RECENT CHANGES TO MINNESOTA'S MEDICAID WAIVER PROGRAMS

In 2003, the Legislature further restricted new openings for the MR/RC Waiver program and limited caseload growth for the Traumatic Brain Injury and Community Alternatives for Disabled Individuals Waiver programs.

The 2003 Legislature enacted changes limiting increases in enrollment and reducing spending for the Medicaid Home and Community-Based Waiver programs. The Legislature limited enrollment in the Community Alternatives for Disabled Individuals Waiver program to a maximum average caseload growth of 95 per month, and it capped the Traumatic Brain Injury Waiver program caseload growth at 150 per year of the biennium.[26] Another change to the MR/RC Waiver program prohibited allocating 300 diversion openings in each year of the 2004-05 biennium. The Legislature reduced county budgets to achieve a 1 percent reduction in MR/RC Waiver program spending. In addition, legislators reduced provider payment rates 1 percent for the Elderly Waiver program, as well as 1 percent for the Community Alternative Care, Community Alternatives for Disabled Individuals, and Traumatic Brain Injury Waiver programs to achieve a 1 percent reduction in state waiver program spending.

Open Enrollment

In 1999, the Legislature passed a law to reduce or eliminate the waiting list for the MR/RC Waiver program (3,300 persons at the time).[27] It increased funding to add an additional 100 persons (for a total of 300) to the waiver program each year. Further, the Legislature required the Department of Human Services to reallocate any waiver program money unused by persons wishing to leave ICFs-MR to other persons on the waiting list. Legislators also designated one-half of the increase in waiver program funding between fiscal years 2000 and 2001 toward serving persons other than those affected by ICF-MR closures. At about the same time, a report commissioned by the Department of Human Services raised concerns about the MR/RC Waiver program's long waiting list, among other issues.

In response to the 1999 legislative requirements, the department instituted "open enrollment," a three-month period from late March through June of 2001 when the state opened the waiver program to all eligible applicants. Counties, waiver

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26 *Laws of Minnesota* (1Sp2003), ch. 14, art. 13C, sec. 2, subd. 9 (f).

27 *Laws of Minnesota* (1999), ch. 245, art. 4, sec. 61, subd. 1 (a). The 2002 Legislature subsequently repealed the subdivision to reduce the waiting list. See *Laws of Minnesota* (2002), ch. 220, art. 14, sec. 20.

28 Amy Hewitt, Sheryl A. Larson, and K. Charlie Lakin, *An Independent Evaluation of the Quality of Services and System Performance of Minnesota's Medicaid Home and Community Based Services for Persons with Mental Retardation and Related Conditions, Executive Summary Report #55* (Minneapolis: University of Minnesota, College of Education and Human Development, Research and Training Center on Community Living, Institute on Community Integration, November 2000), 55. Other recommendations addressed concerns about the need for alternatives to foster care provided by corporations rather than individuals, the shortage and turnover of direct support staff, and a need to improve the system for monitoring and assuring quality of services.

The 2001 open enrollment for the MR/RC Waiver program significantly increased the program's caseload.

program applicants, their families, and advocates for persons, with developmental disabilities responded in an unprecedented fashion to inform and then enroll eligible individuals. About 5,500 new recipients enrolled according to the department, more than a 50 percent increase in the caseload.[29] Many of the children currently served by the MR/RC Waiver program joined the program during open enrollment. In fiscal year 2002, some 3,500 children about two-thirds of whom started during open enrollment, were enrolled in the MR/RC Waiver program.

Consumer-Directed Community Supports

In late 1997, the Department of Human Services received federal approval to add to the MR/RC Waiver program a component called Consumer-Directed Community Supports. With Consumer-Directed services, waiver recipients take direct responsibility for planning and managing their care. They have the option of choosing what services to purchase and whether to use informal providers such as neighbors or family. Participants in Consumer-Directed Community Supports have access to certain services that neither Medicaid nor the regular waiver program covers. According to our survey, 33 counties offered Consumer-Directed services in 2003 (although in 5 counties, no waiver recipients used the services.) Counties have been operating the Consumer-Directed option using procedures spelled out in memoranda of understanding that each county individually developed and had approved by the department.

Consumer-Directed Community Supports allow MR/RC Waiver recipients in certain counties to control their services and who provides them.

In line with a 1999 U.S. Supreme Court decision, the intent of Consumer-Directed services is to individualize services and give waiver recipients greater control over them. In the 1999 ruling on the Olmstead v. L.C. case, the U.S. Supreme Court said that services for persons with mental disabilities should be provided in the most integrated setting appropriate to the needs of the person.[30] Increasing waiver recipients' self-reliance is one of the Minnesota Department of Human Services' objectives for Consumer-Directed

Services for persons with mental disabilities are to be provided in the most integrated setting appropriate to the needs of the person.

29 Minnesota Department of Human Services, *Programs for Persons with Disabilities: Fact Sheets* (St. Paul, November 2002), 2.

30 Centers for Medicare and Medicaid Services, *Americans with Disabilities Act/Olmstead Decision* (Baltimore: Centers for Medicare and Medicaid Services, May 10, 2002); cms.hhs.gov/olmstead/default.asp; accessed December 2, 2003.

services, along with increasing consumer control and choice and improving access to formal and informal resources."

The Department of Human Services awaits federal approval of a proposal to expand the Consumer-Directed option statewide and to use it in other Medicaid Waiver programs.

Since 1998 when Consumer-Directed services first became available in Minnesota, expenditures for these services have expanded dramatically, from just over $44,100 in fiscal year 1998 to nearly $53 million in fiscal year 2002. By fiscal year 2002, counties authorized 3,024 individuals to receive Consumer-Directed services, accounting for 20 percent of all MR/RC Waiver recipients.

In 2001, the Legislature directed the department to expand Consumer-Directed services, and the department plans to make them available in every country. The department has been negotiating a proposal for Consumer-Directed services with *the* federal Centers for Medicare and Medicaid Services, submitted it for final approval in December 2003, and expects to implement it in 2004. The proposal would also extend Consumer-Directed services to the other Home and Community-Based Waiver programs. When implemented, the redesigned Consumer-Directed services for the MR/RC Waiver program will be available initially only in those counties that have previously offered Consumer-Directed services; as experience with the program increases, other counties will offer the option.

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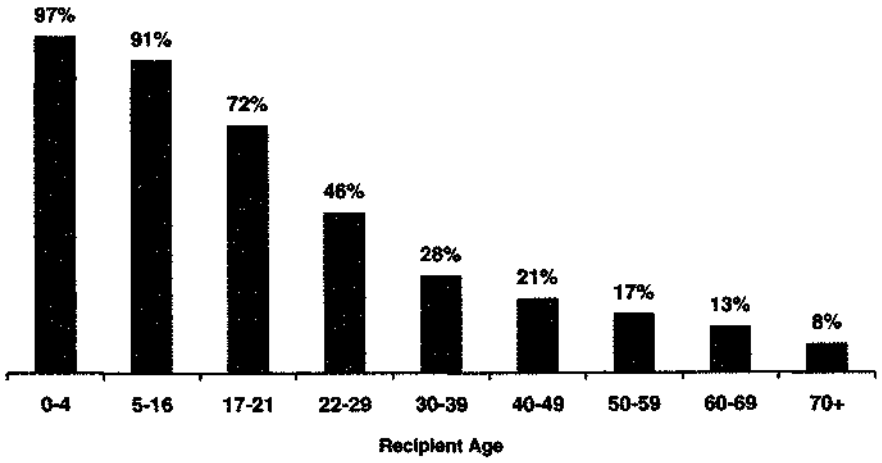
31 Minnesota Department of Human Resources, "The Shift to Increased Consumer Control," *Consumer Directed Community Supports Tool Kit* (St. Paul, 2003), 3.

32 *Laws of Minnesota* (1Sp2001), ch. 9, art. 3, sec. 43.

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

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

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



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

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

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

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

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

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

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

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

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

RECOMMENDATION

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

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

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

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

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

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

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

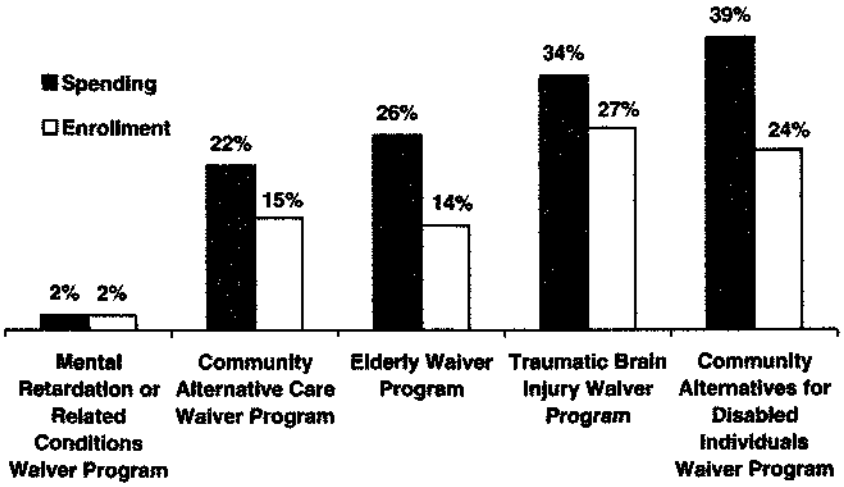
FUTURE WAIVER SPENDING

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

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

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

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



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

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

1. Introduction

The purpose of this report is twofold: to describe the status of the independent evaluation that has been contracted by the Department of Human Services for the Consumer Directed Community Supports service, and to provide very preliminary information relevant to the report requested by the Minnesota state legislature, as stated in Minnesota Laws, Sec. 23.

2. Background on the Consumer Directed Community Supports Service

Consumer directed care represents a growing trend in disability support programs around the country. Briefly defined, consumer directed care means that disabled individuals (and their family members or legal guardians) have greater options to plan, manage, and evaluate the persons, goods, and services they need to maintain independent community living. One of the primary benefits of consumer direction is that it can increase consumers' access to informal supports and services that may be lacking in consistency, quality, or availability. According to a recent report by the National Council of Disabilities, studies of consumer direction "indicate positive outcomes in terms of consumer satisfaction, quality of life, and perceived empowerment. There is no evidence that consumer direction compromises safety—in fact, the opposite appears to be true." To date, the research on the cost effectiveness of consumer directed programs is sparse, and variations in study designs have led to inconclusive results *(ibid, p. 11)*.

In Minnesota, consumer direction is available through four mechanisms: the Consumer Support Grant, the Family Support Grant, the Personal Care Assistance Option, and the Consumer Directed Community Support (CDCS) service. The CDCS began as a pilot program in three grant demonstration counties in 1998. Over the ensuing five-years, 37 counties signed memoranda of understanding with the Department to offer the CDCS; the option was available only to consumers with mental retardation or related conditions (MR/RC) receiving a Medicaid Home and Community-Based (HCBS) waiver.

In December of 2003, DHS submitted waiver amendments to the federal Centers for Medicare & Medicaid Services to expand CDCS statewide and across all five HCBS waiver groups.[2] These amendments were approved in April of 2004. On October 1, 2004, the new policies were phased in for the 37 currently participating counties. By April 1 of 2005, the CDCS becomes available to approximately 40,000 waiver recipients statewide. As shown in Table 1 (next page), consumer enrollment in all of the waiver programs has climbed over the last five years in Minnesota, reflecting both the state's and the nation's movement to de-institutionalize care for the disabled and elderly by enhancing the community-based delivery support system.

[1] National Council of Disabilities (October, 2004), "Consumer Directed Health Care: How Well Does it Work?" (p. 11).

[2] In addition to the five waiver groups, CDCS is now also available to elderly consumers enrolled in Alternative Care (a State-funded, non Medical Assistance program) and in two health plans: Minnesota Disability Health Options (MnDHO) and Minnesota Senior Health Options (MSHO).

Table 1
Growth in the Number of Minnesotans
Receiving Home and Community Based Waivers (2000-2004)

Waiver Program[3]	FY 2000 Recipients	FY 2001 Recipients	FY 2002 Recipients	FY 2003 Recipients	FY2004 Recipients
MR/RC	8,313	14,031	15,264	15,704	15,090
CAC	128	128	126	165	216
CADI	3,957	4,669	6,022	8,420	9,449
TBI	408	474	603	861	1,202
Elderly	9,772	10,890	11,912	13,405	16,259[4]
Total	**22,578**	**30,192**	**33,927**	**38,555**	**42,216**

Source: MN House Research Department (February 2004), updated with DHS November 2004 forecast.

As enrollment in HCBS waiver programs grew, so did the costs (see Table 2). Between 2000 and 2004, the state's annual payments doubled for each waiver except for the Community Alternative Care (CAC) waiver for chronically ill individuals. As enrollment in the MR/RC waiver and CDCS participation grew, so did the costs (see Table 3).

Table 2
Growth in Annual Payments (State Portion Only)
of HCBC Waiver Programs in Minnesota (2000-2004)

Waiver Program	FY2000 Annual State Payments	FY2004 Annual State Payments
MR/RC	175,156,398	377,559,203
CAC	2,343,599	3,004,654
CADI	9,711,772	47,655,032
TBI	5,864,792	23,951,342
EW (Fee for Service)	17,812,794	52,025,485
EW (Managed Care)	1,800,716	4,692,821

Source: DHS staff, February, 2005 (R. Meyer).

Table 3
Growth in CDCS Enrollments (MR/RC Waiver Only) and Costs (1999-2004)

Fiscal Yr	1999	2000	2001	2002	2003	2004
Enrollment (paid)[5]	100	214	1,435	2,923	3,222	3,112
Average payment[6]	$10,112	$20,837	$58,102	$179,814	$156,113	$136,221
Total year payments	$618,778	$1,271,214	$6,788,401	$52,613,971	$69,668,673	$74,915,866

Source: DHS, Disability Services Division, report generated 11/12/04. Includes consumers in foster care.

[3] CAC= Community Alternative Care for chronically ill individuals; CADI = Community Alternatives for Disabled Individuals; TBI = for persons with traumatic brain injury; EW = elderly persons over 65.
[4] Includes EW fee for service (n = 14,781) and EW managed care (n = 1,478)
[5] Based on the number of individuals for whom payments were paid for the fiscal year
[6] Average cost per unit (person) paid during fiscal year

3. Context for Evaluation

Due to concerns about the rising costs of the MR/RC waiver program and anecdotal reports of unusual cost for CDCS participants, the Legislative Auditor was directed to evaluate the MR/RC waiver program during the fall of 2003. The Auditor's report[7] included a specific assessment of the costs, variation in county spending, and types of expenditures of MR/RC persons participating in the CDCS. Their study included analysis of 267 case files as well as surveys with county administrators. The Auditor's results indicated a lack of "sufficient controls over the [CDCS], leading to questionable purchases, inequitable variation in administration, and unmet prospects for cost efficiencies."[8] Costs for CDCS participants also exceeded those for individuals with comparable functional profiles, as determined by the DHS assessment screening document.

The waiver amendments submitted by DHS in 2003 represented several years of planning and revision of CDCS, undertaken in part to respond to state legislation passed in 2001 that instructed DHS to begin making CDCS available to consumers in all five waiver groups. The proposed policy changes were also crafted to address the same types of concerns as those raised in the Auditor's report, and by other stakeholders as well. The challenge to the Department was to maintain consumer flexibility and control (which is the essence of consumer direction), and at the same time reduce questionable expenditures, obtain greater equity in consumer budgets within and across counties for individuals with the same risk levels and service needs, improve accountability mechanisms, and maintain budget neutrality at the state and county levels.

Significant policy and procedural changes in CDCS were ushered into effect as a result of the amendments. Although lead agencies at the county level are responsible for administering and monitoring the service, state-level oversight has increased. As a result of the amendments:

- Eligibility for CDCS is now limited to people living in their own homes; persons who reside in licensed foster care settings are no longer eligible.
- Each CDCS consumer is required to submit a detailed individual support plan, and all waiver services related to the plan must be paid for out of the consumer's CDCS budget.[9]
- The individual support plan can include conventional and self-designed services, paid and unpaid supports, and personal risk management plans to meet health and safety needs. CDCS services cannot begin until the support plan is approved by the (county) lead agency.

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[7] Office of the Legislative Auditor (February, 2004), Medicaid Home and Community-Based Waiver Services for Persons With Mental Retardation or Related Conditions. St. Paul, MN: Program Evaluation Division.

[8] *Ibid*, p. 42.

[9] Previous MR/RC enrollees in CDCS could also access additional funds for services such as Day Treatment & Habilitation as well as their CDCS funds.

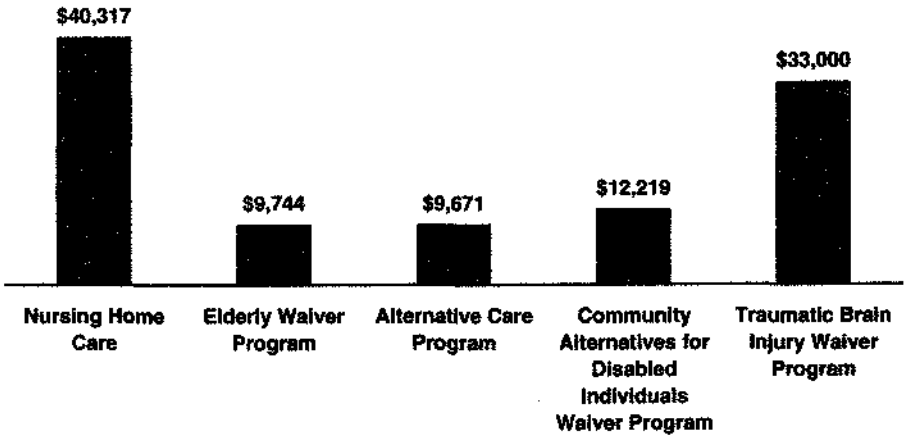
DHS has set new criteria and guidelines on allowable and non-allowable expenses to guide the development of the individual support plan.
A spouse or parent can provide personal assistance and be paid for this assistance for up to 40 hours per week, when other criteria are met.
While counties continue to provide case management for required tasks, consumers (with some exceptions) who need or desire flexible case management for other tasks must pay for it out of their CDCS budget.
Flexible case managers must pass a training course and receive certification from DHS to provide service under CDCS.
Every consumer must have an agreement with a Fiscal Support Entity (FSE) that is an approved Medical Assistance provider. The FSEs are responsible for processing payments to service providers and for approved goods.
Most important, DHS devised and implemented three statewide budget methodologies[10] which set maximum amounts for each individual's budget.[11]
The statewide methodology for MR/RC consumers was based on statistical analyses of factors most predictive of costs in 2003, adjusted to 70% of the statewide average cost of non-CDCS recipients with comparable conditions in the traditional MR/RC waiver program.[12]

Evaluation of how well these policy changes and new controls are working—prior to expanding the program statewide—was one of the Legislative Auditor's specific recommendations to DHS. Additionally, in response to a federal CMS request, the Department agreed to track MR/RC individuals who transition out of the CDCS, and to sponsor an independent evaluation of the CDCS.[13]

Other stakeholder groups invested in the CDCS have also urged an independent evaluation. Consumer families in the MR/RC waiver program and their advocates have lodged ongoing and significant complaints with DHS regarding the statewide budget methodology and the new list of un-allowed expenses; personal testimonies cite serious harm as a result of budget reductions scheduled to take effect in the coming year.[14] Since October 1, 2004, 150 CDCS appeals have been filed; nearly all cite budget reductions or perceived errors in their budget calculations as their main issue. As for county personnel, while supportive of CDCS generally speaking, MR/RC waiver administrators have also voiced concerns with the Department about perceived flaws in the budget methodology and with the process with which the new amendments were crafted and introduced.

[10] As explained later in this report, separate models were developed for MR/RC waiver consumers, EW/AC waiver consumers, and consumers enrolled in CAC/CADI/TBI.
[11] Formerly, each county set the individual consumer budgets based on the county's own policies and management of an aggregate waiver budget allocated by DHS.
[12] As with Minnesota's other MA services, waiver programs are jointly and equally funded by the state's general fund and the federal government. Allocated amounts on a per recipient basis cannot be greater than what would have been spent had the individual been institutionalized.
[13] Letter from Centers for Medicare & Medicaid (Associate Regional Administrator) to DHS, 3-16-04.
[14] The financial transition to new budgets is being phased in for persons whose new budgets are below their former budgets. Such persons have until one year from the date of their next annual review or April 1, 2006 (whichever is earlier) to either revise the support plan within their new budget, or choose to leave CDCS and resume regular waiver services (DHS Letter to County Directors / Administrators, 8-09-05).

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



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

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

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

MR/RC WAIVER ALLOCATIONS TO COUNTIES

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

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

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

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

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

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

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

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

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

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

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

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

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

We found:

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

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

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

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

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

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

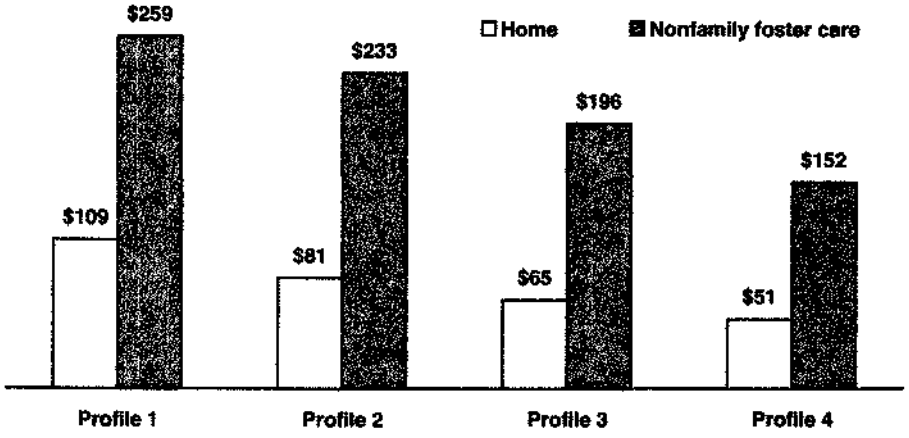
18 This comparison excludes two small counties that did not have any children under age 17 enrolled in the MR/RC Waiver program.

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

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

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

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



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

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

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

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

Introduction

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

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

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

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

- **How much does Minnesota spend on the Medicaid Home and Community-Based Waiver programs? What factors drive spending?**
- **How well does Minnesota's system for allocating MR/RC Waiver program resources to counties work?**
- **Does the state have sufficient controls to ensure that funds are spent appropriately for the component of the MR/RC Waiver program known as Consumer-Directed Community Supports (which allow waiver recipients greater control over their care and service providers)?**

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

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

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

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

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

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

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

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

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

Table 1.1: Minnesota's Medicaid Home and Community-Based Waiver Programs

Waiver Program and Year Started	Targeted Population
Elderly (1982)	People age 65 or older who require a nursing facility level of care.
Mental Retardation or Related Conditions (1984)	People with mental retardation or a related condition who require the level of care provided in an intermediate care facility for persons with mental retardation. Related conditions include cerebral palsy, epilepsy, autism, Prader-Willi syndrome, and any other condition other than mental illness or emotional disturbance that is related to mental retardation in its manifestation or the individual's level of functioning or required treatment.
Community Alternative Care (1985)	People who are chronically ill or medically fragile and who require a level of care provided at a hospital.
Community Alternatives for Disabled Individuals (1987)	People who are disabled and require a nursing facility level of care. Includes individuals with physical disabilities or mental illness.
Traumatic Brain Injury (1992)	People with a traumatic or acquired brain injury that is not congenital, who have significant cognitive and behavioral needs related to the injury, and who require the level of care provided in a specialized nursing facility or neurobehavioral hospital.

SOURCE: Minnesota Department of Human Services, *Health Care Programs Manual (Eligibility Policy) Chapter 0907* (St. Paul, November 2003); http://www.dhs.state.mn.us/HealthCare/reportsmanuals/manualcounty/chapter07.htm#0907.23; accessed December 18, 2003; and Michelle Long, Federal Relations, Health Care Administration, Department of Human Services, interview by author, Telephone conversation, St. Paul, Minnesota, December 12, 2003.

The Legislature restricts the number of new openings each year for the Mental Retardation or Related Conditions Waiver program.

For the MR/RC Waiver program in particular, the state controls both program budgets and the availability of new openings. The Department of Human Services sets county budget allocations annually. The Legislature has controlled the number of new openings available for eligible waiver program enrollees not living in an institution. These openings, called diversion allocations because they divert individuals from entering an institution, numbered 300 per year from 1999 through 2002. At the same time, conversion allocations, so called when individuals leave institutions and an institutional bed is "converted" to one in a community setting, have varied according to the demand for such relocations. There are no limits on the number of conversion allocations because money spent on institutional care transfers instead to community-based care; about 150 conversion allocations occur annually on average.

Counties play many roles in administering the waiver programs, from initially determining eligibility to coordinating service delivery. For persons with mental retardation or a related condition, the county human services agency determines applicants' eligibility using program-specific eligibility criteria (discussed later in this chapter). Once eligibility is determined, the county provides case management services and helps recipients develop individual service plans, which document the individual's needs and goals. County case managers work with each waiver recipient and his or her legal representative to determine the level of

care needed and the services to be provided. By Minnesota Statutes, individual service plans must be tailored to a person's needs and goals.[14] Table 1.2 describes elements that these individual service plans must contain, including the recipients' preferences for services. Another county responsibility is managing contracts with service providers and overseeing provider qualifications and performance. Counties must authorize services by specific providers for waiver recipients and enter recipient and service data into the department's computerized system. They must then ensure that waiver recipients receive the services listed in their plans of care. Counties are also responsible for managing the counties' allocations from the state to pay for the services.

Individual service plans detail MR/RC Waiver recipients' needs and preferences for services.

Table 1.2: Content Required in Individual Service Plans for Mental Retardation or Related Conditions Waiver Recipients, 2003

- Preferences for services as stated by the person or the person's legal representative
- The person's service and support needs based on results of assessment information
- The person's long- and short-range goals
- Specific supports and services to be provided to the person based on available resources, and the person's needs and preferences
- Needed services that are not available and actions to obtain or develop these services
- Whether the provider needs to develop a plan to provide services to the recipient
- Additional assessments to be completed by the provider after initiating service
- A list of any information that providers must submit to the case manager, including how frequently it must be submitted as well as provider responsibilities to implement and make recommendations for modifying the individual service plan
- Notice of the right to request a conciliation conference or a hearing if a person is aggrieved or wishes to appeal an action or decision regarding the waiver program
- Signatures of the person, the person's legal representative, and the case manager at least annually and whenever changes are made
- A health professional's review of the plan if the person has overriding medical needs that impact the delivery of services

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

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13 *Minn. Rules* (2003) ch. 9525.0024, subp. 2. Minnesota Statutes and administrative rules require counties to assemble a service planning team, consisting of the recipient, case manager, the recipient's legal representative or parent if the recipient is a minor, and a qualified mental retardation professional, who may be the case manager if appropriately qualified. See *Minn. Stat.* (2003) §256B.092, subd. 7 and *Minn. Rules* (2003) ch. 9525.0004, subp. 24.

14 *Minn. Stat.* (2003) §256B.092, subd. 1b (1)-(4).