OFFICE OF THE LEGISLATIVE AUDITOR
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**Evaluation Summary / February 2017**

# Home- and Community-Based Services: Financial Oversight

**To improve financial accountability, the Legislature and Department of Human Services (DHS) should increase requirements for home- and community-based services (HCBS) providers.**

## Key Facts and Findings:

- The federal government gives states considerable flexibility to design and administer their Medicaid programs, including the home- and community-based services (HCBS) they choose to offer.
- The Minnesota Department of Human Services (DHS) provides a variety of HCBS to Medical Assistance (MA) recipients with disabilities and the elderly through its state MA plan and five federally approved waivers.
- It is difficult to put a comprehensive price tag on HCBS, mainly due to differing financial reporting requirements and payment methods.
- Medical Assistance expenditures to provide HCBS to about 64,000 adults with disabilities and the elderly totaled $2.4 billion in Fiscal Year 2015; the median cost per recipient was $21,993.
- The median cost per MA recipient with disabilities that received HCBS through the state MA plan was $2,713 in Fiscal Year 2015. For those who received HCBS through a waiver, median costs ranged from $4,191 to $158,554 per recipient in 2015.
- A little more than half of MA spending for HCBS in 2015 was for supported living and foster home/assisted living services, generally provided to people in residential settings to help them live more independently.
- In Fiscal Year 2015, 10 percent of all providers accounted for 70 percent of MA payments for HCBS.
- While Minnesota spends more per capita on HCBS than other states, other measures suggest that it has not been overly successful in helping people with disabilities live or work alongside people without disabilities.
- The Department of Human Services does not collect adequate information to conduct financial oversight of all HCBS providers.
- The Department of Human Services has more stringent reporting requirements for personal care attendants than it does for other workers who do similar work.
- Demographic changes, staff shortages, low wages, and demanding work complicate HCBS providers' ability to hire enough staff to respond to the demand for services, both in Minnesota and across the nation.
- Wages for some types of direct care staff are generally higher in Minnesota than in other states, and they are comparable to the payment rates used by DHS under its waivers.

## Key Recommendations:

- The Legislature should increase its regulation over some types of direct care workers who provide HCBS in recipients' own homes.
- The Legislature should require the Department of Human Services to periodically collect data on direct care staffing in HCBS settings.
- The Legislature and Department of Human Services should adopt a common set of financial reporting requirements and menu of services for HCBS.

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## Report Summary

The federal Medicaid program requires states to develop statewide programs for people who do not have the resources to pay for their medical care. Medical Assistance (MA) is Minnesota's Medicaid program. It served, on average, just over 1 million people monthly in 2015 at a total cost of about $10.5 billion.

The Minnesota Department of Human Services (DHS) is the state's lead Medicaid agency and, as such, is responsible for administering MA. It has, in turn, delegated various responsibilities to counties, tribal governments, and managed care organizations.

**Tracking the full cost of HCBS is difficult due to different reporting and payment requirements.**

### Medical Assistance provides home- and community-based services (HCBS) to people with disabilities and the elderly.

Home- and community-based services help people with limited abilities live more independently. They offer an alternative to nursing homes, hospitals, or other long-term care settings.

Home- and community-based services may include: assistance with eating, dressing, mobility, or obtaining and keeping a job; transportation getting to and from various community settings; residential supervision; physical, occupational, and speech therapies; personal care and home health services; house or yard work; and respite for caretakers.

Minnesota provides HCBS to MA recipients in two ways. First, all MA recipients, regardless of whether they have disabilities, are eligible to receive certain types of HCBS as part of the state's overall MA plan.

Second, MA recipients "certified" as disabled may receive special or expanded HCBS through one of the state's five federally approved waivers. Being certified as having a disability means that an individual is unable to engage in substantial work activities due to a medically determined impairment expected to result in death or last continuously for at least 12 months. To be eligible for a waiver, certified recipients further need the level of care provided in long-term care institutions. The elderly and those diagnosed with developmental disabilities must only meet the latter criteria to be eligible for a waiver.

### It is difficult to put a comprehensive price tag on HCBS.

There are a variety of reasons for this. First, there are differing reporting requirements and payment methods for HCBS. The amount or type of financial data that DHS collects to oversee HCBS varies, depending on (1) whether MA recipients receive HCBS through the state MA plan or waivers, (2) the type of health plan in which recipients are enrolled, (3) the type of HCBS provided, and (4) the type of HCBS provider. To help address this, DHS should adopt a common set of financial requirements for HCBS, regardless of how the services are delivered.

Second, programs other than MA, both inside and outside of DHS, provide similar services for which MA recipients may be eligible. For example, the Minnesota Department of Employment and Economic Development provides vocational services to individuals with disabilities that are similar to the services provided by DHS.

Third, state and national laws, rules, and guidelines for HCBS that have evolved over time have become increasingly complex and confusing. This may make it difficult for DHS to collect adequate financial data from HCBS providers in an efficient manner.

### Medical Assistance expenditures for HCBS for adult recipients with disabilities and the elderly totaled $2.4 billion in Fiscal Year 2015.

About 64,000 adult MA recipients with disabilities and the elderly received HCBS through MA in Fiscal Year 2015. Median and average costs per recipient were $21,993 and $37,438, respectively.

Expenditures on behalf of recipients through the state MA plan were much lower than spending through waivers. For the most part, state plan HCBS may serve a population with less debilitating conditions or those who are able to obtain the assistance they need from sources other than MA, such as family members or other caregivers. Median and average MA costs for HCBS to recipients with certified disabilities through the state MA plan (27,500 recipients) were $2,713 and $12,986, respectively.

For recipients who received HCBS through waivers (41,959), median and average costs were $35,116 and $48,485, respectively. Costs varied widely, however, depending on the type of waiver. For example, annual median cost per recipient in Fiscal Year 2015 was $158,554 for those with chronic health conditions. Annual median costs for the two waivers enrolling the largest number of adult MA recipients were $24,213 for those with physical and other disabling conditions (19,642 enrollees) and $73,166 for those with developmental disabilities (15,226 enrollees).

**The majority of MA spending for HCBS in 2015 was for services provided to people with disabilities in residential settings, including foster homes and recipients' own homes.**

**Services to train adults to live independently and provide basic care in recipients' homes account for most HCBS spending.**

Supported living services, which are provided to people with developmental disabilities living in foster homes or their own homes, accounted for the largest share of total MA expenditures for HCBS ($742.5 million or 31 percent). These services focus on providing and teaching recipients to perform daily activities, such as eating, dressing, and bathing. Spending for foster home/assisted living services provided largely to people with other types of disabilities, accounted for 22 percent of HCBS expenditures ($536.9 million). Services provided mainly to recipients in their own homes by personal care attendants and home health aides accounted for 19 percent ($462.2 million). Day training and habilitation services, generally provided to people with developmental disabilities in nonresidential settings, accounted for 8 percent ($183.1 million). All other types of services, including medically related services such as nursing and therapeutic services, each accounted for 3 percent or less of HCBS spending.

**The Department of Human Services does not collect adequate financial documentation from HCBS providers.**

The Minnesota Department of Human Services began licensing providers of many types of services for people with developmental disability in 1997 and expanded to other types of HCBS providers in 2014. As part of its licensing process, however, DHS does not require or collect financial documentation. In addition, the department does not conduct routine financial investigations of HCBS providers. It only does so when problems come to its attention through processing payment claims or complaints.

In 2014, DHS began setting statewide payment rates for most HCBS. The department's system for processing claims has checks to prevent providers from fraudulently altering payment rates and the services included in recipients' service agreements. (Service agreements are documents counties develop that identify providers and the type, intensity, and frequency of HCBS they agree to provide to individual MA recipients.) However, according to DHS, some providers have found ways to bypass these safeguards to increase their overall payments.

**The Legislature should more closely regulate some types of HCBS direct care staff.**

A 2009 report by our office documented numerous instances of fraud by personal care attendants—those who help MA recipients maintain their independence in the community. We issued several recommendations for greater oversight by DHS, some of which have been enacted into law. These changes helped DHS identify over $1.6 million in personal care

overpayments between 2014 and 2015. However, the changes adopted only apply to personal care attendants. They do not cover other types of direct care staff, such as home health aides and homemakers, who perform similar work in recipients' homes—generally unsupervised.

**While DHS does not conduct routine financial audits of HCBS providers, it should improve financial accountability with increased regulation of some types of direct care staff.**

At a minimum, we recommend the Legislature extend personal care attendant requirements to other types of direct care staff that perform similar work in recipients' own homes. This would involve: (1) requiring additional types of HCBS direct care workers to enroll with DHS, (2) limiting the number of hours that these workers can bill DHS, and (3) requiring documentation of the provision of services.

### The Legislature should require DHS to regularly collect data on direct care staff in HCBS settings.

Providers of HCBS in Minnesota—and across the nation—are facing several staffing issues. First, the number of individuals entering the workforce is growing at a much slower rate than the number of people who may need HCBS in the future. The Minnesota Department of Employment and Economic Development predicts that the number of home health care jobs will increase 30 percent between 2014 and 2024, while the number of people age 65 and older will increase more than 50 percent. It estimates 16,000 job openings for home health aides in Minnesota through 2022.

Second, relatively low wages for many types of direct care staff make it difficult for HCBS providers to compete with other employers. Although hourly wages for home health, nursing, and personal care aides in Minnesota ($11.51 to $12.22) are generally higher than in other states, they are far below the national average across all occupations ($23.23). Moreover, HCBS providers must compete with other healthcare employers, such as hospitals and nursing homes, that provide similar services but pay higher wages. They must also compete with other types of employers, such as grocery stores and gas stations, which can pay employees the same or more for work that is considerably easier than HCBS work.

The department needs to collect data on direct care staff specific to HCBS providers to better understand their workforce problems. These data should include: (1) the number of direct care workers employed by HCBS providers, both full and part time; (2) turnover; (3) the number of job vacancies; (4) average hourly wage; (5) the average benefit package; and (6) advancement opportunities. This type of information is necessary for state policy makers to develop appropriate strategies to address workforce issues confronting HCBS. The information is also needed to assess the impact of those strategies over time and make whatever changes may be necessary.

## Summary of Agency Response

*In a letter dated February 16, 2017, Department of Human Services Commissioner Emily Piper said that the department agrees "that the recommendations in the report highlight areas for continued improvement" and "concur[s] [that the department] should improve how [it] manage[s] these programs into the future." She noted that "the Governor's budget and the Department's policy bill include a number of proposals, which align closely with the recommendations in the report." She concluded by stating that "the Department's policy is to evaluate, monitor, and track until final resolution the progress being made in response to the recommendations in the report."*

The full evaluation report, *Home- and Community-Based Services: Financial Oversight*, is available at 651-296-4708 or: **www.auditor.leg.state.mn.us/ped/2017/hcbs.htm**