Clarification of Policy for Personal Care Assistant (PCA) Services for Managed Care Enrollees

TOPIC
Clarification of policy for PCA services for persons enrolled in managed care for publicly funded programs.

PURPOSE
To improved access to PCA services for managed care enrollees.

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INTRODUCTION

This bulletin clarifies policy regarding the use of personal care assistant (PCA) services for persons enrolled in managed care programs. These programs include: The Prepaid Medical Assistance Program (PMAP), Minnesota Senior Health Options (MSHO), Minnesota Senior Care (MSC), Minnesota Senior Care Plus (MSC+), and Minnesota Disability Health Options (MnDHO).

PCA services offer assistance and support to eligible persons with disabilities and special health care needs, including older adults living in the community. PCA services can be accessed through the Medical Assistance (MA) State Plan benefit alone or in conjunction with home and community-based services (HCBS) waiver programs (e.g., Elderly Waiver [EW] and waivers for persons with disabilities).

To assure consistency in the MA State Plan PCA policy please refer to the basic policy found in the Disability Services Program Manual (DSPM).

ELIGIBILITY DETERMINATION

According to federal regulations, the State Plan PCA service is an MA entitlement. Managed care organizations (MCOs) are responsible for providing State Plan PCA services to members who qualify. Managed care contracts follow the State Plan definitions and parameters for PCA services. The same policy encompasses PCA services for eligible individuals of all ages and for all diagnoses and/or disabilities. The service must be deemed medically necessary as established in Minnesota Rules, parts 9505.0170 to 9505.0475. An individual must meet all eligibility criteria before State Plan PCA services can be authorized.

Extended PCA services exceed the State Plan benefit amount and are provided through the HCBS waivers. Extended PCA services must also be medically necessary and meet the waiver criteria related to the person’s risk of institutionalization. A level of care determination is made through the Long-Term Care Consultation (LTCC) and/or the annual waiver re-assessment processes.

ASSESSMENT

An assessment is required to access PCA services and is considered part of the entitlement. The determination of services is based on an individualized assessment of the person’s need for assistance to remain independent in the community. Assessments must occur annually unless there is a significant change in the person’s condition.
The PCA assessment process includes:

- Documentation of health status
- Determination of need
- Evaluation of service effectiveness
- Identification of appropriate services
- Development and/or modification of a service plan
- Coordination of services to address assessed needs
- Referrals and follow-up to appropriate payers and community resources
- Completion of required reports
- Recommendation of the amount of needed PCA services
- Consumer education about PCA services and delivery options

During the assessment, determinations are made regarding whether PCA services are needed, and the number of minutes for each PCA service component. PCA services include assistance with: Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) and health-related functions, as well as observation, redirection, and intervention of behaviors. Time could be allowed to meet an ADL need even when it is not a dependency. Time may also be allowed in the IADL section only when there is a need for PCA services to address at least one ADL, behavioral issue, or health related function. IADL time is allowed for homemaking and laundry tasks specific to the individual and not for other family members. Time is allowed for accompanying a person to medical appointments when the person requires PCA services during the appointment time. Medication set-up is not a PCA service. However, time is allowed for assisting the person to take medications under his/her or responsible party direction.

There are three types of assessments related to State Plan PCA services:

1. Face-to-Face
2. Service Update
3. 45-Day Temporary Increase

1. Face-to-Face

Managed care enrollees are entitled to an initial assessment that must be face-to-face, and an annual re-assessment for State Plan PCA services. Managed care organizations (MCOs) cannot deny a request for either. The form used for the face-to-face assessment is the Medical Assistance Health Status Assessment form (MAHSA, DHS-#3244). When there is a significant change in condition or in unusual situations, additional assessments may be authorized by the Department of Human Services (DHS) or the MCO.

2. Service Update

A Service Update process may be substituted for the annual face-to-face re-assessment when there is no significant change in the person’s condition or need for PCA services.
The Service Update is conducted by telephone and requires the completion of the *Medical Assistance Home Care Update* form (DHS-3244B). A Service Update may only be used for two consecutive re-assessments and then a face-to-face re-assessment is required. Use of the Service Update is *optional* for MCOs who may require annual face-to-face re-assessments or utilize a different process for updating assessments.

Individuals using the PCA Choice Option may only use the annual face-to-face assessment and not the Service Update process.

3. **45-Day Temporary Increase**

A 45-day temporary increase in PCA services may be authorized when there is a significant change in medical condition that requires additional PCA services for no more than 45 days. If the need exceeds 45 days, then a face-to-face assessment is required. This is an *optional* assessment process for MCOs who may utilize a different process for authorizing PCA service requests.

**Assignment of Home Care Rating**

During the PCA assessment, the person is assigned a home care rating. A person’s home care rating is based upon his/her assessed needs and defines the maximum service dollar limit available to the person for developing the PCA service plan. The *PCA Decision Tree (DHS-4201)* is the tool that must be used to determine the home care rating.

**Appealing the Assessment and Service Authorization Decision**

MCOs cannot deny a request for an initial assessment. Enrollees may appeal a denial of a request for an assessment or the results of an assessment or re-assessment. If an individual disagrees with a completed assessment and service authorization, the individual may request a re-assessment from the MCO and/or appeal the service authorization.

If the MCO has made a change in the service levels recommended in the assessment for the purpose of maximizing third-party resources or non-duplication of services, the MCO must provide the individual with a notice of Denial, Termination of Reduction (DTR) which outlines the enrollee’s right to appeal and reasons for the changes in the original recommended service authorization.

When services are in place and there is no change in condition that warrants a re-assessment, an enrollee’s request for re-assessment can be denied by the MCO. If the MCO denies the re-assessment request, the MCO must send a DTR to the enrollee as required by the DHS contract to outline the enrollee’s right to appeal and reasons for the denial. If the enrollee appeals the denial, the issue under appeal is related to whether a
change in the service authorization is warranted due to a change in condition and not the denial of a new assessment. A re-assessment may be ordered by a human services judge at DHS as a part of the appeals process.

Sharing Assessment Information

MCOs and counties are expected to follow the State Plan PCA policy regarding frequency of assessments and re-assessments, as described above, in order to ensure consistency and efficiency between assessing agencies. This consistency eases the transitions for people when changing MCOs, moving to a new county, or using FFS home care. It is unnecessary to repeat an assessment as a result of these transitions if a PCA assessment was conducted within the last 365 days and there is no significant change in the person’s condition. A current assessment conducted by a county public health nurse (PHN) not under contract with the newly designated MCO is still valid and can be used. However, the MCO may choose to re-assess an enrollee when the assessment was completed by an agency not under contract with the MCO.

*Please refer to Attachment A, a process model for the transfer of assessments for certain managed care enrollees.*

Inability to Locate Enrollee for Assessment

When an enrollee cannot be located for purposes of providing the PCA assessment, a reasonable number of attempts should be made and documented. The MCO must also issue a DTR to the enrollee when the enrollee cannot be reached. The MCO establishes and informs enrollees of their written policy and procedure for this situation.

Assessment Process When MCO Is Not Responsible for the Waiver Benefit and the Waiver Benefit is Being Provided Under Fee-For-Service (FFS)

The PCA assessment must be conducted by PHNs who are independent of the PCA provider agency. MCOs providing PCA services for individuals without an available waiver benefit set through the MCO (i.e., when the MCO is not responsible for home and community-based services) must provide PCA assessments through the PHN or a PHN certified by the Minnesota Board of Nursing under contract with the county. A PHN under a contract with a county for any service may conduct PCA assessments. The county PHN does not have to be from the county where the enrollee resides.

For enrollees over age 65 also receiving disability waiver services (Community Alternatives Care [CAC], Community Alternatives for Disabled Individuals [CADI], Traumatic Brain Injury [TBI]) under fee-for-service (FFS) and where the MAHSA was not conducted during the LTCC process, MCOs must provide PCA assessments. PCA assessments for these members must be conducted by the county PHN or a county contracted PHN. MCOs and counties should establish coordination and communication mechanisms to share information about these assessments. *See Attachment A.*
Assessment Process When the MCO Is Responsible for Both State Plan and Waiver Benefits

For individuals enrolled in MCOs responsible for providing a waiver benefit set (i.e. those who are enrolled in MSHO, MnDHO, or MSC+), the PCA service assessment is the responsibility of the enrollee’s designated MCO. The MCO must also use qualified assessors who are independent of the PCA provider agency. The PCA assessment may occur during the LTCC, the annual waiver re-assessment process, or when requested as provided for in the above paragraph. The *LTCC Services Assessment Form* (LTCC Form [DHS-3428]) should be used, with the MAHSA as a resource tool.

The assessment may be conducted by the MCO care coordinator or care manager, a county PHN, county-contracted PHN, or an MCO PHN independent of the PCA provider agency. When the MCO’s care coordinator or case manager conducting the LTCC or waiver re-assessment process is not a Minnesota Board of Nursing certified PHN, an MCO PHN should be consulted to ensure an accurate determination for PCA services.

When conducting the LTCC assessment, it would be useful for the MCO to obtain MAHSA information from the county PHN if one was completed within the past 365 days to ensure a thorough and accurate assessment and avoid duplication.

Determination of State Plan PCA units and Extended PCA units is completed by the care coordinator or case manager using the assessment information obtained. Extended PCA units are only available after the use of State Plan services. The PCA Comparison Grid for Extended PCA Services is used only for the disability waivers. For EW, the PCA Decision Tree (Form #4201) is used along with the LTCC findings to determine the number of units to be assigned to the State Plan and the balance then to Extended PCA. If an enrollee who is seeking PCA services does not have a waiver services need other than case management, then State Plan PCA services should be used exclusively.

Authorization of PCA Services

Minnesota Statutes are clear in stating that the level of PCA services must be determined by an individualized face-to-face assessment to determine a person’s needs. The assessment must be based on the needs of a person on a typical day regardless of the availability of supports. Authorization of services must also be based upon an individual’s needs. It is DHS policy that lead agencies (counties, managed care organizations, tribes) cannot use their own tools or guidelines that assign specific ranges and/or amounts of time for PCA service components.

MCOs are financially responsible for State Plan and waiver PCA services for members enrolled in managed care products and are therefore allowed to authorize and/or prior authorize PCA services. MCOs that choose to prior authorize PCA services may opt to base their authorization process and practice on DHS’ authorization guidelines as used for FFS State Plan PCA services as established in Minnesota Statutes, section 256B.0655.
It is possible that some individuals may have a PCA service authorization amount that differs from the service amount indicated in the assessment to avoid duplication of services, maximize third party liability and honor consumer choices. MCOs must provide a DTR to the enrollee when authorizing a different PCA service amount than the PCA assessment. MCOs must clearly document and provide explanations in the service plan as to why there is a difference in the assessed and authorized service amounts.

**Communication of the Authorized PCA Services**

People conducting the assessment are responsible for providing the completed MAHSA assessment and recommended service plan to the MCO. The *Medical Assistance Home Care Service Plan (DHS-3244A)* or a similar standardized form to be developed in conjunction with DHS may be used. The MCO is responsible for reviewing the assessment findings and authorizing the amount, duration, and frequency of the PCA services. The MCO is also responsible for establishing a process for timely notification to the enrollee and the PCA provider of the final authorized service amount and for providing them with a copy of the final service plan.

If a waiver participant opts for PCA services, the community support plan will specify the results of the assessment findings, including the amount, duration and frequency of PCA services and other information (e.g., PCA service option) in accordance with waiver policy. The Medical Assistance Home Care Service Plan (DHS-3244A) may also be used in conjunction with the community support plan for this purpose.

**Flexible Service Option**

When a participant requests to use the flexible service option, the amount of assessed and/or authorized services does not change. This option is a method to use authorized hours in a flexible manner in two 6-month date spans throughout a 12-month service authorization period. Using the flexible service option does not change a person’s individual need for service. For more information on this option, go to the DSPM.

**Physician Statement of Need**

A Physician Statement of Need is required to be on file for all persons receiving State Plan PCA services. The Statement of Need is obtained by the PCA provider or by the MCO. It must be updated *annually* or when there is a significant change in the person’s condition. MCOs cannot require that the Statement of Need be obtained before a PCA assessment is conducted, however, MCOs can choose to require it before services are authorized, provided, or billed. The Statement of Need must be provided even when the physician concurs with the assessment result. The MCO may opt to use *DHS-4690 Form: Physician Statement of Need for PCA Services* or may use their own standard form developed in collaboration with DHS.
Written Notice

It is important for MCOs to provide written notice to members regarding the service authorization process; authorized service amount and effective dates; information about PCA service providers; reasons for any changes in the service authorization or differences in service amount from the assessment; notice of appeal rights; and the process for fulfilling the Physician Statement of Need requirement.

AUTHORITY

Minnesota Statutes, sections 256B.0625, 256B.0651, 256B.0655, 256B.0915, 256B.69, Minnesota Rules, parts 9505.0335, parts 9505.0170 to 9505.0475

Disability Services Program Manual
Chapter 26A MHCP Provider Manual

WEB LINKS

For information about DHS-PCA trainings go to: www.dhs.state.mn.us/trainlink
For PCA policy questions please send an email to: dhs.dsd.learn@state.mn.us

ATTACHMENTS
Attachment A - PCA Assessment Transfers between Health Plans
Attachment B - PCA Assessments for Managed Care Enrollees

Special Needs
This information is available in other forms to people with disabilities by contacting us at (651-431-2590 (voice) or toll free at (800) 882-6262. TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.
## PCA Assessment Transfers between Health Plans

<table>
<thead>
<tr>
<th>Provider Agency</th>
<th>New Health Plan</th>
<th>Assessing Agency</th>
<th>Member</th>
<th>Previous Health Plan</th>
<th>Notes</th>
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### Steps:
1. **Provider Agency** sends the PCA assessment to the New Health Plan.
2. The New Health Plan contacts the Assessing Agency for provider authorization.
3. The Assessing Agency confirms the PCA transfer and sends the PCA Assessment to the Member.
4. The Member contacts the Previous Health Plan for provider authorization.
5. The Previous Health Plan approves the PCA transfer and sends the PCA Assessment to the New Health Plan.

### Additional Notes:
- PCA Assessment
- Transfers
- Health Plans
- Assessing Agencies
- Members
- Previous Health Plans

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*PCA Assessment Transfer Diagram*
## PCA ASSESSMENTS FOR MANAGED CARE ENROLLEES

<table>
<thead>
<tr>
<th>Managed Care Product</th>
<th>Special Needs Basic Care (SNBC) – (Persons 18-64 years w/ disabilities)</th>
<th>Minnesota Senior Care (MSC) until phase out on 1-09 Prepaid Medicare Assistance (PMAP) for all members MSHO or MSC+ When Member remains on FFS Disability Waiver</th>
<th>Minnesota Senior Health Options (MSHO) Minnesota Senior Care Plus (MSC+) Minnesota Disability Health Options (MnDHO)</th>
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<tr>
<td>Status/Responsibility</td>
<td>All PCA remains FFS</td>
<td>MCO provides State Plan PCA for all members including seniors on FFS EW (until 1-09) or on FFS Disability Waivers</td>
<td>MCO provides both State Plan and Extended PCA for all members including those receiving waiver benefits through MCO.</td>
</tr>
<tr>
<td>Conducts PCA assessment</td>
<td>County PHN or county contracted PHN</td>
<td>For all State Plan PCA assessments the MCO contracts with county PHN or county contracted PHN. MCO and county also must use county or county contracted PHN for persons on the DD waiver. County case manager may complete the LTCC form for people on CAC/CADI/TBI.</td>
<td>For all PCA services, MCO care coordinator or case manager conducts assessment with consultation from MCO PHN if care coordinator is not a PHN. Or MCO may choose to use a county or county-contracted PHN.</td>
</tr>
<tr>
<td>Form(s) used</td>
<td>MAHSA</td>
<td>MAHSA for State Plan PCA LTCC in conjunction with MAHSA for EW LTCC for disability waiver services</td>
<td>MAHSA or MAHSA used in conjunction with LTCC form.</td>
</tr>
<tr>
<td>Coordination of State Plan PCA and Extended PCA Services</td>
<td>See DSPM</td>
<td>For persons over age 65 years remaining on FFS Waivers: EW (until 1-09): The county case manager uses the PCA Decision Tree along with the LTCC for determining State Plan PCA service amount. DD Waiver: The county PHN and county case manager use the PCA Decision Tree for determining State Plan PCA amount. CAC/CADI/TBI: The county case manager uses the Case Mix Grid for State Plan and Extended PCA.</td>
<td>MCO care coordinator or case manager uses the PCA Decision Tree to determine State Plan PCA service amount. Any balance in service need is then Extended PCA services.</td>
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