1 Background

SUMMARY

Medicaid Home and Community-Based Waiver programs provide alternative health care settings for Medicaid-eligible individuals who would otherwise need institutional care. Minnesota has five Medicaid Waiver programs for: Mental Retardation or Related Conditions, Community Alternative Care, Community Alternatives for Disabled Individuals, Traumatic Brain Injury, and the Elderly. The Mental Retardation or Related Conditions (MR/RC) Waiver program accounts for the majority of Minnesota's spending on waiver programs. Minnesota is a heavy user of the Medicaid Waiver for persons with mental retardation or related conditions, generally serving more individuals and spending more dollars per capita than the national average and most neighboring states. The Minnesota Department of Human Services plans to expand Consumer-Directed Community Supports, which allow waiver recipients and their families to direct their own care, because the option is currently available only for MR/RC Waiver recipients in certain counties.

Medicaid Waiver programs offer community alternatives to institutional care.

Medicaid Home and Community-Based Waiver programs provide an alternative to institutional care for Medicaid-eligible individuals. Minnesota's Medicaid Waiver programs apply to persons with long-term health care needs.[1]

This chapter answers the following questions:

- **What are the Medicaid Home and Community-Based Waiver programs, and how are they administered? What are their eligibility requirements, and what types of services do they cover?**
- **What does Minnesota spend on the Mental Retardation or Related Conditions (MR/RC) Waiver program, and how does Minnesota's spending compare with other states?**[2]
- **How have Minnesota's Medicaid Waiver programs, in particular the MR/RC Waiver program, changed in recent years?**

1 Although Minnesota refers to its Medicaid programs as "Medical Assistance," in this report we use the federal government's term "Medicaid" in all references to the Home and Community-Based Waiver programs.

2 Throughout this report, we refer to persons with "mental retardation or related conditions" because Minnesota Statutes use this language. Elsewhere around the country, the more commonly used term is persons with "developmental disabilities."

To answer these questions, we reviewed documentation and analyzed data provided by the Minnesota Department of Human Services, and we examined relevant state and federal laws. We surveyed county waiver administrators about Consumer-Directed Community Supports. In addition, we reviewed literature regarding waiver caseloads and expenditures around the country.

MEDICAID HOME AND COMMUNITY-BASED WAIVER PROGRAMS

In 1981, Congress amended Title XIX of the Social Security Act to permit the development of the Medicaid Home and Community-Based Services Waiver program.[3] The Medicaid Waiver program was initially created to reduce the growth of Medicaid spending.[4] Congress believed that serving persons in their homes and communities would be less costly than providing care in institutions. Under federal law, program costs are limited by restricting participation in the waiver program to only those individuals who would otherwise require institutionalization, such as in a hospital, nursing facility, or intermediate care facility for persons with mental retardation (ICF-MR).[5]

By law, average spending per recipient for Medicaid Waiver programs must be less than that for institutional care.

States have some flexibility in designing waiver programs, but approval by the federal Centers for Medicare and Medicaid Services requires states to meet certain requirements. For example, states must demonstrate cost-effectiveness, ensuring that the average annual spending per waiver recipient is no greater than the average spending per person in institutions.[6] Each state must provide for an evaluation of the individual applicants to determine whether they would require institutionalization. The plan for providing services must ensure recipients' health and welfare. As another example, funding provided through the program must not replace funding available through other sources, and states must exhaust other sources, such as a state's traditional Medicaid program or special-education services provided by school districts, before using waiver funding.

Medicaid Waiver program requirements differ from those of the traditional Medicaid plan in a number of respects. Medicaid is an entitlement program, meaning anyone eligible may receive services, whereas for the waiver programs, states must set a cap on the number of individuals who can participate.[7] In addition, Medicaid provides uniform services to eligible individuals throughout the state, while the waiver program allows a state to vary the types of services and

3 Omnibus Budget Reconciliation Act of 1981, *Pub. L.* 97-35, sec. 2176.

4 Steven Lutzky, Lisa Maria B. Alecxih, Jennifer Duffy, and Christina Neill, *Review of the Medicaid 1915(c) Home and Community Based Services Waiver Program Literature and Program Data* (Prepared for the Health Care Financing Administration of the Department of Health and Human Services under a contract through the Lewin Group, June 15, 2000), 2.

5 *42 CFR* subpart G, sec. 441.302 (c)(1), (October 1, 2003 edition).

6 *42 CFR* subpart G, sec. 441.303 (f)(1), (October 1, 2003 edition). A previous "cost-neutrality" requirement was more stringent, requiring states to demonstrate that 1) a bed in a Medicaid-certified institution was available or would be available for each waiver participant and 2) the average cost for waiver recipients was lower than the average institutional cost. See Lutzky, Alecxih, Duffy, and Neill, *Review of Waiver Program Literature*, 2.

7 *42 CFR* subpart G, sec. 441.303 (f)(6), (October 1, 2003 edition). Minnesota's cap for fiscal year 2004 is 16,715 or the number authorized by the Legislature.

individuals it serves. Furthermore, the waiver program allows for different financial eligibility requirements for certain populations in different areas of the state, as opposed to Medicaid, which requires use of the same standards throughout the state.[8]

States that comply with requirements receive federal funding for their waiver programs. Federal contributions for each state's waiver programs are determined yearly.[9] Historically, the federal share has accounted for slightly more than half of the total funding of the waiver programs in Minnesota. In fiscal year 2003, the federal government paid 50.7 percent of total expenditures for Minnesota's Medicaid Waiver programs, with the state paying the remainder.

Minnesota has five Medicaid Waiver programs targeted to separate groups of people.

The federal government grants waivers for an initial period of three years and may renew programs for five-year periods.[10] Currently, all states have at least one waiver program for Home and Community-Based Services. Minnesota has five separate Medicaid Home and Community-Based Waiver programs, as described in Table 1.1. These are: the Mental Retardation or Related Conditions Waiver, the Community Alternative Care Waiver, the Community Alternatives for Disabled Individuals Waiver, the Traumatic Brain Injury Waiver, and the Elderly Waiver.

Administering the Waiver Programs

Minnesota's Department of Human Services sets policy and oversees the use of the Medicaid Waiver programs while the state's 87 counties administer them.[11] The state determines how much waiver funding each county receives annually to operate the MR/RC Waiver program.[12] For all Medicaid Waiver programs, the department is responsible for assuring compliance with federal requirements, for proposing waiver changes to the Centers for Medicare and Medicaid Services when needed, and for applying to renew the waivers. The department administers the Medicaid Waiver programs' computerized billing system and offers training and education on the waiver programs to county staff, service providers, and others.

Minnesota's Department of Human Services oversees the Medicaid Waiver programs, but counties administer them.

The Department of Human Services sets maximum reimbursement amounts that counties may pay to providers for most of the services covered by the waiver programs. Counties negotiate rates with service providers within the state-set limits, although counties may petition to exceed the caps. The department has set standard, statewide reimbursement rates for day training and habilitation, which is an MR/RC Waiver program service offering training on vocational and life skills; it sets individual rates for each of the nonprofit day training and habilitation providers. Waiver services are described in more detail later in this chapter.

8 *42 U.S. Code*, sec. 1396n. (c)(3), (2000).

9 *42 U.S. Code*, sec. 1396d. (b), (2000). Based on a formula, states with lower per capita incomes receive greater percentages (within upper and lower limits) of federal funding than other states. In fiscal year 2004, the federal contribution in Minnesota is 50 percent.

10 *42 U.S. Code*, sec. 1396n. (c)(3), (2000).

11 Programs are administered by consortia for two groups of counties: 1) Lincoln, Lyon, and Murray counties and 2) Faribault and Martin counties.

12 The department plans to also set county budgets for the other waiver programs beginning in 2004, with the exception of the Elderly Waiver program.

Table 1.1: Minnesota's Medicaid Home and Community-Based Waiver Programs

Waiver Program and Year Started	Targeted Population
Elderly (1982)	People age 65 or older who require a nursing facility level of care.
Mental Retardation or Related Conditions (1984)	People with mental retardation or a related condition who require the level of care provided in an intermediate care facility for persons with mental retardation. Related conditions include cerebral palsy, epilepsy, autism, Prader-Willi syndrome, and any other condition other than mental illness or emotional disturbance that is related to mental retardation in its manifestation or the individual's level of functioning or required treatment.
Community Alternative Care (1985)	People who are chronically ill or medically fragile and who require a level of care provided at a hospital.
Community Alternatives for Disabled Individuals (1987)	People who are disabled and require a nursing facility level of care. Includes individuals with physical disabilities or mental illness.
Traumatic Brain Injury (1992)	People with a traumatic or acquired brain injury that is not congenital, who have significant cognitive and behavioral needs related to the injury, and who require the level of care provided in a specialized nursing facility or neurobehavioral hospital.

SOURCE: Minnesota Department of Human Services, *Health Care Programs Manual (Eligibility Policy) Chapter 0907* (St. Paul, November 2003); http://www.dhs.state.mn.us/HealthCare/reportsmanuals/manualcounty/chapter07.htm#0907.23; accessed December 18, 2003; and Michelle Long, Federal Relations, Health Care Administration, Department of Human Services, interview by author, Telephone conversation, St. Paul, Minnesota, December 12, 2003.

The Legislature restricts the number of new openings each year for the Mental Retardation or Related Conditions Waiver program.

For the MR/RC Waiver program in particular, the state controls both program budgets and the availability of new openings. The Department of Human Services sets county budget allocations annually. The Legislature has controlled the number of new openings available for eligible waiver program enrollees not living in an institution. These openings, called diversion allocations because they divert individuals from entering an institution, numbered 300 per year from 1999 through 2002. At the same time, conversion allocations, so called when individuals leave institutions and an institutional bed is "converted" to one in a community setting, have varied according to the demand for such relocations. There are no limits on the number of conversion allocations because money spent on institutional care transfers instead to community-based care; about 150 conversion allocations occur annually on average.

Counties play many roles in administering the waiver programs, from initially determining eligibility to coordinating service delivery. For persons with mental retardation or a related condition, the county human services agency determines applicants' eligibility using program-specific eligibility criteria (discussed later in this chapter). Once eligibility is determined, the county provides case management services and helps recipients develop individual service plans, which document the individual's needs and goals. County case managers work with each waiver recipient and his or her legal representative to determine the level of

care needed and the services to be provided.[13] By Minnesota Statutes, individual service plans must be tailored to a person's needs and goals.[14] Table 1.2 describes elements that these individual service plans must contain, including the recipients'

Table 1.2: Content Required in Individual Service Plans for Mental Retardation or Related Conditions Waiver Recipients, 2003

Individual service plans detail MR/RC Waiver recipients' needs and preferences for services.

- Preferences for services as stated by the person or the person's legal representative
- The person's service and support needs based on results of assessment information
- The person's long- and short-range goals
- Specific supports and services to be provided to the person based on available resources, and the person's needs and preferences
- Needed services that are not available and actions to obtain or develop these services
- Whether the provider needs to develop a plan to provide services to the recipient
- Additional assessments to be completed by the provider after initiating service
- A list of any information that providers must submit to the case manager, including how frequently it must be submitted as well as provider responsibilities to implement and make recommendations for modifying the individual service plan
- Notice of the right to request a conciliation conference or a hearing if a person is aggrieved or wishes to appeal an action or decision regarding the waiver program
- Signatures of the person, the person's legal representative, and the case manager at least annually and whenever changes are made
- A health professional's review of the plan if the person has overriding medical needs that impact the delivery of services

SOURCE: *Minn. Rules* (2003), ch. 9525.0024, subp. 3.

preferences for services. Another county responsibility is managing contracts with service providers and overseeing provider qualifications and performance. Counties must authorize services by specific providers for waiver recipients and enter recipient and service data into the department's computerized system. They must then ensure that waiver recipients receive the services listed in their plans of care. Counties are also responsible for managing the counties' allocations from the state to pay for the services.

Eligibility

In addition to being eligible for Medicaid, individuals applying to a Home and Community-Based Waiver program must meet a number of eligibility standards,

13 *Minn. Rules* (2003) ch. 9525.0024, subp. 2. Minnesota Statutes and administrative rules require counties to assemble a service planning team, consisting of the recipient, case manager, the recipient's legal representative or parent if the recipient is a minor, and a qualified mental retardation professional, who may be the case manager if appropriately qualified. See *Minn. Stat*. (2003) §256B.092, subd. 7 and *Minn. Rules* (2003) ch. 9525.0004, subp. 24.

14 *Minn. Stat*. (2003) §256B.092, subd. 1b (1)-(4).

as outlined in Table 1.3.[15] According to federal requirements, states with Home and Community-Based Waiver programs must review applicants' conditions to determine 1) whether they might presently or in the near future need the level of care provided by a hospital, nursing facility, or ICF-MR and 2) whether they would be institutionalized in such a facility unless they receive home or community-based services.[16] Similarly, for waiver programs targeted to individuals of 65 years of age or older, the federal government requires states to serve only people who 1) meet the age requirement, 2) are not inpatients of a hospital or nursing facility, and 3) would be likely to need the level of care furnished in a nursing facility.[17] Recipients must also meet requirements regarding age, Medicaid eligibility, and prescribed levels of care.[18] In addition, recipients of any of the Medicaid Waiver programs must make an informed choice to live in the community rather than an institution.

Services

Each of Minnesota's Medicaid Waiver programs offers its own set of services, although there is some crossover.

The Medicaid Waiver programs may provide services beyond those covered by Medicaid, including both medical and nonmedical services. The Social Security Act specifies the services that the waiver programs may cover.[19] In Minnesota, some services are extensions of traditional Medicaid services, such as occupational therapy and transportation services, while others are unique to the waiver programs. Service providers include for-profit and not-for-profit businesses and individuals; providers must enroll with the Department of Human Services and meet specific standards to bill the department and receive payment for services provided to waiver recipients.[20]

In Minnesota, six services are part of all five of the waiver programs. Services common to all are:

- case management (locating, coordinating, and monitoring social and daily living activities, medical services, and other services needed by a person and his or her family);

- homemaker services (providing general household activities by a trained homemaker when the usual homemaker is unable to do so);

---

15 Some families that are ineligible for Medicaid may have children enrolled in a Medicaid Waiver program because the child's eligibility is determined without regard to the parents' income or assets. Families pay a fee based on family size and the income schedule in *Minn. Stat.* (2003) §252.27, subd. 2a.

16 *42 CFR* subpart G, sec. 441.302 (c)(1) – (2), (October 1, 2003 edition). The code specifies that states should ascertain when there is a "reasonable indication that a recipient might need the [institutional] services in the near future (that is, a month or less) unless he receives home and community-based services."

17 *42 CFR* subpart H, sec. 441.351 (e), (October 1, 2003 edition).

18 In Minnesota, elderly individuals whose incomes or assets are too high to qualify for the Elderly Waiver may be eligible to receive some home and community-based services through Alternative Care, a state-funded, county-administered program for individuals over age 65 with limited income but not eligible for Medicaid. Policy changes by the 2003 Legislature, however, will shift many persons away from Alternative Care and toward the Elderly Waiver program.

19 *42 U.S. Code*, sec. 1396n. (c)(4)(B), (2000).

20 Providers of Consumer-Directed Community Supports include individuals who do not enroll with the department and are typically paid through fiscal agents.

Table 1.3: Eligibility Requirements for Minnesota's Medicaid Home and Community-Based Waiver Programs

	Level of Care	Age Requirement	Medicaid Financial Eligibility
Mental Retardation or Related Conditions	Person with mental retardation or related conditions requires 24-hour care and needs a level of care normally provided by ICFs-MR, but requests community care.[a]	Any age.	Must meet Medicaid financial requirements based solely on the individual's income and assets, disregarding income and assets of spouses or parents. Parents with incomes above 100 percent of federal poverty guidelines pay parental fees for their child's services.[b]
Community Alternatives for Disabled Individuals	Person with a certified disability needs a nursing facility level of care but requests community care.	Under age 65 at the time of screening. Clients who turn 65 are allowed to continue services if other eligibility factors are met.	Same as above.
Community Alternative Care	Person certified as disabled with a chronic illness needs a level of care normally provided in a hospital and would require frequent or continuous inpatient hospitalization over a year, but requests community care.	Under age 65 at the time of screening. Clients who turn 65 are allowed to continue services if other eligibility factors are met.	Same as above.
Traumatic Brain Injury	Person certified as disabled with a traumatic brain injury needs a level of care that is provided in a specialized nursing home or in a long-term neurobehavioral hospital, but requests community care.	Under age 65 at the time of screening. Clients who turn 65 are allowed to continue services if other eligibility factors are met.	Same as above.
Elderly	Person needs a level of care normally provided in a nursing facility but requests community care.	Age 65 years or older.	Must be eligible for Medicaid based on one of two income limits. People with monthly incomes at or below $1,692 are eligible without having to spend down their incomes but must pay for part of waiver services if incomes are above $752. Those above $1,692 are required to spend down.

[a]ICFs-MR are Intermediate Care Facilities for persons with Mental Retardation. State rules specify that an eligible person is either a resident of an ICF-MR or would be placed in one within a year. See *Minn. Rules* (2003) ch. 9525.1820, subp. 1.A.

[b]A federal option allows disabled individuals in families with middle and upper incomes to qualify for waiver programs on the basis of their own income and assets, without regard for a spouse's or parents' income and assets. Minnesota has adopted this option for the MR/RC, CADI, CAC, and TBI Waiver programs.

SOURCE: Minnesota Department of Human Services, *Health Care Programs Manual (Eligibility Policy) Chapter 0907* (St. Paul, November 2003); http://www.dhs.state.mn.us/HealthCare/reportsmanuals/manualcounty/chapter07.htm#0907.23; accessed December 18, 2003.

- equipment, home, or vehicle modifications (modifying equipment, homes, or vehicles, consistent with the person's disability, to help the person achieve greater independence);

- extended personal care assistant services (assisting with eating, bathing, dressing, personal hygiene, and other activities of daily living beyond the scope or variety of services available under the state's traditional Medicaid plan);

- respite care (providing short-term care in the home or out of it, when the usual caregiver is unavailable or needs a rest); and

- transportation (giving the person access to community services, resources, and activities tied to the person's needs and preferences as demonstrated in the plan of care).

Some services, such as respite care, are available through all of Minnesota's Medicaid Waiver programs.

Other services are available only for certain waiver programs. For example, extended prescription medication is covered only by the Community Alternative Care Waiver program; supported employment services are covered only by the Community Alternatives for Disabled Individuals, MR/RC, and Traumatic Brain Injury Waiver programs. Some services are unique to one waiver program; the MR/RC Waiver program covers 14 services that other waiver programs do not include. Two services unique to the MR/RC Waiver program are supported living and day training and habilitation. Supported living services are a set of related services that includes training and assistance in the areas of self-care, communication, interpersonal skills, sensory and motor development, money management, health care, community living, leisure and recreation, and the reduction of challenging behaviors. Typically, waiver recipients purchase these services as part of a bundle of services provided by foster care providers. Day training and habilitation includes training and assistance to help recipients develop vocational and daily life skills and become more involved in the community.

Minnesota's Medicaid Waiver programs pay for home modifications consistent with a person's disability.

Day training and habilitation, which offers assistance with vocational and daily life skills, is covered only by the MR/RC Waiver program.

Persons eligible for, but unable to obtain, MR/RC Waiver services may receive traditional Medicaid services. Medicaid provides services to meet the medical needs of its recipients, including physician and hospital care, personal care

services, and ICFs-MR. In addition, all individuals with mental retardation or a related condition seeking assistance are eligible to receive case management services and home care services and may also receive services through Family Support Grants, Consumer Support Grants, or Semi-Independent Living Services.[21]

WAIVER PROGRAM EXPENDITURES

In fiscal year 2003, Medicaid Waiver expenditures accounted for 21 percent of Minnesota's Medicaid spending.

Expenditures for Minnesota's Medicaid Home and Community-Based Waiver programs totaled $1 billion in fiscal year 2003, representing 21 percent of all Medicaid spending in the state. The MR/RC Waiver program had the largest enrollment and highest spending of the waiver programs, as shown in Table 1.4. The Community Alternative Care Waiver program had the smallest enrollment and expenditures.

Table 1.4: Minnesota's Medicaid Home and Community-Based Waiver Program Enrollment and Expenditures, FY 2003

Waiver Program	Average Monthly Enrollment	Expenditures
Mental Retardation or Related Conditions	14,677	$799,400,194
Elderly	9,644	93,973,690
Community Alternatives for Disabled Individuals	6,014	73,485,533
Traumatic Brain Injury	736	37,646,159
Community Alternative Care	132	7,556,016

SOURCE: Office of the Legislative Auditor, analysis of unpublished tables used in the Department of Human Services' November 2003 forecast.

The MR/RC Waiver program has the largest enrollment and highest spending among Minnesota's five Medicaid Waiver programs.

MR/RC Waiver Program Spending

Although the MR/RC Waiver program accounts for the majority of total waiver expenditures, most of the MR/RC Waiver program spending is concentrated in only a few service categories, as Table 1.5 shows. At 60 percent of total MR/RC spending in fiscal year 2002, supported living services were by far the most costly service type.[22]

21 Department of Human Services, *Bulletin 02-56-11*, (St. Paul, June 21, 2002), Attachment F. Semi-Independent Living Services include training and assistance services intended to help adults with mental retardation or related conditions remain in the community. Family Support Grants are state cash grants to families of children with mental retardation or related conditions. Both programs are for individuals not receiving MR/RC Waiver program services, but Semi-Independent Living Skills are not available to anyone needing a 24-hour plan of care including anyone eligible for the MR/RC Waiver program. Home care services include medical and health-related assistance with daily activities. Consumer Support Grants are state-funded cash grants for services, such as personal care attendants or assistive technology, intended to prevent persons with disabilities or illnesses from being placed out of their homes.

22 We focused on fiscal year 2002 data to ensure that expenditure data captured all or nearly all of providers' claims for services. Providers have up to one year to bill for services.

Table 1.5: Mental Retardation or Related Conditions Waiver Program Spending by Type of Service, FY 2002

Two services, supported living services and day training and habilitation, accounted for 75 percent of MR/RC Waiver spending in fiscal year 2002.

	Expenditures (in Millions of Dollars)	Percentage
Supported living services	$437	60%
Day training and habilitation	111	15
Consumer-Directed services	53	7
In-home services	37	5
Case management	24	3
Personal care	19	3
Respite care	12	2
Crisis respite care	8	1
Environmental modifications and adaptive technology	7	1
Other	15	2
Total	$725	100%

NOTE: Columns do not sum to totals due to rounding.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services' data on individual MR/RC Waiver recipients.

Day training and habilitation is the second largest category, representing 15 percent of total MR/RC Waiver program spending. Consumer-Directed Community Supports, a service that allows recipients greater control over their services and who provides them, made up 7 percent of total spending in fiscal year 2002, an increase from 1 percent or less of the total in previous years. In-home services, which include training of recipients and their families to increase their ability to care for recipients in their homes, represented 5 percent of waiver program spending that year. Other services each represented 3 percent or less of total MR/RC waiver spending.

Minnesota's combined spending on institutional and waiver care for persons with mental retardation or related conditions was fourth highest in the country in fiscal year 2002.

Comparison With Other States

Minnesota ranks among the highest spending states in expenditures for persons with mental retardation or related conditions.[23] In fiscal year 2002, Minnesota ranked fourth highest in the nation with $183 per state resident in combined spending for all of the MR/RC Waiver program, ICFs-MR, and state institutional care for persons with mental retardation or related conditions, compared with $103 nationally.

When we looked separately at spending on the Medicaid Waiver programs for persons with mental retardation or related conditions, Minnesota spent substantially more on a per state resident basis than most states. Table 1.6 shows that in fiscal year 2002, Minnesota spent $139 per capita on the MR/RC Waiver

23 K.C. Lakin, R.W. Prouty, and Gary Smith, eds., *Residential Services for Persons With Developmental Disabilities: Status and Trends Through 2002* (Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration, June 2003), 103. To make interstate comparisons, we combined spending on the MR/RC Waiver program (or its equivalent), ICFs-MR, and state institutional care for persons with mental retardation or related conditions. These figures do not include the cost of serving persons with mental retardation or related conditions in nursing homes, but Minnesota also has more such persons in nursing homes than the national average.

Table 1.6: Spending per Capita for Waiver Services and Institutional Care for Persons With Mental Retardation or Related Conditions, Minnesota Compared With Other States, FY 2002

State	Waiver Spending Per Capita	Institutional Spending Per Capita	Total Spending Per Capita	Total Spending Per Capita Rank
Minnesota	**$139**	**$ 44**	**$183**	**4**
National Average	46	56	103	-
Nearby States				
North Dakota	75	112	187	3
Iowa	43	100	143	10
South Dakota	77	49	126	14
Wisconsin	55	64	119	17

NOTE: Institutional spending excludes spending on nursing facilities. Minnesota uses the term "mental retardation or related conditions," whereas elsewhere the terms "intellectual disabilities" or "developmental disabilities" are more commonly used.

SOURCE: K.C. Lakin, R.W. Prouty, and Gary Smith, eds., *Residential Services for Persons With Developmental Disabilities: Status and Trends Through 2002* (Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration, June 2003), 103.

In fiscal year 2002, Minnesota's per capita spending on institutional care for persons with mental retardation or related conditions was 22 percent less than the national average due in part to the state's emphasis on community-based alternatives.

program, which was second highest in the nation and three times as much as the national average. At the same time, compared with the national average, Minnesota spent 22 percent less per capita on institutional care for persons with mental retardation or related conditions, reflecting the state's efforts to downsize institutions and substitute home and community-based settings.

Minnesota's MR/RC Waiver program serves a larger proportion of the state's population than do programs in most other states.[24] In fiscal year 2002, Minnesota's MR/RC Waiver recipients represented 0.29 percent of the state's population, more than twice the national average of 0.13 percent and ranking fifth in the nation. Among bordering states, Minnesota had a slightly lower rate than North Dakota and South Dakota, but its rate was significantly higher than rates in Wisconsin and Iowa.

In addition to caseload and expenditures, we compared Minnesota's array of MR/RC Waiver services to a sample of other states. A study conducted in 2000 compared, among other things, the types of waiver services offered in six different states.[25] We compared the services covered in Minnesota to those offered in these

24 Possible reasons for this difference include state administrative practices and eligibility requirements, greater public awareness, and the prevalence of mental retardation and related conditions in the states' population. It was beyond the scope of our report to identify specific reasons for the differences described above.

25 Charlie Lakin and Amy Hewitt, *Medicaid Home and Community-Based Services for Persons with Developmental Disabilities in Six States* (Prepared for the Health Care Financing Administration of the Department of Health and Human Services under a contract through the Lewin Group, 2000). The states were Indiana, Kansas, Louisiana, New Jersey, Vermont, and Wyoming; they represented a range of states from those with well-developed programs to others with programs still developing.

states. Minnesota offered at least 23 services compared with a range of 9 to 19 services in the other states, even though half of the states were included in the original sample because they offered a well-developed program.

RECENT CHANGES TO MINNESOTA'S MEDICAID WAIVER PROGRAMS

In 2003, the Legislature further restricted new openings for the MR/RC Waiver program and limited caseload growth for the Traumatic Brain Injury and Community Alternatives for Disabled Individuals Waiver programs.

The 2003 Legislature enacted changes limiting increases in enrollment and reducing spending for the Medicaid Home and Community-Based Waiver programs. The Legislature limited enrollment in the Community Alternatives for Disabled Individuals Waiver program to a maximum average caseload growth of 95 per month, and it capped the Traumatic Brain Injury Waiver program caseload growth at 150 per year of the biennium.[26] Another change to the MR/RC Waiver program prohibited allocating 300 diversion openings in each year of the 2004-05 biennium. The Legislature reduced county budgets to achieve a 1 percent reduction in MR/RC Waiver program spending. In addition, legislators reduced provider payment rates 1 percent for the Elderly Waiver program, as well as 1 percent for the Community Alternative Care, Community Alternatives for Disabled Individuals, and Traumatic Brain Injury Waiver programs to achieve a 1 percent reduction in state waiver program spending.

Open Enrollment

In 1999, the Legislature passed a law to reduce or eliminate the waiting list for the MR/RC Waiver program (3,300 persons at the time).[27] It increased funding to add an additional 100 persons (for a total of 300) to the waiver program each year. Further, the Legislature required the Department of Human Services to reallocate any waiver program money unused by persons wishing to leave ICFs-MR to other persons on the waiting list. Legislators also designated one-half of the increase in waiver program funding between fiscal years 2000 and 2001 toward serving persons other than those affected by ICF-MR closures. At about the same time, a report commissioned by the Department of Human Services raised concerns about the MR/RC Waiver program's long waiting list, among other issues.[28]

In response to the 1999 legislative requirements, the department instituted "open enrollment," a three-month period from late March through June of 2001 when the state opened the waiver program to all eligible applicants. Counties, waiver

26 *Laws of Minnesota* (1Sp2003), ch. 14, art. 13C, sec. 2, subd. 9 (f).

27 *Laws of Minnesota* (1999), ch. 245, art. 4, sec. 61, subd. 1 (a). The 2002 Legislature subsequently repealed the subdivision to reduce the waiting list. See *Laws of Minnesota* (2002), ch. 220, art. 14, sec. 20.

28 Amy Hewitt, Sheryl A. Larson, and K. Charlie Lakin, *An Independent Evaluation of the Quality of Services and System Performance of Minnesota's Medicaid Home and Community Based Services for Persons with Mental Retardation and Related Conditions, Executive Summary Report #55* (Minneapolis: University of Minnesota, College of Education and Human Development, Research and Training Center on Community Living, Institute on Community Integration, November 2000), 55. Other recommendations addressed concerns about the need for alternatives to foster care provided by corporations rather than individuals, the shortage and turnover of direct support staff, and a need to improve the system for monitoring and assuring quality of services.

The 2001 open enrollment for the MR/RC Waiver program significantly increased the program's caseload.

program applicants, their families, and advocates for persons with developmental disabilities responded in an unprecedented fashion to inform and then enroll eligible individuals. About 5,500 new recipients enrolled according to the department, more than a 50 percent increase in the caseload.[29] Many of the children currently served by the MR/RC Waiver program joined the program during open enrollment. In fiscal year 2002, some 3,500 children, about two-thirds of whom started during open enrollment, were enrolled in the MR/RC Waiver program.

Consumer-Directed Community Supports

In late 1997, the Department of Human Services received federal approval to add to the MR/RC Waiver program a component called Consumer-Directed Community Supports. With Consumer-Directed services, waiver recipients take direct responsibility for planning and managing their care. They have the option of choosing what services to purchase and whether to use informal providers such as neighbors or family. Participants in Consumer-Directed Community Supports have access to certain services that neither Medicaid nor the regular waiver program covers. According to our survey, 33 counties offered Consumer-Directed services in 2003 (although in 5 counties, no waiver recipients used the services.) Counties have been operating the Consumer-Directed option using procedures spelled out in memoranda of understanding that each county individually developed and had approved by the department.

Consumer-Directed Community Supports allow MR/RC Waiver recipients in certain counties to control their services and who provides them.

In line with a 1999 U.S. Supreme Court decision, the intent of Consumer-Directed services is to individualize services and give waiver recipients greater control over them. In the 1999 ruling on the Olmstead v. L.C. case, the U.S. Supreme Court said that services for persons with mental disabilities should be provided in the most integrated setting appropriate to the needs of the person.[30] Increasing waiver recipients' self-reliance is one of the Minnesota Department of Human Services' objectives for Consumer-Directed

Services for persons with mental disabilities are to be provided in the most integrated setting appropriate to the needs of the person.

29 Minnesota Department of Human Services, *Programs for Persons with Disabilities: Fact Sheets* (St. Paul, November 2002), 2.

30 Centers for Medicare and Medicaid Services, *Americans with Disabilities Act/Olmstead Decision* (Baltimore: Centers for Medicare and Medicaid Services, May 10, 2002); cms.hhs.gov/olmstead/default.asp; accessed December 2, 2003.

services, along with increasing consumer control and choice and improving access to formal and informal resources.[31]

The Department of Human Services awaits federal approval of a proposal to expand the Consumer-Directed option statewide and to use it in other Medicaid Waiver programs.

Since 1998 when Consumer-Directed services first became available in Minnesota, expenditures for these services have expanded dramatically, from just over $44,100 in fiscal year 1998 to nearly $53 million in fiscal year 2002. By fiscal year 2002, counties authorized 3,024 individuals to receive Consumer-Directed services, accounting for 20 percent of all MR/RC Waiver recipients.

In 2001, the Legislature directed the department to expand Consumer-Directed services, and the department plans to make them available in every county.[32] The department has been negotiating a proposal for Consumer-Directed services with the federal Centers for Medicare and Medicaid Services, submitted it for final approval in December 2003, and expects to implement it in 2004. The proposal would also extend Consumer-Directed services to the other Home and Community-Based Waiver programs. When implemented, the redesigned Consumer-Directed services for the MR/RC Waiver program will be available initially only in those counties that have previously offered Consumer-Directed services; as experience with the program increases, other counties will offer the option.

31 Minnesota Department of Human Resources, "The Shift to Increased Consumer Control," *Consumer Directed Community Supports Tool Kit* (St. Paul, 2003), 3.

32 *Laws of Minnesota* (1Sp2001), ch. 9, art. 3, sec. 43.