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2015 Biennial Report on Long-Term Services and Supports for People with Disabilities

Disability Services Division

January 2015

Legislative Report

Minnesota Department of **Human Services**

For more information contact:

Minnesota Department of Human Services

Disability Services Division

P.O. Box 64967

St. Paul, MN 55164-0967

651-431-4300

This information is available in accessible formats to individuals with disabilities by calling 651-431-4300 or by using your preferred relay service.

For other information on disability rights and protections, contact the agency's ADA coordinator.

Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $15,000.

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Table of contents

I. Executive summary 5

II. Legislation 8

III. Introduction 9

A. Vision and Values: Disabilities Services Division 10

B. Our focus: Long-term services and supports for people with disabilities 12

C. Resources that support long-term services and supports 16

IV. Access 24

A. Information and Referral 24

B. Intake and eligibility 27

V. Person-centered service planning and delivery 30

A. Person-centered service planning 30

B. Self-direction 35

C. Community inclusion 38

D. Responding to changing needs: Case Managers are Essential 39

VI. Provider capacity 42

A. Provider networks and availability 43

B. Provider qualifications 46

C. Provider performance 49

VII. Individual safeguards 51

A. Risk and safety planning 52

B. Positive supports 54

C. Crisis management 58

D. Housing and environment 60

VIII. Individual rights and responsibilities 62

A. Civic and Human Rights 62

B. Individual decision-making authority 63

C. Due process and grievances 64

IX. Individual outcomes and satisfaction 66

A. Individual Satisfaction 67

B. Employment 68

C. Housing 74

X. System performance 80

A. Improving Efficiency: The Disability Waiver Rate System 80

B. Measuring Effectiveness 81

C. Improving Quality 82

D. Individual and stakeholder involvement 84

XI. Summary 86

XII. Appendix 88

A. Medical Assistance Benefits 88

B. DSD value chain helix 89

I. Executive summary

The Minnesota Department of Human Services (DHS) prepared this report in response to legislation passed in 2012. The legislature requires DHS to report every two years on our goals and priorities for people with disabilities and how programs administered by DHS support those goals.

Minnesota is on a continuing journey to transform services for people with disabilities. We have come from history of large state operated regional treatment centers. As they have closed, Minnesotans with disabilities were able move to homes in communities across that state. Community services have been less expensive with better outcomes. We have come to rally around CHOICE outcomes for all people with disabilities:

- **C**ommunity membership
- **H**ealth, wellness and long-term supports
- **O**wn place to live
- **I**mportant long-term relationships
- **C**ontrol over supports
- **E**mployment earnings and stable income

Today, Minnesota continues the journey with higher expectations for inclusion of people with disabilities in community life. This means:

- Greater independence and choice for people with disabilities; people having opportunities to design their own lives.
- People living in their communities, in their own home or family home or with people they want to live with.
- Full inclusion of people with the disabilities, including those with the most significant disabilities, in the workplace.
- Improved access and greater consistency statewide in services and supports.

These overarching goals are being met through specific reforms related to recent legislative and court directions, which are also consistent with the Americans with Disabilities Act:

- A new assessment and service planning process called MnCHOICES.
- An enhanced focus on positive behavioral supports and prohibitions on restraints and seclusion.
- New provider standards and licensing requirements.
- Conversion to a statewide disability waiver rates system.
- Increasing use of home and community based service for crisis and safety net services.
- Supporting people in the most integrated setting appropriate to meet their needs.

New strategies to manage increased demands on financial resources, such as better information and assistance to answer questions when people need information, help accessing housing, use of technology to support people, development of new service options, incentives to providers to improve quality and moratoriums on more expensive service models. A detailed discussion of the reforms and strategies can be found in our 2013 report to the legislature (PDF).

These reforms require all of us to innovate and change long-standing practices. We are not where we want to be and the journey is not smooth. Stakeholders in the disability communities will not always agree on the specifics of how to move forward. We do agree, however, that the journey toward CHOICE for Minnesotans with disabilities is one our state is called to make, with commitment to our obligations under law; knowledge and experience in being, serving and working with people with disabilities; support for the full inclusion of all people with disabilities in our communities; and passion for people with disabilities having the same opportunities other Minnesotans enjoy.

Most people with disabilities live independently in their communities without publicly funded services.

For those who need additional support to live and work as independently as possible, informal supports and social networks are crucial. For those who need additional support, DHS, and more specifically, its Disability Services Division (DSD), is committed to help. We want people with disabilities to be able to integrate fully with their community in all aspects of life. DHS has been a national leader in supporting people with disabilities living at home or with family members, and yet there is so much more to be achieved.

For DSD, promoting quality of life for people with disabilities means that we have to use the resources we have well. Then, we can create a robust network of formal and informal supports. Minnesota invests in a variety of services that do not use federal funding. We will continue to build services in Minnesota with that well-rounded approach.

Together with our partners, DHS strives to help people to have the right support at the right time in the community of their choice. For providers and lead agencies, the comprehensive nature and pace of the changes often has been confusing and difficult to implement. To support the transition, DHS is working with our partners and stakeholders to provide the most current information, technical assistance and resources.

As implementation takes place, DHS will address common misunderstandings while we continue to work to expand awareness of systems change. Ultimately, the result of the many reforms will be a more person-centered and integrated system that puts quality of life for people with disabilities at the center. The road to get there will not be without challenges, however.

During this transition, DHS is going through a transition itself. Commissioner Lucinda Jesson recently announced a reorganization that will create an administration that includes children and adult mental health, alcohol and drug abuse services, deaf and hard of hearing services, housing and disability services. The new administration will more closely align disability services with mental health services. This is an opportunity to continue to seek ways to support people (and not focus solely on programs). We will focus together on what it means to support people well, to live lives that are meaningful to them.

DHS structured this report based on the Centers for Medicare and Medicaid Services (CMS) Home and Community-Based Services (HCBS) Quality Framework. The Minnesota State Quality Council identified indicators for the national framework specific to Minnesota.

KEY TERMS IN THIS REPORT

- **Home and community based services (HCBS):** Services covered by Medical Assistance, under a federally funded waiver program or through Medical Assistance State Plan funds. HCBS waivers allow states flexibility to cover virtually all long-term services and supports people with disabilities need to live and work in their communities and be fully contributing community members
- **HCBS waiver**: A Medical Assistance option that allows states flexibility to cover long-term services and supports(beyond those offered by the state plan) that persons with disabilities need to live and work in their communities and be fully contributing community members
- **Lead agency:** The county, tribal agency or managed care organization that administers home and community-based services for people with disabilities and people who are older.
- **Long-term care consultation (LTCC)**: A service that helps people of any age with long-term or chronic care needs to make decisions about services and supports that will best meet their needs and reflect their preferences.
- **Long-term services and supports (LTSS)**: Services and supports that help a person engage in what is important to them, while also balancing what is important for them. These often are needed over the course of someone's life.
- **Managed care organization (MCO)**: An organization that agrees to provide all defined health care benefits to individuals in return for a capitated payment.
- **Medical Assistance State Plan**: The basic benefit set available to all Medical Assistance participants.

II. Legislation

The 2012 Minnesota Legislature required the Department of Human Services (DHS) to submit a biennial report, beginning Jan. 1, 2013.The report must address DHS' goals and priorities for people with disabilities. This includes how programs administered by the commissioner support those goals and priorities. Specifically, Minn. Stat, §252.34 states:

> 252.34 REPORT BY COMMISSIONER OF HUMAN SERVICES.
>
> Beginning January 1, 2013, the commissioner of human services shall provide a biennial report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and funding. The report must provide a summary of overarching goals and priorities for persons with disabilities, including the status of how each of the following programs administered by the commissioner is supporting the overarching goals and priorities:
>
> (1) home and community-based services waivers for persons with disabilities under sections Minn. Stat. §256B.092 and Minn. Stat. §256B.49;
>
> (2) home care services under section Minn. Stat. §256B.0652; and
>
> (3) other relevant programs and services as determined by the commissioner.

III. Introduction

SUMMARY

- Of the Minnesotans with disabilities who use Medical Assistance, about half need long-term services and supports.
- There are many types of programs for public services, but basics are health care coverage, and the different services either offered as a result of being on Medical Assistance and meeting eligibility criteria for services, such as Personal Care Services, and those offered through a federal home and community-based service waiver.
- Compared with many other states, Minnesota offers a richer state plan benefit so that more people are able to access services without being on a waiver.

The Minnesota Department of Human Services has a mission to work with our partners to help people meet their basic needs. We do this so people with disabilities can live in dignity and fulfill *their* dreams for the future. The Disability Services Division (DSD) plays one part in achieving that mission. DSD is committed to helping people with disabilities fully integrate with the community in all aspects of life. This means that we are also learning with communities how they can be inclusive and welcoming of those with disabilities.

FOR MORE INFORMATION

See the DHS public website for more information about DHS' services for people with disabilities.

DSD plans, develops, administers and evaluates home and community-based services for Minnesotans who have disabilities, including people with:

- Brain injuries
- Chronic health conditions
- Developmental disabilities
- Physical disabilities
- Adults living with a mental illness and children/youth with mental health conditions

A NOTE ABOUT THE DATA IN THIS REPORT

The data included in this report comes from a variety of sources. We have made every effort to identify and include the most recent data available. Time frames may vary depending upon data source.

A. Vision and Values: Disabilities Services Division

DSD strives to:

- Support and enhance the quality of life for people with disabilities.
- Continuously improve how we administer services
- Manage an equitable and sustainable long-term services and supports system that maximizes value
- Promote professional excellence and engagement in our work

We believe that every person, with or without a disability, deserves to have:

- **C**ommunity membership
- **H**ealth, wellness and safety
- **O**wn place to live
- **I**mportant long-term relationships
- **C**ontrol over supports
- **E**mployment earnings and stable income

IMPORTANT POINT

DHS is in the process of aligning disabilities services and mental health services through an agency reorganization. No matter where DSD fits into the DHS structural organization, we will continue to deliver programs people with disabilities might need at various times throughout their lives.

Most people with disabilities live in their communities without publicly funded supports. They typically do not need formal paid support services to do so. Just like for people without disabilities, informal supports and social networks are crucial. For those who need additional support to live and work as independently as possible, informal supports may not be enough.

In the past, the structure of formal services often isolated people with disabilities from their natural support systems and their communities, specifically in areas of:

- Employment
- Every-day life activities
- Housing
- Personal relationships

IMPORTANT POINT

DHS alone cannot guarantee community integration. What we can do is provide a system of services that supports community engagement and delivers high quality services.

There are tens of thousands of dedicated professionals that partner with DSD to assure that our system of services supports natural networks of support rather than separates people with disabilities from their families and communities (Figure 1). These partnerships include other administrations within DHS and extend across state, county and community agencies. We build on the rich network of communities, providers, health plans, educational institutions and advocates who engage and work side-by-side with people with disabilities and their families. We are proud of the work that we have done with our partners.

Figure 1: Services no longer separate people from what matters: family and community

DHS and our partners have worked to reduce barriers for people with disabilities in areas of:

- Community living
- Employment
- Housing
- Supports to families
- Transportation
- Health Care.

Minnesota is on a continuing journey to transform services for people with disabilities. We have come from history of large state operated regional treatment centers. As they have closed, Minnesotans with disabilities were able move to homes in communities across that state. Community services have been less expensive with better outcomes.

Today, Minnesota continues the journey with higher expectations for inclusion of people with disabilities in community life. This means:

- Greater independence and choice for people with disabilities; people having opportunities to design their own lives.
- People living in their communities, in their own home or family home or with people they want to live with.
- Full inclusion of people, regardless of ability, including those with the most significant disabilities, in the workplace.
- Improved access statewide to services and supports that are responsive to the needs of those who use them.

Minnesota's Olmstead Plan documents goals and what steps Minnesota is taking to increase opportunities for people with disabilities to live close to their families and friends, to live more independently, to engage in productive employment and to participate in community life.

DHS alone cannot guarantee community integration and a high quality of life for people with disabilities. However, we are committed to doing the hard work to implement a system that delivers high quality long-term services and supports that promote community engagement.

In short: Our work is not done. This report includes how our programs currently support those goals and priorities.

B. Our focus: Long-term services and supports for people with disabilities

Minnesota has approximately 5.2 million residents. U.S. Census data show an estimated 10 percent of the population identifies as having a disability.

Of the 520,000 people with disabilities in the state, approximately 133,000 use Medical Assistance (MA). About half of the 133,000 need long-term services and supports. Most people who have disabilities do not use services administered by DSD. Our goal is to provide the right services at the right time.

Historically, people with disabilities who needed long-term support received that support in institutional settings. Over time, people began getting services in their homes and communities as institutions closed. The shift toward home and community-based services allows people to continue meaningful engagement in their community.

KEY TERMS IN THIS REPORT

- **Home and community based services (HCBS)**: Services paid for by Medical Assistance, under a federally funded waiver program or through the federal Medical Assistance State Plan
- **HCBS waiver**: A Medical Assistance option that allows states flexibility to cover long-term services and supports(beyond those offered by the state plan) that persons with disabilities need to live and work in their communities and be fully contributing community members
- **Lead agency**: The county, tribal agency or managed care organization that administers home and community-based services for people with disabilities and people who are older.
- **Long-term care consultation (LTCC)**: A service that helps people of any age with long-term or chronic care needs to make decisions about services and supports that will best meet their needs and reflect their preferences.
- **Long-term services and supports (LTSS)**: Services and supports that help a person engage in what is important to them, while also balancing what is important for them. These are often needed over the course of someone's life.
- **Managed care organization (MCO)**: An organization that agrees to provide all defined health care benefits to individuals in return for a capitated payment.
- **Medical Assistance State Plan**: The basic benefit set available to all Medical Assistance participants when medically necessary. Some benefits are mandatory. Others are optional and can be limited. Minnesota offers home care and personal care services to those who need them through the state plan.

People who have choice and flexibility in supports and services are more likely to lead report a higher quality of life. Minnesotans who receive long-term services and supports are more likely than those in any other state (except Hawaii) to receive those services outside of an institutional setting.

In state fiscal year (SFY) 2013, Minnesota served fewer than 2,000 people in intermediate care facilities for persons with developmental disabilities. For the 4,000 people under age 65 with a nursing home stay in SFY 2013, nearly half were discharged in less than 90 days. DHS actively works to serve more people in their own home.

The Disabilities Services Division plays an important role in the design and implementation services for people with disabilities who need on-going support. We work to make sure infrastructure and needed services are available throughout Minnesota, and support community inclusion.

FOR MORE INFORMATION

DSD manages a Community-Based Service Manual (CBSM) for lead agencies. It is the go-to place for program and policy information on programs DHS has for people with disabilities.

As stated, there has been tremendous progress made to reform disability services in the past few decades. Minnesota no longer operates through state-run institutions. We now operate primarily as a home and community-based system. For the most part, that means people can live where they want when they have the necessary services and supports.

An increasing majority of Medicaid-eligible people with disabilities (93 percent in 2013) and older adults (68.4 percent in 2013) who need long-term services and supports are living in their communities rather than in institutional settings.

Reform

The transition to a home and community-based service system has not always been smooth. Making comprehensive changes to a system can be a difficult, although necessary, process. We want people to make informed choices to live their lives as part of the community. We also do not want people's civil rights violated through seclusion, segregation and physical restraints. This means we must make significant changes to the way Minnesota delivers, regulates and evaluates services. However, that fundamental change is difficult to do quickly when the process includes so many agencies and community organizations.

A 2011 court action reinforced the importance of our work. As a result of the Jensen Settlement in 2011, DHS is developing and implementing a comprehensive plan that uses measurable goals to increase the number of people with disabilities receiving services that best meet people's needs in the "most integrated setting." One requirement of the settlement was for Minnesota to develop an Olmstead plan that is consistent with the U.S. Supreme Court's Olmstead decision. The Olmstead Decision was based on the Americans with Disabilities Act and said that states must make available services and supports that help people with disabilities to be fully integrated in their communities. Minnesota's Olmstead Plan requires cooperation by many state agencies. We are committed to seeing it implemented.

Minnesota's services

DHS currently supports people with disabilities through a variety of long-term services and supports:

- Medical assistance state plan home-care services and home and community-based services medical assistance waivers
- State grant programs, such as the Family Support Grant or the Housing Access Grant
- Services delivered in institutional settings (i.e., nursing facilities, intermediate care facilities for persons with developmental disabilities and long term hospital stays)

IMPORTANT POINT

Compared with other states, Minnesota offers a richer state plan benefit so that more people are able to access services without being on a waiver.

The vast majority of funding for long-term services and supports has moved toward supporting home and community-based services. In 1995, there was a 51 to 49 percent split in funding between institutions and home and community-based services. DHS now projects Minnesota will spend 91 percent of long-term services and supports funding in 2015 on home and community-based services.

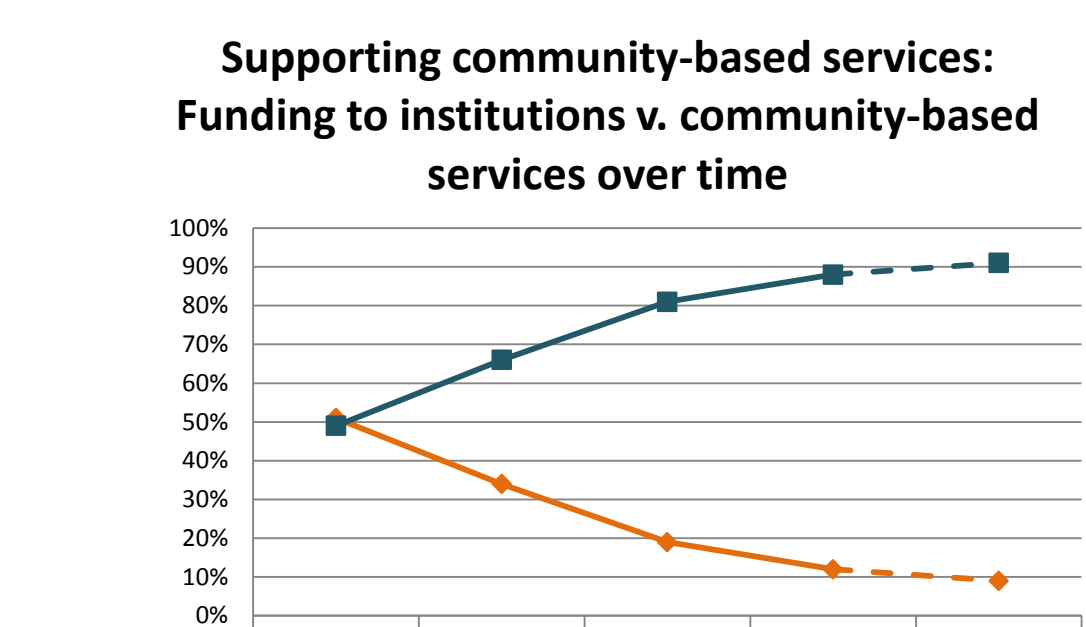
Services provided at home and in the community promote independence. They give more choice and control to the person. Informal support opens doors to the same resources that people without disabilities use. Home and community-based services are less expensive on the average than institutional services.

IMPORTANT POINT

On average, home and community-based services are less expensive than institutional services.

In 2012, Minnesota ranked second in the nation (behind Oregon) in the ratio of funds used to serve people at home or in the community rather than in institutions. This demonstrates the state's long-standing public policy to provide people with access to the right services at the right time.

Figure 2: Funding by type of long-term services for people with disabilities in Minnesota (1995 – 2015)



	1995	2000	2005	2010	2015
% to Institutions	51%	34%	19%	12%	9%
% to HCBS	49%	66%	81%	88%	91%

Regardless of the type of someone's disability or services they might need, there are common expectations of a system that serves people well. Indicators of a high-quality system from CMS are:

Access: Access to information and eligibility processes that are easy to understand – Access

Person-centered planning: Services and supports that are planned and effectively implemented in accordance with each person's unique needs, expressed preferences and decisions concerning his/her life in the community

Provider capacity and capabilities: Sufficient home and community-based services providers and they possess and demonstrate the capability to meet the person's needs

Individual safeguards: Being safe and secure in their homes and communities, taking into account their informed and expressed choices

Individual rights: Support to exercise their rights and in accepting personal responsibilities.-

Outcomes and satisfaction: Satisfaction with services and progress toward individual outcomes

System performance: An effective and efficient system of services and supports that strives to improve quality.

The remainder of this report will describe the people we serve, the work we do and the outcomes of those efforts.

C. Resources that support long-term services and supports

To deliver long-term services and supports that build upon a person's informal supports, Minnesota uses a combination of:

- Medical Assistance State Plan Services
- Medical Assistance Home and community-based service waivers
- State and local funded supports and services

Medical Assistance State Plan

Medical Assistance is a publicly funded insurance program for low-income people and people defined as "medically needy." It provides health-related coverage for children, many seniors and/or people who are blind or have other disabilities.

The federal government jointly funds the program with each state and the District of Columbia. In Minnesota, the federal government pays for 50% of the cost of Medical Assistance services and the state pays the other 50%. States are required to offer some benefits, such as inpatient hospital care, and may offer others, such as personal care and home care nursing (formerly private duty nursing). Minnesota offers a comprehensive Medical Assistance benefit set that includes both federally mandated and optional benefits. States are allowed to have limits on the amount and duration of optional state plan services a person can receive.

Table 1: People Receiving Various Types of Long-term Services and Supports (LTSS) by Age (SFY 2013)

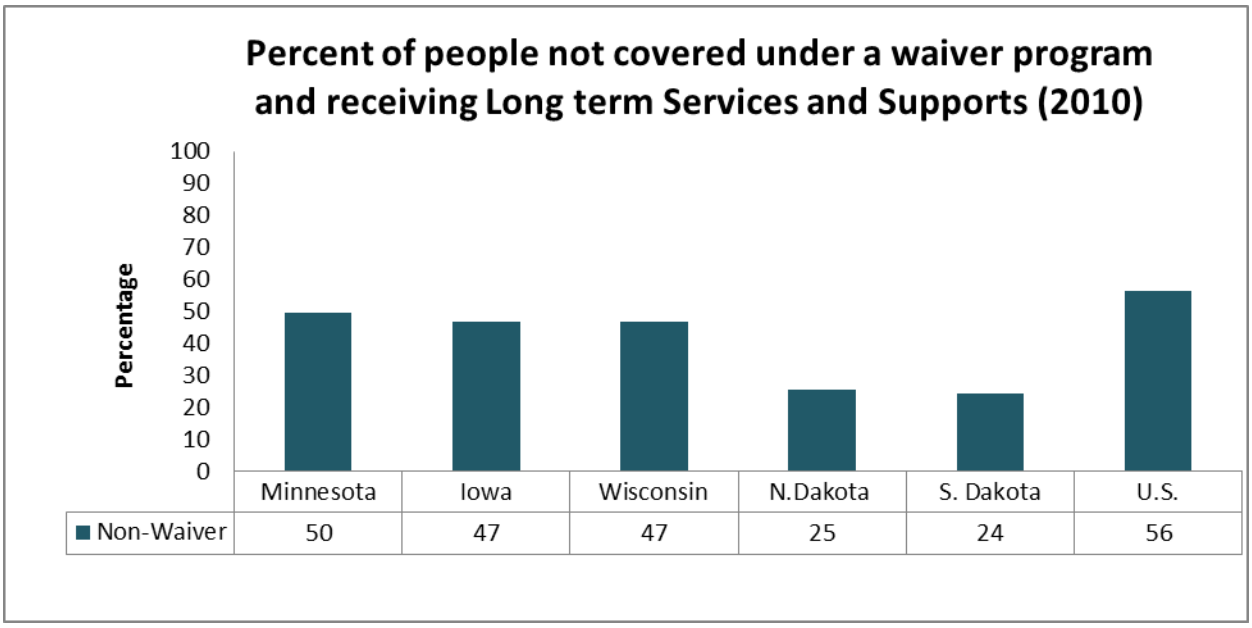
Age	Personal care assistance (PCA)	Home care nursing*	Skilled nurse	Home health aide	Home health therapies
0 to 12	4,904	315	1,949	3	82
13 to 17	2,081	69	134	3	30
18 to 22	1,417	61	340	4	30
23 to 39	3,498	124	1,312	50	166
40 to 64	10,635	209	4,196	661	858
65 to 84	1,432	44	1,505	665	66
85+	329	18	787	514	10

* Formerly private duty nursing

Receiving services in an institution is costly. State plan services offer a range of medical care and support services provided in the person's home and community. Services range from a level of care similar to that provided in a hospital to simple assistance in activities of daily living. There often is some type of prior authorization process. For example, all home-care services require prior authorization through a lead agency (counties, tribal agencies and managed care organizations) or DHS. The state Medical Assistance plan pays for home care services.

People who need long-term services and supports beyond the limits established in the medical assistance state plan may be able to access those services through home and community-based waiver services. More information on waiver services is in the next section.

Figure 3: Percent of people receiving long-term services and not covered under a waiver program (2010)



Home and community-based service (HCBS) waivers

One of the ways Minnesota provides services outside of an institution is through the home and community-based services (HCBS) waiver programs. Waivers, or HCBS waivers, provide services to people with specific needs or diagnoses.

Waiver programs are not an entitlement. Waivers allow states to "waive" certain Medicaid rules to provide long-term care services to specific populations in the community, rather than in institutional settings.

DHS manages the waiver programs under the authority of the Minnesota legislature. The federal government gives DHS permission to offer these services. Home and community-based services waivers offer more services, at an average cost that is less than or equal to the cost of serving people in institutions.

The home and community based waivers provide additional services that are needed to support a person when state plan services are not sufficient in what they provide or how much they provide. The Centers for Medicare & Medicaid Services (CMS) bases eligibility for waiver programs on certain levels of need (also called level of care).

Because waiver services are not an entitlement, the Legislature can set limits on the growth or new money to serve people on a waiver program at a time. This can create waiting lists for some waivers. Waiting lists include individuals who are eligible for waiver services, but are not yet receiving them.

Lead agencies (county, tribal agency or managed care organizations) manage waiting lists for waiver coverage. Individuals on waiting lists do not receive waiver services on a first-come, first-served basis. The time period from when a person first requests services to when they are provided is determined by an individual's urgency of need for services, statutory priorities and a lead agency's capacity to serve that individual within their allowable waiver budget.

A combination of state and federal dollars fund waivers. Minnesota receives federal financial participation (FFP) to match state dollars spent on waiver programs. The current federal financial participation for most waiver services in Minnesota is 50 percent. To obtain this federal match, Minnesota submits waiver plans to CMS for approval. Changes to waiver plans require review and approval by CMS.

Each of the home and community-based services waiver programs meets federal guidelines. That includes the obligation to meet federal guarantees in six areas:

1. Level of care
2. Service plan
3. Qualified providers
4. Health and welfare

5. Administrative authority
6. Financial accountability.

FOR MORE INFORMATION

In the Continuing Care Performance Report, DHS measures the number of people on the disability waivers served in a home or community-based setting.

For statistical information about the percentage of people served at home, see the Development Disabilities (DD) Waiver and the other three disability waivers (CAC, CADI, and BI or CCB).

DHS administers waiver programs in collaboration with public health or social services through counties and tribal agencies. The four waivers specific to disability services in Minnesota are:

1. **Brain Injury (BI) Waiver** is for people with a traumatic or acquired brain injury who need the level of care provided in a nursing facility or neurobehavioral hospital. (1,383 participants in state fiscal year 2014)
2. **Community Alternative Care (CAC) Waiver** serves people who are chronically ill or medically fragile and need the level of care provided at a hospital (383 participants in state fiscal year 2014)
3. **Community Alternatives for Individuals with Disabilities (CADI) Waiver** was designed for people who need the level of care provided in a nursing facility (17,999 participants in state fiscal year 2014)
4. **Developmental Disabilities (DD) Waiver** is for people with developmental disabilities who need the level of care provided at an intermediate care facility for people with developmental disabilities (ICF/DD) (15,938 participants in state fiscal year 2014)

Table 2: People on disability waivers by age (SFY 2013)

Age group	BI	CADI	CAC	DD
0 to 12	15	871	189	563
13 to 17	28	750	58	1,112
18 to 22	59	1,021	49	1,857
23 to 39	413	3,506	78	5,981
40 to 64	914	11,983	57	5,615
65 to 84	78	1,463	6	1,099
85 and over	0	0	0	68

Services authorized under all home and community-based services waiver federal plans must:

- Be necessary to assure health, safety and welfare of the person
- Have a cost that is considered reasonable and customary
- Have no other funding source for the services
- Help a person avoid institutionalization and be an appropriate alternative to institutionalization
- Help a person function with greater independence in the community
- Meet the unique needs and preferences of the person.

Waivers allow states to provide various service options not available or allowed under regular Medical Assistance. They are a crucial piece of our goal to improve quality of life for low-income older Minnesotans or those who have disabilities.

With waiver services and supports, people can live as independently as possible in the community of their choice. In 2010-2011, Minnesota ranked first nationally in the number of people who participate in one of the waiver programs per 1,000 state residents (all waivers).

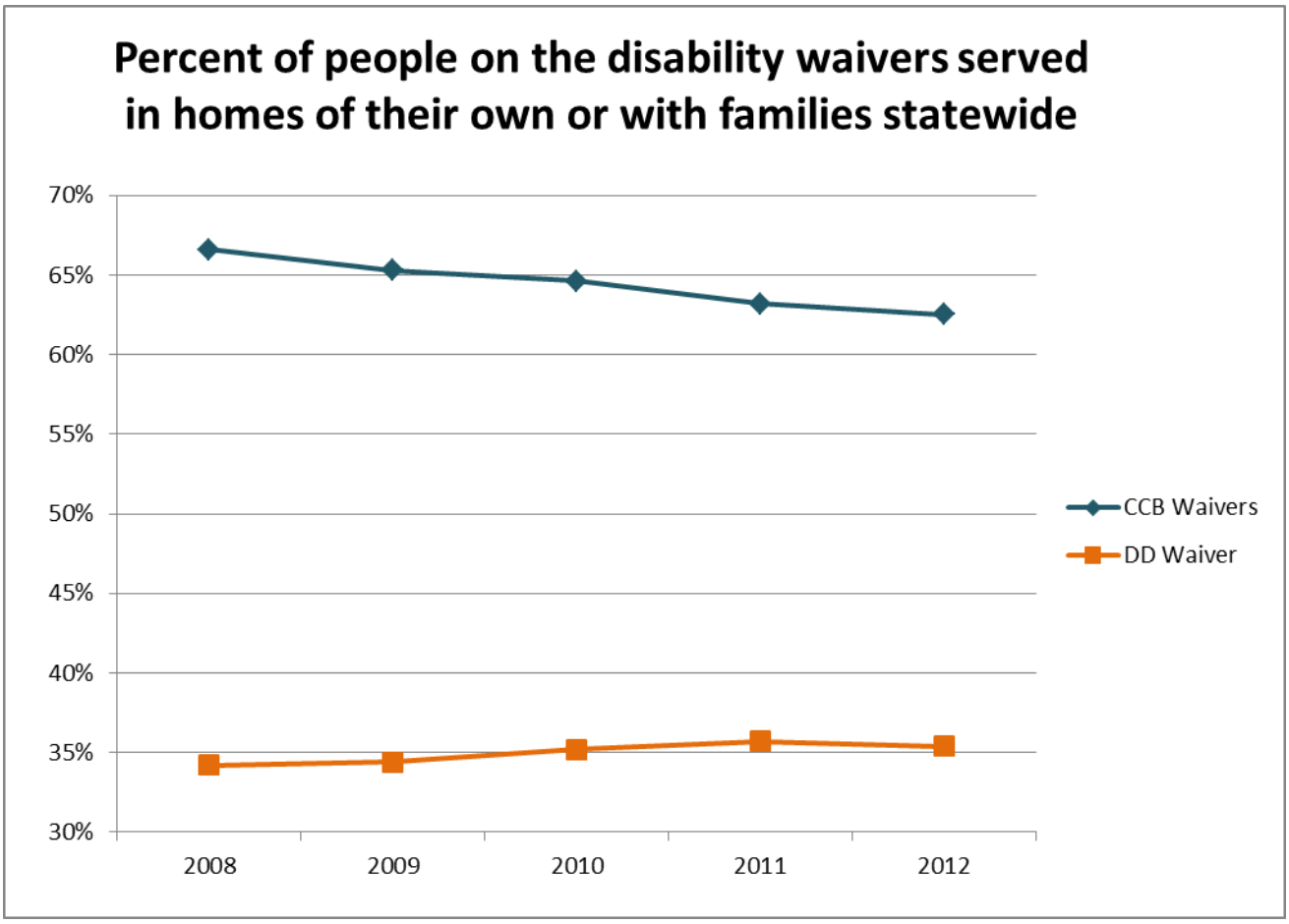
Table 3: Waiver participants per 1,000 state residents: Minnesota and US (2011)

Target population	MN	US	MN rank
Older Adults and People at risk of Nursing Facility Placement	8.89	2.59	1
Developmental Disabilities (including ID and ASD)	2.96	1.88	10
Brain Injuries	0.29	0.04	4
All Waivers	12.14	4.64	1

Table 4: People with disabilities receiving services through home and community-based service waivers by age; annual spending by waiver type (SFY 2013)

Waiver	Total	Age under 18	Age 18 -64	Age 65 and over	SFY 13 actual (in millions)	SFY 19 projected (in millions)
CAC	438	247	184	6	$25	$43
CADI	19,594	1,621	16,510	1,463	$528	$1,098
DD	16,296	1,675	13,453	1,167	$1,051	$1,425
TBI- Nursing Facility	1,108	25	1,018	65	$97	$120
TBI- Neurobehavioral Hospital	399	18	368	13	(combined with above $97)	(combined with above $120)

Figure 4: Percent of people on the disability waivers who are served in non-provider-controlled settings statewide (2008 – 2012)



Waitlists

When a lead agency assessor determines a person is eligible for disability services, they have access to state plan services immediately. State plan services are different from waiver services, and they still provide a certain level of long-term services and supports, such as Personal Care Assistance. If that person also is eligible for a waiver program, they can have access to those services as well, once they are enrolled in the program. Almost everyone eligible for waiver services, but not getting those services yet, receives other publically funded services and supports. It is quite rare for a person who is eligible for services to be receiving no services or support.

Counties and tribal agencies maintain budget reserves to meet unanticipated needs for ongoing and new recipients. Some counties had large reserves during 2013 because they were worried about the risk of overspending and having to repay the state with county dollars. Legislation passed in 2014 has mitigated this risk significantly. Counties and tribal agencies that overspend on waiver services now have another year to control unanticipated waiver costs, and the state has the ability to transfer dollars between counties to avoid a situation where a county is at risk of overspending altogether.

Often people who need services wonder why they cannot get waiver services. While it is important to note that Minnesota offers many-non waiver services for people with disabilities, there have been different legislative limits on the amount of growth that is allowable in these programs for those who request them based on state budget pressures. Two disability waivers do not have limits: the Brain Injury Waiver and the CAC, or Community Alternatives Waiver. Currents limits on growth for the remaining two waivers, and what we expect July 1, 2015, if nothing changes in legislation are found in table 5.

Table 5: Waiver limits

Waiver	Current statewide limit per month	Limits as of July 1, 2015, by month
CADI	85	Unlimited
DD	15	25

For the DD waiver, beginning in state fiscal year 2014, new funding to serve additional people allowed an average of 15 people per month statewide to begin services. Beginning July 1, 2015, it will increase to 25 people per month.

The Legislature also approved additional statewide funding to expand Community Alternatives for Disabled Individuals (CADI) Waiver access by an average of 85 people per month. There are no growth limits beginning July 1, 2015. As of October 2014, 1,447 people were waiting for access to CADI services and 3,501 individuals were eligible for, but not yet receiving, DD Waiver services. It is important to note, however, that all but seven of the people currently on the DD Waiver waitlist are receiving other services.

DHS wrote a January 2015 legislative report on program waiting lists. It determined the costs to opening waiver enrollment with no caps or restrictions. It would require an increase of more than $200 million above the forecast by state fiscal year 2019.

State and local funds

The Minnesota legislature has appropriated funds for specific purposes. Primarily, Minnesota uses state funds for innovative programs serving small numbers of individuals where federal financial participation is not available.

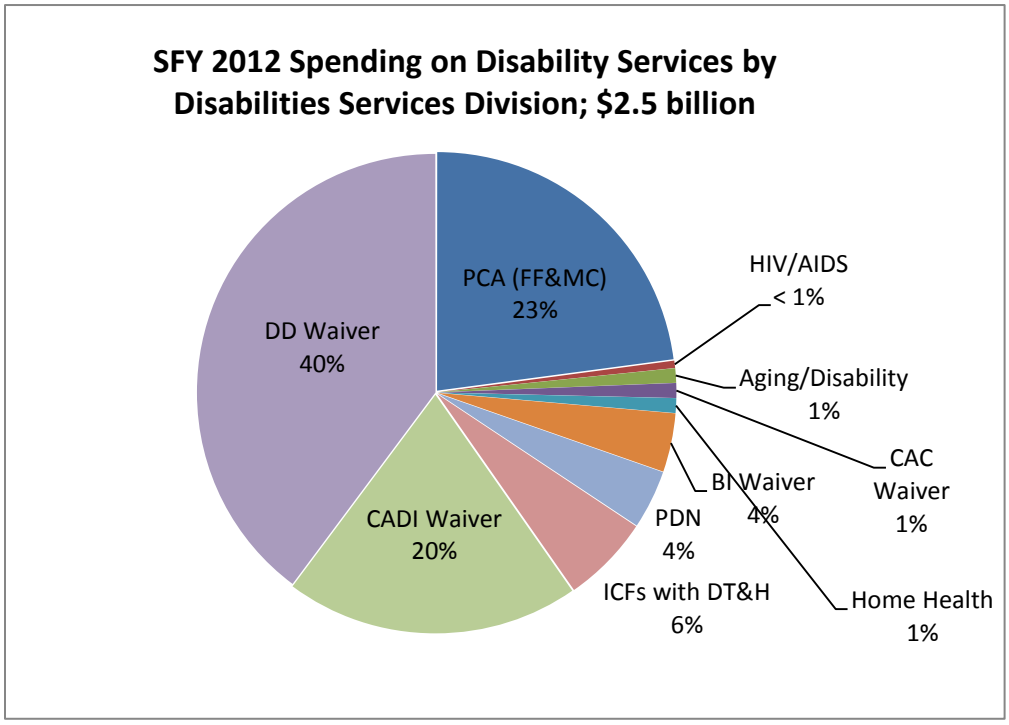
Family Support Grants, Consumer Support Grants and Semi-Independent Living Services are examples of state funded programs. We address Family and Consumer Support Grant programs later in this report.

The semi-independent living services (often referred to as SILS) program helps adults with developmental disabilities live successfully in the community. The goal of semi-independent living services is to support people in ways that enable them to achieve personally desired

outcomes and lead self-directed lives. To be eligible for services, people must be 18 years of age or older and not at risk of placement in an intermediate care facility for people with developmental disabilities. There is a 30% county match to state funds for semi independently living services. Minnesota spent approximately $6.8 million in state dollars on semi-independent living services in state fiscal year 2014.

Depending upon their resources, counties may also fund long-term services and supports for individuals when state and/or federal funds are not immediately available to serve the person.

Figure 5: Disability Services Division spending on services (SFY2012)



IV. Access

What's important: People have access to information and eligibility processes that are easy to understand

SUMMARY

- With the Disability Linkage Line (DLL) and MnHelp.info, Minnesota has a statewide information and referral system to support informed choice and access
- DHS works to make materials accessible and written in plain language which allows everyone to be engaged
- The new MnCHOICES assessment process provides person-centered access to services

A. Information and Referral

It is important for people who need services to understand their options. We want them to be as engaged as they can be when they make decisions about their lives.

Plain language and accessibility

DHS strives to provide information in a way that is easy for everyone to understand. Governor Mark Dayton issued an executive order March 4, 2014 implementing plain language across state agencies, including DHS.[1] We are working to provide information to the public in language that is easy to understand.

DSD is committed to providing information in accessible formats for people with disabilities. We test websites and reports we create and those created by our contractors for accessibility. We want everyone to have a chance to be informed and engaged.

DHS strives to use "person-first" language. Person-first language acknowledges the disability is not as important as the person's individuality. An example of using person-first language would be to say that a person is "someone with a disability" rather than saying "disabled person." Just as we would not refer to someone with cancer as "cancerous," we do not refer to a person with a disability as an adjective. DHS employees are passionate about using person-first language.

DHS also provides information and forms in multiple languages and formats. Translators are available for conversations between people who participate in our programs and DHS employees. Counties are responsible to meet the needs of people in their area too.

Our Waiver Review Initiative (described more fully later) evaluates whether a person's support plan has participant friendly language.[2] In the last round of reviews, 81 percent of support plans used participant friendly language (e.g. "Sally needs" instead of "recipient needs").

[1] Governor Dayton Executive Order Implementing Plain Language in the Executive Branch (PDF)
[2] HCBS Waiver Review Initiative

MinnesotaHelp.info®

MinnesotaHelp.info® is an online resource database. It offers information on a wide range of community services for people with disabilities and older Minnesotans. DHS and the Minnesota Board on Aging worked together to build it. We included and identified licensed, registered, certified and/or approved providers. This allows people to easily search for service providers, which supports informed choice.

Each service type contains a service description MinnesotaHelp.info® staff reviewed to meet plain language requirements, eligibility, application information, contact information, location and maps. People can contact providers directly. Each service type is on a regular schedule for updates (monthly, quarterly, etc.) to make sure the information is current.

Disability Linkage Line®

> *"The woman who helped me was outstanding! The information provided gave me the knowledge to make some major decision about continuing to work, insurance options, and benefits qualifications, thank you!"*
>
> **— DLL customer**

In 2005, DHS launched the Disability Linkage Line® to make it easier for people with disabilities to easily:

- Get the information they need to understand their options
- Connect to community services.

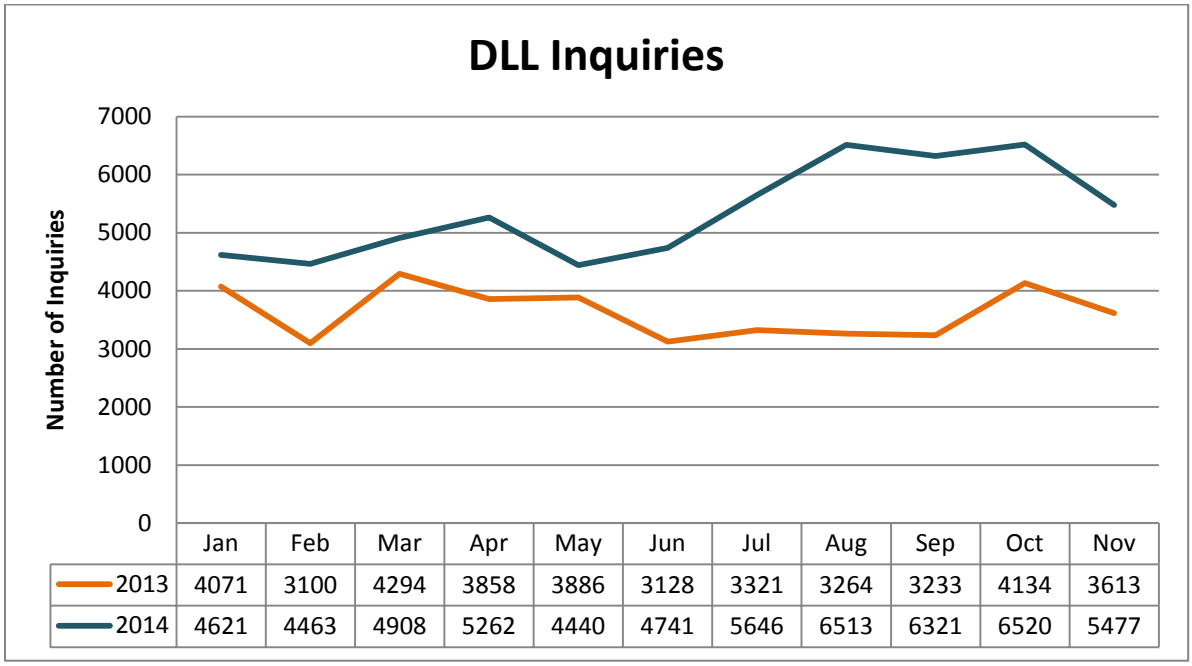
This statewide service provides access to timely, consistent and accurate information that supports self-determination, informed choices and quality of life.

The Disability Linkage Line® can be accessed three ways:

- Email
- Toll-free phone number
- Online chat through Disability Benefits 101 (DB101).

Trained options counselors staff the Disability Linkage Line®. They are located in six regions throughout the state. For one-to-one assistance, they answer calls during regular business hours. The service is a partnership with the broader MinnesotaHelp® network and the Senior LinkAge Line® and Veterans Linkage Line™. Disability Linkage Line®'s reach continues to grow. In 2013, it received 44,308 contacts. During the first 11 months of 2014, it received 54,916 contacts.

Figure 6: Disability Linkage Line® (DLL) inquiries (2013- 2014)



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
2013	4071	3100	4294	3858	3886	3128	3321	3264	3233	4134	3613
2014	4621	4463	4908	5262	4440	4741	5646	6513	6321	6520	5477

Source: Disability Linkage Line® annual reports, MinnesotaHelp Network Extranet

IMPORTANT INFORMATION

In 2013, 96 percent of callers said the information they received was helpful. More than 98 percent said they would refer a friend to the Disability Linkage Line®.
Source: Disability Linkage Line® annual reports, MinnesotaHelp Network Extranet

> *"I feel a lot more secure and less like I'm going to fall apart and need to rely on my brother. The Disability Linkage Line – they help make it like a rope, linking things together, which provides a clear path."*
>
> **— DLL customer**

The Disability Linkage Line® also provides the "Talk to an Expert" feature of Disability Benefits 101 (DB101). DB101 is an online resource for people with disabilities to learn how work and benefits can work together to increase income.

> *"My boss offered me more hours and a pay increase. I wasn't going to take it because I thought it would mess my benefits up, but after going on DB101 and using Talk to an Expert I felt I could say: 'Yes!'"*
>
> **— DB101 customer**

DLL staff has expertise in many areas including employment, public benefits and health care reform.

> *"They went above and beyond in answering several questions I had. They could not have been more helpful. They spent time in making sure that I understood everything clearly and that I knew any other steps I had to take and who I should call. Keep up the good work!!!"*

— DLL customer

Disability Benefits 101 (DB101)

Disability Linkage Line® staff also serves as a resource for Disability Benefits 101. It is Minnesota's dedicated website for employment for people with disabilities. Disability Benefits 101 provides tools and information on health coverage, benefits and employment. It allows people with disabilities to plan on how work and benefits go together. People can:

- Browse the website for information
- Email a question
- Talk to an expert on the phone or via a live Web chat

To see how people learn how income and benefits interact so that they can make informed choices, see Disability Benefits 101 in the employment and living section of this report.

B. Intake and eligibility

It is important for people who participate to understand their options. They also should be as active as they are able to be in determining decisions that affect their lives.

To accomplish this, DHS has been working to streamline four distinct assessments into one assessment – MnCHOICES.

MnCHOICES

Currently, people and their families can go through several assessments before they find the right service to best meet their needs. Potentially having different assessments to learn what services you may be able to receive can be a burden to people with disabilities, their families and their support system. That is not an efficient way to determine eligibility and plan for supports. That issue is what led to the development of MnCHOICES. It requires just one assessment that will determine eligibility for a variety of services and help a person plan for the future.

MnCHOICES is a tool to plan long-term services and supports. It is for people of all ages and disability types in Minnesota. The MnCHOICES tool is a web-based application that certified assessors can use online or off-line in any setting. It embraces a person-centered approach to help providers tailor services to the persons:

- Assessed needs
- Goals
- Preferences
- Strengths

DHS launched MnCHOICES on Nov. 4, 2013. The first lead agencies to use MnCHOICES for new assessments were Dakota County, Ramsey County and the White Earth Nation. The rollout has continued methodically across the state.

As of Jan. 1, 2015, all county lead agencies and two tribal agencies use MnCHOICES to determine eligibility for people who receiving publically funded long-term services and supports for the first time. The full rollout will include all counties, tribal agencies, and managed care organizations. We expect the rollout to be completed by the end of calendar year 2015. Lead agencies will begin using MnCHOICES in 2015 for people who are currently receiving publically funded long-term services and supports and are due for a reassessment, but have not yet had a MnCHOICES assessment.

Prompt assessments

In Minnesota, lead agencies (counties, tribal agencies and managed care organizations), assess eligibility for long-term services and supports. Long-term services and supports programs have eligibility requirements that are specific to each program.

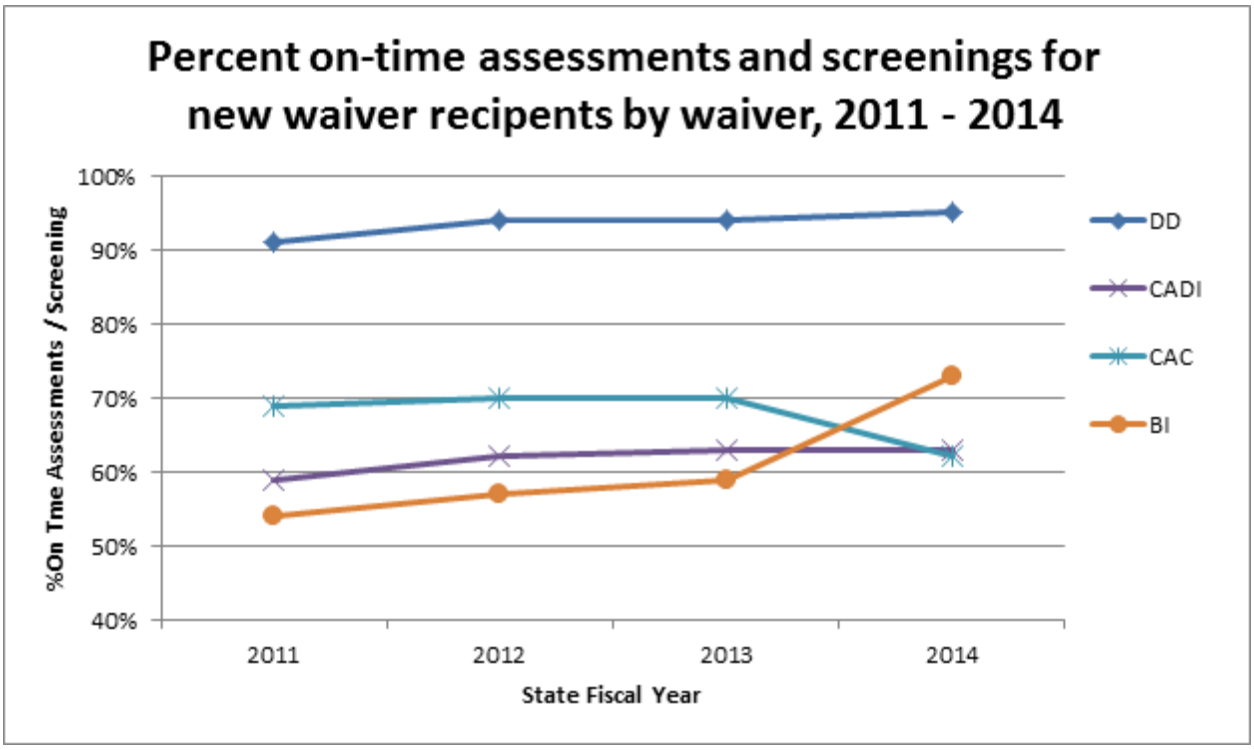
It is important to note there are two types of eligibility:

- Financial (i.e., income and assets)
- Program (i.e., State Plan or waivers) and services (e.g., PCA, case management, supported employment, etc.)

Our goal is to meet the needs of targeted populations in a timely way when a person with disabilities reaches out to their local lead agency for support. Historically, the definition of an on-time assessment and the assessment itself varies by waiver.

To address compliance, specifically from a federal level, DHS has a team of staff that works with every county. They review a sample of cases and documents to assess compliance. In the last round of this Waiver Review Initiative review reports, DHS issued a corrective action to 50 percent of the 24 lead agencies reviewed because their assessments were not timely. We want people to receive timely access to services, to be responsive and to meet people's needs.

Figure 7: On-time assessments and screenings for new waiver recipient by waiver type (2011-2014)



Informed choice

Informed choice means choosing from a range of options and opportunities to make the best personal decision about services. We want people to base their choices on relevant, factual and experiential information. Minnesotans with disabilities must have the right type of information, and experiences with options to understand what choices are available. Then, they are able to make a decision that is right for them.

We also know that people's needs and preferences change over time. That means services and what they want to do with their lives also will change over time. Case managers are one resource to help people be sure that their services are truly the right services at that point in time.

There are many places to find information. For example, MinnesotaHelp.info is available 24 hours a day to provide information when people are looking for it. We need to learn more about where people go for help and how well these tools help them. That is where our inclusion in the National Core Indicators Survey will become so valuable in helping us evaluate ourselves using national benchmarks and comparisons.

V. Person-centered service planning and delivery

What's important: Services and supports are planned, coordinated and implemented in accordance with each person's unique needs, expressed preferences and decisions concerning his/her life in the community.

SUMMARY

- Person-centered planning is a process that helps the person and their support team understand what it important to a person and what is important for the person. The plan is a call to action with the goal of improving the person's quality of life.
- The new MnCHOICES assessment results in a person-centered plan
- 2013 case management redesign improves service delivery

A. Person-centered service planning

Person-centered planning focuses on the person and their hopes and dreams for a fulfilling life. There are excellent examples of good person-centered planning and action on those plans, but we have much to do before this is a reality for everyone.

IMPORTANT POINT
Person-centered planning focuses on the person and their hopes and dreams for a fulfilling life.

The Olmstead plan says person-centered planning is:

> *"An organized process of discovery and action meant to improve a person's quality of life. Person-centered plans must identify what is important to a person (e.g. rituals, routines, relationships, life choices, status and control in areas that are meaningful to the person and lead to satisfaction, opportunity, comfort, and fulfillment) and what is important for the person (e.g. healthy, safety, compliance with laws and general social norms). What is important for the person must be addressed in the context of his or her life, goals and recovery."*

The term person-centered planning refers to a family of approaches, but all value similar goals for a person's life including:

- Being a part of and participating in community life
- Continuing to develop personal competencies
- Expressing preferences and making choices in everyday life
- Gaining and maintaining satisfying relationships
- Having opportunities to fulfill respected roles and to live with dignity.

People tell us that person-centered planning is changing lives:

> *"The person was at first unable to believe that he was being asked for what he wanted until planners began the PATH process. As his dreams appeared in illustrations on the chart, he began to realize that this process was indeed going to incorporate HIS needs and desires. He was overjoyed and expressed his thanks repeatedly"*
>
> **— New Challenges PIPP**

The essential components of a person-centered plan and planning process include:

- A plan that provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible
- A plan that reflects cultural considerations and uses plain language
- A process driven by the individual
- A process that offers choices to the individual regarding services and supports the individual receives and from whom.

Currently, DHS collaborates with the University of Minnesota to offer person-centered thinking/planning training. The training covers changing the culture of service planning. It helps providers and lead agencies learn how to listen to the person. The person is the primary focus when using person-centered planning, not the disability, service or some other issue.

> *"[A participant] cried happily when he realized the intent of the process was to capture and integrate his actual desires in his individual plan."*
>
> **— New Challenges PIPP**

Training in person-centered thinking serves as a foundation for everyone who is involved in supporting people with disabilities. It offers specific ways to discover:

- What is important **to** a person
- What is important **for** a person

DHS promotes the person-centered training through our website and email distribution lists. All DSD employees take an Introduction to Person-Centered Planning course.

DHS designed MnCHOICES to incorporate principles of person-centered planning. It shifts the conversation from "What programs do you qualify for?" to "What do you need to meet your goals?"

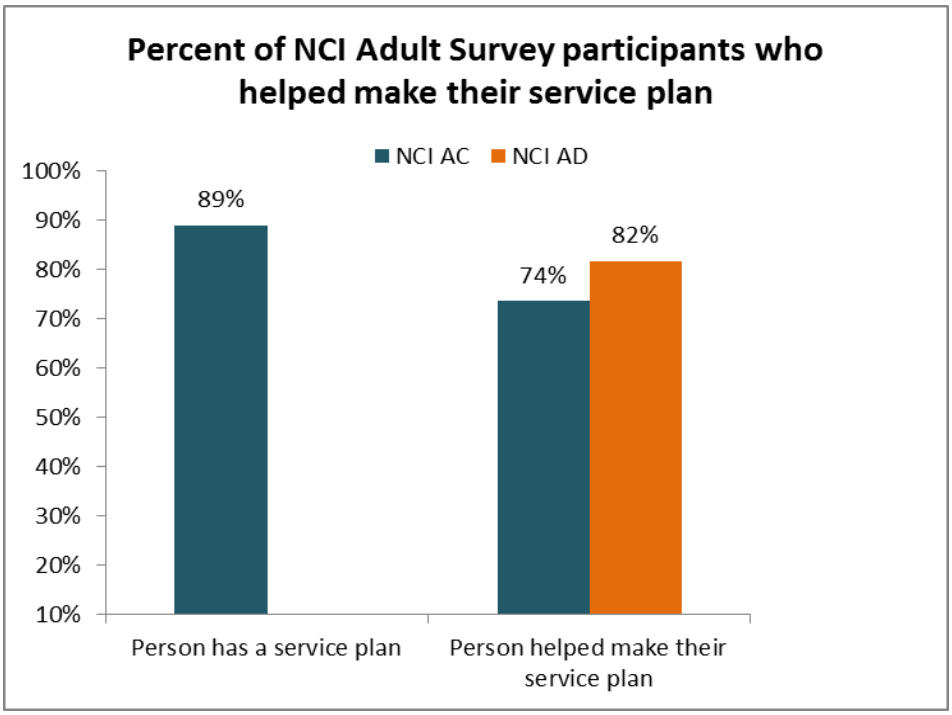
Home and community-based services rule for person-centered planning

In January 2014, CMS issued a new rule that outlines person-centered planning requirements for home and community-based services programs. It was effective March 17, 2014. In Minnesota, this rule affects the five home and community-based services waivers (BI, CAC, CADI, DD and EW) and community first services and supports (CFSS). CFSS is the new program that will replace personal care assistance (PCA) and the Consumer Support Grant (CSG).

The rule requires the service recipient to lead the person-centered planning process where possible. The person's representative, when there is one, should participate in the individual's decision, unless state law requires the legal representative to have decision-making authority. Depending on the level of need of the individual and the scope of services available to the person, their written person-centered plan must:

- Be distributed to the person and other people involved in the plan
- Be finalized and agreed to, with the informed consent of the person in writing, and signed by all individuals and providers responsible for its implementation
- Be reviewed and revised at least every 12 months, when the person's circumstances or needs change significantly, or at the request of the person.
- Be understandable to the person receiving services and supports, and the people important to him or her
- Document any modification to the setting requirements identified in the rule
- Identify the individual and/or entity responsible for monitoring the plan
- Include individually identified goals and desired outcomes
- Reflect clinical and support needs as identified through an assessment of functional need
- Reflect risk factors and the measures in place to minimize them, including individualized back-up plans and strategies when needed
- Reflect that the setting in which the person resides is chosen by the person
- Reflect the person's strengths and preferences
- Reflect the services and supports (paid and unpaid) that will assist the person to achieve goals, and the providers of those services and supports, including natural supports.

Figure 8: Percent of NCI adult survey participants who helped make their service plan (2014)



Support plans and waiver review

Once an individual's strengths and support needs have been assessed through MnCHOICES, the individual and assessor develop a community support plan (CSP). Regardless of program eligibility, every person will have a plan that maps needed services, supports, goals and outcomes. If a person is going to receive services through one of the waivers, the community support plan is further refined by the individual and his or her case manager in a process and document referred to as a Coordinated Service and Support Plan (CSSP).

The support plan is the one document that all participants receive, and it should include personalized and detailed information about their strengths, needs and planned services. A quality support plan should be person-centered and participant-friendly. This means it includes details such as the participant's name instead of "client," "member" or "consumer."

The goals in the support plan should be meaningful and unique to the participant. It should include their preferences. The support plan should not only outline the participant's health, safety and needs, but also explain how planned services will address these needs. In 61 percent of cases reviewed during the last round of waiver reviews, people reported their goals were individualized and meaningful.

The Waiver Review Initiative evaluates whether participant goals in a person's support plan are individualized and meaningful. The waiver review promotes person-centered plans and implementation of those plans. The team reviews all lead agencies (counties, tribal agencies and managed care organizations) once every three years. We just completed the second round of reviews. Of the 68 lead agencies reviewed as of Sept. 1, 2014 (for the period of July 2012 to November 2014), 21 have received the recommendation to improve the "person-centered-ness" of their support plans.

Waiver (and Alternative Care) participants must say if they had choices in their service planning. This includes items such as:

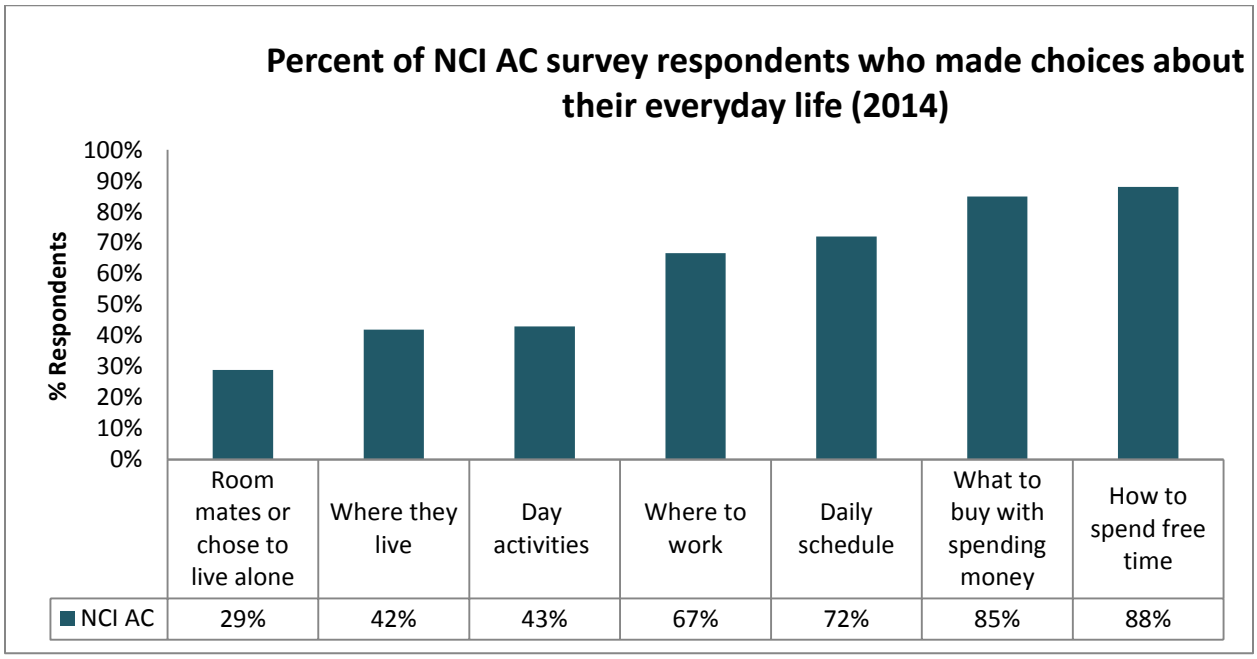
- Choosing to live in the community instead of an institution
- Choosing which services and providers they would like
- Participating in their support planning process.

Planning is a significant first step. How the plan is implemented is even more important. More than 50 percent of Minnesota's National Core Indicators adult consumer survey respondents indicated that they make choices about:

- How they spend their free time
- Their daily schedule
- Their job
- What to buy with their money.

Less than 50 percent of people who participated indicated they chose their own roommates, home and day activities.

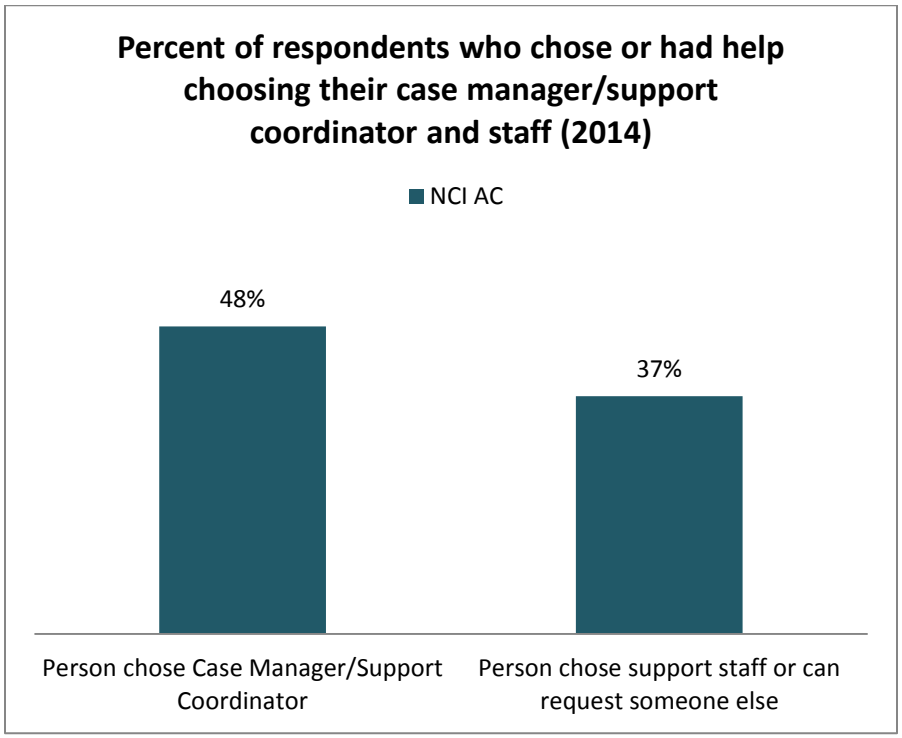
Figure 9: Percent of NCI adult consumer (AC) survey respondents who made choices or had help making choices about their everyday life (2014)



Less than half of Minnesota's National Core Indicators adult survey respondents (those with a developmental disability) said they chose or had help choosing their case manager/support coordinator and support staff. Nationally, on average, more than 50 percent said they did not have input.

Among NCI participants with a developmental disability who indicated they had a service plan, 75 percent indicated that they were involved in creating their service plans.

Figure 10: Percent of NCI adult consumer (AC) survey respondents who chose or had help choosing their case manager/support coordinator and staff (2014)



B. Self-direction

FRAMEWORK INDICATOR

People have the authority and are supported to direct and manage their own services to the extent they wish.

All of our services have an element of self-direction. However, we specifically identify several of our currently available services as "self-directed." This includes:

- Community First Services and Supports (CFSS)
- Consumer-directed community supports (CDCS) through the waivers
- Consumer Support Grant (CSG)
- Family Support Grant (FSG)
- Personal care assistance — Choice (PCA-Choice)

Community First Services and Supports (CFSS)

Community first services and supports (CFSS) is the new service that will replace Personal Care Assistance and Consumer Support Grants as currently configured. Community First Services and Supports is similar to PCA in many ways, but it can offer people more control, flexibility, responsibility and choice in how they use the service if they choose. Community First Services

and Supports is a service that will be available under the Medical Assistance state plan, waiver and Alternative Care programs. Instead of waiting for access to a waiver for one particular service, people may be able to meet their needs through CFSS.

Consumer-directed community supports (CDCS)

Consumer-directed community supports is a unique service option available through the waivers. It can give people greater control, flexibility and responsibility to manage and direct services and supports. Many people choose Consumer Directed Community Supports in in order to customize their services, hire and fire their staff, etc. They are willing to assume greater responsibility for the implementation of their plan because of this increased flexibility.

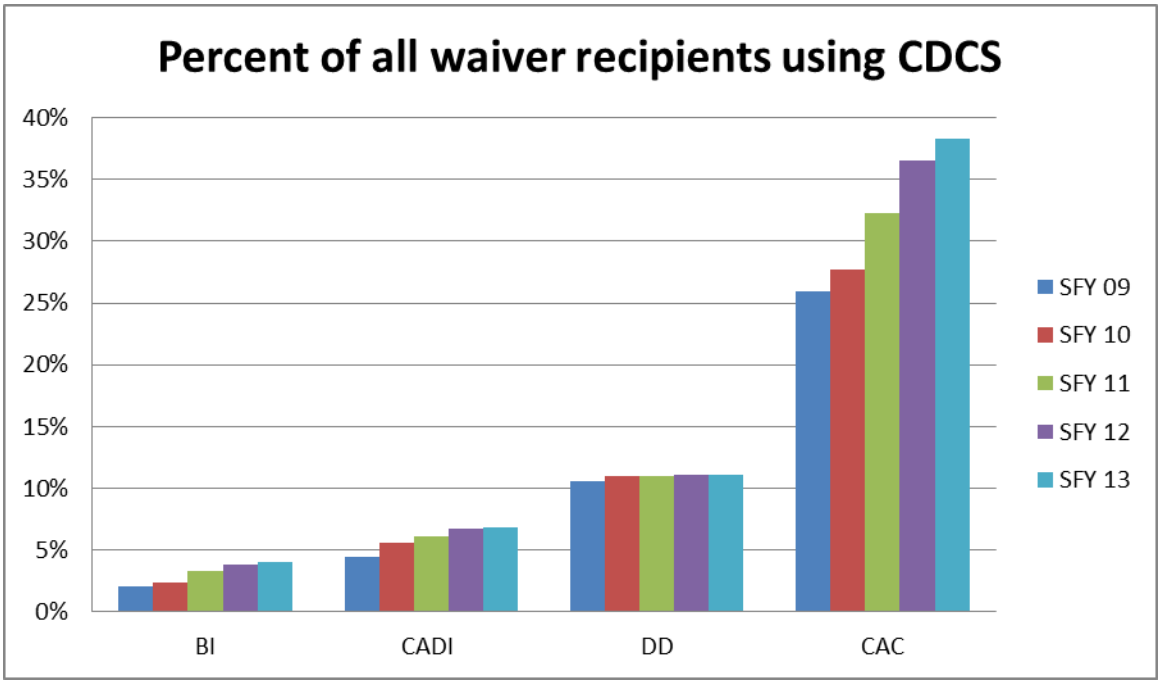
Consumer Directed Community Supports may include services, supports and items currently available through the waivers, such as assistance with personal care or environmental modifications for accessibility. The additional flexibility built into Consumer Directed Community Supports expands a person's choice to purchase support from people such as parents or spouses. People who participate in this decide how much to pay the people they hire to provide their services. In addition, a person may purchase other allowable supports and goods to support their ability to live in and participate in the community. DHS determines individual budget limits for Consumer Directed Community Supports recipients.

Legislation passed in 2014 allows a 20 percent budget increase if necessary to people on Development Disabilities (DD) Waiver or Community Alternative for Individuals with Disabilities (CADI Waiver who:

- Are at least 21 years old
- Have graduated from high school between 2013 and 2015
- Use the CDCS program
- Can demonstrate they would have to leave CDCS in order to purchase day or employment supports because these supports cannot be met within their current CDCS budget limits.

Sixty-six people have used this 20 percent adjustment. It is a time-limited demonstration to learn how the additional money will help graduates with employment. It will expire on June 30, 2017.

Figure 11: Percent of all waiver recipients using CDCS (SFY 2009 – SFY 2013)



Consumer Support Grant

State grants provide flexibility and freedom of choice to participants. The Consumer Support Grant program is an alternative to medical assistance home-care services. Like consumer-directed community supports, it allows for greater freedom of choice in service selection and service delivery. With the Consumer Support Grants, people only use the state share of what otherwise would have been provided through home care.

People can use Consumer Support Grants to purchase a variety of goods, supports and services beyond what is available through medical assistance. It is an alternative to using traditional home-care services. Minnesota spent approximately $19 million on Consumer Support Grants in state fiscal year 2014.

Family Support Grant

The Family Support Grant is a state-funded program that:

- Helps families access disability services and supports
- Prevents out-of-home placement of children with disabilities
- Promotes family health and social well-being.

The Family Support Grant program provides cash grants to eligible families with children who have certified disabilities. These grants offset the high expenses directly related to a child's disability. They can be no more than $3,113.99 in state fiscal year 2015 for each eligible child. Minnesota spent approximately $2.5 million on Family Support Grants in state fiscal year 2014.

C. Community inclusion

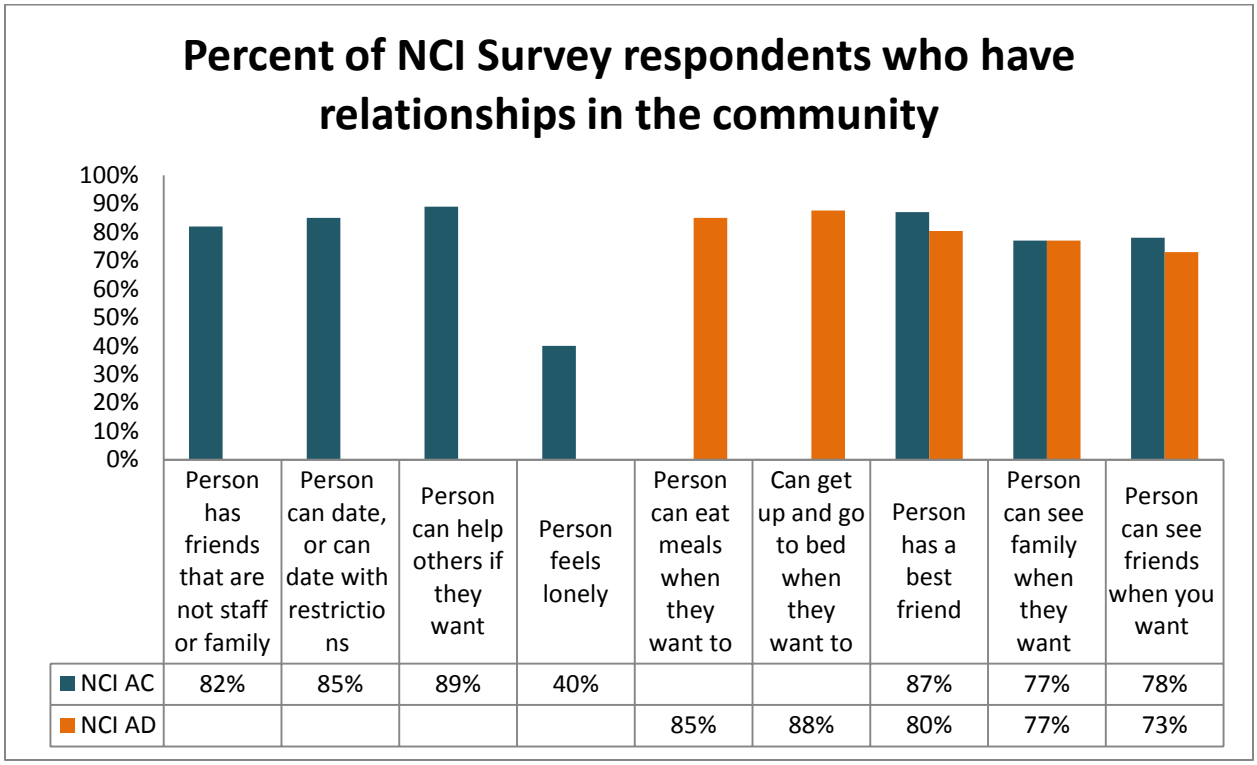
The Americans with Disabilities Act, and Minnesota's Olmstead Plan requires full and meaningful integration for people with disabilities in the community. This aligns with many public policy decisions by the legislature during the past three decades. DHS is committed to making it happen, as we know it benefits everyone. Inclusion establishes more informal/natural supports for people with disabilities and enriches relationships for people with and without disabilities.

As in indicator of progress in that area, the National Core Indicators survey provides insight on how we are doing. We will be able to track our progress over time and how we compare to other states. There are a couple of ways to look at inclusion: In Minnesota, we include relationships with others and engagement in the community.

In the 2014 NCI-AC survey, Minnesotans with intellectual or developmental disabilities were more likely on average than people in other states to report having a best friend, and as likely to have friends other than family or staff, to see their friends when they want to and to date. In terms of community engagement, Minnesota respondents go out for entertainment, out to eat and to religious services as frequently as the national average, but less frequently out for exercise or sports, to shop or to run errands than others.

Minnesota was one of three states to pilot test the NCI-AD survey for older adults and people with disabilities. This survey excludes adults with intellectual or developmental disabilities. Because very few states participated, comparison data is not included here.

Figure 12: Percent of NCI survey participants with relationships in the community (2014)



	Person has friends that are not staff or family	Person can date, or can date with restrictions	Person can help others if they want	Person feels lonely	Person can eat meals when they want to	Can get up and go to bed when they want to	Person has a best friend	Person can see family when they want	Person can see friends when you want
NCI AC	82%	85%	89%	40%			87%	77%	78%
NCI AD					85%	88%	80%	77%	73%

D. Responding to changing needs: Case Managers are Essential

Person-centered services recognize that service needs will change over time. A person's needs or preferences might change as well. People need to know that if they need help getting or changing services, someone will be there to help. That someone often is a case manager. Counties and tribal agencies are responsible for case management functions and may provide them directly or contract with another entity for the services.

Case managers:

- Address the changing needs and preferences of the people we serve
- Link people to services
- Monitor the provision of services.

Through the waiver management reviews, DHS determined that case managers visit with waiver recipients 3.6 times over an 18-month period on average — about once every 100 days.

Table 6: Average number of case manager visits in past 18 months

Waiver	Avg. visits in past 18 months
CAC	3.3
CADI	3.7
BI	3.9
DD	4.1

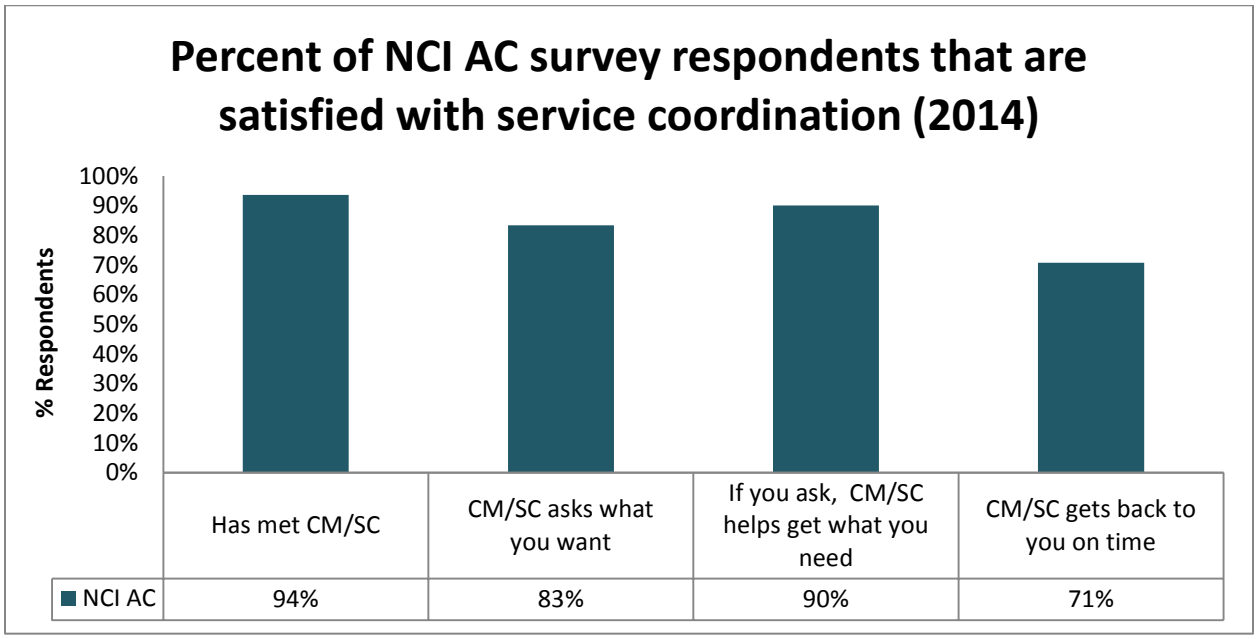
AN EXAMPLE

"Anoka County regularly monitors provider performance and fulfillment of services for people who participate. Anoka County Home and Community Health Care and Community Social Services and Mental Health departments both send out satisfaction surveys to people who participate and/or guardians as well as providers to gather feedback about services. The DD Waiver program has strong quality assurance practices in place. For example, the DD Waiver Specialist has developed a comprehensive plan to conduct evaluation of service providers and provide quality assurance. The results are compiled and shared with case managers and providers. DD unit case managers also use visit sheets to track provider performance and the lead agency issues summary reports to each provider that detail their performance. These practices help ensure that when problems with providers arise, they are identified and addressed in a timely manner."

— Anoka County

National Core Indicators data from 2014 data shows 90 percent of NCI survey participants with developmental or intellectual disabilities indicated their case manager helps them get what they need if they ask. While Minnesota is doing well, there is room for improvement.

Figure 13: Percentage of NCI adult consumer survey participants who are satisfied with service coordination (2014)



In the past decade, several case management reports evaluated and made recommendations on how to improve the current case management structure. While many people have access to various types of case management via the home and community-based services waivers or by being part of specific target groups, others do not. In addition, funding structure is complicated and difficult to navigate.

In 2013, the Legislature required DHS to continue case management redesign. It asked DHS to propose legislation (PDF) to redesign the home and community-based services case management system (Minnesota Laws 2013, Ch. 63 Sect. 19). The advisory workgroup met regularly in the previous year and several times in 2013-2014. Their recommendations were published in a June 2014 joint report on Minnesota Case Management Reform (PDF) with Chemical and Mental Health Services Administration- Adult and Children's Mental Health Divisions.

DHS recommended a process to standardize the definition and services activities of case management administered by mental health and disability services divisions. It also provided guidance on standards, outcome measures, increased choice of service provider, caseload size and payment methodologies and rates.

The implementation of MnCHOICES allows DHS to separate many of the administrative functions assigned to case managers. With MnCHOICES, administrative functions are now more clearly defined, and we pay for the administrative functions associated with assessment, service authorization and resource management in other ways. DHS will look at whether to remove case management as a waiver service and fund it in another way that would be more consistent with other forms of case management. For example, one option is to redefine the target populations to make funding streams and payment for case management services more consistent across populations. Going forward, DHS will look to increase opportunities for people who use case

management to have a choice of who provides that service. We are committed to developing consistent provider standards with a focus on quality outcomes.

VI. Provider capacity

What's important: There are sufficient service and support providers and they possess and demonstrate the capability to effectively serve people.

SUMMARY

- Our system is now truly a home and community-based system. Minnesota's network of providers has risen to the challenge of serving people outside of institutions.
- The transition has not been completely smooth, and developing capacity has caused confusion and disruptions
- The new 245D provider standards and qualifications are in place to standardize services and participant experience.
- The College of Direct Support provides courses online to enhance knowledge to people with disabilities, their families and their providers.

It is crucial for Minnesota to have a strong network of quality service providers and top-notch services. To that end, 2014 brought many changes to Minnesota's disability services system, including:

- A new assessment tool (MnCHOICES)
- A new disability waiver rate setting system (DWRS)
- New provider standards (245D)
- Positive supports.

Just one of these changes alone would have been a major shift in the way the disability service system operates. Together, they were a tidal wave of sometimes difficult, but necessary, changes. DHS knows that counties, tribal agencies, health plans and service providers are struggling to integrate the reforms into their operations.

To help lead agencies (counties, tribal agencies and managed care organizations) and providers make sense of the reforms, DSD has implemented a 'Making sense of systems change' communication plan to illustrate how these changes work together.

These changes are important to deliver personal choice, independence and safety for people with disabilities. We want people with disabilities as engaged as they are able to be when making decisions that affect their lives. Because of the volume of change, DHS feels it is important to address common misunderstandings and provide awareness about what resources are available.

We want to retain and build provider capacity through education of what these changes mean and how they can be used to support people in need of services in a more person-centered and cost-effective manner.

A. Provider networks and availability

Having the ability to make a meaningful choice about service providers is an important aspect of seeing full integration of people with disabilities in the community. In previous reports and surveys, counties and people who participated explained that without sufficient capacity, their choices of where to live or work were limited.

Having a robust, qualified workforce is another critical component of provider availability. The development and retention of direct-care professionals is essential to serving the needs of people with disabilities. Insufficient capacity can exist by geographical region and/or specialty or expertise.

The 2014 legislation that granted a 5 percent rate increase to providers was important to this goal. Eighty percent of the rate increase was dedicated to employee compensation. This adds stability to the system and helps retain providers.

IMPORTANT POINT

Having a robust, qualified workforce is another critical component of provider availability. The development and retention of direct-care professionals is essential to serving the needs of people with disabilities.

DHS implemented a statewide disability waiver rate system on Jan. 1, 2014. The system provides consistent statewide methodologies for establishing service rates for most services provided under the DD, CADI, CAC and BI waivers.

In 2014, the law capped provider rate changes at 0.5 percent for services to all ongoing and most new service recipients. Future rate changes are capped to limit the annual change through 2018 to allow for a five year transition plan to the new rates. DHS issued a legislative report in January 2015 specific to implementation of the statewide disability waiver rate system.

In November of 2014, there were 3,825 home and community-based service providers enrolled with Minnesota medical assistance. They cover 42 services that support people with disabilities. There were 292 day training and habilitation providers and 212 intermediate care facilities for persons with developmental disabilities.

In 2013, DHS surveyed counties about service availability during 2011 and 2012. Every county responded. They indicated:

- Nearly 70 percent of Minnesota counties had unmet service needs in the area of transportation
- Sixty-two percent of the counties did not have as much crisis respite care available as they needed
- More than half the counties needed more:
- Specialist services, chore services, non-crisis respite (tied at 54 percent)
- Night supervision, housing access coordination, behavioral programming (tied at 53 percent)
- Adult day care, adult bath (52 percent).

Counties also identified recruiting and maintaining staff, affordable housing, distance and isolation as barriers to improving access to these services.

People who use services agree that transportation is a major issue. There are not enough transportation options available to meet the need. Other priorities by those who use services include assistance with finding and keeping a job and a need for more supported employment services.

Figure 14: Top services counties reported as having gaps (2011 – 2012)

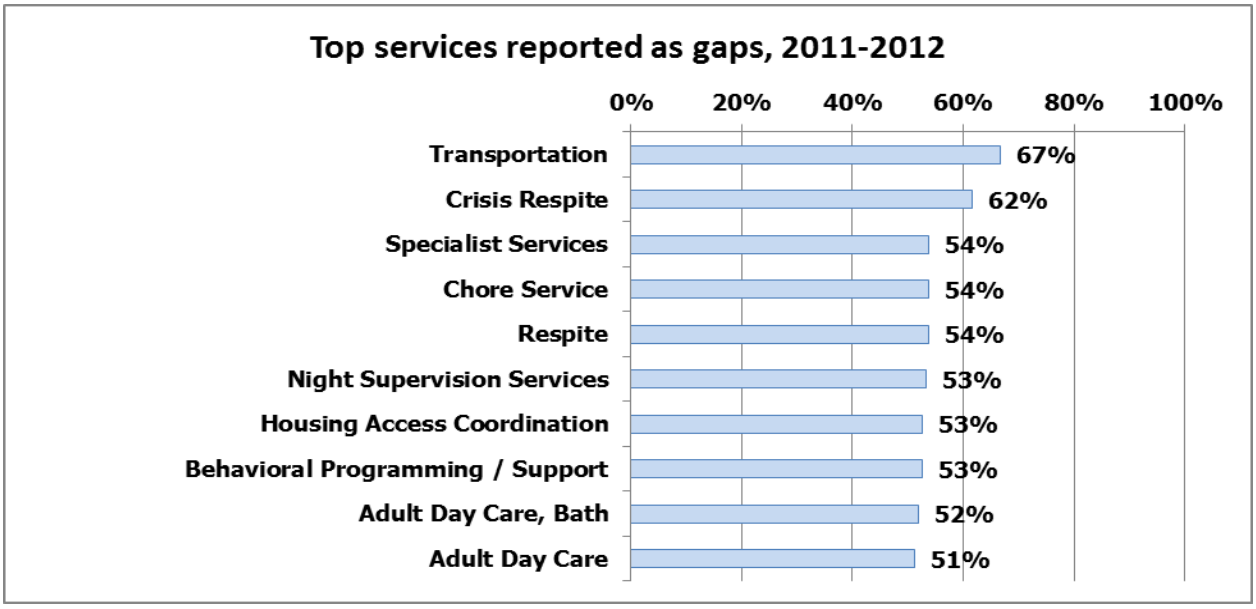
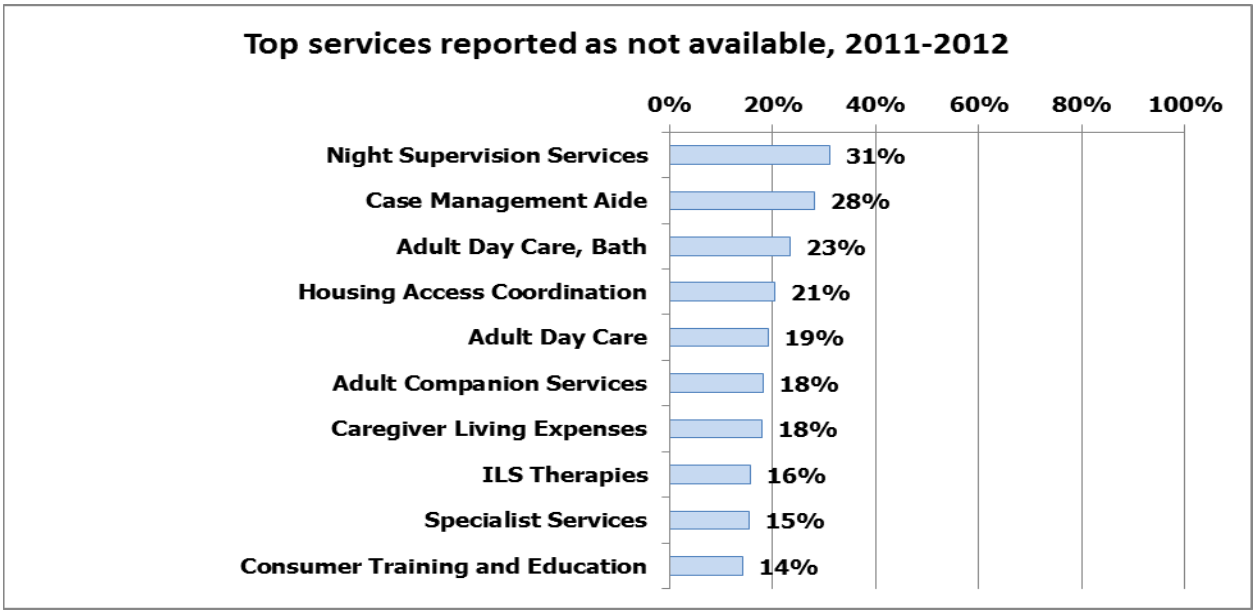


Figure 15: Top services counties reported as not available, 2011-2012



Addressing service gaps

DHS is addressing issues with provider availability, we:

- Are doing studies to determine what the essential services are to help someone remain in their own home
- Are monitoring gaps in services for older Minnesotans, people with disabilities and the availability of mental health service through county surveys and consumer focus groups
- Are studying the impact, if any, that changes in rates and moving from a county-based to a statewide system of determining provider qualifications might have on provider availability
- Have grants to guide some service development.
- Promote self-directed services (such as the Consumer Support Grants, Family Support Grant, and consumer-directed community supports) to allow people who participate to have more flexibility.

Corporate foster care needs determination

The 2009 Minnesota Legislature authorized a moratorium, or freeze, on growth of corporate foster care for adults and children. Corporate foster care is a setting, a home licensed as foster care where the license holder does not live in that home. In 2011, legislation followed establishing a statewide capacity reduction for corporate foster care. The state met that deadline of June 30, 2014.

The goal of the moratorium and statewide capacity reduction was to save money during difficult economic times and promote practices that provide more options for those using services. There was a choice of the moratorium or further limits on the growth in the number of new people who could receive services. Data shows that corporate foster care is a more expensive way to serve people on average. More people can receive services by supporting more people with alternative services that on average cost less than typical foster care. The moratorium was intended to promote the use of foster care by those who most need it, and help more people be supported in settings that are more inclusive in their communities.

As part of the moratorium (MN Stat. §245A.03, subd. 7e), DHS must provide the following to Legislature on an ongoing basis:

- Actions taken to manage statewide long-term care services and supports resources
- Information and data on the overall capacity of licensed long-term care services.

DHS submitted the Initial Needs Determination Report for Disability Waiver Residential and Support Services (PDF) in February 2013. We submitted a follow up Need Determination report (PDF) in June 2014.

The August 2015 needs determination report will be part of the larger long-term services and supports gaps analysis report. DHS worked with county moratorium liaisons to meet the goal of a reduction of 128 licensed corporate foster care beds prior to the June 30, 2014, deadline. As part of this initiative, DHS contracts with counties to use local planning grants to develop alternatives to corporate foster care in their areas. Two counties are working on projects independently and

four metro counties are working collaboratively. A new Request for Proposals went out in December 2014 for state fiscal year 2016-2017 to work on the same goal.

Housing for children with severe autism

DHS developed a pilot project to address the need to serve children with severe autism who already are in out-of-home placement. We requested proposals from current and qualified corporate foster care providers to use up to twelve (12) new corporate foster care beds as an exception to the moratorium.

We successfully negotiated with two providers to establish three locations across the state. REM and Meridian are selecting the sites for these homes. They will build three, four-bed homes for children with severe autism. REM will develop two homes: One located in either Stearns or Benton counties and another home to be located in Blue Earth County. Meridian will develop one four-person home to be located in Anoka County. Once that is completed, we will work with DHS licensing and local agencies for appropriate licensing.

This pilot is one approach. We continue to investigate and encourage alternative models for supporting children with autism and their families, including services that will support families who care for their children at home.

WHOM IT WILL SERVE

As an example, Benton County has identified one child who meets the criteria for being served in these specialized homes. It is currently working with the child's guardian and the person-centered planning team to identify the most appropriate location for the home and best school district to meet the needs of this child.

B. Provider qualifications

It is extremely important to those who receive services and DHS that participants in our programs receive services provided by people who are well versed in meeting the needs of people with disabilities.

Establishing licensure requirements that are clear for both providers and those with disabilities lead to improved compliance by providers. This results in better outcomes for those who use those services.

Federal law requires state to operate waivers uniformly across all geographic areas they serve. As a result, Minnesota has implemented a transition to a centralized provider oversight system that began Jan. 1, 2014.[3] The components of this system include:

- A statewide disability waivers rates system

[3] DHS Bulletin #13-56-02 (PDF) and DHS Bulletin #13-56-04 (PDF)

- New DHS licensure requirements for 12 waiver services and consolidation of licensure programs
- Enhanced DHS standards and enrollment processes for services remaining unlicensed
- Elimination of the use of county and tribal waiver provider contracts and transition to an alternative role for counties/tribal agencies in provider oversight functions.

Licensing

To address the need for statewide consistency in services, the 2013 legislature passed new home and community-based services standards under Minnesota Statutes, Chapter 245D. They became effective January 1, 2014. Twelve home and community-based services that previously did not require a license now require a 245D license.

This was a big change and it has not always been smooth. DHS has supported providers and counties through this change by offering ongoing real-time technical assistance through the provider help desk, webinars, monthly phone calls for counties and more. However difficult, the change was necessary to improve the dignity, health and independence of the people we serve. We now are in step with a larger waiver provider standards initiative.

Because of new legislation, many providers have said they like the ability to serve people across the different disability waivers. They say it enables them to provide a variety of services. It has eliminated the need to contract with individual counties, and to hold individual county specific service licenses. It also has allowed such providers to expand services and options to people being served.

People who participate in our services should receive services from qualified providers. It is also important to DHS that recipients are getting what is paid for.

With the new standards in place, home and community-based services providers now must apply to provide waiver services. DHS verifies provider requirements through an enrollment process. The process ensures providers meet both general and service-specific state requirements. All enrolled providers:

1. Enter into a provider agreement
2. Submit required documents
3. Provide signed assurances as part of enrollment and/or license review.

As of Nov. 20, 2014, there were 1,346 245D licensed providers in Minnesota.

Licensing actions are taken when a program has been determined to be in violation of the applicable licensing requirements. Licensing actions are intended to facilitate compliance with licensing standards. Licensing actions include correction orders and conditional licenses under Minnesota Statutes, section 245A.06; denials of licenses under Minnesota Statutes, section 245A.05; and revocation, suspension and fines under Minnesota Statutes, section 245A.07.

Table 7: Licensing sanctions in adult foster care (July 1, 2013 – June 30, 2014)

Sanction type	Number of sanctions
Conditional	13
Denial	5
Fine	81
Revocation	23
Suspension	0
Temporary Immediate Suspension	1

Table 8: Licensing sanctions in 245D programs (Jan. 1, 2014 – June 30, 2014)

Sanction type	Number of sanctions
Conditional	6
Denial	2
Fine	39
Revocation	1

Provider training

To help providers navigate the new 245D world of training requirements, DHS received an appropriation from the 2013 legislature to expand the availability of College of Direct Support to all of Minnesota's disability service providers. As of Jan. 1, 2014, 245D licensed providers must complete an orientation and annual training to help support the person's goals and community support plan.

The College of Direct Support curriculum helps to meet the 245D licensing requirements. It is on-line and available around the clock. It provides a core curriculum that focuses on:

- Helping people with disabilities lead more self-directed lives
- Improving knowledge
- Promoting quality services.

As of Dec. 1, 2014, there are 12,866 people in Minnesota actively using the educational resources available through the College of Direct Support. This number has been increasing steadily during the past year.

FOR MORE INFORMATION

Please see the College of Direct Support item in the individual decision-making section of this report to learn about how people with disabilities can be better informed about their service options.

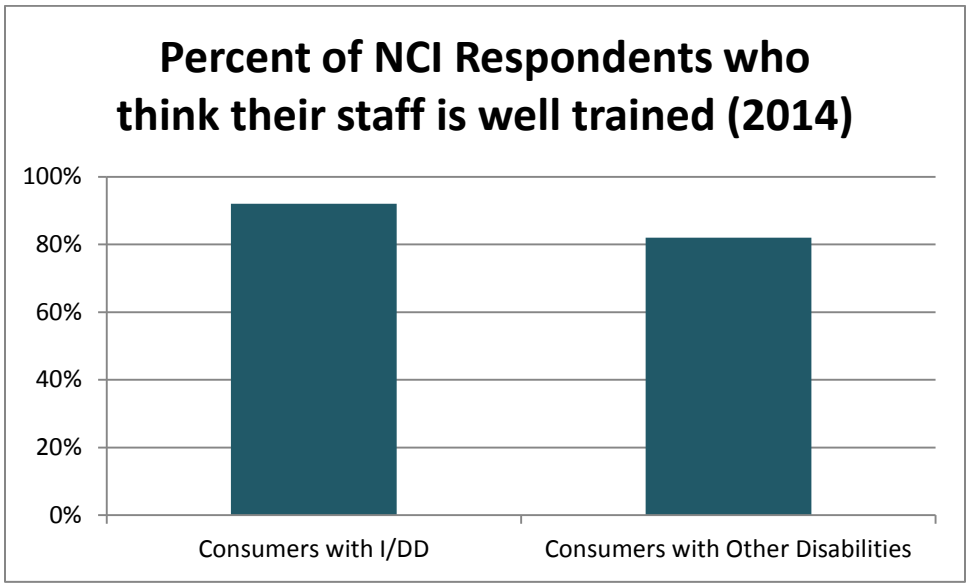
C. Provider performance

Waiver provider monitoring is a coordinated effort. Lead agency case managers continue to provide a critical level of oversight of waiver service delivery. Case managers evaluate and monitor services to ensure that services are being provided consistent with the coordinated service and support plan.

Beyond waiver provider monitoring, DSD is working with the state Management Analysis and Development group to develop a quality monitoring system to provide for a way for lead agency case managers to share information about providers and for the state to monitor system-level concerns.

Analysis of the National Core Indicators Survey indicates that 92% of consumers with intellectual or developmental disabilities believe their support staff have the right training. Among responders with other disabilities, 82% believe paid supports have enough training to meet their needs.

Figure 16: Percent of NCI respondents who think their staff is well trained (2014)



DHS wants to make it possible for people who participate and those who support them to make better and informed decisions about which service to choose. To address that, DHS is developing the home and community-based services (HCBS) report card.[4] It will give consumers the ability to compare providers within a specific service type and learn about others' experiences.

The first phase of implementation, expected to roll out on July 1, 2015, focuses on three topics:

- Independent living skills services
- Registered housing with services
- Supported employment services

[4] HCBS Report Card Legislative Report (PDF)

VII. Individual safeguards

What's important: People are safe and secure in their homes and communities, taking into account their informed and expressed choices.

SUMMARY

- There is an ongoing shift from risk management (or keeping people safe) toward risk mitigation (focusing on informed choice to ensure people define their own quality of life).
- A shift toward person-centered thinking and planning addresses what is important FOR a person and what is important TO a person.

There is a shift occurring away from "risk management" to "risk mitigation" when addressing potential adverse outcomes for people who participate using long-term services and supports.

Up until recently, our "risk management" relied on provider supervision and action to prevent or avoid adverse outcomes for a person. It put the focus on what is *important for* a person in order to keep them safe.

Risk mitigation changes the focus to include what is *important to* the person and allows the person to make decisions about the type and level of risk they are willing to take. This supports informed choice by the person. It allows them to have the quality of life they desire based on their preferences. However, this shift is not simple. It requires an analysis of provider liability. Providers must have incentive to support participant choices. Under risk management, the incentive for the provider is to ensure the person is safe, but that may come at the cost of individual choice.

245D also requires an integrated and normalized environment. This provides the opportunity for self-sufficiency while also ensuring the person receives the required supervision and protection. This level of supervision and protection balances risk — there is a small chance serious harm will happen to the person or others but there is a large chance that the person will have more opportunity to live a self-directed and fulfilling life.

PROTECTIONS IN 245D LICENSING

The 245D licensing standards establish health, safety, welfare, and rights protections for people receiving home and community based services.

A. Risk and safety planning

Identifying a person's risks, safety concerns and potential vulnerabilities is the first step in mitigating risks.

Abuse prevention plans

245A licensed providers must develop an individual abuse prevention plan for each vulnerable adult either residing in their care or receiving other licensed services from them. When services are provided in a licensed facility the provider must also develop a program abuse prevention plan. The plan must contain, at a minimum, an individualized assessment of:

- Statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse
- The person's risk of abusing other vulnerable adults
- The person's susceptibility to abuse by other people, including other vulnerable adults.

Providers and their staff are mandated reporters. This means the law requires them to report suspected or alleged maltreatment. Once identified, the provider must report maltreatment of vulnerable adults to the lead agency's (county, tribal agency or managed care organization) common-entry point contact. Beginning July 1, 2015 there will be a single statewide toll-free number for the common entry point. When a minor is involved, providers must report to the lead agency's child protection unit. From there, lead agency staff refers the report to the appropriate lead investigation agency responsible for conducting the investigation.

Depending on the nature of the allegations and the type of program, the lead investigative team may be DHS, the Minnesota Department of Health or law enforcement. Based on their findings, the lead investigative agency makes a determination of whether maltreatment occurred. When a provider is found responsible for maltreatment, DHS licensing may suspend or revoke the provider's license.

Table 9: Adult Maltreatment: CEP reported maltreatment involving disability waiver participants 18 years and older (2014)

Waiver	Most Recent Reporting Cycle	# County-Investigated Allegations* of Maltreatment with Final Disposition	Number of Substantiated Allegations of Maltreatment	Percent of Substantiated Allegations of Total Allegations Investigated	Most Prevalent Substantiated Allegation Types
BI	4/1/13 - 3/31/14	47	7	14.89%	Caregiver Neglect Self- Neglect
CAC	4/1/13 - 3/31/14	12	1	8.33%	Caregiver Neglect
CADI	9/30/12 - 10/1/13	558	66	11.83%	Self-Neglect Caregiver Neglect
DD	7/1/13 - 6/30/14	304	67	22.04%	Caregiver Neglect Sexual Abuse

**Allegation types include emotional abuse, mental abuse, physical abuse, sexual abuse, financial exploitation, involuntary servitude, caregiver neglect, and self-neglect. Allegation counts do not equal person counts as multiple allegations can be reported for one person or within on alleged maltreatment report.*

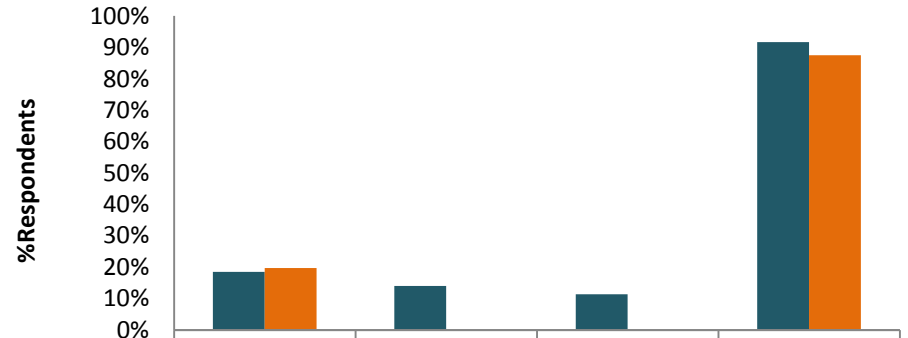
LICENSING REQUIREMENTS

All providers licensed by DHS are subject to the requirements in the Human Services Licensing Act under Minnesota Statutes, Chapter 245A.

In addition, these providers and those licensed by the Minnesota Department of Health, and personal care assistance providers are subject to requirements in the Vulnerable Adult Act (VAA) in Minnesota Statutes, sections 626.557 and 626.5772.

Providers serving children are subject to the Maltreatment of Minors Act (MOMA).

Figure 17: Percent of NCI survey respondents who have felt afraid in their environment (2014)



	Person has felt afraid at home	Person has felt afraid in their neighborhood	Person has felt afraid at work or at day program/activity	Person can talk to someone, if they ever feel afraid
NCI AC	18%	14%	11%	92%
NCI AD	20%			88%

B. Positive supports

Jensen Settlement and the "Modernization of Rule 40"

The Jensen Settlement is the result of a lawsuit filed against DHS in 2009. Residents of the former Minnesota Extended Treatment Options (METO) program alleged they were unlawfully and unconstitutionally secluded and restrained. The agreement allowed the department and the plaintiffs to resolve the claims in a mutually agreeable manner. A Comprehensive Plan of Action outlines the path that the department will take to come into compliance with the terms of the agreement.

DHS agreed to "modernize" the rule that previously governed the use of restrictive interventions including restraint, seclusion and aversive practices for people with developmental disabilities. That rule is commonly known as "Rule 40."

The Comprehensive Plan of Action also required an advisory committee to develop a comprehensive set of recommendations to DHS, which were to be the basis of the new rule. This committee became known as the Rule 40 Advisory Committee, whose recommendations are compiled in the Rule 40 Advisory Committee Recommendations on Best Practices and Modernization of Rule 40 report (PDF).

Key elements of the advisory committee recommendations are:

- Continuous updating of standards to reflect the ever-improving best practices for positive supports, and establish standards for emergency use of manual restraint
- Establishing new monitoring and data collection from the field
- Requiring providers to eliminate all programmatic use of restraints and seclusion
- Requiring the use of positive support strategies and person-centered planning
- Requiring training and competency testing of providers
- Expanding applicability of the rule to all people with disabilities.

On Jan. 1, 2014, 245D laws went into effect. 245D, which oversees many waiver services:

1. Requires that services are provided consistent with the principles of person-centered service planning and delivery
2. Prohibits the use of many restrictive interventions including restraint, seclusion and aversive practices.

The prohibition in Minnesota Statutes chapter 245D on restrictive interventions including restraint, seclusion and aversive practices requires providers to engage in crisis planning to eliminate their use for the persons they serve and substitute them with positive behavioral supports.

In Developing Positive Support Transition Plans: A provider guide for 245D-licensed HCBS services in Minnesota, DHS-6810C (PDF pg. 9), DHS promotes using a crisis framework to de-escalate. We suggest this to create a common understanding and reporting of crises – times when behavioral interventions can be necessary. For the purposes of developing a Positive Supports Transition Plan, DHS-6810 (PDF) as required under section 245D.06, "crisis" refers to a situation that:

- Exceeds a person's resources and coping mechanisms
- Has the potential to endanger the health and safety of the person or others.

The framework also can help support teams to look at ways of reducing recurring crises.

Not every crisis follows a set pattern. Some crises move straight from a trigger phase to a crisis stage. Sometimes a de-escalation phase can escalate back into another crisis. Every crisis can be unique. The crisis support planning necessary for Positive Support Transition Plans required under section 245D.06 identifies ways to support the person in each phase.

245D-licensed providers must submit reports to DHS and the Office of the Ombudsman for Mental Health and Developmental Disabilities when restrictive interventions are used. These reports allow DHS to:

- Respond to incidents of maltreatment
- Track the use of restraint, seclusion and aversive practices
- Provide technical consultation

Providers also must submit their Positive Support Transition Plans to DHS when they are phasing out the use of a restrictive intervention. This allows DHS to track progress of teams as they reduce the use of restrictive practices and instead, implement positive support strategies.

245D-licensed providers must report the use of behavior interventions to DHS and the Office of the Ombudsman for Mental Health and Developmental Disabilities. These include:

- 911 calls
- Aversive procedures
- Deprivation procedures
- Emergency hospitalizations
- Mechanical restraint
- Seclusion
- Administration of as-needed (i.e. PRN) psychotropic medication.
- Emergency use of manual restraint
- Time out

245D requires a phase out of these practices and requires that providers replace these practices with positive support strategies that focus on:

- Increasing a person’s quality of life
- Person-centered planning
- Self-determination.

For people receiving services who have had a restrictive intervention in their plan, providers had 2014 to phase out the procedure and incorporate positive support strategies into their support plan.

Table 10: Aggregate Data from BIRF reports (July 1, 2013 – Sept. 19, 2014*)

Behavior Intervention Reporting Form Data	**Counts**
Number of providers submitting a report:	398
Number of persons reported on:	1,625
Persons with a Positive Support Transition Plan:	669
Number of persons manually restrained:	963
Number of persons mechanically restrained:	40*
Persons using self-injury protection equipment	22*
Persons using seat-belt/auxiliary restraints:	17*
Number of persons secluded:	70*

*NOTE: DHS has refined our reporting process for these categories to include a manual error-search for reports with incorrect personal identification numbers. As a result, we have revised these aggregate totals so that a person who has been reported on under more than one identification number is now counted only once in the total. The corrected aggregate totals marked with an asterisk are lower than those reported in the July 2014 Data Summary.

The sweeping change that prohibits the use of restrictive interventions under 245D supersedes Rule 40. Thus, the primary focus for the proposed new "Positive Supports Rule" – currently under development – is to ensure a focus on the use of positive support strategies and current best practices to guide the behaviors of people who are served by 245D licensed providers.

Positive Support Planning

To establish positive supports and honor the person's preferences, we start with person-centered planning. Person-centered planning focuses on the person's preferences, talents, dreams and goals. In any person-centered plan, the person must always be at the center of the process. The process of person-centered planning includes strategies to increase:

- Activities that build on their strengths, priorities, values, and preferences
- Relationships
- The person's quality of life.

The desired outcome of a person-centered plan is a better life for the child or adult.

In its July 2013 report, the Rule 40 Advisory Committee recommended that all service plans not just focus on alleviating target symptoms or behavior. Instead, it recommends that plans:

- Are positive
- Focus on improving a person's quality of life
- Include building skills to achieve their desired life.

"Positive support strategies" focus on a combination of environmental changes along with support to enhance a person's:

- Ability to use socially acceptable behavior to reduce challenging behavior
- Self-regulatory skills
- Socially acceptable communication skills.

Positive support strategies reinforce desirable behavior while removing the source for challenging behavior. Person centered planning is very important to learn more about a person and their life circumstances. This may help us better understand why certain behaviors and reactions occur and better plan for positive ways to support them.

FOR MORE INFOMATION

See the section on person-centered planning in this report to learn more about what it is and how it is used.

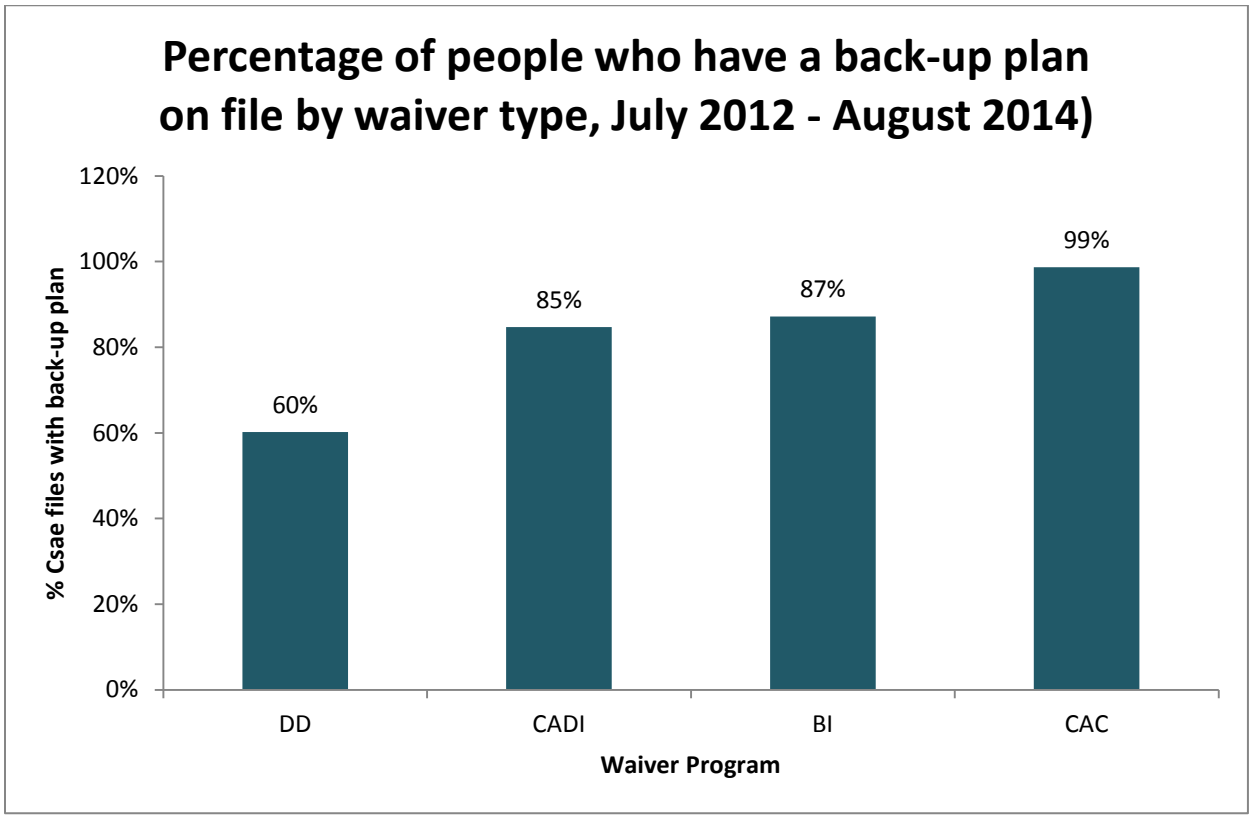
C. Crisis management

There are processes in place to handle difficult or dangerous situations. 245D home and community-based services providers must have plans in place for when people served by the program have a crisis

This requirement stems from our federally approved waiver plans. Compliance has improved as lead agencies (counties, tribal agencies and managed care organizations) understand/learn that this requirement applies to all waiver participants – regardless of waiver program. One specific requirement is the person has a back-up plan that contains:

3. The participant's preferred admitting hospital or medical care provider.
4. Emergency contact in event that primary caregiver cannot be reached.
5. Back-up staffing plans in event that primary staff are unable to provided needed services.

Figure 18: Percent of people who have a back-up plan on file by waiver type (July 2012 – August 2014).



Natural disasters and other public emergencies

We know that when procedures are in place ahead of time, providers are prepared for the unexpected. Providers who had a plan in place when an emergency happened report that they were able continue operations quickly while maintaining health and safety. Events like the 1997 flooding in the Red River Valley, and the subsequent fires in East Grand Forks, Minnesota, are examples of how the unexpected can test even the most prepared provider.

Advanced planning requirements by the programs is crucial in supporting recovery and maintaining essential services in such disasters.

All 245D licensed providers of home and community-based services must be prepared to respond to disasters and emergencies. Emergencies are events that affect the ordinary daily operation of the program. There are DHS supports in place to assist providers when disaster strikes. If they have a good plan in place ahead of time, we can help fund the recovery process.

FOR MORE INFORMATION

The Minnesota State Council on Disability provides a comprehensive guide for emergency

Crisis respite services

Crisis respite services provide specific short-term care and intervention strategies to a person for both medical and behavioral needs that support the caregiver and/or protect the person or others living with that person. Crisis respite services are available to people:

- On the DD Waiver
- Or eligible for the DD Waiver and need access to this service to mitigate a crisis (crisis-only respite).

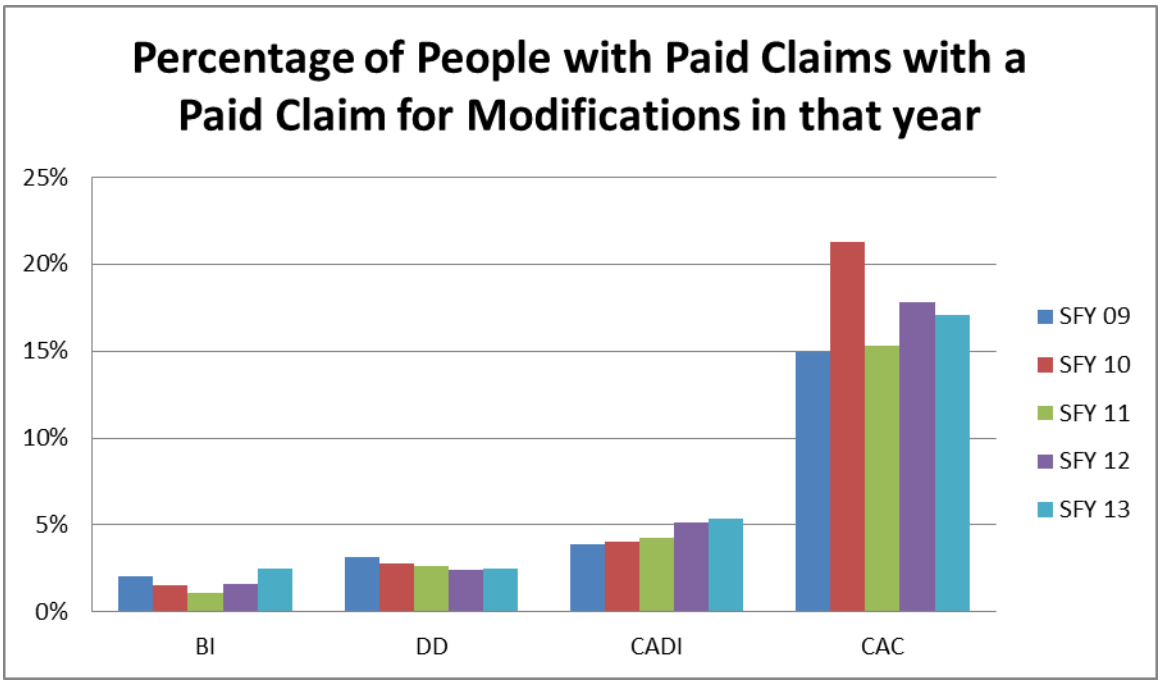
Table 11: Crisis Respite Service Utilization report as of Oct. 3, 2014 (DD Waiver Program only)

CY	Recipient Count	Days of CR Use	Discrete Episodes	Recipient Count With <= 30 Total Days	Recipient Count With 31 - 90 Total Days	Recipient Count With 91 - 180 Total Days	Recipient Count With >= 181 Total Days
2008	589	19,835	6,440	389	161	27	12
2009	566	19,529	6,653	383	145	24	14
2010	578	19,511	6,570	397	144	22	15
2011	551	18,887	6,663	380	132	27	12
2012	521	19,261	6,506	354	134	17	16
2013	493	17,941	5,979	346	106	23	18

D. Housing and environment

Sometimes, someone has a home, but he or she needs adaptations made to the home to make it accessible to him or her. All four waiver plans (BI, CAC, CADI and DD) cover environmental accessibility adaptations for the purchase, installation, maintenance and repairs of environmental modifications and equipment. The repairs must be cost-efficient compared to replacement of the item.

Figure 19: Percentage of people with paid claims with a paid claim for modifications in that year (SFY 2009 – SFY 2013)



Technology for Home

Technology for Home is an initiative available through state funds and a contract between DHS and Live Life Therapy Solutions to offer at-home, in-person assistive technology consultation and technical assistance to help people with disabilities live more independently. Programs like this often can keep someone in their home longer.

With Technology for Home, people who want to stay home or move home direct the outcome. Technology for Home helps with the assistive technology resources. Expert consultants provide possible, cost effective solutions. They communicate with the lead agency to develop a plan for people who receive home care or home and community based waiver services.

The Technology for Home staff consults with eligible people in their own homes, workplaces or public locations. They help people find tools that will help them live in their own homes. The team then follows up to ensure:

- Set up and installation was done properly
- The person and those who support the person knows how to use the tool.

Consultants serve on the person's team to develop a plan to assure that assistive technology goals have been met. Technology for Home consultants have served more than 500 people directly. Of the 250 people with communication difficulties, all have achieved their communication technology goals.

VIII. Individual rights and responsibilities

What's important: People with disabilities receive support to exercise their rights and in accepting personal responsibilities. People are informed of and supported to freely exercise their rights, decision making authority and ability to register grievances and complaints**.**

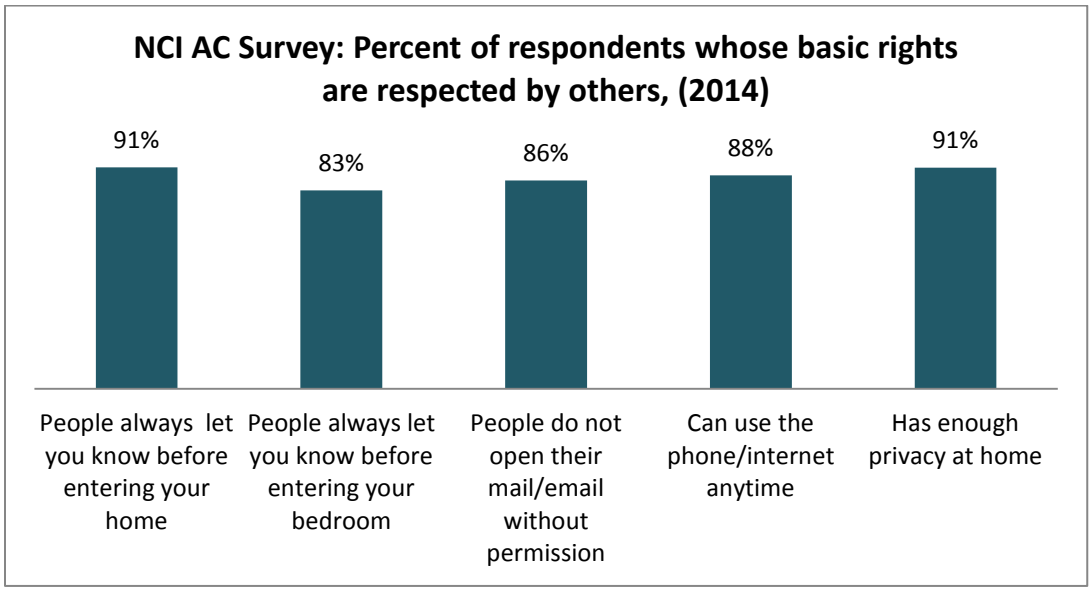
A. Civic and Human Rights

Beyond their rights as service recipients, unless the courts have adjudicated to the contrary people with disabilities have human rights and civil rights to the same extent as others in society. Minn. Stat. §245D.04 gives a set of rights to people who receive home and community based services under. 245D-licensed providers must inform people of their rights in writing within five days of when people first receive their services and every year after that.

Providers are responsible for the use and protection of those rights. There are specific service-related and protection-related rights. These rights may only be restricted to ensure the health, safety and well-being of a person. The provider must document and implement any restriction in the least restrictive way. Providers no longer can restrict rights as a way to control a person's behavior or as a default method to keep a person "safe."

The National Core Indicators Survey identifies how those with I/DD perceive their basic rights are being respected.

Figure 20: Percentage of NCI adult consumer (AC) survey respondents whose basic rights are respected (2014)



Guardianship

The courts decide that certain people with disabilities need someone to act in their best interest and that some of their rights might need to be limited. The Commissioner acts as court-appointed guardian for approximately 2,200 adults with developmental disabilities. These are people who need a high level of supervision and protection when the person does not have another private party who is willing or able to act as guardian.

DSD and county staff works on behalf of the commissioner to substitute as a decision-maker to care for the person. The county staff carries out most of the guardianship duties. This includes completion of annual well-being reports submitted to DSD for review. DSD provides ongoing technical assistance and consultation to the county staff in the performance of their duties. However, certain functions and decisions are not delegated. This includes reviewing requests for the Commissioner's consent for health care decisions for:

- Do Not Intubate
- Do Not Resuscitate
- Limited medical treatment orders.

B. Individual decision-making authority

DHS is making resources available so that people can have the information they need to make decisions. These resources support planning and service delivery that are truly person-centered.

College of Direct Supports for people with disabilities

We collaborate with The College of Direct Support (CDS) to offer free online training to people with disabilities and their families. CDS provides a core curriculum that focuses on:

- Helping people with disabilities lead more self-directed lives.
- Improving knowledge
- Promoting quality services.

DHS promotes this service to people through advertisements in Access Press, exhibit booths at Minnesota-based disability services conferences, as well as referral from the DLL and DSD Response Center.

Advocating Change Together

DHS has a grant contract with Advocating Change Together, a non-profit disability rights organization run by and for people with developmental and other disabilities. ACT programs build self-advocacy in three ways: personal empowerment, disability awareness and systems change.

The Arc of Minnesota

DHS has a grant contract with The Arc of Minnesota, a non-profit, statewide voluntary organization that promotes and protects the human rights of people with intellectual and developmental disabilities and actively supports their full inclusion and participation in the community throughout their lifetimes. Services include information and referral, education and public policy development.

C. Due process and grievances

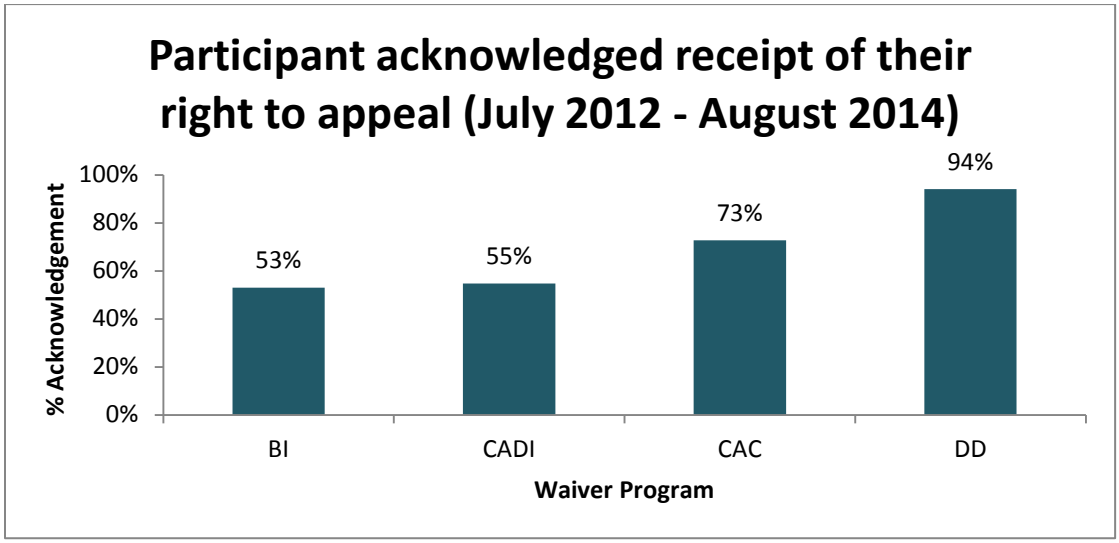
People receiving home and community-based services governed by 245D have the right to bring grievances. Providers must develop and implement policies and procedures that direct how they act on grievances.

Programs that suspend or terminate services are required to provide a written notice to participants that address the person's right to seek temporary order staying the termination of service.

Under 245D standards, providers must develop and implement a policy/procedure that allows people to bring complaints to the person with the most authority in the program. The program is required:

1. Assist the person in bringing the complaint, including who to contact for assistance outside the program.
2. Respond to grievances in a timely manner and must conduct a review of all complaints. (This is seen as a means of continuous quality improvement.)
3. Provide a written summary of the complaint and subsequent resolution to the person and the person's case manager.

Figure 21: Percent of individual files reviewed where the waiver participant acknowledged receipt of their right to appeal information within the past year (July 2012 to August 2014)



The most common corrective action issued to lead agencies in the CCA Waiver Review Initiative is documentation of the participant being informed of their right to appeal (75 percent of 24 lead agencies in the last review round were cited for this issue)

IX. Individual outcomes and satisfaction

What's important: People are satisfied with their supports and services and achieve desired outcomes.

SUMMARY

- DHS works together with other state agencies and stakeholders to provide support across people's lives.
- There is an ongoing shift from monitoring compliances to evaluating people's quality of life.
- DHS surveys people who use our programs to provide additional context to our data about how well services meet their goals.

CARRIE'S STORY

Before I joined the self-advocacy movement, I was treated rather poorly in school and in the community. I was told by various "professionals" that because I had a disability:

- I wouldn't be a contributing member of society
- I'd never get married
- I'd never have children.

I felt like I was a detriment to society, and that there must be something wrong with me because I have a disability. After I got involved in the self-advocacy movement, I became aware of what others with disabilities had gone through and saw that I wasn't alone in the world anymore.

I became an outspoken advocate of making sure everyone has their voice heard, everyone has basic civil and human rights and those rights are retained throughout the duration of their lives. I've been to many conferences and spoke about my experiences and how self-advocacy has helped me and many others have a better quality of life. I've managed to prove all those 'professionals" wrong.

— Carrie Varner, SELF-ADVOCATE

A. Individual Satisfaction

The services and supports we oversee are meant to improve the quality of life for people with disabilities in Minnesota. We have learned that the best way to find out the impact on people's lives is to ask them.

Vital Research, through a contract with DHS, recently completed a survey of adults with developmental disabilities in Minnesota and pilot-tested a survey instrument for adults with physical disabilities and older Minnesotans. This year we will also survey family members of children and adults with developmental disabilities living at home to more fully understand their experience.

Some of the results from that survey have been included throughout this report. As we begin to measure, we will better be able to identify where we can improve our programs to better serve people. By and large, people with intellectual and developmental disabilities and those with other disabilities like their work and living situations. There are indications; however, that given the opportunity, they might like a different living or working situation.

Table 11: Satisfaction with job, living situation and day activities among NCI survey respondents (percent)

Respondents	Likes Job	Wants to Work Elsewhere	Likes where they live	Wants to Live Elsewhere	Likes Day activities	Wants to Change Day Program
Respondents with intellectual/ developmental disabilities	89%	36%	89%	26%	88%	43%
Respondents with other disabilities	N/A	N/A	77%	40%	60%	N/A

In addition to surveys, DHS is evaluating what outcome and satisfaction measures it can add to the MnCHOICES assessment to ensure we have the right data to evaluate the system

performance. That is a key part of ongoing quality improvement. We will ask a specific set of questions as part of every MnCHOICES assessment to identify:

- If individual outcomes are being achieved
- Where the system is doing well
- Where improvement is needed.

B. Employment

People with disabilities are much more likely to live in poverty than people without disabilities. Employment among people with disabilities, even in the best economic times, lags behind their peers without disabilities. Rates of employment differ among different types of disability.

IMPORTANT POINT

Recent data shows 80 percent of Minnesotans without disabilities are working, compared with only 43 percent of Minnesotans with disabilities.

The goal for employment in Minnesota's Olmstead Plan is for people with disabilities to have choices for competitive, meaningful and sustained employment in the most integrated setting.

Among people with intellectual disabilities served through long-term services and supports in Minnesota, only 17 percent work alongside people without disabilities. In other states, this number is as low as 2 percent and as high 87 percent for people in integrated work settings.

Often, young people with disabilities and their families believe that work will have a negative impact on needed supports. As part of the Minnesota Olmstead plan, DHS is developing a strategy to educate families on the benefits of work and the impact on disability benefits. DHS is collaborating with the Minnesota Department of Employment and Economic Development and the Minnesota Department of Education to connect with young people with disabilities. We hope our outreach will show them the benefits of work.

FOR MORE INFORMATION

The Minnesota Department of Employment and Economic Development's program for people with disabilities seeking jobs is helping people achieve rewarding careers.

Employment First

Minnesota's Employment First policy presumes that people with disabilities can work, want to work, and do work. We want to promote informed choice. That allows people with disabilities to choose from a range of options and opportunities. To do so, a person needs information that is relevant, factual, and based on experiences. That is the only way someone can make the best personal decision about integrated competitive employment.

State agencies must ensure that Minnesotans with disabilities understand their options and know about the potential impact of work on their quality of life. The Employment First policy requires

evidence of informed choice by encouraging people with disabilities to participate in experiential activities such as:

- Information about the benefits of work
- Exploration and support
- Work experience and employer engagement.

We have a lot of work to do to achieve an employment-first mindset:

- Only 40 percent of case managers reported that their counties have adequate employment support and prevocational services available.[5]
- In an online survey of community members and stakeholders, 52 percent reported their communities do not have enough supported employment services
- 60 percent responded that their communities lack help with finding and keeping a job.[6]
- 23 percent of providers surveyed reported that community-based employment was a top service gap in their community, consistent across size of communities.[7]

Centers for Medicare and Medicaid Services rules set mandatory qualities of home and community-based settings. This requires those settings to:

- Be integrated
- Optimizes individual initiative, autonomy, and independence in making life choices
- Provides people opportunities to seek employment and work in competitive integrated settings.
- Support access to the greater community.[8]

Over the past two years, DSD has taken several steps to help improve integrated, competitive work outcomes for the people we serve:

- Developed new service options and rates to better align with competitive employment outcomes
- Integrated work discussions into person centered planning (MnCHOICES, Moving Home Minnesota)
- Led the collaboration to develop the Employment First Policy
- Gave technical assistance to our lead agencies and systems to change practice (training on customized employment).

The Olmstead plan and the newly adopted Employment First Policy are critical components in the implementation and service design to align funding with policy.

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[5] DHS Waiver Review, Case Manager Survey 2006-2012, as cited in MN Community Services Input Study Report
[6] Community Services Input Study, Web Survey 2013, as cited in MN Community Services Input Study Report
[7] DHS Waiver Review Provider Survey 2012-2013, as cited in MN Community Services Input Study Report
[8] CMS HCBS Settings Rule PPT online (PDF)

Current norms and acceptable forms of supported employment services in the community are not clear. This leaves providers with a wide range of interpretation and implementation. This results in outcomes that are not always state-of-the-art or best practice. DSD is working to clarify the definition of supported employment services (SES) in the Disability Waiver Plan and Minnesota Statute, to align with Olmstead and the federal Centers for Medicare and Medicaid Services (CMS) Final Rule Regulations. These changes will lead to more community integrated competitive employment and eliminate policy barriers.

A legislative report on the final rule implementation was submitted to the Legislature in January 2015.

Disability Benefits 101

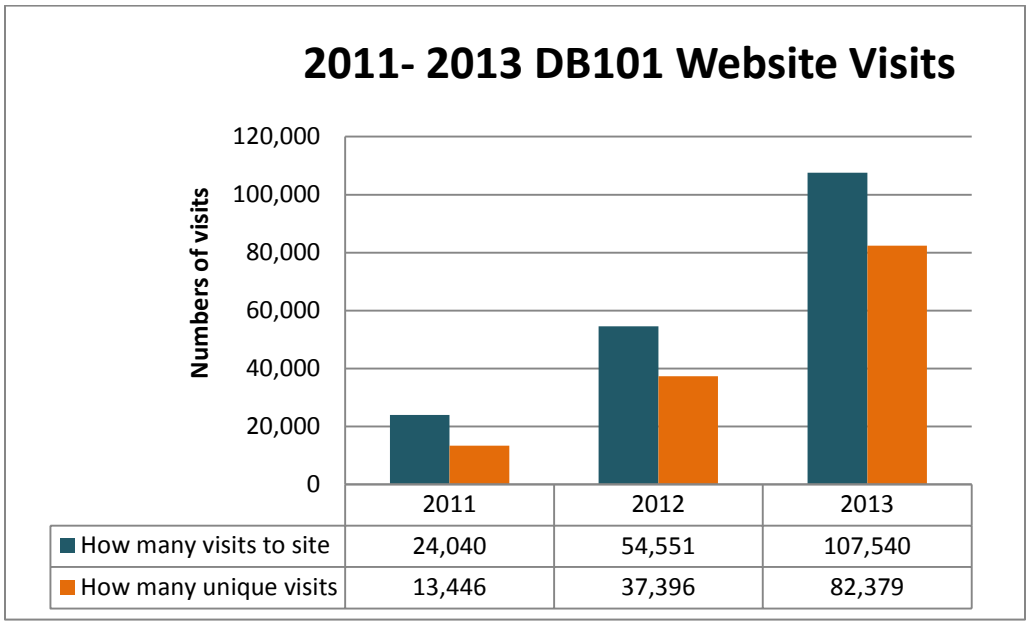
DSD has tools to deliver employment and benefits education. Often people on Social Security benefits do not think work is an option, or they limit their work to avoid impacting their benefits.

To help, in 2010 DSD launched an online tool called Disability Benefits 101 (DB101). DB101 helps people with disabilities learn how income and benefits interact so that they can make informed choices about their work, manage their benefits and maximize their earning potential. The DB101 website offers people consistent information, interactive benefits estimators and real time help.

FOR MORE INFOMATION

See Disability Benefits 101 in the information and referral section of this report to see a brief explanation about how DB101 helps connect people with the right services.

Figure 22: DB101 website visits (2011-2013)



	2011	2012	2013
How many visits to site	24,040	54,551	107,540
How many unique visits	13,446	37,396	82,379

DB101 offers three estimators that allow a person to enter their own benefits information and job scenarios. Then, they can plan for work and understand how work income might affect their benefits. We designed each estimator for specific groups:

- **The School and Work Estimator** is for youth in transition. It walks through important milestones in a young person's move from school to work.
- **The MA-EPD Estimator** helps people interested in learning about Medical Assistance for Employed People with Disabilities (MA-EPD) understand this important work incentive as well as other available healthcare options.
- **The Benefits and Work Estimator** is designed for adults with disabilities, is the most comprehensive with information on how work influences 17 federal and state income and health care benefit programs.

The DB101 "Talk to an Expert" feature is a live-chat staffed by certified options counselors of the Disability Linkage Line®. The live-chat provides people with disabilities instant access to an expert that can answer questions, help navigate DB101, and clarify benefit information successfully to complete an estimator session.

> *"Recently a father who used the "DB101 Talk to an Expert" service shared that his 19 year old son who is on Supplemental Security Income (SSI) recently said he wanted to work. The father said he was going to tell his son he could not work because of what it might do to his SSI benefit; but then thought "I'd better do a little research first". After going to DB101, he said he was surprised to learn how wrong he was. After receiving some additional support via Live Chat, the father shared that he felt he had concrete next steps to help support his son in working and managing his son's SSI benefit."*
>
> — DB101 staff member

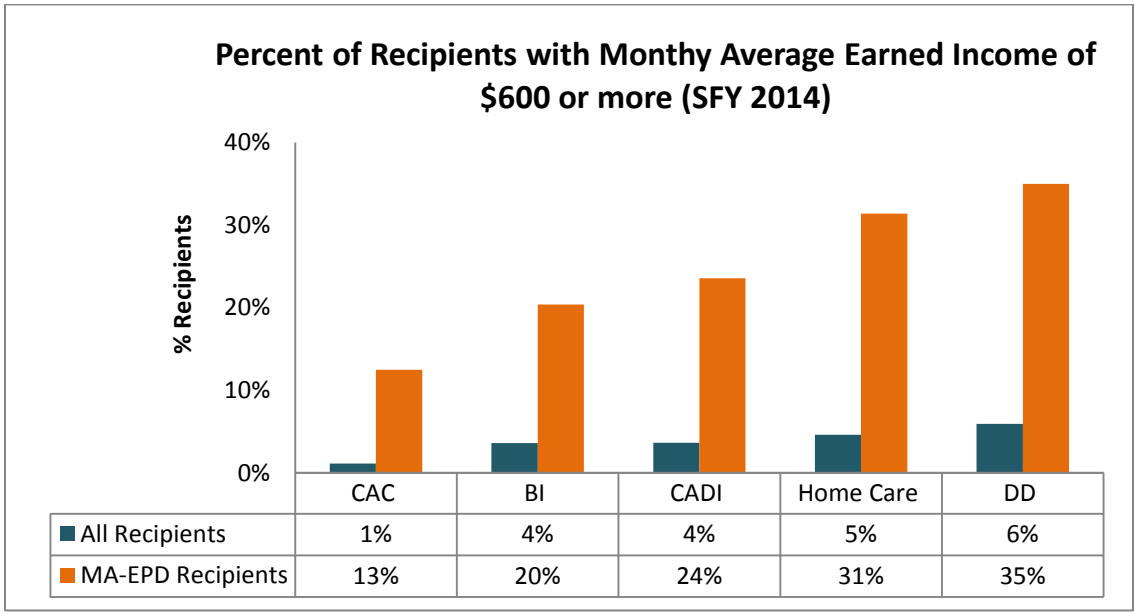
Medical Assistance for Employed People with Disabilities (MA-EPD)

A major barrier for people with disabilities to achieving employment is fear of losing needed healthcare benefits. Medical Assistance for Employed Persons with Disabilities is a work incentive program. It allows people with disabilities to work by allowing them to qualify for Medical Assistance under higher income and assets than regular MA while they are working.

Under MA-EPD, people with disabilities are assured continued access to Medical Assistance for health care services while they are working and earning income. As you can see from Figure 23 (the percent of recipients earning $600 a month or more), people on MA-EPD are much more likely to be earning competitive wages, which for the purposes of the Olmstead Plan measures is defined as $600 per month or more, based on working twenty hours per week at minimum wage.

There are currently around 8,600 people with disabilities on MA-EPD.

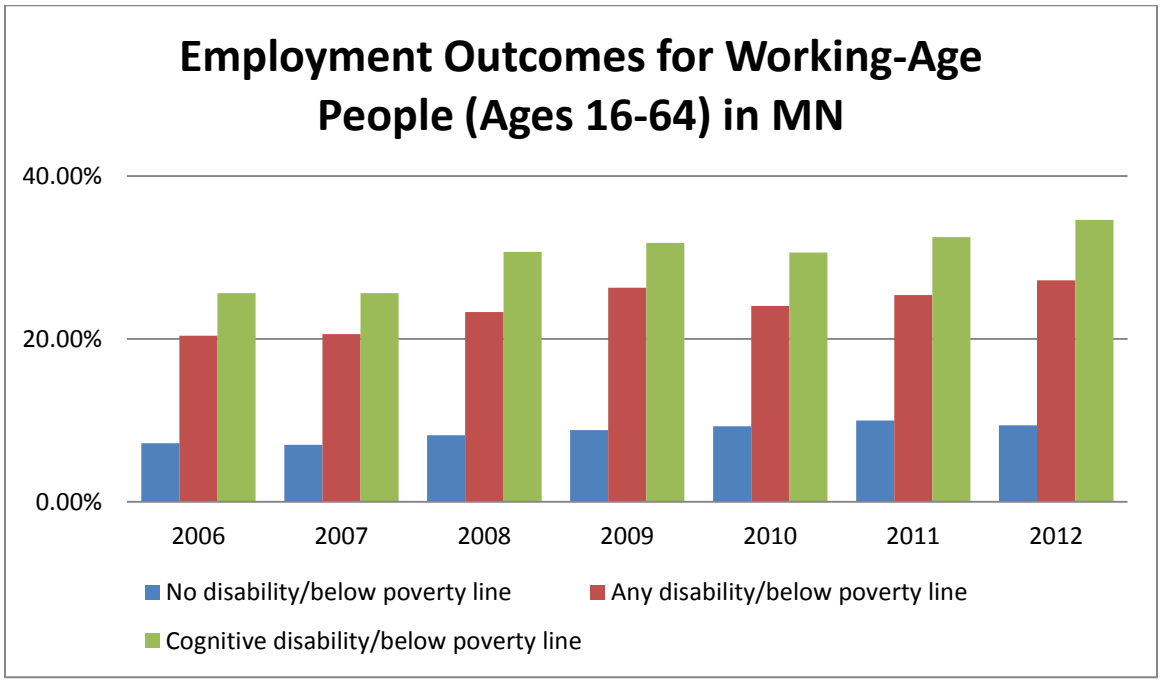
Figure 23: Percent of recipients with monthly income of at least $600.00 (SFY 2014)



Consistently in the past six years, only 22 percent of working age adults on the Developmental Disabilities Waiver earns $250 or more per month. Similarly, around 10 percent of working age adults on the Community Alternative Care (CAC), Community Alternatives for Disabled Individuals (CADI), and Brain Injury waivers earn $250 or more per month. This equates to $3,000 or less each year — well below the current federal poverty guideline of $11,670 per year for one-person households.

While 9.5 percent of the working-age people without disabilities in Minnesota live below the poverty level, 27 percent of those with a disability live in poverty. Thirty-five percent of people with a cognitive disability live in poverty.

Figure 24: Percentage of people in poverty by the presence and type of disability (all Minnesotans) (2006 – 2012)



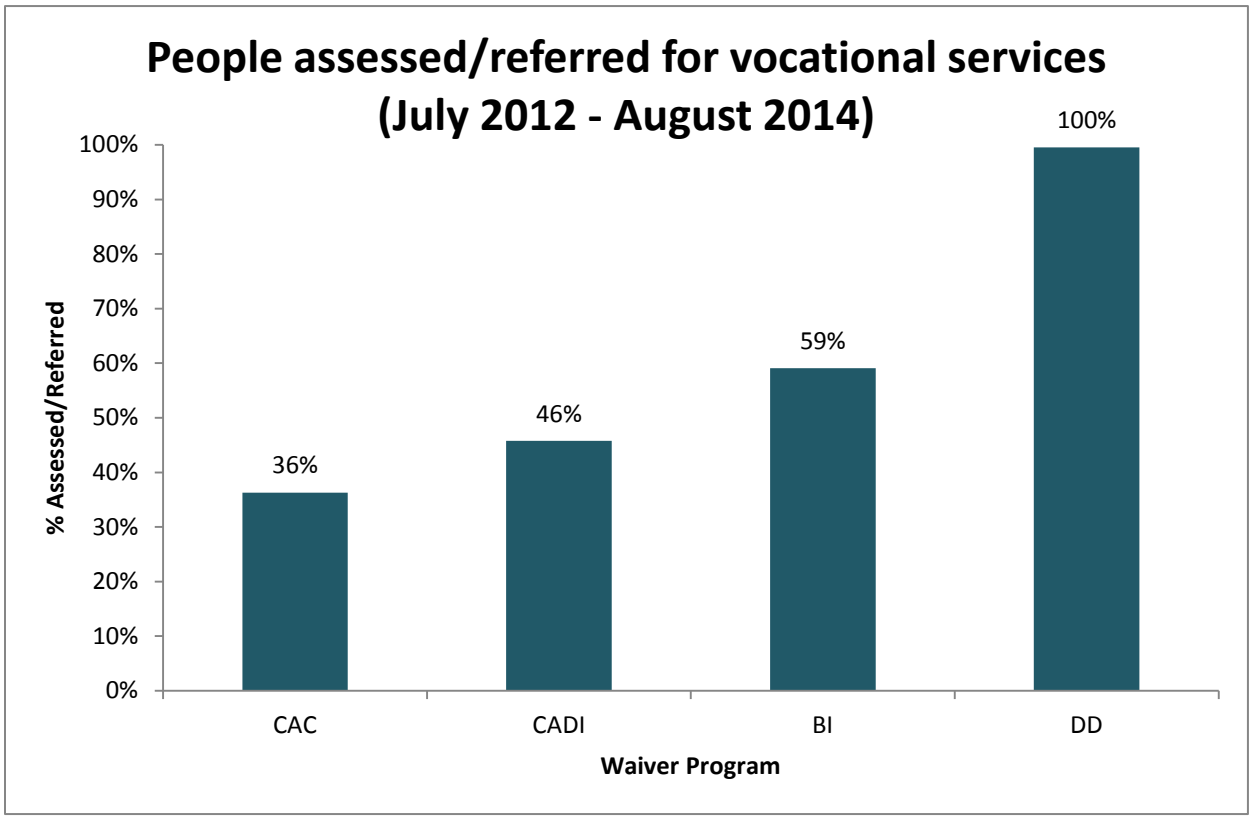
We know that work provides positive social, economic and emotional outcomes for people. To address that, Minnesota law requires that long-term care consultation services must:

> *"Provide information about competitive employment, with or without supports, for school-age youth and working-age adults and referrals to the Disability Linkage Line and Disability Benefits 101 to ensure that an informed choice about competitive employment can be made…"*

The waiver review team works to ensure technical compliance with this for persons on BI, CAC, CADI and DD. Files in the sample for each person 16 to 64 years old are reviewed by the team looks evidence that:

- Work skills and abilities have been assessed
- Employment services were offered to the person.

Figure 25: Percent of individual files reviewed for people 16 to 64 years old who were assessed/referred for vocational services/information, by waiver program (July 2012 to August 2014)



The current assessment tool, the DD Screening Document, DHS-3067 (DHS), includes a service-planning process for employment. This has not been the case with the other waivers. To address this, DHS added questions on this topic to the long-term care consultation legacy document. There also is an entire domain in MnCHOICES assessment on this topic.

C. Housing

Having a sense of control and ownership over one's living space is important to people, including people with disabilities. Supporting people to live independent lives to the extent possible is a priority for DSD – it is important from a human perspective as well as making fiscal sense.

Housing access services

More than 1,160 people with disabilities are living in safe, affordable homes of their own because of a state grant funded program sponsored by the Minnesota Department of Human Services and The Arc of Minnesota. Housing access coordination has been available through the DD Waiver, but the Housing Access Services grant enabled a focused effort at developing this service to serve more people and create a prototype for future inclusion in all the disability waivers as a MA funded service.

Housing access services helps Minnesota adults of all ages. To be considered, a person must be eligible for certain Medical Assistance programs because of their disability or other health-care needs. In addition to housing, the program connects people to employment supports or workforce centers, nutrition programs and other supports that help them to be successful living in the community.

Once people decide they want to move to their own home, housing access services staff help them find housing. Staff can:

- Find affordable furnishings
- Help complete rental applications and lease agreements
- Meet and negotiate with landlords
- Move belongings.

Housing Access Services also can pay application fees and other expenses. It also can connect people to other benefits, such as food assistance.

More than 1,160 people who have moved since the program started in late 2009. They include:

- Adults who had been living in their family homes
- People who moved to their own homes from group homes
- People who moved from assisted living
- People who were homeless.

FOR MORE INFORMATION

See program participants, families, county and staff tell their stories on YouTube.

Return to Community and Moving Home Minnesota

Moving Home Minnesota is a person-centered approach to help people transition from nursing homes, ICF/DD and other institutional settings to a community-based living setting that meet their needs and wants. Moving Home Minnesota provides services to help during the transition. Those services are available to eligible Minnesota residents for up to one year after their move from institutional care.

Return to Community is a comprehensive initiative to help nursing home residents who want to return to homes in the community. The initiative has two general approaches:

- A formal transition program for people living in nursing homes who want to return to the community
- Interventions to motivate and support nursing home providers to facilitate moves to the community.

Financial impact

Supporting people in the community rather than in a provider-controlled setting makes sense from a financial perspective as well. Essentially, we can be more efficient and effective in our use of resources by supporting more people in homes of their own and dedicating more intensive (and expensive) services to people for those who need them. We want to provide the right service at the right time.

Figure 26: Average cost per person across residential service settings (SFY 2012)

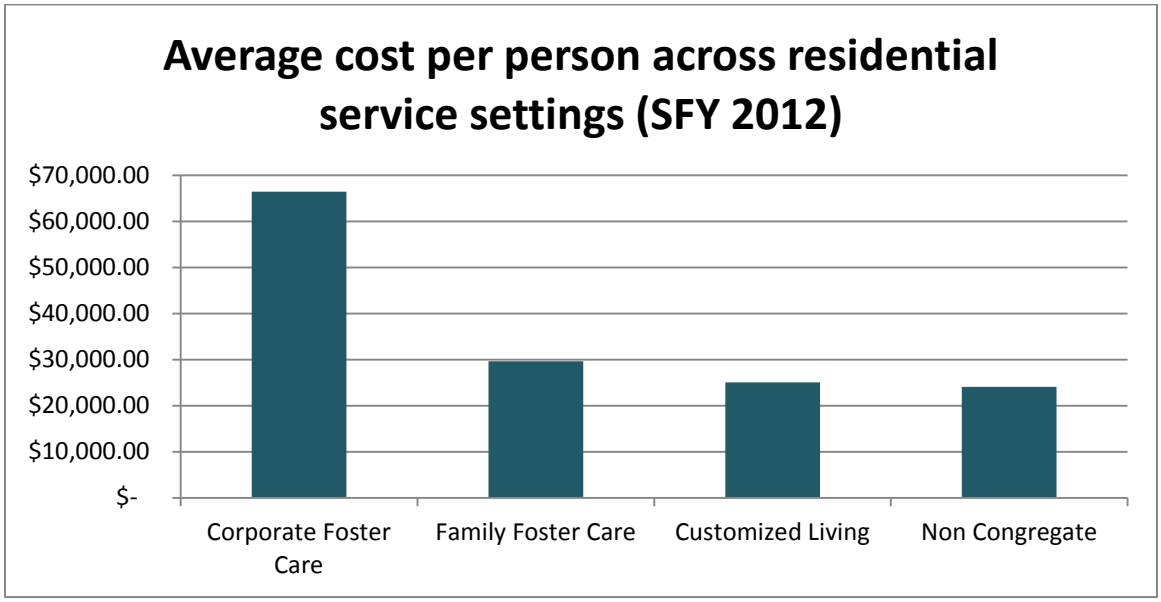
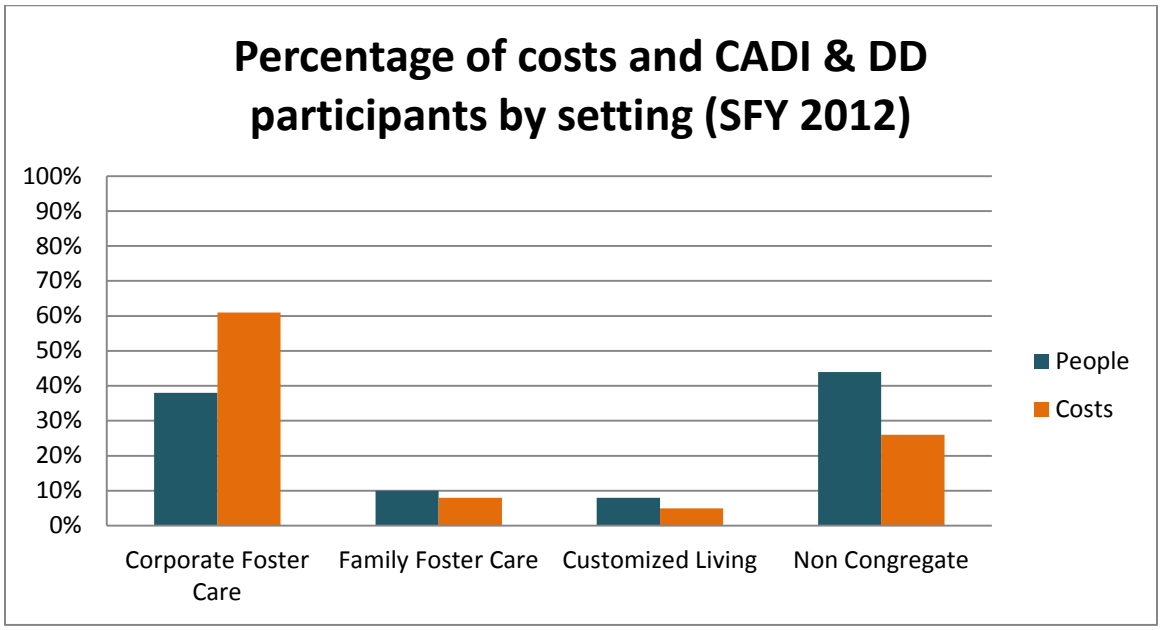


Figure 27: Percentage of costs and CADI and DD participants by setting (SFY 2012)



Home and community-based services rule – setting requirements.

On Jan. 16, 2014, the Centers for Medicare & Medicaid Services issued a final home and community-based services rule. The rule had an effective date of March 17, 2014. The rule identified several components, including criteria for home and community-based settings and person-centered planning requirements. In Minnesota, the rule impacts all home and community-based services waivers, which are the BI, CAC, CADI, DD and Elderly Waiver. The rule allows for a five-year transition plan for existing programs to come into compliance with the home and community-based setting requirements of the rule.

All new programs must comply with the home and community-based setting requirements upon implementation of the new program. This means the state may develop a transition plan for the five home and community-based services waivers (BI, CAC, CADI, DD, and EW), in order to comply with the rule by March 17, 2019. The transition timeline and activities are based on a plan submitted by the state and approved by the Centers for Medicare & Medicaid Services. DHS submitted Minnesota's statewide transition plan on January 8, 2015. The rule also affects the community first services and supports (CFSS) option, which will replace personal care assistance (PCA); however, community first services and supports will need to comply with the rule upon implementation of the service.

General requirements

The home and community-based setting requirements in the rule contain general requirements that apply to all settings, including residential and non-residential setting, where people are receiving home and community-based services. According to guidance from the Centers for Medicare & Medicaid Services, the requirements in the rule establish an outcome-oriented definition that focuses on the nature and quality of a person's experiences.

The requirements maximize opportunities for people to have access to the benefits of community living and the opportunity to receive services in the most integrated setting appropriate to meet an their needs. According to the rule, a home and community-based setting:

- Ensures a person's right to privacy, dignity, respect, and freedom from coercion and restraint
- Ensures the person receives services in the community to the same degree of access as people not receiving home and community-based services
- Facilitates individual choice regarding services and supports, and who provides them
- Is integrated in and supports access to the greater community
- Is selected by the person from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The person-centered plans must document the option available and choices made by the person.
- Optimizes individual initiative, autonomy, and independence in making life choices
- Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources.

The rule is clear that home and community-based settings do not include:

- Hospitals
- Institutions for Mental Disease (IMD)
- Intermediate care facilities for persons with developmental disabilities (ICFs/DD)
- Nursing facilities.

The rule also identifies settings that CMS will presume are not to be home and community-based. States can choose to submit evidence to the Centers for Medicare & Medicaid Services demonstrating how the setting is, in fact, home and community-based. The information submitted will be subject to a heightened scrutiny process by CMS.

The settings that are presumed not to be home and community-based include:

- Settings in a publicly or privately-owned facility providing inpatient treatment
- Settings on the grounds of, or adjacent to, a public institution
- Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid home and community-based services.

Residential settings

The rule includes additional requirements for residential settings where the service provider owns or controls the setting. These additional requirements include:

- All units or dwellings must have a lease, or similar legally enforceable agreement, which includes the same responsibilities and protections from eviction as all tenants under property owner tenant law of state, county, city or other designated entity. If tenant laws do not apply, the written agreement must address eviction processes and appeals comparable to those provided under the jurisdiction's property owner tenant law.
- Each individual has privacy in their sleeping or living unit.
- Units have lockable entrance doors, with the individual and appropriate staff having keys to doors, as needed.
- Individuals sharing units have a choice of roommates.
- Individual have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- Individuals have freedom and support to control their schedules and activities and have access to food at any time.
- Individuals may have visitors at any time.
- Setting is physically accessible to the individual.

The rule does allow for modifications to these additional requirements if it is supported by a specific assessed need for a person, and is justified and documented in the person's person-centered plan. The documentation must include:

- Any prior interventions and less intrusive methods the provider has attempted

- Ongoing data measurement to assure effectiveness of the modification
- The person's informed consent prior to making the modification
- The specific assessed need the modification addresses.

X. System performance

What is important: A system that supports people efficiently and effectively and strives to improve quality.

SUMMARY

- The Disability Waiver Rates System (DWRS) reduces redundant administrative systems and supports providing the right service at the right time.
- DHS is working on a number of quality improvement projects with providers to help improve services for people.
- DSD focuses on results accountability asking three questions of our programs and services:
  1. How much did we do?
  2. How well did we do it?
  3. Is anyone better off? DSD works with a number of work groups representing stakeholders, giving them an active role in shaping the direction of our programs.

It is important that our services and systems are flexible and fluid enough to respond as the needs and expectations of the people we serve change:

- An efficient system will provide needed services to more people with potentially lower costs. It is sustainable. It minimizes administrative duplication. It compensates providers fairly. It supports providing the right service at the right time.
- An effective, high-quality system delivers services that result in positive outcomes.

A. Improving Efficiency: The Disability Waiver Rate System

In 2014, DHS implemented the Disability Waiver Rate System (DWRS). It determines the price of services paid by the disability waivers in a consistent and transparent way. The Centers for Medicare and Medicaid Services require uniform rate-determination methods and standards across a state. The federal government determined that Minnesota was not in compliance with federal standards for rate setting and documentation and must develop a statewide system.

DSD conducted extensive research on the cost of providing disability waiver services in Minnesota. After stakeholder input and legislative negotiations, the 2013 Legislature finalized implementation of the Disability Waivers Rate System. DWRS moved to a more centralized mode of operation on Jan. 1, 2014.

The new Disability Waiver Rate System transfers the responsibility of setting service rates from counties and tribal agencies to the state. The system also promotes quality and participant choice. It recognizes a person's assessed need for particular components within each service. Counties and tribal agencies assign waiver funds according to an individual's assessed needs.

Between 2014 and 2019, DHS will conduct a comprehensive evaluation of the Disability Waiver Rate System to assess the following:

- Impact to program outcomes, such as access to services
- Fiscal impacts of DWRS statewide, by lead agency, or by service
- Specific component values that may need to be modified
- Specific policy areas where the application of the system is not accurately implemented by end users.

DHS submitted a legislative report in January 2015 addressed first year implementation of the statewide rate system. We will continue to study the fiscal impact as well as the impact specific populations. We will address:

- Access to services
- The impact of other laws such as 245D on the price of providing services
- The regional variance in the cost of providing services across the state.

B. Measuring Effectiveness

Our ability to measure performance gives policy makers, stakeholders and ourselves a way to reach desired outcomes through:

- Identifying changes connected to an intervention
- Measuring achievement
- Recognizing and replicating what works.

When we cannot access data, we cannot allocate resources and plan effectively. When that happens, programs suffer and we cannot help Minnesotans be more independent, safer and more integrated in their communities.

DSD participates in a cross-division evaluation initiative to help us better understand and share the story of our programs. We offer training internally to employees on data-driven decision-making and results accountability to help us integrate this thinking into our work. We expect this work to continue across the newly organized administrations.

DSD also participates in a cross-division Performance Management Implementation Team. It measures progress on our strategic goals. Their Continuing Care Performance Reports are available on the DHS public website. Governor Dayton recognized the team in December 2012 for outstanding achievement.

Waiver Review Initiative

The Waiver Review Initiative supports the assurances DHS makes to the Center for Medicare and Medicaid Services about home and community-based services. The Center for Medicare and

Medicaid Services requires states to provide evidence that goals[9] are being met. The initiative also:

- Identifies promising practices that improve the quality of service to home and community-based services participants
- Obtains feedback about DHS
- Tracks local improvements.

DHS and its contracted partner, The Improve Group, post best practices and tools to the Minnesota DHS Waiver Review Initiative website. Individual county waiver review reports from 2012 through the present are available on the DHS public website.[10]

National Core Indicators survey

DHS contracts with Vital Research to conduct the national core indicators (NCI) survey interviews. We recently completed a survey of adults with developmental disabilities in Minnesota and pilot-tested a survey instrument for adults with physical disabilities and older Minnesotans. We will be able to compare the experiences of people with disabilities in Minnesota with others from across the nation. We will also be able to see if we are doing better from year to year, which will be one way to learn if the changes described in this report are making a difference in the experiences of people

C. Improving Quality

DHS has a variety of projects that improve the quality of services provided to people with disabilities and older Minnesotans. The Minnesota Legislature has established quality improvement as a priority in long-term services and supports.

KEY TERMS TO KNOW

Quality assurance includes the activities designed to assure that care and services meet an acceptable standard. At a minimum, consumers of disability services should expect providers meeting established standards.

Quality improvement is a data-driven way to move beyond basic standards. It helps providers implement best practices. This helps avoid problems in the first place and increases the likelihood of positive outcomes for participants.

[9] The six categories of assurances are: level of care, service plan, qualified providers, health and welfare, financial accountability, and administrative authority. CMS Waiver Assurances
[10] DHS Waiver Review Reports

Home and Community-based Services Performance-Based Incentive Payment Program (PIPP)

Authorized in 2013 legislation, the home and community-based services Performance-Based Incentive Payment Program (also called HCBS PIPP) provides one-time grants to providers to implement quality improvement projects.

To be eligible for the program, providers needed to serve older adults or people with disabilities through:

- A waiver program
- Alternative Care Program
- Intermediate care facilities for persons with developmental disabilities
- Medical Assistance state plan-funded home care services.

DHS announced $3.5 million in grants awarded in July 2014, for 27 projects serving people in 39 counties in Minnesota. The projects aim to improve participants' quality of life, improve the quality of services or deliver services more efficiently. Selected projects are focusing on promoting choice and person-centered care; participant and employee wellness; use of dance and other arts in therapy; cultural competence in providing services; participant employment; and care coordination and disease management through technology.

Home and Community-Based Services Quality Improvement Projects

Part of 2014 legislation increasing home and community-based service provider rates by five percent. For most home and community-based service providers, one percentage point of that increase is for implementing self-designed quality improvement projects. Projects will be submitted by the end of 2014 for implementation by June 30, 2015.

DHS Continuing Care provider rate and grant 5 percent rate increase in 2014. Most providers that receive the rate increase are required to submit a quality improvement project to DHS by Dec. 31, 2014.[11]

Home and Community-based Services Service Finder (also known as the HCBS Report Card)

A quality improvement activity, initially referred to as the Home and Community-based Services Report Card and now called the HCBS Service Finder, is designed to help people who need long-term care services and supports, their families, and case managers to identify potential service providers based upon qualities that are important to the individual.

HCBS Quality Improvement website

[11] DHS Public Web CCA Provider Rate and Grant Changes

D. Individual and stakeholder involvement

Meaningful stakeholder is critical. We are committed to their involvement in the design, implementation and evaluation of long-term services and supports. There are different types of stakeholders. Each brings a perspective to the table that contributes to making good decisions. Some include:

- Advocates
- Lead agencies (counties, tribal agencies and managed care organizations)
- Service providers
- People with disabilities
- Their families.

People who access services are experts on how our system functions. Their knowledge is more than theoretical — it gives us a necessary perspective. As experts, they deserve to be a part of high-level decision-making. Those conversations and decisions could affect their lives and their families' lives.

Home and community-based services partners panel

In 2008, DHS initiated and became a member of the Home and Community-Based Services Partners Panel, which it continues to support. The Panel is a group that meets regularly and serves as a communication link among the system's stakeholders and as a means to support specific initiatives. Panel members are people with expert knowledge and experience with long-term services and supports, including representatives of consumer and family advocates, mental health and disability-specific advocates, county groups, existing advisory and policy groups, state agencies and other related groups. Members represent organizations that are engaged in statewide activities to support home and community-based services.

Home and Community Based Services county-state work group

DSD and Aging and Adult Services are members of the County-State Work Group. We formed this group in 2010 as a forum for managing legislatively mandated home and community based service reform initiatives with counties, who are the Department's delegated local administrative agents to act on behalf of the Commissioner. Membership is comprised of county and state staff that oversee the administration of home and community-based services; county representatives appointed by Minnesota Association of County Social Service Administrators, Local Public Health Association, and Association of Minnesota Counties; and, additional county members with particular expertise, as needed.

State Quality Council

Early in 2012, DSD convened a State Quality Council, as directed by the legislature (Minn. Stat. §256B.097). The Council is comprised of a diverse group of stakeholders including people with disabilities and family members of people with disabilities. It monitors disability service quality assurance and improvement practices. It recommends state quality-improvement priorities. The SQC quality indicators workgroup developed the indicators used throughout this report.

Other collaborations

At any one time, DSD, often in collaboration with the Aging and Adult Services Division and other Department divisions, may have one or more temporary work groups with external stakeholders running to advise us on specific projects. Current and recent work groups include:

- Autism Spectrum Disorder Advisory Council
- Case management reform
- Community First Services and Supports workgroup
- County state workgroup
- DHS/MDH leadership committee
- Disability Waivers Rate System and subgroups
- Employment Learning Community
- Home and Community-based Services Rule sessions with people with disabilities
- Home and Community-Based Services Waiver Provider Standards and subgroups
- Home Care Nursing (previously PDN) workgroup
- MnCHOICES
- Money Follows the Person Implementation Council workgroup
- Rule 40 Advisory Group
- State Quality Council
- Traumatic Brain Injury Advisory Committee
- Other ad hoc workgroups created as needed for topic/policy areas
- Public meetings, forums, comment periods for formal and high profile changes.

In 2014, DSD contracted with two advocacy organizations to provide recommendations that would enhance communication between DSD and service participants. DSD plans to implement as many of their recommendations as possible. Among the strategies they proposed were:

- Community meetings
- Meeting with families in their homes
- Providing financial support for people participating in DHS groups.

XI. Summary

Minnesota is on a continuing journey to transform services for people with disabilities. We have come from history of large state operated regional treatment centers. As they have closed, Minnesotans with disabilities were able move to homes in communities across that state. Community services have been less expensive with better outcomes

Since then, we have come to rally around CHOICE outcomes for people with disabilities:

- **C**ommunity membership
- **H**ealth, wellness and long-term supports
- **O**wn place to live
- **I**mportant long-term relationships
- **C**ontrol over supports
- **E**mployment earnings and stable income

Today, Minnesota continues the journey with higher expectations for inclusion of people with disabilities in community life. This means:

- Greater independence and choice for people with disabilities; people having opportunities to design their own lives.
- People living in their communities, in their own home or family home or with people they want to live with.
- Full inclusion of people with the disabilities, including those with the most significant disabilities, in the workplace.
- Improved access and greater consistency statewide in services and supports.

These overarching goals are being met through specific reforms related to recent legislative and court directions, which are also consistent with the Americans with Disabilities Act:

- A new assessment and service planning process called MnCHOICES.
- An enhanced focus on positive behavioral supports and prohibitions on restraints and seclusion.
- New provider standards and licensing requirements.
- Conversion to a statewide disability waiver rates system.
- Increasing use of home and community based service for crisis and safety net services
- New strategies to manage increased demands on financial resources, such as better information and assistance to answer questions when people need information, help accessing housing, use of technology to support people, development of new service options, incentives to providers to improve quality and moratoriums on more expensive service models.

These reforms require all of us to innovate and change long-standing practices. We are not where we want to be and the journey is not smooth. We will not always agree on the specifics of how to move forward. We do agree, however, that the journey toward CHOICE for Minnesotans with disabilities is one our state is called to make, with commitment to our obligations under law;

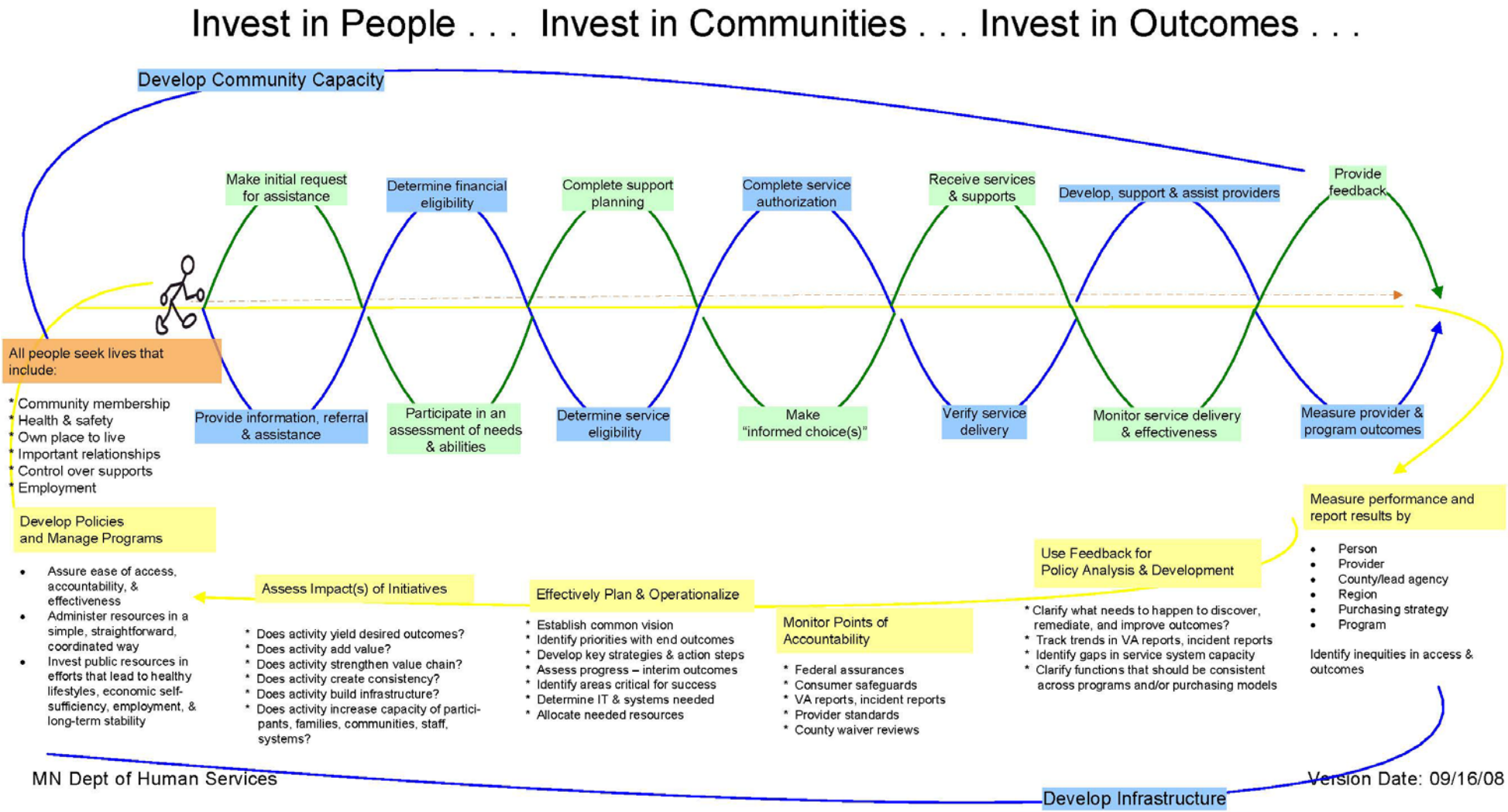
knowledge and experience in being, serving and working with people with disabilities; support for the full inclusion of all people with disabilities in our communities; and passion for people with disabilities having the same opportunities other Minnesotans enjoy.

XII. Appendix

A. Medical Assistance Benefits

States establish and administer their own Medicaid programs. They determine the type, amount, duration and scope of services within broad federal guidelines. The Centers for Medicare and Medicaid Services require states to cover certain "mandatory benefits," and can choose to provide other "optional benefits" through the Medicaid program.

Mandatory benefits	Optional benefits
• Inpatient hospital services • Outpatient hospital services • EPSDT: Early and Periodic Screening, Diagnostic and Treatment Services • Nursing facility services • Home health services • Physician services • Rural health clinic services • Federally qualified health center services • Laboratory and X-ray services • Family planning services • Nurse midwife services • Certified pediatric and family nurse practitioner services • Freestanding birth center services (when licensed or otherwise recognized by the state) • Transportation to medical care • Tobacco cessation counseling for pregnant women	• Prescription drugs • Clinic services • Physical therapy • Occupational therapy • Speech, hearing and language disorder services • Respiratory care services • Other diagnostic, screening, preventive and rehabilitative services • Podiatry services • Optometry services • Dental services • Dentures • Prosthetics • Eyeglasses • Chiropractic services • Other practitioner services • Private duty nursing services • Personal Care • Hospice • Case management • Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD) • Services in an intermediate care facility for persons with developmental disabilities • State Plan Home and Community Based Services- 1915(i) • Self-Directed Personal Assistance Services- 1915(j) • Community First Choice Option- 1915(k) • TB Related Services • Inpatient psychiatric services for individuals under age 21 • Health Homes for Enrollees with Chronic Conditions – Section 1945 • Other services approved by the Secretary (This includes services furnished in a religious nonmedical health care institution, emergency hospital services by a non-Medicare certified hospital, and critical access hospital (CAH).

B. DSD value chain helix

B. DSD value chain helix