Admin Minnesota
DEPARTMENT OF ADMINISTRATION

MINNESOTA GOVERNOR'S COUNCIL ON DEVELOPMENTAL DISABILITIES

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PUBLIC POLICY COMMITTEE

MINNESOTA GOVERNOR'S COUNCIL
ON DEVELOPMENTAL DISABILITIES

Wednesday, April 7, 2004
9:30 a.m.-11:30 a.m.
Continuing Education and Conference Center
University of Minnesota, St Paul Campus
1890 Buford Avenue, St. Paul, Minnesota 55108

CONFERENCE ROOM 155

MINUTES

MEMBERS PRESENT

Pat Tietz, Chair
Peg Booth
Ella Gross
Anne Henry

Kathryn Jacobson
Sherri Larson
Shamus O'Meara
Dan Reed
Ordean Rosaasen
Jeff Skwarek
Sarah Thorson
Ann Zick

STAFF PRESENT

Colleen Wieck

MEMBERS EXCUSED

Sharon Heuring

GUESTS

Deborah Denning, Interveener for Jeff Skwarek
Karen Giese
Dan Giese
Jody Hauer, Office of the Legislative Auditor
Tony Hudson, PCA for Jeff Skwarek
Steve Larson, The Arc of Minnesota
Jan Sandberg, Office of the Legislative Auditor

I. CALL TO ORDER

Pat Tietz, Chair, called the meeting to order at 9:30 a.m.

II. INTRODUCTIONS

Everyone present introduced themselves.

III. APPROVAL OF AGENDA

Tietz asked for approval of the Agenda.

MOTION: Rosaasen moved, seconded by Skwarek to approve the Agenda. Motion carried unanimously.

IV. APPROVAL OF MINUTES OF FEBRUARY 4, 2004

Tietz asked for approval of the Minutes as written for February 4, 2004.

MOTION: Jacobson moved, seconded by Rosaasen to approve the Minutes as written for February 4, 2004. Motion carried unanimously.

V. FINDINGS OF THE WAIVER STUDY

Jody Hauer and Jan Sandberg, Office of the Legislative Auditor, distributed three handouts: the official report of the program evaluation, a PowerPoint summary of the report, and an evaluation report summary of major findings. Jody then presented a PowerPoint summary of the report.

The following is a summary of the questions and discussion by the Committee members:

Q: What are the key factors that contribute to the growth in expenditures for the past 12 years?

A: Caseload growth and average costs.

Q: Why did the study use the overall inflation rate rather than a health care inflation rate?

A: Because of the type of services purchased with the waiver. The services are not medical.

Q: What was the overall growth rate of Medicaid?

A: Fourteen (14) percent.

Q: Isn't it possible that the waiver growth rate is less than the inflation rate for Medicaid or the inflation rate for health care expenditures?

A: There is no index specific to long-term care.

Q: When you look at the decisions that Minnesota has made, specifically, to close institutions and use the waiver aggressively, then we chose to spend our money serving more people in non-institutional settings. If we had not made that decision then MN would be spending more money on institutions today than it is.

A: Each state sets its own package of waiver services.

Q: Our state addressed the waiting list during the Ventura administration unlike other states that have long waiting lists. The graphic in this presentation does not tell the complete story.

A: The graphic shows that 12,000 people were added to the waiver in the last 12 years and that institutional use decreased during that same period.

Q: If Minnesota had continued the growth of institutions, we would be spending as much or more than we are today.

Q: How do you define institutions?

A: Institutions include regional treatment centers and community ICFs/MR (group homes).

Q: We need another line on this graph to show the impact of the sound decision making in the early 1980s to pursue the waiver. As a result of that decision, we are serving more people at the same or less cost.

Q: Would 12,000 people have been institutionalized if it had not been for the waiver? The people might be eligible because of their disability or

they may have qualified for institutional care, but would people actually have been placed?

A: During open enrollment, many five and six year olds were added to the waiver. These children would have probably stayed with their families.

Q: But older children, 15 and 16 year olds might have been placed in four bed ICFs/MR. The picture given by this report is that the waiver growth is out of control. That picture is not complete or accurate.

Q: Families have been told for years to sign up for the waiver because of the waiting list. Because of better and earlier diagnostics, survival rates, and greater information, people did enroll.

A: The waiting list is back up to 4,000 people.

Q: In some counties, people can be on the waiver, but they don't receive any services.

A: During the evaluation we did discover very low expenditures for some people.

Q: Funding allocations do not seem to recognize changes such as the number of students leaving schools to become employed or receive day services.

Q: Regarding the statements about CDCS expenditures, how many people out of the sample of 170 cases purchased season tickets?

A: Many people purchased occasional tickets, but I don't have the precise number of season tickets.

Q: The report gives a false impression by not giving exact numbers for season tickets.

Q: Did you compare these questionable expenditures with other program audit findings?

A: No, because each program varies.

Q: Sometimes, people with disabilities and families do not know how to write a plan correctly so that it passes these types of tests.

A: The county should be assisting individuals because the county has ultimate responsibility.

Q: In footnote #2, the term mental retardation is used. Why are we using out of date language? We need to change the term mental retardation to intellectual disability or developmental disabilities. These statutes need to be amended.

A: That's up to the Legislature. If the term developmental disabilities is used, then there may be some winners and losers. The replacement of mental retardation with intellectual disability has occurred internationally. There are some policy briefs on this topic that can be shared.

Q: Regarding the face to face monitoring visits, did the person with a disability or family member refuse to allow the case manager to visit?

A: Don't know.

Jody Hauer was thanked for her time and effort and her presentation to the Committee today.

Steve Larson announced that Rep. Bradley would be doing followup work on this report and that the Public Policy Committee should stay involved. Larson later said that Representative Bradley is reviewing funding for the waiver and a comprehensive study that would be comparable to the 2030 study or something similar to that study.

VI. STATE LEGISLATIVE UPDATE

Anne Henry distributed a copy of a side by side comparison of the Supplemental Budget on disability and health items, and Legislative action taken to date. She then discussed several items including METO, the implementation date of the poverty guidelines, the University of Minnesota Dental School requirements of $750 cash in advance, the use of the term disease management, and the implementation of the Olmstead decision.

Steve Larson from The Arc of Minnesota updated the Committee about the special education changes. He said there is no growth rate for special education and there may be a task force established to look at aversive deprivation procedures in school settings.

VII. INTERAGENCY REPORTS AND UPDATES

State Independent Living Council (SILC): Zick reported that the SILC will meet on April 8-9, 2004 to discuss the development of the State Plan. Implementation of the Olmstead decision is the top priority.

State Quality Design Commission: Skwarek has been ill and unable to attend meetings. There has not been that much activity.

State Solutions (Dual Eligibility & Medicare Savings Program): Wieck distributed copies of the latest marketing flyer from the Department of Human Services (DHS).

She also distributed copies of a Special Care in Dentistry journal.

She described the final press conferences and next steps for the Citizens Forum on Health Care Costs.

Several letters have been sent to Congress and state legislators in response to action alerts.

VIII. OTHER BUSINESS

Anne Henry asked that everyone look at the new waiver provisions for the CADI, TBI, and CAC waivers at the DHS web site. Comments will be taken until April 30, 2004. Peg Booth will send the web site link.

IX. ADJOURNMENT

MOTION: Rosaasen moved, seconded by Jacobson to adjourn the meeting. The meeting was adjourned at 11:30 a.m.

Respectfully submitted,

Colleen Wieck

Colleen Wieck
Executive Director

APPENDIX A

MINNESOTA CITIZENS FORUM ON HEALTH CARE COSTS

ISSUES AND SUGGESTIONS FOR IMPROVING DELIVERY OF HEALTH CARE SERVICES

Minnesota Governor's Council on Developmental Disabilities (GCDD)
December 4, 2003

On Wednesday, December 3, 2003 at a regular meeting of the GCDD, a portion of the meeting time was devoted to a discussion and brainstorming session on health care and delivery system issues. We are submitting the following to you for consideration together with input gathered through the Town Hall Meetings to address health care reform in Minnesota.

1. All people, including people with disabilities, should have equitable access to health care and dental care services. Access means/refers to location of the service, cost, timeliness in providing the service, proximity to transit/transportation, and knowledgeable/competent health care professionals.

2. All health care providers should be nonprofit organizations.

3. There should be no elitism in access to, availability, or delivery of health care and dental services.

4. Encourage universal participation in health care through large purchasing pools.

5. Acute care and long term care services should be combined.

6. Increase the number of people in professional education programs (some programs, such as physical therapy and occupational therapy, accept a very limited number of students).

7. Increase and ensure that health care professionals who provide services for people with disabilities receive the proper training.

8. Reduce administrative costs.

9. Increase access to, and reduce wait times and loopholes in obtaining durable medical equipment.

10. Reduce duplication.

11. Increase the quality of health care practices through the use of technology.

12. Eliminate the pre-existing condition exclusion.

13. Control drug company profits.

14. Promote wellness; provide incentives for improving one's personal health and well being.

15. People with disabilities should have full access to all aspects of health care, including primary care, preventive care, and specialty care.

16. Eliminate waste resulting from redundant visits to get to a specialist.

17. Increase habilitative services.

18. Stop pharmaceutical incentives to doctors.

19. Five year patent protection for prescription drugs.

20. Provide more health care education.

21. Reintroduce house calls.

22. Provide full access to preventive health care for people with disabilities.

23. Break up the power of insurance companies.

24. Refocus from high tech to common sense.

25. Don't reduce specialty care to promote primary care.

26. Health care reform efforts should result in the "majority" health care system serving people with disabilities. The current system does not.

27. The loser should pay in tort reform efforts.

28. Provide better pain control at end of life.

29. Stop blaming.

30. Stop the myth of the magic pill.

31. Promote wellness in one's home environment, how to live well.

32. Smarter use of health care dollars and health care systems.

33. Better psychic prediction of end of life to reduce costs.

Of the above items, numbers 1, 4, 5, 15, 16, 17, 18, 24, 31, and 32 were identified as priorities.