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OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

EVALUATION REPORT

Medicaid Home and Community-Based Waiver Services for Persons With Mental Retardation or Related Conditions

FEBRUARY 2004

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February 18, 2004

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Minnesota's Medicaid Home and Community-Based Waiver programs provide alternatives to institutional care for certain Medicaid-eligible persons and cost about $1 billion in fiscal year 2003. The programs have expanded significantly over the years, with annual rates of growth averaging 23 percent since 1991. The Department of Human Services oversees Minnesota's five Medicaid Waiver programs, and counties administer them. Because of concern over spending increases and questions about variation in county expenditures and practices, the Legislative Audit Commission directed the Office of the Legislative Auditor to evaluate Minnesota's Medicaid Waiver programs. We started the evaluation in June 2003.

We identified problems with the Department of Human Services' method of allocating funds for the Mental Retardation or Related Conditions (MR/RC) Waiver program, which is the largest of Minnesota's Medicaid Waiver programs. The department should improve how funding is distributed among counties. We found that the department lacks sufficient controls over the component of the MR/RC Waiver program known as Consumer-Directed Community Supports, which allow waiver recipients greater control over their services. To ensure appropriate spending, the department should implement additional safeguards.

This report was researched and written by Jody Hauer (project manager), Dan Jacobson, Jan Sandberg, and Todd Wilkinson. Department of Human Services' staff and county waiver personnel provided full cooperation with our work.

Sincerely,

/s/ James Nobles

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- During the past 12 years, total spending on Minnesota's five Medicaid Home and Community-Based Waiver programs grew at an average annual rate of 23 percent, far higher than inflation and population growth. Caseload growth was the primary factor driving costs (p. 18).
- Average annual costs per recipient for services under the Mental Retardation or Related Conditions (MR/RC) Waiver program have consistently been lower than costs per recipient for institutional care. But, savings achieved by shifting recipients from institutions to the MR/RC Waiver program have been more than offset by increased spending due to large caseload growth in the waiver program (p. 25).
- The large number of children currently enrolled in the MR/RC Waiver program and the numbers of people waiting for MR/RC Waiver services will likely add pressure for increased spending (p. 36).
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- The Department of Human Services lacks sufficient controls over Consumer-Directed Community Supports, leading to questionable purchases, inequitable variation in administration, and unmet prospects for cost efficiencies (p. 42).
- Counties generally follow state rules on determining and updating MR/RC Waiver recipients' needs in a timely way and ensuring the availability of services, but there are exceptions (p. 53).

Recommendations:

- The Department of Human Services should modify its method of allocating MR/RC Waiver funds to 1) avoid incentives that encourage counties to spend to their budget limits and 2) improve the distribution of funding to counties by better reflecting the needs of waiver caseloads (p. 34).
- The department should set additional controls to ensure appropriate spending of Consumer-Directed Community Support funds. Before expanding Consumer-Directed services statewide, the department should first evaluate how well its proposed controls work (pp. 50-51).
- When the department reviews how counties administer Medicaid Waiver programs, it should evaluate county compliance with state rules governing the MR/RC Waiver program (p. 58).

Report Summary

Expenditures for Medicaid Waiver programs grew rapidly as state policies encouraged community alternatives to institutions.

Medicaid Home and Community-Based Waiver programs, which are granted by the federal government, allow the state to use Medicaid money to fund services in alternative settings for people who would otherwise receive care in hospitals, nursing facilities, or intermediate care facilities. Minnesota has five waiver programs targeted to separate populations: 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. Minnesota's Department of Human Services oversees the waiver programs, but counties administer them. The waiver programs allow recipients to receive medical and nonmedical services beyond those covered by traditional Medicaid.

Expenditures for Minnesota's five waiver programs totaled $1 billion in fiscal year 2003, which is about 21 percent of all Medicaid spending in the state. About 79 percent of waiver expenditures were for the Mental Retardation or Related Conditions (MR/RC) Waiver program. Minnesota spends more per capita than most other states on waiver programs and institutional care for persons with mental retardation or related conditions.

Average annual costs of the MR/RC Waiver program have been less than those for institutional care, but caseload increases have more than offset savings.

The MR/RC Waiver program has changed substantially in the last few years. In 1998, the state introduced "Consumer-Directed Community Supports" in certain counties. This option allows recipients and their families to select their services and employ informal care providers such as friends and family members. In addition, the MR/RC Waiver program's caseload jumped more than 50 percent in 2001 following an "open enrollment" period used to reduce the program's long waiting list. However, due to that surge in program enrollment and subsequent state budget problems, the department reduced the rate of growth in counties' MR/RC Waiver budgets in 2003. The department also changed the way it allocates waiver funds to counties, by basing budgets on prior-year spending. Lawsuits filed in early 2003 limited counties' options for cutting spending, making it more difficult to manage tighter budgets.

Medicaid Waiver Expenditures Grew Far Faster Than Inflation

Expenditures for the state's Medicaid waiver programs increased from $82 million in fiscal year 1991 to about $1 billion in 2003, an average increase of 23 percent per year. This far exceeds an average inflation rate of 3 percent and general population growth of 1 percent. The rapid growth reflects state policies that promote community alternatives to institutional care.

Caseload growth was the primary cost driver. Enrollment growth rates for the five programs over the past 12 years ranged from 7 to 30 percent annually. Average costs per waiver recipient grew slower than caseloads but faster than inflation for all but the smallest of the waiver programs (Community Alternative Care Waiver). For the MR/RC Waiver program, average costs per recipient outpaced inflation due in part to increases in average provider reimbursement rates and an expansion of services.

MR/RC Waiver Caseload Growth Has More Than Offset Savings From Replacing Institutional Care

Each year since the MR/RC Waiver program began, its average costs per recipient have been less than costs per recipient for institutional care. For

example, in fiscal year 2002 the average annual cost of medical services and group residential housing was $55,449 per MR/RC Waiver recipient, while the average cost of institutional care for persons with mental retardation or related conditions was $76,977 per recipient. To the extent that waiver programs replaced institutional care, the state saved money. However, these savings were more than offset by cost increases resulting from rapidly expanding MR/RC Waiver enrollments. The growth in waiver caseloads exceeded the decline in institutional caseloads by a ratio of 4 to 1 between fiscal years 1991 and 2003.

Pressures for Increased Spending Will Continue

Limiting access to the MR/RC Waiver program helps control spending but creates equity concerns.

The Legislature controls overall spending on the MR/RC Waiver program by setting the number of new openings the program will have each year. In addition, the Department of Human Services controls spending when it sets counties' MR/RC Waiver budgets, which counties may not exceed unless they pay for the excess.

Pressures to increase spending on the MR/RC Waiver program are likely to continue for two reasons. First, as the large numbers of children currently enrolled in the waiver reach an age when they may leave the care of their families, there will be pressure to accommodate their more independent (and costly) living arrangements. Second, growing waiting lists will continue to exert pressures to expand access to the program.

Addressing these budget pressures poses difficult policy choices. Appropriating more money to a program that has recently experienced significant spending growth would be difficult. But alternatives, such as spending less per recipient by limiting the array of services that the MR/RC Waiver program covers, could result in unmet needs for some waiver recipients.

The Method for Allocating MR/RC Waiver Funds Needs Improvement

The Department of Human Services' method for allocating MR/RC Waiver funds to counties is based on prior-year spending, which creates an incentive for counties to spend to the maximum level. Plus, it does not fully reflect the relative needs of waiver recipients, raising concerns that the method does not distribute funds to counties in proportion to their caseloads' needs.

When recipients fill new openings in the waiver program, the department assigns the recipients one of four "profiles" based on criteria such as their functioning level and behavioral challenges. Each of the four profiles has a different funding amount. But the profiles do not account for large cost differences between living at home and in foster care; nor do they account for other factors that clearly influence costs.

The Department of Human Services should change its method of allocating MR/RC Waiver funds to counties to better reflect characteristics of caseloads and differences in key factors, such as living arrangement, that drive costs. Waiver recipients' age correlates strongly with living arrangement and could be used in the methodology. In addition, the method should avoid incentives to spend to the limit and reduce administrative burdens on counties.

Services funded through Consumer-Directed Community Supports vary among counties offering them.

Consumer-Directed Community Supports Need Additional Controls

The Department of Human Services lacks sufficient controls over Consumer-Directed Community Supports, a component of the MR/RC

Waiver program that gives recipients and their families greater control over their choice of services and care providers. Presently, only 33 counties offer Consumer-Directed services to MR/RC Waiver recipients, although the department has submitted a proposal to the federal government to expand the program statewide and cover the other four Medicaid Waiver programs.

Not all Consumer-Directed purchases in the past year appeared justified when we reviewed case files in 12 counties. For example, we found instances in which Consumer-Directed funds paid for questionable items, such as Internet connectivity fees and tickets to Minnesota Wild games. In our review, we noted purchases that were unusual by type or amount, and although most items were related to needs articulated in individual service plans, about 11 percent were not connected to any stated recipient need.

Lacking sufficient state controls, counties' administration of Consumer-Directed services has varied around the state. Some items allowed in one county are forbidden in another, which raises equity concerns. Also, recipients and their families in many counties decide whether to use Consumer-Directed services, but in some counties, they are involved very little, if at all, in deciding to use the program, which undermines an objective of consumer direction. Five of the counties offering Consumer-Directed services reported that they do not have policies to terminate use when problems occur. In addition, even though the Consumer-Directed option offers opportunities for achieving efficiencies, we found that MR/RC Waiver spending on Consumer-Directed participants was higher than spending on other MR/RC Waiver recipients with similar characteristics.

The department should set additional controls to ensure appropriate spending of Consumer-Directed funds.

The Department of Human Services should set additional controls to ensure equitable and appropriate spending of Consumer-Directed funds. Although the department's pending proposal to change Consumer-Directed services does offer more guidance, additional questions are likely to arise, including what factors counties should consider when deciding among various proposed expenses. Once the department receives federal approval to revise the program, it plans to phase in implementation, starting with the counties that currently offer Consumer-Directed services. The department should evaluate its proposed controls for Consumer-Directed Community Supports in these counties before implementing the program statewide.

Counties Generally Follow State Rules for the MR/RC Waiver Program, But There Are Exceptions

State rules require counties to take certain steps when determining and updating waiver recipients' needs. For instance, although the state requires counties to update each recipient's individual service plan annually, we estimated that 6 percent of the case files in 12 counties we visited lacked an up-to-date service plan or similar document. State rules also require case managers to visit each waiver recipient at least semiannually. In the counties we visited, 40 percent of the waiver recipients or their families had fewer than two face-to-face visits with case managers in the past year, and 17 percent had no meeting.

In 2004, the Department of Human Services plans to formally review how counties administer the Medicaid Waiver programs. In conducting the reviews, the department should specifically evaluate county compliance with practices required in state rules for the MR/RC Waiver program.

Introduction

Medicaid program waivers, which are granted by the federal Centers for Medicare & Medicaid Services, allow the state to use Medicaid money to fund services in alternative settings for Medicaid-eligible people who would otherwise receive care in hospitals, nursing facilities, or intermediate care facilities. Since 1982, when the waiver programs began in Minnesota, eligible persons have increasingly chosen home and community-based settings over institutions.

The Medicaid Waiver program for persons with mental retardation or related conditions is by far the largest of Minnesota's five waiver programs and the only one currently with a waiting list.

Minnesota has five Home and Community-Based Waiver programs, each targeted to different populations. By far the largest is the Mental Retardation or Related Conditions (MR/RC) Waiver program. Because of a long waiting list of persons eligible for MR/RC Waiver services, the 1999 Legislature directed the Department of Human Services to reduce the size of the list. The department opened enrollment to all eligible persons for a three-month period in 2001, resulting in about a 50 percent increase in MR/RC Waiver program recipients that year alone. Shortly after this enrollment surge, the state's budget situation deteriorated. To manage waiver expenditures during a time of tight resources, the 2003 Legislature discontinued new openings in the MR/RC Waiver program, and the department changed its method for allocating MR/RC Waiver funds.

Although the state oversees the waiver programs, counties administer them. Questions about variation in counties' expenditures and practices, combined with concern about the current waiting list and the department's response to forecasted growth in spending, led to legislative interest in more information on the MR/RC Waiver program. In June 2003, the Legislative Audit Commission directed the Office of the Legislative Auditor to evaluate the Medicaid Home and Community-Based Waiver programs, in particular the waiver for persons with mental retardation or related conditions. Our evaluation addressed the following questions:

- **How much does Minnesota spend on the Medicaid Home and Community-Based Waiver programs? What factors drive spending?**

- **How well does Minnesota's system for allocating MR/RC Waiver program resources to counties work?**

- **Does the state have sufficient controls to ensure that funds are spent appropriately for the component of the MR/RC Waiver program known as Consumer-Directed Community Supports (which allow waiver recipients greater control over their care and service providers)?**

To answer these questions, we analyzed Department of Human Services' data on caseloads, spending, and forecasted growth. We also analyzed data on

characteristics of individual MR/RC Waiver recipients and their waiver spending. We interviewed department personnel as well as county personnel in charge of administering waiver programs. For additional information on counties' administrative practices, we surveyed county MR/RC Waiver program administrators. For a broader set of perspectives, we interviewed representatives from organizations that advocate on behalf of recipients, and we surveyed advocacy organizations and associations of providers. We also reviewed 267 randomly selected case files from 12 counties offering Consumer-Directed Community Supports.

We did not evaluate the quality of care that Medicaid Waiver recipients receive. Nor did we assess questions about how well counties determine eligibility for the Medicaid Waiver programs.

Chapter 1 of this report provides background information on the Medicaid Home and Community-Based Waiver programs in general and the MR/RC Waiver program in particular. In Chapter 2, we examine spending and caseload trends for Medicaid Waiver programs and for institutional care. We also discuss funding issues for the MR/RC Waiver program. Chapter 3 focuses exclusively on the MR/RC Waiver program and evaluates controls intended to ensure appropriate MR/RC Waiver spending as well as county compliance with select state rules.

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);

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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.

2 Waiver Spending and Funding

SUMMARY

Minnesota's spending on Medicaid Home and Community-Based Waiver programs has increased at an average annual rate of 23 percent during the past 12 years, far above the rate of inflation. Although cost per recipient increased faster than inflation in the four largest Medicaid Waiver programs, caseload growth has been the primary cost driver. The Mental Retardation or Related Conditions (MR/RC) Waiver program has a lower average cost per recipient than institutional care, but these savings have been more than offset by increased spending due to caseload growth, particularly during the 2001 open-enrollment period. Minnesota allocates MR/RC Waiver funds to counties based on prior-year spending, giving counties an incentive to spend to their budget limits. In addition, the allocation method only partially reflects the needs of waiver recipients, raising equity concerns that funds are not distributed to counties in proportion to their recipients' needs. We recommend that the Department of Human Services modify its method of allocating funds to counties to 1) avoid incentives that encourage counties to spend to their budget limits and 2) improve the distribution of funding to counties by better reflecting the needs of each county's MR/RC Waiver caseload. Demographic factors and waiting lists will likely add pressure for increasing MR/RC Waiver program spending. The state's policy of limiting access to the program helps control spending but raises equity concerns.

Medicaid Home and Community-Based Waiver programs were intended to be less costly than institutional care.

Medicaid Home and Community-Based Waiver programs were originally designed to help control rising Medicaid costs while also providing community alternatives to institutional care. In this chapter, we explore the extent to which increasing reliance on the waiver programs has actually resulted in savings for Minnesota. Specifically, we address the following questions:

- **How much does Minnesota spend on Medicaid Waiver programs? How have waiver program expenditures changed compared with inflation and population growth?**
- **What factors drive spending on Minnesota's waiver programs?**
- **Have waiver programs resulted in lower spending per recipient and lower overall state spending?**

- **How well does Minnesota's method for allocating resources to the Mental Retardation or Related Conditions Waiver program work?**
- **How are spending and caseloads forecasted to change?**
- **What are the main policy options for controlling the MR/RC Waiver program spending?**

To answer these questions, we obtained spending and recipient data from the Department of Human Services for each of the Medicaid Waiver programs. We obtained similar data for institutional care under Medicaid, including intermediate care facilities for persons with mental retardation, state regional treatment centers, and nursing homes. We analyzed the Mental Retardation or Related Conditions Waiver program in more depth, using individual data on recipient characteristics. Finally, we reviewed a sample of case files for MR/RC Waiver recipients who received Consumer-Directed Community Supports.[1]

SPENDING TRENDS

Overall expenditures for the Medicaid Waiver programs increased from $82 million in fiscal year 1991 to about $1 billion in 2003, an average increase of 23 percent per year.[2] In comparing this rate of increase with inflation rates and population growth, we found:

- **During the past 12 years, overall Medicaid Home and Community-Based Waiver expenditures grew at rates far higher than inflation and population growth rates.**

Rapid growth in Minnesota's Medicaid Waiver programs reflects state policies to encourage community alternatives to institutions.

As Figure 2.1 shows, the four largest Medicaid Waiver programs (the Mental Retardation or Related Conditions Waiver, the Elderly Waiver, the Community Alternatives for Disabled Individuals Waiver, and the Traumatic Brain Injury Waiver) grew at annual rates of more than 20 percent per year, much higher than the average annual inflation rate of 3 percent and population growth of 1 percent. In contrast, the Community Alternative Care Waiver, the smallest waiver program, grew by an average of just 2 percent per year, a rate that was less than inflation. Table 2.1 lists the spending trends for each program.

This rapid growth in spending on waiver programs reflects the state policy to promote less expensive community alternatives to institutional care. Later in this chapter we examine trends in institutional spending and address the extent to which the increased spending on the waiver programs resulted in cost savings for the state.

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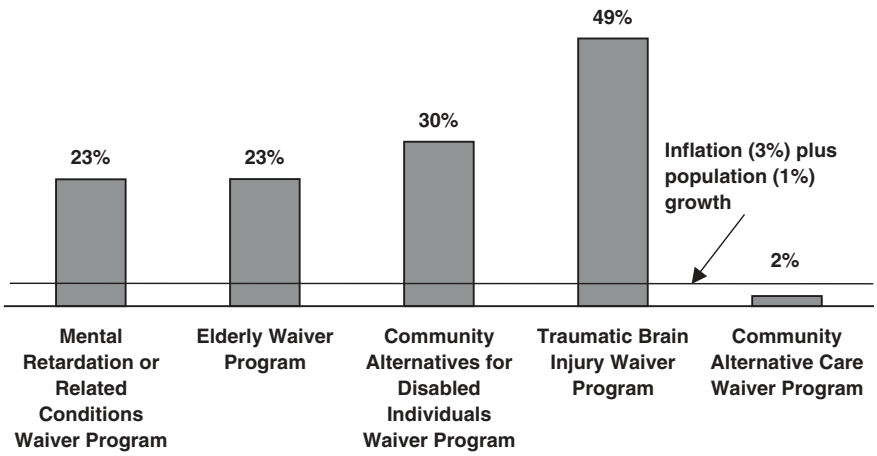
1 Additional details on the methodologies we followed are available on-line at www.auditor.leg.state.mn.us/ped/2004/pe0403.htm.

2 These figures were not adjusted for inflation.

Figure 2.1: Average Annual Rates of Change in Medicaid Waiver Program Expenditures, FY 1991-2003



Expenditures on Minnesota's four largest Medicaid Waiver programs grew at average annual rates of 23 to 49 percent over the past 12 years.

NOTE: The rate for the Traumatic Brain Injury Waiver program is based on the change from fiscal years 1994 to 2003 because this waiver program did not start until 1992.

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

Table 2.1: Expenditures on Medicaid Waiver Programs for Select Years Between FY 1991-2003 (In Millions of Dollars)

Fiscal Year	Mental Retardation or Related Conditions Waiver Program	Elderly Waiver Program	Community Alternatives for Disabled Individuals Waiver Program	Traumatic Brain Injury[a] Waiver Program	Community Alternative Care Waiver Program	Total
1991	$ 65	$ 8	$ 3	—	$ 6	$ 82
1994	129	14	6	$ 1	10	161
1997	252	24	12	7	9	305
2000	412	43	24	14	5	498
2001	508	58	30	18	5	619
2002	702	74	44	25	6	851
2003	799	94	73	38	8	1,012

NOTE: Rows may not sum to totals due to rounding.

[a]The Traumatic Brain Injury Waiver program began in 1992.

SOURCE: Department of Human Services, Reports and Forecasts Division, unpublished tables used in November 2003 forecast.

FACTORS THAT AFFECT WAIVER SPENDING

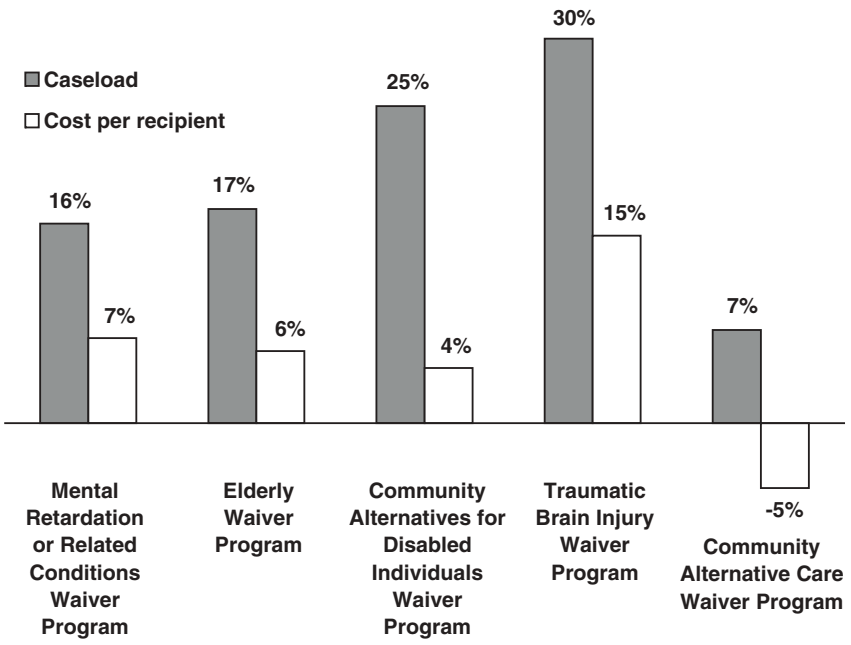
For each waiver program, we broke down cost increases between 1991 and 2003 into two components: caseload growth and increases in cost per recipient. We found that:

- **Although waiver program costs per recipient increased faster than inflation, caseload growth was the primary cost driver for Minnesota's Medicaid Home and Community-Based Waiver programs between fiscal years 1991 and 2003.**

As Figure 2.2 shows, annual enrollment growth rates were substantially higher than the average annual growth rates in cost per recipient. Among the four largest waiver programs over the past 12 years, average annual enrollment growth rates ranged from 16 percent for the MR/RC Waiver program to 30 percent for the Traumatic Brain Injury (TBI) Waiver program.[3] For the smallest waiver program

Caseloads for Minnesota's Medicaid Waiver programs grew faster than costs per recipient since fiscal year 1991.

Figure 2.2: Average Annual Rates of Change in Caseload and Cost per Recipient by Waiver Program, FY 1991-2003



NOTE: The rates for the Traumatic Brain Injury Waiver program are based on the change from fiscal years 1994 to 2003 because this waiver program did not start until 1992.

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

3 We measured enrollment using average monthly enrollment. Because the TBI Waiver program did not begin until 1992, we used the average annual growth rate between fiscal years 1994 and 2003.

(Community Alternative Care or CAC), enrollment grew by an average of 7 percent per year.

Changes in eligibility requirements added to caseload growth.

For three of the waiver programs, administrative and eligibility changes contributed to enrollment spikes. Although enrollment growth continued throughout this 12-year period, the Community Alternatives for Disabled Individuals (CADI), TBI, and MR/RC Waiver programs had unusually large enrollment increases in recent years. For example, enrollment in the CADI Waiver program increased by 43 percent from fiscal years 2002 to 2003. A few years ago, the Department of Human Services clarified for counties that people with mental illness who were certified disabled and at risk of nursing home placement were eligible for the CADI Waiver program. After the department clarified this policy and provided training for counties, enrollment increased at a faster rate. This suggests that it was the administrative change, not an increase in prevalence, that led to the higher rate of increase. Similarly, enrollment in the TBI Waiver program grew 49 percent between fiscal years 2002 and 2003. According to the department, three changes contributed to this increase, including: (1) allowing persons with degenerative brain injuries to be eligible for the TBI Waiver program, (2) moving control over TBI Waiver program entry from the state to the counties, and (3) increasing demand in the community to move disabled persons under age 65 out of nursing homes. For the MR/RC Waiver program, following annual growth rates averaging 13 percent between fiscal years 1991 and 2000, enrollment increased by 53 percent between fiscal years 2001 and 2002. As discussed in Chapter 1, this dramatic growth was due in large part to open enrollment.

Although caseload growth was the primary cost driver, average cost per recipient increased faster than inflation for the four largest waiver programs. Between fiscal years 1991 and 2003, average costs per recipient grew at annual rates of about 4 to 7 percent for the MR/RC, Elderly, and CADI Waiver programs and about 15 percent for the TBI Waiver program. This compares to a 3 percent annual inflation rate during that same time span. In contrast, the average cost per recipient for the CAC Waiver program declined by 5 percent per year.

For the MR/RC Waiver program, we examined additional factors contributing to cost increases. We found:

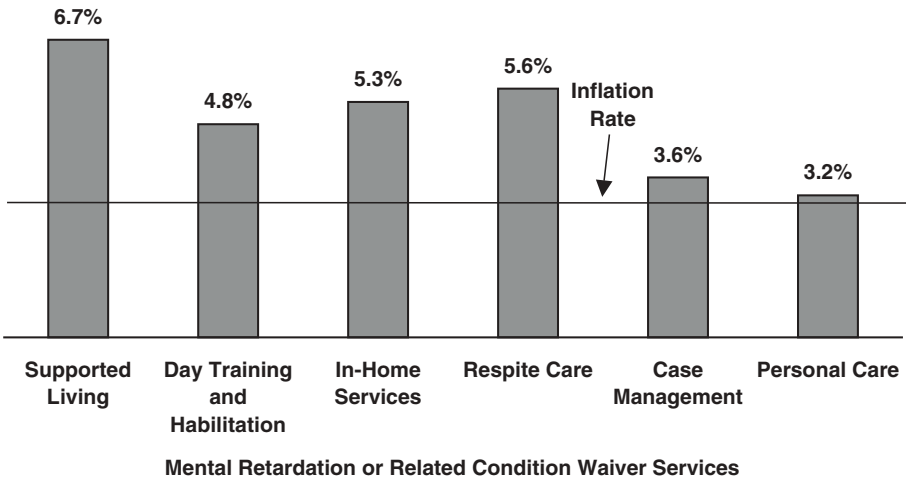
- **Increases in average rates paid to providers and expansion of services contributed to the growth in average costs per MR/RC Waiver recipient.**

Between fiscal years 1995 and 2002, average provider reimbursement rates generally increased faster than inflation.

Average provider reimbursement rates for MR/RC Waiver services tended to increase faster than inflation between 1995 and 2002, as Figure 2.3 shows. For instance, rates paid for supported living services (the largest sector of MR/RC Waiver spending) grew at an average annual rate of nearly 7 percent during this time period. Average annual rate increases for other services were between 3 and 6 percent.

The array of services covered by the MR/RC Waiver program expanded during this period, which also contributed somewhat to growth in spending. In 1998, the MR/RC Waiver program added or expanded several services, including Consumer-Directed services, transportation services, extended personal care

Figure 2.3: Average Annual Provider Reimbursement Rate Increases by Type of Service in the Mental Retardation or Related Conditions Waiver Program, FY 1995-2002



NOTE: The increase in rates for supported living services is based on fiscal years 1995 to 2001 because fiscal year 2002 rates are not comparable to rates from previous years.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services' data on MR/RC Waiver program spending by type of service.

attendant services, chore services, and live-in caregiver expenses. As we describe in Chapter 3, our analysis of a sample of 168 Consumer-Directed cases found that 11 percent of the Consumer-Directed services were not typically funded by the MR/RC Waiver program. If these new services were used by the statewide Consumer-Directed caseload in the same proportion as in our sample, the cost of these new services would have been about $5.7 million in fiscal year 2002. The other services added in 1998 accounted for about $1.2 million in fiscal year 2002.

Average daily costs in fiscal year 2002 for MR/RC Waiver recipients living at home were about one-third of those for recipients in nonfamily foster care.

We also examined individual characteristics that affected MR/RC Waiver spending. We found that:

- **The MR/RC Waiver recipient's living arrangement affected spending more than other recipient characteristics.**

Average costs for recipients living at home were $72 per day, compared with $204 per day for recipients living in nonfamily foster care. Other factors that had smaller effects on spending include the degree of mental retardation, medical needs, behavior problems, size of county, and time of enrollment (whether or not recipients enrolled during the 2001 open-enrollment period). Table 2.2 shows how average daily spending varied by these individual characteristics during fiscal year 2002.

Table 2.2: Average Spending per Day for the Mental Retardation or Related Conditions Waiver Program, by Individual Characteristics, FY 2002

	Number of Recipients	Average Spending Per Day
Living Arrangement		
Home	6,375	$ 72
Family foster care	764	104
Nonfamily foster care	6,629	204
Recipient Age		
0-16	3,455	84
17-21	1,621	103
22-29	2,285	142
30-39	2,426	163
40-49	2,232	171
50 or older	2,544	173
Diagnosis		
Mild mental retardation	5,170	121
Moderate mental retardation	3,920	127
Severe mental retardation	2,171	168
Profound mental retardation	1,445	222
Related conditions	1,322	107
Under 5 years of age with probable mental retardation	533	80
Profile of Recipients' Functional Characteristics[a]		
Profile 4	3,150	99
Profile 3	5,812	132
Profile 2	4,036	161
Profile 1	1,565	172
Aggressive Physical Behavior[b]		
None	7,461	120
Mild	3,238	141
Moderate	2,045	153
Severe	1,209	172
Very severe	599	199
Medical Needs		
No serious/specialized needs	3,342	105
Needs specialized medical attention in-office	9,561	137
Needs on-call medical attention	989	198
Needs on-site medical attention, but less than 24 hours per day	502	210
Needs on-site medical attention 24 hours per day	164	206
Time of Enrollment in Waiver		
During open enrollment	5,268	74
Not during open enrollment	9,295	173
Size of County		
Small	4,116	126
Medium-sized	1,985	129
Large	8,455	144
Total	14,563	137

NOTE: The table includes recipients who received services for at least six months in fiscal year 2002. Total number of recipients varies by characteristic because of missing data.

[a]Profiles rank recipients from 1 to 4 with Profile 1 reflecting high needs and Profile 4 reflecting relatively low needs.

[b]Aggressive physical behavior is one of nine behavior scales used on the Department of Human Services' screening document used to document waiver recipients' needs.

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

The department assigns MR/RC Waiver recipients into one of four profiles associated with recipients' service needs.

Average spending also varied by recipients' "profile." Based on recipients' functional characteristics, the department assigns recipients into one of four profiles that are designed to correlate with recipients' service needs. Profile 1 reflects high self-care needs and/or obstructive behavior, and Profile 4 reflects limited self-care needs and no major behavior problems. As we discuss later in this chapter, profiles are used to allocate part of the MR/RC Waiver program funds to counties.

While spending also varied by recipient's age, this is explained by the fact that older recipients tend to live away from home more so than younger recipients. Spending varied little by age within the same living arrangement and showed no consistent pattern.

Time of enrollment also affected spending during fiscal year 2002 because of delays in making the full range of services available to people who enrolled during the open-enrollment period of 2001. The spending figures in Table 2.2 reflect these delays as well as the fact that MR/RC Waiver recipients who enrolled during open enrollment were more likely than other recipients to be lower-cost children living at home.

Because older waiver recipients are more likely to live away from home than younger recipients, average spending tends to increase with age.

Variation in County Spending for the MR/RC Waiver Program

From our analysis of MR/RC Waiver recipients' expenditures we found that:

- **Average daily MR/RC Waiver program expenditures per recipient vary among counties, but the characteristics of counties' caseloads explain much of the variation.**

We categorized counties into three groups of large, medium-sized, and small counties and compared each county's expenditures per recipient with the average of its peer group of similar-sized counties. Figure 2.4 shows that in fiscal year 2002, average daily expenditures per recipient for 18 counties were more than 10 percent above the average of their peer counties. Average spending per recipient exceeded peer spending by more than 20 percent in 6 of the 18 counties.

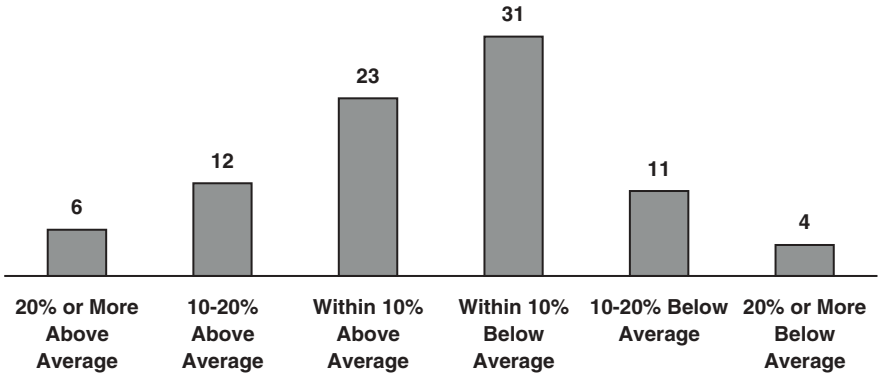
Among these 18 counties with higher than average spending per recipient, about half of the difference with peer spending levels is due to differences in living arrangement, profile ratings, degree of mental retardation, and whether recipients enrolled during open enrollment. Among the 6 counties that spent more than 20 percent above peer spending levels, these four factors explain 62 percent of the difference.

Another factor that helps explain variation in county spending, especially for counties with small caseloads, is unusually expensive cases.[4] Even a small number of high-cost cases can affect a county's average spending. Statewide, 19 cases each cost over $200,000 in fiscal year 2002, compared with an average annual cost of $49,000 per recipient. In a few counties, eliminating these cases

4 According to one county, such cases involve waiver recipients who are medically fragile with multiple needs and challenging behaviors.

Figure 2.4: Number of Counties Above or Below Average Spending per Recipient for the Mental Retardation or Related Conditions Waiver Program, FY 2002

In 18 counties, average daily expenditures per MR/RC Waiver recipient were at least 10 percent higher than in similar-sized counties.



NOTE: We grouped counties by size and compared each county's spending to the average for its size category.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services' data on county spending.

from the analysis substantially reduced the spending disparity between the county and its peers, although most were still above their peer average.

WAIVER AND INSTITUTIONAL SPENDING

To determine whether waiver programs helped contain Medicaid spending, we compared the cost of serving waiver recipients in the community with the cost in institutions. However, while waiver programs are substitutes for institutional care, they also attract people who are not interested in institutional care. Accordingly, we also examined recipient and expenditure trends for waiver and institutional programs combined.

MR/RC Waiver Program

The MR/RC Waiver program was originally designed as an alternative to institutional care in state-operated regional treatment centers or intermediate care facilities for persons with mental retardation (ICFs-MR). We found that:

- **Although the MR/RC Waiver program has a lower average cost per recipient than institutions, these savings have been more than offset by increased spending due to large caseload growth.**

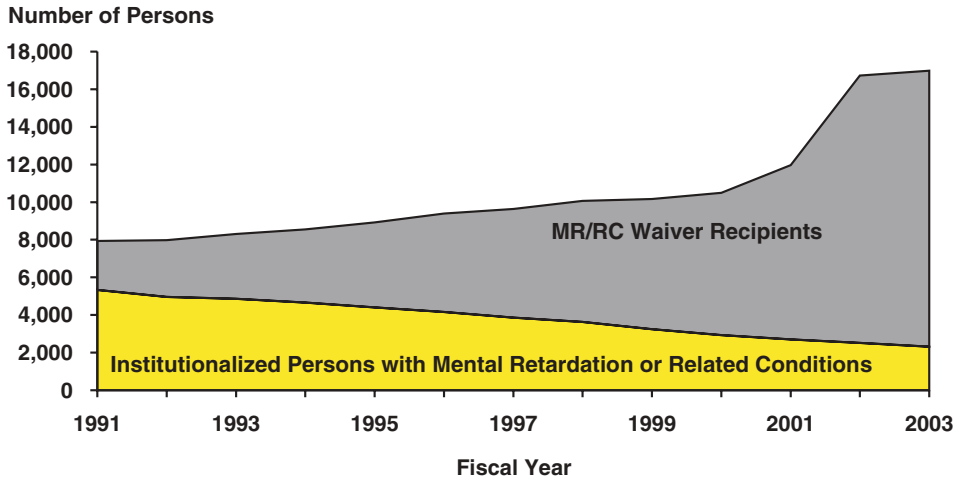
On average, institutional care cost about $22,000 more per recipient each year than the MR/RC Waiver program.

Each year since the waiver program began in 1984, MR/RC Waiver services have cost less per recipient than institutional care. For example, in fiscal year 2002 the annual cost of Medicaid services and group residential housing was $55,000 per MR/RC Waiver recipient, compared with $77,000 per recipient for institutionalized Medicaid recipients with mental retardation or related conditions.[5] This difference of $22,000 is a rough estimate of the average cost savings when institutionalized care is replaced by MR/RC Waiver program services.

While the MR/RC Waiver program has reduced costs by replacing institutional care, these cumulative savings are smaller than the increase in costs due to expanding enrollment. Between fiscal years 1991 and 2003, the number of Medicaid recipients with mental retardation or related conditions living in institutions declined by about 3,000, saving roughly $260 million in institutional spending. However, during the same time period, the number of MR/RC Waiver program recipients increased by about 12,000, as shown in Figure 2.5.[6] Even allowing for the fact that many of the new recipients had below-average costs, we estimate that these cases cost roughly an additional $600 million.

Caseloads for the MR/RC Waiver program grew far more since 1991 than institutional caseloads declined.

Figure 2.5: Number of Waiver Recipients and Institutionalized Persons With Mental Retardation or Related Conditions, FY 1991-2003



NOTE: Recipient counts are average monthly enrollments.

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

5 These cost figures are from unpublished data from Department of Human Services' reports to the federal government for fiscal years 1985 to 2002. The $55,000 and $77,000 cost figures differ from other figures in this chapter because they include expenses covered by regular Medicaid as well as the waiver program. Because institutions' normal rates include some services normally paid for by regular Medicaid, the department included these nonwaiver costs to make a fairer comparison.

6 In fiscal year 1991, there were 1,233 persons with developmental disabilities who lived in state-operated regional treatment centers and about 4,106 people who lived in ICFs-MR. All people with developmental disabilities left regional treatment centers by 1998, and by 2003, the number in ICFs-MR had declined to 2,314. The number of MR/RC Waiver recipients increased from 2,595 in fiscal year 1991 to 14,677 in 2003. All of the above figures are average monthly recipient counts.

Open enrollment in 2001 significantly increased spending on the MR/RC Waiver program but did not significantly reduce spending on institutional care.

The three months of open enrollment (late March through June 2001) clearly increased combined Medicaid institutional and waiver spending by a large amount. During open enrollment, waiver enrollment increased by about 5,500 persons, but the institutional caseload declined by only about 200 between fiscal years 2001 and 2002. While the growth in waiver enrollment was unprecedented, the decline in institutional caseload was not much different than previous years, as Figure 2.5 shows. The cost of serving persons who enrolled during open enrollment was $142 million in fiscal year 2002. This is much larger than the savings associated with the 200 people leaving institutions, which is roughly $16 million.[7]

To some extent, this increase in Medicaid spending following open enrollment could represent a shift in funding from counties to the state and federal governments since these recipients may have been receiving county-funded services prior to enrolling in the MR/RC Waiver program. However, county officials told us that the waiver program provides a much more extensive array of services than county-funded programs, which means that the amount of county funds that could have been shifted was small compared with the spending increases in the MR/RC Waiver program.

MR/RC Waiver recipients who joined during open enrollment were much more likely than others to be children living at home with their families.

Rather than replacing institutional care, open enrollment appears to have replaced or supplemented services provided in the home.[8] Open-enrollment recipients are much more likely than other recipients to live at home where they receive supports and services from their families. In fiscal year 2002, 85 percent of open-enrollment recipients lived at home, compared with 26 percent of other MR/RC Waiver recipients. In addition, open-enrollment recipients are less likely than other recipients to have diagnoses of severe or profound mental retardation and more likely than other recipients to have diagnoses of mild mental retardation. At the same time, when comparing recipients' profiles—a measure of recipients' functional abilities—open-enrollment recipients are similar to other MR/RC Waiver recipients.[9]

Other factors that may affect the combined institutional and MR/RC Waiver caseload growth include population growth and changes in prevalence, but their impact on caseload growth has not been measured. For example, according to the University of Minnesota's Institute on Community Integration, medical advances have extended the lifetimes of people with mental disabilities. This suggests that the number of Minnesotans with mental retardation or related conditions is increasing by more than the state's population growth rate of 1 percent per year, but how much more is not clear.

In addition, part of the growth during open enrollment consisted of children from middle- and upper-income families. Although the MR/RC Waiver program

7 Between fiscal years 2001 and 2002, the average monthly recipients in ICFs-MR declined by 186. In fiscal year 2002, ICFs-MR had an average cost of $83,470 per recipient for a full year of service. This figure differs from the figure used in the department's institutional cost comparison because the department's figure was based on the average annual cost for all recipients regardless of how long they were in the institution.

8 In this study, we did not review eligibility of MR/RC recipients, including those who enrolled during open enrollment.

9 While we did not study differences in participation rates among racial and ethnic groups for the MR/RC Waiver program, the department reported that because of open enrollment, the waiver program made significant progress in serving persons with minority racial and ethnic backgrounds.

primarily serves a low-income population, children from middle- and upper-income families can qualify on the basis of their own income and assets without regard to their parents' income and assets. Many of these parents pay fees to the department that are based on family size and income. Not all parents of the 3,500 children receiving waiver services reported income to the Department of Human Services to determine their waiver fees, but of the two-thirds who did, the average family income was $50,000 in 2002 (and the median was $46,000). The average fee paid by these families in early fiscal year 2004 was $151 per month.[10] About 1,000 of MR/RC Waiver children had parents with incomes exceeding $50,000 during 2002.

Waiver Alternatives to Nursing Home Care

Three waiver programs are designed as alternatives to nursing home care—the Elderly Waiver, the CADI Waiver, and the TBI Waiver.[11] In addition, the state-funded Alternative Care program is an alternative to nursing homes for elderly persons who are at risk of nursing home care but whose income or assets make them ineligible for Medicaid. [12] We found that:

- **The Elderly Waiver, Community Alternatives for Disabled Individuals Waiver, and the Traumatic Brain Injury Waiver programs each cost less per recipient than nursing home care. Savings for the Elderly Waiver program have been roughly matched by spending increases due to expanding enrollments, but it is not clear how the other two waiver programs affected overall spending.**

Annual costs per recipient in the Elderly Waiver program were one-fourth of the cost per recipient in nursing homes.

In fiscal year 2003, the average annual cost per recipient for nursing homes was about $40,300, about four times as high as the cost per recipient for the Elderly Waiver and the Alternative Care programs, about three times as high as the cost for the CADI Waiver program, and about 20 percent higher than the cost of the TBI Waiver program, as shown in Figure 2.6.[13] This means that the enrollment in these waiver programs can increase by a substantially higher amount than the resulting decline in nursing home usage without increasing overall spending. For example, to break even, the state needs to reduce nursing home usage by just one person for every four recipients added to the Elderly Waiver program.[14]

Results of the model used by the Department of Human Services to forecast Medicaid expenditures indicate that the state roughly breaks even for the Elderly Waiver program. This model takes into account some of the other factors that affect nursing home usage, including changes in Minnesota's elderly population

10 Fees for fiscal year 2004 are based on income during 2002.

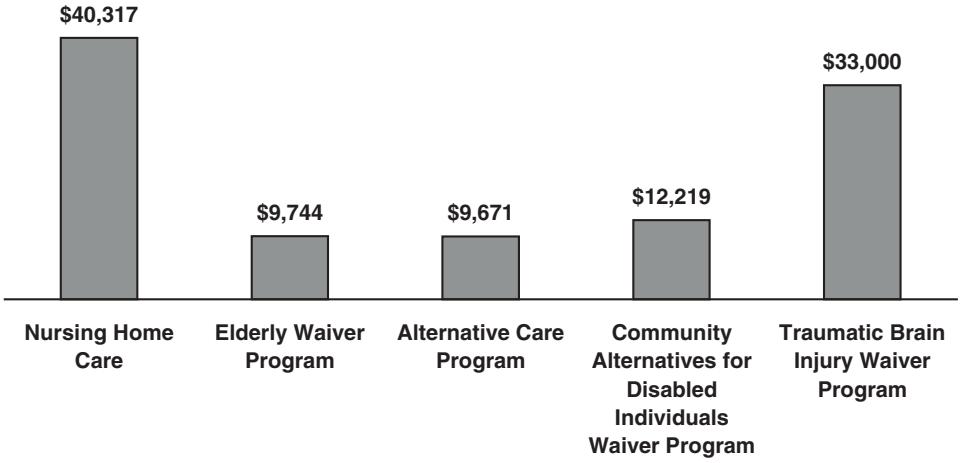
11 The TBI Waiver program has two components—one is an alternative to nursing home care and the second is an alternative to neurobehavioral hospital care. In this section, all of the data refers to the nursing home alternative.

12 People over age 65 may qualify for Alternative Care if they would become eligible for Medicaid within 180 days of entering a nursing facility and meet other asset requirements.

13 TBI is a much smaller program than the other three nursing-home alternatives. With an enrollment of only 570 persons in 2003, TBI had only a small effect on nursing home usage.

14 Enrollment in these three programs increased by 19,075 between 1991 and 2003 (from 4,571 in fiscal year 1991 to 23,646 in 2003). During the same time period, nursing home enrollment declined by 5,676 (from 28,508 to 22,832). Enrollment in the nursing home component of the TBI Waiver program increased by about 570.

Figure 2.6: Annual Costs per Recipient for Nursing Homes, Medicaid Waiver Programs, and Alternative Care, FY 2003



NOTE: Figure for Traumatic Brain Injury Waiver Program includes only the nursing home portion of the waiver.

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

and general economic conditions. Specifically, the model's results suggest that the number of nursing home residents declines by one for every four recipients added to the Elderly Waiver program. The model indicates that the Alternative Care program affects nursing home usage by about the same amount as the Elderly Waiver program, but the Alternative Care program has a less beneficial impact on state spending because the state pays the full cost of the Alternative Care program while the cost savings from people leaving nursing homes are divided between the federal and state governments. In the past, the department tried estimating the impact of the CADI Waiver program on nursing home usage, but the results were not statistically significant. The impact of the TBI Waiver program is difficult to measure because it is much smaller than other programs that affect nursing home usage.

MR/RC WAIVER ALLOCATIONS TO COUNTIES

In 2003, the state began basing its MR/RC Waiver allocations on spending from the prior year.

To control spending increases, the Department of Human Services in January 2003 adopted a new method for allocating MR/RC Waiver funds to counties. In a process known as "rebasing," the department decided to base 2003 allocations to counties on the amounts of actual paid claims during the prior year plus an adjustment for inflation and other cost factors.[15] Initially, this change reduced

15 The initial rebasing amount was actual spending for fiscal year 2002 with increases of 3 percent for inflation, 1 percent to cover the cost of changes in recipients' needs, and nearly 4 percent to cover the full annual costs of persons added to the waiver program during the year.

MR/RC Waiver funds that counties could spend by $55 million from what the previous method would have provided. After the department made three adjustments to the rebasing during 2003, the size of the reduction was reduced to $16 million. Also, the department for the first time allocated money for reserve accounts (intended to provide respite services when waiver recipients experience crises) within county budgets instead of keeping the reserves as separate accounts.[16] Finally, the 2003 Legislature adopted a department initiative to make counties responsible for funding any spending in excess of their allocation amounts.

The 2003 MR/RC Waiver allocation to counties was less than it would have been under the former allocation method.

These changes were designed to ensure that spending would stay within the state budget by reducing the flexibility counties had to increase their spending. Under the previous allocation method, most counties had flexibility to increase spending because their allocations were often considerably higher than their actual spending. For example, during the past five years, the statewide difference between actual spending and the amount allocated to counties ranged from 5 to 18 percent.[17] These gaps between allocations and actual spending were common because counties did not want to risk overspending their allocation. The gap between budgeted and actual expenditures often occurs because unanticipated changes, such as recipients using fewer respite care hours than planned or emergencies forcing a recipient off the waiver and into an ICF-MR for some period of time, affects how much money is actually spent on waiver services.

While the department's 2003 allocation method reduced the amount by which counties can increase their spending, counties have various ways to manage their budgets to meet the needs of their recipients. First, after counties receive their allocations for a year, they are free to use their resources as they think best meets the needs of their waiver recipients, as long as the counties stay within their overall allocations. Second, when recipients leave the program, counties may use the funds they spent on those recipients to increase services for other recipients or to fund services for new recipients. In addition, when counties have lacked resources to meet the health and safety needs of waiver recipients, the department has adjusted county budgets to meet those needs.

To manage their MR/RC Waiver budgets, counties may decline to add persons to the waiver program should a recipient leave.

We examined the department's current funding allocation method in terms of the following dimensions:

1. State budget control, meaning whether the system allows the state to manage its budget;
2. Equity among counties, that is, how well the allocation method provides resources to counties in proportion to their recipients' needs;
3. Incentives to spend prudently; and

16 The result, according to some counties, was a reduction in their general waiver budgets by whatever amount they set aside for the reserve.

17 The gap between allocations and actual spending reached a peak of 18 percent in fiscal year 2002, when counties were allocated $883 million but actually spent $723 million. This gap was especially large because many low-cost children who lived at home enrolled during the open-enrollment period in 2001, but the amount allocated to counties for those children did not take into account their lower spending requirements. The $723 million in actual spending includes about $21 million in home care services that are not part of the MR/RC Waiver program. The department includes funds for these services in county allocations. MR/RC Waiver expenditures presented earlier in this chapter do not include this program.

4. Administrative simplicity, meaning the degree to which the allocation method creates administrative burdens on counties or the state.

We found:

- **The Department of Human Services' method of allocating MR/RC Waiver funds to counties allows the state to control spending, but it only partially reflects the needs of MR/RC Waiver recipients. It also creates incentives for counties to spend to their budget limit. In addition, delays in setting final county allocations make it difficult for counties to manage their budgets.**

State Budget Control – The new allocation method appears to have reduced spending growth in the MR/RC Waiver program. The department reported that counties as a whole have kept their spending under the new reduced budget amounts during the first three months of fiscal year 2004.

Equity Among Counties – The new allocation method does not allocate resources to counties in proportion to the needs of their caseload. Because the department is basing county allocations largely on the prior year's spending levels, counties that spent prudently in the prior year would receive disproportionately low allocations compared with other counties with similar needs. In effect, the allocation method rewards counties with high spending and penalizes counties that were frugal.

The allocation method rewards counties that were high spending and penalizes counties that were frugal.

A second problem with using historical spending as a basis for county allocations is that the allocations will not change when a county's overall needs change more (or less) than in other counties. For instance, counties with relatively large proportions of children on the waiver program are likely to bear a larger burden than other counties when these children move away from home. Recipients who live with their families one year but move into foster care the next will require higher expenditures that the initial year's spending does not recognize. The large variation in proportions of children enrolled in the MR/RC Waiver program after open enrollment heightens this problem over time. After open enrollment, the proportion of children age 16 or under in county caseloads ranged from 46 percent in Chisago County to 5 percent in Ottertail County.[18] Also, should a very needy recipient be

Whether waiver recipients live in their families' homes or in foster care affects costs.

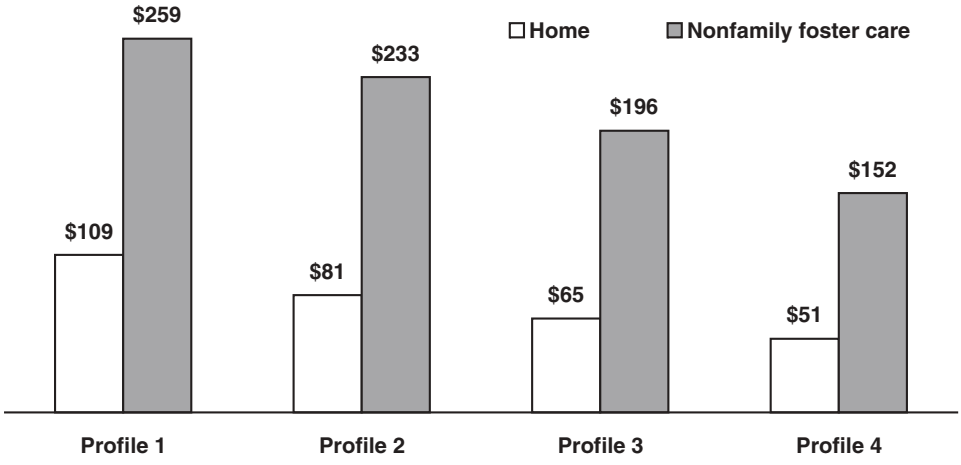
18 This comparison excludes two small counties that did not have any children under age 17 enrolled in the MR/RC Waiver program.

replaced by a less needy recipient, the county receives a higher level of funding in the current year than it actually needs because the prior year's spending will include dollars spent on that very needy recipient.[19]

Another problem is the department's use of profiles. In developing its profile methodology, the department explicitly decided against including the recipient's living arrangement because it wanted instead to base waiver resources on recipients' functional characteristics.[20] This was predicated on the belief that recipients generally needed similar levels of support to address their functional abilities regardless of their living arrangement or the availability of family-provided supports. While important at the time because of the concern that recipients were being "institutionalized unnecessarily to receive additional waiver resources," the methodology does not reflect the large cost differences between living at home and foster care. Figure 2.7 shows that costs vary significantly by living arrangement within each profile. In Profile 1, for example, recipients living at home had average expenditures of $109 per day, which is

Within any of the four profiles of MR/RC Waiver recipients, average costs per day were higher for recipients in foster care than for those living at home with their families.

Figure 2.7: Mental Retardation or Related Conditions Waiver Expenditures per Day by Profile and Living Arrangement, FY 2002



NOTE: Profiles were calculated for all recipients, including those without an official profile.

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

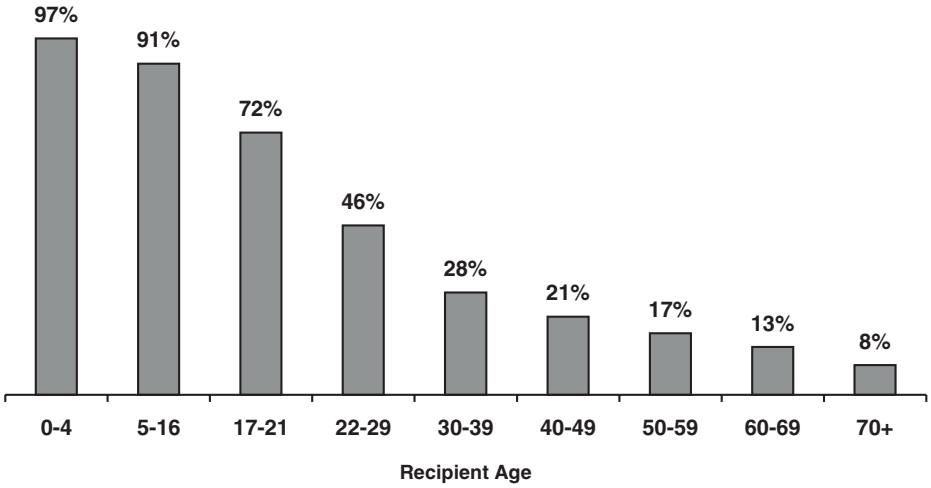
19 In addition, basing allocations on historical spending perpetuates problems that existed in the previous allocation method. For example, recipients who were already enrolled in the waiver when the profile system started in 1995 were not assigned a profile; instead they became part of a "base" for which the department made a separate allocation that was based on historical spending. Second, after the profile of a new recipient was determined, the allocation for that recipient continued to be based on his or her original profile regardless of whether the recipient's characteristics changed. Third, when a new recipient replaced a person who left the waiver program, the allocation for the new recipient was based on the profile of the previous recipient. As a result, if this profile system were continued unchanged for decades, the allocations would have eventually been based primarily on the characteristics of people who were no longer in the program.

20 Department of Human Services, Division for Persons with Developmental Disabilities, *Summary Report: The MR/RC Waiver Allocation Structure* (St. Paul, March 1996), 9.

$150 dollars less than the average expenditures for recipients living in nonfamily foster care at $259 per day.

Using age in the profiles would reflect the costs of waiver recipients' differing needs without creating an incentive to inappropriately place persons in institutions. Age is highly correlated with living arrangement, as is shown in Figure 2.8. Age, by itself, is not a measure of need. It does, however, reflect the fact that younger recipients are more likely to live at home and receive support from their family, reducing the need to provide expensive public supports as in corporate-style foster care.

Figure 2.8: Percentage of Mental Retardation or Related Conditions Waiver Recipients Living at Home, by Recipient Age, FY 2002



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

The department's profiles do not fully reflect cost differences associated with the severity of MR/RC Waiver recipients' degree of mental retardation.

The profiles also do not reflect cost differences associated with the degree of mental retardation. All four profiles contain recipients that range from mild through moderate, severe, and profound levels of mental retardation. Regardless of the profile, persons with a higher degree of mental retardation typically cost more than others. Within Profile 1, waiver spending in fiscal year 2002 differed by an average $32 per day between recipients with mild mental retardation and recipients with profound mental retardation. The corresponding difference within Profile 2 was $97 per day, and within Profile 3 it was about $83 per day.[21]

Incentives – Because the allocation method used for 2003 is tied to prior-year spending, it creates incentives for counties to spend to the maximum. If they spend less than the full amount budgeted, they jeopardize the size of future years' budgets.

21 The difference in Profile 4 was $39 per day, though this is not a very meaningful comparison because there were only 13 cases with profound mental retardation who were classified as Profile 4.

Administrative Burden – The department's MR/RC Waiver funding allocation method increased administrative burdens on counties. Counties did not know what their actual allocation would be for calendar year 2003 until the second half of 2003, making it difficult to plan for services. Initially, the department based county allocations for 2003 on the actual claims submitted for services in fiscal year 2002, plus an adjustment for inflation and other factors. Three adjustments totaling about $39 million were made between June and October 2003 to reflect the full annual cost of services that were being provided in 2002. The adjustments occurred this late in the year because of lags between the dates that services were provided and the dates that providers submitted the claims. If the department continues to use this process in the future, counties will not know their actual allocations until late in the year.

The 2003 allocation method caused delays that made planning difficult for counties.

More than two-thirds of counties reported it is difficult or very difficult to manage the gap between amounts allowed and amounts actually spent. The current allocation method heightens the consequences of not managing this gap because counties' future budgets are at risk if they do not spend to their budget limit. In their responses to our survey, numerous counties wrote of the inability of current mechanisms to provide an accurate and up-to-date description of spending for their MR/RC Waiver recipients. Many counties believe additional state assistance is needed to help administer the MR/RC Waiver Program. One form of assistance that counties reported would be very useful is a method to monitor spending on a real-time basis.[22]

The department's new allocation method also increased administrative burdens on counties because the budget cuts led to an increase in appeals filed by recipients.[23] Minnesota Statutes provide the right to challenge counties' social service decisions under various circumstances, including the reduction of MR/RC Waiver services.[24] This increase in appeals could occur under any change that cuts recipients' services.

RECOMMENDATION

The Department of Human Services should change its allocation method to 1) improve the distribution of funding by better reflecting the needs of county caseloads, 2) avoid incentives for counties to spend to their budget limits, and 3) reduce administrative burdens on counties.

Revising the method of allocating counties' budgets could improve the distribution of dollars according to caseload needs.

Although designing a new allocation method falls outside the scope of this study, it is important that the Department of Human Services consider the effects over time of basing allocations on prior-year spending. The department is studying its processes for determining eligibility and assigning benefits across all of the

22 Although such a tool may not be possible, the department may be able to make improvements, such as by updating Waiver Management System data on a more frequent basis. One of the impeding factors is that under federal Medicaid regulations, providers have up to a year to submit claims for services provided.

23 Department personnel roughly estimated that whereas the department might have received one or two MR/RC Waiver appeals a month in previous years, it received about 100 during the first 11 months of 2003.

24 *Minn. Stat.* (2003) §256.045, subd. 3 (a) (1).

Medicaid Home and Community-Based Waiver programs.[25] It hopes to achieve a streamlined process for assessing waiver recipients' needs and a new method of rationally assigning benefits to waiver recipients. As part of this study, the department should examine how to more closely tie the allocation method to the cost of services needed by recipients. This would not only make the method more equitable, it would avoid the incentive to spend to the budget limit. It could also reduce the administrative burden on counties by using readily available data on recipient characteristics rather than prior-year claims data, which is not complete until about six months into the following year. This would allow the final budget to be set earlier than is possible under the current method.

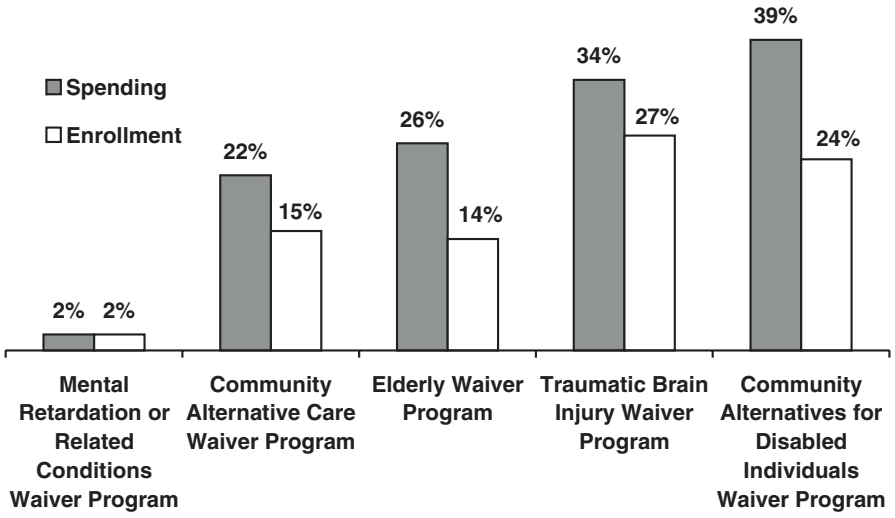
FUTURE WAIVER SPENDING

While MR/RC spending accounts for a majority of total waiver expenditures, growth in the MR/RC Waiver program is expected to be far smaller than in the other waiver programs, as shown in Figure 2.9. The Department of Human Services has forecast annual spending on the MR/RC Waiver to increase 2 percent annually, a much slower rate than the double-digit annual increases expected for the CADI, TBI, CAC, and Elderly Waiver programs.

Differences are similarly striking in forecasted caseload growth. MR/RC Waiver program enrollment is expected to increase 2 percent annually over the next four

Over the next four years, growth rates for the MR/RC Waiver program are forecasted to be much smaller than growth in the other Medicaid Waiver programs.

Figure 2.9: Projected Average Annual Growth in Spending and Enrollment for the Home and Community-Based Waiver Programs, FY 2003-07



SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services' November 2003 forecast data.

25 Minnesota Department of Human Services, Continuing Care Administration, *Request for Proposals for: Technical Assistance for the Development of a Comprehensive Long-Term Care Infrastructure Framework* (St. Paul, December 2003).

fiscal years, compared with far higher increases for the other Home and Community-Based Waiver programs.

The department has forecast low growth rates for the MR/RC Waiver program because of actions taken by the department and the Legislature in early 2003. As we described earlier in this chapter, the department reduced county allocations in January 2003. In addition, the 2003 Legislature reduced MR/RC Waiver program caseload growth by eliminating diversion allocations entirely for the 2004-2005 biennium.[26]

The 2003 Legislature restricted new openings in the MR/RC Waiver program for the 2004-05 biennium.

In early 2003, some waiver recipients along with an advocacy organization and a provider association filed lawsuits related to the department's rebasing, but these lawsuits have not affected the department's forecast. A temporary restraining order imposed in March 2003 directed counties to refrain from any further changes to provider contracts due to the rebasing and directed the state to ensure no further reductions in authorized spending for individual beneficiaries.[27] Although the order limited counties' opportunities to reduce spending, the department did not revise its forecast because counties held down MR/RC Waiver spending below the levels of their allocations.

The Legislature and county and state officials who operate the MR/RC Waiver program can expect ongoing pressures for additional spending. We found that:

- **Long waiting lists for the MR/RC Waiver program and a large proportion of children currently enrolled in the program will likely add pressure for increased spending.**

As the large share of children now receiving MR/RC Waiver services age, they will be more likely to live away from home and require higher spending. Children under 17 years of age made up 23 percent of MR/RC Waiver recipients following open enrollment, compared with just 11 percent prior to open enrollment. The percentage of recipients living at home declines

When children now receiving waiver services age, they will be more likely to live away from home.

26 In 2003, the Legislature also limited the growth in allocations for the Traumatic Brain Injury and Community Alternatives for Disabled Individuals Waiver programs, but these limits were less restrictive than the growth limits imposed on the MR/RC Waiver program. Also, the forecast, reflecting current law, assumes that the Legislature will not continue the restrictions for the TBI and CADI Waiver programs beyond the 2004-05 biennium.

27 Although the March temporary restraining order was lifted at the end of August, the judge imposed a second temporary restraining order in mid-September prohibiting reductions in spending for waiver beneficiaries. The judge lifted the second order in early January 2004.

with age, and foster care living arrangements are more costly than living at home. In fiscal year 2002, 92 percent of waiver recipients 16 years of age or younger lived at home, compared with 14 percent of recipients aged 50 and older.

Although waiting lists shrunk during the open-enrollment period in 2001, many people are currently on waiting lists, and the number is growing. With the addition of 5,500 MR/RC Waiver program recipients during open enrollment from late March through June of 2001, the number of people on waiting lists fell 35 percent, from 4,568 to 2,986 individuals. The decrease did not last long, however, as the waiting list increased about 30 percent over the next two years, reaching 3,877 at the end of fiscal year 2003. The actual number of people potentially waiting for the MR/RC Waiver program is even higher, as county staff told us that not all residents eligible for the MR/RC Waiver program are on the waiting list. The number of people on waiting lists may also grow because of the 2003 Legislature's decision to eliminate diversion allocations in fiscal years 2004 and 2005.

Waiting lists for the MR/RC Waiver program decreased following open enrollment in 2001 but increased 30 percent over the next two years.

As might be expected, waiting lists are longest in the metropolitan-area counties, which tend to have the highest MR/RC Waiver caseloads.[28] Numbers of individuals on waiting lists in the seven-county metropolitan area represented 49 percent of all persons waiting for the waiver program at the end of fiscal year 2003; Hennepin County alone accounted for 22 percent of the state total. Only three counties (Kittson, Norman, and Wilkin) had no individuals on waiting lists at that time.

Waiting lists are likely to remain tight because once recipients begin receiving waiver services, they may continue to do so as long as they remain eligible. With any action the state takes to reduce waiting lists, it must continue to "assure the health, welfare, and rights of all individuals already enrolled in the waiver."[29] This prevents the department from removing persons from the waiver program even if others on the waiting lists have more severe needs.

POLICY OPTIONS FOR CONTROLLING MR/RC WAIVER PROGRAM SPENDING

The state controls MR/RC Waiver program costs largely with limits on access to the program and through the department's method for allocating county MR/RC Waiver budgets. We found that:

- **The state's policy of limiting access to the MR/RC Waiver program helps control spending but raises equity concerns. Alternative methods to control spending will involve difficult policy decisions.**

28 *Minn. Stat*. §256B.0916, subd. 2(b) requires counties to consider certain factors, such as applicants' unstable living situations and the need to avoid out-of-home placement for children, when determining which applicants should have priority. According to our survey of county waiver administrators, counties were similar in their ratings of important or very important criteria for managing their waiting lists.

29 Timothy M. Westmoreland, Director, U.S. Department of Health and Human Services Center for Medicaid and State Operations, letter to State Medicaid Directors, *Olmstead Update No: 4 Subject: HCFA Update,* January 10, 2001.

By controlling the number of new openings for the MR/RC Waiver program, the state limits access to the program but creates waiting lists. Because persons waiting for MR/RC Waiver services may have needs that are the same as or greater than persons already receiving waiver services, the waiting lists raise equity issues. The state could change how it manages MR/RC Waiver resources by using some mix of other cost controls. But while the options to control program costs may ease equity concerns, each has drawbacks and presents the Legislature with difficult dilemmas over the extent to which current MR/RC Waiver recipients can be served.

People waiting for MR/RC Waiver services may have needs equal to or greater than current waiver recipients, which creates equity concerns.

Obviously, one option for dealing with funding pressure and limited access is to increase appropriations for the waiver program. More dollars can serve more people and avoid limiting services. The feasibility of this approach, however, is limited by the budget realities the state faces. According to the Minnesota Department of Finance, Minnesota's economic outlook has weakened slightly since the end of the 2003 legislative session. In its November 2003 forecast, the department predicted a $185 million deficit for the existing 2004-2005 biennium.[30] Although the forecasted deficit appears small compared to the $4.6 billion deficit that confronted the 2003 Legislature, it portends a smaller likelihood for increased program spending. While the forecast showed that the state's budget reserve has grown by $110 million to $631 million, use of that reserve can only occur through legislative and gubernatorial action and is at best a short-term solution.

Other options to manage MR/RC Waiver resources are summarized in Table 2.3. Each option would reduce spending and leave room for new recipients, either by reducing the numbers of existing waiver recipients or reducing dollars spent on them, but each option has disadvantages. Controlling spending will produce tradeoffs regardless of the method or combination of methods used. Further, for any spending control, the Legislature would have to decide whether to apply it to all persons, in which case some portion of current recipients may lose eligibility, or apply it to only new enrollees, which would protect current recipients but bifurcate the caseload and slow the opportunity for capturing savings. A summary of these spending controls follows.

Options to control MR/RC Waiver spending present difficult tradeoffs and policy choices.

Table 2.3: Options to Control Mental Retardation or Related Conditions Waiver Program Spending

- Further restrict eligibility
- Limit the array or amounts of waiver services
- Lower expenditure levels for current recipients or set statewide caps on their budgets
- Further control payments to providers
- Design incentives to encourage lower-cost living arrangements

SOURCES: Office of the Legislative Auditor, analysis of 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), 29-31.

30 Minnesota Department of Finance, *November 2003 Economic Forecast* (St. Paul, December 3, 2003), 3.

Further Restrict Eligibility – The state could further restrict eligibility for the MR/RC Waiver, but federal approval would be required. Pending approval, the state could base eligibility on the severity of individuals' needs or restrict program openings to those individuals who are at immediate risk of institutionalization.[31] Either of these actions would create policy issues for the Legislature, such as determining to which group of eligible participants the waiver program should target funds.

Limit the Array or Amount of Services – The state could limit the types or amounts of services covered by the MR/RC Waiver program. As mentioned earlier, Minnesota's MR/RC Waiver program covers a broad array of services, which advocates have pointed to as a program strength. Limiting the type or amount of service would prevent the waiver from tailoring services to individual needs as much as has occurred in the past. A variation of this spending control would be to impose a statewide definition of "need." The focus could be on services that meet health and safety needs, to the exclusion of other services, such as chore services. Such a focus would, however, diminish the emphasis traditionally placed on defining needed services based on individuals' own plans of care.[32] Abiding by a centralized standard of need would also reduce county flexibility in dealing with people of widely varying needs.

Lower Expenditures for Current Recipients – The state could lower the level of expenditures for existing waiver recipients. This could be done in at least one of two ways. First, the state could reduce counties' budgeted dollar amounts and let counties decide how best to apportion the reduced spending among their recipients. In effect, this would be akin to another rebasing. Counties would have the flexibility to decide how to best spend the money, but they would face some of the same dilemmas they faced in January 2003 in determining how to serve recipients' changing needs without additional resources. Further, any existing inequities among counties could be exacerbated. Another version of this would base an overall reduction in county budgeted dollars on a revised allocation method that uses the profiles to a greater extent after improving them by incorporating important criteria, such as age. Such a change would reduce dollars overall and redistribute those dollars among counties in ways that better reflect the factors that drive costs. Counties would retain the flexibility to decide how to best spend their budgeted dollars. At the same time, though, many counties would still face dilemmas over fulfilling recipients' needs with reduced funds.

Expenditures could be lowered while still retaining counties' flexibility over distributing their pool of funds, but lowering expenditures might still pose dilemmas over providing adequate services to waiver recipients.

A second way of lowering expenditures for existing recipients would be to set statewide caps on budgets for individuals according to their level of need. No recipient could receive an amount of spending that exceeded the state-set cap. While several counties have adopted their own budget limits for waiver recipients, grouping waiver recipients according to need is a difficult task. For example, as described earlier, the four profiles used to categorize new waiver enrollees are subject to a great deal of variation and do not reflect either the person's degree of mental retardation or living arrangement. They do not change as a person's needs change over time. Further, a state cap would not allow a county to spend more on

31 Increasing the service fees paid by parents on a sliding scale depending on income level is another mechanism to target services to those with lower abilities to pay.

32 Such limits might also conflict with the Olmstead decision that people with disabilities receive services in the most integrated setting appropriate to their needs.

unusually needy individuals unless there is also a process for approving exceptions to the cap.

Further Control Payment Rates – The state could further limit payment rates to providers. This could also be achieved if the state set rates for all MR/RC Waiver services (while accounting for cost-of-living differences around the state). Whether rate controls are an effective way to control spending is debatable, however. This method would also impose artificial constraints on the market place, obviating any price reductions occurring due to free market competition. Plus, rate reductions might jeopardize some providers' financial wherewithal to continue serving current waiver recipients.

Encourage Lower-Cost Living Arrangements – The state could design incentives that encourage waiver recipients to stay in their families' homes. Because recipients that live with their families have lower average costs than those living in corporate foster care settings, such incentives would help the state avoid higher-cost living arrangements. At the same time, though, they could prevent individuals from achieving the independence they desire and work against the program objective of self-determination. Lower-cost, out-of-home options could be explored, such as consumer-controlled cooperative housing. Because of the longer timeline needed to develop cooperative housing, this alternative would produce effects only in the long term; it would not affect spending in the short term.

3 Program Safeguards

SUMMARY

The Department of Human Services lacks sufficient controls over Consumer-Directed Community Supports, which were intended to give MR/RC Waiver recipients and their families the option to directly manage their own services and choose their care providers. Insufficient controls have led to questionable purchases, inequitable variation in how counties administer Consumer-Directed services, and unmet prospects for cost efficiencies. We recommend that the department design additional safeguards and evaluate how well its proposed controls work before implementing the Consumer-Directed option statewide. Counties reported taking various measures to ensure that waiver recipients received services for which the MR/RC Waiver program was billed, but there were inconsistencies in following the most common measures. The Department of Human Services does not know how many providers may be billing incorrectly. Counties generally follow state rules on determining and updating MR/RC Waiver recipients' needs in a timely way and ensuring the availability of services, but there are exceptions. We recommend that the department assess county compliance with state rules when it begins its county reviews in 2004.

In Minnesota, both state and county governments are involved with safeguards for the Mental Retardation or Related Conditions (MR/RC) Waiver program, including the component of the program known as Consumer-Directed Community Supports. In this chapter, we address the following questions:

State and county governments are involved with safeguards for the MR/RC Waiver program.

- **Does the state have sufficient controls to ensure that funds for the Consumer-Directed Community Supports component of the MR/RC Waiver are spent appropriately?**
- **Are safeguards sufficient to verify that MR/RC Waiver recipients receive the services for which the program is billed?**
- **How well do counties comply with certain state rules that govern the administration of the MR/RC Waiver program?**

To answer the questions, we analyzed literature on controls over Medicaid Home and Community-Based Waiver programs. We interviewed personnel from the Department of Human Services and from a number of counties. To gather information and opinions on MR/RC Waiver administration and Consumer-Directed Community Supports, we conducted separate surveys of county MR/RC

Waiver administrators, advocacy organizations, and associations of service providers.

Finally, we reviewed a stratified random sample of 267 individual case files in 12 counties around the state, chosen from counties that offered Consumer-Directed Community Supports in fiscal year 2003.[1] Our sample is representative of the 12 counties, which account for about 94 percent of the 3,074 recipients using Consumer-Directed services in the first half of fiscal year 2003. All cases in the 12 counties, including people using Consumer-Directed services and others using traditional MR/RC Waiver services, represented 55 percent of MR/RC Waiver recipients at that time. Our sample is not representative of the entire state.[2]

In this chapter, we examine the extent of controls used to regulate appropriate spending of funds on Consumer-Directed Community Supports. We assess the adequacy of controls to verify whether recipients receive services for which the MR/RC Waiver program is billed. We also consider how well counties comply with select state rules that govern how the MR/RC Waiver program is administered.

SAFEGUARDS FOR CONSUMER-DIRECTED COMMUNITY SUPPORTS

Consumer-Directed Community Supports allow MR/RC Waiver recipients the option to take direct control for planning and managing their own services, as Chapter 1 described. For fiscal year 2002, Consumer-Directed services were offered in 33 counties and accounted for 7 percent of all MR/RC Waiver spending, but this amount will likely increase because the Department of Human Services intends to expand the use of Consumer-Directed Community Supports statewide as well as to each of the other Medicaid Waiver programs. In assessing whether waiver funds are spent appropriately through Consumer-Directed services, we looked at the controls over the services to determine 1) whether purchases were appropriate, 2) how consistent the service option was from county to county, and 3) whether the cost of Consumer-Directed services was comparable to other MR/RC Waiver service costs. As Consumer-Directed Community Supports now stand, we found that:

In fiscal year 2002, Consumer-Directed services accounted for 7 percent of all MR/RC Waiver spending.

- **The Department of Human Services lacks sufficient controls over Consumer-Directed Community Supports, which has led to questionable purchases, inequitable variation in how counties administer the services, and unmet prospects for cost efficiencies.**

1 The 12 counties were: Blue Earth, Crow Wing, Dakota, Hennepin, Mower, Olmsted, Ramsey, Saint Louis, Scott, Steele, Todd, and Washington. About 63 percent of the cases were of persons using Consumer-Directed services, and about 37 percent were of persons using traditional MR/RC Waiver services.

2 Additional details on the methodologies we followed are available on-line at www.auditor.leg.state.mn.us/ped/2004/pe0403.htm.

Insufficient state controls raise equity questions about services and supports that are allowed in some counties but denied in others.

Consumer-Directed Purchases

Counties and waiver recipients use Consumer-Directed services to fund informal supports and services typically not included among the traditional MR/RC Waiver services, which was, in part, one of the objectives. Allowing recipients greater leeway in choosing from among informal providers of care, such as relatives or neighbors, has been a success, according to many participants.[3] We examined the Consumer-Directed budgets in 168 case files chosen randomly from the 12 counties that served as our case studies. From this review we concluded that:

- **Controls were insufficient to prevent questionable expenditures on Consumer-Directed services.**

Although the Department of Human Services does not control spending on Consumer-Directed Community Supports, and it has not defined unacceptable purchases, counties typically reported having procedures to control Consumer-Directed spending. In answering our survey, 26 of 27 counties said they consistently followed a county policy that set general parameters for services allowed under the Consumer-Directed option; the remaining county indicated it somewhat followed such a policy. About 79 percent of counties reported consistently having case managers or waiver teams decide about Consumer-Directed services based on their perceptions of the waiver recipients' needs. Table 3.1 illustrates other ways counties reported controlling the selection of Consumer-Directed services.

Most counties offering Consumer-Directed services reported that they set their own policies on what services are covered.

Table 3.1: Controls Counties Reported Using Over Recipients' Selection of Consumer-Directed Services, 2003

	Does Consistently	Does Somewhat	Does Not Do
Follow county policy describing general parameters for allowable services (*N*=28)	96%	4%	0%
Case manager or team decides based on perceived MR/RC waiver recipient needs (*N*=29)	79	14	7
Follow guidance from Department of Human Services (*N*=28)	70	26	4
Use county list of disallowed items (*N*=27)	65	12	23
Rely on MR/RC waiver recipient's choices (within budget limits and state parameters) (*N*=30)	59	41	0
Use county list of allowed items (*N*=28)	52	19	30

NOTES: The question read: "In what ways does your county control the types of CDCS services that recipients may select?" Rows may not sum to 100 percent due to rounding.

SOURCE: Office of the Legislative Auditor, County Questionnaire on the Mental Retardation or Related Conditions Waiver, September 2003.

3 Minnesota Department of Human Services, *Consumer Directed Community Supports Focus Groups Summary of Findings* (St. Paul, June 2002), 12.

Consumer-Directed Community Supports paid for some questionable items, such as Internet fees.

Despite the counties' spending controls, Consumer-Directed spending for items that are not covered by Medicaid went beyond informal caregivers and included questionable items. For example, Consumer-Directed Community Supports have been used in the past year to pay for cell phones, playground equipment, Internet connectivity fees, tax preparation costs, and various community activities such as museum memberships, tickets to Minnesota Wild hockey games, and annual passes to Camp Snoopy at the Mall of America. While Minnesota's Consumer-Directed Community Supports do not prohibit these activities or supports, some counties have disallowed them, as is discussed later in this chapter.

About three-quarters of the 168 case files we reviewed had budgets that included at least one item (other than informal caregivers) that the Medicaid MR/RC Waiver program does not typically fund. In total, the items amounted to about $620,000, representing 11 percent of all the services and items budgeted through Consumer-Directed services in the cases we reviewed.

Although most spending of Consumer-Directed funds in the files we reviewed was supported by documentation, not all purchases appeared justified. In our review, we noted whether items in budgets for Consumer-Directed services were unusual by type or amount. Of the 376 items we characterized as unusual, 89 percent were related to needs articulated in the individual service plans.[4] At the same time, 41 services or products (about 11 percent of the unusual items and amounting to about $64,850) were not connected to any needs described in the waiver recipient's individual service plan or related Consumer-Directed planning documents. As an example, one case tapped Consumer-Directed Community Supports for $1,600 of vacation expenses even though the file did not relate this expenditure to the recipient's needs. In another case, Consumer-Directed Community Supports paid $1,200 for concerts, plays, movies, and arcades, which by itself was not uncommon when compared to other cases that contained similar services but were related to recipients' needs. This case, however, presented no link between such community activities and the recipient's stated needs.

VARIATION IN CONSUMER-DIRECTED COMMUNITY SUPPORTS

Although the Department of Human Services has set the general parameters for Consumer-Directed services, the 33 counties that have chosen to offer the option have had a great deal of flexibility in administering it. This has proven to be a double-edged sword in that it provided for individualization but allowed practices to differ from county to county and within a given county. A June 2002 department report remarked that one of the challenges was that "policies regarding [Consumer-Directed services] frequently differ from county to county."[5] A study in early 2002 of Consumer-Directed users and their families revealed mixed results: Interviews with users and a survey showed a high degree of support for Consumer-Directed services but revealed families' concerns about

4 We accepted the needs listed in service plans at face value and did not judge their appropriateness.

5 Department of Human Services, *Consumer Directed Community Supports Focus Groups*, 2.

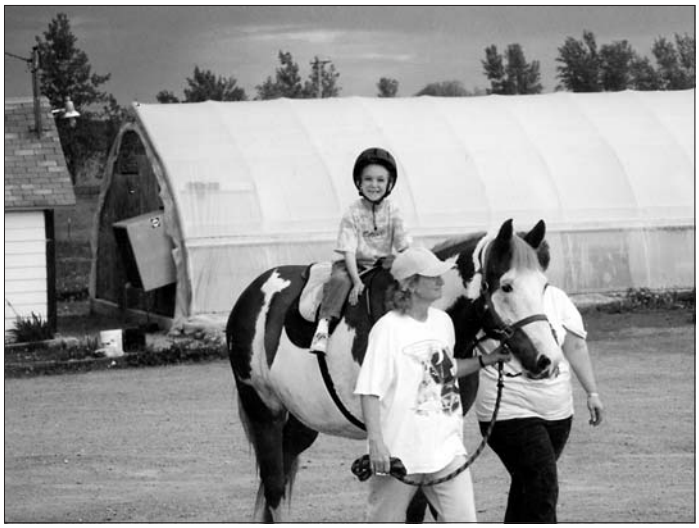
too much micromanaging and increasing restrictiveness, as well as inconsistent guidelines.[6]

Our analysis also shows that:

- **Without adequate statewide controls, Consumer-Directed services have varied among counties, and counties' uses of the Consumer-Directed option have varied, raising questions about inequities and meeting objectives.**

In some counties, Consumer-Directed Community Supports paid for certain items that other counties expressly forbid.

The items and services paid for with Consumer-Directed Community Supports funding vary from county to county. Our file review showed that some counties allow Consumer-Directed expenditures on services that are disallowed in other counties. For instance, some counties allowed the purchase of dietary supplements while others did not. Some allowed the purchase of clothing, while others expressly disallowed it. One county prohibited spending on extra pairs of eyeglasses, while another permitted it.



Services covered by Consumer-Directed funds vary from county to county.

Five of 30 counties offering Consumer-Directed Community Supports reported that they do not have a policy to terminate use when problems occur.

Another point of inconsistency is that not all counties have policies to stop the use of Consumer-Directed services when problems occur. Five of 30 counties with Consumer-Directed services reported in our survey that they have not established a policy to terminate the use of Consumer-Directed services when recipients overspend, commit fraud, or compromise their health and safety.

Some counties have used Consumer-Directed services mostly in instances when the county, not the recipients or their families, determines who might benefit from the services. Key objectives of Consumer-Directed Community Supports are to increase consumer control and self-reliance and provide activities at the request and direction of the recipients and their legal representatives.[7] When recipients and their families do not choose the Consumer-Directed option, these objectives are not fully met. In these cases, the option functions less as a reflection of the

6 Minnesota Governor's Council on Developmental Disabilities, *Consumer Directed Supports Survey Individual Comments* (St. Paul, May 2002), 2-3.

7 Minnesota Department of Human Services, "New Services Available Through the MR/RC Waiver: A Guidebook for County Agencies," in *MR/RC Waiver Amendments Announced Bulletin 98-56-15* (St. Paul, October 1998), 3; and Minnesota Department of Human Services, "The Shift to Increased Consumer Control," from *Consumer Directed Community Supports Tool Kit – 2003* (St. Paul, 2003), 3.

recipient's self-direction and more as a supplementary funding source. As an example, in one of the counties we visited, county staff realized that a specialized form of physical therapy would not be eligible for Medicaid reimbursement, but they agreed with the family that the therapy could help the recipient develop tolerance to physical contact. Consequently, the county opted to pay for the touch therapy using Consumer-Directed services as the billing mechanism even though the waiver recipient and his family did not choose Consumer-Directed services. By contrast, in other counties, recipients and their families decide whether to use Consumer-Directed Community Supports (often with county guidance).

In some counties, MR/RC Waiver recipients and their families were not involved in the decision to use Consumer-Directed services.

The degree of oversight in using money for Consumer-Directed services varied, according to our interviews with county personnel. In some counties, all payments for Consumer-Directed services were made through the county. Elsewhere, counties set up checking accounts for families using Consumer-Directed services. Families wrote checks off the accounts when purchasing Consumer-Directed services. Oversight of the accounts varied by county and occurred weeks or months after purchases were made. Several counties told us that they discontinued use of the checking accounts after problems arose.

Prospects for Cost Efficiencies

Allowing recipients and their families to manage their own direct-care workers is viewed both as a way to increase self reliance and "maximize the public dollars" spent for support because waiver recipients may choose care providers from among family and friends instead of exclusively from formal service providers.[8] In its 2001 report to the Legislature, the Department of Human Services acknowledged the need to improve Consumer-Directed services so that services better meet personal needs and preferences and recipients avoid institutional care "within an efficient and cost-effective framework."[9] Particularly during a time of tight resources, it is important to review whether Consumer-Directed Community Supports achieve possible cost efficiencies. We found:

- **MR/RC Waiver spending on participants using Consumer-Directed services was higher than spending on other MR/RC Waiver recipients with similar characteristics.**

We compared the cost of serving MR/RC Waiver recipients who used Consumer-Directed services with the cost of serving recipients with similar needs who did not use such services in fiscal year 2002. We restricted our comparisons to waiver recipients who lived at home because most Consumer-Directed participants live at home, and living arrangement has a large effect on cost, as Chapter 2 described. We separately analyzed two county groups: (1) the ten

8 Minnesota Department of Human Services, "The Disability Service Division's Consumer Directed Services Initiative," from *Consumer Directed Community Supports Tool Kit – 2003* (St. Paul, 2003), 3. While some observers told us that using informal caregivers could be less expensive than other care providers, others said certain MR/RC Waiver families used Consumer-Directed services so they could pay their caregivers higher salaries and retain those aides with whom they were most satisfied.

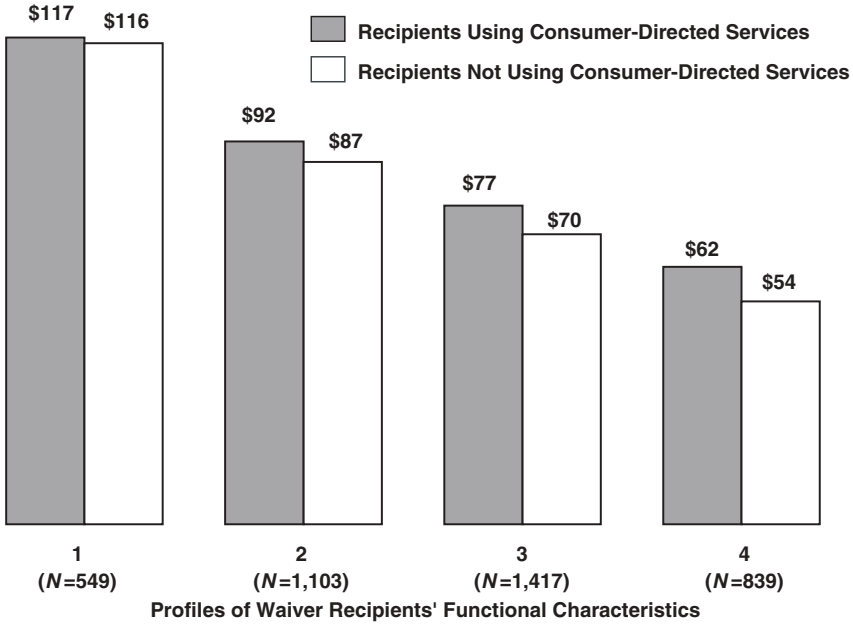
9 Minnesota Department of Human Services, *Home and Community Based Services for Persons with Mental Retardation and Related Conditions: A Report to the Minnesota Legislature* (St. Paul, December 2001), 24.

largest counties and (2) nine small or medium-sized counties that had three or more participants using Consumer-Directed services in fiscal year 2002.[10] For each group of counties, we compared recipients within the same profile.[11]

The large counties spent, on average, 8 percent more on Consumer-Directed participants than nonparticipants with the same profile. The spending gap ranged from an average $1 to $8 per recipient per day, as shown in Figure 3.1, representing 1 to 16 percent higher costs for the Consumer-Directed participants.[12] We obtained a similar pattern of results for the small or

In large counties, spending on Consumer-Directed participants was, on average, 8 percent higher than spending on other MR/RC Waiver recipients in fiscal year 2002.

Figure 3.1: Mental Retardation or Related Conditions Waiver Average Spending per Day, Consumer-Directed Recipients Compared With Other Recipients in 10 Large Counties, by Profile, FY 2002



NOTE: These comparisons include only MR/RC Waiver recipients who lived at home during fiscal year 2002 and only those who had received Consumer-Directed services for at least 180 days that year.

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

10 The ten large counties were: Anoka, Carver, Dakota, Hennepin, Olmsted, Ramsey, St. Louis, Scott, Stearns, and Washington counties. The nine small or medium-sized counties were: Blue Earth, Crow Wing, Houston, Morrison, Mower, Rice, Steele, Todd, and Wright counties. Other counties offering Consumer-Directed services had too few cases for analysis.

11 Following the department's methodology for assigning profiles, we classified waiver recipients who had not been assigned their own profile by the department into a profile appropriate to their diagnosis and behavior challenges.

12 Overall results for the 10 large counties were statistically significant at the 95 percent confidence level. We also compared costs for recipients with the same open-enrollment status because recipients who joined during open enrollment tend to have lower average costs than other recipients, as Chapter 2 described. We found a similar pattern of results when we compared costs by profile and open-enrollment status.

medium-sized counties that offered Consumer-Directed services, with an average 19 percent difference in costs between Consumer-Directed participants and nonparticipants with the same profile. Because these counties had much lower participation rates in Consumer-Directed Community Supports, however, the low number of cases was too small to show statistical significance.

Need for State Controls

Statewide controls over Consumer-Directed Community Supports could help ensure appropriate program spending and diminish equity concerns. Most counties we surveyed reported that they would welcome certain state assistance for working with Consumer-Directed services. About 82 percent of counties with Consumer-Directed services indicated in our survey that state requirements on allowable uses of Consumer-Directed money would be very useful, as Table 3.2 shows. Further, one of the items that users of Consumer-Directed services liked least was inconsistency regarding services, according to the 2002 Department of Human Services study mentioned above.[13] For instance, one participant remarked on the arbitrary nature of decisions on services because it "varied from social worker to social worker." In addition, advocacy organizations we surveyed indicated that guidance on what purchases are allowed may be insufficient. Five of the 12 advocate organizations either disagreed or somewhat disagreed that

Most counties offering Consumer-Directed services told us that state requirements on allowable uses of Consumer-Directed funds would be useful or very useful.

Table 3.2: County Opinions on Potential Usefulness of State Assistance for Working With Consumer-Directed Community Supports, 2003

	Very Useful	Useful	Somewhat Useful	Not Useful
Requirements on allowable uses of CDCS money (*N*=29)	82%	11%	4%	4%
General parameters outlining allowable use of CDCS money (*N*=31)	77	13	3	7
Specifications for allowable environmental modifications and equipment (*N*=30)	76	10	10	3
Standardized budget worksheets (*N*=31)	63	13	10	13
State-set recipient budgets calculated using a formula (*N*=28)	56	22	4	19
Limits on amounts allowed for a single expense, e.g., home modifications (*N*=29)	50	18	14	18
Cost estimates for environmental modifications and equipment (*N*=30)	48	24	21	7
Training for county staff working with CDCS (*N*=31)	47	33	13	7
Training for recipients and families receiving CDCS (*N*=31)	40	27	20	13
Training for fiscal agents working with CDCS recipients (*N*=30)	34	38	14	14

NOTES: The question read: "To what extent would state assistance be useful to your county for working with CDCS?" Rows may not sum to 100 percent due to rounding.

SOURCE: Office of the Legislative Auditor, County Questionnaire on the Mental Retardation or Related Conditions Waiver, September 2003.

13 Department of Human Services, *Consumer Directed Community Supports Focus Groups*, 13.

counties provide sufficient guidance on what Consumer-Directed expenses may or may not be funded, and six organizations only "somewhat agreed," as Table 3.3 shows.

Table 3.3: Advocacy Organizations' Opinions on Consumer-Directed Community Supports, 2003

	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Don't Know
Counties typically provide sufficient guidance on what expenses may or may not be funded through CDCS	0%	50%	33%	8%	8%
Generally, CDCS is administered consistently from county to county	0	0	8	58	33

NOTES: The question read: "Considering how consumer-directed community supports generally operate in counties today, please indicate whether you agree or disagree with the following statements." Rows do not sum to 100 percent due to rounding. (*N*=12)

SOURCE: Office of the Legislative Auditor, Mental Retardation or Related Conditions Waiver Questionnaire for Advocacy Groups, October 2003.

The Department of Human Services has proposed changes to Consumer-Directed Community Supports that will limit use of the option to waiver recipients living in their own homes.

In its proposal to expand Consumer-Directed services statewide and across all Home and Community-Based Waiver programs, the Department of Human Services is adding state requirements to govern the option. For instance, the proposal requires each participant to submit a community support plan that identifies the goods and services to be provided and reflects the individual's strengths, needs, and preferences. Another change is that the state will set a maximum amount for each individual's Consumer-Directed budget. Eligibility for Consumer-Directed services will be limited to waiver recipients who live in their own home rather than in a licensed setting such as foster care. Further, the proposal provides guidelines on allowable expenditures and lists specific items that will not be allowed, such as Internet access and tickets to sporting events. Table 3.4 lists many of the changes the department proposes in its amendment of Consumer-Directed Community Supports.

The department plans to begin implementing the revised Consumer-Directed services six months following the proposal's approval by the federal Centers for Medicare and Medicaid Services. It expects to use this time to revise its Consumer-Directed materials and help prepare counties. Counties currently offering Consumer-Directed services will be the first to use the revised services, with statewide implementation to occur sometime later.

We think the department should be prepared to offer more guidance on items not allowed by Consumer-Directed funding. Although the proposal for the revised Consumer-Directed services contains lists of "allowable" and "unallowable" expenditures, certain items remain questionable. For instance, there is no guidance on setting priorities among expenditures, such as when a county faces a decision between approving dietary supplements or recreational equipment. Certain purchases, such as cell phones or computer software, may be justifiable under particular circumstances but may appear as lower priority in other situations. For these types of items it may be appropriate for the department to require additional county review prior to approving the purchases. Further, it is

Table 3.4: Department of Human Services' Proposed Changes for Consumer-Directed Community Supports, 2003

- Recipients must develop a community support plan reflecting their needs and defining all goods and services to be paid through the program
- Only waiver recipients living at home will be eligible
- State will set the maximum budget amount for recipients' budgets; maximum spending may not exceed 70 percent of average costs of nonCDCS recipients with comparable conditions and service needs
- Recipients must verify goods or services before claims are paid
- County must review expenditures quarterly for consistency with approved plans
- Certain items, such as membership dues, are expressly prohibited
- Environmental modifications (e.g., wheelchair ramps) and assistive technology (e.g., computer adaptations) exceeding $5,000 per year require county approval
- Criteria are specified to declare a recipient ineligible for consumer-directed services
- County must provide notice and suspend recipients' services under certain conditions, such as concerns about recipients' health and safety
- Billing for services must occur through designated "fiscal support entities" (persons designated to provide payroll and billing assistance)
- Fiscal entities must maintain records of all spending for consumer-directed supports and services
- Parents or spouses may be paid through the program under certain conditions

SOURCE: Department of Human Services, *Consumer Directed Community Supports Proposal Submitted to the Centers for Medicare & Medicaid Services* (St. Paul, December 11, 2003).

Even with the department's proposed changes, county-by-county differences in Consumer-Directed services could occur.

unclear whether the amounts for certain expenditures are reasonable, such as $7,000 for yard fencing. Without more detailed guidance, additional county-by-county differences could result as counties judge what is or is not appropriate.

The department should consider providing additional guidance on conditions for terminating the use of Consumer-Directed services. Although the department's proposal would give authority to counties to suspend Consumer-Directed services when health and safety concerns arise or for misuse or abuse of public funds, it does not define what constitutes "misuse." Nor does it specify whether suspension should occur after a single incident.

RECOMMENDATION

The Department of Human Services should set additional controls to ensure equitable and appropriate spending of Consumer-Directed funds.

Before implementing Consumer-Directed Community Supports statewide, the state should evaluate how well its proposed controls work. Based on what it learns from counties that use the revised option, the department can make additional adjustments to prevent problems from recurring in other counties. Although such an evaluation will come at a cost, and it could further delay the

opportunity for Consumer-Directed services in counties that have not heretofore offered them, it is preferable to perpetuating problems that serve to weaken the option and frustrate users.

RECOMMENDATION

The Department of Human Services should evaluate its proposed controls for the revised Consumer-Directed Community Supports before implementing Consumer-Directed services statewide.

VERIFYING SERVICES FOR WHICH THE MR/RC WAIVER PROGRAM IS BILLED

The state and counties follow procedures to ensure that MR/RC Waiver program recipients receive services for which providers bill the program. In looking at how well these procedures verify service delivery, we found:

- **Counties reported taking measures to ensure that waiver recipients received services for which the MR/RC Waiver program was billed, but there were inconsistencies in following the most common measures. The Department of Human Services does not know how many providers may be billing incorrectly.**

The Department of Human Services monitors county activities for verifying services only when complaints arise. All but two counties reported taking certain measures to regularly verify services, and most reported taking multiple steps, as Table 3.5 presents. However, although counties most commonly reported that their case managers visit on-site periodically to verify service delivery, from our case file reviews we estimated that 17 percent of the cases in the 12 counties

Although most counties reported that case managers visit waiver recipients on-site to verify service delivery, we estimate that 17 percent of cases in 12 counties we visited had no evidence of face-to-face contacts.

Table 3.5: Methods Counties Reported Using to Verify That Waiver Recipients Receive Services for Which the Program is Billed, 2003

	Percentage of Counties
Case managers periodically visit on-site to verify service delivery	93%
Monitor periodic provider reports	77
Routinely solicit feedback from recipients (or families)	75
Regularly review invoices submitted by providers	63
Monitor feedback from providers about service cancellations	48

NOTE: The question read: "How does your county verify that MR/RC waiver recipients actually receive authorized services billed by providers?" (*N*=83)

SOURCE: Office of the Legislative Auditor, County Questionnaire on the Mental Retardation or Related Conditions Waiver, September 2003.

we visited showed no evidence of face-to-face contacts between case managers and waiver recipients or their families in the past year.[14] For cases where the case manager had not met personally with the waiver recipient, it would have been difficult to conduct an on-site verification of service delivery.[15]

Not all service providers produce reports of the services they provide to waiver recipients.

Counties also said they commonly verify services by reviewing periodic reports they receive from providers. This method for verifying services is of limited value, however, because some counties told us that not all service providers present counties with periodic reports of the services they offer to MR/RC Waiver recipients. In addition, on our survey of provider associations, only four of eight associations reported that all or nearly all of their members provide at least quarterly reports to counties on services provided. The other associations either did not know how many of their members provided such reports or said that either some or most of their members did so.

On-site visits and provider reports are safeguards, but by themselves they cannot identify all types of problems or potential fraud. Such methods would not, for instance, determine whether a provider submits bills for more services than were actually provided. A separate study our office released in August 2003 focused on improper payments in the state's Medicaid program, including the Home and Community-Based Waiver programs. It concluded that, despite the department's various payment control activities, the department has not comprehensively assessed the amount or nature of improper Medicaid payments occurring in Minnesota.[16] As a result, the state does not know how many providers may be billing incorrectly or the size of the problem.

The Department of Human Services has taken steps to control payments to service providers. The department sends forms to recipients indicating the services for which providers are being reimbursed. When consumers review these "explanation of medical benefits" forms, they help safeguard against inappropriate spending, but the extent to which waiver recipients or their families read and use the forms is unknown. In addition, the Department of Human Services has designed its computerized billing system, which pays service providers for Medicaid services including MR/RC Waiver services, in ways to help detect problems, such as when providers bill for more services than were authorized. As part of processing the claim, the system automatically checks for several items, including whether the claim duplicates or conflicts with other claims and whether the county has authorized the service for the recipient. In this study we did not investigate the reliability of the department's systems for identifying and correcting service and billing problems.

14 We calculated a confidence interval to indicate the range of values within which we expect the actual value to fall; we can be 95 percent confident that between as few as 11 percent and as many as 25 percent of the cases in the 12 counties we visited were unlikely to have had face-to-face contacts.

15 Case managers often check logs of services provided, which is useful but does not verify that recipients actually received what was planned.

16 Office of the Legislative Auditor, *Controlling Improper Payments in the Medicaid Program* (St. Paul, August 2003), 19.

COUNTY COMPLIANCE WITH STATE RULES ON THE MR/RC WAIVER PROGRAM

We looked at how well counties complied with select state rules to administer the MR/RC Waiver program. We analyzed rules related to: 1) determining MR/RC Waiver recipients' needs and updating the needs; 2) the availability of services to meet recipients' needs; and 3) the timeliness of determining MR/RC Waiver recipients' needs. Although we assessed county compliance with state rules, we did not study the effect that lack of compliance might have on waiver recipients. We found that:

- **Counties generally follow state rules on determining and updating MR/RC Waiver recipients' needs in a timely way and ensuring the availability of services, but there are exceptions.**

Determining and Updating Waiver Recipients' Needs – State rules contain several requirements intended to govern how counties determine MR/RC Waiver recipients' needs and how the needs might change over time. These are important because counties base waiver recipients' services on the recipients' identified needs. To the extent the documented needs are inaccurate or out of date, recipients may not receive appropriate services. The rules we examined apply to: the need for up-to-date individual service plans, the need for case managers to monitor recipients' services, periodic reviews of recipients' diagnoses, and the content of the individual service plans. Although we reviewed county compliance with these rules, we did not determine the extent to which waiver recipients may have received inappropriate services due to noncompliance.

From reviewing cases in 12 counties, we estimate that 6 percent of cases did not contain a 2003 individual service plan or equivalent document.

Minnesota Rules require counties to update each waiver recipient's individual service plan at least annually.[17] The service plans are intended to help determine appropriate services, among other things, as Chapter 1 describes. When we visited a select number of counties to review case files, we saw that although most of the files contained a 2003 individual service plan or similar document, about 6 percent did not, as shown in Figure 3.2.[18] Beyond that, about 15 percent of cases with a service plan (or similar document) in a recent year did not have one from the year prior.[19] These case files held no evidence that the waiver recipients' service plans had been updated on an annual basis.

Another state rule requires case managers to conduct a monitoring visit with each waiver recipient at least semiannually.[20] Such interactions between case managers and waiver recipients or their families help ensure that case managers have the information needed to update the service plan and determine that the recipient is getting needed services. Based on our case file review, 40 percent of all waiver recipients or their families had fewer than two face-to-face contacts in

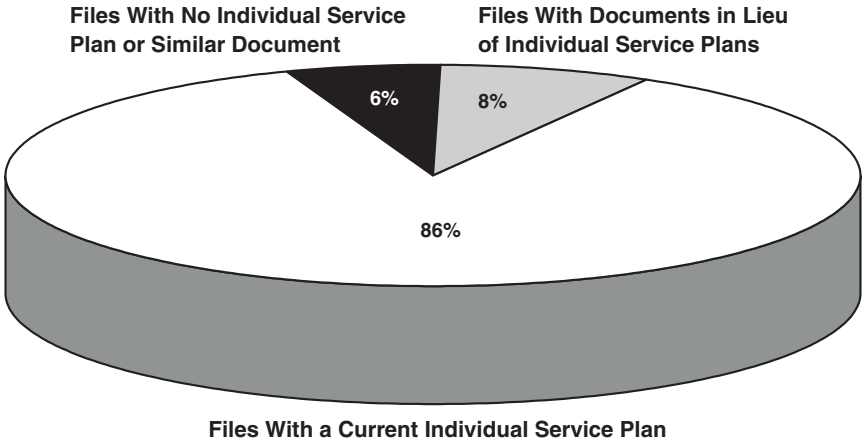
17 *Minn. Rules* (2003), ch. 9525.0016, subp. 13.

18 We can be 95 percent confident that the value is between 4 percent and 12 percent of the cases.

19 We can be 95 percent confident that the value is between 9 percent and 22 percent of the cases.

20 *Minn. Rules* (2003) ch. 9525.0024, subp. 8. The rule does not define "monitoring visit."

Figure 3.2: Individual Service Plans for Mental Retardation or Related Conditions Waiver Recipients, 2003



NOTE: *N*=194 case files.

SOURCE: Office of the Legislative Auditor, Review of County Case Files, October 2003.

the past year, as shown in Table 3.6.[21] When we counted face-to-face visits together with telephone contacts, 21 percent of waiver recipients in our case studies still had fewer than two case manager contacts in the past year.[22] As reported earlier, in 17 percent of the cases, there was no evidence that case managers had any face-to-face meetings with waiver recipients or their families. In response to our survey, about three-fourths of counties reported having a standard for a minimum number of contacts with waiver recipients, and in all but one of these counties the standard was a minimum two contacts per year. More than half of the counties with minimums reported that they did not meet them for all of their waiver recipients.[23]

State rules also require that counties review a waiver recipient's diagnostic assessment once every three years.[24] These reviews are needed to determine whether diagnoses reflect recipients' current levels of functioning. We asked counties whether they take steps to ensure that case managers review the diagnoses every three years, and eight counties reported that they did not. Many counties reported that they review the diagnosis on a yearly basis at the same time they review the recipients' needs and services. Five counties specified that they

21 We can be 95 percent confident that the value is between 32 percent and 48 percent of the cases.

22 We can be 95 percent confident that the value is between 14 percent and 29 percent of the cases.

23 The most common reasons given for failing to meet the minimum was "other demands on case managers' time," particularly in small counties, and "lack of waiver recipient cooperation."

24 *Minn. Rules* (2003), ch. 9525.0016, subp. 6. By state rule, the diagnostic assessment that counties review contains several components, including tests of intellectual functioning administered by qualified psychologists.

Table 3.6: Number of Case Manager Contacts, 2003

	Contacts With Recipient or Family					Contacts With Others				
	Face-to-Face	Phone	Written	Face-to-Face or Phone	All Types	Face-to-Face	Phone	Written	All Types	Total of All Types of Contacts
Mean	3.2	5.3	1.3	8.5	9.8	1.5	9.8	2.5	13.8	23.6
Median	2	3	0	6	7	1	4	1	8	17
Maximum	25	67	13	77	77	19	107	42	168	201
Cases with fewer than two contacts	62	66	127	28	20	119	47	99	23	5
Cases with no contacts	23	45	89	13	7	74	27	67	12	1

NOTE: The term "Others" includes persons such as service providers or special education teachers who work with the waiver recipient. (*N*=172 case files.)

SOURCE: Office of the Legislative Auditor, Review of County Case Files, October 2003.

use a different schedule for reviewing diagnoses, such as every five years for adults and every three years for children.

Minnesota Rules also mandate the content of waiver recipients' individual service plans, as Chapter 1 described. One component required of service plans is the recipient's long- and short-range goals.[25] One percent of the case files in the 12 counties we visited had neither short- nor long-term goals.[26] This is consistent with county responses to our survey, in which all counties indicated that they verify the completeness of individual service plans by using at least one of several methods, such as a form listing all of the required information.[27] Although nearly all service plans we reviewed contained goals as required, 15 percent did not clearly distinguish between short- and long-range goals or contained one or the other but not both types of goals. The distinction between short- and long-range goals may be important in determining how well the services are directed at achieving recipients' goals, as state rules require.[28]

Nearly all of the individual service plans we reviewed for cases in 12 counties contained short- and long-range goals, as state rules require.

Availability of Services – State rules pertaining to the availability of services are designed to ensure that waiver recipients receive services they need regardless of where in the state they reside. The rules say that case managers shall arrange for authorized services consistent with, among other things, the needs and preferences of the waiver recipient as identified in the individual service plan.[29] Case managers are responsible for assisting waiver recipients to secure the services identified in their individual service plans, even if the services are not currently available.[30] In our assessment of service availability, we did not independently verify how many waiver recipients may have been affected by unavailable services.

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

26 We can be 95 percent confident that the value is likely between 0.5 percent and 3.7 percent of the cases.

27 One county did not respond to the question.

28 *Minn. Rules* (2003), ch. 9525.0024, subp. 8 A.

29 *Minn. Rules* (2003), ch. 9525.0016, subp. 11 A.

30 *Minn. Rules* (2003), ch. 9525.0024, subp. 5-6.

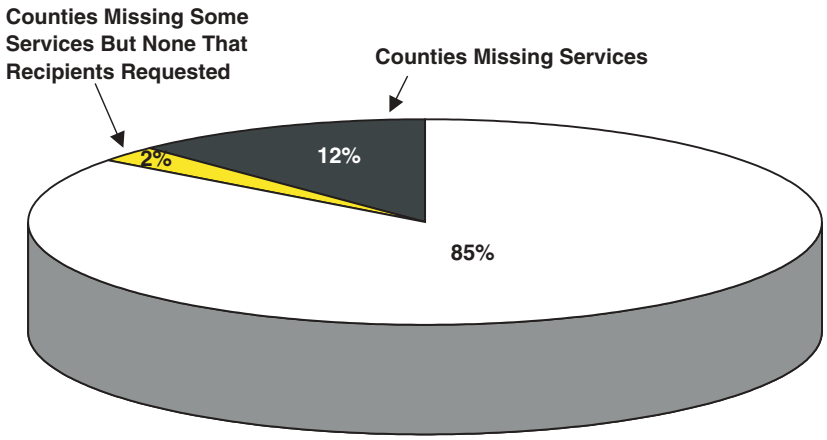
The Department of Human Services does not monitor the availability of services from county to county. About one in eight counties reported on our survey that they did not have a full range of MR/RC services available at the end of 2002 for their MR/RC Waiver recipients. Another two counties said they did not have all services but did have available those services being requested at the time, as Figure 3.3 shows. Most often, counties reported that the unavailable services were 24-hour emergency assistance, adult day care service, and housing access coordination. All of the counties without full services, however, reported taking steps to correct the situation. Counties most often said that they either approach current providers to discuss expanding existing services or attempt to obtain the service from providers in neighboring counties.

One in eight counties reported that they did not have a full range of MR/RC Waiver services available at the end of 2002.

The open-enrollment period of 2001 exacerbated the lack of services in certain counties. Only 20 percent of counties, most of which were smaller counties, reported having services in place when open enrollment ended in July 2001 to accommodate all or nearly all of MR/RC Waiver recipients' needs. Within six months of the end of open enrollment, 73 percent of all counties reported having full services available. Two counties indicated they did not have full services available a year and a half after open enrollment ended.[31]

Ensuring Assessment of Needs in a Timely Way – Several state rules specify timelines for certain county activities. One applies to the timing for completing

Figure 3.3: Range of Services Available in 2002 as Reported by Counties, 2003



NOTES: The question read: "As of the end of 2002, was the full range of MR/RC waiver services available for your county's MR/RC Waiver recipients?" Percentages do not total 100 percent due to rounding. (*N*=82)

SOURCE: Office of the Legislative Auditor, County Questionnaire on the Mental Retardation or Related Conditions Waiver, September 2003.

31 In one case, most of the new waiver recipients were children, but the county's services at the time were more appropriate for adults. In another case, a county reported that its remote location and small number of potential recipients made it difficult to attract providers.

diagnostic evaluations, and a second applies to the initial meeting of screening teams. These rules help ensure that applicants for waiver services and new recipients do not wait excessively before receiving services to which they are entitled. In reviewing county compliance, we did not assess how the lack of timeliness affected waiver recipients.

Many counties acknowledged difficulties in meeting timeliness requirements for completing diagnostic evaluations of MR/RC Waiver applicants.

When individuals apply for the MR/RC Waiver program, state rules require counties to complete diagnostic evaluations within 35 days to determine applicants' eligibility.[32] The Department of Human Services does not review the timeliness of counties' activities, but many counties acknowledged difficulty in meeting the timeline for completing the diagnostic evaluations. Just 29 percent of counties reported in response to our survey that they completed the diagnostic evaluations in a timely way for all applicants in 2002; about a third of counties reported meeting the timeline for less than 90 percent of their applicants.[33] State statutes give waiver recipients the right to file an appeal when they believe that a county agency has taken longer to act than statutes require.[34] Appeals are an insufficient method for controlling county timeliness because the appeals process can be time consuming and drawn out, and recipients file relatively few appeals for any reason, with just 6 MR/RC Waiver appeals in 2001 and 16 in 2002.

Service planning teams identify waiver recipients' needs and preferences for services.

A second timing requirement applies to screening teams, which review diagnostic evaluations and other data and determine a person's level of needed care. State rules require that counties convene screening team meetings within 60 days of a person's initial request for service.[35] About one-third of counties reported in our survey that they did not meet the screening team deadline for all of their MR/RC

32 *Minn. Rules* (2003), ch. 9525.0016, subp. 3.

33 In addition, three counties, including two of the largest counties, responded that they did not have information to answer the question. About 79 percent of counties reported that they did not meet the timelines because applicants did not meet their responsibilities to complete the diagnostic evaluations and 72 percent of counties reported that the limited availability of psychologists to administer tests was a barrier to meeting the timelines, although this was far more common in the medium- and small-sized counties than in the large ones.

34 *Minn. Stat.* (2003) §256.045, subd. 3.

35 *Minn. Rules* (2003), ch. 9525.0016, subp. 7.

Waiver recipients, but most reported meeting the 60-day requirement for 90 to 99 percent of their waiver recipients.[36]

NEED FOR STATE REVIEW OF COUNTY ADMINISTRATION

In 2004, the Department of Human Services plans to begin reviewing county administration of all Medicaid Home and Community-Based Waiver programs. Its goals for the county reviews are to: gain familiarity with local practices, target training and technical assistance, and correct any inappropriate behavior.

The Department of Human Services' county reviews will allow the department to help ensure compliance with state rules.

RECOMMENDATION

When the Department of Human Services begins formally reviewing county administration of Home and Community-Based Waiver programs in 2004, it should assess county compliance with practices required in state rules for the MR/RC Waiver program.

All counties are obligated to follow state rules governing the MR/RC Waiver program. Formal county reviews offer the department an opportunity to examine county practices more closely and help ensure compliance. While addressing our recommendation may increase the cost of the reviews, it fits with the department's goals for the reviews.

36 Counties most commonly said that the reason for delay was that recipients did not meet their responsibilities to participate in a meeting. A number of smaller counties volunteered that the need to wait for eligibility determinations or diagnostic information prevented them from meeting the timing requirement.

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Minnesota Department of Human Services

February 6, 2004

James R. Nobles, Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

Thank you for the opportunity to review and comment on your report, "Medicaid Home and Community-Based Waiver Services for Persons with Mental Retardation or Related Conditions."

The Department of Human Services agrees with the findings of your report and is pursuing those recommendations.

Yours sincerely,

/s/ Kevin Goodno

Kevin Goodno
Commissioner

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