Vision: ✓ Check client's ability to see (with corrective lenses if used)

- ☐ 0 Normal vision; sees adequately including newsprint, medication labels.
☐ 1 Partially impaired; cannot see newsprint or med labels; can see obstacles in path.
☐ 2 Severely impaired; cannot see obstacles; cannot find way around without feeling or using cane; cannot locate objects without hearing or touching them. Vision completely lost/essentially blind.
☐ 3 Not determined.

Reassessment 1	Reassessment 2

Reassessment 1	Reassessment 2

Reassessment 1	Reassessment 2

9. BEHAVIOR Complete this section to document Level I, II, or III Behavior.

Level I Behavior	Predictable?		FREQUENCY (1-5)	DURATION (1-5)		
	Yes ✓	No ✓				
Self Injurious						
Client exhibits, or without supervision, observation, or redirection would exhibit, behaviors which lead or have the potential to lead to hospitalization because of self inflicted injury (including those sustained during property destruction, pica, etc.)					Reassessment 1	Reassessment 2
Client exhibits, or without supervision, observation, or redirection would exhibit, behaviors which lead or have the potential to lead to outpatient medical treatment because of self inflicted injury.						
Client exhibits, or without supervision, observation, or redirection would exhibit, behaviors which lead or have the potential to lead to first aid because of self inflicted injury.						
Client exhibits, or without supervision, observation, or redirection would exhibit, hitting, pinching, or otherwise attacking self without requiring first aid or medical treatment. This includes pica where it is unclear if physical damage is occurring.						
Physical Injury to Others						
Client exhibits, or without supervision, observation, or redirection would exhibit, behaviors which cause or have the potential to cause someone else to require hospitalization because of client's aggression.					Reassessment 1	Reassessment 2
Client exhibits, or without supervision, observation, or redirection would exhibit, behaviors which cause or have the potential to cause someone else to require outpatient medical treatment because of client's aggression.						
Client exhibits, or without supervision, observation, or redirection would exhibit, behaviors which cause or have the potential to cause someone else to require first aid because of client's aggression.						
Client exhibits, or without supervision, observation, or redirection would exhibit, behaviors such as pinching, hitting, or slapping but no one has needed first aid because of the behavior.						
Destruction of Property						
Client has exhibited, or without supervision, observation, or redirection would exhibit, behaviors causing or having the potential to cause structural damage to the client's residence (i.e. broken windows, holes in walls, etc.)					Reassessment 1	Reassessment 2
Client has exhibited, or without supervision, observation, or redirection would exhibit, behaviors causing or having the potential to cause damage to appliances, electronics, or furniture.						
Client has exhibited, or without supervision, observation, or redirection would exhibit, behaviors causing or having the potential to cause damage to household items (i.e. dishes, lamps, etc.)						
Client has exhibited, or without supervision, observation, or redirection would exhibit, behaviors causing or having the potential to cause damage to personal items (i.e. clothing, books, toys, etc.)						

Level I Behavior Determination:

Level I behavior documentation must be reviewed by the nurse and submitted along with the service plan. ✓ Check the following areas that best describes the client's behavior:

✓ ☐ N/A

✓ ☐ Self Injurious

✓ ☐ Physical Injury to Others

✓ ☐ Destruction of Property

Level I Behavior Continued:

1. Explain **self injurious behavior** and appropriate intervention required by a caregiver:

Frequency Per 24 Hours: _____

Describe frequency for a paid caregiver: _____ Duration: _____ Total time requested for paid caregiver: _____

Goal: _____

2. Explain **physical injury to others behavior** and appropriate intervention required by a caregiver:

Frequency Per 24 Hours: _____

Describe frequency for a paid caregiver: _____ Duration: _____ Total time requested for paid caregiver: _____

Goal: _____

3. Explain **destruction of property behavior** and specify items damaged and appropriate intervention required by a caregiver:

Frequency Per 24 Hours: _____

Describe frequency for a paid caregiver: _____ Duration: _____ Total time requested for paid caregiver: _____

Goal: _____

Level II Behavior: ✓ Check the appropriate box.

- ☐ 1 None
☐ 2 Unusual/Repetitive Habits
☐ 3 Withdrawal
☐ 4 Socially Offensive

_____ Daily _____ Weekly _____ Monthly

Level III Behavior: ✓ Check the appropriate box.

- ☐ 1 Needs no prompts or assistance
☐ 2 Needs prompts/assistance to initiate task
☐ 3 Needs intermittent prompts/assistance during task
☐ 4 Needs ongoing prompts/assistance during task

_____ Daily _____ Weekly _____ Monthly

10. ACTIVITIES OF DAILY LIVING (ADLs) ✓ Check the box within each ADL section that best describes the client's ability to function within the community.		✓ Check if the need is:					
MET	PARTIALLY MET	UNMET	TIME				
A. Dressing (includes application of orthotics, prosthetics) Frequency: _____/day						Reassessment 1	Reassessment 2
<input type="checkbox"/> 0 - Independent: does not need help or supervision of another person in any part of this activity							
<input type="checkbox"/> 1 - Intermittent supervision: needs and receives occasional reminders or instruction, but does not need physical presence of another person at all times to dress, lay out clothes, or fasten clothes.							
<input checked="" type="checkbox"/> 2 - Constant supervision: needs and receives help of another person constantly present during this activity, but does not need physical help.							
<input type="checkbox"/> 3 - Help of another: needs and receives physical help and presence of another person during all of this activity. Client is able to physically participate.							
<input type="checkbox"/> 4 - Dependent on another: needs and receives physical help from other person to carry out this activity. Client is unable to physically participate.							
<input type="checkbox"/> N/A - If age appropriate.							
Factors impacting level of function: <input type="checkbox"/> Pain <input type="checkbox"/> Spasticity <input type="checkbox"/> Behavior <input type="checkbox"/> Other Comments: _____							
B. Grooming Frequency: _____/day						Reassessment 1	Reassessment 2
<input type="checkbox"/> 0 - Independent: does not need help of another person in any part of this activity.							
<input type="checkbox"/> 1 - Intermittent supervision: needs and receives occasional reminders or instructions, but does not need physical presence of another person at all times to groom.							
<input type="checkbox"/> 2 - Constant supervision: needs and receives constant supervision of another person, but does not need physical help.							
<input type="checkbox"/> 3 - Help of another: needs and receives physical help of another person to complete task, but client is able to physically participate.							
<input type="checkbox"/> 4 - Dependent on another: needs and receives physical help from other person to carry out this activity. Client is unable to physically help.							
<input type="checkbox"/> N/A - If age appropriate.							
Factors impacting level of function: <input type="checkbox"/> Pain <input type="checkbox"/> Spasticity <input type="checkbox"/> Behavior <input type="checkbox"/> Other Comments: _____							
C. Bathing Frequency: _____/day						Reassessment 1	Reassessment 2
<input type="checkbox"/> 0 - Independent: does not need help or supervision of another person in any part of this activity.							
<input type="checkbox"/> 1 - Intermittent supervision: needs and receives occasional reminders or instruction, but does not need physical presence of another person at all times during bath.							
<input type="checkbox"/> 2 - Able to bathe in shower or tub with assistance of another: (a) for intermittent supervision reminders; or (b) needs and receives help to get in and out of tub; or (c) washing difficult areas.							
<input type="checkbox"/> 3 - Constant supervision: Receives help of another person during this activity to assist or supervise. Participates in bathing self in shower or tub.							
<input type="checkbox"/> 4 - Requires physical assistance of another person, but recipient can participate. Unable to use shower or tub and is bathed in bed or bedside chair; can participate.							
<input type="checkbox"/> 5 - Dependent on another: needs and receives physical help from another person to carry out washing and/or drying. Client is physically unable to participate.							
<input type="checkbox"/> N/A - If age appropriate.							
Factors impacting level of function: <input type="checkbox"/> Pain <input type="checkbox"/> Spasticity <input type="checkbox"/> Behavior <input type="checkbox"/> Other Comments: _____							

ADL's Continued		✓ Check if the need is:					
		MET	PARTIALLY MET	UNMET	TIME		
D. Eating Frequency: _____/day <input type="checkbox"/> 0 - Independent: feeds self without help of any kind (includes drinks from glass and cuts food with knife). <input type="checkbox"/> 1 - Needs and receives personal supervision (reminders) in eating or due to functional limitations is unable to prepare own meals. <input type="checkbox"/> 2 - Needs constant supervision and/or receives personal assistance to cut meat, arrange food, butter bread, etc. at meal time. <input type="checkbox"/> 3 - Needs and receives physical help from another person to eat and/or drink. Client can participate. Includes observation for choking due to documented incidences of choking once per week or more related to diagnosis or disability. Includes person who requires assistance with application of orthotics. <input type="checkbox"/> 4 - Needs and receives total feeding from another person. Includes tube feeding. <input type="checkbox"/> N/A - If age appropriate.						Reassessment 1	Reassessment 2
Factors impacting level of function: <input type="checkbox"/> Pain <input type="checkbox"/> Spasticity <input type="checkbox"/> Behavior <input type="checkbox"/> Other Comments: _____							
E. Transfers Frequency: _____/day <input type="checkbox"/> 0 - Independent: requires no supervision or physical assistance to complete necessary transfers. May use equipment such as railings and trapeze. <input type="checkbox"/> 1 - Intermittent supervision: needs and receives guidance only. Requires physical presence of another person during transfer (i.e. verbal cuing, guidance). <input type="checkbox"/> 2 - Needs and receives physical help from another when transferring. Client may participate in transfer. <input type="checkbox"/> 3 - Needs and receives physical help from another. Includes one or two person transfer. Client is unable to participate. <input type="checkbox"/> 4 - Must be transferred using a mechanical device (i.e. Hoyer lift). <input type="checkbox"/> N/A - If age appropriate.						Reassessment 1	Reassessment 2
Factors impacting level of function: <input type="checkbox"/> Pain <input type="checkbox"/> Spasticity <input type="checkbox"/> Behavior <input type="checkbox"/> Other Comments: _____							
F. Mobility Frequency: _____/day <input type="checkbox"/> 0 - Independent: ambulatory without a device. <input type="checkbox"/> 1 - Can use a device such as cane, walker, crutch, or wheelchair without physical help of another person. <input type="checkbox"/> 2 - Needs intermittent physical help of another person. <input type="checkbox"/> 3 - Needs and receives constant physical help from another person. Includes total dependence with propelling wheelchair. Includes persons who remain bedfast. <input type="checkbox"/> N/A - If age appropriate.						Reassessment 1	Reassessment 2
Factors impacting level of function: <input type="checkbox"/> Pain <input type="checkbox"/> Spasticity <input type="checkbox"/> Behavior <input type="checkbox"/> Other Comments: _____							

ADLs Continued		✓ Check if the need is:					
		MET	PARTIALLY MET	UNMET	TIME	Reassessment 1	Reassessment 2
G. Positioning Frequency: _____/day <input type="checkbox"/> 0 - Positions self in bed or chair without help. <input type="checkbox"/> 1 - Needs and receives occasional help from another person or device to change position less than daily. <input type="checkbox"/> 2 - Needs intermittent help from another person on a daily basis to change position. Client is able to participate. <input type="checkbox"/> 3 - Needs and receives turning and positioning. Client is unable to participate. <input type="checkbox"/> N/A - If age appropriate. Factors impacting level of function: <input type="checkbox"/> Pain <input type="checkbox"/> Spasticity <input type="checkbox"/> Behavior <input type="checkbox"/> Other Comments: _____							
H. Toileting Frequency: _____/day <input type="checkbox"/> 0 - Independent: needs no supervision or physical assistance (includes client who manages the problem of dribbling or incontinence). <input type="checkbox"/> 1 - Intermittent supervision: needs and receives intermittent supervision or cuing or minor physical assistance. (For example, clothes adjustment or washing hands). No incontinence. <input type="checkbox"/> 2 - Usually continent of bowel and bladder, but occasional accidents requiring physical assistance. <input type="checkbox"/> 3 - Needs assistance with bowel and bladder programs and appliances (i.e., colostomy, ileostomy, urinary catheter). <input type="checkbox"/> 4 - Usually continent of bowel and bladder, but needs and receives physical assistance and/or constant supervision with most/all parts of the task. <input type="checkbox"/> 5 - Completely incontinent of bowel and/or bladder. Diapered constantly. <input type="checkbox"/> N/A - If age appropriate. Factors impacting level of care: <input type="checkbox"/> Pain <input type="checkbox"/> Spasticity <input type="checkbox"/> Behavior <input type="checkbox"/> Other Comments: _____							

11. INSTRUMENTAL AND SUPPORTIVE ACTIVITIES OF DAILY LIVING (IADLs) (SADLs)

ACTIVITY	Needs No Assistance	Needs Some Assistance/ is Helped by Person	Needs More Help		Time	Comments	Reassess #1 Date	Reassess #2 Date
			yes	no				
*Meal Preparation/ Groceries								
*Light Housekeeping integral to personal care								
*Laundry integral to personal care								
*Accompany to Medical Appointments								
Shopping/Errands								
Using Telephone								
Appointment Management								
Other: _____								
Initial Evaluation: Time: _____							Time: _____	Time: _____

12. ✓ CHECK APPLIANCES, AIDS, OR SPECIAL EQUIPMENT USED OR NEEDED BY CLIENT AND TIME REQUEST								Reassess # 1 Date	Reassess #2 Date	
ITEM	USES	NEEDS	MAINTENANCE TIME	ITEM	USES	NEEDS	MAINTENANCE TIME			
Medical Alert/Lifeline				Cane/Walker						
Prosthetic/Orthotics				Wheelchair (Manual, electric)						
Standing Board				Tub Chair/Bench						
Hearing Aid				Grab Bar						
Dentures				Communication Board						
Glasses/Contact Lenses				Catheter						
Hospital Bed				Oxygen/Nebulizer						
Special Transferring Equipment				Suction Machine						
Special Toileting Equipment				Ventilator						
Special Dressing Equipment				Other/Specify _____						
Adaptive Eating Equipment				Total Time Request: _____						

13. SUMMARY OF SECTION TIME TOTALS		Initial Time	Reassess # 1	Reassess #2
Section 3.	Medications	_____	_____	_____
Section 7.	Complex Medical Needs and Treatments	_____	_____	_____
Section 8.	Seizures	_____	_____	_____
Section 9.	Level I Behavior	_____	_____	_____
Section 10.	Activities of Daily Living (ADLs)	_____	_____	_____
Section 11.	Instrumental and Supportive Activities of Daily Living (IADLs) (SADLs)	_____	_____	_____
Section 12.	Appliances/Aids/Special Equipment	_____	_____	_____
Total time converted to Units of Service: _____ Service Need is: <input type="checkbox"/> Short Term (<=6 months) <input type="checkbox"/> Long Term (>6 months)				

14. HOME CARE RATING AND COST-EFFECTIVENESS COMPARISON: To determine a client's home care rating, count the number of dependencies in Section 10 (Activities of Daily Living) and check one of the following:

✓ ☐ Low ADLs (1-3 Dependencies) ✓ ☐ Medium ADLs (4-6 Dependencies) ✓ ☐ High ADLs (7-8 Dependencies)

Non vent dependent, RTC level:

(a.) Home Care Rating (See Personal Care Limit Decision Tree): _____ Monthly Cost Limit: \$ _____

(b.) Foster Care Difficulty of Care (D.O.C.) Monthly Amount: \$ _____

(c.) Total Monthly Cost of all **other** required MA Reimbursed Home Care Services (SNV, HHA, PDN): \$ _____

(*d.) Maximum Allowable Monthly PCA and RN Supervision Cost Limit (a-b-c): \$ _____

(e.) Recommended daily/weekly amount of PCA service converted to monthly cost (units x unit cost x 365 days ÷ 12 months or 52 weeks): \$ _____

(f.) Recommended monthly amount of RN Supervision units _____
Converted to monthly cost (units x unit cost): \$ _____

(*g.) Total monthly cost of Recommended PCA Service (line e + line f): \$ _____

* If line (g.) is equal to or less than line (d.), PCA care is determined to be cost-effective. If line (g.) is greater than line (d.), PCA service amount is determined according to line (d.)

Vent Dependent: For vent-dependent clients, contact the MA Home Care Unit for consultation.

15. SERVICE RECOMMENDATIONS

☐ No Medical Assistance home care/PCA needed; community resources adequate. ☐ Needs can be met through other resources than PCA program.

☐ Needs both community resources and MA home care services (See Service Plan). ☐ Other/Specify: _____

NURSE SIGNATURE		TELEPHONE	DATE
COUNTY	ADDRESS		ZIP
LENGTH OF VISIT:			

MA Home Care Service Plan

CLIENT NAME: _____ PCA Care Requirement: _____ (daily/weekly)

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

TELEPHONE _____

PHYSICIAN _____ TELEPHONE _____

Physician Address _____

Check ☒ Long Term Need (>6 months) ☐ Short Term Need

PCA Service Approval: ☐ yes ☐ no ☐ pending ☐ temporary only

PCA Authorization Period: _____

Date Service Plan Revised: _____

Date Case Discharged: _____

FUNDING SOURCES ☒ Check all that apply:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Medicare Part A | <input type="checkbox"/> Medical Assistance/No application | <input type="checkbox"/> VA Benefits |
| <input type="checkbox"/> Medicare Part B | <input type="checkbox"/> Medical Assistance/Pending | <input type="checkbox"/> Private Pay |
| <input type="checkbox"/> Private Insurance or HMO | <input type="checkbox"/> Medical Assistance/Approved | <input type="checkbox"/> Other |

Informal Supports: ☒ Check:

- ☐ Family ☐ Neighbor ☐ Friend ☐ Church
- ☐ Sitter ☐ Volunteer ☐ Self-help groups ☐ Other/specify: _____

SUMMARY OF AREAS OF CONCERN FROM ASSESSMENT: ☒ Check all that apply:

- | | | | | | | |
|--|--|------------------------------------|---------------------------------------|---|---|--|
| <input type="checkbox"/> Cognitive | <input type="checkbox"/> Hearing | <input type="checkbox"/> Dressing | <input type="checkbox"/> Meal Prep | <input type="checkbox"/> Bowel Care | <input type="checkbox"/> Caregivers | <input type="checkbox"/> Errands |
| <input type="checkbox"/> Supervision | <input type="checkbox"/> Vision | <input type="checkbox"/> Grooming | <input type="checkbox"/> Transfers | <input type="checkbox"/> Housework | <input type="checkbox"/> Money Mgmt. | <input type="checkbox"/> Chores |
| <input type="checkbox"/> Med Mgmt. | <input type="checkbox"/> Complex Medical | <input type="checkbox"/> Bathing | <input type="checkbox"/> Mobility | <input type="checkbox"/> Grocery Shopping | <input type="checkbox"/> Use of Telep. | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Safety | <input type="checkbox"/> Seizures | <input type="checkbox"/> Skin Care | <input type="checkbox"/> Positioning | <input type="checkbox"/> Access Resources | <input type="checkbox"/> Medical Appts. | |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Behavior | <input type="checkbox"/> Eating | <input type="checkbox"/> Bladder Care | <input type="checkbox"/> Housing | <input type="checkbox"/> Transportation | |

Comments: _____

SERVICE RECOMMENDATION: ☒ Check item that applies:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Community-based care;
adequate supports/resources | <input type="checkbox"/> Nursing Facility/Skilled 24 hr. Care) | <input type="checkbox"/> MA Waivers | <input type="checkbox"/> Other/Specify: _____ |
| <input type="checkbox"/> PCA <input type="checkbox"/> Home Health Agency | <input type="checkbox"/> Boarding Care Home | <input type="checkbox"/> Foster Care | _____ |
| <input type="checkbox"/> Informal Supports | <input type="checkbox"/> Hospital/Inpatient Services | <input type="checkbox"/> ICF/MR | _____ |
| | <input type="checkbox"/> Alternative Care Facility | <input type="checkbox"/> School/Special Ed | _____ |

Comments Regarding Recommendation: _____

Goal(s) with Care Recommendation: _____

Discharge Plan: _____

Client's Service Preference: _____

PCA Service Provider: (1) _____ Telephone: (____) _____ MA Provider No. _____

PCA Service Provider: (2) _____ Telephone: (____) _____ MA Provider No. _____

PCA Provider Comments: (Contact Person: _____)

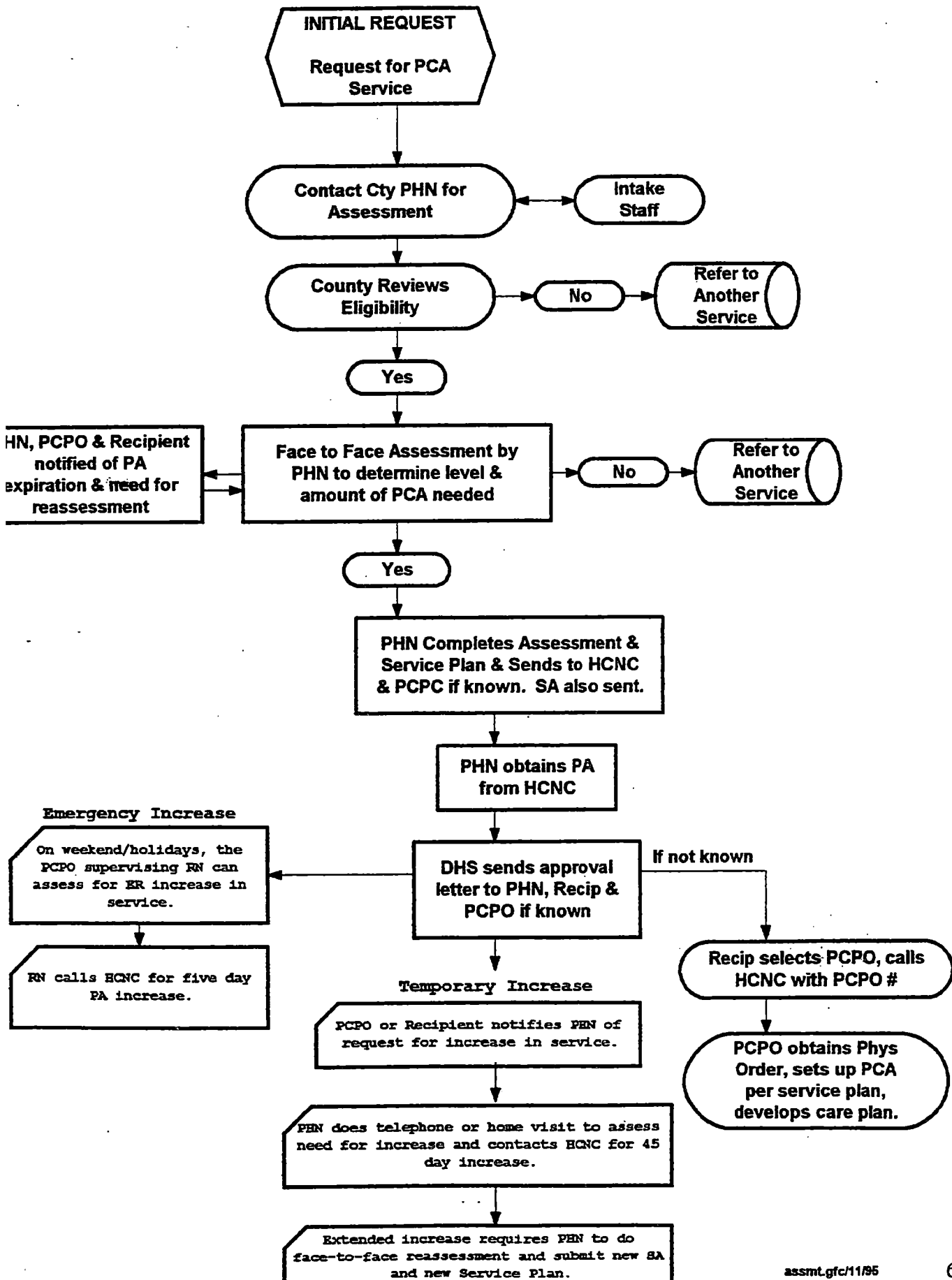
Community-based Care Section: * Complete only if using MA state plan (non-waivered) home care services:**

Service Category	Funding Source	Service Provider (paid/unpaid)	Specific Service (specify care or circle all that apply)	Amount and Frequency	Client Referred to:
Meals/Snacks	___ Title III ___ Private Pay		Congregate/ Home Delivered		
Adult/Child Care				_____ days/wk	
Homemaker			clean/shop/laundry		
Homemaker			clean/shop/laundry		
Respite					
Medical Transportation					
School Aide					
School Aide					
Personal Care Assistant					
Personal Care Assistant					
PCA/RN Supervision	Medical Assistance			_____ month	
Home Health Agency	___ Medicare ___ Medical Assistance ___ Private Pay ___ Other		Skilled Care/Specify:	SNV: _____ Aide: _____ OT/PT/ST: _____ MSW: _____	
Home Health Agency	___ Medicare ___ Medical Assistance ___ Private Pay ___ Other		Skilled Care/Specify	SNV: _____ Aide: _____ OT/PT/ST: _____ MSW: _____	
Hospice	___ Medicare ___ Medical Assistance		Palliative Care	Daily	
Medical Equipment	___ Medicare ___ Medical Assistance ___ Private/Other		Resp./Bed/IV equip./pulse ox/suction/other		
Other					
Other					

This service plan has been developed with the client and is based upon the Health Status Assessment. It represents an accurate reflection of the client's condition and care needs. A copy of this service plan have been provided to the client.

Signature Public Health Nurse	Telephone	Date
County	Address	State/Zip
Client Signature/Responsible Party/ or Legal Guardian		Date

FLOW CHART FOR PRIOR AUTHORIZATION PROCESS



Proposal Review Tool

SERVICE NAME: ORIGIN:			CHANGE		
SERVICE PARAMETERS	CURRENT	PROPOSED	IMPACT	COST SAVINGS	
				Fund Transfers	
				From	To
Service Description					
Method of Delivery					
Who are the providers?					
Who are the recipients? ■ Age of recipients					
■ Physical					
■ Behavioral (mental)					
■ Both					
■ Dependency level					
■ Eligibility					
■ Number served					
What is the cost of operating the program? ■ DHS (operational)					
■ Service (operational)					
■ Total Program Cost					
Comments/Recommendations:					
Estimated implementation date: (Include clarification of cost savings, calculations, and assumptions)					

Definitions for Proposal Review Tool

Service Name	Name of service
Origin	What committee or state agency is this proposal from?
Row	
Service Description	Briefly describe the service being offered
Method of Delivery	Include location of the service, provider to recipient ratio, supervision, etc.
Who are the providers?	Include agency type and staff type (qualifications)
Who are the recipients? <ul style="list-style-type: none"> ■ Age or recipients ■ Physical ■ Behavioral (mental) ■ Both ■ Dependency level ■ Eligibility ■ Number served 	(Self explanatory) Will this program serve individuals needing help with ADLs? Will this program serve individuals needing supervision of behavior? Will this program serve individuals needing assistance with both physical and behavioral issues (i.e., one person both needs)? What dependency level will this service serve? Who is eligible? Number of people who will receive the service
What is the cost of operating the program? <ul style="list-style-type: none"> ■ DHS (operational) ■ Service (operational) ■ Total Program Cost 	Cost for DHS staff Cost of the program dollars given to providers DHS (operational) + Service (operational)
Columns	
Current	What is being provided now
Proposed	What is being proposed
Change <ul style="list-style-type: none"> – Impact – Cost Savings 	What is the service or system impact? What are the cost savings?

Notes

1. 1994 Head and Spinal Cord Injuries in Minnesota, Minnesota Department of Health
2. Report to Congress in Safety Belts and Motorcycle Helmets, Based on Data from CODES The Crash Outcome Data Evaluation System. April 1995.
3. August 1995 Survey Conducted by the Minnesota Department of Public Safety
4. Evaluation of California Safety Belt Law Changes to Primary Enforcement
5. 1994 Head and Spinal Cord Injuries in Minnesota, Minnesota Department of Health
6. Ibid.
7. Ibid.
8. Ibid.
9. Ibid.
10. Ibid.
11. Ibid.
12. Thompson R.S. et. al.: A Case Control Study of the Effectiveness of Bicycle Safety Helmets
13. 1994 Head and Spinal Cord Injuries in Minnesota, Minnesota Department of Health
14. Ibid.
15. Ibid.