What We Have

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Olmstead Planning Committee

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Terminology disclaimer
The terminology used to describe people with disabilities has changed over time. The Minnesota Department of Human Services ("Department") supports the use of "People First" language. Although outmoded and offensive terms might be found within documents on the Department's website, the Department does not endorse these terms.

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INTRODUCTION

Minnesota is a national leader in providing long-term care services and supports to people with disabilities. In a recent report by American Association of Retired Persons AARP, the Commonwealth Fund and the Scan Foundation, Minnesota ranked first in long-term care for older adults and people with disabilities.[1] Reports such as these support Minnesota's efforts over many years to increase community living and provide the supports to help people with disabilities live as independently as possible. The priority of community-based care is highlighted in the "*DHS Framework for the Future: 2012*" which includes the goal to "Increase the number of Minnesotans served in their homes and communities rather than in institutions".

This commitment to increasing community living for all Minnesotans extends to priorities within the Department of Human Services (DHS) Continuing Care and Chemical and Mental Health Administrations and continues to guide several reform efforts underway to Minnesota's long term services and supports (LTSS) system. Directed by the 2011 Minnesota Legislature to reform Medical Assistance (MA), *Reform 2020* builds on Minnesota's history of improvements to the system to address community integration, person-centered services, self-direction and choice, independence and recovery, individual planning, and quality outcomes.

This report describes the current system for people with disabilities of all ages, based on the structure of the Olmstead Planning Committee's recommendations:

- Community-Based Services and Supports
- Where People Live
- Where People Work

The report concludes with a description of future changes to further increase community integration for people with disabilities and baseline budget information. A brief history and background of Minnesota's movement to date from a reliance on institutional services toward increased access to community-based services and supports is provided in Appendix A. Several statutes and rules that govern the LTSS system in Minnesota are also provided.

This report was completed with support from Truven Health Analytics under contract with DHS. This report updates and summarizes information from a comprehensive description of Minnesota's LTSS system published in December 2009 called the Minnesota State Profile Tool, which was written by Truven Health and the University of Minnesota's Institute for Community Integration.[2]

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[1] "Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers." September 8, 2011. www.longtermscorecard.org/Report.aspx

[2] Eiken, S., Gold, L., Larson, S. and Lakin, KC. *Minnesota State Profile Tool: An Assessment of Minnesota's Long-Term Support System.* MN DHS: December 3, 2009 Accessed on-line August 16 at www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs16_144888.pdf

COMMUNITY-BASED SERVICES AND SUPPORTS

Many types of supports are necessary for people of all ages with disabilities to live, work, learn and participate in their communities. Brief descriptions of all Long Term Services and Supports (LTSS) programs that provide publicly funded services to older adults and people with disabilities on an ongoing basis are listed below. Particular types of supports are then listed, followed by utilization data and information regarding people on a waiting list for certain services.

Medicaid programs are described first because Medicaid has a very large role in the support system for people with disabilities.

Publicly Funded Community-Based Services and Supports

In 1982, Congress authorized the use of Medicaid for home and community-based services (HCBS) as alternatives to Medicaid reimbursed institutional services. This authority enabled the federal government to waive federal regulations the use of Medicaid according to plans that states submitting describing the services and assurances that they would provide for home and community based services. Thus the "waivers" began.

Medicaid services and supports – See Appendix C for a matrix of all waiver services

- **Elderly Waiver (EW)***:* HCBS Waiver that provides an array of services for people age 65 or older who qualify for nursing facility services. Almost all seniors—including EW participants—must receive services through managed care. People can enroll in Minnesota Senior Health Options (MSHO) or Minnesota Senior Care Plus (MSC+). MSHO includes traditional Medicare, Medicare Part D, and all Medicaid services. MSC+ is similar to MSHO but only includes Medicaid services.

- **Developmental Disabilities (DD) Waiver**: HCBS Waiver that provides an array of services to people with developmental disabilities as an alternative to ICF/DD.

- **Community Alternatives for Disabled Individuals (CADI) Waiver**: HCBS Waiver that provides services as an alternative to nursing facility care for people who are under age 65 at the time they enter the waiver.

- **Community Alternative Care (CAC) Waiver**: HCBS Waiver that serves people with complex medical needs who require a hospital level of care.

- **Brain Injury (BI) Waiver**: HCBS Waiver that serves people with brain injuries as an alternative to a nursing facility or a neurobehavioral hospital unit.

- Several Medicaid State Plan services provide LTSS or mental health rehabilitative services. Unlike an HCBS Waiver, a person does not need to meet institutional level of care criteria to qualify for these services, but the person must be eligible for Medicaid and the services must be medically necessary. These services often are able to meet the needs of an individual. If additional services are necessary, these services can be used in conjunction with an HCBS waiver services:

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- **Personal Care Assistance (PCA):** Assistance with activities of daily living and health-related tasks

- **Private Duty Nursing (PDN):** In-home care by a licensed nurse

- **Home Health services:** Medicaid home health services provide: (1) short-term care following an acute care episode such as a hospitalization, and (2) long-term care for people with ongoing needs related to medical care or daily living activities. Home health includes skilled nursing, home health aide services, and physical, occupational, speech, and respiratory therapies

- **Adult Rehabilitative Mental Health Services (ARMHS):** Services to enable people to develop and enhance psychiatric stability, emotional adjustment, and independent living skills

- **Assertive Community Treatment (ACT):** An intensive, multidisciplinary rehabilitative service that includes case management; support and skills training for daily life skills and social and interpersonal skills; education regarding mental illness provided to the person and family members; medication management; and assistance in obtaining housing

- **Intensive Residential Treatment Services (IRTS):** Treatment in a residential setting that serves five to 16 adults with mental illness. Services are designed to last only a few months and are provided in adult mental health treatment facilities licensed under Rule 36, which previously provided long-term residential supports

- **Children's Therapeutic Services and Supports (CTSS):** A rehabilitative service with a lower functional eligibility threshold than previous Medicaid services. This service is available to any Medicaid-eligible child with a mental health diagnosis to facilitate early intervention before symptoms become more severe.[3]

Non-Medicaid funded services and supports:

- **Day Training and Habilitation (DT&H):** Licensed services to help adults with developmental disabilities improve and maintain independence; enhance personal skills; empower choice making abilities; and improve integration into the community. Services include vocational supports, such as supported employment, as well as non-vocational supports. Medicaid pays for most day habilitation through the DD Waiver and ICFs/DD which can include DT&H. Counties may pay for DT&H for individuals who do not receive ICFs/DD or DD Waiver services.[4]

- **Alternative Care (AC):** a state-funded cost-sharing program that supports certain home and community-based services for eligible Minnesotans, age 65 and over. It provides home- and community-based services to prevent and delay transitions to nursing facility level of care. The program prevents the impoverishment of eligible seniors and shares the cost of care with clients by maximizing use of their own resources. It is administered by counties and tribal health agencies. See Appendix C for matrix of Alternative Care services.

[3] MN DHS *Uniform Application FY 2009 – State Plan: Community Mental Health Services Block Grant* Submitted to SAMHSA Center for Mental Health Services October 5, 2008

[4] MN DHS, Disability Services Division *Continuing Care Matrix of Services to People with Disabilities: FY 2007 Service Costs* April 2008

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- **Consumer Support Grant (CSG):** a state-funded alternative to Medicaid-reimbursed home care. Eligible participants receive monthly cash grants to pay for a variety of goods and services in lieu of home health aide, personal care attendant and/or private duty nursing.[5]

- **Semi-Independent Living Services (SILS):** training and assistance in managing money, preparing meals, shopping, personal appearance and hygiene, and other activities needed to maintain and improve the capacity of an adult with an intellectual disability to live in the community. The state provides 70% of funding for SILS, with the county providing the remainder. Some counties also fund 100% of costs for some persons not served through the state supported allocations.[6]

- **Family Support Grant (FSG):** provides state-funded cash assistance to prevent the out-of-home placement of children with disabilities and promote family health and social well-being. Approved categories of expenses include medications, education, day care, respite, special clothing, special diet, special equipment and transportation.[7]

- **Aging Network services:** The Minnesota Board on Aging (MBA) and regional Area Agencies on Aging (AAA) administer grants from the Federal Administration on Aging and state General Revenue appropriations. AAAs and their contracted providers offer nutrition services, provided both at congregate dining sites or through home delivered meals, and other services such as caregiver support, transportation, chore, and information and assistance.

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[5] MN DHS *Continuing Care Matrix of Services to People with Disabilities: FY 2007* April 2008
[6] MN DHS *Continuing Care Matrix of Services to People with Disabilities: FY 2007* April 2008
[7] MN DHS *Continuing Care Matrix of Services to People with Disabilities: FY 2007* April 2008

Utilization trends for these supports are shown in Table 1, with fewer people receiving AC and PDN, and several types of support with double-digit annual growth e.g., CADI, PCA, CSG, ACT, and CTSS.

Table 1: Average Monthly Number of People Receiving Publicly Funded Community-Based Services, 2006 - 2010

Program	2006	2007	2008	2009	2010	Avg Annual Increase
Alternative Care Services (AC)	3,334	3,410	3,419	3,311	3,188	-1%
Brain Injury Waiver (BI)	1,263	1,341	1,394	1,424	1,420	3%
Community Alternatives for Disabled Individuals Waiver (CADI)	10,316	11,913	13,990	15,092	16,082	12%
Community Alternative Care Waiver (CAC)	247	282	314	326	342	8%
DD Waiver	14,273	14,094	14,126	14,443	14,994	1%
Elderly Waiver (EW)	16,808	18,553	19,859	21,063	22,081	7%
Personal Care Attendant Services (PCA)	14,231	15,516	18,477	23,076	24,926	15%
Private Duty Nursing Services (PDN)	1,264	1,011	816	724	716	-13%
Consumer Support Grants (CSG)	85	770	1,146	1,365	1,430	103%
Adult Rehabilitative Mental Health Services (ARMHS)	5,787	5,831	5,415	6,123	7,432	6%
Children's Therapeutic Services and Supports (CTSS)	3,850	4,056	3,959	4,986	6,940	16%
Assertive Community Treatment (ACT)	1,113	1,197	1,238	1,471	1,603	10%
Non-Medicaid Day Training and Habilitation (DT&H)	n/a	1,808	n/a	n/a	n/a	n/a
Semi-Independent Living Skills (SILS)	1,561	1,552	1,560	n/a	n/a	n/a
Family Support Grant (FSG)	1,628	1,628	1,810	n/a	n/a	n/a

Notes:

- Data may include duplicate participants. Some individuals may have received multiple services and/or services with multiple types of billing units e.g., 15 minute units and day units.

Source:

- Truven Health Analytics analysis of MMIS data, CY 2006 through CY 2010; data extracted January 2012

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Waiver Waiting Lists

As shown in Table 1 above, the number of people receiving the DD Waiver increased by an average of one percent per year from 2006 through 2010. This limited growth authorized by the Minnesota legislature means that people on a waiting list for the DD Waiver often don't know when they will be able to receive the comprehensive services of that waiver. In addition, DHS maintains waiting lists for CADI waiver for people under age 65. While on a waiver waiting list, a person may still access other services for which they are eligible. This report includes data regarding waiting list trends and services people receive while on a waiting list.

Table 2 provides the number of people on HCBS Waiver waiting lists in recent years. The data indicate an increase in people on a waiting list between 2010 and 2012.

Table 2: Number of People on a Waiting List for a HCBS Waiver, Recent Dates for Which Data are Available

Waiting List	Feb 2008	Feb 2009	Nov 2009	Dec 2010	Mar 2012	Jun 2012
Developmental Disabilities (DD) Waiver	4,893	4,974	3,858	2,936	4,499	n/a
Community Alternatives for Disabled Individuals (CADI)	311	692	598	213	n/a	968

Notes:

- n/a means data are not available.
- The DD and CADI Waiver waiting list increase between 2010 and 2012 were caused in part by legislated resource or enrollment limits that required slower enrollment growth than in previous years. A historical summary of the allocation for these waivers is provided in Appendix D
- Starting in 2009, DHS required a DD reassessment at least every three years for individuals identified as waiting for the DD Waiver. This requirement likely contributed to the decline in persons on the waiting list in 2009 and 2010.

Sources:

- February 2008 data are from MN DHS "Annual Report on the Use and Availability of Home and Community-Based Services Waivers for Persons with Disabilities" February 2008
- February 2009 data are from MN DHS "Annual Report on the Use and Availability of Home and Community-Based Services Waivers for Persons with Disabilities" February 2009
- November 2009 data are from MN DHS "Use and Availability of Home and Community-Based Waivers for Persons with Disabilities" January 2010
- December 2010 data are from Truven Health Analytics analysis of MMIS data, CY 2006 through CY 2010; data extracted January 2012
- March 2012 data for CADI are from MN DHS "CAC, CADI and BI Waiver Waitlist by County, Age and Diagnosis" from www.publicreports.dhs.state.mn.us/Reports.aspx?ReportID=25 on August 9, 2012
- June 2012 data for the DD Waiver are from MN DHS "DD Waiver Waitlist by Current Services and Residence" from www.publicreports.dhs.state.mn.us/Reports.aspx?ReportID=15 on August 9, 2012

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Table 3 identifies the services individuals on the waiting list used in March 2012, the most recent data available entered on screening documents for DD Waiver eligibility. The most common services were case management and special education; the latter is consistent with the fact that most people on the DD Waiver are children. More than 130 people used institutional services—ICF/DD or the Anoka Metro Regional Treatment Center—while on the waiting list. In addition, Table 4 on the next page provides information on home care and mental health services access while on a waiting list.

Table 3: Services Received While on the DD Waiver Waiting List as Identified on the DD Screening Document, March 30, 2012

Program	People who Received Service	Percent of Total Waiting List
Case Management	2,891	64%
Special Education	2,175	48%
Consumer Support Grant (CSG)	573	13%
Day Training and Habilitation (DT&H)	470	10%
Family Support Grant (FSG)	412	9%
Other County-Funded Services	349	8%
Respite	191	4%
Other Waivers for People with Disabilities	135	3%
Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD)	132	3%
Modifications/equipment	65	1%
Jobs and Training	39	1%
Other	13	0%
Homemaker	10	0%
Adult Education	9	0%
Anoka Metro Regional Treatment Center (AMRTC)	< 5	0%
Relocation Service Coordination	< 5	0%
Statewide Total with Services	**3,610**	**80%**

Notes:

- Other Waivers for People with Disabilities are the CADI Waiver, the CAC Waiver, and the BI Waiver.

Source:

- MN DHS "DD Waiver Waitlist by Current Services and Residence" downloaded from www.publicreports.dhs.state.mn.us/Reports.aspx?ReportID=15 on August 9, 2012

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Table 4 provides information for both waiting lists regarding PCA and mental health services, to identify the extent to which use these services while on a waiting list. At the end of 2010, 89% of people on the DD Waiver waiting list and 79% of people on the CADI, CAC, and BI waiting list used at least one of these services.[8]

Table 4: Number of People Receiving Personal Care Attendant (PCA) and Mental Health Services While on HCBS Waiver Waiting Lists, CY 2010 Utilization for People on the Waiting List as of December 31, 2010

Waiting List	Age Group	Total on Waiting List	PCA	CTSS	ARMHS	MH-TCM	IRTS	ACT	Rule 5
DD Waiver	0 to 5	374	259	80	0	0	0	0	0
DD Waiver	6 to 17	1,535	1,244	315	0	0	0	0	0
DD Waiver	18 to 20	338	204	16	6	0	0	0	0
DD Waiver	21 to 64	678	299	0	11	0	0	0	0
DD Waiver	0 to 64	2,925	2,006	411	17	0	0	0	0
Other Waivers for People with Disabilities	All Ages	213	88	15	38	49	14	5	< 5

Notes:

- Data were not analyzed for the 11 individuals on the DD Waiver waiting list who were age 65 or older.

Sources:

- Truven Health Analytics analysis of MMIS data, CY 2006 through CY 2010; data extracted January 2012

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[8] Truven Health Analytics analysis of MMIS data, CY 2006 through CY 2010; data extracted January 2012

WHERE PEOPLE LIVE

Housing is a fundamental necessity regardless of whether or not one needs other types of support. Offering a sufficient variety of affordable and accessible housing options for people with disabilities and older adults is particularly difficult because (1) people with disabilities are nearly twice as likely as those with no disability to have incomes below the federal poverty level,[9] and (2) many people with disabilities need not only affordable housing but also physical accessibility features and/or on-site supportive services. Individuals' needs for housing and support vary greatly.

Supportive housing is a broad concept that refers to affordable housing "with linkages to services necessary . . . to maintain housing stability, live in the community, and lead successful lives".[10] A wide range of supports can fit this definition.

Three state agencies have important roles in enabling people with disabilities of all ages to live in more independent settings and/or ensuring quality of service for people in residential settings. They are Department of Human Services (DHS), Minnesota Department of Health (MDH) and the Minnesota Housing Finance Agency (Minnesota Housing). See Appendix B for a description of the state agencies and their roles and responsibilities.

Minnesota has moved away from providing publicly funded services primarily in institutions to offering community-based services and supports. Facilitating the movement from institutions to the community was the development of the HCBS waivers. The HCBS waivers do not pay for housing costs, thus, the room and board costs are paid for with the individual's SSI and either Group Residential Housing (GRH) or Minnesota Supplemental Aid (MSA). These two state programs are described below:

Group Residential Housing (GRH) provides a monthly income supplement to federal Supplemental Security Income (SSI) participants to pay for rent in *licensed or registered residential facilities* that provide room, board, and personal assistance. A majority of participants receive services from Medicaid home and community-based services waivers.[11] The provider receives most of the payment for care-related expenses, but the resident is able to keep a personal needs allowance.

Minnesota Supplemental Aid (MSA) provides a supplement to SSI participants *who do not live in licensed residential settings*. Additional special needs payments are available for certain individuals with specific, usually time-limited costs such as medically prescribed diets, costs for relocating from an institution to the community, and non-recurring home repairs.[12] One of these special needs payments, MSA – Shelter Needy Option, is also available for people who live in provider-controlled, multi-family housing that has six or more units, as long as 50% or fewer of the residents receive the MSA – Shelter Needy Option.[13]

[9] U.S. Census Bureau, American Community Survey "Table S1201. Disability Characteristics from the 2005-2007 American Community Survey 3-Year Estimates" August 2008

[10] MN DHS, MN Department of Corrections, and MN Housing Finance Agency *Ending Long-Term Homelessness in Minnesota: Report and Business Plan of the Working Group on Long-Term Homelessness* March 2004

[11] MN DHS "Group Residential Housing Program" Updated October 6, 2008

[12] MN DHS "Minnesota Supplemental Aid" Updated March 16, 2009

[13] MN DHS "Bulletin 09-48-02: 2009 Legislative change to the MSA Supports Options Initiative with extra allowance for Shelter-Needy clients with special needs" August 12, 2009

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Residential Settings

The most common types of *licensed or regulated residential services* are nursing facilities and Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD). Those types of facilities and others are described below. Trend data regarding the number of people with publicly funded supports in these settings follows the descriptions.

- **Nursing Facilities (NF):** Provide nursing and related medical services and are paid by Medicaid.

- **Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD):** Provide supervision, counseling, and DHS-licensed habilitative or rehabilitative program services and are paid by Medicaid.

- **Children's Residential Treatment (Rule 5)**: Rule 5 facilities provide rehabilitative services to children up to age 21 and are paid by Medicaid as psychiatric residential treatment facilities.

- **Housing with Services Establishments**: Minnesota has an unusual licensing structure for residential services for older adults. Most states license a facility that provides both housing and services. Minnesota and a few other states have separate regulatory structures for housing and for services.[14] Buildings in which a package of services is offered to residents must be registered with the Minnesota Department of Health (MDH) as housing with services establishments if 80% of the residents are age 55 or older. The separate housing registration and services licensure allows an establishment to contract with a service provider instead of furnishing services directly. Providers often have a separate licensure that authorizes their services. The most common licensure types are home care licensure and licensure as a board and lodging establishment.[15] The most common types of home care licensure are Class A, which authorizes provision of home care in any community residence and includes Medicare-certified home health agencies, and Class F, which is specific to housing with services establishments.

- **Assisted Living**: Since January 2007 housing with services establishments have been able to register with the Minnesota Department of Health as an "assisted living" provider if they meet additional criteria. Registration as an assisted living provider and services provided by a licensed Class A or Class F home care provider are required if an establishment or provider uses the term "assisted living" in marketing. The Elderly Waiver (EW), the Community Alternatives for Disabled Individuals (CADI) Waiver and the Brain Injury (BI) Waiver offer a service called Customized Living that is provided by assisted living providers in housing with services establishments. However, most people who receive assisted living do not receive publicly funded services.

- **Foster Care**: Foster care provides services in small-group residential settings. DHS distinguishes between ***family foster care,*** in which a family lives with the persons with a disability that reside there—and ***corporate foster care,*** in which an organization has the licensure and provides staffing. Information about current use of family foster care and corporate foster care, and an analysis of capacity needed, will be available in the February 2013 foster care needs determination report to the

[14] Mollica, Robert; Sims-Kastelein, Kristin; and O'Keeffe, Janet *Residential Care and Assisted Living Compendium: 2007* Nov 30, 2007
[15] Mollica, Robert; Sims-Kastelein, Kristin; and O'Keeffe, Janet *Residential Care and Assisted Living Compendium: 2007* Nov 30, 2007

legislature. Approximately 60% percent of DD Waiver participants live in foster care settings,[16] and all other waivers have participants receiving foster care services. For waiver participants, the waiver pays for services. Room and board is often covered by Group Residential Housing and a portion of the resident's income.

As shown in Table 5, the number of people receiving publicly funded institutional services (i.e., nursing facilities and ICF/DD0 has decreased in recent years, while the number of people receiving non-institutional, residential services has increased for most services.[17] However, as data in the Community Based Services and Supports section show, the growth of residential services in recent years has been slower than overall enrollment in HCBS waivers. In other words, the number of people NOT receiving residential services is growing at a faster rate than the number of people using residential services.

Table 5: Monthly Data for Number of People Receiving Publicly Funded Services in Congregate Settings, 2006 – 2010

Program	2006	2007	2008	2009	2010	Avg Annual Increase
Nursing Facilities (NF)	21,011	20,233	19,468	18,783	18,219	-4%
Intermediate Care Facilities/DD (ICF/DD)	1,897	1,864	1,850	1,825	1,779	-2%
Children's Residential Treatment (Rule 5)	227	225	242	180	202	-3%
Alternative Care Services (AC)	531	472	363	210	71	-40%
Brain Injury Waiver (BI)	807	847	889	920	885	2%
Community Alternatives for Disabled Individuals Waiver (CADI)	3,542	4,055	4,582	4,876	5,136	10%
Community Alternative Care Waiver (CAC)	49	51	51	53	51	1%
DD Waiver – Corporate Foster Care	7,642	n/a	n/a	7,808	8,252	2%
DD Waiver – Family Foster Care	1,086	n/a	n/a	975	899	-5%
Elderly Waiver (EW)	6,416	6,696	6,780	6,780	6,479	0%

Notes:

- n/a means not are not available for this report because data were not analyzed for these years.
- NF and ICF/DD data are based on the average monthly number of people receiving Medicaid services in a SFY
- Data for NF do not include individuals under age 65 at two facilities that are IMD. A private facility, Andrew Residence, served 221 people in 2011 according to Truven Health analysis of Minimum Data Set data provided by DHS in May 2012.
- Data for AC, BI, CADI, CAC, and EW are based the number of people as of December of the year with a current living arrangement of "congregate setting" indicated in the most recent assessment.
- Data for the DD Waiver are based on the number of people as of December 2006, July 2009, or December 2010 with a current support listed as "Foster Care – shift staff" i.e., corporate foster care, "Foster Care – family" or "Foster Care – live-in caregiver". Family or live-in caregiver foster care arrangements are categorized as Family Foster Care.

Sources:

- NF and ICF/DD data from MN DHS, November 2011 Forecast
- DD Waiver data for 2009 provided by the Minnesota DHS in July 2009
- Other services data from Truven Health Analytics analysis of MMIS data, CY 2006 through CY 2010; data extracted January 2012.

[16] Truven Health Analytics analysis of MMIS data, CY 2006 through CY 2010; data extracted January 2012.

[17] The number of people served in Alternative Care AC decreased because that program no longer offers a service that pays for around-the-clock supports in a residential setting, such as customized living. It is still possible for an AC participant to receive homemaker or other services paid on an hourly basis while living in a congregate setting such as a housing with services establishment.

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Within Minnesota's HCBS programs, thousands of people receive residential services where the entity that owns the residence also furnishes services at the location. Some of these individuals may be better served in their own home or apartment, with the ability to change service providers without moving.

Housing Supports

The US Department of Housing and Urban Development (HUD) provides assistance to help individuals stay in their own apartments or homes. This assistance includes a variety of programs such as:

- **Housing Choice Voucher Program (Section 8)** is the federal program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market. Since housing assistance is provided on behalf of the family or individual, participants are able to find their own housing, including single-family homes, townhouses and apartments.

  The participant is free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects. A family that is issued a housing voucher is responsible for finding a suitable housing unit of the family's choice where the owner agrees to rent under the program. This unit may include the family's present residence. Rental units must meet minimum standards of health and safety, as determined by the PHA.

  A housing subsidy is paid to the landlord directly by the PHA on behalf of the participating family. The family then pays the difference between the actual rent charged by the landlord and the amount subsidized by the program. Under certain circumstances, if authorized by the PHA, a family may use its voucher to purchase a modest home.

  Over 16,800 people in households that included adults with disabilities received Section 8 vouchers or lived in low-rent public housing between May 2008 and August 2009. During the same time period, over 11,800 people in households that included older adults received Section 8 vouchers or lived in low-rent public housing.[18] This data does not include people living in housing that received development assistance.

- **Supportive Housing for the Elderly (Section 202)** - HUD provides capital advances to finance the construction, rehabilitation or acquisition with or without rehabilitation of structures that will serve as supportive housing for very low-income elderly persons, including the frail elderly, and provides rent subsidies for the projects to help make them affordable.

- **Supportive Housing for Persons with Disabilities (Section 811) -** HUD provides funding to develop and subsidize rental housing with the availability of supportive services for very low-income adults with disabilities.

- **Housing Opportunities for Persons with AIDS (HOPWA)** program provides grants that can be used to meet the housing needs of persons with Acquired Immune Deficiency Syndrome (AIDS),

[18] U.S. Department of Housing and Urban Development *Resident Characteristics Report* August 31, 2009. Data reflect the characteristics of housing residents in low-rent public housing and of people using Section 8 vouchers. Data do not reflect the type of the housing occupied. For example, some older adults and people with disabilities live in housing units designed for general occupancy.

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HIV-positive status or related diseases, and their families. The program authorizes grants for both housing assistance and services. HOPWA funds are appropriated by Congress to HUD. The City of Minneapolis receives and administers a direct grant for the 13-county Minneapolis/Saint Paul Metropolitan Statistical Area. Minnesota Housing receives a direct award of funds for the portion of the State not covered by the City of Minneapolis grant and contracts with the Minnesota AIDS Project Greater Minnesota Emergency Program to administer these funds in the given geographical area.

- **HUD Continuum of Care Program** - Promotes community-wide commitment to the goal of ending homelessness; provides funding for efforts by nonprofit providers and State and local governments to quickly re-house homeless individuals and families to minimize trauma and dislocation; promotes access to and effective utilization of mainstream programs; and optimizes self-sufficiency among individuals and families experiencing homelessness.

  Grants offered through a competitive process for new construction; acquisition, rehabilitation, or leasing of buildings to provide transitional or permanent housing; rental assistance; payment of operating costs; supportive services; re-housing services; payment of administrative costs; and grants for technical assistance.

In addition to the housing supports offered by HUD, Minnesota Housing Finance Agency (Minnesota Housing) provides rental assistance, development assistance and home improvement loans to eligible participants. Some of those programs include:

- **Bridges Program** is a tenant-based voucher program that operates in selected counties throughout the state, administered by local housing organizations. Grants provide temporary rental assistance and security deposits on behalf of participants with a serious mental illness. Payments are paid directly to landlords and tenants are responsible for their portion of the rent, equal to 30 percent of their income. Participants are required to be on a waiting list or eligible for a permanent rent subsidy, typically a Section 8 Housing Choice Voucher. Referral to the program must be made by a mental health professional. DHS and Minnesota Housing collaborate on the administration of this program. DHS operates a similar program that provides housing assistance to people with serious mental illness in crisis situations.

- **Bridges Regional Treatment Center (RTC) Pilot Program** provides eligible participants transitional rental assistance, housing access, and supportive service coordination beginning in 2012.[19] The program serves people with a serious mental illness that are:

  - Hospitalized at the Anoka Metro Regional Treatment Center (AMRTC) and do not meet hospital level of care, have significant or complex barriers to accessing and retaining housing, are homeless, near homeless and/or rent burdened upon AMRTC admission or discharge; or

  - For whom Bridges RTC Pilot assistance will divert or prevent re-admission to the AMRTC. The Bridges RTC Pilot Program assists people with serious mental illness in obtaining and retaining affordable housing along with mental health and supportive services.

  The Bridges RTC Pilot Program transitions individuals out of the hospital to permanent supportive housing in the community. DHS partners with the Minnesota Housing Finance Agency to award fund and align the program with Minnesota Housing Bridges transitional rental subsidy program.

[19] www.mnhousing.gov/initiatives/housing-assistance/rental/mhfa_000479.aspx

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- **Family Homeless Prevention and Assistance Program (FHPAP)** provides grants to encourage and support innovations at the county, region, or local level in establishing a comprehensive homelessness response system or in redesigning an existing one. Funds are used for a broad range of purposes aimed at preventing homelessness, shortening the length of stay in emergency shelters or length of homelessness, and assisting individuals and families experiencing homelessness to secure transitional or permanent affordable housing.

  Grant funds are awarded through a competitive application process for the State biennium. In the Minneapolis/Saint Paul metropolitan seven-county area, a county is the only eligible applicant. In Greater Minnesota, eligible applicants include a county, a group of contiguous counties jointly acting together, or a community-based nonprofit organization with a sponsoring resolution from each of the county boards of the counties located within its operating jurisdiction.

- **Housing Access Services** were funded in 2009 by the legislature and provided through a contract between DHS and the Arc of Minnesota to help eligible people with disabilities seek and locate suitable, affordable, accessible housing. The program helps people with moving, negotiating with landlords, applications for publicly financed housing, finding affordable furnishings, and other moving-related tasks. Similar services have been available through the DD waiver, and will be added to the other waivers to make it available through Medicaid for waiver recipients.

- **Housing with Supports for Adults with Serious Mental Illness (HSASMI)** has provided operating subsidy funding to supportive housing projects since 2008. The program funds a range of supports and non-reimbursable services that are vital for persons with serious mental illness to obtain and retain affordable rental housing. Supports vary by housing project but include: tenant service coordination, front desk cost, security, and gap financing for rent stabilization for persons with very low income. HSASMI projects are located across Minnesota in metro and rural areas, in counties and on reservations. DHS partners with the Minnesota Housing Finance Agency to award funding to sustainable capital funding housing projects.

- **Crisis Housing Fund (CHF)** program provides temporary rental, mortgage, and utility assistance for persons with serious and persistent mental Illness to retain their home while they are using their income to pay for needed mental health or chemical health treatment. Assistance is available for up to 90 days, and individuals may reapply if they need to return to treatment. Since 1993 the CHF has been available to eligible persons across Minnesota to prevent homelessness.

- **Housing Trust Fund (HTF)** can be used for three types of activities:

  - Capital financing for acquisition, construction, rehabilitation of affordable and/ or permanent supportive housing

  - Operating subsidies for unique costs associated with operating a low-income or supportive housing development or for revenue shortfall to help reduce the difference between the costs of operating a low-income housing development and the rents that the tenants can afford to pay

  - Rental assistance in the form of a tenant-based, sponsor-based, or project-based contract. Rental Assistance is intended to be temporary in nature and provide assistance to individual households.

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Funds can be provided as grants or deferred with no or low interest. Funding priority is given to housing proposals that serve tenants with incomes at 30 percent of the median family income for the Minneapolis/ Saint Paul metropolitan area. Priority also is given to proposals serving households experiencing long-term homelessness.

The Minnesota Department of Human Services (DHS) gathers local information about the current capacity and gaps in services and housing needs to support older persons in Minnesota. Since 2001 all counties in Minnesota have been requested to respond to a biennial survey of local capacity to meet long-term care needs of current residents, including any significant "gaps" in services or supports. This information is submitted to DHS through a County Gaps Analysis Survey.

The 2009 Long-Term Care Gaps Analysis indicates barriers to gaps in housing capacity in several areas including subsidies for low income persons needing housing modifications (65% of counties); subsidized rental apartments with support services or supervision and health care services (60%); subsidized rental apartments with support services only (57%); and resources to track available accessible and affordable housing (53%).[20] Compared to a similar survey in 2007, the 2009 Gaps Analysis showed a significant decrease in the perceived need for housing options.

A new gaps analysis will be completed in 2013, and will include an assessment of community resources and services and create plans to develop services and resources where there are gaps.

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[20] MN DHS *Status of Long-Term Care in Minnesota 2010*

WHERE PEOPLE WORK

Many people with disabilities have the ability and desire to work, earn income, and contribute to society. This portion of the report describes the state agencies with responsibility for employment supports and presents data regarding employment of people with disabilities receiving public supports, including the utilization of supported employment and other supports that people typically receive during the work day.

Two state agencies have management responsibility for employment supports. DHS provides employment support services through the home and community-based service (HCBS) waivers, including supported employment services and mental health services. The Department of Employment and Economic Development (DEED) determines eligibility for disability-related benefits from the Social Security Administration and administers federal and state vocational rehabilitation programs.

DHS Employment Services

DHS provides employment support services through the home and community-based service (HCBS) waivers, including supported employment services and mental health services.

Day Training & Habilitation Services

Day training and habilitation (DT&H) services include the supervision, training or assistance of a person to develop and maintain life skills, engage in productive and satisfying activities of their own choosing and participate in community life. DT&H services are designed and implemented in accordance with the individual service and individual habilitation plans to help persons reach and maintain their highest level of independence, productivity and integration into the community.

Over 16,000 individuals access DT&H services annually. There are 296 licensed DT&H provider sites in 84 of Minnesota's 87 counties.[21]

The DD waiver is the largest source of funding for this service. 81% of those receiving DT&H services have a Developmental Disability diagnosis. DT&H services can be center based or community based.

DT&H service definitions may be separated into four categories:

- *Facility-based*: paid tasks and work performed within the building and/or grounds of the facility
- *Group community employment*: paid work crews or job enclaves within community businesses or organizational settings
- *Independent placement*: one person occupying and working at a single, paid job position at any given time within a community employer's business or organizational premises receiving intensive-to-no employment coaching and support

[21] Source: Minnesota DT& H Survey Results Report, September 2011 https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6459-ENG

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- *Self-employment:* Sole proprietorship businesses, entrepreneurial micro-enterprise owners/operators, etc. w/in the community

The percentage of people in different types of employment and work experiences include:

- Facility-based employment: 61%
- Group community employment: 34%
- Individual job placement – community: 12%
- Self-employment: 1%
- Non-paid community work/volunteer: 8%
- Non-paid DT&H work: 3%
- Non-paid community and DT&H work: 5%
- Non-paid only work/volunteering: 4%

DT&H services can be reimbursed at sub-minimum or commensurate wage. Following is a description of wages earned in respective service settings:

- Facility-based: 85% earn commensurate special or sub-minimum wage and 13% earn minimum wage
- Community-based group: 61% earn commensurate special or sub-minimum wage and 32% earn minimum wage
- Community-based independent: 9% earn commensurate special or sub-minimum wage and 55% earn minimum wage
- Self-employment: 9% earn commensurate special or sub-minimum wage while 50% earn minimum wage

The following tables provide supported employment and other day service utilization for people age 21 to 64 receiving HCBS waivers including BI, CADI and DD Waivers. The percentage of individuals receiving supported employment Table 6 is less than the percentage of people earning $250 or more per month Table 8 below, indicating many people work without supported employment services. These individuals may or may not need other supports to obtain and maintain employment, such as Personal Care Assistance (PCA) and non-medical transportation.

Table 6: Percentage of HCBS Waiver Participants Age 21 to 64 Receiving Supported Employment in December, 2006 - 2010

Program	2006	2007	2008	2009	2010
BI Waiver - 15 minute units	4%	6%	6%	6%	6%
BI Waiver - day units	8%	10%	10%	10%	11%
CADI Waiver - 15 minute units	4%	5%	5%	6%	5%
CADI Waiver - day units	4%	5%	6%	6%	6%
DD Waiver - 15 minute units	3%	4%	4%	4%	4%
DD Waiver - day units	2%	2%	2%	2%	2%
DD Waiver - part day units	0%	1%	1%	1%	1%

Notes:

- Data may include duplicate participants. Some individuals may have received services with multiple types of billing units e.g., 15 minute units and day units.
- CAC Waiver is not included because it does not offer supported employment.

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Source:

- Truven Health Analytics analysis of MMIS data, CY 2006 through CY 2010; data extracted January 2012

The percentage of people in HCBS waivers age 21 – 64 who receive supported employment has increased steadily in recent years. The same trend applies to the percentage of people in the Brain Injury (BI) and Community Alternatives for Disabled Individuals (CADI) Waivers who receive prevocational services as shown in Table 7. The percentage of individuals receiving adult day services, day training and habilitation, and structured day program varied based on unit of service, but the percentage of waiver participants using these services increased at a slower rate than supported employment and prevocational services.

Table 7: Percentage of HCBS Waiver Participants Age 21 to 64 Receiving Day Services other than Supported Employment in December, 2006 - 2010

Program		2006	2007	2008	2009	2010
BI Waiver, Adult Day Services -	15 minute units	5%	5%	5%	5%	5%
BI Waiver, Adult Day Services -	day units	3%	3%	6%	6%	5%
BI Waiver, Prevocational Services -	15 minute units	3%	4%	5%	4%	5%
BI Waiver, Prevocational Services -	day units	7%	9%	12%	12%	13%
BI Waiver, Structured Day Program -	15 minute units	2%	2%	3%	2%	3%
BI Waiver, Structured Day Program -	day units	15%	15%	15%	14%	14%
CADI Waiver, Adult Day Services -	15 minute units	4%	4%	4%	4%	4%
CADI Waiver, Adult Day Services -	day units	3%	3%	3%	3%	3%
CADI Waiver, Prevocational Services -	hourly units	1%	2%	2%	2%	3%
CADI Waiver, Prevocational Services -	day units	3%	4%	6%	6%	7%
DD Waiver , Adult Day Services -	15 minute units	0%	0%	1%	1%	1%
DD Waiver , Adult Day Services -	day units	1%	1%	0%	0%	0%
DD Waiver, DT&H - pilot rates	15 minute units	7%	8%	8%	8%	8%
DD Waiver , DT&H -	part day rate	37%	57%	56%	56%	54%
DD Waiver, DT&H -	day rate	72%	74%	74%	73%	73%

Notes:

- Data may include duplicate participants. Some individuals may have received multiple services and/or services with multiple types of billing units e.g., 15 minute units and day units.
- CAC Waiver is not included because no participants received day services.

Source:

- Truven Health Analytics analysis of MMIS data, CY 2006 to CY 2010; data extracted January 2012

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Thousands of individuals receiving publicly funded LTSS and mental health rehabilitative services have some amount of earned income. The percentage of participants age 21 to 64 with earned income has decreased during recent years for most programs, as shown in Table 8.

Table 8: Percentage of Program Participants Age 21 to 64 with Earned Income of Any Amount in December, 2006 - 2010

Program	2006	2007	2008	2009	2010
Brain Injury Waiver (BI)	40%	41%	41%	42%	41%
Community Alternatives for Disabled Individuals Waiver (CADI)	24%	25%	25%	24%	24%
Community Alternative Care Waiver (CAC)	14%	7%	7%	10%	6%
DD Waiver	71%	71%	71%	70%	69%
Personal Care Assistance Services (PCA)	14%	14%	13%	11%	10%
Private Duty Nursing Services (PDN)	14%	13%	14%	14%	15%
Consumer Support Grants (CSG)	63%	63%	49%	52%	52%
Adult Rehabilitative Mental Health Services (ARMHS)	34%	32%	29%	26%	24%
Assertive Community Treatment (ACT)	22%	23%	20%	15%	16%
Intensive Rehabilitative Treatment Services (IRTS)	18%	24%	22%	17%	13%

Source:

- Truven Health Analytics analysis of MMIS data, CY 2006 to CY 2010; data extracted January 2012

However, the percentage of people receiving $250 or more per month is significantly smaller for the programs for which data have been published, the HCBS waivers for people under age 65 Table 9.

Table 9: Percentage of Home and Community-Based Services Waiver Participants Age 22 to 64 with Earned Income above $250 per Month in January, 2007 – 2011

Program	2007	2008	2009	2010	2011
Brain Injury Waiver (BI) and Community Alternatives for Disabled Individuals Waiver (CADI) - combined total	10%	10%	10%	10%	10%
DD Waiver	23%	22%	22%	22%	22%

Note:

- The CAC Waiver is not included because a small number of participants are adults and few individuals are employed.

Source:

- Minnesota DHS *Continuing Care Performance Report* Accessed on-line August 14 www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_166609

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Medical Assistance for Employed Persons with Disabilities (MA-EPD)

In 1999, under the authority of the Balanced Budget Act of 1997, Minnesota created a Medicaid buy-in program, called MA-EPD. This program allows more than 7,000 Minnesotans with disabilities to earn income, accumulate assets and maintain Medicaid eligibility.[22]

Table 10 below shows the number of persons receiving MA-EPD has grown steadily in recent years.

Table 10: Medical Assistance for Employed Persons with Disabilities: Enrollees and Earned Income for Enrollees as of December, 2006 - 2010

	2006	2007	2008	2009	2010	Avg Annual Increase
MA-EPD Enrollees	6,765	7,009	7,425	7,568	7,658	3%
MA-EPD Average Earned Income	$528	$531	$548	$540	$534	0%
MA-EPD Earned Income, in thousands	$3,572	$3,722	$4,069	$4,086	$4,088	3%

Notes:

- Earned income was calculated based on enrollment multiplied by average monthly earned income.

Source:

- Minnesota DHS Medical Assistance for Employed Persons with Disabilities MA-EPD Semi-Annual Data Report. Multiple reports accessed on-line August 14 at www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_017470

Department of Employment and Economic Development (DEED) Services

The Department of Employment and Economic Development (DEED) determines eligibility for disability-related benefits from the Social Security Administration and administers federal and state vocational rehabilitation services. DEED administers the following programs:

- **Vocational Rehabilitation (VR) Program** is a federal-state partnership which provides short-term, time-limited job placement employment and training program for persons with significant disabilities. VR is a statewide program and serves about 22,000 people annually.

- **Extended Employment (EE) Program** provides ongoing job supports to employed persons with significant disabilities. EE is a statewide program run by 28 community rehabilitation organizations serving 6,000 people annually.

- **Independent Living (IL) Program** provides services and training that enable Minnesotans with disabilities to live independently in the community. IL is a statewide program with core services independent living skills training, peer mentoring, advocacy services, and information and referral

[22] MN DHS *Medicaid Assistance for Employed People with Disabilities MA-EPD Semi Annual Data Report July – December 2007* December 2007

delivered through 8 Centers for Independent Living. IL serves 7,000 people annually, including 150 who were relocated from nursing homes into homes of their choice.

Currently there is a continuum of employment supports for people with disabilities. It is not a simple choice between center-based and community employment. There are four key definitions:

- *Center-based Employment*: A facility where most employees have disabilities, and have access to job related assistance and supervision at all times. Also known as a sheltered workshop.

- *Competitive employment*: Full-or part-time work in the general labor market at or above minimum wage. Coworkers may or may not have disabilities.

- *Integrated Setting*: A site where individuals with and without disabilities work or receive services at the same level.

- *Supported employment*: is a system of supports that help people with significant disabilities find and maintain employment.[23]

REFORM UNDERWAY

Minnesota's investments into home and community based services reflects a history of public policy supporting community living. While there is still a need to improve the capacity of community services to assure there are alternatives to institutional services, Minnesota also faces the next and perhaps more complex challenge of further defining outcomes and strategies to evaluate quality of life and characteristics of inclusive community living. The past few years have seen a convergence of reforms such as Reform 2020,[24] which includes initiatives to better support people in having a meaningful life at all life stages, according to their own goals, providing opportunities to make meaningful contributions, and building upon what's important to them. This reform highlights seven projects that were submitted to CMS in August 2012 for approval to demonstrate new approaches.

They include:
- conversion of our Personal Care Assistance (PCA) program to a more flexible and self-directed service called Community First Services and Support (CFSS) and a care coordination demonstration,
- housing and employment initiatives, and
- new mental health services and
- federal participation in the Anoka Metro Regional Treatment Center (AMRTC)

The Reform 2020 document includes a section which outlines additional reforms that are underway or planned, in addition to the projects listed above.

These include:
- Development of autism services, including early intervention and coordination
- Enhancement of mental health recovery services

[23] Center-Based Employment-The Continuum of Employment Supports for People with Disabilities – Summary report by Minnesota Sate Rehabilitation Council and Vocational Rehabilitation Services
[24] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6535B-ENG

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- New assessment and service planning process MnCHOICES
- Enhancements to the MinnesotaHelp Network of information and assistance linkage lines, in person assistance, interactive web tool and printed materials
- Reform of processes to divert admissions to nursing facilities when unnecessary, and to facilitate timely return home after appropriate nursing facility stays
- Development of a HCBS Report Card regarding the quality of services to help people make informed decisions about which provider to use.
- Integration of LTSS with state certified health care homes
- Health homes demonstrations e.g.: Alzheimer's and behavioral health
- Increasing access to evidence based health promotion
- Gaps Analysis to assess community resources and services and create plans to develop services and resources where there are gaps
- Needs determination to understand how foster care is being used, and plan for the future
- Critical access study to determine where there are gaps in needed services to support people in their own homes
- Redirection of residential and nursing facility services by creating access thresholds, and focus on community services to support people in their own home.
- Enhance current HCBS through actions such as a common service menu, new services to support in home support and technology, updating of employment services, revisions to consumer directed community supports (CDCS), new budget methodologies, and future creation of individual service budgets as examples of what is included
- Enhanced Provider standards and quality outcome standards, with a focus on positive approaches, and prohibitions on practices such as restraint and seclusion
- Provider rate methodologies to create a uniform process that also captures the individualized nature of the services and the individuals' needs
- Redesign of case management to separate out administrative functions, reduce duplication and redundancy, increase choice and provider better outcomes
- Improve statewide crisis intervention and prevention
- Create a statewide centralized system for reports of vulnerable adult maltreatment and response

Minnesota also received a federally funded Money Follows the Person grant which is being used to facilitate the discharge of people from institutional settings, and increasing community capacity to avoid future need for institutional services.

The Olmstead Committee recommendations will further inform reform initiatives, and establish benchmarks to evaluate progress.

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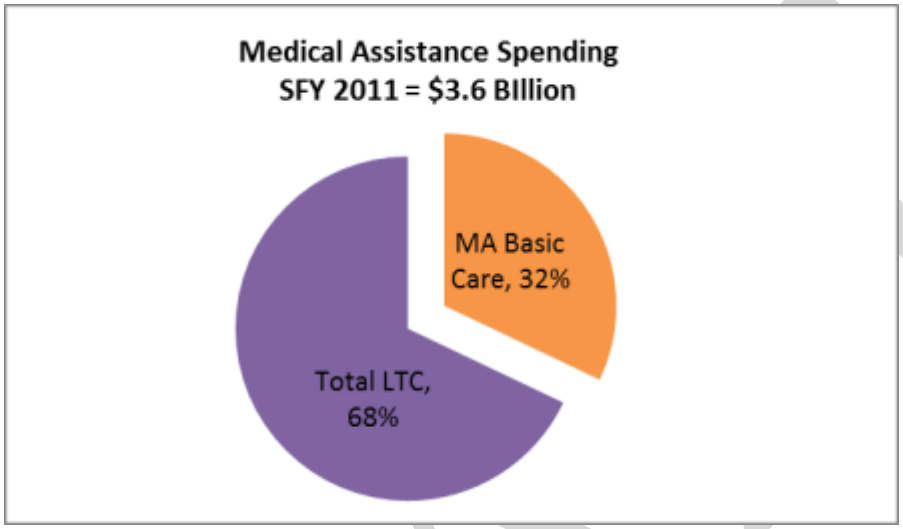
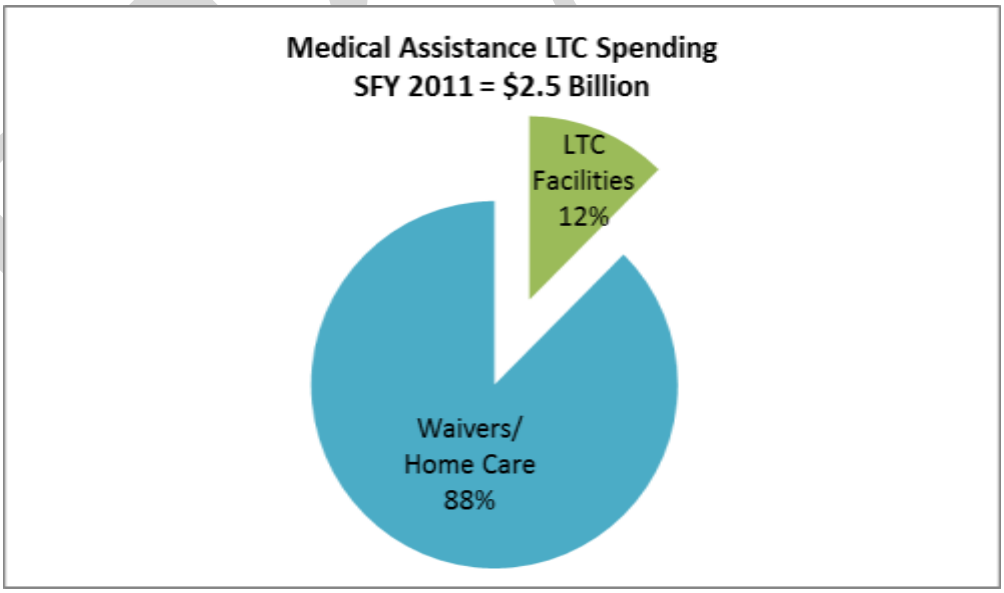
BASELINE BUDGETARY INFORMATION

The following six figures and two tables provide a snapshot of Minnesota's state spending for fiscal years 2010 and 2011.

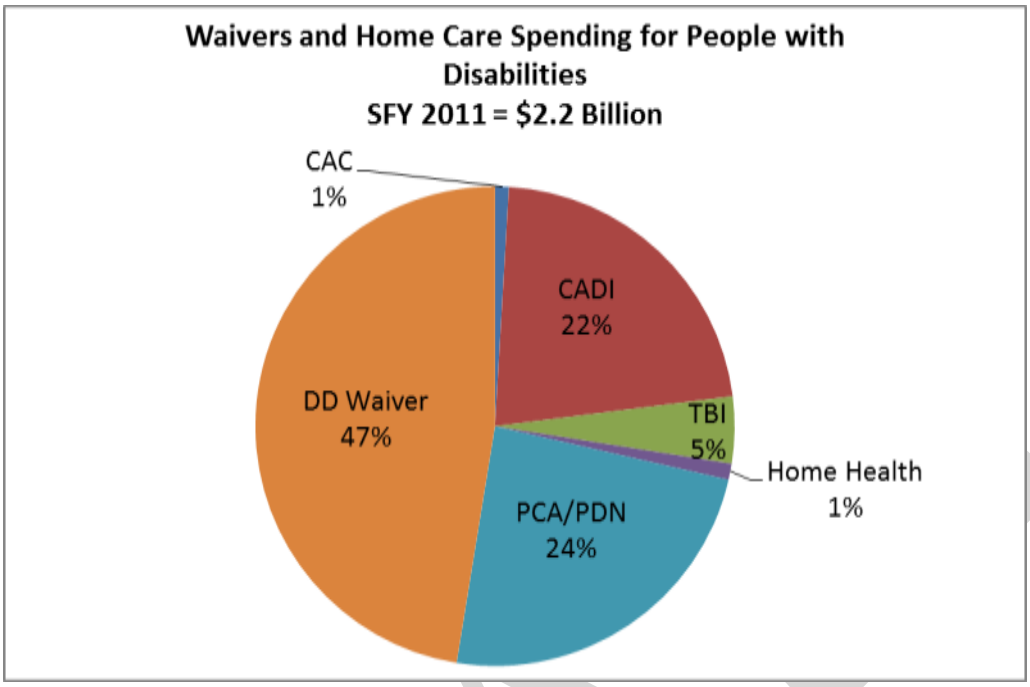


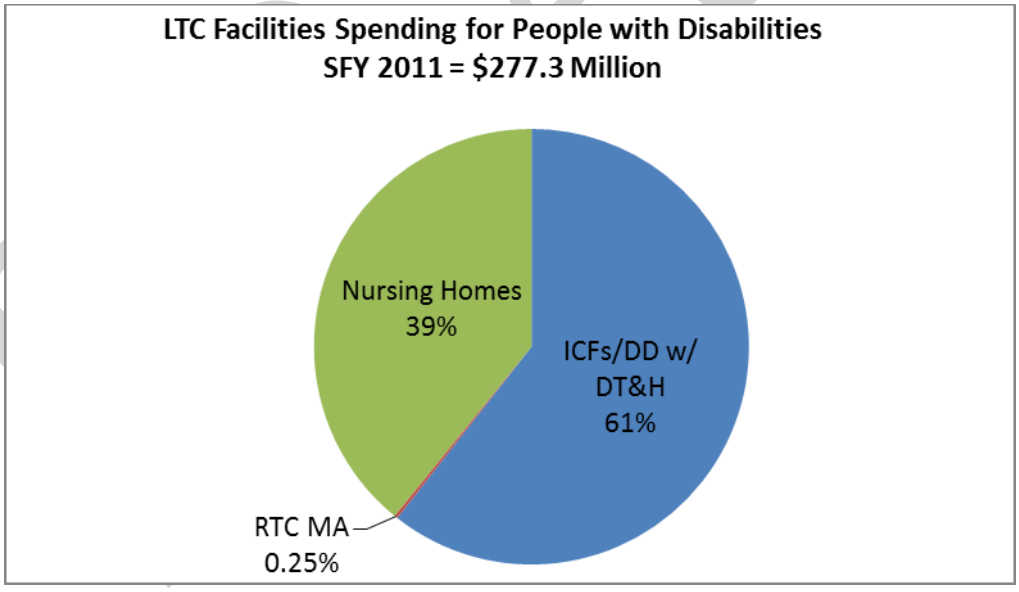
- MA Basic Care includes payments for participants under 65 who have a disability
- Long-term Care includes long-term care facilities, waivers, and home care services



- LTC Facilities includes nursing homes stays for people under age 65, ICFs/DD, and MA portion of Regional Treatment Centers

- Waivers and Home Care include the CAC, CADI, BI, and DD waivers as well as personal care, private duty nursing, home health services, and community support grants





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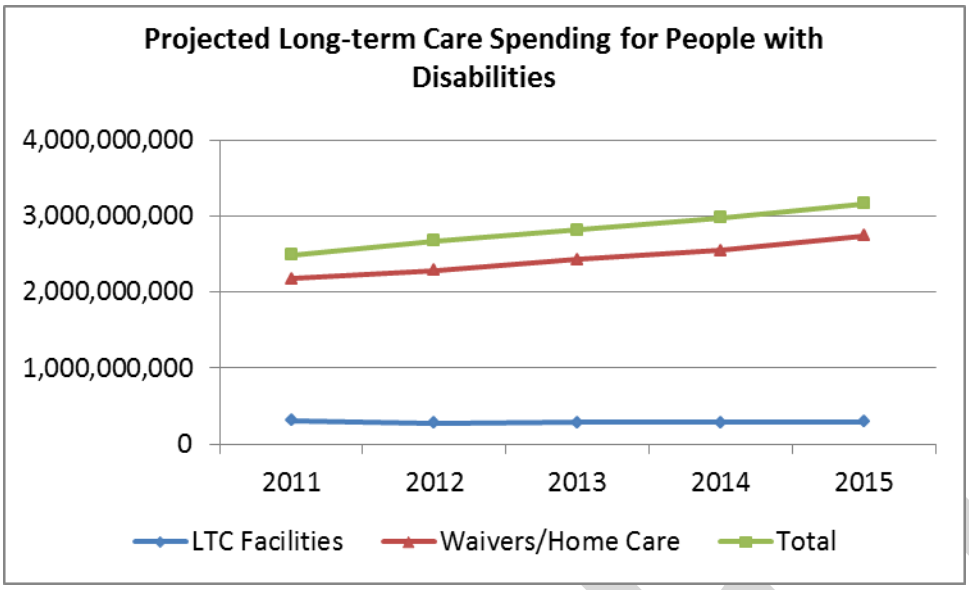

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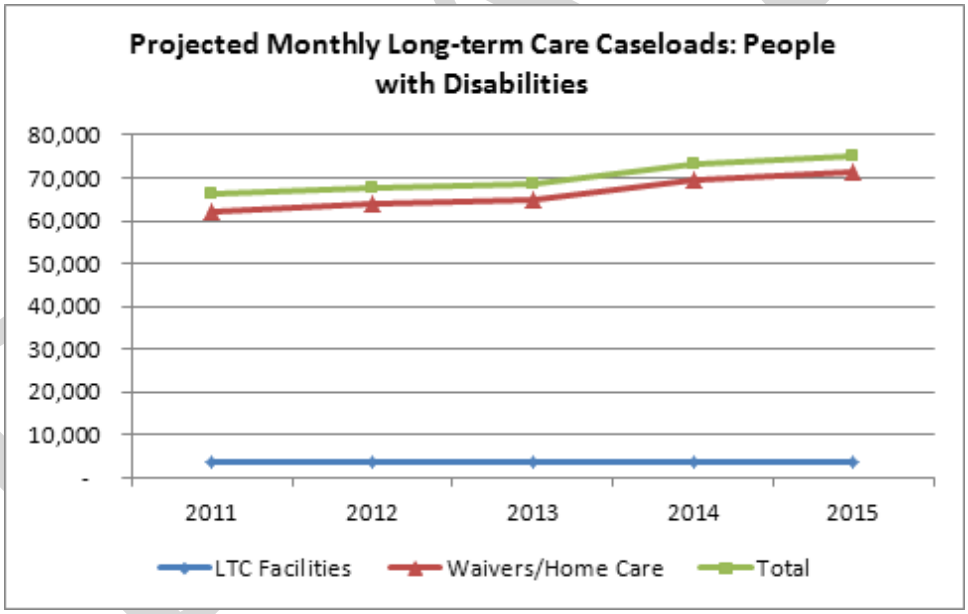

- Waivers and Home Care include the CAC, CADI, BI, and DD waivers as well as personal care, private duty nursing, home health services, and community support grants.

Table 11: Expenditures for MA Funded Institutional Services, State Fiscal Year 2008 – 2012

MA Funded Institutional Services					
	FY 08	**FY 09**	**FY 10**	**FY 11**	**FY 12**
NF-Under Age 65					
Avg # recipients monthly	2,292	2,254	2,190	2,160	2,099
Avg Cost per recipient monthly	3,479	3,696	3,771	3,783	3,831
Total Annual Payments	111,256,409	113,867,491	111,977,713	108,587,001	106,864,606
Federal Share	55,628,205	65,162,735	68,849,717	65,000,179	53,432,303
State Share	54,367,035	47,515,842	42,157,957	42,612,670	52,185,342
County Share	1,261,170	1,188,913	970,039	974,152	1,246,961
NF-Age 65 and over					
Avg # recipients monthly	17,176	16,529	16,029	15,375	14,939
Avg Cost per recipient monthly	3,479	3,696	3,771	3,783	3,831
Total Annual Payments	701,539,643	719,207,207	712,554,204	687,375,909	676,472,826
Federal Share	350,769,821	411,579,359	438,115,356	411,463,219	338,236,413
State Share	342,817,373	300,118,463	268,266,146	269,746,125	330,342,920
County Share	7,952,448	7,509,386	6,172,702	6,166,565	7,893,493
ICF/DD					
Avg # recipients monthly	1,850	1,825	1,779	1,770	1,749
Avg Cost per recipient monthly	6,392	6,491	6,411	6,390	6,423
Total Annual Payments	141,893,823	142,169,506	136,871,265	135,759,183	134,844,796
Federal Share	70,946,912	81,359,077	84,155,567	81,265,447	67,422,398
State Share	67,302,494	57,464,691	50,195,802	51,885,021	64,257,779
County Share	3,644,418	3,345,739	2,519,896	2,608,715	3,164,619
DT&H					
Avg # recipients monthly	1,498	1,489	1,443	1,459	1,445
Avg Cost per recipient monthly	1,768	1,843	1,830	1,842	1,874
Total Annual Payments	31,793,112	32,932,184	31,699,342	32,256,443	32,485,161
Federal Share	15,896,556	18,846,039	19,490,403	19,308,707	16,242,581
State Share	15,082,873	13,314,687	11,620,731	12,318,682	15,456,995
County Share	813,683	771,458	588,208	629,054	785,585
SOS-MI					
Avg # recipients monthly	55	36	31	3	3
Avg Cost per recipient monthly	18,780	17,174	20,568	19,116	6,010
Total Annual Payments	12,413,839	7,316,211	7,733,686	688,191	216,363
Federal Share	6,206,919	4,186,834	4,755,072	411,951	108,182
State Share	4,655,190	2,347,032	2,233,960	207,180	81,136
County Share	1,551,730	782,344	744,653	69,060	27,045
Total Institutional Spending*	**998,896,826**	**1,015,492,599**	**1,000,836,210**	**964,666,727**	**950,883,752**

**includes state, federal, and county shares*

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Table 12: Expenditures for MA Funded Waivers, State Fiscal Year 2008 – 2012

MA Funded Home and Community-Based Waiver Services	FY 08	FY 09	FY 10	FY 11	FY 12
BI Waiver					
Avg # Recipients monthly	1,315	1,357	1,359	1,349	1,353
*Residential***	904	934	934	925	915
*Non-residential***	411	423	425	424	438
Avg Cost per Recipient monthly	5,588	5,883	5,913	5,969	6,184
Total Annual Cost Incurred	88,152,050	95,819,057	96,396,848	96,596,297	100,415,877
Federal Share	44,076,024	54,834,192	59,269,791	57,822,543	50,207,939
State Share	44,076,026	40,984,865	37,127,057	38,773,754	50207938.5
*Residential***	40,162,725	37,486,365	33,723,723	35,073,161	45,406,631
*Non-residential***	3,913,300	3,498,500	3,403,334	3,700,593	4,801,307
County Share	0	0	0	0	0
DT&H	3,547,715	3,851,906	3,941,130	4,050,439	3,989,937
Supported Employment	1,368,507	1,456,250	1,591,456	1,536,431	
CAC Waiver					
Avg # Recipients monthly	279	300	313	314	332
*Residential***	44	46	45	41	43
*Non-residential***	235	254	268	273	289
Avg Cost per Recipient monthly	5,106	5,364	5,085	5,283	5,703
Total Annual Cost Incurred	17,064,201	19,303,360	19,115,670	19,931,351	22,684,585
Federal Share	8,532,101	11,046,698	11,753,307	11,930,907	11,342,293
State Share	8,532,101	8,256,662	7,362,363	8,000,444	11,342,293
*Residential***	3,431,983	3,088,239	2,394,893	2,656,752	3,880,245
*Non-residential***	5,100,117	5,168,424	4,967,470	5,343,692	7,462,048
County Share	-	-	-	-	-
CADI Waiver					
Avg # Recipients monthly	11,763	13,320	14,228	15,695	16,756
*Residential***	3,778	4,542	5,014	5,484	5,975
*Non-residential***	7,985	8,778	9,214	10,211	10,781
Avg Cost per Recipient monthly	2,070	2,294	2,417	2,516	2,566
Total Annual Cost Incurred	292,163,020	366,627,944	412,623,428	473,839,434	515,966,424
Federal Share	146,081,511	209,809,486	253,702,328	283,640,285	257,983,212
State Share	146,081,509	156,818,458	158,921,100	190,199,149	257,983,212
*Residential***	105,314,357	114,563,836	116,691,957	138,920,749	187,811,734
*Non-residential***	40,767,153	42,254,623	42,229,143	51,278,399	70,171,478
County Share	-	-	-	-	-
Prevocational Services	148,106,239	153,863,861	158,915,722	165,081,236	174,264,644

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Supported Employment	4,260,076	4,581,523	4,951,420	5,637,606	
DD Waiver					
Avg # Recipients monthly	13,971	14,176	14,652	15,165	15,490
*Residential***	9,193	9,312	9,506	9,753	10,020
*Non-residential***	4,778	4,864	5,146	5,261	5,470
Avg Cost per Recipient monthly	5,537	5,673	5,595	5,596	5,628
Total Annual Cost Incurred	928,369,470	965,104,543	983,708,433	1,018,355,465	1,046,143,382
Federal Share	464,184,736	552,298,566	604,835,067	609,587,582	523,071,691
State Share	464,184,734	412,805,977	378,873,366	408,767,883	523,071,691
*Residential***	383,349,418	340,893,188	310,132,453	331,489,416	422,899,710
*Non-residential***	80,835,317	71,912,789	68,740,912	77,278,469	100,171,981
County Share	-	-	-	-	-
DT&H	148,106,239	153,863,861	158,915,722	165,081,236	174,264,644
Supported Employment	4,260,076	4,581,523	4,951,420	5,637,606	
EW – Fee for service					
Avg # Recipients monthly	4,642	2,765	1,810	1,967	2,024
Avg Cost per Recipient monthly	1,399	1,521	1,619	1,578	1,512
Total Annual Cost Incurred	77,922,580	50,484,531	35,156,140	37,242,461	36,725,473
Federal Share	38,961,290	25,242,265	20,118,738	22,898,600	18,362,737
State Share	38,961,290	25,242,266	15,037,402	14,343,861	18,362,737
County Share	0	0	0	0	-
EW – Managed care					
Avg # Recipients monthly	13,724	16,889	19,012	19,816	20,601
Avg Cost per Recipient monthly	1,083	1,146	1,167	1,155	1,122.19
Total Annual Payments	178,323,902	232,174,777	266,291,405	274,756,876	277,419,588
Federal Share	89,161,951	116,087,387	152,390,083	168,934,805	138,709,794
State Share	89,161,951	116,087,390	113,901,322	105,822,071	138,709,794
County Share	0	0	0	0	0
Total Waiver Spending*	**1,581,995,223**	**1,729,514,212**	**1,813,291,924**	**1,920,721,884**	**1,999,355,329**

**includes state, federal, and county shares*

*** Residential includes foster care homes, customized living, residential services, out of home supportive living services*

*** Non-residential includes individuals who receive waiver and home care services that may be delivered in their own home, a relative's home, or other home setting such as a friend's home. (There may be some duplication across the home care programs).*

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Table 13: Expenditures for Publicly-Funded Community Supports, State Fiscal Year 2008 – 2012

Community Supports					
	FY 08	**FY 09**	**FY 10**	**FY 11**	**FY 12****
Personal Care Assistant					
Avg # Recipients monthly (w/o waiver)	9,436	10,975	12,212	12,923	13,708
Avg Cost per Recipient monthly	2,240	2,264	2,045	2,024	2,045
Total Annual Payments	343,155,151	402,364,206	404,264,975	422,260,288	440,975,525
Federal Share	171,577,576	230,260,209	248,563,116	252,765,008	220,487,763
State Share	171,577,576	172,103,997	155,701,859	169,495,280	220,487,763
County Share	-	-	-	-	-
Private Duty Nursing					
Avg # Recipients monthly (w/o waiver)	211	237	257	299	323
Avg Cost per Recipient monthly	11,405	11,555	12,321	12,665	12,917
Total Annual Payments	65,317,352	70,415,959	81,378,174	92,507,388	97,236,972
Federal Share	32,658,676	40,296,809	50,035,530	55,374,922	48,618,486
State Share	32,658,676	30,119,150	31,342,643	37,132,465	48,618,486
County Share	-	-	-	-	-
Home Health Agencies					
Avg # Recipients monthly (w/o waiver)	2,914	2,879	2,795	3,059	3,565
Avg Cost per Recipient monthly	411	401	400	376	388
Total Annual Payments	25,246,640	23,849,214	23,088,373	23,346,773	24,789,991
Federal Share	12,623,320	13,648,145	14,195,932	13,975,378	12,394,995
State Share	12,623,320	10,201,069	8,892,441	9,371,395	12,394,995
County Share	-	-	-	-	-
Personal Care Assistant – Managed Care (Fam. w/ Children)					
Avg # Recipients monthly		6,812	8,625	9,336	8,912
Avg Cost per Recipient monthly		2,264	2,045	2,024	2,045
Total Annual Payments		15,421,247	17,638,690	18,897,066	18,225,639
Federal Share		8,825,088	10,845,183	11,311,784	9,112,820
State Share		6,596,159	6,793,507	7,585,282	9,112,820
County Share		-	-	-	-
Consumer Support Grant					
Avg # Recipients monthly	1,040	1,256	1,412	1,483	1,629
Avg Cost per Recipient monthly	957	994	885	834	879
Total Annual Payments	11,945,494	14,982,399	14,995,056	14,853,137	17,189,937
Federal Share	0	0	0	0	0
State Share	11,945,494	14,982,399	14,995,056	14,853,137	17,189,937

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County Share	0	0	0	0	0
Alternative Care					
Avg # Recipients monthly	3,371	3,314	3,186	3,086	3,039
Avg Cost per Recipient monthly	732	762	780	769	778
Total Annual Cost Incurred	29,592,432	30,304,087	29,832,669	28,481,602	28,366,539
Federal Share	0	0	0	0	0
State Share	29,592,432	30,304,087	29,832,669	28,481,602	28,366,539
County Share	0	0	0	0	0
DD Targeted Case Management					
Total Annual Cost Incurred	9,105,598	9,428,932	9,279,928	8,471,726	10,128,444
Federal Share	4,552,799	5,395,877	5,705,782	5,071,175	5,064,222
State Share	-	-	-	-	
County Share	4,552,799	4,033,055	3,574,146	3,400,551	5,064,222
Mental Health Case Management					
Total Annual Cost Incurred	61,867,211	75,535,421	67,034,257	61,013,808	62,347,751
Federal Share	30,933,605	43,226,513	41,216,145	36,522,866	31,173,876
State Share	-	-	-	-	-
County Share	30,933,605	32,308,907	25,818,112	24,490,943	31,173,876
Semi-Independent Living Skills					
Avg # Recipients monthly	1,560	n/a	n/a	n/a	n/a
Total Annual Cost Incurred	7,688,017	6,081,495	7,869,275	7,046,578	6,964,166
Federal Share	-	-	-	-	0
State Share	5,381,612	4,257,047	5,508,493	4,932,605	4,874,916
County Share	2,306,405	1,824,449	2,360,783	2,113,973	2,089,250
Family Support Grant					
Avg # Recipients monthly	1,810	n/a	n/a	n/a	n/a
Total Annual Cost Incurred	3,950,273	3,408,057	4,045,233	3,622,784	3,735,318
Federal Share	-	-	-	-	0
State Share	3,950,273	3,408,057	4,045,233	3,622,784	3,735,318
County Share	-	-	-	-	0
Total Community Support Spending*	**557,868,168**	**636,372,034**	**641,789,985**	**661,606,108**	**691,736,688**

**includes state, federal, and county shares*

***FY12 Forecasts, actuals for Semi-independent Living Skills and Family Support Grant*

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Table 14: Expenditures for State Funded Housing Services and Supports, State Fiscal Year 2008 - 2012

Housing Services					
	FY 08	**FY 09**	**FY 10**	**FY 11**	**FY 12**
Group Residential Housing					
Avg # Recipients monthly	15,699	16,442	17,469	18,194	18,993
Avg Cost per Recipient monthly	454	499	539	537	555
Nursing Facilities (IMD)	0	0	0	0	0
State Dollars Spent	7,596,255	7,846,792	7,674,264	7,443,974	7,702,203
Number of People Served	233	231	229	222	226
Board and Care	0	0	0	0	0
State Dollars Spent	2,916,663	2,225,375	2,935,021	2,792,675	1,246,530
Number of People Served	310	333	289	302	315
Group Homes	0	0	0	0	0
State Dollars Spent	30,128,867	31,125,897	36,931,939	34,278,298	32,407,991
Number of People Served	10,857	11,229	11,635	11,578	11,268
Own Home/Sup've Housing (HWS Hmls)	0	0	0	0	0
State Dollars Spent	1,159,130	3,074,766	5,609,371	11,530,740	16,263,556
Number of People Served	177	337	602	1,156	1,532
Own Home/Sup've Housing (Metro Demo)	0	0	0	0	0
State Dollars Spent	2,296,031	2,455,127	2,631,364	2,704,146	2,839,020
Number of People Served	237	242	240	248	243
Total Annual GRH Payments	0	0	0	0	0
State Share	44,096,945	46,727,957	55,781,958	58,749,833	60,459,300
County Share	1,520,996	1,706,026	1,600,000	1,637,121	1,500,000
MSA Shelter Needy					
State Dollars Spent	251286	188512	767859	950151	
Number of People Served	79	70	258	397	
Supportive Housing					
Bridges					
State Dollars Spent	2,862,416	2,996,126	2,680,913	2,131,899	-
Number of People Served	756	800	664	588	-
LTH SSF	-	-	-	-	-
State Dollars Spent	6,000,000	5,212,500	6,410,000	6,410,000	5,260,000
Number of People Served	3,286	3,496	3,584	3,534	3,500
Scattered Site Rent Assistance	-	-	-	-	-
State Dollars Spent	6,648,944	8,763,282	10,618,666	10,772,986	-
Number of People Served	1,467	1,824	2,106	1,993	-
Site-based operating subsidy	-	-	-	-	-
State Dollars Spent	1,711,381	1,711,381	1,235,630	1,235,630	104,721
Number of People Served	-	-	-	-	-
Housing Access Grants					

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# Recipients	-	-	86	136	251
State Payments	-	-	450,000	450,000	459,000
Housing with Supports for Adults with Serious Mental (HSASMI)					
# Recipients	655	422	604	703	770
AMHI Grants Awarded	2,038,315	0	554,064	562,929	549,955
MN Housing Awarded	1,858,244	1,500,000	1,006,500	853,492	1,061,575
Total HSASMI Spent	3,896,559	1,500,000	1,500,000	1,352,011	1,598,134
Crisis Housing Fund					
# Recipients	410	316	276	291	266
State Funding	388,243	302,932	284,698	282,812	276,799
Total State Housing Spending**	**65,855,774**	**67,402,690**	**79,729,724**	**82,335,322**	**68,157,954**

***only includes state spending*

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Table 15: Expenditures for Treatment Facilities, State Fiscal Year 2008 - 2012

Treatment Facilities					
	FY 08	**FY 09**	**FY 10**	**FY 11**	**FY 12**
Residential treatment (Rule 5) for children (MA Portion)					
Total Annual Cost Incurred	7,886,973	9,388,211	8,034,628	7,475,599	5,232,942
Federal Share	3,943,487	5,372,574	4,940,107	4,474,893	2,616,471
State Share	-	-	-	-	-
County Share	3,943,487	4,015,637	3,094,521	3,000,705	2,616,471
Psychiatric Hospital (AMRTC)					
Avg # Recipients monthly	325	291	265	277	310
Avg Cost per Recipient monthly	8571	9,663	9,941	9,822	8,922
Total Annual Payments	33,425,756	33,743,152	31,611,154	32,647,047	33,188,846
Federal Share	-	-	6,850,000	-	-
State Share	33,425,756	33,743,152	24,761,154	32,647,047	33,188,846
County Share	-	-	-	-	-
Forensics (Minnesota Security Hospital)**					
Avg # Recipients monthly	374	349	360	371	377
Avg Cost per Recipient monthly	14,513	15,360	15,787	15,541	14,936
Total Annual Payments	65,133,978	64,327,896	68,198,291	69,187,053	67,569,982
Federal Share	-	-	62,062,067	-	-
State Share	65,133,978	64,327,896	6,136,224	69,187,053	67,569,982
County Share	-	-	-	-	-
Total Treatment Facility Spending*	**106,446,707**	**107,459,259**	**107,844,073**	**109,309,699**	**105,991,770**

**includes state, federal, and county shares*

***Data Source for FY2008 - 2011: MAPS Appropriation Summary Balance Information Report*
Data Source for FY2012: SWIFT Allotment Balance Within Appropriation by Approp ID

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APPENDIX A: HISTORY AND BACKGROUND

Minnesota's public long-term care system has moved steadily toward home and community based services since 1980. Minnesota led the nation in per capita Medicaid LTSS spending in 1980, with almost all spending for services in nursing facilities and intermediate care facilities for people with developmental disabilities (ICF/DD).[25] For three decades, Minnesota has encouraged home and community-based services instead of institutional care. As shown in Table A, Minnesota is now a leader in the proportion of Medicaid LTSS expenditures for home and community-based services (HCBS) and ranked fifth in per capita Medicaid LTSS expenditures in 2009.[26]

Table A: Percentage of Medicaid Expenditures for Non-Institutional (LTSS): Top 10 States for 2009 and National Average, 2005 – 2009

	2005	2006	2007	2008	2009
New Mexico	66.5%	67.2%	71.5%	74.7%	82.8%
Oregon	67.7%	69.3%	69.3%	68.3%	74.5%
Minnesota	**58.1%**	**60.9%**	**63.5%**	**66.5%**	**68.0%**
Arizona	n/a	n/a	n/a	66.2%	66.9%
Vermont	59.8%	n/a	n/a	64.2%	64.9%
Alaska	59.4%	57.8%	57.5%	59.0%	62.7%
Washington	53.3%	56.2%	57.5%	59.4%	62.1%
Colorado	48.8%	50.8%	54.3%	57.1%	58.1%
California	47.4%	51.8%	55.3%	55.8%	57.0%
Hawaii	37.2%	37.7%	41.1%	42.1%	54.8%
United States	***35.1%***	***37.3%***	***39.9%***	***42.1%***	***44.0%***

Notes:

- Years are Federal Fiscal Years (October through September)
- n/a means complete data are not available.
- Non-Institutional LTSS are Home and Community-Based Services Waivers, Home Health, Personal Care Assistance, and Home and Community-Based Services provided under Sections 1115, 1915(a), 1915(i), and 1915(j) of the Social Security Act.
- Institutional Services are Nursing Facility Services, ICF/DDs, and Mental Health Facilities.

Source:

- Eiken, S.; Sredl, K.; Burwell, B.; and Gold, L. Medicaid Long-Term Care Expenditures: 2011 Update Cambridge, MA: Thomson Reuters October 3, 2011

The decisions that facilitated the transition from institutional supports have varied based on the target population for services. As a result, this section briefly summarizes this history for four population groups: people with developmental disabilities; people with serious mental illness; older adults; and people with other disabilities.

[25] Truven Health analysis of data from the Centers for Medicare & Medicaid Services, Form 64 Reports and the Census Bureau, Current Population Estimates

[26] Eiken S, Sredl K, Burwell B, Gold L. *Medicaid Expenditures for Long-Term Services and Supports: 2011 Update.* Thomson Reuters: October 31, 2011 Accessed October 2011 at http://www.hcbs.org/moreInfo.php/nb/doc/3661/

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People with Developmental Disabilities

Starting in the 1970s, Minnesota was one of the first states to develop community ICF/DDs, typically with fewer than fifteen people, as an alternative to help people leave large state ICF/DD institutions that housed hundreds of people. This development occurred when Medicaid funded ICF/DD but did not provide funding for community supports. Community ICF/DD helped Minnesota comply with the 1980 *Welsch v. Noot* class action lawsuit settlement that required a reduction of state institution census.[27]

In 1983, two years after states first had an option to offer Medicaid HCBS waivers; Minnesota established a moratorium on ICF/DD development and started the Developmental Disabilities (DD) Waiver.[28] Some ICF/DD residents moved to adult foster care settings, which typically serve up to four people, with services funded by the DD Waiver. Minnesota had a legislatively authorized closure plan for large state institutions for people with developmental disabilities and closed the last of the large state institutions in the early 2000s. The state had a continued role as a community provider and has served as a safety net when needed. The state further encouraged alternatives to ICF/DD in 2003 when it required counties to pay 20% of the state share of ICF/DD expenditures. This percentage was reduced to 10% in 2007.

The use of DD Waiver services has increased over time and in 2010 almost 15,000 people per month received DD Waiver services[29] while only 1,779 people received ICF/DD services.[30] In addition, over 3,000 people with DD received services in other waivers for people under age 65 in 2010.[31] That year, over 9,000 DD waiver participants received services in a foster care setting, including over 8,000 in corporate foster care.[32] In 2009, the state legislature passed a moratorium on the creation of new corporate foster care beds and established grants to support the use of technology, and housing access services to encourage independent housing options for people with developmental disabilities.

In 2009, Minnesota ranked 16th among 51 states and Washington, DC, in the percentage of Medicaid expenditures targeted to people with developmental disabilities (See Table B). These expenditures do not include supports for people with developmental disabilities other than ICF/DD and the DD Waiver, such as the Community Alternatives for Disabled Individuals (CADI) Waiver.

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[27] MN DHS: Disability Services Division *Plan for ICFs/MR in Minnesota* January 2009
[28] MN DHS *Assessment of the Impact of the ICF/MR Moratorium* January 1988
[29] Truven Health Analytics analysis of MMIS data, CY 2006 through CY 2010; data extracted January 2012
[30] MN DHS, November 2011 Forecast
[31] Truven Health Analytics analysis of MMIS data, CY 2006 through CY 2010; data extracted January 2012
[32] Truven Health Analytics analysis of MMIS data, CY 2006 through CY 2010; data extracted January 2012

Table B: Percentage of Medicaid Expenditures for Non-Institutional LTSS Targeting People with Developmental Disabilities: Minnesota, Top 10 States for 2009, and National Average 2005 - 2009

	2005	2006	2007	2008	2009
Michigan	94.9%	93.3%	93.5%	93.8%	99.2%
Vermont	99.0%	n/a	n/a	99.1%	99.1%
Oregon	100.0%	100.0%	94.8%	96.7%	98.7%
Alaska	100.0%	100.0%	99.8%	n/a	98.4%
New Hampshire	98.2%	98.2%	98.3%	98.1%	98.1%
Arizona	n/a	n/a	n/a	95.8%	96.0%
Colorado	79.7%	83.4%	92.4%	93.1%	93.5%
Maryland	84.8%	88.2%	88.5%	89.0%	93.1%
New Mexico	91.9%	90.4%	92.2%	92.3%	92.3%
Hawaii	90.0%	91.1%	92.1%	92.7%	91.9%
Minnesota (rank: 16)	**83.0%**	**83.7%**	**83.8%**	**84.0%**	**84.4%**
United States	***58.1%***	***59.7%***	***62.9%***	***64.3%***	***66.2%***

Notes:

- Years are Federal Fiscal Years (October through September)
- n/a means complete data are not available.
- Non-Institutional LTSS are Home and Community-Based Services Programs provided under Sections 1915(c), 1115, 1915(a), 1915(i), and 1915(j) of the Social Security Act that target people with intellectual disability, autism spectrum disorder, and/or other developmental disabilities.
- Institutional Services are ICF/DD.

Source:

- Eiken, S.; Sredl, K.; Burwell, B.; and Gold, L. Medicaid Long-Term Care Expenditures: 2011 Update Cambridge, MA: Thomson Reuters October 3, 2011

People with Serious Mental Illness

As in many states, Minnesota's institutional service system began in the last third of the 19th century with state-operated institutions. In the 1960s and 1970s, the state hospitals for people with mental illness, substance abuse, and developmental disabilities became regionally based with each institution serving all three populations for a particular catchment area. The facilities also began providing community-based services, using smaller residential settings such as adult foster care and psychosocial rehabilitative services. Starting in the 1970s, Minnesota closed some of its state-operated facilities for people with mental illness, substance abuse, and developmental disabilities. The remaining facilities were renamed Regional Treatment Centers (RTCs) in 1985 to reflect their regional focus and a mission beyond institutional services.[33]

In 1987, the Minnesota Comprehensive Adult Mental Health Act was passed. It mandated that counties provide certain community services including case management community support services and emergency services and grant funding for Community-Based Mental Health Services for Adults with Serious and Persistent Mental Illness (Rule 78).

[33] MN DHS, State Operated Services *The evolution of State Operated Services* October 2007

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In 1989 the Minnesota Comprehensive Mental Health Act for Children was passed. This act parallels services in the adult act. Grants for Children with Severe Emotional Disturbance and Their Families were enacted. These acts formed the basis of the mental health system in Minnesota and were the beginning of a movement to expand access to community based services. Over time, services funded by the state, counties, and the Medicaid program have expanded to increase access to alternatives to institutional services.[34]

As more people began to be served in the community, the barrier of housing costs received more attention. In 1991, DHS received legislative funding to begin a small housing initiative for persons with serious and persistent mental illness. DHS began a modified Section 8 program funded by state grants which was very successful.

In 1993, Minnesota Legislature authorized and appropriated funds to Minnesota Housing under provisions of Minnesota Statutes Section 462A.2097 to operate a rental assistance program for persons with mental illness. This rental assistance program is commonly known as Bridges and is still in existence.

After the closure of Moose Lake Regional Treatment Center in 1995, DHS began contracting with local community services to provide extended services to people with mental illnesses. Today there are 8 community hospitals across the state and one in South Dakota provide mental health extended stays. This service allows an individual to stay in one hospital to receive their services rather than be transferred to a large institution for longer term care. Most stays in these hospitals are less than one month.

Also in 1995, legislation was passed that allowed counties to come together regionally to provide services that one county often could not provide. These Adult Mental Health Initiatives developed a variety of grant funded services that helped to maintain community living.

Since 2000, Minnesota had added services to the Medicaid rehabilitation benefit in order to direct the mental health system toward individualized services and recovery.[35] In 2001, DHS developed a set of medical assistance services. These services include Adult Rehabilitative Mental Health Services (ARMHS), Assertive Community Mental Health Services (ACT), Intensive Residential Treatment Services (IRTS) Adult and Children's Crisis Response Services (CRS) and Children's Therapeutic Supports and Services (CTSS).

These services significantly increased access for both adults and children. Service utilization data indicate that in 2001, 52,091 adults and 20,314 children received publicly funded community mental health services. By 2010 this number had risen to 145,789 adults and 55,136 children. Regional treatment center hospitalization between 2001 and 2010, reduced from 2,137 adults and 143 children to 1,835 adults and 74 children.

By 2007, all large state-operated hospitals for people with mental illness were closed except for the Anoka Metro Regional Treatment Center. In 2006 and 2007, the state established 16-bed facilities across

[34] MN DHS *Uniform Application FY 2009 – State Plan: Community Mental Health Services Block Grant* Submitted to SAMHSA Center for Mental Health Services October 5, 2008
[35] MN DHS *Uniform Application FY 2009 – State Plan: Community Mental Health Services Block Grant* Submitted to SAMHSA Center for Mental Health Services October 5, 2008

the state called Community Behavioral Health Hospitals (CBHH).[36] There are currently seven CBHH, which focus on short-term stays, to improve the state's capacity for acute mental health services.

Older Adults

Minnesota's nursing facility supply declined slowly for several years after the state enacted a moratorium on licensure and certification of new nursing home beds and on major nursing facility construction projects in 1983. Starting in 2000, a combination of incentives encouraged nursing facilities to reduce beds and/or close facilities.[37] Despite an aging population, the number of licensed Minnesota nursing home beds decreased 30 percent between its peak in 1987 and 2009, from 48,307 to 33,878.[38]

Medicaid payment incentives coincided with a time in which demand for nursing facility services decreased, including in the private sector. This decreased demand is expected to continue into the future as people exercise their preference for smaller home-like settings. In addition, the nursing facility business is increasingly moving toward short-term rehabilitative stays.[39] For example, 82% of people admitted to Minnesota nursing facilities in State Fiscal Year 2006 were discharged within 90 days.[40]

Minnesota started the state-funded Alternative Care (AC) program, the Elderly Waiver (EW), and HCBS waivers for people under age 65 with disabilities in the 1980s to provide community-based alternatives to nursing facility services. The role of AC and EW has grown over time as more people have chosen community-based services. In 2010, 61 percent of people served in LTSS programs targeting older adults were served in the community, not in a nursing facility (See Table C). This percentage has grown steadily since the Minnesota legislature enacted a comprehensive package of reforms recommended by a state long-term care task force in 2001.[41]

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[36] MN DHS, Mental Health Divisions *Minnesota 2007 Implementation Report: Community Mental Health Services Block Grant* 2007
[37] These incentives are described on page 77 of Eiken, S., Gold, L., Larson, S. and Lakin, KC. *Minnesota State Profile Tool: An Assessment of Minnesota's Long-Term Support System* MN DHS: December 3, 2009 Accessed on-line August 16 at www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs16_144888.pdf
[38] MN DHS *Status of Long-Term Care in Minnesota 2010* 2010
[39] *Creating the Care Center of the Future: Recommendations and Next Steps* March 5, 2009 and Larson Allen *The Demand Model* The Long-Term Care Imperative: Undated
[40] Arling, Greg; Kane, Robert L.; and Bershadsky, Julie *Targeting Criteria and Quality Indicators for Promoting Resident Transition from Nursing Homes to Community* MN DHS: Revised January 5, 2009
[41] MN DHS *Status of Long-Term Care in Minnesota 2010* 2010

Table C: Percentage of Seniors Age 65 or Older Receiving Long-Term Services and Supports Supported in Homes and Communities, 2000 – 2010

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Home and Community-Based Services	40%	43%	46%	48%	48%	50%	51%	54%	56%	59%	61%
Institutional Services	60%	57%	54%	52%	52%	50%	49%	46%	44%	41%	39%

Notes:

- Data are for unduplicated persons served in a State Fiscal Year.
- Home and Community-Based Services are Alternative Care and the Elderly Waiver.
- Institutional Services are Nursing Facility Services for people age 65 or older.

Source:

- Minnesota DHS Dashboard, accessed August 9, 2012 at http://dashboard.dhs.state.mn.us/measure01.aspx

People with Other Disabilities

Minnesota also expanded community-based supports for people under age 65 at risk of nursing facility placement. Over 17,800 people received service in an HCBS waiver for people under age 65 other than the DD waiver in December 2010.[42] As Table D shows, 94 percent of people in services targeted to people under age 65—regardless of diagnosis—were served in the community in 2010, compared to 79 percent ten years earlier.

Table D: Percentage of People with Disabilities Receiving Long-Term Services and Supports Supported in Homes and Communities, 2000 – 2010

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Home and Community-Based Services	79%	82%	86%	88%	89%	90%	91%	92%	93%	94%	94%
Institutional Services	21%	18%	14%	12%	11%	10%	9%	8%	7%	6%	6%

Notes:

- Data are for unduplicated persons served in a State Fiscal Year.
- Home and Community-Based Services are the Brain Injury Waiver, the Community Alternatives for Disabled Individuals Waiver, the Community Alternative Care Waiver, the Developmental Disabilities Waiver, Personal Care Assistance, and Private Duty Nursing Services.
- Institutional Services are Nursing Facility Services for people under age 65 and ICF/DDs.

Source:

- Minnesota DHS Dashboard, accessed August 9, 2012 at http://dashboard.dhs.state.mn.us/measure01-2.aspx

[42] Truven Health Analytics analysis of MMIS data, CY 2006 through CY 2010; data extracted January 2012

As a result of the progress in reducing nursing facility utilization and expanding community services for people of all ages, Minnesota ranked third in the nation in the percentage of Medicaid LTSS expenditures for community-based services in 2009, as shown in Table E. This data include expenditures for people with developmental disabilities served in programs other than the DD waiver.

Table E: Percentage of Medicaid Expenditures for Non-Institutional LTSS Targeting Older Adults and/or People with Physical Disabilities: Top 10 States for 2009 and National Average, 2005 – 2009

	2005	2006	2007	2008	2009
New Mexico	52.2%	54.6%	61.4%	64.6%	78.7%
Washington	51.5%	55.0%	55.9%	59.8%	62.1%
Minnesota	**41.0%**	**46.3%**	**51.2%**	**57.7%**	**59.8%**
Oregon	56.1%	56.1%	56.7%	54.9%	59.1%
Alaska	51.6%	51.6%	50.6%	n/a	55.7%
California	54.0%	50.8%	54.0%	54.4%	55.1%
Texas	46.2%	46.0%	44.8%	48.9%	49.6%
Washington DC	18.1%	25.3%	34.9%	41.8%	45.6%
Arizona	n/a	n/a	n/a	41.9%	43.7%
Colorado	34.7%	37.0%	39.3%	42.4%	43.6%
United States	***28.4%***	***29.7%***	***32.3%***	***34.9%***	***36.1%***

Notes:

- Years are Federal Fiscal Years (October through September).
- n/a means complete data is not available.
- Non-Institutional LTSS are Home Health, Personal Care Assistance, and Home and Community-Based Services Programs provided under Sections 1915(c), 1115, 1915(a), 1915(i), and 1915(j) of the Social Security Act that target older adults and/or people with physical disabilities.
- Institutional Services are Nursing Facility Services.

Source:

- Eiken, S.; Sredl, K.; Burwell, B.; and Gold, L. Medicaid Long-Term Care Expenditures: 2011 Update Cambridge, MA: Thomson Reuters October 3, 2011

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Assessment, Referral, and Coordination

Most of the state agencies as listed in Appendix B, administer services in partnership with a network of local entities. The local agencies often provide information and assistance, determine eligibility for public services (sometimes called the need determination), assess need for services, develop service plans, and help people obtain necessary services. Common local agencies are described below, followed by information and referral challenges people face when learning about services and state initiatives to address those challenges.

In Minnesota, counties have historically played a significant role in publicly funded services. Counties assess eligibility for most public services provided on a fee-for-service basis, including mental health services, Personal Care Assistance, Private Duty Nursing, nursing facility care, ICF/DD, and the HCBS Waivers for people under age 65. Counties provide case management for all these services except personal care and private duty nursing. The county or its contracted case management agency develops a service plan to meet the person's needs identified in the assessment, and helps the person obtain services.

In addition, counties offer Long Term Care Consultations (LTCC) to people who are not eligible for public programs but who want information and assistance in selecting options. The state also contracts with two tribes for assessment and case management for HCBS Waivers and Alternative Care. When tribes provide these services, residents living on their tribal reservation can receive services from either their county or their tribe.

Managed care organizations (MCOs) assess functional eligibility and coordinate services in public managed care programs, including almost all Medicaid community services for older adults and Medicaid mental health services for many individuals. In addition, until 2010 Minnesota offered a managed care program for adults with disabilities under age 65, which included HCBS waiver services and other LTSS. The managed care plan assesses eligibility for nursing facility placement and is responsible for the first 100 to 180 days of nursing facility care (the number of days varies by program). The health plans employ their own staff to conduct assessment and service planning or contract with private care coordination organizations and/or counties for these functions. Other managed care organizations are regional collaborations of county governments (called county-based purchasing). Effective July 1, 2009, managed care organizations also provide targeted mental health case management for children and adults who are enrolled in managed care, including people enrolled in the managed care program that serves families with children. Some MCOs have contracts with counties and other vendors who provided fee-for-service mental health case management.

According to one study of care coordination for older adults, counties tend to use a social model[43] that focuses on non-medical needs such as housing, employment, and independent living, while MCOs tend to be more involved in health services. While this finding was an overall pattern, the reality can vary across plans and counties. Some MCOs contract with counties to provide care coordination. In other cases, MCOs have contracted with case management organizations that specialize in managing both health care and LTSS. Also, some MCOs have a contract with health care provider organizations where the provider provides care coordination, called a "care system." According to a 2007 study, supports coordinators in care systems had greater communication with the participant's primary care providers than supports

[43] Johnson, Alison; Ripley, Jeanne; Nwoke, Susan; Malone, Joelyn; Morishita, Lynne; Paone, Deborah *A Study of Care Coordination and Case Management in Minnesota's Publicly-Funded Managed Health Care Programs for Seniors* Halleland Health Consulting: November 2007

coordinators working for the health plan or a county.[44] A delivery system care coordination arrangement is similar to the health care homes defined in Minnesota's 2008 health care reform legislation, where clinicians, care coordinators, and patients with disabilities or chronic health conditions work together to plan health care services.[45]

In addition to counties and MCOs, other local and regional agencies involved in long-term supports include:

- Local school districts for special education and early intervention services
- Area Agencies on Aging (AAAs) that administer state and federal grants to provide services to older adults
- Centers for Independent Living that provide independent living services for people with disabilities
- Local public housing authorities—at the city or county level—that administer public housing funding

The local and regional agencies can help people obtain important services, but only if people know to contact them. Minnesota has undertaken important efforts to help individuals differentiate among service and support options for themselves. Long-Term Care Consultations (LTCCs) can help keep people in their homes or return them home more quickly from a nursing facility. LTCCs are usually conducted by a county social worker in conjunction with a public health nurse, though tribes or health plans may conduct them as well.[46] They include an overall assessment, a screening to determine public program eligibility, and help in navigating service and support options to help people live independently.

DHS is working to develop an information, intake, and assessment network model across these multiple access points to create a "virtual" single point of entry to long-term care. The MinnesotaHelp Network™ utilizes direct telephone and face-to-face assistance, a web-based consumer resource base, and community outreach sites (such as clinics, community centers, libraries, CILs and AAAs) to expand information accessibility. This network includes three toll-free call centers: Senior LinkAge Line®, Disability Linkage Line®, and Veterans Linkage Line™. In addition, MinnesotaHelp.info® is an online resource database offering information on a variety of community services for older adults and persons with disabilities.

When asked how people learn about services for the 2009 State Profile Tool,[47] experts regarding Minnesota's HCBS system mentioned many referral sources—in addition to the state resources described above—that inform people about both public and privately available supports, including word of mouth from family and friends and county staff, particularly county social workers or financial eligibility workers. The health risk assessment which the state requires MCOs to administer was credited with identifying people who needed long-term support, especially for people in cultural minority communities who are less likely to seek assistance. In addition, a service provider may be the most visible long-term care organization in a community, and refer a person to a county, managed care organization, or other agency for eligibility determination. Many people reportedly turn to health care providers, especially their physician. In addition, the 2005 Survey of Older Minnesotans by the Minnesota Board on Aging found other common resources people turn to include disease-specific advocacy organizations, their church, and their human resources office at work.[48]

[44] Johnson, Alison; Ripley, Jeanne; Nwoke, Susan; Malone, Joelyn; Morishita, Lynne; Paone, Deborah *A Study of Care Coordination and Case Management in Minnesota's Publicly-Funded Managed Health Care Programs for Seniors* Halleland Health Consulting: November 2007

[45] MN Department of Health *Proposed Expedited Permanent Rules Related to Health Care Homes* July 6, 2009

[46] MN DHS *Long-Term Care Consultation Services*, undated

[47] Eiken, S., Gold, L., Larson, S. and Lakin, KC. *Minnesota State Profile Tool: An Assessment of Minnesota's Long-Term Support System.* MN DHS: December 3, 2009 Accessed on-line August 16 at www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs16_144888.pdf

[48] MN DHS *Data Tables: 2005 Survey of Older Minnesotans* undated

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At times, how people learn about services varies by type of disability or when the disability occurs during the lifespan. For example, health care professionals are common referral sources, especially for systems related to particular diagnoses such as mental health services and services for people with HIV/AIDS and brain injury. Minnesota's Early Childhood Screening for pre-school children detects potential disabling conditions, allowing the medical community to connect parents or guardians with appropriate services. Finally, schools are a common referral source to connect people with developmental disabilities to the adult service system.

Many experts spoke of the complexity of the long-term supports system across populations and the need for someone to help people understand available supports and options. The system is more complex when a person needs publicly funded services, because one must consider the requirements of the funding system as well as what supports best meet a person's needs. Either too little or too much information can be a problem. HCBS Expert Panel members noted that abundant information sources can overwhelm people when they need fast answers. System navigators are particularly important for people new to the system and during critical decision points such as transitioning to adulthood, during a hospital stay, or upon the diagnosis of a disabling condition.

Pathways to Employment (PTE)

The Minnesota Department of Human Services (DHS), Department of Employment and Economic Development (DEED) and the Minnesota State Council on Disability formed a partnership to encourage employment called Pathways to Employment (PTE). The mission of PTE, which was funded through a CMS Medicaid Infrastructure grant was to increase competitive employment of Minnesotans with disabilities and meet Minnesota's workforce needs by bringing together people with disabilities, employers, businesses, government and providers. PTE accomplishments include:

- Integrating employment into DHS Disability Services Division policies. Employment is incorporated into each of the Continuing Care Administration's transformation initiatives – the Disability Waiver Rate System, HCBS Waiver Provider Standards, and the MnCHOICES long-term care assessment.

- Developing and implementing Disability Benefits 101, an on-line tool that gives comprehensive information on health coverage, benefits, and employment so people can plan ahead and learn how work and benefits go together.

- Building capacity among Minnesota employers for successfully recruiting, hiring and retaining employees with disabilities. A web-based tool, the Disability Employment Resource was developed by DEED Business Service Specialists in consultation with the business community. The Disability Employment Resource is a coordinated, comprehensive body of accurate information and resources; that supports employers in recruiting, hiring and retaining employees with disabilities. [49]

- PTE also funded the 2009 establishment of the Minnesota Employment Training and Technical Assistance Center, which provides training to individuals and businesses regarding employment of people with disabilities.

- All activities with PTE included linkages to the state's Medicaid buy-in program.

[49] MN DHS, MN Department of Employment and Economic Development, and MN State Council on Disability *Pathways to Employment: Progress Report Quarter 1, CY 2009* www.positivelyminnesota.com/Business/Hiring_People_With_Disabilities/index.aspx

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Relevant Minnesota Statutes - Long-Term Care and Mental Health Programs

Program Name/Description	MN Statutes (2011)
Department of Health	Chapter 144
Nursing Home Admission Contracts	§144.6501
Facilities for Alzheimer's Disease or Related Disorder	§144.6503
Health Care Bill of Rights	§144.651
Traumatic Brain Injury and Spinal Cord Injury Registry	§144.662
Nursing Homes and Home Care *MDH Regulations - Nursing Facilities* *MDH Regulations - Home Care*	Chapter 144A
Definitions	§144A.01
Moratorium on Certification of Nursing Home Beds	§144A.071
Exceptions to Moratorium; Review	§144A.073
Voluntary Receivership	§144A.14
Involuntary Receivership	§144A.15
Nursing Home and Boarding Care Home Resident Relocation	§144A.161
Home Care Bill of Rights	§144A.44
Assisted Living Bill of Rights Addendum	§144A.441
Assisted Living Clients; Service Termination	§144A.442
Licensure - *Home care licensure*	§144A.46
Class F Provider	§144A.4605
Office of Health Facility Complaints	§144A.52
Registration of Supplemental Nursing Services Agencies	§144A.70
Supplemental Nursing Services Agency Registration	§144A.71
Department of Human Services	Chapter 245
Adult Mental Health Act	§245.164-§245.4711
Community Support & Day Treatment Services	§245.4712-§245.4863
Children's Mental Health Act	§245.487-§245.4888
Ombudsman for Mental Health and Developmental Disabilities	§245.91-§245.99
Human Services Licensing	Chapter 245A
Citation	§245A.01
Definitions	§245A.02
Who Must be Licensed	§245A.03
Unlicensed Emergency Relative Placement	§245A.035
Application Procedures	§245A.04
Systems and Records	§245A.041
Denial of Application	§245A.05
Correction Order and Conditional License	§245A.06
Sanctions	§245A.07
Hearings	§245A.08
Consolidation of Hearings; Reconsideration	§245A.085
Rules	§245A.09
Rules for Programs Serving People with Mental Illnesses	§245A.095
Fees	§245A.10
Special Conditions for Residential Programs	§245A.11

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Program Name/Description	MN Statutes (2011)
Voluntary Receivership for Residential Programs	§245A.12
Involuntary Receivership for Residential Programs	§245A.13
Special Conditions for Nonresidential Programs	§245A.14
Family Adult Day Services	§245A.143
Reduction of Risk of Sudden Infant Death Syndrome in Licensed Programs	§245A.1435
Sudden Infant Death and Shaken Baby Syndrome for Child Foster Care Providers	§245A.144
Training on Risk of Sudden Infant Death Syndrome and Shaken Baby Syndrome by Other Programs	§245A.1444
Dangers of Shaking Infants and Young Children	§245A.1445
Child Care Program Reporting Notification	§245A.145
Crib Safety Requirements	§245A.146
Regulation of Family Day Care by Local Government	§245A.15
Fire Marshal Inspection	§245A.151
Care of Individuals on Medical Monitoring Equipment	§245A.155
Disclosure of Communicable Disease	§245A.156
Standards for County Agencies and Private Agencies	§245A.16
Mental Health Training Requirement	§245A.175
Child Passenger Restraint Systems	§245A.18
HIV Training in Chemical Dependency Treatment Program	§245A.19
Independent Living Assistance for Youth	§245A.22
Licensing Prohibition for Certain Facilities Serving Children	§245A.30
Child Care Center Training Requirements	§245A.40
Family Child Care Training Requirements	§245A.50
Maltreatment of Vulnerable Adults	§245A.65
Feral Grants to Establish and Maintain a Single Common Entry Point for Reporting Maltreatment of a Vulnerable Adult	§245A.655
Requirements; Maltreatment of Minors	§245A.66
Services for Developmental Disabilities	Chapter 245B
Rule Consolidation	§245B.01
Definitions	§245B.02
Applicability and Effect	§245B.03
Accreditation, Alternative Inspection, and Deemed Compliance	§245B.031
Consumer Rights	§245B.04
Consumer Protection Standards	§245B.05
Staffing for Day Training and Habilitation Services	§245B.055
Service Standards	§245B.06
Management Standards	§245B.07
Compliance Strategies	§245B.08
Human Services Background Studies	Chapter 245C
Title	§245C.01
Definitions	§245C.02
Background Study; Individuals to Be Studied	§245C.03
When Background Study Must Occur	§245C.04
Background Study; Information and Data Provided to Commissioner	§245C.05
Study Subject Affiliated with Multiple Facilities	§245C.07
Background Study; Commissioner Reviews	§245C.08
Failure or Refusal to Cooperate with Background Study	§245C.09

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Program Name/Description	MN Statutes (2011)
Background Study; Fees	§245C.10
Background Study; County Agencies	§245C.11
Background Study; Tribal Organizations	§245C.12
Background Study Processing	§245C.13
Disqualification	§245C.14
Disqualifying Crimes or Conduct	§245C.15
Disqualified Individual's Risk of Harm	§245C.16
Notice of Background Study Results	§245C.17
Obligation to Remove Disqualified Individual from Direct Contact	§245C.18
Termination of Affiliation Based on Disqualification Notice	§245C.19
License Holder Record Keeping	§245C.20
Requesting Reconsideration of Disqualification	§245C.21
Review and Action on a Reconsideration Request	§245C.22
Commissioner's Reconsideration Notice	§245C.23
Disqualification; Bar to Set Aside a Disqualification; Request for Variance	§245C.24
Consolidated Reconsideration of Maltreatment Determination and Disqualification	§245C.25
Reconsideration of Disqualification for an Individual Living in a Licensed Home	§245C.26
Fair Hearing Rights	§245C.27
Contested Case Hearing Rights	§245C.28
Conclusive Determinations or Dispositions	§245C.29
Variance for a Disqualified Individual	§245C.30
Notification of Set-Aside or Variance	§245C.301
Individual Regulated by a Health-Related Licensing Board; Disqualification Based on Maltreatment	§245C.31
System and Records	§245C.32
Adoption Background Study Requirements	§245C.33
Adoption and Child Foster Care Background Studies; Tribal Organizations	§245C.34
Home and Community-Based Services Standards	Chapter 245D[50]
Citation	§245D.01
Definitions	§245D.02
Applicability and Effect	§245D.03
Service Recipient Rights	§245D.04
Health Services	§245D.05
Protection Standards	§245D.06
Service Needs	§245D.07
Record Requirements	§245D.08
Staffing Standards	§245D.09
Policies and Procedures	§245D.10
Services for Persons with Developmental Disabilities *TEFRA,* *Day Training & Habilitation*	Chapter 252
State Hospitals for Persons with Developmental Disabilities - *METO*	§252.025
Provision of Residential Services	§252.038
Children's Services; Parental Contribution - *TEFRA*	§252.27

[50] Chapter 245D was created by MN Laws 2012, Chapter 216, Article 18, Sections 16-25. The Revisor of Statutes website has not been updated to include the new chapter as of this report's writing (August 2012).

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Program Name/Description	MN Statutes (2011)
Semi-Independent Living Services for Persons with Developmental Disabilities	§252.275
Commissioner of Human Services; Duties	§252.28
ICF/MR Local System Needs Planning	§252.282
Criteria for Downsizing of Facilities - *ICF/DD Downsizing*	§252.294
Family Support Grant	§252.32
Service Principles and Rate-Setting Procedures - *Day Training & Habilitation*	§252.40
Definitions - *Day Training & Habilitation*	§252.41
Service Principles - *Day Training & Habilitation*	§252.42
Commissioner's Duties - *Day Training & Habilitation*	§252.43
Supported Employment Services; Departmental Duties; Coordination	§252.431
County Board Responsibilities - *Day Training & Habilitation*	§252.44
Vendor's Duties - *Day Training & Habilitation*	§252.45
Business Agreements; Support and Supervision of Disabled Persons *Day Training & Habilitation*	§252.451
Payment Rates - *Day Training & Habilitation*	§252.46
State-Operated Programs	§252.50
Developmental Disability Protection *Guardianship*	Chapter 252A
Policy and Citation	§252A.01
Definitions	§252A.02
Nomination of Commissioner as Guardian or Conservator	§252A.03
Comprehensive Evaluation	§252A.04
Commissioner's Petition for Appointment as Public Guardian or Public Conservator	§252A.05
Petition for Appointment of Public Guardian or Public Conservator	§252A.06
Filing of Comprehensive Evaluation	§252A.07
Notice of Hearing	§252A.081
Appointment of Counsel	§252A.09
Hearing	§252A.101
Powers and Duties of Public Guardian or Conservator	§252A.111
Appointment of Conservator Not a Finding of Incompetency	§252A.12
Commissioner as Advisor	§252A.14
Annual Review	§252A.16
Effect of Succession in Office	§252A.17
Transfer of Venue	§252A.171
Modification of Conservatorship; Restoration to Legal Capacity	§252A.19
Costs of Hearings	§252A.20
General Provisions	§252A.21
Human Services	Chapter 256
Vulnerable Adult Maltreatment Review Panel	§256.021
Consumer Support Grant	§256.476
Disabled Person; Definition	§256.481
Council on Disability - *Minnesota State Council on Disability*	§256.482
Report Regarding Programs and Services for People with Disabilities	§256.4825
Purchase of Continuation Coverage for AIDS Patients	§256.9365
Services for Deaf	§256.971
Office of Ombudsman for Long-term Care; Local Programs	§256.974

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Program Name/Description	MN Statutes (2011)
Definitions	§256.9741
Duties and Powers of the Office - *Office of Ombudsman for Long-term Care*	§256.9742
Office Data - *Office of Ombudsman for Long-term Care*	§256.9744
Minnesota Board on Aging	§256.975
Senior Nutrition Programs	§256.9752
Volunteer Programs for Retired Senior Citizens	§256.9753
Community Services Development Grants Program	§256.9754
Foster Grandparents Program	§256.976
Senior Companion Program	§256.977
Reverse Mortgage Proceeds Disregarded	§256.99
Medical Assistance (MA) for Needy Persons	Chapter 256B
Medical Assistance Reform Waiver - *Reform 2020 Authority*	§256B.021
Managed Care	§256B.035
Duties of State Agency - *DHS*	§256B.04
Eligibility Categories - *MA Eligibility Categories*	§256B.055
Eligibility Requirements - *MA Income and asset guidelines*	§256B.056
Eligibility Requirements for Special Categories *Infants & Pregnant Women* *Employed Persons with Disabilities*	§256B.057
Long-term Care Partnership Program	§256B.0571
Availability of Income for Institutionalized Persons	§256B.0575
Treatment of Income of Institutionalized Spouse	§256B.058
Treatment of Assets When a Spouse is Institutionalized	§256B.059
Payment of Benefits from an Annuity	§256B.0594
Mental Health Case Management	§256B.0596
Mental Health Certified Peer Specialist	§256B.0615
Covered Services: Targeted Care Management Services	§256B.0621
Intensive Rehabilitative Mental Health Services	§256B.0622
Adult Rehabilitative Mental Health Services Covered	§256B.0623
Adult Crisis Response Services Covered	§256B.0624
Covered Services *Services covered under the state plan including: Medical care, Personal care assistance, Mental health case management, Day treatment services*	§256B.0625
Cost Sharing	§256B.063
Medical Assistance Co-Payments	§256B.0631
Home Care Services	§256B.0651
Authorization and Review of Home Care Services	§256B.0652
Home Health Agency Services	§256B.0653
Private Duty Nursing	§256B.0654
Consumer-Directed Home Care Project	§256B.0656
Self-Directed Supports Option	§256B.0657
Housing Access Grants	§256B.0658
Personal Care Assistance Program	§256B.0659
Performance Reporting and Quality improvement System	§256B.072
Health Care Homes	§256B.0751
Long-Term Care Consultation Services	§256B.0911
Alternative Care Program	§256B.0913

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Program Name/Description	MN Statutes (2011)
Medicaid Waiver for Elderly Services	§256B.0915
Expansion of Home and Community-Based Services	§256B.0916
Seniors' Agenda for Independent Living (SAIL) Projects	§256B.0917
Employee Scholarship Costs	§256B.0918
Adult Foster Care and Family Adult Day Care	§256B.0919
Services for Persons with Developmental Disabilities *Developmental Disabilities Waiver Program*	§256B.092
Targeted Case Management Services	§256B.0924
Admission Review Team; Intermediate Care Facilities	§256B.0926
Statewide Caregiver Support and Respite Care Project	§256B.0928
Services for Persons with Traumatic Brain Injuries	§256B.093
Child Welfare Targeted Case Management Services	§256B.094
Children's Therapeutic Services and Supports	§256B.0943
Children's Mental Health Crisis Response Services	§256B.0944
Services for Children with Severe Emotional Disturbance	§256B.0945
Treatment Foster Care	§256B.0946
Intensive Rehabilitative Mental Health Services	§256B.0947
Foster Care Rate Limits	§256B.0948
Quality Assurance System Established	§256B.095
Quality Assurance Commission	§256B.0951
County Duties; Quality Assurance Teams	§256B.0952
Quality Assurance Process	§256B.0953
Certain Persons Defined as Mandated Reporters	§256B.0954
Duties of the Commissioner of Human Services	§256B.0955
Quality Management, Assurance, and Improvement System for Minnesotans Receiving Disability Services	§256B.096
State Quality Assurance, Quality Improvement, and Licensing System	§256B.097
Claims Against Estates	§256B.15
Payments to Certified Facilities - *Nursing Facilities*	§256B.25
Agreements with Other State Departments	§256B.26
Personal Needs Allowance; Persons in Certain Facilities *Skilled Nursing Facilities* *Intermediate Care Facilities*	§256B.35
Special Personal Allowance for Certain Individuals *Nursing Facilities* *Intermediate Care Facilities*	§256B.36
Private Insurance Policies, Causes of Action	§256B.37
Intent - *Nursing Facility Rates*	§256B.41
Compliance with State Statutes - *Nursing Facility Rates*	§256B.411
Definitions - *Nursing Facility Rates*	§256B.421
Rate Determination - *Nursing Facility Rates*	§256B.431
Long-Term Care Facilities; Office Costs *Nursing Facility Rates*	§256B.432
Ancillary Services - *Nursing Facility Rates*	§256B.433
Alternative Payment Demonstration Project -*Nursing Facility Rates*	§256B.434
July 1, 2001, Nursing Facility Reimbursement System - *Nursing Facility Rates*	§256B.435
Voluntary Closures; Planning -*Nursing Facility Rates*	§256B.436
Nursing Facility Voluntary Closure; Alternatives -*Nursing Facility Rates*	§256B.437
Implementation of a Case Mix System - *Nursing Facility Rates*	§256B.438

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Program Name/Description	MN Statutes (2011)
Long-Term Care Quality Profiles -*Nursing Facility Rates*	§256B.439
Recommendation for a New Reimbursement System - *Nursing Facility Rates*	§256B.440
Value-Based Nursing Facility Reimbursement System *Nursing Facility Rates*	§256B.441
Nonallowable Costs; Notice of Increases -*Nursing Facility Rates*	§256B.47
Conditions for Participation -*Nursing Facility Rates*	§256B.48
Home and Community-Based Service Waivers for the Disabled *Community Alternative Care Waiver, Community Alternative for Disabled Individuals Waiver, Brain Injury Waiver*	§256B.49
Waivered Services	§256B.491
Home and Community-Based Waivers; Providers and Payment	§256B.4912
Nursing Facility Receivership Fees	§256B.495
Appeals - *Nursing Facilities*	§256B.50
Rates for Community-Based Services for Disabled	§256B.501
ICF/DD Reimbursement System Effective October 1, 2000	§256B.5011
ICF/DD Payment System Implementation	§256B.5012
Payment Rate Adjustments	§256B.5013
Financial Reporting	§256B.5014
Pass-Through of Other Services Costs	§256B.5015
ICF/DD Managed Care Option	§256B.5016
Nursing Homes; Cost of Home Care	§256B.51
Attendants to Ventilator-Dependent Recipients	§256B.64
Prepaid Health Plans	§256B.69
County-Based Purchasing	§256B.692
State-Operated Services; Managed Care	§256B.693
Reimbursement for Mental Health Services	§256B.761
Reimbursement for Health Care Services	§256B.762
Critical Access Mental Health Rate Increase	§256B.763
Coordinated Service Delivery System for Disabled	§256B.77
Mental Health Provider Appeal Process	§256B.81
Prepaid Plans and Mental Health Rehabilitative Services	§256B.82
Disabled Persons	Chapter 256C
Position of the State with Regard to the Blind and Disabled	§256C.01
Public Accommodations	§256C.02
Housing Accommodations	§256C.025
Blind of Deaf Pedestrians; Civil Liability	§256C.03
Proclamation by Governor	§256C.04
Criminal Penalty	§256C.05
Citation	§256C.06
Deaf and Hard-of-Hearing Services Act; Citation	§256C.21
Definitions	§256C.23
Duties of State Agencies - *Deaf and Hard of Hearing Services Division*	§256C.233
Regional Service Centers	§256C.24
Interpreter Services	§256C.25
Employment Services	§256C.26
Services for Deafblind Persons	§256C.261
Commission on Deaf, Deafblind, and Hard of Hearing Minnesotans	§256C.28

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Program Name/Description	MN Statutes (2011)
Communications Devices Required in Bus Terminals	§256C.29
Duties of Human Services Commissioner	§256C.30
Unitary Residence and Financial Responsibility	Chapter 256G
Application; Citation; Coverage	§256G.01
Definitions	§256G.02
Establishing Residence	§256G.03
Determination of Residence	§256G.04
Responsibility for Emergencies	§256G.05
Detoxification Services	§256G.06
Moving to Another County	§256G.07
Reimbursement Responsibility for Commitments	§256G.08
Determining Financial Responsibility	§256G.09
Derivative Settlement	§256G.10
No Retroactive Effect	§256G.11
Statute of Limitations	§256G.12
Group Residential Housing	Chapter 256I
Citation	§256I.01
Purpose	§256I.02
Definitions	§256I.03
Eligibility for Group Residential Housing Payment	§256I.04
Monthly Rates	§256I.05
Payment Methods	§256I.06
Respite Care Pilot Project; Family Adult Foster Care	§256I.07
County Share for Certain Nursing Facility Stays	§256I.08
Vulnerable Children and Adults	Chapter 256M
Citation	§256M.01
Definitions	§256M.10
Duties of Commissioner of Human Services	§256M.20
Service Plan	§256M.30
Grant Allocation	§256M.40
Federal Grant Allocation	§256M.50
Duties of County Boards	§256M.60
Fiscal Limitations	§256M.70
Program Evaluation	§256M.80
Counties; Powers, Duties, Privileges	Chapter 373
Peace Officers; Authority; Training; Reporting	Chapter 626
Reporting of Maltreatment of Vulnerable Adults	§626.557
Multidisciplinary Adult Protection Team	§626.5571

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Relevant Minnesota Rules - Long-Term Care and Mental Health Programs

Program Name/Description	Minnesota Rules
Assistance Payments Programs • Hospital MA Reimbursement • General Assistance • General Assistance Eligibility • Administration of the Prepaid MA Program • Commissioner's Consent to Paternity Suit Settlements	Chapter 9500
Health Care Programs • MA Eligibility • MA Payments • Hospital Admissions Certification • Early and Periodic Screening, Diagnosis, and Treatment • Surveillance and Integrity Review Program • Conditions for MA and General Assistance Medical Care Payment • Dept. Health Care Program Participation Requirements for Vendors and HMOs • Family Planning Program	Chapter 9505
Rates for Health Care Facilities • Special Needs Rate Exception for Very Dependent Persons With Special Needs • Medical Care Surcharge	Chapter 9510
State Hospital Administration • Administration of Specified Therapies to State Hospital Patients • Reimbursement for Cost of Care of Patients and Residents in State Facilities • Minnesota Sexual Psychopathic Personality Treatment Center	Chapter 9515
Mental Health Services • Community Mental Health Services • Licensing Residential Programs for Adults Who are Mentally Ill • Mental Health Center and Mental Health Clinic Standards • Case Management for Children with Severe Emotional Disturbance	Chapter 9520
Programs for Persons with Developmental Disabilities • Case Management Services • Daytime Activity Centers • Grants for Providing Semi-Independent Living Services • Training and Habilitation Reimbursement Procedures for ICF/DD's • Licensure of Training and Habilitation Services • Funding and Administration of Home and Community-Based Services • Use of Aversive and Deprivation Procedures in Licensed Facilities • Public Guardianship of Persons with Mental Retardation	Chapter 9525
Programs Grants; Persons Who Are Mentally Ill • Residential Services for Adults Who Are Mentally Ill • Family Community Support Service	Chapter 9535
Licensure of Programs • Family Day Care and Adult and Child Foster Care	Chapter 9543
Nursing Facility Payment Rates	Chapter 9549
Payment; Intermediate Care Facilities	Chapter 9553

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Program Name/Description	Minnesota Rules
• Determination of Payment Rates for ICF/DD	
Residential Programs and Services for Physically Disabled	Chapter 9570

APPENDIX B: State Agencies, Descriptions, Roles and Responsibilities

Acronym	Agency Description, Roles and Responsibilities
DHS	**Department of Human Services** (DHS) performs several important functions, including: • Administration of publicly funded LTSS and community mental health services; • Direct service provision to people with mental illness, chemical dependency, and disabilities. State-operated services typically serve people who private providers have had difficulty serving; • Licensure of adult foster care providers and community mental health residential treatment providers • Administration of programs that help low-income individuals meet basic needs; • Administration of two publicly funded programs that support housing for people with disabilities
MDH	**Minnesota Department of Health** (MDH) licenses, certifies, and registers many long term care providers including nursing facilities, ICFs/MR, and home health agencies, including home health agencies that provide assisted living services in registered housing with services establishments. Minnesota registers housing sites that provide housing with services, and has a separate licensure process for providers that furnish services. MDH also manages health improvement initiatives for people with chronic conditions and a program for Children with Special Health Care Needs funded through Title V of the Social Security Act.
	Minnesota Housing Finance Agency (Minnesota Housing) provides rental assistance to help older adults and people with disabilities afford housing; development assistance to increase the supply of affordable and accessible housing; and offers home improvement loans for eligible homeowners that can improve housing accessibility.
MDE	**Minnesota Department of Education** (MDE) oversees special education services, the largest public funding source for services to children with disabilities
DEED	**Department of Employment and Economic Development** (DEED) determines eligibility for disability-related income support from the Social Security Administration; administers Federal and state programs for vocational rehabilitation services to adults and transition-age youth with all types of disabilities; and administers Federal and state grants for independent living services.
MnDOT	**Minnesota Department of Transportation** (MnDOT) funds public transit programs in 80 of the 87 Minnesota counties, including accessible transit programs for older adults and people with disabilities in the Duluth, Moorhead, Rochester, Saint Cloud, and Twin Cities areas.[51]
MSCOD	**Minnesota State Council on Disabilities** advises the Governor, the Legislature, state

[51] MN Department of Transportation *Minnesota Statewide Transportation Plan: Moving People and Freight from 2003 to 2023* August 2003

	agencies, and others about legislation and policies that affect Minnesotans with disabilities.
	Minnesota Governor's Council on Developmental Disabilities provides information, education and training to promote the independence and inclusion of people with developmental disabilities.
	Minnesota State Advisory Council on Mental Health advises the Governor and heads of departments and agencies about policy, programs, and services affecting people with mental illness.
	Minnesota Office of the Ombudsman offices advocate for the rights, health, and welfare of individuals who need long-term support services. • **Office of Ombudsman for Mental Health and Developmental Disabilities** is an independent state agency that advocates for people with mental illness, developmental disabilities, chemical dependency and emotional disturbance. • **Office of Ombudsman for Long-Term Care** (part of the Minnesota Board on Aging) advocates for people who receive nursing facility, home health, HCBS waivers, and other long-term care services. • **Office of the Ombudsman for State Managed Care Programs** operates within DHS and helps people enrolled in a publicly funded managed health care plan.

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APPENDIX C: Services Provided by Waivers and Alternative Care

Service Provided	CAC	CADI	BI	DD	EW	AC
24-Hour Emergency Assistance		X	X	X		
Adult Companion Services		X	X		X	X
Adult Day Care	FADS only	X	X	X	X	X
Adult Day Care Bath		X	X	X	X	X
Assistive Technology				X		
Behavioral Programming (being renamed to Behavioral Support) • Behavior Professional • Behavior Analyst • Behavior Specialist • Behavior Aide (being eliminated)		on hold NO	X			
Caregiver Living Expenses		X	X	X		
Caregiver Training & Education				X	X	X
Case Management	X	X	X	X	X	X
Case Management Aide	X	X	X		X	X
Chore Service		X	X	X	X	X
Consumer Directed Community Supports (CDCS)	X	X	X	X	X	X
Consumer Training and Education				X		
Crisis Respite				X		
Customized Living Services		X	X		X	
Customized Living Services, 24-Hour		X	X		X	
Day Training and Habilitation				X		
Environmental Accessibility Adaptations	X	X	X	X	X	X
Extended Home Health Care Services: • Extended home health aid • Extended nursing services (LPN & RN) • Extended therapies (OT, PT, Speech and RT)	X X	X X			X	
Extended Personal Care Assistance	X	X	X	X	X	
Extended Private Duty Nursing	X	X	X		X	
Family Adult Day Services (FADS)	Included in Adult Day Care				X	X
Family Training and Counseling	X	X	X	X		
Foster Care	X	X	X		X	
Home Delivered Meals	X	X	X	X	X	X
Home Health Services (AC Program only): • Home health aide • Nursing services (LPN & RN) • Personal care assistance • Skilled nurse visits						X

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Service Provided	CAC	CADI	BI	DD	EW	AC
• Tele-homecare						
Homemaker	X	X	X	X	X	X
Housing Access Coordination		X	X	X		
ILS Therapies			X			
Independent Living Skills (ILS) Training		X	X			
Night Supervision Services			X			
Nutritional Services						X
Personal Support				X		
Prevocational Services		X	X	not yet		
Residential Care Services		X	X		X	
Residential Habilitation (In-Home Family Support, Supported Living Services)				X		
Respite	X	X	X	X	X	X
Specialist Services				X		
Specialized Supplies and Equipment	X	X	X		X	X
Structured Day Program			X			
Supported Employment Services		X	X	X		
Transitional Services	X	X	X	X	X	
Transportation	X	X	X	X	X	X

NOTE: Caregiver Training & Education and Consumer Training & Counseling are being consolidated into Family Training & Counseling. Once approved in the DD waiver, the 2 yellow highlighted services will be eliminated for DSD, but will still exist for EW and AC

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APPENDIX D: Historical Summary of Waiver Allocation Limits

The tables below provide a historical summary of the allocation limits for the Developmental Disability (DD) Waiver, and the Brain Injury (BI) and Community Alternatives for Disabled Individuals (CADI) waivers, by fiscal year.

DD historical waiver limits

Calendar Year	DD (new allocations per year)
2004	50
2005	50
2006	50
2007	50
2008	50
2009	No limits (forecasted 300)
2010	180
2011	72
2012 (fiscal year)	72
2013 (fiscal year)*	72
2014 (fiscal year)*	180
2015 (fiscal year)*	180

* these are future limits that passed during the 2011 legislative session

BI and CADI historical waiver limits

Fiscal Year	BI waiver (new allocations per year)	CADI waiver (new allocations per year)
2004	150	1140
2005	150	1140
2006	150	1140
2007	150	1140
2008	150	1140
2009	No limits	No limits
2010	150	1140
2011	72	720
2012	No limits	720
2013*	No limits	720
2014*	No limits	1020
2015*	No limits	1020

* these are future limits that passed during the 2011 legislative session

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