Home- and Community-Based Services: Financial Oversight

2017
EVALUATION REPORT

Program Evaluation Division
OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

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Members of the Legislative Audit Commission:

Minnesota provides a variety of home- and community-based services (HCBS) through its Medical Assistance program. These services are intended to help the elderly and adults with disabilities live in the community rather than institutions.

Minnesota spent about $2.4 billion in Fiscal Year 2015 to provide these services to approximately 64,000 individuals. The median cost per recipient was about $22,000.

Despite the significant amounts of money spent for HCBS, we found that the Minnesota Department of Human Services does not provide adequate financial oversight of all HCBS providers.

To improve financial accountability, we recommend that the Legislature and department increase reporting requirements for HCBS providers. We also recommend that the Legislature require the department to periodically collect certain workforce-related data on HCBS workers.

Our evaluation was conducted by Jo Vos (project manager), Ellen Dehmer, Jennyfer Hildre, and Jolie Wood, with assistance from Emily Wiant.

The Minnesota Department of Human Services cooperated fully with our evaluation, and we thank the department for its assistance.

Sincerely,

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Summary

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. (pp. 4-8)
- 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. (pp. 3, 21-24)
- It is difficult to put a comprehensive price tag on HCBS, mainly due to differing financial reporting requirements and payment methods. (pp. 17-18)
- 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. (p. 19)
- 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. (pp. 19-21)
- 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. (pp. 23-24)
- In Fiscal Year 2015, 10 percent of all providers accounted for 70 percent of MA payments for HCBS. (pp. 34-36)
- 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. (pp. 13-16)
- The Department of Human Services does not collect adequate information to conduct financial oversight of all HCBS providers. (pp. 39-40, 47-48)
- The Department of Human Services has more stringent reporting requirements for personal care attendants than it does for other workers who do similar work. (pp. 50-51)
- 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. (pp. 53-58)
- 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. (pp. 55-56)

Key Recommendations:

- The Legislature should increase its regulation over some types of direct care workers who provide HCBS in recipients' own homes. (p. 51)
- The Legislature should require the Department of Human Services to periodically collect data on direct care staffing in HCBS settings. (p. 57)
- The Legislature and Department of Human Services should adopt a common set of financial reporting requirements and menu of services for HCBS. (p. 61)

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

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

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.

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.

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 disabilities 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

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

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.

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.

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.

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Introduction

Over the last several years, the state of Minnesota has been under increased pressure to ensure that all Minnesotans with disabilities are afforded the opportunity to live and participate in their local communities rather than in institutional settings. Services provided in institutional settings, such as nursing homes and hospitals, segregate people with disabilities from the rest of society.

To this end, the Department of Human Services (DHS) provides a variety of services through its Medical Assistance (MA) program to help low-income adults achieve as much independence as possible. These services, commonly referred to as home- and community-based services (HCBS), cover a wide range of activities, including training to help individuals live independently; 24-hour emergency assistance; homemaker, personal care, and home health aide services; specialized equipment and technology; and vocational support. Services are provided in a variety of settings, including recipients' own homes; provider controlled residential settings, such as foster homes or assisted living; or daytime settings, such as adult day care centers or sheltered workshops.

In March 2016, the Legislative Audit Commission directed the Office of the Legislative Auditor (OLA) to evaluate HCBS for MA recipients with disabilities. Our evaluation addressed the following research questions:

- **What types of HCBS are provided to adult MA recipients with disabilities and the elderly, and in what settings are they delivered?**

- **How much does the state spend, in terms of MA, to provide HCBS, what types of organizations provide HCBS, and what do the different types of HCBS cost?**

- **To what extent has DHS developed the necessary tools to provide financial oversight of HCBS providers?**

We used a variety of methods to answer these questions. First, we reviewed state and federal laws, rules, and regulations, and district and federal court rulings related to HCBS. Second, we examined DHS policies, procedures, reports, and other documents, and we reviewed the national literature on HCBS. Third, we used DHS's management information systems to analyze all claims paid to provide HCBS to adult MA recipients with disabilities during Fiscal Year 2015. We supplemented these data with other DHS data on housing assistance and data from the Department of Employment and Economic Development regarding vocational rehabilitation services provided to the same group of HCBS recipients. Fourth, we talked with state and county staff, HCBS providers, and representatives from various advocacy organizations.[1] Finally, we attended various task force and advisory group meetings as well as information and training sessions for the public and other stakeholders.

[1] We spoke with staff from 10 counties and 16 HCBS providers throughout Minnesota. We selected providers based on the amount MA paid them for HCBS in Fiscal Year 2015 and the types of services they delivered. We tried to focus on providers that received relatively high amounts of MA payments relative to their geographic area. Once we selected our provider sample, we talked with the counties where those providers were based. Our two samples are not representative of either population, and their comments cannot be generalized to all counties or providers.

Our evaluation took a broad look at HCBS, and there are several important issues that we did not examine, including: HCBS housing concerns (including the moratorium on corporate foster care homes); eligibility; the availability of services (including waiting lists); program quality; or effectiveness.[2] Although we discuss providers' concerns about DHS's methodology for determining HCBS payment rates, we did not fully analyze the various factors going into the formula. Finally, although some legislators wanted us to examine HCBS providers' profit margins, lack of financial reporting requirements and inconsistent data collection across providers prevented us from doing so.

[2] The 2009 Minnesota Legislature authorized a moratorium on the growth of licensed corporate foster care settings beyond a predetermined threshold. The moratorium remains in effect. *Laws of Minnesota* 2009, chapter 79, art. 8, sec. 8. Regarding waiting lists, the number of people with disabilities waiting for HCBS has decreased since May 2014, due in part to additional funding from the Legislature. Currently, there is only a waiting list for people with developmental disabilities. Minnesota Department of Human Services, *Disability Waiver Financial Management and Waiting Lists* (St. Paul, December 2016), 5.

Chapter 1: Background

With the nationwide shift away from institutional care that began in the late 1960s, providing services to people with disabilities in community-based settings has become a more commonly used approach to long-term care. Minnesota provides a variety of home- and community-based services (HCBS) through its publicly funded healthcare programs to help low-income people with disabilities remain in their local communities. This chapter discusses the major legal provisions that guide the state's approach to providing HCBS, funding sources, and how Minnesota compares with other states in overall HCBS spending and service delivery.

The federal government has given states considerable flexibility to design and administer their HCBS systems. This includes the specific services states choose to offer and the groups of individuals eligible for them. Minnesota was one of the first states to take advantage of this flexibility, with some of its HCBS programs dating back more than 25 years. More recent federal requirements and court cases, however, question the adequacy of the state's efforts to ensure equal opportunities to low-income people with disabilities.

Definitions

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

Minnesota provides a variety of home- and community-based services (HCBS) to help low-income people with disabilities live and participate in local communities rather than institutions.

These services may include: assistance with eating, dressing, mobility, or obtaining and keeping a job; transportation to community events or one's place of employment; residential supervision; physical, occupational, and speech therapies; training in living skills; house or yard work; and respite for caretakers. Chapter 2 more explicitly defines HCBS and provides detailed cost and utilization data for specific types of HCBS provided to a subset of low-income individuals.

Providing HCBS has many purposes: helping people with disabilities live in the most integrated settings of their choice and as independently as possible; honoring people's preferences; and promoting cost effective options to institutional care and services. Individuals considered to be living "in the community" may reside in their own homes; with their families; or in certain types of regulated residential facilities, including assisted living and foster care homes (both family and corporate).[1]

[1] In family foster care, the licensed provider actually lives in the home alongside residents. For the most part, this individual is considered the primary caregiver. In corporate foster care, the licensed provider hires workers to provide care in a home where he or she does not live.

Institutional settings include nursing homes, hospitals, treatment centers, intermediate care facilities for people with developmental disabilities, and other state-licensed residential facilities. For the most part, state- and federally funded HCBS are not available to individuals living in these settings, unless the services are provided to help transition individuals from an institution to the community. In addition, in the last few years, federal regulations caution states that some individual foster homes can be considered institutional if their environments are too restrictive.[2]

Legal Framework

State and federal laws, Centers for Medicare and Medicaid Services (CMS) regulations, and judicial rulings authorize and guide Minnesota's HCBS system. Exhibit 1.1 provides an overview of this legal framework, which we discuss in greater detail below.

Medicaid

In 1965, Congress established Medicaid as part of the *Social Security Act*.[3] The Centers for Medicare and Medicaid Services in the U.S. Department of Health and Human Services administers the program by issuing regulations and guidelines that states must follow to receive federal funding. Medicaid requires participating states to offer basic healthcare services to certain categories of low-income individuals, including people age 65 and older, adults who are permanently and totally disabled, pregnant women, and children.[4] Mandatory services include physician care, inpatient and outpatient hospital care, and certain home health services, among others.

The federal government gives states considerable flexibility in how they design and administer their Medicaid programs, including the HCBS they choose to offer.

Medicaid allows states to include additional services and categories of individuals in their programs if they so choose. Optional services may include mental health services, physical and occupational therapies, and HCBS, among others. Further, if states choose to offer HCBS, the federal government allows them to decide (1) who will be eligible for their state HCBS programs and (2) the different types of services they will offer.

Over the last several years, the federal government has given states a variety of options for administering these "extra" services. One of the first options available allows states to simply choose to offer some HCBS as part of their overall state Medicaid plans, which generally makes all Medicaid recipients eligible to receive the HCBS if needed. Minnesota has chosen to expand its public healthcare plans in this way to make some HCBS available to all health plan enrollees. For example, HCBS available to all health plan enrollees include personal care attendants, physical and occupational therapies, and certain types of case management services.[5]

[2] 42 *CFR*, sec. 441.301 (2014).

[3] *Social Security Act of 1965*, 42 *U.S. Code*, sec. 1396.

[4] *Social Security Act of 1965*, 42 *U.S. Code*, sec. 1396d.

[5] The federal government requires states to include certain home health services as part of their overall benefit packages.

Exhibit 1.1: Legal Framework for Providing Home- and Community-Based Services

Year Enacted	Provision	Authority	What it Does
1965	*Social Security Act* (Title XIX)	U.S. Congress	• Establishes the federal Medicaid program • Requires participating states to offer basic healthcare services to certain categories of low-income individuals
1967	*Minnesota Statutes* 2016, Chapter 256B	MN Legislature	• Establishes a statewide program for people who do not have the resources to pay for medical care • Is the basis for Minnesota's Medicaid program, Medical Assistance (MA)
1981	*Omnibus Budget Reconciliation Act* (OBRA)	U.S. Congress	• Allows states to use Medicaid to provide home- and community-based services (HCBS) to people who would otherwise require Medicaid-covered services in an institutional setting • Establishes federal waiver program
1990	*Americans with Disabilities Act* (ADA)	U.S. Congress	• Landmark civil rights legislation that guarantees equal opportunity for people with disabilities in public accommodations, employment, services, and telecommunications
1999	*Olmstead v. L.C.*	U.S. Supreme Court	• Ruled that unjustified segregation of people with disabilities violates Title II of the 1990 *Americans with Disabilities Act* • Requires states to provide community-based services to persons with disabilities when (1) such services are appropriate, (2) affected individuals do not oppose it, and (3) the services can be reasonably accommodated
2011	*Jensen v. DHS*, Jensen Settlement	U.S. District Court (MN)	• Requires that the state of Minnesota and Department of Human Services (DHS) develop and implement a plan to help ensure that people with disabilities receive services that effectively meet their needs in the most integrated settings possible, in compliance with Olmstead • Led to creation of Minnesota's Olmstead Plan, which was approved in 2015
2012	*Minnesota Statutes* 2016, 245D	MN Legislature	• Adds additional types of HCBS to DHS's licensing authority • Establishes additional licensing standards
2013	*Minnesota Statutes* 2016, 256B.4914	MN Legislature	• Requires DHS to determine payment rates for certain HCBS and sets forth a rate-setting methodology
2014	42 *CFR*, secs. 441.301 and 441.530 (2014)	Centers for Medicare and Medicaid Services	• Establishes new requirements for HCBS financed through several Medicaid programs, including HCBS waivers • Requires that HCBS be provided in integrated settings that allow recipients full access to their communities • Mandates person-centered planning
2014	*Workforce Innovation and Opportunity Act* (WIOA)	U.S. Congress	• Helps people with barriers to employment have access to services they need to succeed in the labor market

SOURCE: Office of the Legislative Auditor, review of state and federal laws, regulations, and court rulings.

States can also choose to limit HCBS or certain types of HCBS to distinct groups of Medicaid recipients or to certain geographic areas. To do so, states must apply for one or more federal "waivers." Receiving a waiver allows states to forgo certain Medicaid requirements concerning service comparability and availability.[6] Authorized in 1981, the provision allows states to provide HCBS to individuals who would otherwise require Medicaid-covered hospital, nursing home, or other long-term institutional care.[7] Using this option requires "cost-neutrality," which means that states must show it is no more expensive, on average, to provide HCBS than to provide institutional care to comparable Medicaid recipients.[8] Almost all states, including Minnesota, use this option to provide at least some HCBS.

Medical Assistance

Medical Assistance (MA) is the state's response to the federal Medicaid program. Passed in 1967, state law establishes MA as a statewide program for people who do not have the resources to pay for their medical care.[9] It served, on average, just over 1 million people monthly during Fiscal Year 2015 at a total cost of about $10.5 billion.[10]

The federal government and states share in financing MA according to a formula known as the Federal Medical Assistance Percentage. This formula determines the federal share based on each state's per capita income in relation to the national per capita income—the higher a state's income, the lower the federal share. In Fiscal Year 2015, the federal government paid about 57 percent ($5.9 billion) of Minnesota's total MA costs, with the state paying 42 percent ($4.3 billion) and counties 1 percent ($154 million).[11]

Over one-quarter of Medical Assistance expenditures paid for HCBS in Fiscal Year 2015.

As noted above, MA spending in Fiscal Year 2015 totaled about $10.5 billion.[12] About $2.8 billion of this amount—27 percent—went toward providing HCBS to MA recipients.[13] The Department of Human Services estimates that the proportion of MA expenditures going to HCBS will continue to increase.

[6] Generally, state plans must be in effect throughout the entire state, with the same scope of coverage statewide. *Social Security Act of 1965*, 42 *U.S. Code*, sec. 1396n, subs. (c).

[7] *Social Security Act of 1965*, 42 *U.S. Code*, sec. 1396n, subs. (c). These waivers are commonly referred to as Section 1915(c) waivers.

[8] *Social Security Act of 1965*, 42 *U.S. Code*, sec. 1396n, subs. (c)(2)(D).

[9] *Laws of Minnesota* 1967, Extra Session, chapter 16, sec. 1, codified as *Minnesota Statutes* 2016, 256B.

[10] Minnesota Department of Human Services, "Background Data Tables for November 2016 Forecast," https://mn.gov/dhs/general-public/publications-forms-resources/reports/financial-reports-and-forecasts.jsp, accessed February 9, 2017.

[11] *Ibid.*

[12] *Ibid.*

[13] Expenditures for HCBS include MA payments for waivers, home health agency services, personal care, and home care nursing services.

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

Like other states, Minnesota has chosen to expand its Medicaid program to provide HCBS to people with disabilities and the elderly.

Minnesota provides HCBS to MA recipients in two major ways.[14] First, low-income Minnesotans enrolled in MA may receive state- and federally funded HCBS as part of the state's overall MA plan. By using this option, Minnesota makes certain types of HCBS generally available to all MA recipients, regardless of whether they have disabling conditions. For example, nonemergency transportation, certain medical equipment and supplies, personal care assistance, and various types of therapies such as physical and occupational therapies, are available to all MA recipients, if needed.[15]

Second, MA recipients with disabilities, including the elderly, may receive special or expanded HCBS through one of the state's five federally approved waivers, which we describe in Exhibit 1.2. As an early adopter of HCBS waivers, Minnesota established all five waivers under a federal option that requires eligible recipients to need a level of care provided in long-term care facilities. Consequently, it must show that providing HCBS through waivers is no more costly than institutional care for comparable individuals. As shown earlier in Exhibit 1.1, the federal government made this option available to states in 1981.

As a first step to determining waiver eligibility, MA recipients must generally be (1) "certified" as having a disability, (2) diagnosed with a developmental disability, or (3) at least 65 years old and need the level of care provided in nursing homes. Being certified as having a disability means that people are unable to engage in substantial gainful activities due to any medically determined physical or mental impairment.[16] In addition, the impairment must be expected to result in their death or last continuously for at least 12 months.[17] The U.S. Social Security Administration sets the criteria for these determinations based on individuals' work status, the severity of their conditions, and whether their conditions are included on a federal list of disabilities.[18]

[14] We describe these services in more detail in Chapter 2.

[15] Throughout this report, we refer to HCBS generally available to all MA recipients, regardless of whether they have disabling conditions, as "state MA plan services."

[16] The Social Security Administration uses the term "substantial gainful activity" to describe a level of work activity and earnings. Work is "substantial" if it involves doing significant physical or mental activities or a combination of both. Work is "gainful" if it is generally performed for pay or profit, regardless of whether a profit is realized. Social Security Administration, *2016 Red Book* (Washington, DC, 2016), 5.

[17] *Social Security Act of 1965,* 42 *U.S. Code* 1382c, 1396a, and 1396d.

[18] The Social Security Administration also makes all decisions on whether individuals qualify for Social Security benefits on the basis of a disability.

Exhibit 1.2: Minnesota's Home- and Community-Based Services Waivers

Name of Waiver	Eligibility
Brain Injuries	People certified as disabled and have acquired or traumatic brain injuries who would otherwise require the level of care provided in a specialized nursing facility or neurobehavioral hospital
Chronic Health Conditions and Medically Fragile	People certified as disabled and are chronically ill or "medically fragile" who would otherwise need the level of care provided in a hospital
Physical and Other Disabling Conditions	People certified as disabled and have physical or other types of disabilities, including cognitive or behavioral conditions, who would otherwise require the level of care provided in a nursing facility
Developmental Disabilities	People diagnosed with developmental disabilities who would otherwise require the level of care provided in an Intermediate Care Facility for Persons with Developmental Disabilities
Elderly	People ages 65 and older who require the level of care provided in a nursing facility and choose to live in the community

SOURCE: Minnesota Department of Human Services, *Community-Based Services Manual: Disability Services Program Manual* (St. Paul, 2016).

In Minnesota, a disability must be certified by the Social Security Administration or the State Medical Review Team (SMRT). Individuals seeking certification may be referred to SMRT if they have applied for Social Security benefits and are awaiting a decision.[19] The review team is part of DHS.

Medical Assistance recipients who have been certified as having a disability, diagnosed with a developmental disability, or are 65 years or older do not automatically qualify to receive HCBS through waivers.

Once an MA recipient is certified as having a disability or diagnosed with a developmental disability, or is at least 65 years of age, the recipient's home county, tribal organization, or, in some cases, his or her managed care organization uses a DHS-developed assessment tool known as MnCHOICES to determine whether that recipient is eligible to receive HCBS through one of the state's five waivers. To be eligible to participate in a waiver, MA recipients must also need the level of care provided in long-term care institutions, such as hospitals, nursing homes, or intermediate care facilities. Local staff conduct a needs assessment to determine which HCBS the individual needs and how many hours of services he or she will receive. The needs assessment forms the basis of a waiver recipient's coordinated services and support plan that staff must develop.

[19] *Minnesota Statutes* 2016, 256.01, subd. 29; and 256B.055, subd. 7(b); and Minnesota Department of Human Services, *Minnesota Health Care Programs Eligibility Policy Manual* (St. Paul, 2016), sec. 2.3.2.2, 24-25.

The Home- and Community-Based Settings Rule

In January 2014, CMS issued its final regulations establishing new requirements for HCBS funded through waivers.[20] The regulation, effective March 2014, is sometimes referred to as the "HCBS Settings Rule." It establishes quality requirements for the settings where Medicaid recipients receive HCBS through waivers.

To receive federal funding, states must provide HCBS in the most integrated settings possible—ones that allow individuals full access to their communities.

Any residential or nonresidential setting where Medicaid recipients live or receive HCBS must be integrated into the community. This means that HCBS sites must offer recipients opportunities for competitive employment, civic involvement, and control of their personal resources. Furthermore, service settings must ensure individuals' rights of privacy, dignity, respect, and freedom from coercion and restraint. Recipients must have the opportunity to make their own decisions about the HCBS they receive, including how, when, and where they receive those services.

While previous regulations banned providing HCBS in institutions such as nursing homes, hospitals, and other types of large care facilities, some settings, such as corporate foster homes, have been considered appropriate. The new HCBS Settings Rule, however, requires that HCBS be provided in settings that do not have the "qualities of an institution."[21] This means that individuals living in foster homes must enjoy the same types of freedoms that people without disabilities typically have in their homes—going to bed when they choose, watching television programs of their choosing, and having snack food available. It also means that HCBS recipients should have the opportunity to work alongside people without disabilities.

States must be fully compliant with the new rule by March 2019. The rule requires that states develop "transition" plans that address how they will ensure compliance by 2019.[22] Minnesota submitted its plan to CMS in December 2016 and is currently awaiting federal approval.[23]

The Workforce Innovation and Opportunity Act

In 2014, Congress passed the *Workforce Innovation and Opportunity Act*.[24] It is designed, in part, to help individuals with barriers to employment, including those with disabilities, have access to the training and support services they need to succeed in the labor market.

[20] 42 *CFR*, Parts 430, 431, 435, 436, 440, 441, and 447 (2014). In Minnesota, this applies to MA recipients receiving HCBS through the state's five waivers.

[21] 42 *CFR*, sec. 441.301 (2014).

[22] *Ibid.*

[23] Minnesota Department of Human Services, *Minnesota's Home and Community-Based Services Final Rule Statewide Transition Plan* (St. Paul, 2016).

[24] *Workforce Innovation and Opportunity Act*, 29 *U.S. Code*, sec. 3101 (2014).

Recent federal workforce requirements focus on giving people with disabilities opportunities to have jobs that pay at or above minimum wage.

Although the law pertains to a much larger population than Medicaid recipients, two provisions are especially relevant to HCBS. First, the Act requires that state workforce agencies spend at least 15 percent of their federal vocational rehabilitation funds for pre-employment transition services for special education high school students.[25] Many of these students may be receiving HCBS through MA. The goal is to help them move into regular jobs that pay at least minimum wage, rather than work in sheltered workshops. The Department of Employment and Economic Development (DEED) is Minnesota's lead workforce agency.

Second, effective July 2016, DEED must play a more active role in assisting people with disabilities already in subminimum wage jobs explore other options. It must provide career counseling and information and referral services to any disabled individual currently employed or seeking employment in a job paying less than minimum wage.[26] Again, many of these individuals may be receiving HCBS through Minnesota's MA plan or one of its waivers.

Judicial Requirements

In addition to legislation, two major court cases have set forth new expectations for HCBS in Minnesota: the 1999 U.S. Supreme Court ruling, *Olmstead v. L.C.*, and the 2011 *Jensen v. DHS* settlement in U.S. District Court.[27]

The courts have directed state agencies to (1) move people with disabilities out of restrictive settings and into their communities and (2) provide them with the services they need to live independently.

Olmstead v. L.C. involved two women with disabilities who were confined to an institution, even though health professionals determined they were ready to move into a community-based setting. In 1999, the U.S. Supreme Court upheld the Eleventh Circuit Court's decision that the unjustified segregation of people with disabilities violates Title II of the 1990 *Americans with Disabilities Act*.[28] Title II regulations require that public entities provide services in the most integrated setting appropriate to the needs of qualified individuals with disabilities.[29] The most integrated setting is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible."[30] The ruling requires Minnesota (and all other states) to provide HCBS to persons with disabilities when (1) such services are appropriate; (2) the individuals affected do not oppose it; and

[25] 29 *U.S. Code*, sec. 419d(1) (2014).

[26] 29 *U.S. Code*, sec. 794g (2014).

[27] *Olmstead v. L.C.*, 527 U.S. 581 (1999); and Final Approval Order for Stipulated Class Action Settlement Agreement, *Jensen v. Minnesota Department of Human Services*, No. 09-1775 (D. Minn. Dec. 5, 2011).

[28] *Olmstead v. L.C.*, 527 U.S. 581 (1999).

[29] 28 *CFR*, 35.130(d) (1991).

[30] 28 *CFR*, Appendix B, Part 35, subpart B, sec. 35.130 (2010).

(3) the services can be reasonably accommodated, taking into account state resources and the needs of others receiving disability services from the state.[31]

About ten years later, in July 2009, a federal class-action lawsuit against DHS was filed in U.S. District Court. In this case, *Jensen v. DHS*, the plaintiffs alleged that people with developmental disabilities living in a DHS-operated intermediate care facility were unlawfully and unconstitutionally secluded and restrained.[32] In December 2011, the court approved the *Jensen Settlement Agreement*.[33] Among other things, the agreement requires the state of Minnesota and DHS to develop and implement a comprehensive plan to help ensure that people with disabilities can build and maintain relationships with their family and friends, live more independently, work at regular jobs, and participate in community life.

About a year later, in January 2013, Governor Mark Dayton established the Olmstead Subcabinet.[34] With representatives from nine state agencies, the subcabinet has several responsibilities. First, the subcabinet was to develop and implement Minnesota's *Olmstead Plan* in accordance with the Supreme Court decision in *Olmstead v. L.C.* The subcabinet successfully completed this task; in September 2015, the courts accepted the third draft of Minnesota's *Olmstead Plan*.[35] This document sets forth measurable goals to increase the number of people with disabilities receiving appropriate services in the most integrated settings possible.

The subcabinet has several other continuing responsibilities.[36] For example, it is to provide ongoing recommendations regarding the *Olmstead Plan* and how it may be improved. It must convene public meetings to discuss plan implementation. Also, the subcabinet must create a plan for developing quality of life measurements for people with disabilities.

More recently, a 2016 class-action lawsuit filed by the Minnesota Disability Law Center accuses DHS of violating the Olmstead ruling by forcing individuals with disabilities to live in segregated corporate foster homes, where they are cut off from mainstream society and deprived of basic autonomy.[37] The Department of Human Services has challenged the case for a number of reasons, including contending that statutes do not impose the standard of care or require the level of services the Plaintiffs request. As of December 2016, the case had not been heard.

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[31] *Olmstead v. L.C.*, 527 U.S. 581 (1999).

[32] Amended Class Action Complaint and Request for Injunctive Declaratory Relief, Demand for Jury Trial, *Jensen v. Minnesota Department of Human Services*, No. 09-CV-1775 (D. Minn. Jul. 30, 2009).

[33] Final Approval Order for Stipulated Class Action Settlement Agreement, *Jensen v. Minnesota Department of Human Services*, No. 09-1775 (D. Minn. Dec. 5, 2011).

[34] Mark Dayton, Executive Order 13-01, "Supporting Freedom of Choice and Opportunity to Live, Work, and Participate in the Most Inclusive Setting for Individuals with Disabilities through the Creation of Minnesota's Olmstead Plan," January 28, 2013.

[35] Olmstead Subcabinet, *Putting the Promise of Olmstead into Practice: Minnesota's Olmstead Plan* (St. Paul, June 2016).

[36] Mark Dayton, Executive Order 15-03, "Supporting Freedom of Choice and Opportunity to Live, Work, and Participate in the Most Inclusive Setting for Individuals with Disabilities through the Implementation of Minnesota's Olmstead Plan," January 28, 2015.

[37] Complaint, *Gordon v. Minnesota Department of Human Services*, No. 16-2623 (D. Minn. Aug. 3, 2016).

Other Programs

While our evaluation focused on HCBS provided through Minnesota's MA program, other state and federal programs may provide similar services to help people with disabilities live as independently as possible. This section highlights a few of those programs that, while focused on other groups of individuals with disabilities or low-income people in general, may also provide similar services to the same recipients with disabilities as MA.[38]

It is important to note that state agencies do not necessarily define a disability in the same manner as DHS. Some state agency programs, such as some of Minnesota Housing Finance Agency's mortgage programs, report participation rates for people with disabilities, but they identify people as having disabilities if the individuals say they do. Others agencies may require a doctor's assessment, while still others, such as DHS, may require certification by the Social Security Administration or a medical team convened by DHS. For example, certain benefits available to veterans with disabilities require that they have their conditions documented by their doctors, while regulations regarding certain housing supports for people with disabilities may not require review by a physician.

Although Medical Assistance pays for most HCBS, several other programs help low-income adults with disabilities live more independently.

Several programs provide cash and food assistance to people with disabilities. For example, Supplemental Security Income (SSI) and Social Security Disability Income (SSDI), both federal programs, provide recipients with basic incomes, which is an essential component for independent living. In Minnesota, SSI recipients may qualify for additional cash assistance through the Minnesota Supplemental Assistance Program, and MA recipients may qualify for food assistance through the Supplemental Nutrition Assistance Program. In a similar vein, the Minnesota Department of Veterans Affairs provides short-term financial assistance (for up to six months) to veterans unable to work due to temporary disabilities and those waiting to receive permanent disability benefits.

Various state and federal housing programs help people with disabilities live in their communities. For example, MA recipients with disabilities may qualify for Group Residential Housing, a state-funded program designed to help recipients pay for certain living expenses, such as room and board. In addition, people with disabilities who meet certain income requirements may qualify for Section 8 Housing Choice Vouchers. The vouchers provide federal subsidies that allow renters to pay reduced rents equivalent to a fixed portion of their incomes. The Minnesota Housing Finance Agency's Bridges Program provides subsidies through local housing organizations for temporary rental assistance and security deposits for people with serious mental illnesses. The Minnesota Housing Partnership administers the DHS-funded Crisis Housing Fund, which assists people receiving mental health or chemical health treatment with temporary rental, mortgage, and utility assistance. Finally, the Legislature funds the Housing Access Services program, which is administered by DHS, to help eligible people with disabilities locate suitable, affordable, and accessible housing.

[38] Appendix A provides more detail on state and federal programs that may serve MA recipients with disabilities.

Finally, several state programs address the educational and vocational needs of people with disabilities. The Minnesota Department of Education oversees special education services, including transitional programs for students with disabilities ages 18 to 21 to prepare them for integrated employment, independent living, community participation, and postsecondary education or training. The Department of Employment and Economic Development provides job counseling and placement services, training opportunities, and on-the-job supports to people with disabilities. In addition, the Minnesota departments of Veterans Affairs and Employment and Economic Development partner with one another to provide employment assistance to veterans with service-connected disabilities.

Minnesota and the Nation

By some measures, Minnesota compares well with other states in providing HCBS to low-income people with disabilities. At the same time, other measures suggest room for improvement. However, comparing states in terms of spending and outcomes is difficult for two major reasons. First, states have structured their HCBS programs differently, providing different services to different populations. Some states provide HCBS through managed care programs, so detailed spending for specific services may be unavailable. They may also categorize their spending differently. Second, states have taken different approaches to moving people with disabilities from institutions into community-based settings. Minnesota began this process, called deinstitutionalization, by closing most of its state hospitals and moving many people into smaller group home settings. However, evolving state and federal requirements have raised the standards for the settings in which people with disabilities live and work.

While Minnesota ranks high among states in spending for HCBS, it ranks lower in helping people with disabilities live or work in integrated settings.

Minnesota's spending on HCBS has grown over the last few years, and a large share of MA spending goes for HCBS. While Minnesota's growing HCBS spending reflects a nationwide trend, it has also devoted a far higher proportion of its MA spending to HCBS than the nation as a whole. According to a 2016 report compiling CMS data through Fiscal Year 2014, Minnesota spent nearly twice as much of its Medicaid expenditures on HCBS (31 percent) than the nation as a whole (17 percent).[39]

At 31 percent, Minnesota also spent a higher share of its Medicaid spending on HCBS than several other states, including Wisconsin (28 percent), Alaska (25 percent), Oregon (23 percent), Vermont (17 percent), and Washington (17 percent).[40] Furthermore, as shown in Exhibit 1.3, Minnesota ranked third nationally in terms of Fiscal Year 2014 HCBS expenditures per state resident ($571 per resident). Only New York and the District of Columbia spent more per resident ($651 and $637, respectively).

It is important to note that Minnesota's high spending levels for HCBS do not necessarily mean that Minnesota is "more successful" than lower spending states. Other measures suggest that Minnesota is lacking in two areas: housing and employment. In Minnesota, a relatively low proportion of people with disabilities live at home. About 44 percent of

[39] *Improving the Balance: The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS), FY 1981-2014* (Ann Arbor, MI: Truven Health Analytics, 2016), 33 and 201.

[40] *Ibid*., 201, 383, 47, 299, 355, and 369 (respectively).

people with intellectual or developmental disabilities live with their families or in their own homes in Minnesota.[41] This is much lower than the national average of 67 percent, as Exhibit 1.3 shows. While the goal is to have people living in the most integrated settings possible, Minnesota ranks 35th among 49 states and the District of Columbia.

In addition, Minnesota lags in the proportion of people with disabilities provided integrated employment services.[42] As shown in Exhibit 1.3, the state serves a very low proportion of people with intellectual and developmental disabilities (13 percent) with integrated employment services, ranking 34th among 45 states and the District of Columbia.

While Minnesota has relatively high employment rates among people with disabilities, data suggest that it has one of the more segregated workforces for people with disabilities in the country. A 2014 report shows that Minnesota places a high proportion of people receiving employment services in "facility-based work," commonly known as sheltered workshops.[43] This is a far higher percentage than most other states—only Ohio, Oklahoma, and South Dakota segregate a higher proportion of workers with developmental disabilities in sheltered workshops than Minnesota.[44] The majority of employees in these settings have disabilities, and employees—often referred to as clients—earn subminimum wages.

In October 2016, the U.S. Justice Department released guidance to state agencies providing employment services to people with disabilities, which could have legal ramifications for DHS. This guidance advised that "unnecessary segregation" of people with disabilities in sheltered workshops may represent a violation of the *Americans with Disabilities Act*.[45] In 2016, the Minnesota Department of Human Rights issued a charge of discrimination against a nonprofit organization that employs people with disabilities. According to the department, because the organization had a policy of not hiring people it served with supported employment services for permanent positions, it likely discriminated on the basis of disability.[46] The organization and the human rights department reached a settlement in November 2016.[47] As a result of the settlement, the company agreed to change its hiring policies to allow anyone who receives job supports or other services to be considered for regular employment.

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[41] Sheryl Larson, Libby Hallas-Muchow, Faythe Aiken, Brittany Taylor, Sandy Pettingell, Amy Hewitt, Mary Sowers, and Mary Lee Fay, *In-Home and Residential Long-Term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and trends through 2013* (Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration, 2016).

[42] Competitive integrated employment is defined as work performed for paid wages consistent with those paid to people without disabilities; at least minimum wage; benefits-eligible; in an environment where people with disabilities can interact with people without disabilities; and with opportunities for advancement. See 29 *U.S. Code*, sec. 705 (2014).

[43] Institute for Community Inclusion, *StateData: The National Report on Employment Services and Outcomes* (Boston: University of Massachusetts, 2014), 21.

[44] Data from other states may include duplicate counts of individuals who are served in multiple settings. Minnesota's data, however, do not include duplicate counts.

[45] U.S. Department of Justice, *Statement of the Department of Justice on Application of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C. to State and Local Governments' Employment Service Systems for Individuals with Disabilities* (Washington, DC, 2016).

[46] Minnesota Department of Human Rights, *Charge of Discrimination: Opportunity Partners* (St. Paul, April 2016).

[47] Chris Serres, "Minn. Nonprofit to Reform Hiring Practices in Major Disability Rights Settlement," *StarTribune*, November 21, 2016.

Exhibit 1.3: State Rankings on Selected Measures

State	Fiscal Year 2014 HCBS Expenditures per Capita	Percentage of People Living in Family or Own Home[a]	State Rank: Living in Family or Own Home	Percentage of People Receiving Integrated Employment Services[b]	State Rank: Integrated Employment Services
New York	$651	70%	13	13%	34
District of Columbia	637	35	42	12	38
Minnesota	**571**	**44**	**35**	**13**	**34**
Rhode Island	468	54	26	33	8
Alaska	446	47	32	26	17
Massachusetts	442	52	29	29	12
Vermont	421	58	22	38	6
Connecticut	407	32	47	49	3
Oregon	393	63	18	33	8
Maine	392	37	40	28	15
West Virginia	369	52	30	41	4
Wisconsin	364	69	15	21	22
New Mexico	335	34	44	33	8
Arkansas	335	42	37	–	–
Iowa	333	–	–	17	31
Ohio	322	82	4	21	22
North Dakota	314	70	14	–	–
Pennsylvania	297	60	20	18	26
New Hampshire	291	44	34	38	6
Missouri	284	73	10	12	38
Maryland	277	34	43	40	5
California	254	83	3	12	38
Washington	251	79	6	86	1
Montana	245	39	38	12	38
Delaware	232	58	21	29	12
New Jersey	230	56	25	11	42
Wyoming	227	53	27	18	26
Colorado	224	57	23	27	16
Nebraska	206	47	33	–	–
Kansas	198	33	46	13	34
Tennessee	198	70	12	19	25
Idaho	190	63	19	–	–
Louisiana	186	76	8	31	11
Virginia	186	18	50	24	18
Texas	182	32	48	8	43
North Carolina	176	68	16	22	21
South Dakota	173	52	3	18	26
Kentucky	172	32	49	18	26
Arizona	171	87	2	21	22
Illinois	167	38	3	6	44
Indiana	164	65	17	15	32
Oklahoma	153	56	2	62	2
Alabama	147	36	41	4	45

Continued on next page.

Exhibit 1.3: State Rankings on Selected Measures (continued)

State	Fiscal Year 2014 HCBS Expenditures per Capita	Percentage of People Living in Family or Own Home[a]	State Rank: Living in Family or Own Home	Percentage of People Receiving Integrated Employment Services[b]	State Rank: Integrated Employment Services
Mississippi	$137	34%	45	–	–
Hawaii	137	71	11	2%	46
South Carolina	125	75	9	29	12
Georgia	115	43	36	13	34
Michigan	105	82	5	23	19
Florida	99	78	7	14	33
Nevada	90	94	1	18	26
Utah	85	52	28	23	19
United States	257	67	–	19	–

[a] This percentage is based on people with intellectual or developmental disabilities with a reported living arrangement who received one or more funded long-term supports and services from the state's intellectual and developmental disability agency. In Minnesota this would be the Department of Human Services, Disability Services Division. Data reported through June 30, 2013.

[b] This percentage is based on people with intellectual or developmental disabilities who received say and employment services from the state's intellectual and developmental disability agency. It does not measure the number of people actually employed in integrated employment settings. Integrated employment takes place in a community setting and pays wages to the participant. It includes competitive employment, individual supported employment, group supported employment, and self-employment supports. Data reported for Fiscal Year 2013.

SOURCES: *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014: Managed LTSS Reached 15 Percent of LTSS Spending* (Ann Arbor, MI: Truven Health Analytics, 2016), Table J; Sheryl Larson, Libby Hallas-Muchow, Faythe Aiken, Brittany Taylor, Sandy Pettingell, Amy Hewitt, Mary Sowers, and Mary Lee Fay, *In-Home and Residential Long-Term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and trends through 2013* (Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration, 2016), 16 and 177; and Institute for Community Inclusion, *StateData: The National Report on Employment Services and Outcomes* (Boston: University of Massachusetts, 2014), 17 and 21.

Chapter 2: Cost and Use of Home- and Community-Based Services

Over the last several decades, Minnesota—and other states across the country—has been working to help low-income residents with disabilities live in their communities rather than institutions. Since the 1960s, Minnesota has made tremendous strides toward achieving this goal by closing most of its large institutions housing people with disabilities and moving them instead into small foster care homes. As discussed in Chapter 1, Minnesota spends more per capita on home- and community-based services (HCBS) than most other states. Other measures, however, suggest the state may not be doing enough to ensure that people with disabilities have sufficient opportunities to fully integrate into their communities.

This chapter looks at how much Minnesota spends to provide HCBS to Medical Assistance (MA) recipients with disabilities and the elderly.[1] We describe the specific HCBS they receive; the cost to deliver these services; and the businesses, agencies, and organizations providing the services.

Overall, we found that MA expenditures to provide HCBS to adult MA recipients with disabilities varied widely in Fiscal Year 2015. Much of the variation can be explained by the specific types and intensity of services recipients received. For those receiving HCBS through one of the state's five federal waivers, the majority of expenditures paid for supported living and foster home/assisted living services provided in residential settings.[2] For those served under the state MA plan, personal care attendant/home health aide services, generally provided in residential settings that are private homes, accounted for the largest share of costs.

Overall Expenditures

Although MA recipients may receive assistance from a variety of funding sources across several state and federal agencies, we focused our analysis on MA expenditures for HCBS provided in community settings.

It is difficult to put a comprehensive price tag on the home- and community-based services (HCBS) provided to Medical Assistance recipients with disabilities.

There are a variety of reasons for this. Most important, though, are the different financial reporting requirements and payment methods across or within the managed care or fee-for-

[1] Having a certified disability means that an individual has a physical or mental condition that significantly limits his or her ability to perform daily living activities such as dressing, eating, or walking. Further, the disabling condition must be expected to last continuously for at least 12 months or result in that person's death. For the sake of simplicity, whenever we refer to "individuals with disabilities served through the state MA plan" in this and subsequent chapters, we mean individuals with certified disabilities who may need HCBS.

[2] As we discussed in Chapter 1, Minnesota has four waivers that address HCBS for MA recipients with developmental disabilities, brain injuries, chronic health conditions, and physical and other disabling conditions. The state's fifth waiver covers elderly MA recipients who need the level of care provided in nursing homes.

service health plans that enroll MA recipients.[3] In addition, state and national laws, rules, and guidelines that have evolved over time to improve the lives of people with disabilities have become increasingly complex and confusing, which may make them more difficult to administer.

Our analysis focuses on a subset of HCBS recipients and costs: adults (18 years of age and over) at or below the poverty line with certified disabilities or who were enrolled in one of the state's five waivers and who received HCBS in Fiscal Year 2015. We define HCBS broadly to include services offered as part of the state's overall MA plan and through waivers.

It should be noted that this includes only some HCBS provided to MA recipients enrolled in managed care health plans. For example, our data include personal care attendants, nursing services, and nonemergency transportation for managed care health plan enrollees with certified disabilities who received HCBS through the state MA plan. Our data also include HCBS for managed care health plan enrollees who participated in four of the state's five waivers. With the exception of services provided through the elderly waiver, HCBS provided through waivers are paid for separately by the state on a fee-for-service basis, regardless of whether recipients are enrolled in a managed care or fee-for-service health plan. Most elderly MA recipients are enrolled in managed care health plans.[4] Our data capture only about 11 percent of HCBS expenditures through the elderly waiver. When people receive HCBS through the elderly waiver and are enrolled in managed care plans, managed care organizations (MCOs) receive a capitated payment from DHS as part of their public healthcare contracts. Managed care organizations then pay for waiver services for the elderly themselves. Finally, our data capture all adult MA recipients with disabilities receiving HCBS through fee-for-service health plans.

We chiefly relied on two management information systems in DHS for our data: MAXIS and Medicaid Management Information System (MMIS).[5] We used these systems to identify MA recipients with disabilities and the providers that serve them, categorize the different types of HCBS available to them, and calculate the utilization and cost of providing those services. Medical Assistance expenditures for HCBS include federal, state, and county shares.[6]

For the most part, MA expenditures for HCBS are based on individual service rates established or approved by DHS—they do not necessarily reflect providers' costs or expenditures. The Department of Human Services' Disability Waiver Rate System

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[3] Over the last several years, the state has been gradually moving more MA recipients, including the elderly and those with disabilities, to managed care as opposed to fee-for-service health plans. Under managed care health plans, managed care organizations (MCOs) provide healthcare for a flat rate, regardless of how many services recipients may receive. Under fee-for-service plans, enrollees can generally access any healthcare providers who have agreed to participate in MA. Participating providers submit bills to DHS, which in turn pays them. In Fiscal Year 2015, about 1 million individuals were eligible for MA each month. As of August 2016, about 814,000 recipients were enrolled in managed care plans and 236,000 in fee-for-service plans. Minnesota House of Representatives Research Department, *Medical Assistance: An Overview* (St. Paul, November 2016), 2.

[4] The Department of Human Services has two managed care health plans for MA recipients who are elderly: Minnesota Senior Care Plus and Minnesota Senior Health Options.

[5] Medical Assistance is funded by federal, state, and local governments and pays for the bulk of HCBS in Minnesota. MAXIS is a computer system used by state and county workers to determine eligibility for various public assistance and healthcare programs, including MA. The Medicaid Management Information System stores data on MA services and expenditures at the individual recipient level; HCBS providers submit payment claims to MMIS.

[6] As we discussed in Chapter 1, the federal government paid for about 57 percent of MA costs in 2015, the state 42 percent, and counties 1 percent.

calculates many payment rates for HCBS. Implemented in January 2014, the system is designed to provide consistent statewide methodologies for establishing payment rates for most HCBS.[7] However, the system is being phased in gradually, and payment rates for most HCBS providers will not be fully implemented until 2019 or 2020.

Medical Assistance expenditures to provide HCBS to adults with disabilities and the elderly were approximately $2.4 billion in Fiscal Year 2015.

As Exhibit 2.1 shows, 63,878 adult MA recipients with disabilities and the elderly received HCBS through MA in Fiscal Year 2015. The overall median cost for providing these services was $21,993 for Fiscal Year 2015. Partly because MA provides HCBS to a wide range of recipients with disabling conditions, average costs per recipient were substantially higher—$37,438.

Exhibit 2.1: Adult Medical Assistance Recipients with Disabilities Receiving Home- and Community-Based Services, Fiscal Year 2015

	Fiscal Year 2015			
Source of HCBS	Number of Recipients	Cost (in $1,000s)	Median Cost	Average Cost
State Medical Assistance plan	27,500	$ 357,110	$ 2,713	$ 12,986
Waiver				
Developmental disabilities	15,226	$1,128,639	$73,166	$ 74,126
Physical and other disabilities	19,642	717,619	24,213	36,535
Brain injuries	1,428	103,898	66,610	72,758
Elderly[a]	5,595	47,910	4,191	8,563
Chronic health conditions	214	36,315	158,554	169,696
Waiver Subtotal	41,959[b]	$2,034,381	35,116	48,485
Total	63,878[b]	$2,391,491	$21,993	$ 37,438

[a] These data capture only a small portion of HCBS expenditures through the elderly waiver. Most elderly Medical Assistance (MA) recipients are enrolled in managed care health plans. Managed care organizations (MCOs) receive a capitated payment from the Department of Human Services (DHS) as part of their public contracts to provide healthcare to MA recipients. When people receive HCBS through the elderly waiver and are enrolled in managed care plans, MCOs pay for HCBS directly. According to data compiled by DHS, 25,300 managed care enrollees received HCBS through the elderly waiver at a cost of about $400.5 million ($15,831 per recipient, on average) in Fiscal Year 2015.

[b] These figures refer to the subtotal and total number of MA recipients receiving HCBS paid for by DHS for the fiscal year shown. Because some recipients received services through both the waiver and state plan or through more than one waiver during the year, the waiver subtotal and total do not equal the number of recipients served by individual waivers and the state plan.

SOURCE: Office of the Legislative Auditor, analyses of data obtained from the Minnesota Department of Human Services.

State Plan Expenditures

As shown previously, nearly 64,000 adults with disabilities received at least one HCBS through MA in Fiscal Year 2015. Of these, 27,500 received HCBS through the state MA plan.

[7] We discuss DHS's rate payment system in greater detail in Chapter 3.

The median expenditure for HCBS for recipients with certified disabilities through the state Medical Assistance plan was $2,713 in Fiscal Year 2015.

Average per recipient spending for HCBS was much higher than median spending—$12,986 in Fiscal Year 2015. Both median and average HCBS expenditures on behalf of recipients through the state plan, though, were much lower than spending through waivers. State plan recipients generally do not need the level of care provided in long-term institutions, or they may be able to obtain the assistance they need from sources other than MA, such as family members or other caregivers. As we will see later in this chapter, state plan recipients tend to receive services in their own homes rather than foster homes. Finally, the state plan does not offer the full array of services available through waivers, nor does it always provide the same level of intensity or frequency of services.

Waiver Expenditures

For the most part, waivers are intended to serve populations that are more at risk than state plan recipients and whose needs cannot be met through state plan services alone. Not only must most waiver recipients be severely limited in their abilities to live independently, but they must also be at risk of institutionalization in hospitals, nursing homes, or intermediate care facilities for people with developmental disabilities if they do not receive HCBS.[8]

Most of the nearly 64,000 adults with disabilities who received HCBS in Fiscal Year 2015 did so through waivers, rather than the state Medical Assistance plan.

As shown in Exhibit 2.1, 41,959 MA recipients received HCBS through one of Minnesota's five waivers in Fiscal Year 2015. As discussed in Chapter 1, to be eligible for a waiver, MA recipients must generally be unable to engage in substantial activity by reason of any medically determined physical or mental impairment expected to last for a continuous period of at least 12 months; be diagnosed with a developmental disability; or be at least 65 years old. They must also be at risk of institutionalization if they do not receive HCBS.

Of the nearly 42,000 adults receiving HCBS through waivers in Fiscal Year 2015, 47 percent were enrolled in the waiver designed for people with physical or other disabilities, 36 percent in the waiver for those with developmental disabilities, 13 percent in the waiver for the elderly, and 3 percent in the waiver for those with brain injuries. About 1 percent was enrolled in the waiver for those with chronic health conditions.

Medical Assistance expenditures for HCBS for recipients through waivers varied widely, with annual median spending of $35,116 per person in Fiscal Year 2015.

The median annual cost to provide HCBS to recipients through waivers was considerably higher than the cost to provide HCBS through the state MA plan. Average costs per recipient were also higher—$48,485. Expenditures varied widely, however, across the individual waivers. For example, annual median costs per recipient in Fiscal Year 2015

[8] Intermediate care facilities are residential facilities licensed as health care institutions by the Minnesota Department of Health and certified by the federal government to provide health or rehabilitative services to persons with developmental disabilities who require active treatment.

ranged from a low of $4,191 for those receiving services through the elderly waiver to a high of $158,554 for those with chronic health conditions.[9] 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).

Expenditures by Type of Service

As we have discussed, HCBS are designed to help recipients live as independently as possible in the community.[10] In this section, we first examine the specific types of HCBS that accounted for the bulk of total expenditures, regardless of whether those services were provided through the state MA plan or waivers. We then examine expenditures for specific types of services provided through the state plan and each individual waiver.

We grouped the various types of HCBS available to eligible MA recipients into the categories shown in Exhibit 2.2.[11] Classifying the different types of services identified as HCBS is difficult for a variety of reasons. First, DHS sometimes uses different terms to describe similar services. For example, although DHS makes distinctions among personal care attendants and home health aides, the services they perform overlap considerably. Department documents say that personal care attendants and home health aides can help clients perform daily living activities, such as eating, toileting, grooming, dressing, and mobility, among others.[12] Both types of workers can also perform various health-related tasks, such as changing wound dressings.

Likewise, services classified as "foster home" and "supported living" involve some similar tasks. The former is aimed at *providing* basic services, such as helping with dressing, walking, and eating, while the latter also tries to *teach* recipients to do the tasks themselves. Foster home and supported living are both performed in residential settings. While foster care is only provided in foster homes, supported living may be provided in recipients' own homes or in foster homes. When recipients with developmental disabilities live in foster homes, the HCBS services they receive in those homes is not called foster care, but rather supported living (also referred to as residential habilitation). Personal care attendants/home health aides generally perform some of the same types of services (helping with daily living skills) for those with other types of disabilities in recipients' own homes. Services aimed at helping people with developmental disabilities develop and maintain living skills that are provided in nonresidential settings (that is, separate from a person's own home or foster home) are called day training and habilitation.

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[9] As we explained in Exhibit 2.1, our data capture only a small portion of HCBS expenditures through the elderly waiver.

[10] MAXIS and MMIS do not provide definitive information on where HCBS recipients lived at the time of service (that is, in their own homes, family homes, foster care homes, or other regulated settings). When HCBS providers submit payment claims, they are given a variety of residence options to check (including other) that are not mutually exclusive. Consequently, we do not provide data on recipients' living arrangements.

[11] Home- and community-based services are provided in a variety of settings that generally exclude institutions such as nursing homes, hospitals, and intermediate care facilities. Furthermore, as we discussed in Chapter 1, CMS regulations that become effective in 2019 require that sites where HCBS are provided through waivers be "noninstitutional" in nature. However, some transitional HCBS may be provided to MA recipients living in institutions, with the goal being to move the recipients into community settings.

[12] Minnesota Department of Human Services, *Personal Care Assistance Fact Sheet* (St. Paul, undated); and Minnesota Department of Human Services, *Provider Manual: Home Health Aide Services* (St. Paul, revised September 26, 2012).

Exhibit 2.2: Home- and Community-Based Services Available to Adult Medical Assistance Recipients with Disabilities and the Elderly

Type of Service	Description
Adult day services	Various support and leisure services provided to recipients in licensed day facilities
Behavioral therapy/education	Specific interventions designed to decrease severe maladaptive behavior
Case management/home assessments/ transition services	Activities aimed at coordinating recipients' services, including activities to help move them from one setting to another
Companion/peer/night supervision services	Nonmedical care, assistance, supervision, and socialization
Consumer directed community supports	Services that help recipients take more responsibility for arranging and managing their own services
Crisis intervention	Short-term medical and behavioral care and intervention strategies to alleviate stress
Day training and habilitation	Services to help recipients acquire, retain, and improve the skills needed for community living; generally provided in non-residential settings
Emergency response systems/technology	Devices, such as remote sensors, to improve recipients' physical safety by alerting caregivers about recipients' movements
Financial management	Services to assist recipients manage their own services, such as budgeting and payroll
Foster home/assisted living	Regular supportive services provided in licensed or regulated residential settings
Home care training	Training and consultation to family and non-family caregivers to support participants' placement in the community
Homemaker services/meals/chores	General household activities, such as cleaning, meal preparation, and yard maintenance
Home/vehicle modifications	Modifications made to homes or cars to help individuals maintain their independence
Medical supplies/equipment	Supplies or devices that improve recipients' physical health or safety, such as automatic pill dispensers, respiratory equipment, and wheelchairs, among others
Nonemergency transportation	Individual assistance getting to or from community settings, including reimbursement for mileage, taxis, or bus fares
Nursing services	Services provided by licensed or certified health specialists, such as nurses, speech therapists, or occupational therapy assistants; does not include home health aides
Personal care attendant/home health aide services	Wide range of direct care services provided in individuals' own homes to help them live independently
Prevocational training/supported employment/education	Services to help individuals obtain and keep employment, regardless of the wage level
Relocation support	Services to help recipients move from institutional living to a community setting (also referred to as Moving Home Minnesota)
Respite/crisis respite	Services provided on a short-term basis to provide relief to regular caregivers
Speech/physical/occupational/respiratory/ activity therapy	Specific therapeutic services provided in recipients' homes to improve their functioning
Supported living (residential habilitation)	Services to help recipients acquire, retain, and improve the skills needed for community living; generally provided in residential settings

NOTE: Not all services may be available to all recipients with disabilities or the elderly.

SOURCE: Office of the Legislative Auditor, analyses of Minnesota statutes and documents from the Department of Human Services.

Simply having a service available, however, does not mean that an individual with a disability is entitled to receive that service. Managed care organizations, tribal governments, or county human services agencies must first determine that eligible recipients need particular services before they authorize provision of those services.

A little more than half of Medical Assistance expenditures for HCBS in Fiscal Year 2015 were for supported living and foster home/assisted living services.

Exhibit 2.3 shows MA expenditures for specific HCBS for MA recipients with disabilities in Fiscal Year 2015. Overall, supported living services—provided to recipients with developmental disabilities in residential settings—accounted for the largest share of total MA expenditures—31 percent. As discussed earlier, these services focus on both *providing* and

Exhibit 2.3: Cost of Home- and Community-Based Services by Type of Service, Fiscal Year 2015

Type of Service	Number of Recipients		Cost	Percentage of Total Cost
	State Plan	Waivers		
Supported living (residential habilitation)	0	10,668	$ 742,525,000	31%
Foster home/assisted living	0	12,579	536,874,000	22
Personal care attendant/home health aide services	13,811	8,407	462,208,000	19
Day training and habilitation	0	10,850	183,053,000	8
Nursing services	7,015	3,524	77,190,000	3
Consumer directed community supports	0	2,131	71,280,000	3
Case management/home assessments/transition services	84	40,777	70,394,000	3
Companion/peer/night supervision services	196	1,801	47,407,000	2
Speech/physical/occupational/respiratory/activity therapy	896	5,956	46,849,000	2
Prevocational habilitation/supported employment/education	0	4,611	35,516,000	1
Homemaker services/home delivered meals/chores	0	9,335	25,109,000	1
Respite/crisis respite	0	2,650	24,828,000	1
Nonemergency transportation	10,986	16,361	23,881,000	1
Adult day services	0	2,112	17,139,000	1
Crisis intervention	3	877	9,304,000	<1
Home/vehicle modifications	0	1,367	8,014,000	<1
Behavioral therapy/education	0	579	5,375,000	<1
Medical supplies/equipment	161	4,570	2,296,000	<1
Emergency response systems/technology	1	4,075	1,546,000	<1
Relocation support	4,323	0	402,000	<1
Home care training	0	82	260,000	<1
Financial management	0	324	42,000	<1
Total	27,500[a]	41,959[a]	$2,391,491,000	100%

NOTES: These data capture only a small portion of HCBS expenditures through the elderly waiver. Most elderly Medical Assistance (MA) recipients are enrolled in managed care health plans. Managed care organizations (MCOs) receive a capitated payment from the Department of Human Services (DHS) as part of their public contracts to provide healthcare to MA recipients. When people receive HCBS through the elderly waiver and are enrolled in managed care plans, MCOs pay for HCBS directly. According to data compiled by DHS, 25,300 managed care enrollees received HCBS through the elderly waiver at a cost of about $400.5 million ($15,831 per recipient, on average) in Fiscal Year 2015. Percentages and totals may not sum to the totals shown due to rounding.

[a] These figures refer to the total number of MA recipients receiving HCBS paid for by DHS. Because recipients typically receive more than one type of service, the total does not equal the number of recipients receiving individual services.

SOURCE: Office of the Legislative Auditor, analyses of data from the Minnesota Department of Human Services.

teaching recipients to perform daily activities (for example, eating, dressing, and moving about). Medical Assistance expenditures for foster home/assisted living services—similar services provided largely to people with other types of disabilities in regulated residential settings—accounted for 22 percent of HCBS expenditures. Services provided largely to recipients in their own homes by personal care attendants/home health aides comprised 19 percent, and day training and habilitation accounted for 8 percent of expenditures. All other types of services, including more medical-related services such as nursing and therapeutic services, each comprised 3 percent or less of total MA spending on HCBS.

State Plan Expenditures by Service

Medical Assistance recipients with certified disabilities who receive HCBS through the state MA plan do not have access to the full array or intensity of HCBS described in Exhibit 2.2. For example, the state does not use MA to provide vocational services to this group. Exhibit 2.4 shows the specific HCBS that MA recipients with certified disabilities received through the state MA plan in Fiscal Year 2015.

Exhibit 2.4: Costs of Home- and Community-Based Services through the State Medical Assistance Plan to Adults with Certified Disabilities, Fiscal Year 2015

Type of Service	Number of Recipients	Cost	Percentage of Total Cost	Average Cost per Recipient
Personal care attendant/home health aide services	13,811	$298,698,000	84%	$21,628
Nursing services	7,015	47,471,000	13	6,767
Nonemergency transportation	10,986	8,884,000	2	809
Speech/physical/occupational/respiratory therapy	896	1,280,000	<1	1,428
Relocation support	4,323	402,000	<1	93
Companion/peer/night supervision services	196	298,000	<1	1,518
Medical supplies/equipment	161	43,000	<1	268
Case management/home assessments/ transition services	84	35,000	<1	412
Crisis intervention	3	<1,000	<1	184
Emergency response systems/technology	1	<1,000	<1	155
Total	27,500[a]	$357,110,000	100%	$12,986

NOTE: Percentages and totals may not sum to the totals shown due to rounding.

[a] This figure refers to the total number of MA recipients receiving HCBS through the state Medical Assistance plan. Because recipients typically receive more than one type of service, the total does not equal the number of recipients receiving individual services.

SOURCE: Office of the Legislative Auditor, analyses of data from the Minnesota Department of Human Services.

Personal care attendant/home health aide services accounted for 84 percent of the cost of HCBS for adults with certified disabilities through the state Medical Assistance plan in Fiscal Year 2015.

Personal care attendant/home health aide services accounted for the majority of HCBS spending under the state plan—84 percent, while licensed nurses accounted for 13 percent. Most of the remaining costs involved transportation and various types of therapies, although each comprised only a small share of costs—2 percent or less.

HCBS through the State MA Plan, Fiscal Year 2015

Total MA Expenditures	$357,110,000
Number of Recipients	27,500
Median Cost	$2,713
Average Cost	$12,986

While average costs to provide HCBS to MA recipients through the state plan are relatively low in comparison to waiver costs, annual per recipient costs varied widely—ranging from less than $100 to a high of $372,000. To examine the factors explaining the wide variation, we looked at the specific services recipients received by quintile—for example, the services provided to the 20 percent of recipients incurring the highest costs. At the high end, recipients typically incurred significantly more costs for nurses and less for personal care attendants than did recipients in lower-cost quintiles. At the most extreme end, 85 percent ($316,600) of the total costs incurred by one individual ($372,000) was for nurses, while 6 percent ($21,800) was for personal care attendants. In comparison, for recipients in the middle cost quintile (40th to 60th percentile), most costs incurred were for personal care attendants.

Waiver Expenditures by Service

The type and extent of HCBS provided to MA recipients through the state's five waivers varied considerably across the individual waivers. Below we discuss specific service costs incurred under each waiver, starting with the waiver that accounted for the largest share of MA expenditures in Fiscal Year 2015: the developmental disabilities waiver.

Developmental Disabilities Waiver

As discussed earlier, Minnesota's waiver for MA recipients with developmental disabilities served about 15,000 recipients in Fiscal Year 2015. Exhibit 2.5 shows the specific HCBS provided to them along with the average cost for each type of service.

Medical Assistance expenditures to provide HCBS through the developmental disabilities waiver totaled about $1.1 billion in Fiscal Year 2015, most of which paid for supported living and day training and habilitation services.

As shown, nearly all of the 15,226 MA recipients enrolled in the developmental disability waiver received services to help them live independently—at an average cost of $69,603 for supported living services and $17,170 for day training and habilitation services per recipient. All other HCBS each made up 4 percent or less of total expenditures, the most significant of which were consumer

HCBS through the Developmental Disabilities Waiver, Fiscal Year 2015

Total MA Expenditures	$1,128,639,000
Number of Recipients	15,226
Median Cost	$73,166
Average Cost	$74,126

directed community supports, companion/peer/night supervision services, and personal care attendant/home health aide services.

While the same types of services were often provided to most of the recipients in the developmental disabilities waiver, they were provided in varying degrees of frequency. For example, recipients at the lowest cost quintile (20th percentile and below) had individual costs ranging from less than $100 to slightly more than $35,000 in Fiscal Year 2015.[13] These recipients tended to incur most of their costs for day training and habilitation services.

At the high end of the scale (80th cost percentile and above), recipients received the same set of services, but costs to do so were more than $104,000 per individual. At the most extreme, MA expenditures to provide HCBS to one individual with developmental disabilities came to about $1.1 million in 2015, with almost all costs allocated to supported living services. Eight other recipients with developmental disabilities each received waiver services costing MA more than $500,000 per recipient. Together, MA expenditures for these nine MA recipients came to $6.1 million in Fiscal Year 2015. For the most part, these individuals were all relatively young (between the ages of 22 and 35), with complex health needs generally involving multiple disabling conditions.

Exhibit 2.5: Costs of Home- and Community-Based Services through the Developmental Disabilities Waiver, Fiscal Year 2015

Type of Service	Number of Recipients	Cost	Percentage of Total Cost	Average Cost per Recipient
Supported living (residential habilitation)	10,668	$ 742,525,000	66%	$69,603
Day training and habilitation	10,308	176,993,000	16	17,170
Consumer directed community supports	1,258	49,415,000	4	39,281
Companion/peer/night supervision services	1,588	46,437,000	4	29,242
Personal care attendant/home health aide services	2,398	40,922,000	4	17,065
Case management/home assessments/transition services	14,900	26,907,000	2	1,806
Respite/crisis respite	2,305	22,243,000	2	9,650
Prevocational/supported employment/education	1,328	7,683,000	1	5,785
Nonemergency transportation	8,099	5,718,000	1	706
Adult day services	345	4,663,000	<1	13,515
Crisis intervention	161	2,064,000	<1	12,821
Home/vehicle modifications	235	1,581,000	<1	6,726
Homemaker services/meals/chores	341	685,000	<1	2,009
Nursing services	127	533,000	<1	4,195
Medical supplies/equipment	158	120,000	<1	757
Emergency response systems/technology	101	78,000	<1	774
Home care training	35	57,000	<1	1,627
Financial management	222	16,000	<1	72
Total	15,226[a]	$1,128,639,000	100%	$74,125

NOTE: Percentages and totals may not sum to the totals shown due to rounding.

[a] This figure refers to the total number of Medical Assistance recipients receiving HCBS through the waiver. Because recipients typically receive more than one type of service, the total does not equal the number of recipients receiving individual services.

SOURCE: Office of the Legislative Auditor, analyses of data from the Minnesota Department of Human Services.

[13] Waiver recipients at the very low end of the quintile may not have received HCBS for the entire year or may not have been enrolled in MA for the entire year.

Physical and Other Disabling Conditions Waiver

Exhibit 2.6 shows the specific services MA recipients received through the waiver for those with physical and other disabilities in Fiscal Year 2015. This waiver can cover a broad range of disabling conditions, including conditions such as multiple sclerosis, spinal cord injuries, and mental illness.

Foster home/assisted living and personal care/home health aide services accounted for almost three-fourths of the cost to provide HCBS through the physical and other disabilities waiver in Fiscal Year 2015.

Exhibit 2.6: Costs of Home- and Community-Based Services through the Physical and Other Disabling Conditions Waiver, Fiscal Year 2015

Type of Service	Number of Recipients	Cost	Percentage of Total Cost	Average Cost per Recipient
Foster home/assisted living	7,642	$416,029,000	58%	$54,440
Personal care attendant/home health aide services	5,116	110,923,000	15	21,682
Speech/physical/occupational/respiratory/activity therapy	5,573	42,047,000	6	7,545
Case management/home assessments/transition services	19,370	35,473,000	5	1,831
Prevocational/supported employment/education	3,281	27,826,000	4	8,481
Homemaker services/meals/chores	7,728	22,176,000	3	2,870
Consumer directed community supports	718	14,678,000	2	20,443
Adult day services	1,524	11,319,000	2	7,427
Nursing services	2,516	8,735,000	1	3,472
Nonemergency transportation	7,385	8,200,000	1	1,110
Crisis intervention	656	6,570,000	1	10,015
Home/vehicle modifications	1,011	5,652,000	1	5,590
Respite/crisis respite	290	2,087,000	<1	7,197
Behavioral therapy/education	244	2,046,000	<1	8,386
Medical supplies/equipment	3,483	1,814,000	<1	521
Emergency response systems/technology	3,299	1,324,000	<1	401
Companion/peer/night supervision services	156	533,000	<1	3,414
Home care training	39	184,000	<1	4,712
Financial management	58	3,000	<1	46
Total	19,642[a]	$717,619,000	100%	$36,535

NOTE: Percentages and totals may not sum to the totals shown due to rounding.

[a] This figure refers to the total number of Medical Assistance recipients receiving HCBS through the waiver. Because recipients typically receive more than one type of service, the total does not equal the number of recipients receiving individual services.

SOURCE: Office of the Legislative Auditor, analyses of data from the Minnesota Departments of Human Services.

As Exhibit 2.6 shows, of the 19,642 MA recipients receiving HCBS through this waiver, 7,642 recipients (39 percent) received foster home/assisted living services. These costs—about $416 million—accounted for 58 percent of MA expenditures for this group, averaging about $54,000 per recipient. Another 5,116 recipients (26 percent) received personal care attendant/home health aide services, which accounted for 15 percent of total expenditures ($111 million). These costs averaged $21,682 per recipient.

HCBS through the Physical Disabilities and Other Conditions Waiver, Fiscal Year 2015

Total MA Expenditures	$717,619,000
Number of Recipients	19,642
Median Cost	$24,213
Average Cost	$36,535

As with the other waivers, services and costs varied widely. Waiver recipients at the more costly end of the spectrum tended to receive more foster home services in licensed settings and less personal care services in unlicensed settings. For example, the individual most costly to serve under this waiver in Fiscal Year 2015 incurred practically all of his or her total cost of $406,479 for residential care services. Recipients less costly to serve tended to receive more services from personal care attendants as well as various homemaker services, such as housekeeping and meal preparation—services largely provided in private residences.

Brain Injuries Waiver

As shown in Exhibit 2.7, 1,428 MA recipients with brain injuries received waiver services in Fiscal Year 2015. Brain injuries can be the result of physical injuries from sport-related concussions, car accidents, or military combat. Common symptoms can include anger, memory loss, or depression.

Almost three-fourths of Medical Assistance expenditures to provide HCBS through the brain injuries waiver were for foster home/assisted living services in Fiscal Year 2015.

The most significant cost driver for MA recipients with brain injuries was for services provided in licensed residential settings—generally foster homes, which cost $77 million in Fiscal Year 2015. A large number of recipients (542) also received day training and habilitation services. These services totaled about $6.1 million and averaged $11,181 per recipient. Fewer recipients (138) received personal care/home health aide services.

Services and costs varied widely within the brain injury waiver—from less than $1,000 dollars to a little more than half a million dollars per recipient. Waiver recipients in the top cost quintile (80th to 100th percentile) incurred most of their costs for foster home services. Per recipient costs to provide HCBS to these individuals generally fell between $117,000 and $518,000. At the low end (0 to 20th percentile), costs ranged from less than $1,000 to slightly more than $22,000 per recipient. These individuals generally received a wider variety of services, including assisted living, activity therapy, personal care attendants, homemaking services, and meal delivery.[14]

HCBS through the Brain Injuries Waiver, Fiscal Year 2015

Total MA Expenditures	$103,898,000
Number of Recipients	1,428
Median Cost	$66,610
Average Cost	$72,758

[14] The Department of Human Services' glossary of terms and acronyms does not define activity therapy.

Exhibit 2.7: Costs of Home- and Community-Based Services through the Brain Injuries Waiver, Fiscal Year 2015

Type of Service	Number of Recipients	Cost	Percentage of Total Cost	Average Cost per Recipient
Foster home/assisted living	964	$ 77,066,000	74%	$79,944
Day training and habilitation	542	6,060,000	6	11,181
Personal care attendant/home health aide services	138	3,938,000	4	28,539
Case management/home assessments/transition services	1,417	3,608,000	3	2,546
Speech/physical/occupational/respiratory/activity therapy	379	3,377,000	3	8,911
Behavioral therapy/education	334	3,328,000	3	9,964
Consumer directed community supports	56	2,034,000	2	36,325
Nonemergency transportation	633	986,000	1	1,558
Adult day services	124	883,000	1	7,124
Homemaker services/meals/chores	227	691,000	1	3,043
Crisis intervention	60	669,000	1	11,153
Nursing services	100	453,000	<1	4,527
Respite/crisis respite	31	379,000	<1	12,226
Home/vehicle modifications	41	163,000	<1	3,986
Companion/peer/night supervision services	13	129,000	<1	9,924
Medical supplies/equipment	142	86,000	<1	603
Emergency response systems/technology	65	28,000	<1	437
Home care training	8	19,000	<1	2,406
Financial management	6	<1,000	<1	46
Total	1,428[a]	$103,898,000	100%	$72,758

NOTE: Percentages and totals may not sum to the totals shown due to rounding.

[a] This figure refers to the total number of Medical Assistance recipients receiving HCBS through the waiver. Because recipients typically receive more than one type of service, the total does not equal the number of recipients receiving individual services.

SOURCE: Office of the Legislative Auditor, analyses of data from the Minnesota Department of Human Services.

Elderly Waiver

As shown in Exhibit 2.8, 5,595 MA recipients received HCBS through the elderly waiver in Fiscal Year 2015, at an average cost of $8,563 per recipient.[15]

Services provided in foster home/assisted living settings accounted for about three-fourths of Medical Assistance expenditures to provide HCBS through the elderly waiver in Fiscal Year 2015.

Medical Assistance costs to provide services in regulated facilities (either foster home or assisted living settings) totaled about $36.2 million in Fiscal Year 2015 and averaged $9,212 per recipient. The next largest category of expenditures was for personal care attendant/home health aide services, which totaled about $4 million, for an average of $6,011 per recipient.

[15] Our expenditure data do not capture all HCBS provided to elderly MA recipients who were enrolled in managed care health plans in Fiscal Year 2015.

As with the other waivers, services and costs varied widely. Waiver recipients at the 80th to 100th percentile of spending incurred most of their costs for assisted living services. Per recipient costs to provide HCBS to these recipients ranged from about $15,000 to nearly $60,000. At the lowest cost quintile, per person costs were less than $1,200 per recipient. The most costly HCBS provided to these recipients involved case management and assisted living services. Similarly, the most costly services provided to recipients in highest cost quintile involved assisted living, personal care attendants, and case management services.

HCBS through the Elderly Waiver, Fiscal Year 2015	
Total MA Expenditures	$47,910,000
Number of Recipients	5,595
Median Cost	$4,191
Average Cost	$8,563

Exhibit 2.8: Costs of Home- and Community-Based Services through the Elderly Waiver, Fiscal Year 2015

Type of Service	Number of Recipients	Cost	Percentage of Total Cost	Average Cost per Recipient
Foster home/assisted living	3,929	$36,194,000	76%	$9,212
Personal care attendant/home health aide services	671	4,034,000	8	6,011
Case management/home assessments/transition services	4,878	3,961,000	8	812
Homemaker services/meals/chores	1,009	1,476,000	3	1,463
Nursing services	639	1,137,000	2	1,779
Consumer directed community supports	47	314,000	1	6,678
Adult day services	119	274,000	1	2,302
Medical supplies/equipment	732	182,000	<1	249
Emergency response systems/technology	600	113,000	<1	188
Nonemergency transportation	239	90,000	<1	378
Home/vehicle modifications	38	75,000	<1	1,971
Respite/crisis respite	20	26,000	<1	1,301
Financial management	35	23,000	<1	666
Companion/peer/night supervision services	44	11,000	<1	248
Total	5,595[a]	$47,910,000	100%	$8,563

NOTES: These data capture only a small portion of HCBS expenditures through the elderly waiver. Most elderly Medical Assistance (MA) recipients are enrolled in managed care health plans. Managed care organizations (MCOs) receive a capitated payment from the Department of Human Services (DHS) as part of their public contracts to provide healthcare to MA recipients. When people receive HCBS through the elderly waiver and are enrolled in managed care plans, MCOs pay for HCBS directly. According to data compiled by DHS, 25,300 managed care enrollees received HCBS through the elderly waiver at a cost of about $400.5 million ($15,831 per recipient, on average) in Fiscal Year 2015. Percentages and totals may not sum to the totals shown due to rounding.

[a] This figure refers to the total number of MA recipients who are enrolled in fee-for-service plans and receiving HCBS through the waiver. Because recipients typically receive more than one type of service, the total does not equal the number of recipients receiving individual services.

SOURCE: Office of the Legislative Auditor, analyses of data from the Minnesota Department of Human Services.

As noted in Exhibit 2.8, our data capture only about 11 percent of HCBS expenditures through the elderly waiver in Fiscal Year 2015. Most elderly MA recipients are enrolled in one of two managed care health plans. When people receive HCBS through the elderly waiver and are enrolled in managed care plans, MCOs receive a capitated payment from DHS as part of their public healthcare contracts. Managed care organizations then pay for HCBS directly. According to data compiled by DHS, 25,300 managed care enrollees received HCBS through the elderly waiver at a cost of about $400.5 million ($15,831 per recipient) in Fiscal Year 2015. About 40 percent of these costs were for various health-related and support

services provided to recipients living in certain types of regulated residential settings, and 29 percent were for personal care attendant/home health aide services generally provided in recipients' own homes.

Chronic Health Conditions Waiver

As discussed in Chapter 1, MA waiver recipients with chronic illnesses or who are medically fragile may have a broad array of disabling conditions, such as congestive heart failure, chronic kidney disease, or lung cancer. Exhibit 2.9 shows the specific services received by adult MA recipients through this waiver in Fiscal Year 2015.

Nursing services accounted for slightly more than half of Medical Assistance expenditures to provide HCBS through the chronic health conditions waiver in Fiscal Year 2015.

Exhibit 2.9: Costs of Home- and Community-Based Services through the Chronic Health Conditions Waiver, Fiscal Year 2015

Type of Service	Number of Recipients	Cost	Percentage of Total Cost	Average Cost per Recipient
Nursing services	142	$18,862,000	52%	$132,829
Foster home/assisted living	44	7,585,000	21	172,397
Consumer directed community supports	52	4,838,000	13	93,041
Personal care attendant/home health aide services	84	3,693,000	10	43,961
Home/vehicle modifications	42	543,000	1	12,926
Case management/home assessments/transition services	212	410,000	1	1,934
Speech/physical/occupational/respiratory/activity therapy	4	146,000	<1	36,386
Respite/crisis respite	4	93,000	<1	23,315
Homemaker services/meals/chores	30	81,000	<1	2,694
Medical supplies/equipment	55	51,000	<1	920
Prevocational/employment support/education	2	7,000	<1	3,358
Emergency response systems/technology	10	4,000	<1	362
Nonemergency transportation	5	2,000	<1	415
Behavioral therapy/education	1	1,000	<1	1,327
Financial management	3	<1,000	<1	58
Total	214[a]	$36,315,000	100%	$169,696

NOTE: Percentages and totals may not sum to the totals shown due to rounding.

[a] This figure refers to the total number of Medical Assistance recipients receiving HCBS through the waiver. Because recipients typically receive more than one type of service, the total does not equal the number of recipients receiving individual services.

SOURCE: Office of the Legislative Auditor, analyses of data from the Minnesota Department of Human Services.

HCBS through the Chronic Health Conditions Waiver, Fiscal Year 2015

Total MA Expenditures	$36,315,000
Number of Recipients	214
Median Cost	$158,554
Average Cost	$169,696

While average expenditures were $169,696 per recipient, individual recipient costs ranged from less than $500 to nearly $450,000 in Fiscal Year 2015. Almost two-thirds of the 214 recipients receiving HCBS through this waiver received nursing services in 2015 at a total cost of $18.9 million. Although a high-cost item on a per person basis, relatively few recipients (44 recipients or 21 percent) received foster home/assisted living services, which made up 21 percent of total costs and averaged $172,397 per recipient. Nearly one-fourth of waiver recipients received consumer directed community supports, at an average cost of $93,041 per recipient. (As explained in Exhibit 2.2, this service helps recipients take more responsibility for managing their own services.)

Related Services from Other Sources of Funding

In addition to HCBS reimbursed by DHS through MA, we looked at expenditures for similar or complimentary services from two other funding sources: (1) Group Residential Housing, a state-funded program in DHS designed to help low-income Minnesotans pay certain living expenses that MA does not cover, such as room and board; and (2) Vocational Rehabilitation Services, a jobs program for people with disabilities funded through the Minnesota Department of Employment and Economic Development (DEED) and the federal government.

For the most part, DHS sets the housing rate using a federal and state standard of what an individual needs, at a minimum, to live in the community. As of July 1, 2015, the rate was $891 per month.[16]

Expenditures for related services from some non-Medical Assistance sources for adult Medical Assistance recipients with certified disabilities or enrolled in waivers came to $41.4 million in Fiscal Year 2015.

As shown in Exhibit 2.10, 13,271 MA recipients (21 percent of total HCBS recipients) were served by DHS's Group Residential Housing program in Fiscal Year 2015, and 1,003 (2 percent) were served by DEED's Vocational Rehabilitation Services program. The housing program spent $38.7 million on MA recipients receiving HCBS through MA in 2015, while the Vocational Rehabilitation Services program contributed $2.7 million. Expenditures for DEED's jobs program reflect costs the department pays outside contractors to serve people with disabilities. They do not include costs incurred when its own staff provide the same types of services.

Of the 13,271 MA recipients receiving Group Residential Housing assistance in Fiscal Year 2015, about 12,000 (90 percent) received HCBS through waivers. Half of them (about 6,000) received HCBS through the developmental disability waiver and about 5,000 through the waiver for recipients with physical and other disabling conditions.

[16] In some cases, for example, when group residential housing recipients do not receive HCBS through waivers, DHS may supplement this amount with an additional $483. Supplemental services include, but are not limited to: oversight and up to 24-hour supervision; medication reminders; assistance with transportation; and setting up various meetings and appointments.

Exhibit 2.10: Selected Non-Medical Assistance Expenditures for Related Services to Medical Assistance Recipients Receiving Home- and Community-Based Services, Fiscal Year 2015

	Fiscal Year 2015			
	Number of MA Recipients[a]	Cost (in $1,000s)	Median Cost	Average Cost
Group Residential Housing	13,271	$38,657	$2,940	$2,913
Vocational Rehabilitation Services	1,003	2,726	2,076	2,718
Total	14,018	$41,382	$2,940	$2,952

[a] These figures refer to the total number of MA recipients with certified disabilities receiving HCBS for the fiscal year shown that also received HCBS through the Department of Human Services' Group Residential Housing program or the Department of Employment and Economic Development's Vocational Rehabilitation Services program. The figures do not sum to the total shown because some recipients received both housing and vocational rehabilitation services.

SOURCE: Office of the Legislative Auditor, analyses of data obtained from the Minnesota departments of Employment and Economic Development and Human Services.

About 1,000 MA recipients who received HCBS in Fiscal Year 2015 also received vocational rehabilitation services from DEED. Vocational services help recipients seek and maintain employment. Department of Employment and Economic Development expenditures totaled about $2.7 million in 2015. Most of the MA recipients that DEED served received HCBS from DHS through the waiver for individuals with a physical or other disabling conditions (516) or developmental disabilities (154).

Although both the departments of Employment and Economic Development and Human Services provide vocational services to Medical Assistance recipients with disabilities, there is little overlap in clients served.

Because both DEED and DHS provide vocational services, we looked at the extent to which the two departments provided job-related services to the same clientele. Available to all waiver recipients but the elderly, relatively few recipients received vocational services from DHS through MA. As we showed earlier in Exhibit 2.3, 1 percent of MA expenditures was spent on job-related activities for 4,611 recipients in Fiscal Year 2015. Overall, only 117 of DEED's clients received similar services from DHS in 2015 (about 3 percent).

Payments to Providers

Each year, DHS pays a wide variety of organizations, businesses, and public agencies for providing HCBS to MA recipients with disabilities through the MA program. Providers include county social services agencies, home health agencies, corporations providing a variety of foster care and other services, personal care attendants, transportation companies, restaurants, and yard service companies, among others.

In Fiscal Year 2015, over 4,000 organizations, mostly for-profit businesses, received about $2.4 billion from Medical Assistance for providing HCBS to adults with certified disabilities and waiver recipients.

As Exhibit 2.11 shows, for-profit businesses represented the majority of providers of HCBS for MA recipients with disabilities in Fiscal Year 2015. They accounted for 66 percent of all providers receiving payments (2,661), and they received 65 percent of the total payments in Fiscal Year 2015 ($1.6 billion). In comparison, nonprofit organizations accounted for 25 percent of HCBS providers, and their payments came to 29 percent of total costs ($703 million in Fiscal Year 2015). Public agencies—often county social services departments that provide individual case management to waiver recipients—comprised about 8 percent of providers and 6 percent of payments.

Exhibit 2.11: Providers of Home- and Community-Based Services to Adult Medical Assistance Recipients with Disabilities, Fiscal Year 2015

	Fiscal Year 2015		
Type of Provider	Number	Recipients Served	Payments (in $1,000s)[a]
For profit	2,661	50,324	$1,554,369
Nonprofit	1,027	35,440	702,808
Public	321	38,515	132,150
Other	69	419	2,164
Total	4,062[b]		$2,391,491

[a] Payments refer to the amount the Department of Human Services (DHS) paid providers through the Medical Assistance (MA) program for services delivered. These data do not include payments made to providers serving managed care enrollees who received HCBS through the elderly waiver. Most elderly MA recipients are enrolled in managed care health plans. When people receive HCBS through the elderly waiver and are enrolled in managed care plans, managed care organizations pay for HCBS directly. According to data compiled by DHS, 25,300 managed care enrollees received HCBS through the elderly waiver at a cost of about $400.5 million in Fiscal Year 2015.

[b] In the Medicaid Management Information System, 16 providers had multiple identification numbers reflecting different types of ownership for Fiscal Year 2015. Consequently, the total shown does not equal the sum of provider types.

SOURCE: Office of the Legislative Auditor, analyses of data obtained from the Minnesota Department of Human Services.

Nearly half of all providers (44 percent) delivered foster home/assisted living services in residential facilities, as shown in Exhibit 2.12. Seventeen percent of all providers delivered supported living services to MA recipients with developmental disabilities. These two services made up about 53 percent of Fiscal Year 2015 payments to providers. Finally, 20 percent and 5 percent of all providers delivered personal care attendant/home health aide and day training and habilitation services, respectively.

In Fiscal Year 2015, 10 percent of all providers accounted for 70 percent of total Medical Assistance payments for HCBS.

Exhibit 2.12: Payments to Providers for Specific Home- and Community-Based Services, Fiscal Year 2015

Type of Service	Number of Providers	Percentage of Providers	Payments[a]	Percentage of Payments
Supported living (residential habilitation)	701	17%	$ 742,525,000	31%
Foster home/assisted living	1,799	44	536,874,000	22
Personal care attendant/home health aide services	814	20	462,208,000	19
Day training and habilitation	215	5	179,723,000	8
Nursing services	319	8	77,190,000	3
Consumer directed community supports	13	<1	71,280,000	3
Case management/home assessments/transition services	194	5	70,394,000	3
Companion/peer/night supervision services	178	4	47,407,000	2
Speech/physical/occupational/respiratory/activity therapy	322	8	46,849,000	2
Prevocational training/supported employment/education	258	6	38,845,000	2
Homemaker services/meals/chores	583	14	25,109,000	1
Respite/crisis respite	403	10	24,828,000	1
Nonemergency transportation	568	14	23,881,000	1
Adult day services	147	4	17,139,000	1
Crisis intervention	52	1	9,304,000	<1
Home/vehicle modifications	140	3	8,014,000	<1
Behavioral therapy/education	29	1	5,375,000	<1
Medical supplies/equipment	178	4	2,296,000	<1
Emergency response systems/technology	93	2	1,546,000	<1
Relocation support	77	2	402,000	<1
Home care training	28	1	260,000	<1
Financial management	24	1	42,000	<1
Total	4,062[b]		$2,391,491,000	100%

NOTE: Percentages and totals may not sum to the totals shown due to rounding.

[a] Payments refer to the amount the Department of Human Services (DHS) paid providers through the Medical Assistance (MA) program for HCBS. These data do not include payments made to providers serving managed care enrollees who received HCBS through the elderly waiver. Most elderly MA recipients are enrolled in managed care health plans. When people receive HCBS through the elderly waiver and are enrolled in managed care plans, managed care organizations pay for HCBS directly. According to data compiled by DHS, 25,300 managed care enrollees received HCBS through the elderly waiver at a cost of $400.5 million in Fiscal Year 2015.

[b] This figure refers to the total number of providers. Because they typically provide more than one type of service, the total does not equal the number of providers delivering individual services.

SOURCE: Office of the Legislative Auditor, analyses of data from the Minnesota Department of Human Service.

The amount each provider was paid varied widely, from a few dollars to millions of dollars. In fact, ten providers (about 0.25 percent of all HCBS providers) accounted for about 14 percent of expenditures, each receiving from $16.5 million to $142.4 million in payments in Fiscal Year 2015. As Exhibit 2.13 shows, the ten providers generating the most in MA payments generally provided a wide range of services, including foster home/assisted living and supported living services.

For the most part, MA recipients—especially those receiving services through waivers—are often served by more than one provider, and typically more than one type of service provider. For example, MA recipients receiving HCBS through the waiver for those with physical and other disabling conditions generally can receive case management services from their home county (or their agent) and foster home services from another type of

organization. If they live in their own homes, they may receive personal care services to help in dressing or moving about from other service providers. Of the nearly 64,000 MA recipients receiving HCBS in Fiscal Year 2015, 79 percent were served by one or more for-profit businesses, 60 percent by public agencies (largely for case management services), and 55 percent by nonprofit organizations.

Exhibit 2.13: Top Ten Providers of Home- and Community- Based Services to Medical Assistance Recipients with Disabilities, Fiscal Year 2015

Provider	Number of Recipients Served	Medical Assistance Payments[a]	Major Services Provided[b]
REM Minnesota	2,636	$142,442,000	Supported living; foster care; activity therapy; care attendants; crisis intervention; respite; companion services; transportation; transition services; and comprehensive community support services
Dungarvin Minnesota LLC	1,228	38,219,000	Supported living; foster care; crisis intervention; case management; care attendants; activity therapy; assisted living; vocational support; transportation; respite; and companion services
Accra Care	1,456	29,770,000	Personal care services; companion services; respite; homemaking services; nursing care; home health aides; and activity therapy
Divine House Inc.	416	23,046,000	Supported living; foster care; respite; personal care services; activity therapy; care attendants; vocational support; companion services; and assisted living
Habilitative Services	466	21,980,000	Supported living; foster home/assisted living; personal care/care attendants; activity therapy; respite; companion services; homemaking services; and vocational support
ACR Healthcare Services	198	21,170,000	Supported living; foster home; respite; home modifications; and transportation
Thomas Allen Inc.	2,947	18,592,000	Supported living; case management; foster home; activity therapy; care attendants; and respite
Prairie Community Services, Inc.	334	17,200,000	Supported living; foster care; activity therapy; care attendants; and respite
ResCare Minnesota	914	16,877,000	Supported living; foster home; activity therapy; case management; care attendants; vocational support; crisis intervention; and transportation
Community Living Options Inc.	200	16,453,000	Supported living; foster care; personal care/care attendants; activity therapy; respite; assisted living; and homemaking services

[a] Payments refer to those made by the Department of Human Services. They do not include payments made by managed care organizations that enroll Medical Assistance recipients who received HCBS through the elderly waiver.

[b] Services are in descending order in terms of payments received and only includes services generating at least $5,000 in Fiscal Year 2015.

SOURCE: Office of the Legislative Auditor, analyses of data from the Minnesota Department of Human Services.

Chapter 3: Financial Oversight

As discussed in Chapter 2, expenditures for home- and community-based services (HCBS) for Medical Assistance (MA) recipients are significant and, therefore, should be subject to routine financial oversight. The Department of Human Services (DHS) provides financial oversight of HCBS through licensing, rate setting and provider payments, and fraud and abuse investigations. These oversight responsibilities are managed largely by two separate DHS units, the Disability Services Division and the Office of the Inspector General (OIG). The Disability Services Division oversees HCBS policies and programs, including setting rates for services. The department's OIG investigates financial fraud and abuse, licenses providers, and conducts background checks on staff who work with vulnerable people. In this chapter, we focus on the Disability Services Division's rate setting and the OIG's licensing authority and fraud and abuse investigations as financial oversight tools. Although DHS holds primary responsibility for oversight, other state agencies, counties, and tribal governments also play a role.

Overall, we think that HCBS financial oversight should be improved to ensure HCBS providers deliver the services for which they are responsible. The Legislature and DHS should establish more extensive regulations and require more systematic data collection of HCBS providers and their staff.

Licensing

One way in which DHS provides program oversight is by requiring that HCBS providers be licensed, certified, or approved. To license a provider, DHS staff may conduct a site visit, as well as review a provider's policies and procedures and conduct background checks on its HCBS staff.

Not all providers must be licensed. Those who are not licensed may be *certified* by a state agency or approved by DHS or a county.[1] Providers who predominantly offer programs or services to the general public rather than MA recipients, such as restaurants, lawn services, and personal care agencies, need certification or approval. Generally, to become certified or approved, a provider must meet certain criteria and agree to the terms of participation. Compared with licensing, certifications and approvals are less intensive reviews. An individual may also seek DHS's approval to indicate he or she meets certain criteria to provide services, including HCBS. In this section, we discuss state agencies' and counties' licensing, certification, and approval practices for HCBS providers.

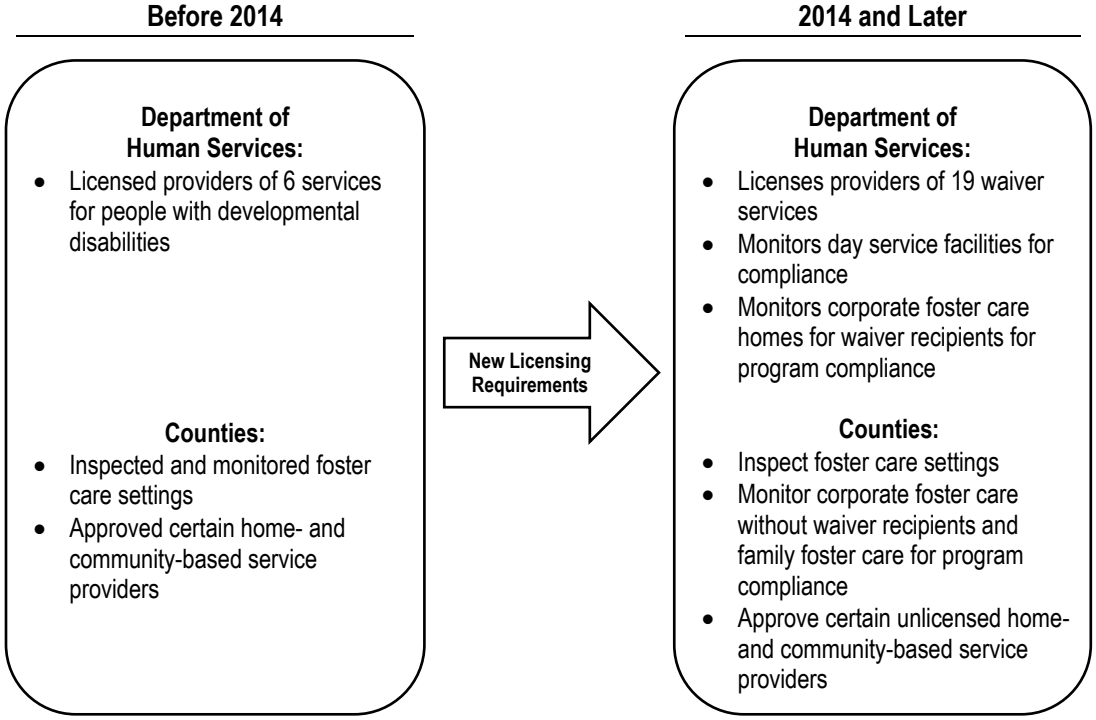
Department of Human Services

According to DHS, in 2008, the Centers for Medicare and Medicaid Services (CMS) determined that Minnesota's waiver programs were out of compliance with federal

[1] For clarity and readability purposes, we use the term "certify" to describe a less intensive process state agencies use to review some HCBS providers. The departments of Human Services and Transportation use the term "certify," while the Department of Health uses "register." We describe the certification process in general, not specific to one agency.

regulations.[2] The centers said that counties held too much authority, which created inconsistencies in how Medicaid was administered. To increase statewide consistency and comply with federal standards, DHS assumed licensing authority for some HCBS providers. The department previously licensed only six types of HCBS providers who served individuals with developmental disabilities.[3] The Legislature passed a law in 2012, which it amended in 2013, expanding DHS's authority to license many (but not all) HCBS providers, as shown in Exhibit 3.1.[4] The department began issuing licenses in 2014, when its licensing authority took effect.[5]

Exhibit 3.1: The Department of Human Services' and Counties' Roles Before and After New Licensing Requirements



NOTES: Waiver recipients qualify to receive Medicaid-funded services in home- and community-based settings. Minnesota offers five home- and community-based service waivers that serve people with: brain injuries; chronic illnesses; developmental disabilities; physical or other disabilities, including mental illness; and those who are 65 years or older.

SOURCE: Office of the Legislative Auditor, based on review of *Minnesota Statutes* 2012, 245B.03; *Minnesota Statutes* 2016, 245D.03, subd. 1; *Minnesota Rules* 9555.9640; and Department of Human Services' documents.

[2] As noted in Chapter 1, CMS administers the federal Medicaid program and issues regulations and guidelines that states must follow to receive federal funding. Minnesota Department of Human Services, *Changing County and Tribal Roles Home and Community-Based Services Waiver Provider Oversight* (St. Paul, 2013), 8-9.

[3] *Minnesota Statutes* 2012, 245B.03, subd. 1.

[4] *Laws of Minnesota* 2012, chapter 216, art. 18, sec. 18; and *Laws of Minnesota* 2013, chapter 109, art. 8, sec. 23.

[5] *Laws of Minnesota* 2013, chapter 108, art. 8, sec. 23 (effective January 1, 2014).

The Department of Human Services does not license all home- and community-based services (HCBS) providers, and not all licensed providers have been reviewed under the new licensing standards.

The Department of Human Services licenses many waiver service providers.[6] For example, DHS licenses providers of foster home and supported living services. Other entities, including counties and the departments of Health and Transportation, also license or oversee certain kinds of HCBS providers.[7]

The Department of Human Services also certifies HCBS providers who are not otherwise licensed. Specifically, personal care agencies and the staff employed by those agencies do not need to be licensed.[8] However, the department enrolls personal care agencies and ensures that personal care attendants have fulfilled training and employment requirements, including passing background checks.[9]

When DHS assumed authority for licensing many providers of HCBS waiver services in 2014, it began by reviewing new applications from previously unlicensed providers. Due to the newness of the licensing laws, some HCBS providers with existing licenses have yet to be reviewed using the new standards. The department completed reviews of new provider licenses in 2014 and 2015 and began reviews of existing licenses in 2016.

As part of its licensing requirements, the Minnesota Department of Human Services does not require or collect financial documentation or engage in any routine financial auditing of HCBS providers.

Before issuing a license, DHS ensures licensees have developed policies and procedures to protect the health and well-being of clients. Policies and procedures involve sanitary practices, coordination of health services and care, medication administration, and emergency plans, among other things.[10] To be approved for a license, applicants must demonstrate that their facilities are safe and sanitary; for example, buildings must be free of peeling paint, mold, and vermin.[11] In addition, corporate foster care and day service providers have more specific standards in that they must ensure that buildings meet code requirements, have adequate space for activities, and have the necessary furniture.[12]

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[6] Minnesota offers five HCBS waivers that serve people with: brain injuries; chronic illnesses; developmental disabilities; physical or other disabilities, including mental illness; and those who are 65 years or older.

[7] The Department of Human Services delegates some licensing oversight to counties, although the department issues the licenses. For example, DHS instructs counties to implement health-related inspections of foster homes.

[8] In Fiscal Year 2015, 846 personal care agencies, which accounted for 20 percent of all HCBS providers, received payments from DHS for HCBS.

[9] The Department of Human Services "enrolls" some HCBS providers and some individual workers. Enrollment involves a review, similar to certification, in which DHS completes background checks and assesses completion of training requirements. We use the term "enrollment" and its derivatives later in the chapter to describe reviews of individual workers.

[10] *Minnesota Statutes* 2016, 245D.11, subd. 2.

[11] *Minnesota Statutes* 2016, 245D.22.

[12] *Minnesota Statutes* 2016, 245D.21, 245D.24, and 245D.28.

Neither statutes nor rules require DHS to review HCBS licensees regularly; however, statute does allow DHS to review HCBS licensees biennially.[13] When it does review licensed providers, DHS verifies that providers have complied with the policies and procedures that the department approved during the licensure application process. The department determines compliance through site visits, document reviews, and interviews. If DHS finds a licensee non-compliant with regulations, it may require corrective action, levy a fine, apply a conditional status to the license, or suspend or revoke the license. For example, if a HCBS licensee fails to provide annual training to its employees, DHS may require the licensee to provide the training or it will impose a fine.

However, the department does not require providers to submit any routine financial documentation, such as profit and loss statements, as part of its licensing process. Although many providers with whom we spoke undergo regular financial audits, the department neither requires nor reviews them.[14] Without standardized financial reports from HCBS providers, DHS's financial oversight is limited.

While HCBS providers need not submit detailed financial documentation for DHS to have thorough financial oversight of providers, we think DHS can improve its financial oversight of HCBS through other means. As a condition of certification or licensure, DHS should require worker identification on claims submissions, place limits on hours for certain types of HCBS workers, and require workers to document their provision of services. We discuss these recommendations later in this chapter.

Other State Agencies

At least two state agencies, in addition to DHS, have responsibility to regulate and oversee some types of service providers that often provide HCBS to MA recipients with disabilities and the elderly. Regardless of which agency monitors the provision of services, DHS has ultimate responsibility for MA funds.

The departments of Health and Transportation have regulatory authority over some HCBS providers.

As of March 2016, the Minnesota Department of Health (MDH) had licensed 1,303 home care providers and 200 home health agencies.[15] Home care providers assist with activities of daily living, such as dressing, toileting, bathing, and giving medication reminders.[16] Home health agencies provide medical-related services in one's home, such as nursing; speech, physical, or occupational therapy; nutritional services; social services; and home health aide tasks.

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[13] *Minnesota Statutes* 2016, 245A.09, subd. 7(e).

[14] As described in the Introduction, we spoke with staff from 10 counties and 16 HCBS providers throughout Minnesota. We selected providers based on the amount MA paid them for HCBS in Fiscal Year 2015 and the types of services they delivered. We tried to focus on providers that received relatively high amounts of MA payments relative to their geographic area. Once we selected our provider sample, we talked with the counties where those providers were based. Our two samples are not representative of either population, and their comments cannot be generalized to all counties and providers.

[15] Minnesota Department of Health, *2016 Directory Licensed, Certified, and Registered Health Care Facilities and Services* (St. Paul, 2016), I.

[16] As we discuss in Chapter 2, home care services are similar to personal care services and those provided by some types of direct care staff in foster home settings.

If a home care provider is licensed by MDH but is also providing HCBS to MA recipients, that provider may choose to receive an "integrated license" from MDH.[17] This means the home care provider may provide a limited selection of services without needing a separate license from DHS for services that would otherwise be licensed by that department. However, as the HCBS licensing law is still relatively new, some providers have decided to continue seeking separate licenses from MDH and DHS as they have done in the past.

The Department of Health also certifies providers of home management services. Home management services include housekeeping, meal preparation, and shopping. These services do not require advanced training or expertise, but staff must attend an orientation discussing matters related to people who are elderly or have disabilities.

The Department of Transportation certifies some providers of HCBS transportation services.[18] These services include ambulatory and non-ambulatory nonemergency transportation.[19] Home- and community-based transportation services help MA recipients with disabilities access community resources.

Counties

Before DHS took over licensing responsibilities, counties contracted with providers and negotiated HCBS rates. The department allowed counties to develop their own contracts but required that they address providers' responsibilities; waiver requirements; monitoring and evaluation duties; and terms of payment, among other things. Counties used contracts to help ensure countywide consistency in service delivery as well as compliance with waiver regulations. Providers could not be reimbursed if they did not have some type of agreement with a county.

Counties no longer contract with most HCBS providers. If county staff have concerns about the health and safety of their clients, they may recommend that DHS take a negative licensing action.[20] The Department of Human Services, as the primary licensing authority, may take action against the licensee, for example, revoke or suspend its license.

While DHS licenses foster care homes, it delegates health-and safety-related inspections of the homes to counties. Counties inspect sanitary practices, the safety of the environment, as well as availability of safe food and water. For foster homes that do not provide waiver services, counties perform inspections in addition to other monitoring responsibilities.

Counties also oversee some services that do not require a DHS license. Some county staff said they encourage vendors of chore services, such as lawn mowing and home modification services, who do not need to be licensed, to enroll with the department. If a vendor does not enroll, it must be approved by a county. Some county staff with whom we met indicated that they did not use a standardized process to evaluate vendors before or after the provision of services.[21]

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[17] *Minnesota Statutes* 2016, 144A.484, subd. 1(b).

[18] *Minnesota Statutes* 2016, 174.30.

[19] When individuals can get into and out of a vehicle independently, with or without a wheelchair, it is considered ambulatory transportation. When they need assistance, it is considered non-ambulatory.

[20] *Minnesota Rules*, 9555.6145, subp. 2, published electronically October 15, 2013.

[21] The Department of Human Services publicized a required, standardized form for counties to use when approving vendors in December 2016.

With their role in licensing HCBS providers recently limited, counties reported unclear lines of authority and only vague guidance from the Department of Human Services.

Statutes do not clearly delineate counties' roles in monitoring the financial or quality aspects of the HCBS providers they use. County staff with whom we met viewed DHS as the lead monitoring agency, in the absence of any explicit county oversight authority. However, on its website, DHS identifies counties as being responsible for monitoring provider performance, yet the county staff with whom we met did not have a clear understanding of their role.[22]

Some county representatives said that DHS expects counties to monitor providers but does not grant them the authority or funding to do so. In addition, counties do not have direct authority to affect providers' licenses, which limits their ability to take disciplinary action. With these limitations, counties often provide oversight on a client-by-client basis rather than evaluating providers as a whole. They rely on county case managers to oversee services provided to individuals enrolled in the waiver program.

In terms of financial monitoring, representatives from a few counties said they lacked the information and authority to provide financial oversight of HCBS providers. Staff from some counties said they do not have aggregate financial information for each provider, and it would take too much staff time to put it together. Staff from a few counties said they do not have the capacity to routinely monitor individual claims for fraudulent billing and, even if they found fraud, they would have little recourse.

Rate Setting

Similar to licensing, DHS's system for establishing standardized HCBS payment rates is relatively new. The department monitors providers' payments through the system's regulation of rates and quantity of services. More broadly, DHS oversees the funding it allocates to counties to provide HCBS.

Rates

The Minnesota Legislature established statewide rates for HCBS waiver services effective January 1, 2014.[23] The new rates override previous service rates set through counties' contracts with providers. However, to ease providers' transitions to the new system, many individual payment rates are being adjusted gradually until the rate management system is fully implemented in 2019 or 2020. Most providers will not receive the full effect of the new rates during the transition period. However, rates for recipients starting new residential services are affected immediately.

Although the rates only pertain to waiver and state plan MA recipients, some providers said they use the same rates for their other clients. Waiver and state plan services subject to DHS's rate management system include: foster care, supported living, and day training and

[22] Minnesota Department of Human Services, *State and Lead Agency Oversight Responsibilities* (St. Paul, 2014), http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000723, accessed January 3, 2017.

[23] *Laws of Minnesota* 2013, chapter 108, art. 13, sec. 11-12.

habilitation, and services provided by personal care attendants, home health aides, companions, and homemakers, among others.

The Department of Human Services considers the following items when it sets payment rates: supervision costs, staff compensation, staffing/supervisory patterns, program-related expenses, and general and administrative expenses.[24] The department is charged with making recommendations to the Legislature on adjusting the terms and values associated with the rate management system, as any adjustments require a change in law. In 2017 and every five years thereafter, DHS must update rate components, including base wages, administrative costs, and vacation and sick leave.[25] The department must adjust rate components using data from the Bureau of Labor Statistics and Consumer Price Index.

Although DHS and the Legislature, working with stakeholders, developed the rate formulas, counties make final spending determinations by developing individual clients' service agreements.[26] Each service agreement has day or hour limits on services to be provided, as well as inputs that describe the extent to which services will be provided. Before entering service inputs into the rate system, county staff consult with providers to determine staffing ratios and hours of services to meet clients' assessed needs. County staff ultimately enter all inputs that may affect clients' final rates, such as staffing ratios or transportation needs, into the rate system.

The rate management system prevents HCBS providers from fraudulently altering payment rates.

When submitting claims, providers may only enter hours of services provided; they do not have access to the rates used to calculate the payment. Providers receive screenshots of the rates produced by the rate management system and can access a public framework to determine what rate the system will produce with the inputs provided to the county. If changes need to be made to service agreements or rates, only counties have the authority and access to make those changes. By limiting who can adjust rates, DHS may be preventing fraud. In this way, DHS is providing financial oversight through its standardized rate and payment systems. However, according to DHS, some providers have found ways to bypass these safeguards.

Staff from a few counties we visited spoke positively of the rate management system and standardized HCBS rates. They said the system prevents providers from submitting duplicate hours of service for the same day. It also prohibits providers from claiming service hours beyond what is specified in service agreements. County staff expressed appreciation for not having to negotiate HCBS rates with providers, because the system uses standardized rates. They described the system's controls as being advantageous for counties and DHS in terms of financial oversight.

However, as we discuss in Chapter 4, both county staff and providers expressed concern with the rate management system and the rates it produces. First, they said the system does

[24] *Minnesota Statutes* 2016, 256B.4912, subd. 3.

[25] *Minnesota Statutes* 2016, 256B.4914, subd. 5(i).

[26] The Department of Human Services routinely monitors counties' and tribal governments' HCBS waiver programs to assess quality and compliance. In these reviews, DHS audits samples of clients' case files for content but does not evaluate the appropriateness of individual clients' services.

not account for all state and federal regulations. Moreover, because there is not a profit margin built into the system, providers must make up for any shortfalls in major cost drivers, such as wages for direct care staff, elsewhere in their businesses.[27] This can be problematic for providers who need to pay staff for overtime to make up for staffing shortages, which are becoming common as workers leave direct care positions for less difficult, higher-paying jobs. Additionally, the system does not easily accommodate the difficulty of the client or the skill level needed to care for clients when it determines wages, so providers must seek special approval to receive higher payment rates for difficult clients.

Rate Exceptions

Service needs for individuals who qualify for waiver services vary, depending on their functional abilities, cognition, behavior needs, and health status. Working with some MA recipients can be dangerous or require very staff-intensive services. For example, some waiver recipients have disabilities that are characterized by challenging behaviors, such as biting, hitting, running away, or injuring themselves. Some providers told us that more difficult HCBS recipients often require staff with more training or experience.

Unlike some other payment systems, the system for HCBS does not adjust wage rates for direct care staff to account for different levels of disability or assistance needed.[28] All direct care staff are reimbursed at the same rate, regardless of the complexity of recipients' conditions, needs, or behaviors. This creates a disincentive for providers to serve those with high needs when they could serve individuals with less complex needs for the same payment amount. It also presents problems for counties trying to find placements for more difficult-to-serve MA recipients.

To account for this, HCBS providers can ask for rate exceptions by submitting requests to counties. Providers must document and submit information on costs that go over, or are not included in, the system's calculated rates. Counties, in turn, recommend whether DHS should approve or deny providers' requests.[29] To qualify for a rate exception, a recipient must meet one of the following criteria: (1) additional service hours will not address the individual's needs, (2) a provider has warned that it will stop providing services under the current rate, or (3) an individual's behavioral needs require a change in care.[30] According to statute, county staff may deny rate exception requests that clearly do not meet the criteria described above.[31] For example, if client needs can be addressed through additional service hours, a county representative may make the final decision to deny the rate exception request and instead approve more service hours.

Counties interpret their role in requesting rate exceptions differently, which leads to inconsistent practices.

[27] In most instances, providers are not required to spend payments in any particular manner. For example, providers are not required to pay their employees the wage rates that DHS uses to calculate their payments. Providers may pay their employees higher or lower wages. However, the rate system is not fully implemented, so many providers are not yet fully affected by the system's rates.

[28] The formula only pays higher rates for staff who work with blind or hearing-impaired clients.

[29] *Minnesota Statutes* 2016, 256B.4914, subd. 14(b).

[30] *Minnesota Statutes* 2016, 256B.4914, subd. 14(c).

[31] *Minnesota Statutes* 2016, 256B.4914, subd. 14(f).

Counties must forward all requests that meet the exception criteria to DHS for final action, regardless of counties' recommendations.[32] Some county staff with whom we spoke said they send all provider requests to DHS, while others only submit those that meet the criteria and have the county's approval. Some outstate counties said they are so desperate to find providers that they feel compelled to recommend approval of any requests.

In 2016, DHS received 979 exception requests; staff approved 764 of them (78 percent) and denied 26.[33] Of the remaining 189, counties themselves denied 26 and withdrew 125 for a variety of reasons, such as the individual's needs could be met in other ways.[34] In some instances, counties authorized additional units of services rather than approving rate exceptions. Half of the approvals were for residential services, such as foster care.

County staff told us that providers generally suggest the amount of the rate exception, which could create inconsistencies. Staff expressed concern about the rates some providers have requested to serve high-needs recipients. The Department of Human Services predicted that the average rate exception, when final rates are in effect, could be as high as 82 percent above the payment system level.[35]

The Department of Human Services does not provide additional funding to counties when it approves rate exceptions, so counties must use their existing waiver allocations to cover the higher rates. According to department projections, MA spending to accommodate rate exceptions is likely to be more than $58.8 million in Fiscal Year 2020.[36]

Some county staff commented on the high number of exception requests they received from providers. According to DHS, even when the final rates go into effect in 2019 or 2020, HCBS providers will still request rate exceptions.[37]

When the department asked providers why they would request an exception, many responded that the staff person serving the client would need a higher wage.[38] In the future, DHS projects that rate exceptions for corporate foster home, supported living services, and day training and habilitation will have the greatest financial impact on the state.[39]

Allocations

The Department of Human Services oversees waiver costs through its allocations to counties and tribal governments. The allocation acts as a budget, indicating the total amount of funding county or tribal governments will receive in a year to cover waiver costs.

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[32] Counties must submit providers' cost driver information as well as descriptions of recipients' extraordinary needs in their exception requests.

[33] The Department of Human Services and counties review and monitor rate exceptions. Vicki Kunerth, Minnesota Department of Human Services, e-mail message to Jo Vos, "Follow-up OLA's Audit of HCBS," January 6, 2017.

[34] By the end of the year, 38 requests did not have a final status.

[35] Minnesota Department of Human Services, *Disability Waivers Rate System Report* (St. Paul, January 2016), 35.

[36] *Ibid.*

[37] *Ibid.*

[38] *Ibid.*, 36-37.

[39] *Ibid.*, 35.

The allocation formula reflects historic costs with occasional adjustments made by the Legislature.

Counties and tribal governments manage their HCBS allocations by approving waiver enrollments and individual service agreements.

Counties and tribal governments must ensure they have sufficient funding to support new waiver enrollments and service agreements, as they are generally ongoing expenses. Counties and tribal governments are also responsible for confirming that HCBS recipients are receiving only necessary services, which includes being enrolled in suitable waivers. However, some DHS staff and HCBS advocates with whom we met felt that case managers sometimes enroll participants in the waiver for which they have more funding, rather than the waiver that best meets their needs.

The Department of Human Services developed an online tool, called the Waiver Management System, to assist counties and tribal governments in managing their allocations. The system tracks claims paid through the Medicaid Management Information System (MMIS). The Waiver Management System allows counties and tribal governments to identify who is currently in or eligible for their waiver programs. It also has a simulation feature that allows counties and tribal governments to predict the cost of modifying service agreements or adding waiver recipients.

Department staff monitor counties' and tribal governments' expenditures by examining their allocations quarterly. Staff also assess trends in service authorizations on a monthly basis and provide guidance to counties and tribal governments if spending is far greater or less than the allocation. The system gives providers a one-year window to submit payment claims for the HCBS they provide. Having such a long period for submitting claims could interfere with a county or tribal government's ability to make budget projections. For example, if providers delay claims submissions and counties are not aware of the delays, the counties may underestimate actual service use and therefore overestimate available funding. Moreover, the system shuts down monthly to update MMIS data; a few counties mentioned that the lack of real-time claims data was problematic for managing their allocations.

Fraud Investigations and Prevention

The federal government provides financial oversight of Medicaid, including HCBS, through audits and investigations. At the state level, DHS completes financial fraud and abuse investigations, most of which are brought to its attention through analyzing payment claims or complaints.

Federal Audits and Investigations

The Centers for Medicare and Medicaid Services (CMS) and the federal Office of the Inspector General (OIG) monitor HCBS on behalf of the federal government. The Centers for Medicare and Medicaid Services monitors providers by reviewing Medicaid payments, and the federal OIG monitors federal Department of Health and Human Services' programs for fraud, waste, and abuse. Most often, the OIG's work involves overseeing Medicare and Medicaid, which account for a large portion of federal funding.

The Centers for Medicare and Medicaid Services monitors Medicaid payments through the Payment Error Rate Measurement (PERM) program, which audits each state and the District of Columbia every three years. The PERM audit may assess all types of Medicaid claims, which CMS regards as being susceptible to erroneous payments. The audit requires providers to submit supporting documentation for a limited number of claims, which may include HCBS. The PERM report does not specify the number of audited claims that fall within the purview of HCBS.

The Center for Medicare and Medicaid's most recent audit of states' payment systems included DHS claims from Fiscal Year 2012.[40] The federal government reports states' results in the aggregate, so it does not permit comparison of Minnesota's Medicaid payment system with those of other states.

For Medicaid fraud investigations, the federal OIG reports some criminal conviction data by state. Additionally, the reports indicate the type of provider, some of which administer HCBS.

Many of the Medicaid fraud convictions reported by the federal Office of Inspector General involve HCBS providers.

Although the federal OIG investigates all Medicaid fraud, many of the convictions involve HCBS providers.[41] Of the 1,097 total Medicaid fraud criminal convictions reported nationwide, 439 (40 percent) involved personal care attendants or other home care aides. In response to the prevalence of personal care attendant fraud, the federal OIG issued recommendations for prevention, which we discuss later in this chapter.

In its Fiscal Year 2015 report, the federal OIG stated that Minnesota had 417 open Medicaid fraud investigations; some of the investigations likely involved HCBS. In that year, the state also had 22 criminal indictments or charges and 17 criminal convictions.

State Investigations

As stated at the beginning of this chapter, the Minnesota Department of Human Services' Office of Inspector General (OIG) completes financial fraud and abuse investigations for the state. Within OIG is the Surveillance and Integrity Review Section (SIRS), which is federally mandated to oversee the state's Medicaid program. This unit reviews all MA services, not just HCBS, through its three units: Provider Investigations, Minnesota Restricted Recipient Program, and Provider Screening.

The Minnesota Department of Human Services does not routinely conduct financial investigations of HCBS providers unless problems come to its attention through processing payment claims or complaints.

[40] The Centers for Medicare and Medicaid Services reviewed Fiscal Year 2015 claims across several states, including Minnesota, but the updated aggregated results have not been published. The Centers for Medicare and Medicaid Services, *Medicaid and CHIP 2015 Improper Payments Report* (Washington, DC, 2015).

[41] U.S. Department of Health and Human Services, Office of Inspector General, *Medicaid Fraud Control Units Fiscal Year 2015 Annual Report* (Washington, DC, 2016).

The Department of Human Services' waiver agreements with CMS assert that SIRS will monitor the delivery and use of waiver services by providers and participants by: (1) routinely analyzing claims data for unusual patterns, (2) periodically reviewing selected providers, and (3) investigating identified or reported fiscal integrity issues.

Inspector General staff told us that they receive more complaints against providers than they have the resources to investigate. Some waiver services lack statutory documentation requirements, making investigations into waiver service more time consuming and less fruitful. The most timely and cost-effective way to determine if services actually occurred is to compare documentation to other verifiable resources, such as outside employment, hospitalizations, school attendance, or other medical appointments. Without documentation requirements for some waivered services, SIRS is limited in its ability to recover overpayments or remove fraudulent waivered providers.

In 2015, SIRS investigated 218 personal care providers, 37 home and community service providers, 11 day training and habilitation centers, and 10 home health agencies.[42] Investigations may result in: referral to a prosecuting authority; suspension or termination of the provider's enrollment in Minnesota's health care program; education for the provider to prevent further overpayment; recovery of overpayments; or withholding further payment to the provider.

While screening providers that CMS or DHS considers at high or moderate risk of fraud, SIRS investigators make unscheduled visits to ensure that the organizations exist. Investigators focus on the organizations as a whole, rather than evaluating the services.

The Department of Human Services does not collect adequate information to conduct financial oversight of all HCBS providers.

Although DHS is able to do some monitoring of providers, financial monitoring could be improved if additional information were routinely collected. For example, DHS does not receive information about workers who provided services or documentation about services provided for most types of HCBS. Both pieces of information would give DHS more information about the provision of services. If DHS had more information, at least in regard to those services most susceptible to fraud, it could provide better financial oversight and, thereby, help prevent fraud.[43]

Fraud Prevention

As Minnesota provides more opportunities for people with disabilities and the elderly to live independently in the community, more people will receive services in their homes from direct care staff. This shift increases the opportunity for fraud, because workers who provide in-home services, such as personal care attendants and home health aides, often do not have direct supervision.

[42] Minnesota Department of Human Services, Office of Inspector General, *2015 Annual Report* (St. Paul, 2016), 13.

[43] We address this issue in a recommendation later in this chapter.

In our 2009 report on personal care assistance, we found that Minnesota's personal care program was vulnerable to fraud and abuse.[44] In our report, we discussed issues with personal care attendants not providing the services for which they billed. We also identified numerous cases in which DHS paid claims that indicated that personal care attendants worked more than 24 hours in a day. Additionally, we found that personal care agencies did not always maintain documentation to support their claims submissions.

To address these problems, we issued recommendations, some of which involved greater oversight from DHS. To identify potentially fraudulent or erroneous claims, we recommended that DHS regularly analyze claims data. We recommended that personal care service providers make periodic visits or phone calls to verify that their personal care attendants are actually providing the expected services.[45] We acknowledged problems with inadequate documentation, although we did not make any explicit recommendations requiring additional documentation.

The federal OIG also found that personal care attendants sometimes bill for services that are improbable, such as serving multiple clients at one time. The federal OIG issued guidance to address fraud among personal care services, with an additional recommendation to enroll personal care assistants with a state agency.[46] The federal OIG recommended that states enroll personal care attendants and give them unique identification numbers to prevent fraud in claims submissions.[47]

State legislation regarding the personal care program has addressed many recommendations from our 2009 report and the federal OIG. Although DHS began requiring personal care attendants to enroll in 2005, the Legislature did not enact legislation to that effect until 2009.[48] In 2009, the Legislature adopted legislation requiring personal care attendants to document daily activity for each day they provided services to recipients.[49] This information must be submitted on a monthly basis to the agencies for which the personal care attendants are working. The Legislature enacted legislation in 2010 that prevents personal care attendants from billing for more than 275 hours in a month.[50] The 2015 Legislature adopted our 2009 recommendation, requiring that for each service recipient, personal care providers make at least one unscheduled telephone call every 90 days to verify that a personal care attendant is present on site.[51]

These changes have helped the state OIG identify over $1.6 million in personal care overpayments between 2014 and 2015.[52] However, the changes do not apply to other in-

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[44] Office of the Legislative Auditor, Program Evaluation Division, *Personal Care Assistance* (St. Paul, 2009).

[45] *Ibid.*, 72.

[46] Gary Cantrell, Deputy Inspector General for Investigations, Office of Inspector General, memorandum to Vikki Wachino, Deputy Administrator and Director, Centers for Medicare & Medicaid Services, Investigative Advisory on Medicaid Fraud and Patient Harm Involving Personal Care Services, October 3, 2016.

[47] *Ibid.*, 7.

[48] Office of the Legislative Auditor, *Personal Care Assistance* (St. Paul, 2009), 77; and *Laws of Minnesota*, 2009, chapter 79, art. 8, sec. 31, subd. 11(a)(3).

[49] *Laws of Minnesota* 2009, chapter 79, art. 8, sec. 31, subd. 12.

[50] *Laws of Minnesota* 2010, First Special Session, chapter 1, art. 15, sec. 7.

[51] *Laws of Minnesota* 2015, chapter 78, art. 4, sec. 53.

[52] Minnesota Department of Human Services, Office of Inspector General, *2015 Annual Report* (St. Paul, 2016), 20.

home service providers. Other types of HCBS direct care workers, such as home health aides, companions, and homemakers, also work in recipients' homes; however, DHS puts forth less monitoring and fewer requirements for them. Similar to personal care attendants, other direct care staff have limited supervision in clients' homes, making them just as susceptible to fraud.

The Department of Human Services does not routinely monitor all HCBS direct care staff to ensure that they are providing the services for which they are billing, nor does it direct counties or providers to do so.

Staff from the state's OIG suggested that the best way to ensure that HCBS staff are present in clients' homes is to make unscheduled phone calls or visits to the homes. With the exception of personal care attendants, DHS does not use this approach to monitor other types of HCBS direct care staff, nor does it require it of all HCBS providers or counties.[53] However, some county staff and providers told us they make calls and visits anyway.

Some case managers make scheduled or unscheduled visits to recipients to ensure HCBS workers are providing the expected services. However, case managers' workloads can affect their ability to provide thorough oversight. In interviews, staff from some counties said their workloads are too heavy or they spend too much time traveling to meet with their clients residing in other counties.

Some providers told us that they have taken it upon themselves to monitor their employees' service delivery. A few providers use technology to track employees' locations and their notes of services provided. Although not required, some HCBS providers make unannounced visits or phone calls to ensure staff are present. As noted previously, statute requires personal care, but not other types of HCBS providers, to make unscheduled phone calls.[54]

Currently, if a case manager or provider does not make unscheduled visits or phone calls to the client's home, there is no oversight mechanism to ensure HCBS workers are actually providing services. Additionally, MA recipients with disabilities who receive HCBS through the state MA plan may not have case workers to oversee their services, so they would have to self-report if workers do not show up. Given the current HCBS worker shortages, recipients may not report workers' absence in fear that they would not find a replacement.[55]

Aside from personal care attendants, the Department of Human Services does not (1) require other types of direct care staff to enroll with the department, (2) limit the number of hours for which workers can bill, or (3) require documentation supporting the provision of services.

Personal care attendants must submit their personal enrollment information on claims, which helps DHS identify fraudulent billing. By tracking the individual personal care

[53] Providers must supervise, assist, and train direct care staff to ensure their competency in delivering services; however, providers are not specifically required to confirm that services were actually delivered.

[54] *Minnesota Statutes* 2016, 256B.0705, subd. 2.

[55] We discuss staffing issues in Chapter 4.

attendant, DHS can look across clients and agencies to identify if a personal care attendant claims too many hours. Without enrollment information for other HCBS workers, DHS is limited in its ability to track individual workers' claims submissions.

When individual direct care workers are not enrolled with the department, DHS's system cannot detect when the workers bill for an unreasonable number of hours in a month. While the system does not monitor individual workers' hours, it does detect discrepancies in providers' billing submissions. It compares providers' submissions to service agreements to prevent a provider from billing for more than the total hours listed in a service agreement. For example, if a client's service agreement dictates he or she can receive 1,040 hours of a service in a year, a provider cannot bill for more than 1,040 hours.

Documentation of services provided helps DHS investigate complaints or suspected fraud. Since DHS does not require other HCBS providers to maintain documentation of the provision of services, providers may not require their employees to keep notes on the services they provide. The department cannot verify the provision of services without supporting documentation.

RECOMMENDATION

The Legislature should increase its regulation over some types of direct care workers who provide HCBS in recipients' own homes.

Overall, as shown in Exhibit 3.2, financial oversight of some types of direct care staff could be improved by extending current regulations for personal care attendants to other types of direct care staff who do similar work. At a minimum, we think these regulations should be extended to other direct care staff who provide services in clients' own homes, because with limited supervision, they pose a greater risk for fraud.

We think legislation is especially needed in three areas. First, comparable to personal care attendant legislation, the Legislature should consider requiring HCBS providers to make unscheduled phone calls or visits to staff working in recipients' homes to ensure their provision of services.[56] Alternatively, the Legislature could require either county or DHS staff to make these phone calls or visits. Although we did not evaluate the effectiveness of the personal care model, we think periodic check-ins could improve HCBS oversight.

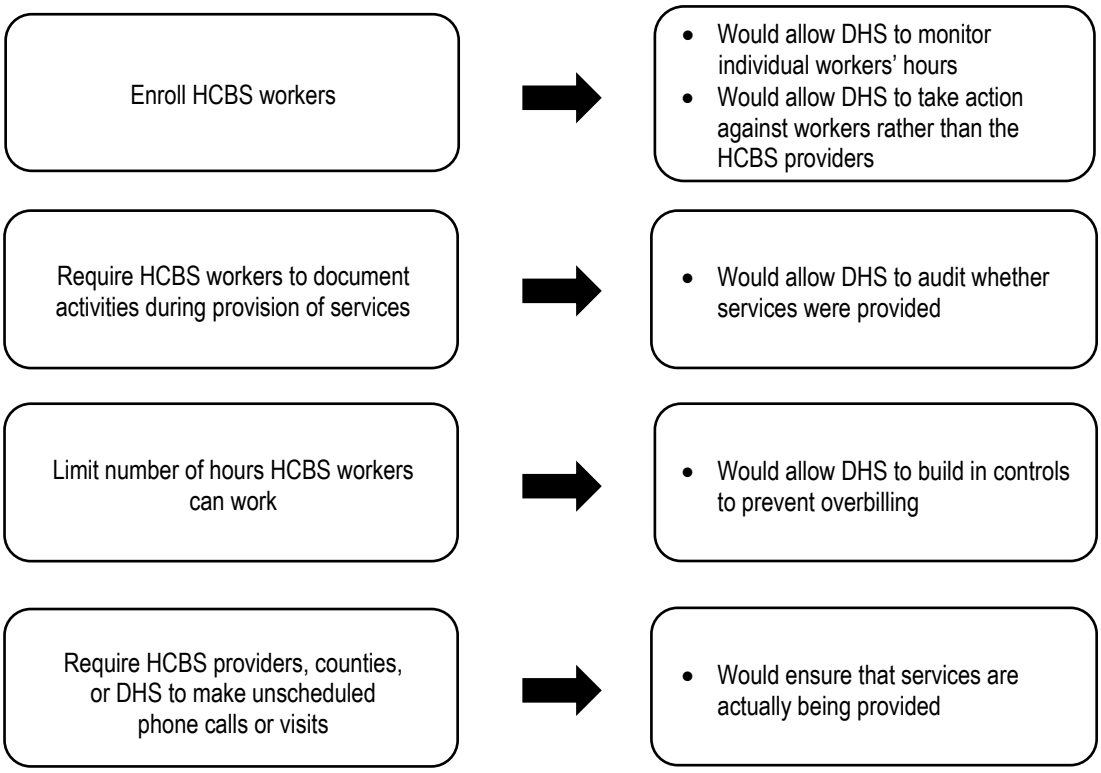
Second, the Legislature should limit the number of hours some types of HCBS direct care workers can work in a month. Implementing monthly hour caps and documentation requirements, such as daily activity notes, for workers (similar to the personal care program) could increase DHS's ability to detect fraud and monitor HCBS finances. Again, at a minimum, we think these requirements should be applied to services provided in recipients' own homes. While it may not be necessary for DHS to routinely collect documentation, providers should have it available upon the department's request.

Third, the Legislature should require some HCBS direct care workers to enroll with DHS and require that certain staff information be provided when providers file claims for payment. Department staff emphasized that personal care attendant enrollment is one of the

[56] *Minnesota Statutes* 2016, 256B.0705.

most powerful tools they have to prevent personal care attendant fraud.[57] We think it would be just as powerful for overseeing other HCBS. With the exception of personal care attendants, DHS does not enroll other HCBS workers or require them to provide identifying information on claims. Again, enrollment is particularly needed for HCBS direct care workers providing services in recipients' own homes.

Exhibit 3.2: Actions to Prevent Fraud among Home- and Community-Based Services Workers



NOTES: DHS refers to the Minnesota Department of Human Services and HCBS refers to home- and community-based services.

SOURCE: Office of the Legislative Auditor.

[57] The FY 18-19 Governor's Budget Recommendations include a recommendation to enroll some other types of in-home direct care staff and include their identification on claims submissions. Minnesota Management and Budget, *FY18-19 Governor's Budget Recommendations: Minnesota Department of Human Services* (St. Paul, January 2017), 89-91.

Chapter 4: Other Issues

While Minnesota has made significant progress over the last several years in moving Medical Assistance (MA) recipients with disabilities out of large institutions and into their own homes or foster homes, much work still remains. As we saw in previous chapters, in comparison with other states, Minnesota relies more heavily on foster home settings, many operated by for-profit businesses. Also, Minnesota's MA expenditures for home- and community-based services (HCBS) are sizeable compared with other states' spending.[1] At the same time, the state has implemented few oversight mechanisms to ensure that HCBS are being delivered as planned.

During the course of our evaluation, we learned about other challenges and issues, aside from financial accountability, facing policy makers, people with disabilities, and those that work with or for them. This final chapter discusses some of those issues.

Additional Challenges

As part of our research, we asked representatives from several counties, HCBS providers, and advocacy organizations about the biggest issues facing the HCBS system.[2] This section identifies two of providers' biggest concerns: workforce staffing and payment rates. Counties were also concerned about these issues.

Direct Care Workforce

Direct care staff, such as home health aides, nursing assistants, and personal care attendants, provide much of the routine nonmedical care people with disabilities and the elderly need to live in community settings. They help with activities people without disabilities may take for granted, such as eating, walking, bathing, or dressing. Currently, providers who employ these types of direct care staff are confronting several interrelated workforce issues that are not easily resolved: demographic changes, staff shortages, low wages, and demanding work. Some issues, such as demographics, are beyond the state's control.

In Minnesota and across the nation, the number of individuals entering the workforce is growing at a much slower rate than the number of people needing assistance.

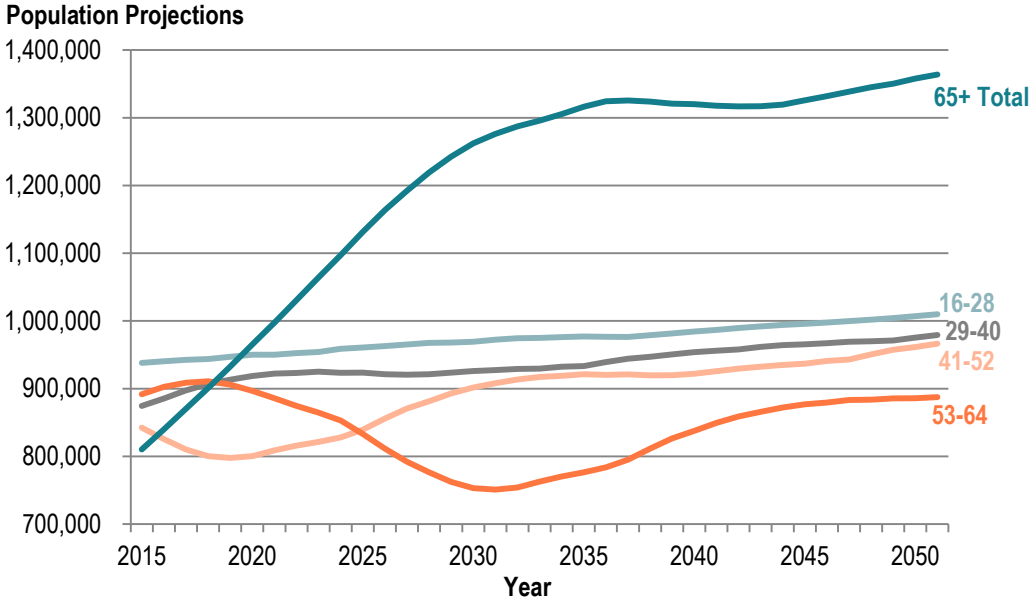
As Exhibit 4.1 shows, the number of Minnesotans ages 16 to 24 in the workforce will be relatively stagnant over the next several years. At the same time, the population of people ages 65 and older (who may need HCBS) will increase dramatically. The Minnesota State

[1] While the federal government requires that participating states provide basic healthcare services to low-income people, it generally does not require them to provide all types of HCBS. Consequently, states vary considerably regarding the HCBS they provide and the specific groups of individuals eligible to receive those services. This, in turn, affects their spending.

[2] As we explained in our Introduction, we spoke with staff from 10 counties and 16 HCBS providers throughout Minnesota. We selected providers based on the amount of MA payments they received for HCBS in Fiscal Year 2015, geographic location, and the types of services they delivered. Once we selected our provider sample, we talked with the counties where those providers were based. Because our two samples are not representative of either population, their comments cannot be generalized to all counties or providers.

Demographer estimates that, between 2019 and 2028, Minnesota's population ages 25 to 64 will experience a net loss of about 40,800 people.[3] The demographer predicts that the ten years following 2019 will likely be the most severe in terms of labor supply shortage in Minnesota, barring major changes in immigration or migration patterns.

Exhibit 4.1: Population Projections for Minnesota by Age Group, 2015 through 2050



SOURCE: Office of the Legislative Auditor, based on data from the Minnesota State Demographic Center.

According to the Department of Employment and Economic Development (DEED), the number of home health care jobs will increase 30 percent between 2014 and 2024, and the number of people age 65 and older will increase more than 50 percent.[4] The department lists home health aides sixth in terms of jobs with the highest projected number of openings between 2014 and 2024.[5] The department predicts that there will be 16,000 job openings for home health aides in Minnesota through 2022.[6]

Minnesota is not alone. Americans in general are living longer. Baby boomers are getting older, and medical advances are allowing more people with chronic illnesses and disabilities to live longer and more independently in the community. According to The Henry J. Kaiser Family Foundation, the number of Americans age 65 years and older is expected to more than

[3] Minnesota State Demographic Center, *Demographic Considerations for Long-Range and Strategic Planning* (St. Paul, September 2015), 8.

[4] Minnesota Department of Employment and Economic Development, *H is for Home Health Aide* (St. Paul, 2016), 1. The department defines home health care jobs as work typically done in clients' homes or nursing facilities as opposed to hospitals or clinics. In addition to administering some basic medical care, home health aides help recipients with daily activities, such as eating or dressing.

[5] Minnesota Department of Employment and Economic Development, *Employment Outlook Projections: Occupations with the Most Job Openings from Employment Growth and Replacement Needs 2014-2024* (St. Paul, 2016).

[6] Minnesota Department of Employment and Economic Development, *H is for Home Health Aide*, 1.

double between 2012 and 2050, while the number of people 85 years and older will more than triple.[7] It is estimated that, among people age 65 and older, 70 percent will use long-term services and supports.[8] Individuals age 85 and older—the fastest growing segment of the U.S. population—are four times more likely to need long-term services compared with people ages 65 to 84. Approximately seven in ten people age 90 and older have a disability, and among people between the ages of 40 and 50, almost one in ten, on average, will have a disability that may require long-term services. Meanwhile, with fewer people entering the national workforce (barring major changes in immigration or relocation patterns), competition for workers in all segments of the nation's economy is expected to be fierce.[9]

Low wages for some types of direct care staff, both in Minnesota and across the nation, further complicate home- and community-based services (HCBS) providers' ability to hire enough staff to respond to the demand for services.

In our interviews, HCBS providers told us about their current difficulties hiring some types of direct care staff, which they attribute, at least in part, to overall workforce shortages coupled with low wages. They said they compete with other healthcare employers, such as hospitals and nursing homes, which provide similar services but pay higher wages. Home- and community-based service providers also compete with other types of employers, such as grocery stores, gas stations, and hotels, for staff. They said it is difficult to compete with other types of employers that can pay the same or more for work that is considerably easier than being a direct care worker in an HCBS setting. Some providers told us they have stopped or reduced certain types of services due, in part, to staff shortages. Counties also expressed concern that some providers have stopped or will stop providing services in response to staff shortages.

Wages for some types of direct care staff are generally higher in Minnesota than in most other states, and they are generally comparable to the wage rate used by the Department of Human Services to pay HCBS providers.

Exhibit 4.2 shows wage rates for home health, nursing, and personal care aides in Minnesota compared with other states, as of May 2015.[10] Home health aides in Minnesota earned, on average, $12.22 per hour, while personal care aides averaged $11.51. These two job titles are frequently used in HCBS settings in Minnesota. The average hourly wage for nursing assistants, generally employed in nursing homes, was higher ($13.79).

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[7] *Medicaid and Long-Term Services and Supports: A Primer* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, December 2015), 3-4.

[8] Long-term services and supports are broadly defined as the paid and unpaid medical and personal care assistance needed when people experience problems taking care of themselves due to aging, chronic illness, or disability. Services may be provided in a variety of settings, including nursing homes and hospitals as well as in recipients' own homes.

[9] Several studies have documented the shortage of certain types of direct care workers nationwide and the growing gap between available workers and an aging population. For example, see Commission on Long-Term Care, *Report to the Congress* (Washington, DC: Government Printing Office, September 30, 2013); and *Long-Term Care Workforce: Better Information Needed on Nursing Assistants, Home Health Aides, and Other Direct Care Workers* (Washington, DC: Government Accountability Office, August 2016).

[10] These figures include staff employed in a variety of settings, not just HCBS settings. For example, statewide rates reflect pay scales in hospitals, nursing homes, and treatment facilities, among other settings.

Exhibit 4.2: Mean and Median Hourly Wages of Direct Care Workers by State, May 2015

	Home Health Aides		Nursing Assistants		Personal Care Aides	
State	Mean	Median	Mean	Median	Mean	Median
Alabama	$ 9.48	$ 9.07	$10.65	$10.37	$ 8.73	$ 8.64
Alaska	14.50	14.80	17.93	17.70	14.84	15.22
Arizona	11.18	10.70	13.89	13.66	10.35	10.19
Arkansas	9.05	8.64	10.61	10.41	9.06	8.73
California	13.26	11.42	14.96	14.01	11.12	10.47
Colorado	12.59	11.54	14.12	13.80	10.63	10.39
Connecticut	12.95	12.90	15.33	14.79	12.69	12.24
Delaware	13.90	13.06	13.63	13.47	11.17	10.92
District of Columbia	12.55	12.61	15.71	15.38	12.01	12.00
Florida	11.02	10.62	11.78	11.43	10.46	10.02
Georgia	10.08	9.52	10.89	10.61	9.64	9.13
Hawaii	12.70	12.72	14.80	14.62	11.53	10.61
Idaho	10.44	9.51	11.70	11.39	9.73	9.44
Illinois	11.36	10.71	12.54	11.76	10.60	10.51
Indiana	10.62	10.51	11.70	11.31	9.51	9.39
Iowa	11.50	11.17	12.64	12.07	11.05	10.83
Kansas	11.12	10.90	11.54	11.21	10.14	10.29
Kentucky	11.36	10.54	11.77	11.53	10.29	9.83
Louisiana	9.69	9.02	10.05	9.68	8.70	8.63
Maine	11.50	10.99	12.12	11.76	10.48	10.37
Maryland	11.67	11.32	13.82	13.47	11.56	11.08
Massachusetts	13.78	13.47	14.48	14.00	13.05	13.01
Michigan	10.68	10.04	13.46	13.38	10.39	9.95
Minnesota	**12.22**	**11.87**	**13.79**	**13.39**	**11.51**	**11.15**
Mississippi	10.23	10.44	10.23	9.64	8.51	8.56
Missouri	10.73	10.82	11.48	11.06	9.68	9.33
Montana	10.82	10.72	12.12	11.71	10.69	10.57
Nebraska	11.69	11.26	12.18	11.60	11.07	10.86
Nevada	12.35	10.98	15.73	14.92	10.49	10.53
New Hampshire	12.82	12.61	14.30	13.96	11.22	11.01
New Jersey	11.07	10.71	13.61	13.30	13.50	11.50
New Mexico	11.23	9.97	12.86	12.44	9.54	9.17
New York	11.23	10.85	16.06	16.20	11.98	11.17
North Carolina	9.46	9.12	11.07	10.84	9.79	9.48
North Dakota	14.50	14.13	14.19	13.98	14.64	14.37
Ohio	10.09	9.83	12.09	11.61	10.35	9.71
Oklahoma	11.32	10.61	11.01	10.81	9.09	8.85
Oregon	11.33	10.88	14.49	14.12	11.30	10.98
Pennsylvania	10.58	10.26	13.68	13.46	10.65	10.54
Rhode Island	12.79	11.55	13.99	13.60	11.16	10.88
South Carolina	9.75	9.59	11.59	10.90	9.22	9.09
South Dakota	12.74	12.60	11.68	11.21	10.30	10.16
Tennessee	9.35	9.15	11.02	10.77	9.13	8.99
Texas	9.59	8.85	11.80	11.23	8.65	8.61
Utah	11.76	10.90	11.52	11.23	10.52	9.98
Vermont	12.71	12.73	13.27	13.13	–	–
Virginia	10.77	10.50	12.07	11.75	9.28	8.95
Washington	12.37	11.51	14.15	13.68	12.01	11.44
West Virginia	9.19	8.91	11.58	11.07	9.10	8.89
Wisconsin	11.67	11.11	13.18	12.95	10.29	10.32
Wyoming	12.88	13.18	13.47	13.29	10.85	10.64

SOURCE: *Long-Term Care Workforce: Better Information Needed on Nursing Assistants, Home Health Aides, and Other Direct Care Workers* (Washington, DC: Government Accountability Office, August 2016), 33-34.

According to a recent report from the Government Accountability Office, these types of direct care workers in long-term care industries nationwide were paid, on average, $11.21 per hour in 2015.[11] Personal care aides in long-term care industries had the lowest hourly wage of direct care workers at $10.42, while psychiatric aides had the highest at $12.62. This is in the bottom quartile of all U.S. wages. The average hourly wage across all occupations nationwide was $23.23—more than twice that of these types of direct care workers.

As we discussed in Chapter 3, the Department of Human Services (DHS) collects very little financial data from HCBS providers, including wage data. This may be due, in part, to the fact that DHS does not require HCBS providers to pay certain wage rates. The department factors statewide wage rates for various types of direct care staff, including foster home staff, home health aides, homemakers, and personal care attendants, into its payment system. Payment levels for HCBS direct care staff, such as personal care attendants, home health aides, and companions, ranged from $11.86 to $12.41 in 2015—depending on the type of service. These rates are basically the same as the statewide wage rates for comparable jobs, as shown previously.

At the same time, DHS pays its own direct care staff considerably more than what is built into its payment formula, and its wage rates are higher than wage rates statewide.[12] For example, the hourly wage rate for human services technicians in state-operated foster homes ranged from $13.28 to $21.06 in Fiscal Year 2015.[13] Statewide, home health aides averaged $12.22 in 2015, as Exhibit 4.2 showed.

In recognition of HCBS workforce problems, DHS convened a workforce "summit" in July 2016 to search for possible solutions. Participants focused their attention in four areas: recruitment and use of technology, retention and compensation, training and credentialing, and career ladders and work environment. Five possible strategies emerged from the conference: (1) increase compensation, (2) expand the worker pool, (3) enhance training, (4) increase job satisfaction, and (5) raise public awareness.[14]

RECOMMENDATION

The Legislature should require the Department of Human Services to periodically collect data on current and future direct care staffing needs in HCBS settings.

[11] Government Accountability Office, *Long-Term Care Workforce: Better Information Needed*, 9-10. Wages for direct care staff reflect wages across all industries and are not exclusive to HCBS settings.

[12] The department itself is a licensed provider of HCBS in that it operates several adult foster care homes for people with disabilities.

[13] Jeffrey Schmidtman, Minnesota Management and Budget, e-mail message to Jo Vos, "MSOCS Data," October 4, 2016. The hourly wage rate for human services technicians in state-operated foster homes was, on average, $19.00 in October 2016. Human services technician is the job title the department uses to identify the majority of staff employed in its foster homes. Their duties are similar to those of home health aides, nursing assistants, and personal care attendants—helping foster home residents with their daily needs, such as dressing, eating, and bathing.

[14] Minnesota Department of Human Services, *Direct Care/Support Workforce Summit Summary Report Draft* (St. Paul, October 2016), 5.

State law requires DHS to adjust the wage rates it uses to set payment rates every five years, beginning in 2017.[15] As the law dictates, DHS uses statewide wage rates for selected job classifications, as collected by the Bureau of Labor Statistics. Although we do not object to using statewide data to set payment rates, the data do not provide sufficient insight into HCBS providers' experiences for the state to address broader workforce issues. Minnesota's HCBS system is, to a large extent, dependent on direct care staff working in recipients' own homes or foster homes. The work environment for these staff is quite different than that of direct care staff working in hospitals and nursing homes. For example, HCBS staff working in recipients' own homes are more likely to work without direct supervision, have unpredictable work schedules, and be more isolated from coworkers. Direct care staff working in foster homes are also more likely than hospital or nursing home staff to find themselves, at times, working without direct supervision.

The department needs additional data specific to HCBS providers on direct care staffing to develop effective strategies to address the problems faced by the HCBS system. These data should include: (1) the number of direct care workers employed by HCBS providers, on both a full- and part-time basis; (2) turnover; (3) the number of job vacancies; (4) average hourly wage; (5) the average benefit package, and (6) advancement opportunities. As a first step, the department should determine the extent to which other state agencies already collect related data that may be of use. To the extent that this occurs, the department should seek data sharing agreements with the agencies.

Various state and national groups and legislative bills introduced in Minnesota have made similar recommendations over the years.[16] Most recently, the Governor's 2018-2019 biennial budget recommended requiring that HCBS providers submit data on their workforce to DHS to help analyze staffing issues.[17] As has been argued, such information is necessary for state policy makers to develop appropriate strategies to address workforce issues. The information is also needed to assess the impact of those strategies over time and make whatever changes may be required.

Payment Rates

As discussed in Chapter 3, the 2013 Legislature adopted a statewide rate-setting methodology for HCBS.[18] It is intended to ensure that DHS uses uniform processes to determine payment rates. The Department of Human Services began implementing the system in January 2014, and it should be fully operational in 2019 or 2020. It is a complex system and represents a substantial change from 2012, when each county negotiated its own rates for HCBS providers. All parties involved—counties, providers, DHS, and recipients—are adjusting to the change.

Some HCBS providers with whom we talked favored having one uniform methodology to calculate rates, rather than negotiating them with each county. However, most providers expressed frustration regarding various elements of the methodology. While some county

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[15] *Minnesota Statutes* 2016, 256B.4914, sec. 12, subd. 5h.

[16] National Direct Service Workforce Resource Center, *The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection* (Washington, DC: Government Printing Office, February 2009), iv; Government Accountability Office, *Long-Term Care Workforce: Better Information Needed*, 20; and H.F. 3838 and S.F. 3332, 2016 Leg., 89th Sess. (MN), art. 3, sec. 6.

[17] Minnesota Management and Budget, *FY18-19 Governor's Budget Recommendations: Minnesota Department of Human Services* (St. Paul, January 2017), 47.

[18] *Laws of Minnesota* 2013, chapter 108, art. 13, sec. 12.

staff that we talked with also favored having statewide rates for HCBS, some cited problems with the system.

Some HCBS payment rates do not fully reflect state and federal requirements.

The Department of Human Services is responsible for adjusting payment rates to reflect HCBS costs affected by changes in state or federal laws.[19] Most providers that we talked with said that this has not always happened. For example, recent changes to federal Fair Labor Standards Act regulations require HCBS providers to pay minimum wage for some direct care staff who are allowed to sleep during their time on the job.[20] Because some staff must be available at night, providers pay them while they sleep onsite. The Department of Human Services pays providers a lower rate for "sleep" staff than it does for staff that must stay awake. The current sleep rate—$7.66—is below the minimum wage rate of $7.75 per hour for small employers and $9.50 per hour for large employers.[21]

Federal labor regulations also require that certain staff be compensated at no less than time and a half for overtime hours.[22] However, DHS's payment formula does not adjust rates for overtime. Many providers that we talked with expressed frustration over the amount of money they have to put toward overtime costs due to staffing shortages.

Finally, state law requires that medical professionals, such as licensed nurses, periodically provide onsite direct supervision of some direct care staff who visit HCBS recipients in their homes.[23] But DHS does not always recognize indirect supervisory costs that providers may incur when calculating payment rates. While day and foster home service rates incorporate some administrative activities, other services do not fully account for work time spent away from clients.[24] For example, for some recipient training activities, staff must document a recipient's progress, even though these types of administrative costs are not fully reflected in the rate for this service.

RECOMMENDATION

The Legislature and the Department of Human Services should ensure that HCBS payment rates adequately account for changes or requirements in state and federal regulations.

Given concerns about workforce shortages, it is important that DHS be timely about incorporating regulatory changes into its rate-setting system. The department's payment formula does not include a profit margin for HCBS providers. Consequently, providers

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[19] *Minnesota Statutes* 2016, 256B.4914, subd. 10(d).

[20] 29 *CFR*, secs. 785.21 and 785.22 (2011); and 29 *CFR*, sec. 552.3 (2013).

[21] *Minnesota Statutes* 2016, 256B.4914, sec. 12, subd. 5a(3); and 177.24, subd. 1. As noted earlier, state law requires DHS to adjust the base wage rates used in its rate management system once every five years, beginning in 2017. *Minnesota Statutes* 2016, 256B.4914, sec. 12, subd. 5h.

[22] 29 *CFR*, sec. 552 (2013), effective January 2015.

[23] *Minnesota Statutes* 2016, 144A.4797, subd. 3.

[24] *Final Report: Non-Wage Provider Costs in Home and Community-Based Disability Waiver Services* (Ann Arbor, MI: Truven Health Analytics, May 31, 2016), 12.

must incur losses when the payment formula does not cover their expenses or make up for losses elsewhere in their operations. Small providers may not have the necessary cushion in their budgets to either incur losses or make up for them elsewhere in their budgets.

Framework for Delivering Home- and Community-Based Services

As we discussed in Chapters 2 and 3, the amount or type of data that DHS collects to provide financial oversight of the HCBS program vary, depending on (1) whether MA recipients with disabilities receive HCBS through the state MA plan or waivers, (2) whether recipients are enrolled in managed care or fee-for-service health plans, (3) the type of HCBS provided, and (4) the type of HCBS provider.[25] This makes it difficult for DHS to provide adequate financial oversight of HCBS providers. It also makes it difficult to understand how HCBS operates.

Overall, Minnesota's system for providing HCBS to Medical Assistance recipients with disabilities and the elderly is complex, confusing, and, at times, poorly communicated to interested parties.

For example, MA recipients with disabilities may receive HCBS as a service covered under the state's MA plan and available to all MA recipients, or as a service available only to recipients who are enrolled in one of the state's waiver programs. The same types of services are often available under both approaches, although they may differ in terms of frequency or intensity. Also, recipients may receive HCBS through either a managed care or fee-for-service health plan. As we explained in Chapter 2, DHS does not pay for HCBS in a consistent manner across both types of plans. Furthermore, different terms are sometimes used for the same or similar services across individual waivers.

In addition, information on DHS's website about HCBS is not always accurate or available in a timely manner. For example, DHS's website contains conflicting information about whether recipients who had been receiving services before the new rate system went into effect are eligible for a rate exception.[26] In another instance, counties noted that it took DHS two months to notify them about errors in certain types of transportation claims.[27] Although the claims were being submitted properly, system edits prevented them from processing correctly. Counties had to ask HCBS providers to void the affected claims and refile them once adjustments were made.

[25] As discussed in Chapter 1, Minnesota offers five HCBS waivers. They serve people with: brain injuries; chronic illnesses; developmental disabilities; physical and other disabling conditions, including mental illnesses; and recipients who are 65 years and older.

[26] Minnesota Department of Human Services, "DWRS frequently asked questions–April 2014" (April 2014), http://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/disability-waiver-rates-system/frequently-asked-questions/, accessed January 13, 2017.

[27] Minnesota Department of Human Services, "Edit 437 incorrectly posting for waiver transportation code," Disabilities Services Division eList, electronic mailing, September 1, 2016.

RECOMMENDATION

The Legislature and Department of Human Services should adopt a common set of financial reporting requirements and menu of services for HCBS, regardless of how those services are delivered.

To better understand overall spending on HCBS, there should be greater consistency in financial data collection and reporting across health plans, waivers, and the different populations of recipients with disabilities eligible for HCBS. As we discussed in Chapter 2, DHS has different data collection requirements for managed care and fee-for-service health plans—both of which enroll MA recipients with disabilities. Further, as we discussed in Chapter 3, there are different requirements for different types of direct care staff—even though they do similar work and represent similar types of financial risk. This makes it difficult for DHS to oversee HCBS providers and the services they offer. It also hampers legislative oversight because there is no way of knowing how much the state is spending for HCBS across health plans or the types of HCBS services being delivered. As a result, it is difficult for legislators and state policy makers to know whether HCBS funds are being spent in a cost-effective manner.

Having a common menu of HCBS for MA recipients with disabilities and the elderly—using uniform and consistent definitions—would make the system easier to understand. We do not think that this change would increase the amount or type of HCBS that individual recipients receive. The needs assessment process, performed by counties, would remain the main determinant of the specific services each recipient should receive via their individual service agreements. In developing its common set of services, we encourage the department to use terms and phrases that are easily understood by policy makers, counties, providers, and the public.

A recent report from the Government Accountability Office likewise recommended that the federal government do more to standardize policies, programs, and reporting requirements across programs.[28] The accountability office noted that more consistency would help "the federal government and states better manage risks to beneficiaries and protect the integrity of the program."[29]

One way Minnesota may be able to accomplish this would be by consolidating its five waivers into a single waiver. Over the last several years, the federal government has given states a variety of options for administering HCBS. For example, it has expanded states' abilities to establish more innovative service-delivery systems to improve care, increase efficiency, and reduce costs. In response, some states have made broad changes in how they administer their waivers. For example, Rhode Island received federal approval to operate its entire Medicaid program under a single demonstration waiver. It covers all Medicaid participants, including people with disabilities. Arizona also manages its entire Medicaid program under a demonstration waiver, as does Vermont. According to The Henry J. Kaiser Family Foundation, these three states "administer statewide Medicaid

[28] *Medicaid Personal Care Service: CMS Could Do More to Harmonize Requirements across Programs* (Washington, DC: Government Accountability Office, November 2016), 45-46.

[29] *Ibid*., unpaginated.

capitated managed care programs that include all HCBS covered for all populations."[30] Unlike Minnesota, they do not have individual waivers for people with certain types of disabilities.

We think combining Minnesota's five HCBS waivers into a single waiver could make the system easier to understand and administer.[31] For example, counties are currently limited in how many MA recipients can receive services under the developmental disability waiver by the amount of money they receive from DHS for that waiver. When counties run out of money, they must either (1) petition DHS for an adjustment, (2) wait until they have sufficient money, or (3) enroll recipients with more than one disabling condition in another waiver where funds are available.

Combining Minnesota's five HCBS waivers into a single waiver—with one menu of services available to all waiver participants—could help counties better address clients' needs. It could also make the entire HCBS system easier to understand for policy makers, people with disabilities and their families, and the general public.

[30] *Medicaid Home and Community-Based Services Programs: 2013 Data Update* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, October 2016), 10.

[31] As part of his 2018-2019 biennial budget proposal, the Governor recommended hiring an outside contractor to study whether the state should combine its four disability-based waivers into a single waiver. Minnesota Management and Budget, *FY18-19 Governor's Budget Recommendations: Minnesota Department of Human Services*, 37.

List of Recommendations

- The Legislature should increase its regulation over some types of direct care workers who provide home- and community-based services (HCBS) in recipients' own homes. (p. 51)

- The Legislature should require the Department of Human Services (DHS) to periodically collect data on current and future direct care staffing needs in HCBS settings. (p. 57)

- The Legislature and DHS should ensure that HCBS payment rates adequately account for changes or requirements in state and federal regulations. (p. 59)

- The Legislature and DHS should adopt a common set of financial reporting requirements and menu of services for HCBS, regardless of how those services are delivered. (p. 61)


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Appendix A

Several state and federal programs aside from Medical Assistance and Medicaid support people with disabilities. Some of these programs provide assistance primarily to low-income households, where people with disabilities may live, while others are directed more generally at people with disabilities.

Other State and Federal Programs

Program	Agency	Description	Eligibility
Bridges Rental Assistance Program	Minnesota Housing Finance Agency (MHFA) and Minnesota Department of Human Services (DHS)	Temporary rental assistance payments and security deposits paid directly to landlords on behalf of qualified participants	People with very or extremely low incomes and a serious mental illness, who are waiting for Housing Choice Voucher or another rental subsidy
Crisis Housing Fund	Minnesota Housing Partnership, under contract with DHS	Rental, mortgage, and utility assistance to retain current housing	Low- and moderate-income adults with a serious mental illness, residing in community-based housing, who are receiving facility-based mental health or chemical dependency treatment for 90 days or less
Disabled Veterans Program	Minnesota Department of Employment and Economic Development (DEED)	Job search counseling and assistance, including resume development; skills-building in interviewing, networking, and use of social media; and direct referral to employers with available jobs	Veterans who have left the service in the last three years, have significant challenges finding or keeping a job, or have service-connected disabilities
Energy Assistance Program	Minnesota Department of Commerce	Financial assistance to pay for various energy related items, including bills, utility disconnections, fuel deliveries, or repair or replacement of broken heating systems	Households with income at or below 50 percent of the state median income; other criteria include energy cost and household size
Extended Employment Program	DEED	Ongoing employment support services necessary to maintain and advance employment	People with significant disabilities
Group Residential Housing	DHS	Living expenses such as room and board	Low-income adults with disabilities and low-income seniors
Housing Access Services	DHS	Assistance in seeking and applying for accessible and suitable housing, including negotiating with landlords, moving, furnishing one's home, and developing a household budget	Adults who have been assessed as eligible for Medical Assistance (MA) state plan home care or waiver services, who want to move into their own homes in the community

Continued next page.

Other State and Federal Programs (continued)

Program	Agency	Description	Eligibility
Medical Assistance for Employed Persons with Disabilities	DHS	Medicaid buy-in program covering all or part of certain health care services, depending on income	People with disabilities who are working and who earn too much to qualify for MA, and who meet the asset limit
Minnesota Supplemental Aid (MSA)	DHS	Supplemental cash assistance to help Social Security recipients pay for basic needs	Adults who receive Social Security; some people who are blind, have a disability, or are older than 65, who qualify for Social Security except for the income limit, may be eligible for supplemental aid if they meet income limit
Minnesota Supplemental Aid (MSA) Housing Assistance	DHS	Cash assistance to help cover housing costs	Adults under 65 who are eligible for MSA, with housing costs over 40 percent of income and either (1) living in their own home or apartment and receiving HCBS waiver services, (2) moving to the community from an institution or treatment facility for people with serious mental health problems, or (3) eligible for personal care assistance under MA state plan
Section 8 Housing Choice Vouchers	U.S. Department of Housing and Urban Development	Provides vouchers for housing that allows renters to pay a fixed portion of their income for rent	People who meet income limits; preference may be given to people with disabilities or people aged 62 and older
Short Term Financial Assistance (Subsistence)	Minnesota Department of Veterans' Affairs (MDVA)	Income- and asset-based temporary assistance with shelter payments (rent/mortgage), utility bills, and health insurance premiums, up to six months	Veterans unable to work due to a temporary disability, or who are permanently disabled and waiting to receive a permanent benefit
Special Education	Minnesota Department of Education	Special education services individualized to the student's needs and goals	Students who have a disability and are in need of specialized education services
Social Security Disability Income	U.S. Social Security Administration	Monthly income	Those who cannot work because they have a medical condition expected to last at least one year or result in death
Supplemental Nutrition Assistance Program	U.S. Department of Agriculture	Assistance to purchase approved food items for the household from approved retailers	Low-income households that meet certain resource/asset limits

Continued next page.

Other State and Federal Programs (continued)

Program	Agency	Description	Eligibility
Supplemental Security Income	U.S. Social Security Administration	Monthly income	Low-income seniors and adults with disabilities and/or blindness; pays benefits based on financial need
Telephone services assistance including the Telephone Equipment Distribution (TED) program, Minnesota Telephone Assistance Plan (TAP), Telecommunications Access Minnesota (TAM), Lifeline, and Link-Up	DHS, Minnesota Public Utilities Commission, Minnesota Department of Commerce, local service providers, and the Federal Communications Commission (Lifeline and Link-Up)	TED loans telephone equipment; TAP provides monthly credits to low-income households; TAM provides telecommunications relay service between communication-impaired persons and conventional telephone subscribers; Lifeline provides monthly telephone service discounts; Link-Up provides discounts on telephone service installations	Low-income households, except for TED and TAM, which are designed for people with disabilities
Vocational Rehabilitation Services	DEED	Vocational rehabilitation assistance including job counseling, guidance, and search services; occupational/vocational training; and other forms of training	People with significant disabilities

SOURCE: Office of the Legislative Auditor, analyses of state and federal laws and regulations and agency documents, budgets, and websites.


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DEPARTMENT OF HUMAN SERVICES

February 16, 2017

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

Dear Mr. Nobles:

Thank you for the opportunity to review and respond to the program evaluation report from the Office of The Legislative Auditor on the financial oversight of Home and Community Based Services (HCBS). Home and community based services are the backbone of supports for people with disabilities and older adults, enabling Minnesota to close state hospitals and dramatically reduce more expensive institutional care, while providing services that help people live, work, and enjoy life in their communities. While we have much to be proud of, we agree that the recommendations in the report highlight areas for continued improvement.

Home and community based services developed over time, and were developed through the conversion of investments that had been made in institutional services such as nursing homes and intermediate care facilities for persons with intellectual and developmental disabilities. In fact, Minnesota, at one time, had the highest per capita capacity in these institutional services. We have worked hard to change that, and now have 94% of people with disabilities receiving home and community based services rather than institutional care. Minnesota has been ranked first in a national scorecard for services for older adults and people with disabilities by the Scan Foundation.

While we have been successful at building a system of flexible and preferred home and community based services that can adapt over different life stages, we concur we should improve how we manage these programs into the future. We spend over $2.4 billion on these services annually, involving dozens of different services and thousands of providers, and need improved tools to ensure proper oversight. The Governor's budget and the Department's policy bill include a number of proposals, which align closely with the recommendations in the report, including:

1. **Authority to collect more and better information** to improve oversight of the system, specifically for rate setting, workforce planning, and service verification.
    - Collecting workforce information from providers annually, such as rates of pay, benefits, staff turnover, and other labor measures. This will help us to plan and respond to workforce issues, with the goal of increasing the recruitment and retention of a viable home and community based services workforce.
    - Obtaining documentation from providers of their costs to deliver services to ensure rate setting methodologies accurately reflect provider costs over time.
    - Increasing required documentation by providers to verify that services billed were delivered and to enable appropriate investigations into any questionable billings

2. **Expanding provider enrollment requirements** for certain home and community based services, including personal care assistance, qualified professional services by nurses, and consumer directed community supports, so the Department can verify required qualifications and service delivery.

3. **Studying a more streamlined system**.
    - Researching and developing recommendations for the consolidation of the four disability home and community based services waivers into one program to make the system easier to understand and administer so that people are able to access the right service at the right time.
    - Studying and recommending an individual budgeting model for disability waiver recipients to increase choice in the authorization and purchasing of home and community based services, which will be even more important in determining appropriate service levels for waiver recipients if the four disability waivers are consolidated into one waiver program.

4. **Preventing fraud** by requesting ten additional staff for our Medical Assistance fraud investigation unit.
    - The additional staff will increase our capacity to investigate complaints and use data analytics to better target investigations.
    - The Department is also examining administrative options, such as additional edits in the Medicaid Management Information System to ensure services are authorized and delivered appropriately.

Thank you again for the professional and dedicated efforts of your staff during this program evaluation. These are complex programs, and we appreciate the time and diligence your staff took to complete their analysis and prepare the recommendations.

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. If you have any further questions, please contact Gary L. Johnson, Internal Audit Director, at 651-431-3623.

Sincerely,

Emily Piper

Emily Piper
Commissioner

Forthcoming OLA Evaluations

Clean Water Fund Outcomes
Minnesota State High School League
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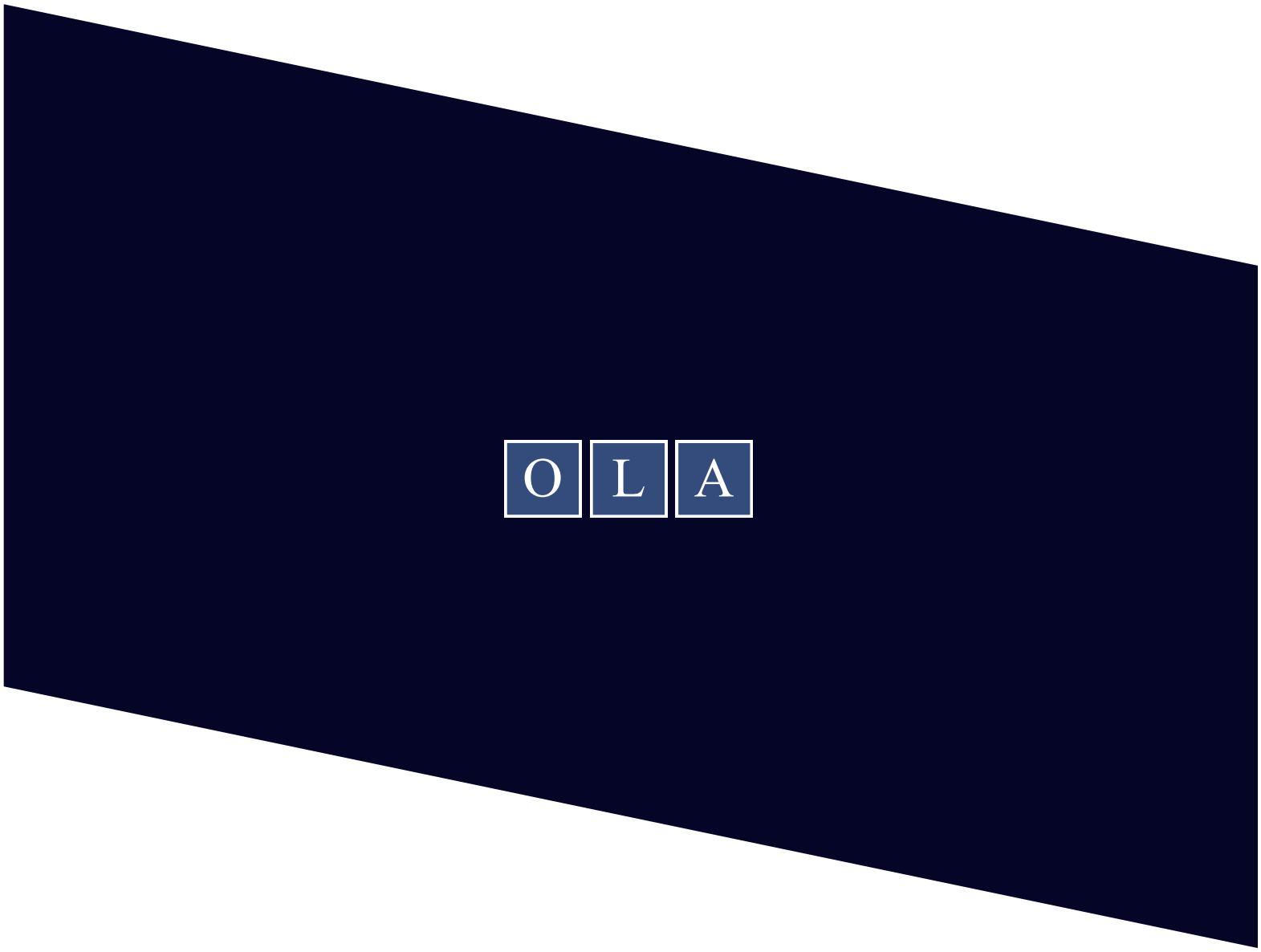

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