INFORMATION BRIEF
Minnesota House of Representatives
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September 2006

Overview of Programs for People with Disabilities

Minnesota provides a variety of services for people with disabilities. This information brief provides information about those programs and services. It contains a general Medical Assistance (MA) overview, including some expenditure and cost comparisons; an overview of MA disability programs and services, including home and community based waiver services, intermediate care facility for persons with mental retardation (ICF/MR), day training and habilitation (DT&H), case management, home care, and personal care assistant (PCA) services; and an overview of state disability programs and services, including group residential housing (GRH), family support grants, consumer support grants, and semi-independent living skills (SILS). In addition, a list of acronyms is included at the end of the report.

Contents

Minnesota provides a variety of services for people with disabilities. Some of these services are provided through the federal Medicaid program and some services are provided through state programs. The first section provides an overview of the Medicaid program. The following sections provide overviews of federal disability programs and services and state disability programs and services.

Overview of Medical Assistance

Medical Assistance (MA), the state's Medicaid program, provides payment for health care services provided to eligible low-income persons. The federal government pays a share of the cost of state MA expenditures. This is referred to as the federal medical assistance percentage (FMAP). Minnesota's federal match for covered services is 50 percent. The state pays the remaining 50 percent for most services (some services have a county share, such as long-term placements in ICFs/MR with seven or more beds).

MA Eligibility

To be eligible, an individual must meet income and asset standards and satisfy other program eligibility requirements. Eligible groups include pregnant women, families and children, persons with disabilities or who are blind, and the elderly (over age 65).

MA Disability Qualification

In order to qualify as disabled, a person must satisfy the disability criteria used by the federal Social Security Administration (SSA) or a State Medical Review Team (SMRT). In most cases, the SMRT uses the same criteria for disability and blindness as the SSA. Under the SSA definition of disability, an adult is considered disabled if he or she is unable to engage in any substantial gainful activity due to a medically determinable physical or mental impairment that is expected to result in death or to last for a continuous period of not less than 12 months. A child under age 18 is considered by the SSA to be disabled if he or she has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, that is expected to result in death or to last for a continuous period of not less than 12 months. Medicaid uses the Supplemental Security Income (SSI) definition of "blind, " which is vision of 20/200 or less with the use of corrective lenses or tunnel vision of 20 degrees or less.

Some of the health conditions for which individuals are likely to be found as disabled by the SSA or SMRT include the following:

- Arthritis of a major joint in each upper extremity
- Certain types of amputation
- Hearing loss not restorable by a hearing aid
- Ischemic heart disease with chest pain
- Chronic liver disease meeting specified criteria

- Impaired renal function meeting specified criteria
- Paraplegia or quadriplegia
- Multiple sclerosis
- Muscular dystrophy
- Certain psychotic and nonpsychotic disorders
- Severe mental retardation meeting specified criteria

Pathways to MA Disability Eligibility

Common eligibility pathways for persons with disabilities include being blind or disabled, being a child who is disabled, being eligible under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), or being an employed person with disabilities. An adult must be determined as disabled by SSA or SMRT or meet the criteria for blindness. The income limit for disabled or blind adults is 100 percent of the federal poverty guidelines (FPG), or a person can spenddown to 75 percent of FPG to become eligible. The asset limit is $3,000 for an individual and $6,000 for a household of two, with $200 added for each additional dependent (certain assets such as homestead, household goods, and a vehicle are excluded from the asset limit). In Minnesota, SSI recipients are not automatically eligible, but the vast majority qualify for MA.

A disabled or blind individual who is under age 21 can apply for MA as a child and be subject to income and asset eligibility criteria that are less stringent than those that apply to adults. The income limit is 280 percent of FPG for children under age 2, 150 percent of FPG for children ages 2 to 18, and 100 percent of FPG for children ages 19 and 20. There is no asset limit, and the spenddown limit is 100 percent of FPG.

TEFRA is an optional eligibility category. Under this option, only the child's income is counted and parents pay a parental fee. In order to be eligible under the TEFRA option, an individual must:

- Be under age 18;
- Have a disability determination from the SMRT;
- Require a level of home health care comparable to the care provided in a hospital, nursing facility, or ICF/MR;
- Have MA home care costs that do not exceed the cost to MA of institutional care;
- Live with at least one parent; and
- Meet the MA income standard (the income limit is 100 percent of FPG and only the child's income is counted).

There is no asset limit under the TEFRA option.

Employed persons with disabilities (MA-EPD) is another optional category. Federal law provides an exception from the prohibition on substantial gainful activity for MA eligibility. This category allows persons with disabilities to work productively and still retain health benefits. In order to be eligible under this option a person must:

- Be certified as disabled by SSA or SMRT;

- Be between age 16 and 65;
- Receive more than $65/month in earned income and pay Medicare and Social Security taxes; and
- Pay required monthly premiums and unearned income obligation.

There is no income limit under MA-EPD. The asset limit is $20,000 (certain assets are excluded, such as retirement accounts, medical expense accounts, and other exclusions that apply to persons with disabilities).

Spenddown

Individuals who do not meet the MA income limit may qualify through a spenddown. An individual who is disabled can qualify under a spenddown by incurring medical bills in an amount that exceeds the amount by which his or her income exceeds the MA spenddown limit for the disabled of 75 percent of FPG.

MA Covered Services

The MA benefit package tends to be comprehensive, compared to private sector health coverage. In addition to covering standard services such as physician, inpatient hospital, dental, therapy, and prescription drug services, MA covers many services used heavily by persons with disabilities. These services include the following:

- Nursing facility services
- ICF/MR services
- Home health care
- Case management
- Personal care assistant services
- Private duty nursing
- Home and community-based waiver services

Most MA recipients with disabilities receive services on a fee-for-service basis. However, some disabled MA recipients receive services through a managed care program, the Minnesota Disability Health Options (MnDHO) program.

Enrollee Cost-Sharing

Federal law requires Medicaid cost-sharing to be "nominal." Cost-sharing does not apply to pregnant women and children. In Minnesota, the MA payment rate is reduced by the amount of the copayment. A recent district court ruling held that providers cannot deny services to enrollees who do not pay the copayment. Minnesota requires nonpregnant adults to pay the following copayments:

- $3 per nonpreventive visit

- $3 for eyeglasses
- $6 for nonemergency visits to a hospital emergency room
- $3 for brand name drugs/$1 for generic drugs ($12/month limit)

Parental Fees

Parents with minor children on MA who do not live with them, or for whom parental income and assets are not counted when determining the child's eligibility, are assessed a parental fee to pay for part of the MA cost of care for the child. Parents who are court-ordered to pay medical support are not subject to parental fees. Some of the groups of children whose parents are subject to a parental fee include:

- children eligible under TEFRA;
- children receiving services under a home and community-based waiver service;
- children on MA in 24-hour care facilities with mental retardation, severe emotional disturbance, or a physical disability; and
- children in foster care placement.

The parental fee ranges from zero for parents with adjusted gross income (AGI) of less than 100 percent FPG to 12.5 percent for parents with AGI equal to or greater than 975 percent of FPG. The current formula reflects changes effective July 1, 2005, that increased the progressivity of the fee scale for persons with middle incomes.

Expenditure and Cost Comparisons

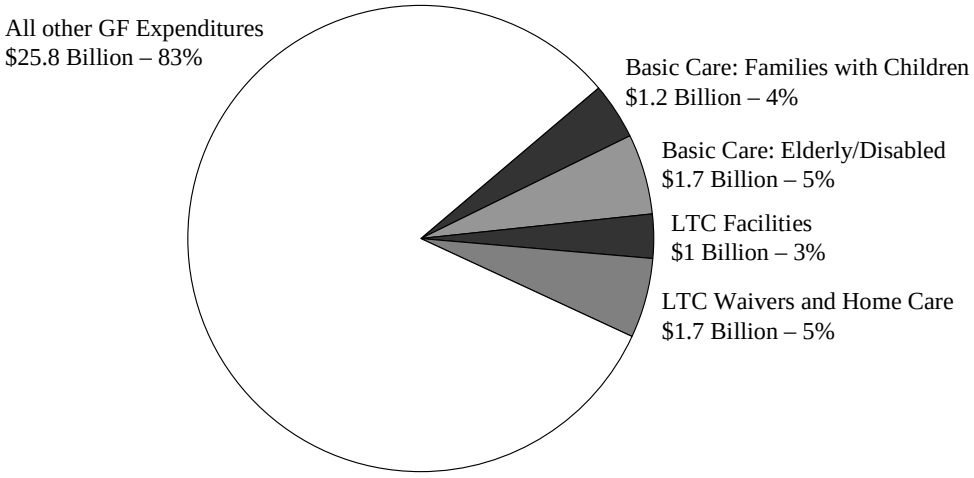
This section includes several figures that compare expenditures and costs for various MA programs.

In figures 1 and 5 to 7 home care and elderly waiver (EW) fee-for-service is included in the LTC waivers and home care category. The other waivers included in this category include services provided on both a fee-for-service and managed care basis. Figures 1 to 3 and 5 to 7 include information from the Department of Human Services' February 2006 Forecast, any dollar amounts for fiscal year 2006 and on are projected.

Figure 1 shows the MA state general fund expenditures by category and percentage of total general fund expenditures. MA general fund expenditures account for 17.8 percent of total general fund expenditures in fiscal years 2006-07.

Figure 1

Medical Assistance GF Expenditures and Percent of Total GF Expenditures
FY 2006-07 Total GF Expenditures: $31.4 billion
FY 2006-07 Total State Share MA Expenditures: $5.6 billion

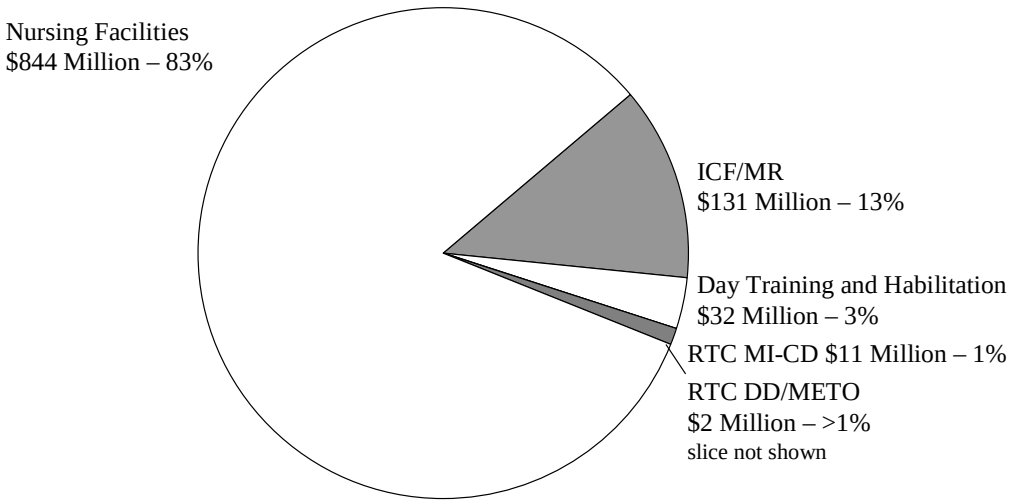


Source: House Fiscal Analysis Department

Figure 2 shows MA long-term care (LTC) facility expenditures by category. Nursing facilities make up 83 percent of the total MA LTC facilities state share expenditures in fiscal years 2006-07.

Figure 2

Medical Assistance Long-Term Care Facilities
FY 2006-07
Total LTC Facilities State Share: $1 billion

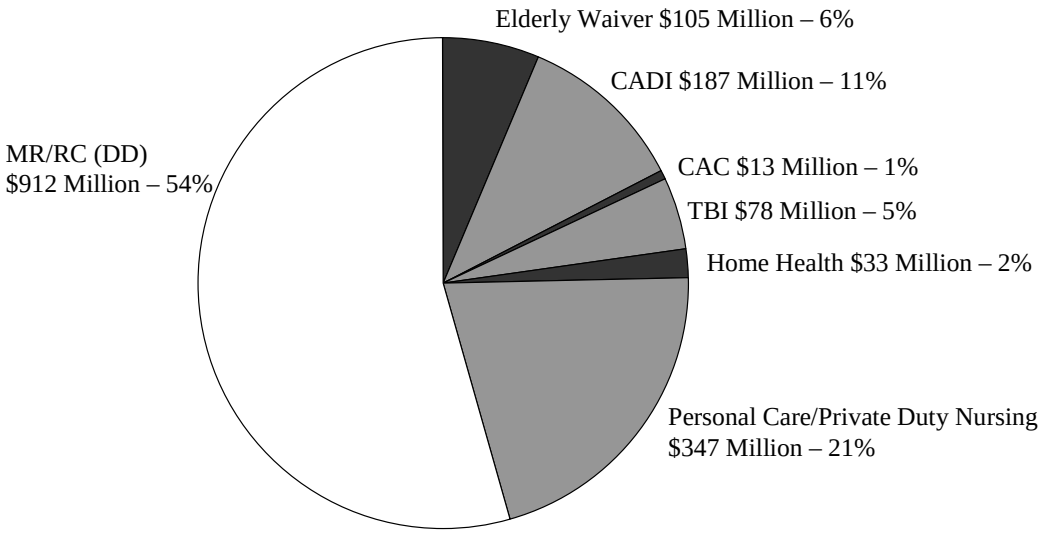


Source: House Fiscal Analysis Department

Figure 3 shows MA LTC waiver and home care expenditures by category. The Mental Retardation or Related Conditions (MR/RC) waiver constitutes 54 percent of the total MA LTC waivers and home care state share expenditures in fiscal years 2006-07.

Figure 3

Medical Assistance Long-Term Care Waivers/Home Care
FY 2006-07
Total LTC Waivers State Share: $1.675 billion

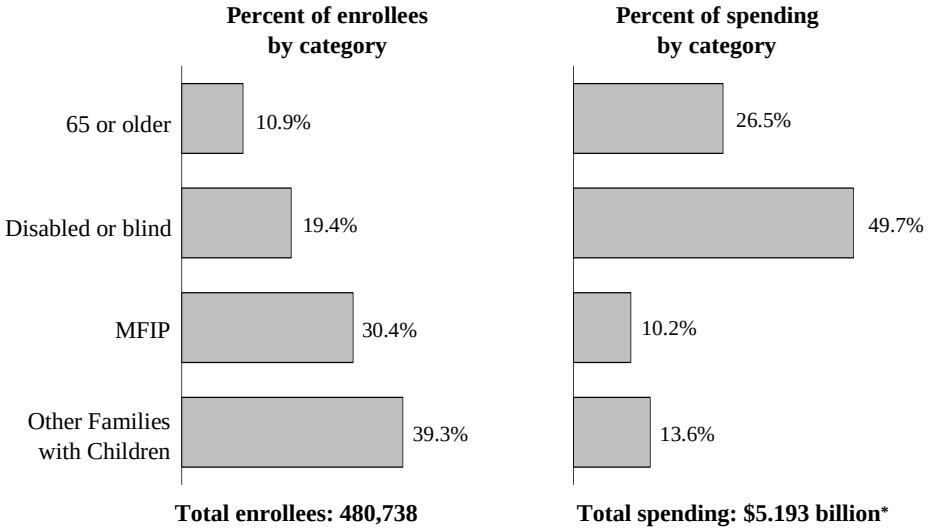


Source: House Fiscal Analysis Department

Figure 4 compares the percentage of MA enrollees by category to the percentage of MA spending by category. In fiscal year 2005, other families with children accounted for 39.3 percent of MA enrollees but only 13.6 percent of MA spending, while disabled or blind persons accounted for 19.4 percent of MA enrollees and 49.7 percent of MA spending.

Figure 4

Minnesota Medical Assistance Eligibles – SFY 2005



* Does not include special funding items and adjustments

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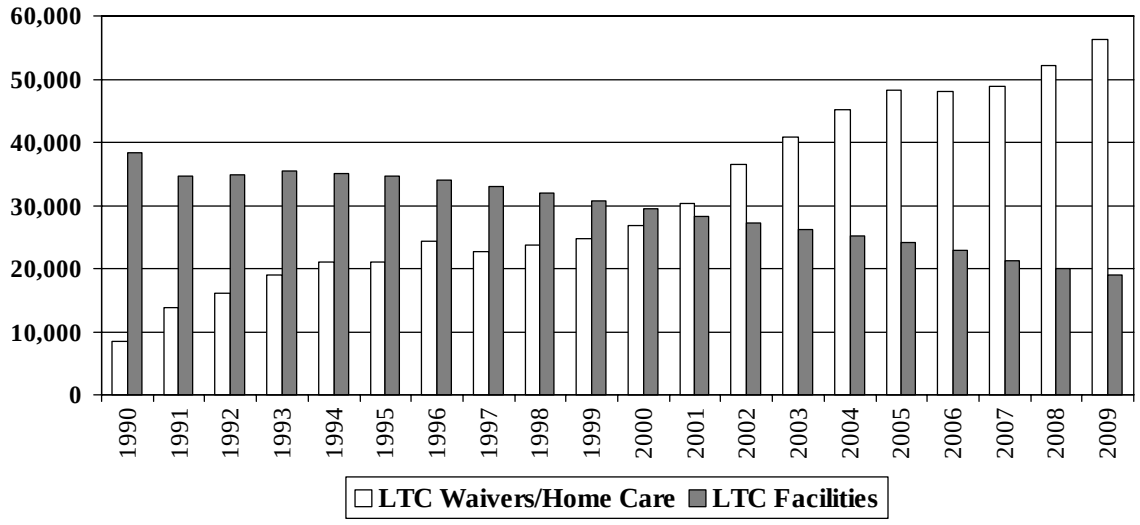
Figure 5 compares MA LTC facilities and waiver/home care monthly average recipients over time. MA LTC facilities monthly average recipients have been declining over time while MA LTC waiver and home care monthly average recipients have been increasing during the same time period.

Figure 5

Medical Assistance Long-Term Care Facilities and Waivers/Home Care Monthly Average Recipients, FY 1990-2009

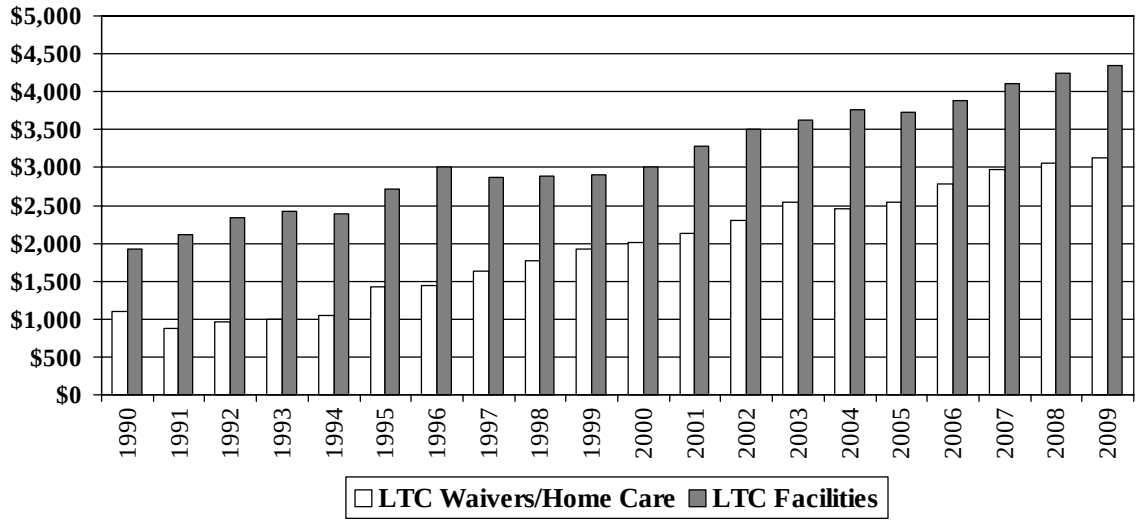


Source: House Fiscal Analysis Department

Figure 6 compares MA LTC facilities and waiver/home care monthly average payments over time. MA LTC facilities and wavier and home care monthly average payments per recipient have been increasing over time; however, LTC facilities monthly average payments per recipient are higher than LTC waiver and home care monthly average payments.

Figure 6

Medical Assistance Long-Term Care Facilities and Waivers/Home Care Monthly Average Payments Per Recipient, FY 1990-2009

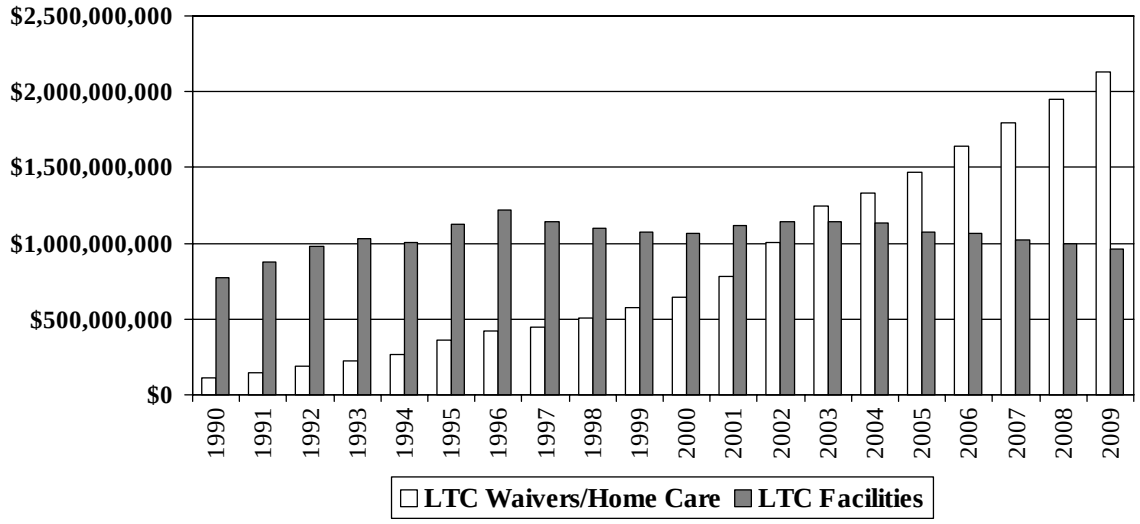


Source: House Fiscal Analysis Department

Figure 7 compares MA LTC facilities and waiver/home care total expenditures over time. MA LTC facilities total expenditures have begun to decrease over the past few fiscal years while LTC waivers and home care total expenditures have been rapidly increasing.

Figure 7

Medical Assistance Long-Term Care Facilities and Waivers/Home Care Total Expenditures, FY 1990-2009

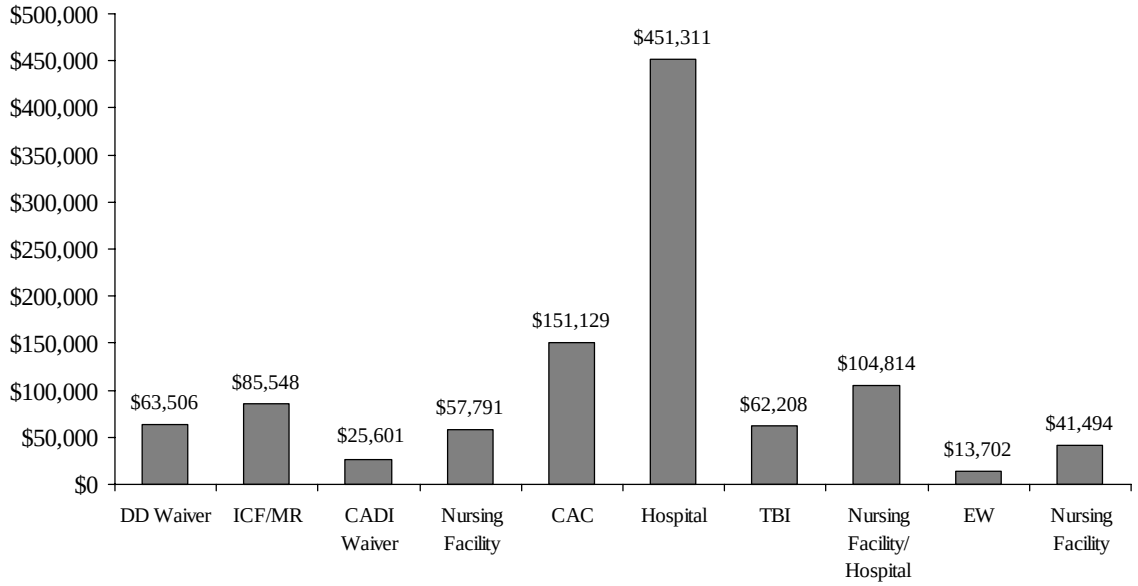


Source: House Fiscal Analysis Department

Finally, figure 8 shows home and community-based waiver cost effectiveness as compared to other LTC facilities. The CAC waiver is very cost-effective as compared to care in a hospital setting.

Figure 8

Home and Community Based Waiver Cost Effectiveness 2004
Average Annual Cost Per Recipient *



* Annual costs per recipient include LTC and basic care costs. For waiver recipients, GRH costs are also included.

Source: House Fiscal Analysis Department

Overview of MA Disability Programs and Services

The MA disability programs and services described in this section include home and community-based waiver services, ICFs/MR, DT&H, case management, home care, and PCA services.

Home and Community-Based Waiver Services (HCBS)

HCBS offer service options that allow people to live in the community instead of going into or staying in an institutional setting. HCBS cover two types of services: (1) services necessary to avoid institutionalization that are not offered in Minnesota's MA state plan, and (2) services that are extensions of Minnesota's MA state plan services. Minnesota has four HCBS waivers:

- Community Alternatives for Disabled Individuals (CADI): Provides services for individuals with disabilities who need the level of care provided in a nursing home.
- Traumatic Brain Injury (TBI): Provides services for individuals with brain injury who need the level of care provided in a nursing home or neurobehavioral hospital.
- Mental Retardation or Related Conditions (MR/RC): Provides services for individuals with mental retardation or related conditions who need the same level of care as provided in an ICF/MR.
- Community Alternatives for Chronically Ill Individuals (CAC): Provides services for individuals with chronic illness who need the level of care provided in a hospital.

To be eligible for an HCBS waiver, a person must meet all of the following conditions:

- Be under age 65
- Be certified disabled
- Choose home and community-based service
- Meet MA income and asset requirements
- Have a plan of care that ensures health and safety
- Have anticipated costs through the HCBS waiver program that do not exceed the cost of services that are or would be provided in an institution or health care facility
- Meet all other program requirements

A person's waiver budget is determined by an assessment of the person's functional needs. State plan services must be used before extended services. Supports are purchased from a menu of possible waiver services. DHS allocates "slots" to counties. If a county determines that it is able to serve more people than the slots it has available under the MR/RC waiver, the county can do so, as long as the county stays within its overall waiver budget.

Each county's HCBS allocation is set by DHS for a certain number of slots (base allocation plus any inflation). The MR/RC waiver is a separate annual allocation. All other waivers (CADI, CAC, TBI) are allocated every six months. One exception is the consumer directed community support (CDCS) option. This is a state-set limit for individual budgets and allowable

services/expenses (included in the county allocation). The MR/RC, CADI, and TBI waiver slots are currently capped for diversions in fiscal years 2006-07, which means only a limited number of slots may be allocated for each of these programs during this time period. The CAC waiver slots are not under caps and are allocated based on demand.

HCBS waiver services include the following:

- Adult day care
- Case management
- Consumer-directed community supports
- Extended home health aid, nursing
- Extended home health therapies
- Extended PCA
- Extended supplies and equipment
- Family counseling and training
- Foster care
- Homemaker services
- Home modifications
- Independent living skills
- Respite care
- Supported employment
- Transportation

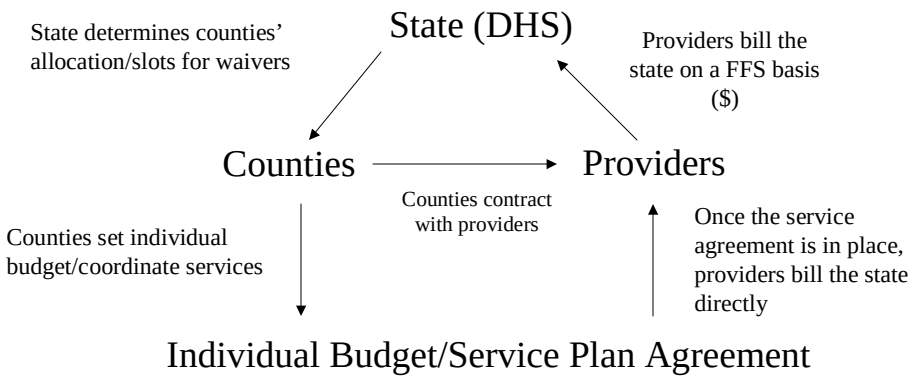
The HCBS waiver programs are federal-state funded programs, funded with 50 percent federal MA funds and 50 percent state general funds.

HCBS Waiver Program Statistics FY 2005

Program	Monthly Average Recipients	Monthly Average Cost/Recipient	Total Expenditures (millions)
CADI	7,831	$1,324	$122.6
TBI	1,109	$4,623	$61.1
MR/RC	14,430	$4,871	$834.9
CAC	182	$3,555	$7.6
Total	23,552	$14,373	$1,026.2

House Research and House Fiscal Analysis Departments

Flow of Dollars for Waiver Programs



Source: House Fiscal Analysis Department

Recent HCBS waiver policy changes include the expansion of the CDCS service option, development of a common service menu, creation of transitional supports, open enrollment of the MR/RC waiver in fiscal year 2001, and limitations on waiver growth. The CDCS option provides for increased consumer choice, control, and autonomy. This option puts consumers in control in terms of the supports they receive and how those services and supports are secured and purchased. This used to only be an option within the MR/RC waiver and was only available in certain counties. In fiscal year 2005, this option was expanded to all of the other waiver programs and is now available in all counties.

A common service menu among all of the waiver programs will eliminate the need for consumers to "chase" certain waiver programs to assure they can access the services that they need and it simplifies local administration of these programs.

Transitional supports provide bridges to help persons move from institutions to communities. These supports include one-time modifications, assistive technology, housing access, and more intensive assistance before and during relocations.

In the last quarter of fiscal year 2001, the enrollment for the MR/RC waiver was opened due to under-spending that had occurred in the program. As a result of the open enrollment, 5,534 recipients were added to the MR/RC waiver.

In both fiscal years 2003 and 2005, growth limitations were placed on certain waiver programs as a way to contain costs. Limits were placed on the growth of the CADI, TBI, and MR/RC waiver programs.

Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR)

ICFs/MR are MA facilities that serve persons with mental retardation and related conditions who require the level of care provided in an ICF/MR and who choose such services.

In order to be eligible for ICF/MR services, a person must:

- Have mental retardation or a related condition;
- Require a 24-hour plan of care;
- Require active treatment;
- Meet MA income and asset requirements; and
- Request ICF/MR services.

Minnesota contracts with ICF/MR facilities for services and sets rates for each facility. Persons may pay through private insurance, Medicare, MA, and/or a combination of all three. Services are a pre-designed package and include:

- Room and board;
- Services during the day and active treatment; and
- Transportation.

Related medical services may be covered as part of the rate.

ICFs/MR funding sources include MA funds (50 percent federal MA funds and 50 percent state general funds) and some private and county pay.

The flow of dollars for ICFs/MR begins with the state-determined rate (rate multiplied by the number of days). ICF/MR rates are set by facility. The county share of the cost for facilities with seven or more beds is 5 percent of total cost, 10 percent of nonfederal share. In nursing facilities, rates are set based on each facility's RUGs (a needs assessment, resource utilization groups). There is a county share for persons under 65 only (10 percent of total cost, 20 percent of nonfederal share).

ICF/MR program statistics for fiscal year 2005:

- Total expenditures: $137.1 million
- Average monthly recipients: 1,962
- Average monthly cost per recipient: $5,825

Recent ICF/MR policy changes include implementation of a new ICF/MR reimbursement system, which began in fiscal year 2001, and a requirement that counties pay a portion of the cost of certain placements in ICFs/MR with seven or more beds. Beginning on October 1, 2000, a new ICF/MR payment system was implemented which eliminated one-time rate adjustments, cost-based rate increases, and comprehensive cost reporting. In addition, a new variable rate system for medical, behavioral changes, equipment, crisis, and retirement was created. Two additional policy changes include a 90-day occupancy rate for empty beds and profile changes, which automatically paid facilities an increased amount when a client's medical or behavioral

needs changed. Finally, facility rates were to be adjusted annually. However, these changes were all eliminated in subsequent years.

Beginning July 1, 2004, counties were required to pay 20 percent of the cost of certain placements in ICFs/MR with seven or more beds. Beginning July 1, 2005, the county share was reduced to 10 percent.

Day Training and Habilitation (DT&H)

DT&H providers are licensed supports to help adults develop and maintain life skills, participate in community life, and engage in proactive and satisfying activities of their own choosing.

To be eligible for DT&H services a person must meet all of the following conditions:

- Be 18 years of age or older and have a diagnosis of mental retardation or a related condition
- Receive a screening for home and community-based services or reside in an ICF/MR
- Have their health and safety in the community addressed in their plan of care
- Make an informed choice to receive DT&H as part of their individual service plan (ISP)

DT&H services are an option under the MR/RC waiver. However, in order to be eligible, the waiver recipient must have at least one residential service offered through the waiver (such as homemaker services or respite care). DT&H services are offered as part of the pre-designed package provided to ICF/MR residents.

For people who do not have MA funding (MR/RC waiver or reside in an ICF/MR), counties are to provide DT&H services to the degree that they are: (1) identified as needed in the person's ISP; and (2) something the county can afford to provide given the funding available.

Services provided include:

- Supervision, training, and assistance in the areas of self-care, communication, socialization, and behavior management;
- Supported employment and work-related activities;
- Community integrated activities, including the use of leisure and recreation time;
- Training in community survival skills, money management, and therapeutic activities that increase the adaptive living skills of an individual; and
- Nonmedical transportation services to enable persons to participate in the above listed services.

For persons receiving DT&H services through the MR/RC waiver or an ICF/MR, funding is made up of 50 percent federal MA funds and 50 percent state general funds. For non-MA persons, funding is made up of county funding sources and other sources.

DT&H program statistics for fiscal year 2005:

- Total expenditures: $32.6 million
- Average monthly recipients: 1,679
- Average monthly cost per recipient: $1,617

(These numbers are for ICF/MR residents only.)

Recent DT&H policy changes include elimination of the DT&H mandate, elimination of the prohibition on DT&H services being provided in a person's own home or residence, authorization of county participation in a voluntary individualized payment rate structure, and a 1 percent rate reduction in 2003. The elimination of the DT&H mandate allows people living in an ICF/MR the option of receiving an alternative habilitative service during the day and results in ICF/MR residents having day service choices that are more similar to those of persons receiving home and community-based services.

Authorization of county participation in a voluntary individualized payment rate structure allows counties the flexibility to change from a site-based payment structure to an individual payment rate structure for the DT&H service providers in the county.

Case Management

Case management is assisting an individual to gain access to needed medical, social, educational, and other services. Case management eligibility varies by program. Counties determine consumer eligibility based on the state MA plan, the state MA waiver amendments, and Minnesota Statutes. Persons who meet specific eligibility criteria receive state mandated services and optional services based on county Child and Community Services Act (CCSA) plans.

Case managers perform both administrative and service activities. Administrative functions include the following:

- Intake
- Eligibility determination
- Screening
- Service authorization
- Review of eligibility
- Conciliations and appeals

Service activities include the following:

- Plan development
- Assisting in accessing services
- Service coordination
- Service evaluation and monitoring
- Annual plan review

Case management funding sources include county funding sources, CCSA state grants to counties, federal financial participation for waiver services or targeted case management, and federal reimbursement when provided as part of the state MA plan.

Case Management Program Statistics, FY 2004

Waiver	Total Expenditures FY 2004	Average Per Recipient
MR/RC	$25,852,082	$1,731
CAC	$507,555	$2,339
CADI	$14,308,224	$1,530
TBI	$2,649,586	$2,217
Total	**$43,317,447**	**$7,817**

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The case management expenditures in the above table are included in the overall waiver expenditures included in the table on page 15. Targeted case management is not included in the expenditures in either of these tables.

Recent case management policy changes include modifications to the definition of relocation targeted case management to allow for both county targeted case management and public or private vendor service coordination.

Home Care

Home care provides medical and health-related services and assistance with day-to-day activities to people in their home. It can be used to provide short-term care for people moving from a hospital or nursing home back to their home, or it can also be used to provide continuing care to people with ongoing needs. Home care services may also be provided outside the person's home when normal life activities take them away from home.

Home care services are provided to MA eligible persons and must be:

- Medically necessary;
- Ordered by a licensed physician;
- Documented in a written service plan;

- Provided at a recipient's residence (not a hospital or LTC facility); and
- Provided by a Medicare-certified agency.

A registered nurse from a Medicare-certified home health agency completes an assessment to determine the need for service. The assessment identifies the needs of the person, determines the outcomes for a visit, is documented, and includes a plan. In general, all home health services provided by a home health aide must have a prior authorization. The maximum benefit level is one visit per day for home health aide services, one visit per discipline per day for therapies (except respiratory therapy), and two visits per day for skilled nurse visits.

Home care services include:

- Intermittent home health aide visits provided by a certified home health aide;
- Medically oriented tasks to maintain health or to facilitate treatment of an illness or injury provided in a person's place of residence;
- Personal care assistant services;
- Private duty nursing;
- Therapies (occupational, physical, respiratory, and speech);
- Intermittent skilled nurse visits provided by a licensed nurse; and
- Equipment and supplies.

Home care services are federal-state funded programs, funded with 50 percent federal MA funds and 50 percent state general funds.

Home care program statistics for fiscal year 2005:

- Total expenditures: $29.2 million
- Monthly average recipients: 6,102
- Average monthly cost per recipient: $399

Recent home care policy changes include allowing a recipient whose spouse is a licensed nurse to be paid to provide private duty nursing services in certain circumstances, allowing self-employed private duty nurses (PDNs) to receive the same reimbursement rate as PDN agencies, defining complex and regular PDN, increasing skilled nurse visits from five to nine visits before a prior authorization is needed, increasing the skilled nurse visit limit from one to two visits per day, reimbursing telehomecare skilled nurse visits, allowing assistant therapists to be paid for home care services, and increasing the fiscal year 2006 reimbursement rate.

Personal Care Assistant (PCA) Services

Personal care assistants provide assistance and support to persons with disabilities, elders, and others with special health care needs living independently in the community.

In order for a person to receive PCA services, the services must be:

- Medically necessary;

- Authorized by a licensed physician;
- Documented in a written service plan; and
- Provided at the recipient's place of residence or other location (not a hospital or health care facility).

In addition, the recipient of PCA services must be in stable medical condition and be able to direct his or her own care or have a responsible party who provides support.

The determination of the amount of service available to a person is based on the PCA assessment and the PCA decision tree. PCA services provided include:

- Assistance with activities of daily living;
- Assistance with instrumental activities of daily living;
- Assistance with health related functions; and
- Redirection and intervention for behavior including observation and monitoring.

PCA services are federal-state funded services, funded with 50 percent federal MA funds and 50 percent state general funds.

Sixty percent of home care, PCA, and PDN recipients are MA nonwaiver recipients receiving home health and PCA/PDN services through a local public health agency; 40 percent of recipients are MA waiver recipients (mostly CAC and CADI waivers) whose care is coordinated by counties in service plans. Providers bill the state directly on either a fee-for-service or managed care basis.

PCA program statistics for fiscal year 2005:

- Total expenditures: $284.9 million
- Monthly average recipients: 9,616
- Average monthly cost per recipient: $2,470

Recent PCA policy changes include adding choice of supervision for PCA services, removing the PCA hardship waiver, adding social workers as qualified professionals who can supervise a PCA, making PCA hours available as flexible use. Several 2005 legislative reforms intended to tighten administration of the program, including requiring a physician's statement of need in order to receive payment, requiring personal care provider organizations to meet certain standards, and requiring prior authorization of flexible use of hours.

Overview of State Disability Programs and Services

The state disability programs and services described in this section include GRH, family support grants, consumer support grants, and SILS.

Group Residential Housing (GRH)

GRH is a state-funded income supplement program that pays for room-and-board costs for low-income adults who have been placed in a licensed or registered setting with which a county human service agency has negotiated a monthly rate.

In order to be eligible for GRH payments, a person must have county approval for residence in a GRH setting and must: (1) be aged, blind, or over 18 years old and disabled, and meet specified income and asset standards; or (2) belong to a category of individuals potentially eligible for General Assistance and meet specified income and asset standards.

Beginning July 1, 2006, the GRH basic room and board rate was set at $737 per month. Recipients in certain GRH settings may also qualify for a supplemental payment that is in addition to the GRH basic room and board rate. GRH pays for room and board in a number of licensed or registered settings, including the following:

- Adult foster care
- Board and lodging establishments
- Supervised living facilities
- Noncertified boarding care homes
- Various forms of assisted living settings registered under the Housing with Services Act

Currently, if an eligible person needs to live in a licensed setting and needs additional services, he or she may receive the services in the setting. Persons residing in a setting with a GRH rate are usually considered to be living in the community in their own home. As such, these persons can receive services from most community sources, such as home care and home and community-based waiver programs.

The GRH program is funded with state general funds.

GRH program statistics for fiscal year 2005:

- Total expenditures: $80.9 million
- Average monthly recipients: 14,400
- Average monthly cost per recipient: $511

The Minnesota room and board rate was recently defined as the GRH rate for persons living in corporate adult foster care homes. This rate defines all costs necessary to serve disabled persons in corporate adult foster care homes in excess of the GRH base rate as “services,” making them

eligible for payment by a home and community-based wavier. Another recent change allows congregate settings for the elderly to register with the Minnesota Department of Health as housing with services facilities. This makes congregate settings for the elderly eligible for GRH if a setting receives all or part of its funding from the Minnesota Housing Finance Agency for the purpose of ending long-term homelessness.

Family Support Grants

The Family Support Grant program provides state cash assistance for maintaining a child with mental retardation or a related condition in their family home. Funds are for those expenses that are incurred as a result of the disability, not for costs that would normally occur even if the child did not have the disability.

In 2003, Family Support Grant eligibility was expanded to families of children with disabilities whose needs meet institutional levels of care in ICFs/MR, nursing facilities, hospitals, or Institutions of Mental Disease (IMDs) and the age of eligible dependent children was lowered from under age 22 to under age 21. Prior to expanding eligibility to families of children with disabilities whose needs meet certain institutional levels of care, this program was for families with a developmentally disabled child.

The following are eligible for a Family Support Grant:

- Families of children with a certified disability, under age 21, living in their biological or adoptive home
- Children currently residing in a regional treatment center, ICF/MR, or other licensed residential service or facility who would return to their family home if a grant was awarded are also eligible
- Families with an annual adjusted gross income of less than $76,171
- Children receiving services through a CADI, TBI, or CAC waiver who may receive a Family Support Grant if they meet the eligibility criteria

Children receiving services through an MR/RC waiver are not eligible for a Family Support Grant. Family Support Grants are limited to $3,000 annually.

Approved expense categories include the following:

- Medications
- Education
- Day care
- Respite
- Special clothing
- Special diet
- Special equipment

- Transportation
- Other

Family Support Grants are 100 percent state funded. Some counties provide similar support programs with 100 percent county funding.

Family Support Grant program statistics:

- Fiscal year 2005 total expenditures: $3.6 million
- Fiscal year 2004 total recipients: 1,653
- Fiscal year 2004 average annual cost per recipient: $2,480

Consumer Support Grants

The Consumer Support Grant program is a state-funded alternative to MA-reimbursed home care, specifically the home care services of a home health aide, PCA, and PDN. Eligible participants receive monthly cash grants to replace fee-for-service home care payments and manage and pay for a variety of home and community-based services. Currently, only 20 counties choose to offer Consumer Support Grants to their residents with disabilities.

In order to be eligible for a Consumer Support Grant, a person must:

- Be a recipient of MA;
- Have a long-term functional limitation requiring ongoing supports;
- Live in a natural home setting;
- Be able to direct and purchase their own supports or have an authorized representative act on their behalf; and
- Be eligible to receive home care services from an MA home care program.

A person's Consumer Support Grant amount is calculated as the state share of the assessed value of home health aide, PCA, and private duty nursing services.

Allowable services include home care, PCA, and private duty nursing. The Consumer Support Grant program is funded with 100 percent state funds.

Consumer Support Grant program statistics for fiscal year 2005:

- Total expenditures: $7.8 million
- Monthly average enrollees: 527
- Monthly average allocation: $1,240

Recent Consumer Support Grant policy changes include 2001, 2002, and 2005 cost-of-living adjustment (COLA) increases, a 2003 funding decrease, and the creation of state-established protocols to control costs (Consumer Support Grants are state-calculated budgets based on assessed needs).

Semi-Independent Living Skills (SILS)

SILS services are provided to adults with mental retardation or a related condition in their home and community to maintain or increase their ability to live in the community. In order to be eligible for SILS, a person must:

- Be at least 18 years old;
- Have mental retardation or a related condition;
- Not be at risk of institutionalization; and
- Require systematic instruction or assistance in order to manage activities of daily living.

Each county receives an allocation from the state and must determine how to distribute the allocation among eligible clients.

SILS services include instruction or assistance in the following areas:

- Meal planning and preparation
- Shopping
- Money management
- Apartment/home maintenance
- Self-administration of medications
- Telephone use
- Generic resources
- Accessing public transportation
- Socialization skills

The SILS program is a joint state-county funded program, funded with 70 percent state general funds and 30 percent county funds. Some counties provide county dollars above the county matching requirements. Some counties also fund 100 percent of the cost for some persons not served through state supported allocations.

SILS program statistics:

- Fiscal year 2005 total expenditures: $10.5 million (state and county shares)
- Fiscal year 2004 total recipients: 1,436
- Fiscal year 2004 average annual cost per recipient: $5,311

Recent SILS policy changes include 2001, 2002, and 2005 COLA increases and a 2003 funding decrease.

State Disability Program Statistics, FY 2005

Program	Average Monthly Recipients	Average Monthly Cost/Recipient	Total Expenditures
GRH	14,400	$511	$80,900,000
Family Support Grants	1,653 (FY 2004)	$2,480 (FY 2004 avg. annual cost)	$3,600,000
Consumer Support Grants	527	$1,240	$7,800,000
SILS	1,436 (FY 2004)	$5,311 (FY 2004 avg. annual cost)	$10,500,000

Acronyms

AGI – Adjusted Gross Income
CAC – Community Alternatives for Chronically Ill Individuals
CADI – Community Alternatives for Disabled Individuals
CCSA – Minnesota Child and Community Services Act
CDCS – Consumer Directed Community Supports
COLA – Cost-of-Living Adjustment
DHS – Minnesota Department of Human Services
DT&H – Day Training and Habilitation
EW – Elderly Waiver
FMAP – Federal Medical Assistance Percentage
FPG – Federal Poverty Guidelines
GRH – Group Residential Housing
HCBS – Home and Community-Based Waiver Services
ICF/MR – Intermediate Care Facility for Persons with Mental Retardation
IMD – Institution of Mental Disease
ISP – Individual Service Plan
LTC – Long-Term Care
MA – Medical Assistance
MA-EPD – Medical Assistance Employed Persons with Disabilities
MR/RC – Mental Retardation or Related Conditions
MnDHO – Minnesota Disability Health Options
PCA – Personal Care Assistant
PDN – Private Duty Nurse
RTC – Regional Treatment Center
RUGs – Resource Utilization Groups
SILS – Semi-Independent Living Skills
SMRT – State Medical Review Team
SSA – Social Security Administration
SSI – Supplemental Security Income
TBI – Traumatic Brain Injury
TEFRA – Tax Equity and Fiscal Responsibility Act of 1982

For more information about assistance programs, visit the health and human services area of our web site, www.house.mn/hrd/issinfo/hlt_hum.htm.