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INFORMATION BRIEF
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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 developmental disabilities (ICF/DD), day training and habilitation (DT&H), case management, home care, personal care assistant (PCA) services, home care nursing, Community First Services and Supports, and Moving Home Minnesota; and an overview of state disability programs and services, including housing support services, family support grants, consumer support grants, semi-independent living skills (SILS), and self-advocacy grants. In addition, a list of acronyms is included at the end of the report.

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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, pays 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 usual federal match for covered services is 50 percent (recent federal legislation provided a temporary enhanced FMAP). The state pays the remaining 50 percent for most services (some services have a county share, such as long-term placements in ICFs/DD 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 developmental disabilities meeting specified criteria

Pathways to MA Disability Eligibility

Common eligibility pathways in Minnesota 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 (each of these categories is discussed below).

Blind or Disabled Adults

Blind or disabled adults 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 spend down to 81 percent of FPG to become eligible. (See page 21 for 2017 FPGs.) 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.

Disabled Children

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 283 percent of FPG for children under age 2, 275 percent of FPG for children ages 2 to 18, and 133 percent of FPG for children ages 19 and 20. There is no asset limit, and the spenddown limit is 133 percent of FPG.

Eligibility Through TEFRA

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 SMRT;
- require a level of home health care comparable to the care provided in a hospital, nursing facility, or ICF/DD;
- 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

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;
- 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 whose income exceeds the regular 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 81 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 drugs, MA covers many services used heavily by persons with disabilities. These services include the following:

- Nursing facility services
- ICF/DD services
- Home health care
- Case management
- Personal care assistant services
- Home care 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 Special Needs

Basic Care Program. People with disabilities are enrolled in special needs plans, unless they choose to opt out of managed care enrollment and remain in fee-for-service.

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. MA enrollees are subject to the following cost-sharing:

- $3 per nonpreventive visit
- $3.50 for nonemergency visits to a hospital emergency room (this copayment will be increased to $20 upon federal approval)
- $3 for brand name drugs/$1 for generic drugs ($12/month limit)
- A monthly family deductible for each period of eligibility

Total monthly cost-sharing must not exceed 5 percent of family income.

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 subject to parental fees, but the court-ordered support is annualized and subtracted from the parent's adjusted gross income, which is used to calculate the parental fee. 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 developmental disabilities, severe emotional disturbance, or a physical disability; and
- children in foster care placement.

The usual parental fee ranges from zero for parents with adjusted gross income (AGI) of less than 275 percent FPG to 8.81 percent for parents with AGI equal to or greater than 975 percent of FPG.

Overview of MA Disability Programs and Services

The MA disability programs and services described in this section include home and community-based waiver services, intermediate care facilities for persons with developmental disabilities, day training and habilitation, case management, home care, personal care assistant (PCA) services, home care nursing, Community First Services and Supports, the early intensive developmental and behavioral intervention benefit, and Moving Home Minnesota.

Home and Community-Based Waiver Services (HCBS)

HCBS offers service options that allow people to live in the community instead of going into or staying in an institutional setting. HCBS covers 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 disability waivers:

- Community Access for Disability Inclusion (CADI): Provides services for individuals with disabilities who need the level of care provided in a nursing home

- Brain Injury (BI): Provides services for individuals with brain injury who need the level of care provided in a nursing home or neurobehavioral hospital

- Developmental Disabilities or Related Conditions (DD): Provides services for individuals with developmental disabilities or related conditions who need the same level of care as provided in an ICF/DD

- Community Alternative Care (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.

Each county's HCBS allocation is set by DHS for a certain number of slots (base allocation plus any inflation). The DD waiver is a separate annual allocation. All other waivers (CADI, CAC,

BI) 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). If a county determines that it is able to serve more people than the slots it has available under the DD waiver, the county can do so, as long as the county stays within its overall waiver budget.

HCBS waiver services include the following:

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

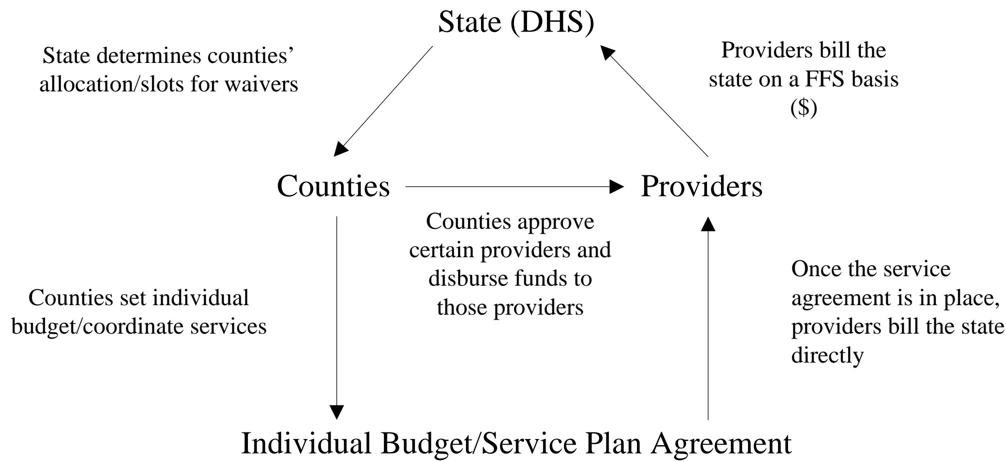
The HCBS waiver programs are federal-state funded programs, funded with 50 percent federal MA funds and 50 percent state general funds.

HCBS Waiver Program Statistics FY 2017

Program	Unduplicated Annual Recipients	Average Cost/Recipient	Total Expenditures (millions)
CADI	26,902	$30,365	$816.9
BI	1,352	73,123	98.9
DD	18,599	69,199	1,287.0
CAC	564	64,818	36.8
Total	47,417	47,226	2,239.4

Source: Expenditure Forecast for November 2017

Flow of Dollars for Waiver Programs



Source: House Fiscal Analysis Department

Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD)

ICFs/DD are MA facilities that serve persons with developmental disabilities and related conditions who require the level of care provided in an ICF/DD and who choose such services. These facilities are licensed supervised living facilities and serve from four to 64 persons.

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

- have a developmental disability or a related condition;
- require a 24-hour plan of care;
- have substantial limitations in functioning and manifest conditions before his or her 22nd birthday;
- meet MA income and asset requirements; and
- request ICF/DD services.

Minnesota contracts with ICF/DD 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 predesigned package and include:

- room and board;
- services during the day, active treatment, and functional skill development; and
- transportation.

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

ICFs/DD 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/DD begins with the state-determined rate (rate multiplied by the number of days). ICF/DD rates are set by each 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, for placements that have exceeded 90 days. 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/DD program statistics for fiscal year 2017:

- Total expenditures: $134.9 million
- Average monthly recipients: 1,552
- Average monthly cost per recipient: $7,242

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 developmental disability or a related condition
- Receive a screening for home and community-based services or reside in an ICF/DD
- Have his or her health and safety in the community addressed in their plan of care
- Make an informed choice to receive DT&H as part of his or her individual service plan (ISP)

DT&H services are an option under the DD 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 predesigned package provided to ICF/DD residents.

For people who do not have MA funding (DD waiver or reside in an ICF/DD), counties are to provide DT&H services to the degree that they are: (1) identified as needed in the person's individual service plan (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 (see https://mn.gov/dhs/people-we-serve/people-with-disabilities/services/home-community/programs-and-services/dth.jsp).

For persons receiving DT&H services through the DD waiver or an ICF/DD, 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 2017 (for ICF/DD residents only):

- Total expenditures: $28.9 million
- Average monthly recipients: 1,197
- Average monthly cost per recipient: $2,014

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 Vulnerable Children and Adults Act (VCAA) plans.

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

- Intake
- Eligibility determination
- Screening
- Service authorization
- Conciliations and appeals
- Diagnosis

Service activities include the following:

- Plan development
- Consulting with relevant medical experts or service providers
- Assisting in accessing services
- Assisting in the identification of potential providers

- Service coordination
- Service evaluation and monitoring
- Plan review and recommendations for service authorization

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

Case Management Program Statistics, FY 2016

Waiver	Total Expenditures FY 2016	Average Per Recipient
DD	$32,112,470	$1,882
CAC	$964,405	$1,980
CADI	$43,774,617	$1,852
BI	$3,772,076	$2,677
Total	**$80,623,568**	**$1,893**

House Research and House Fiscal Analysis Departments

The case management expenditures in the above table are included in the overall waiver expenditures included in the table on page 7. Targeted case management is not included in the expenditures in either of these tables.

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 nursing.

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;
- home care 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 (does not include PCA or home care nursing services) for fiscal year 2017:

- Total expenditures: $15.2 million
- Monthly average recipients: 2,916
- Average monthly cost per recipient: $435

Personal Care Assistant (PCA) Services

Personal care assistants provide assistance and support to persons with disabilities, the elderly, 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;
- 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 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 an assessment of need. PCA services provided include:

- assistance with activities of daily living including grooming, dressing, bathing, transferring, mobility, positioning, eating, and toileting;
- assistance with instrumental activities of daily living, including meal planning and preparation, assistance with paying bills, and shopping for essential items;

- assistance with health-related procedures and tasks; and
- intervention for behavior including observation and redirection.

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

PCA program statistics for fiscal year 2017 (fee-for-service only):

- Total expenditures: $632.3 million
- Monthly average recipients: 21,342
- Average monthly cost per recipient: $2,469

PCA services will be replaced by CFSS in fiscal year 2019.

Home Care Nursing

Home care nursing services are provided by a registered nurse or licensed practical nurse to maintain or restore a person's health.

In order for a person to receive home care nursing services, the services must be:

- medically necessary;
- ordered by a licensed physician;
- documented in a plan of care that is reviewed by the physician at least once every 60 days;
- assessed by a registered nurse;
- authorized by the commissioner; and
- provided in the recipient's home or outside the home when normal life activities require.

Home care nursing services must be used when the recipient requires more care than can be provided during a skilled nurse visit and when the care required is outside the scope of services provided by a home health aide or personal care assistant (Minn. Stat. § 256B.0654, subd. 2a).

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

Home care nursing services statistics for fiscal year 2017:

- Total expenditures: $124.9 million
- Monthly average recipients: 777
- Average monthly cost per recipient: $13,397

Community First Services and Supports (CFSS)

CFSS were created by the 2013 Legislature and are intended to replace the PCA and consumer support grant programs. CFSS will be available statewide to eligible individuals to provide assistance and support to persons with disabilities, the elderly, and others with special health care needs living independently in the community.

CFSS will be available to a person who meets one of the following criteria:

- Is a MA enrollee
- Is a participant in the alternative care program
- Is a MA waiver participant
- Has medical services identified in a participant's individualized education program and is eligible for MA special education services

In addition to meeting the eligibility criteria above, a person must also:

- require assistance and be determined dependent in one activity of daily living (ADL) or Level I behavior based on an assessment;
- not be a family support grant recipient; and
- live in the person's own apartment or home (not an institutional setting).

CFSS services include:

- assistance with ADLs, including eating, toileting, grooming, dressing, bathing, mobility, positioning, and transferring;
- assistance with health-related procedures and tasks that can be delegated or assigned by a state-licensed health care or mental health professional and performed by a support worker;
- assistance to acquire, maintain, or enhance skills necessary for the participant to accomplish ADLs, instrumental ADLs, or health-related procedures and tasks;
- expenditures for items, services, supports, environmental modifications, or goods, including assistive technology; and
- assistance with instrumental ADLs, including meal planning and preparation, shopping, laundry, housecleaning, assistance with medications, managing finances, and communicating needs and preferences.

CFSS will be a federal-state funded service, with 50 percent paid with federal MA funds and 50 percent paid with state general funds. CFSS will replace PCA and consumer support grants in fiscal year 2019.

Early Intensive Developmental and Behavioral Intervention Benefit

The early intensive developmental and behavioral intervention benefit was created by the 2013 Legislature to provide coverage for a comprehensive, multidisciplinary evaluation, ongoing progress monitoring, and medically necessary early intensive treatment of autism spectrum disorder or a related condition.

The benefit is available to a child under the age of 21 enrolled in MA who:

- has a diagnosis of autism spectrum disorder or a related condition; and
- meets the criteria for medical necessity for the early intensive developmental and behavioral intervention services.

The autism early intensive intervention benefit will be a federal-state funded benefit, funded with 50 percent federal MA funds and 50 percent state general funds.

This benefit went into effect on July 1, 2015.

Moving Home Minnesota

Moving Home Minnesota is the name of the state's federal Money Follows the Person Rebalancing Demonstration. This program promotes activities to reduce or eliminate barriers to receiving services in home and community-based settings.

In order to be eligible for the demonstration, a person must:

- be a MA recipient;
- be eligible for at least one day of institutional care;
- reside in a qualified institution for 90 or more consecutive days (qualified institutions include Anoka Metro Regional Treatment Center, child and adolescent behavioral health facility, community behavioral health hospitals, hospitals, ICFs/DD, and nursing facilities); and
- move into a qualified residence (qualified residences include an apartment with an individual lease, a home owned or leased by the person or the person's family member, residence in a community residential setting where no more than four unrelated people reside).

Demonstration services include:

- Caregiver education (Family Memory Care)
- Case consultation and collaboration (Pre-discharge and post-discharge)
- Certified peer specialist services
- Comprehensive community support services
- Durable medical equipment and assistive technology
- Environmental modifications
- Membership fees

- Moving Home Minnesota Case Management Services
- Overnight Assistance
- Nonmedical transportation to find housing and/or employment
- Personal emergency response systems
- Psychoeducation services
- Respite services
- Supported employment services
- Tools, clothing, and equipment necessary for employment
- Transition planning and transition coordination services

In addition, enhanced federal match is available for the HCBS waivers and certain children's mental health state plan services.

In fiscal year 2017, demonstration expenditures were $2,490,000.

Overview of State Disability Programs and Services

The state disability programs and services described in this section include housing support services, family support grants, consumer support grants, and semi-independent living services.

Housing Support Services

Housing Support Services are a state-funded income supplement 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 housing support payments, a person must have county approval for residence in a housing support services setting and must: (1) be aged, blind, or over 18 years old and disabled, and meet specified income and asset standards; (2) belong to a category of individuals potentially eligible for General Assistance and meet specified income and asset standards; or (3) receive licensed residential crisis stabilization services and MA housing support services.

The housing support services basic room and board rate is $891 per month. Recipients in certain housing support services settings may also qualify for a supplemental payment that is in addition to the basic room and board rate. Housing support services pays for room and board in a number of licensed or registered settings, including the following:

- Adult foster care
- Community residential setting
- 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 housing support services 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.

Housing support services are funded with state general funds.

Housing support services statistics for fiscal year 2017:

- Total expenditures: $160.5 million
- Average monthly recipients: 20,291
- Average monthly cost per recipient: $659

Family Support Grants

The Family Support Grant program provides state cash assistance for maintaining a child with a physical or developmental disability in the family home in order to prevent out-of-home placement of children with disabilities. 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.

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/DD, 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 $101,751

Children receiving services through a BI, CAC, CADI, or DD waiver, personal care assistance, or a consumer support grant are not eligible for a Family Support Grant. Family Support Grants are limited to $3,114 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 2017 total expenditures: $3,481,687
- Calendar year 2017 total recipients: Not available

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 home care nurse. 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. In 2016, 45 counties and one tribe had Consumer Support Grant participants.

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

- be a recipient of MA or be approved to receive a family support grant;
- 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 receiving MA PCA, home health aide services, home care nursing, a family support grant, or alternative care is not eligible for a consumer support grant.

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

Allowable services include home care services, equipment, and transportation. The Consumer Support Grant program is funded with 100 percent state funds.

Consumer Support Grant program statistics for fiscal year 2017:

- Total expenditures: $27.2 million
- Monthly average enrollees: 2,335
- Monthly average allocation: $972

Consumer Support Grants will be replaced by CFSS in fiscal year 2019.

Semi-Independent Living Services (SILS)

SILS are provided to adults with a developmental disability 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 developmental disabilities 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 include instruction or assistance in the following areas:

- Meal planning and preparation
- Shopping
- Money management
- Apartment/home maintenance
- Self-administration of medications
- Telephone use
- Personal appearance and hygiene
- Getting help in an emergency
- Social, recreation, and transportation 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 2017 total expenditures: $5,949,551
- Calendar year 2017 total recipients: Not available

Work, Empower, and Encourage Independence Demonstration

On July 1, 2014, DHS established a demonstration project to promote economic stability, increase independence, and reduce applications for disability benefits while providing a positive impact on the health and future of participants. Services provided under the demonstration project include navigation, employment supports, and benefits planning. These services are provided to a targeted group of federally funded Medicaid recipients (Minn. Stat. § 256B.021, subd. 6). The demonstration project will be funded with state general funds.

In fiscal year 2017, funding for the demonstration was $502,000

Self-Advocacy Grants

The self-advocacy grant is a state-funded grant to Advocating Change Together to establish and maintain a statewide self-advocacy network for people with intellectual and developmental disabilities.

Advocating Change Together is an organization governed by people with intellectual and developmental disabilities that has a statewide network of disability groups to maintain and promote self-advocacy services and support for people with intellectual and developmental disabilities.

According to Minn. Stat. § 256.477, the self-advocacy network must:

(1) ensure that persons with intellectual and developmental disabilities are informed of their rights in employment, housing, transportation, voting, government policy, and other issues pertinent to the intellectual and developmental disability community;
(2) provide public education and awareness of the civil and human rights issues people with intellectual and developmental disabilities face;
(3) provide funds, technical assistance, and other resources for self-advocacy groups across the state; and
(4) organize systems of communications to facilitate an exchange of information between self-advocacy groups.

In fiscal year 2017, the self-advocacy grant was $133,000.

State Disability Program Statistics, FY 2017

Program	Average Monthly Recipients	Average Monthly Cost/Recipient	Total Expenditures
Housing Support Services	20,291	$659	$160,506,803
Family Support Grants	NA	NA	$3,946,000
Consumer Support Grants	2,335	$972	$27,235,385
SILS	NA	NA	$5,949,551 (state share)

Source: Department of Human Services

2017 Federal Poverty Guidelines

Family Size	75%	100%	150%	200%
1	$9,045	$12,060	$18,090	$24,120
2	12,180	16,240	24,360	32,480
3	15,315	20,420	30,360	40,840
4	18,450	24,600	36,900	49,200

Expenditures and Cost Comparisons

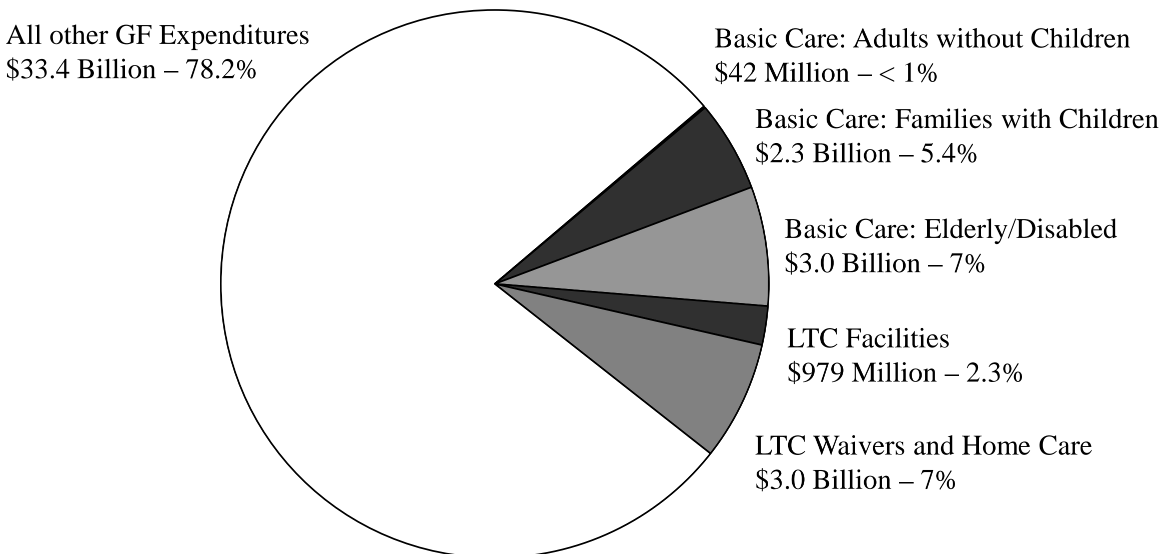
This section includes several figures that compare expenditures and costs for various MA programs for persons with disabilities.

Figures 1 and 5 to 7 include home care and elderly waiver (EW) fee-for-service in the long-term care (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 November 2017 Forecast. Beginning with fiscal year 2018, all dollar amounts are projected.

Figure 1 shows the MA state general fund and health care access fund expenditures by category and percentage of total expenditures for those funds. MA general fund expenditures account for 24 percent of total general fund and health care access fund expenditures in fiscal years 2016-2017.

Figure 1

Medical Assistance GF and HCAF Expenditures and
Percent of Total GF and HCAF Expenditures
FY 2016-2017 Total GF Expenditures: $42.7 billion
FY 2016-2017 Total State Share MA Expenditures: $9.6 billion

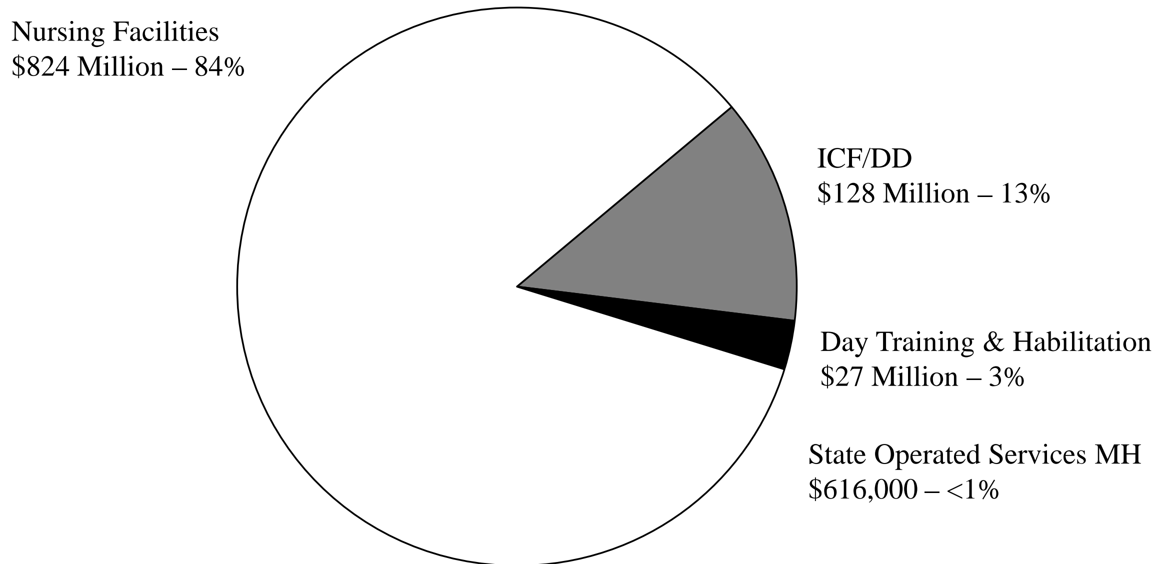


Source: November 2017 DHS Forecast Summary Data

Figure 2 shows MA long-term care (LTC) expenditures by facility category. Nursing facilities make up 84 percent of the total MA LTC facilities state share expenditures in fiscal years 2016-2017.

Figure 2

Medical Assistance Long-Term Care Facilities
FY 2016-2017
Total LTC Facilities State Share: $979 million

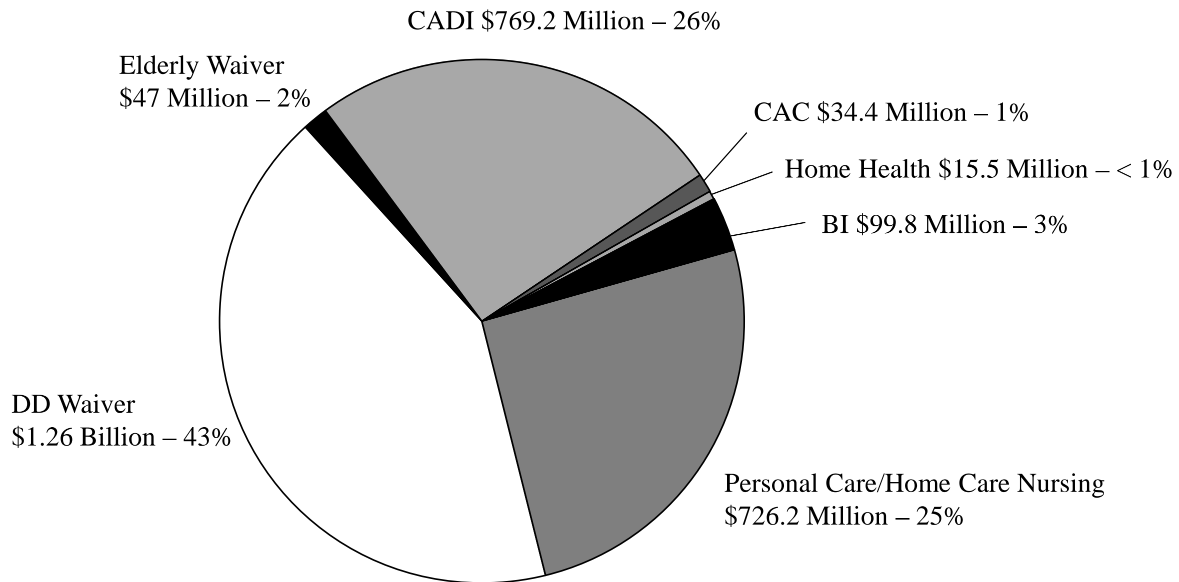


Source: November 2017 DHS Forecast Data

Figure 3 shows MA LTC waiver and home care expenditures by program. The Developmental Disabilities or Related Conditions (DD) waiver constitutes 43 percent of the total MA LTC waivers and home care state share expenditures in fiscal years 2016-2017.

Figure 3

Medical Assistance Long-Term Care Waivers/Home Care
FY 2016-2017
Total LTC Waivers State Share: $2.9 billion

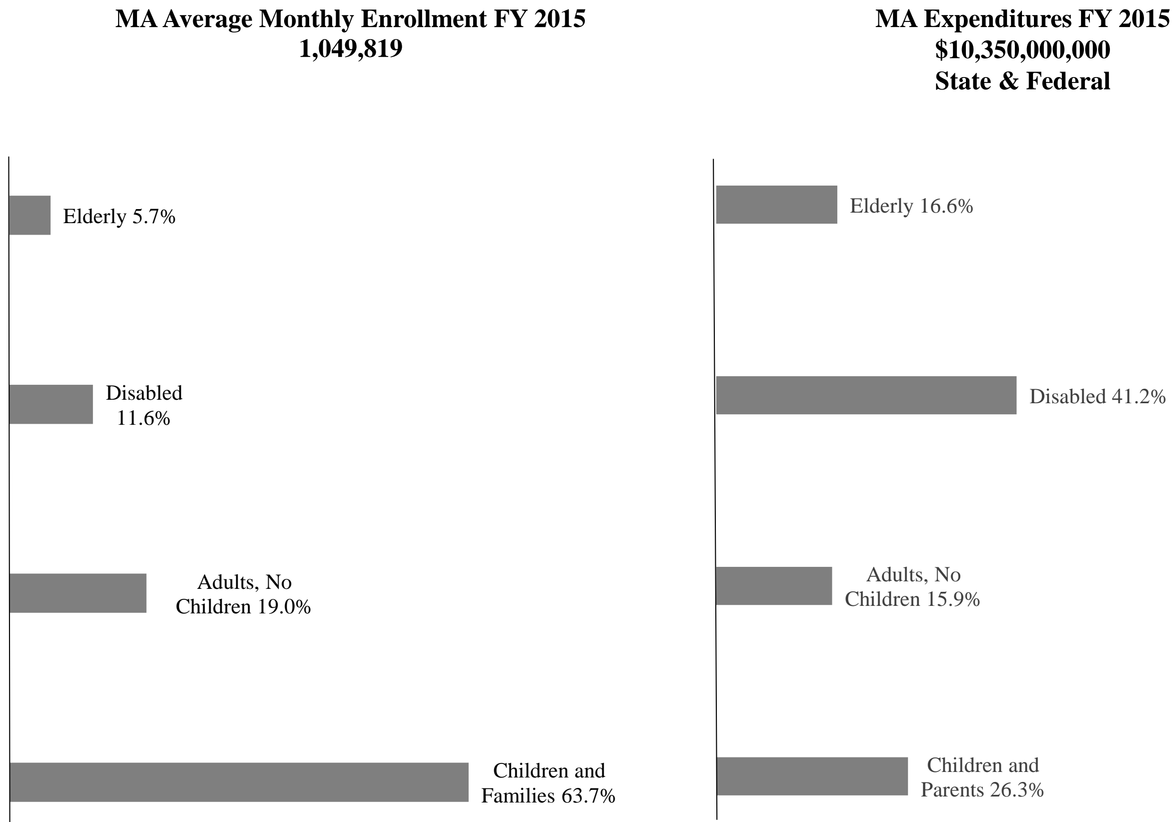


Source: November 2017 DHS Forecast Data

Figure 4 compares the percentage of MA enrollees by category to the percentage of MA spending by category. In fiscal year 2015, families with children accounted for 63.7 percent of MA enrollees but only 26.3 percent of MA spending, while disabled or blind persons accounted for 11.6 percent of MA enrollees and 41.2 percent of MA spending.

Figure 4

Minnesota Medical Assistance Eligibles – SFY 2015

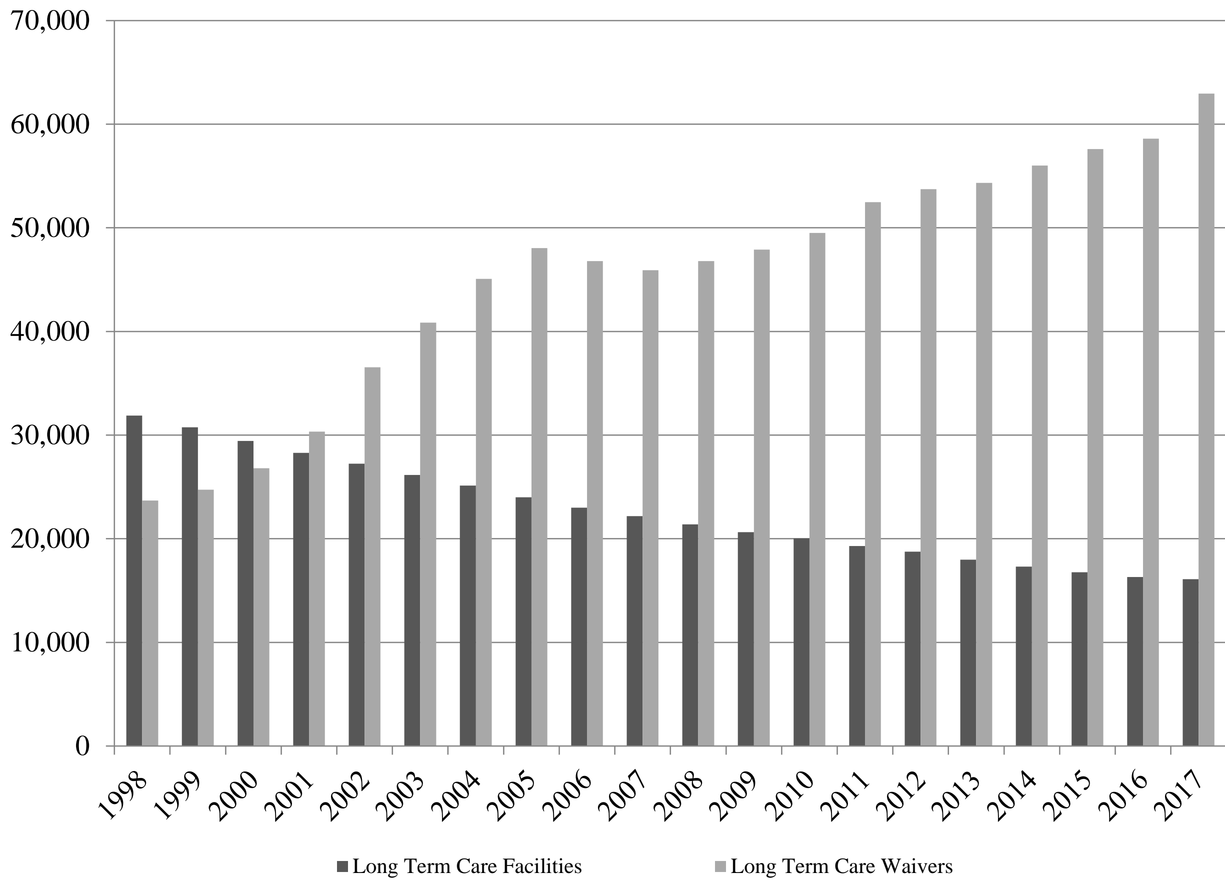


Source: Department of Human Services

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

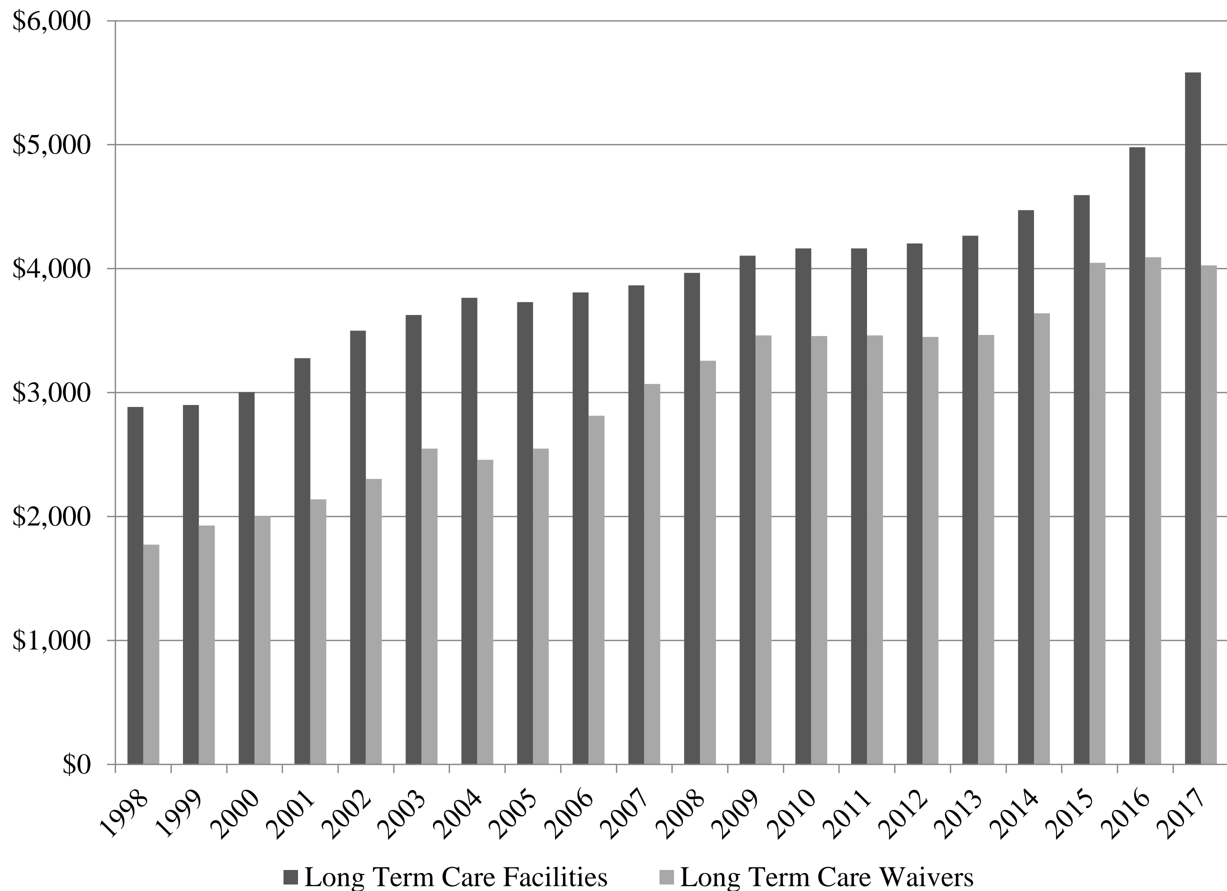


Source: November 2017 DHS Forecast Data

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 both 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

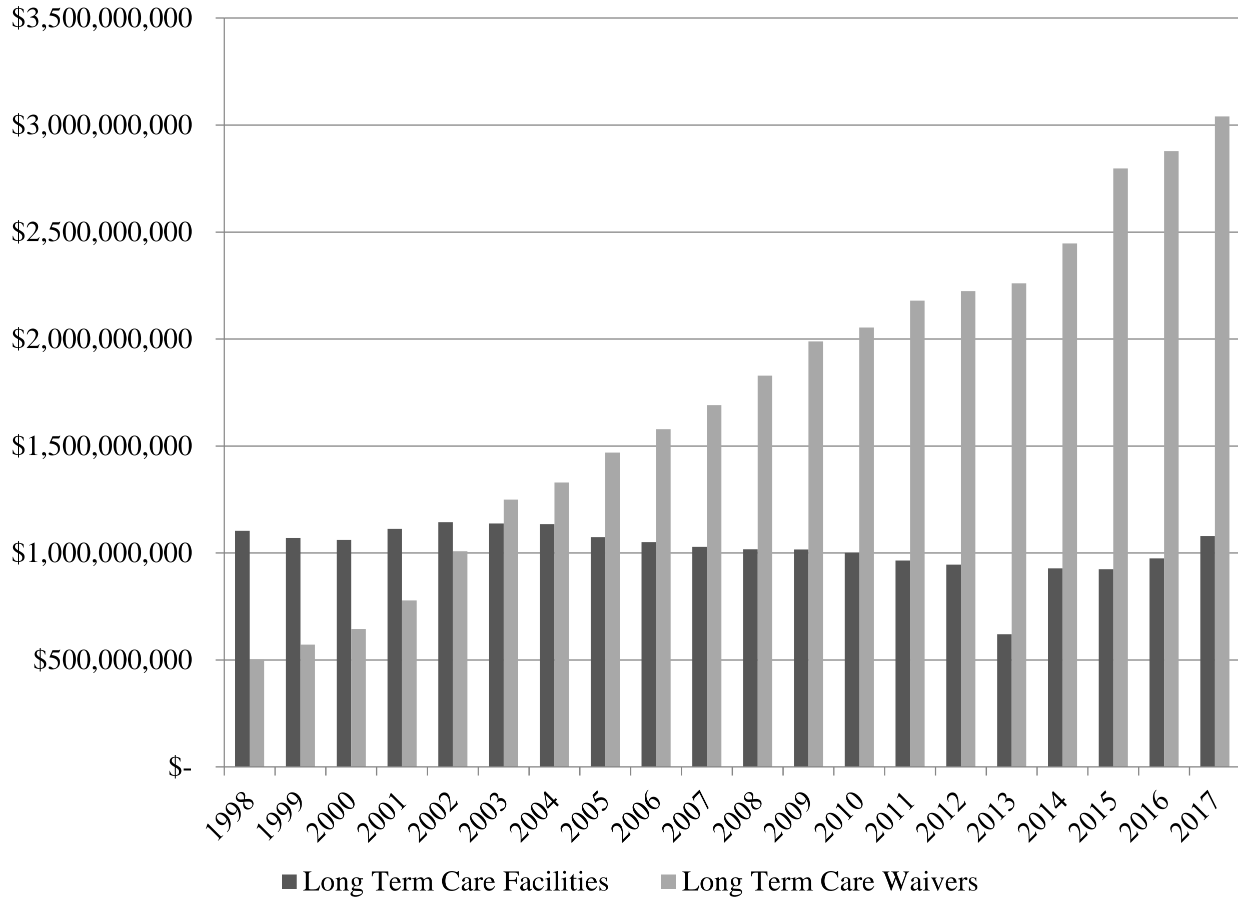
Medical Assistance Long-Term Care Facilities and Waivers/Home Care Monthly Average Payments Per Recipient



Source: November 2017 DHS Forecast Data

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

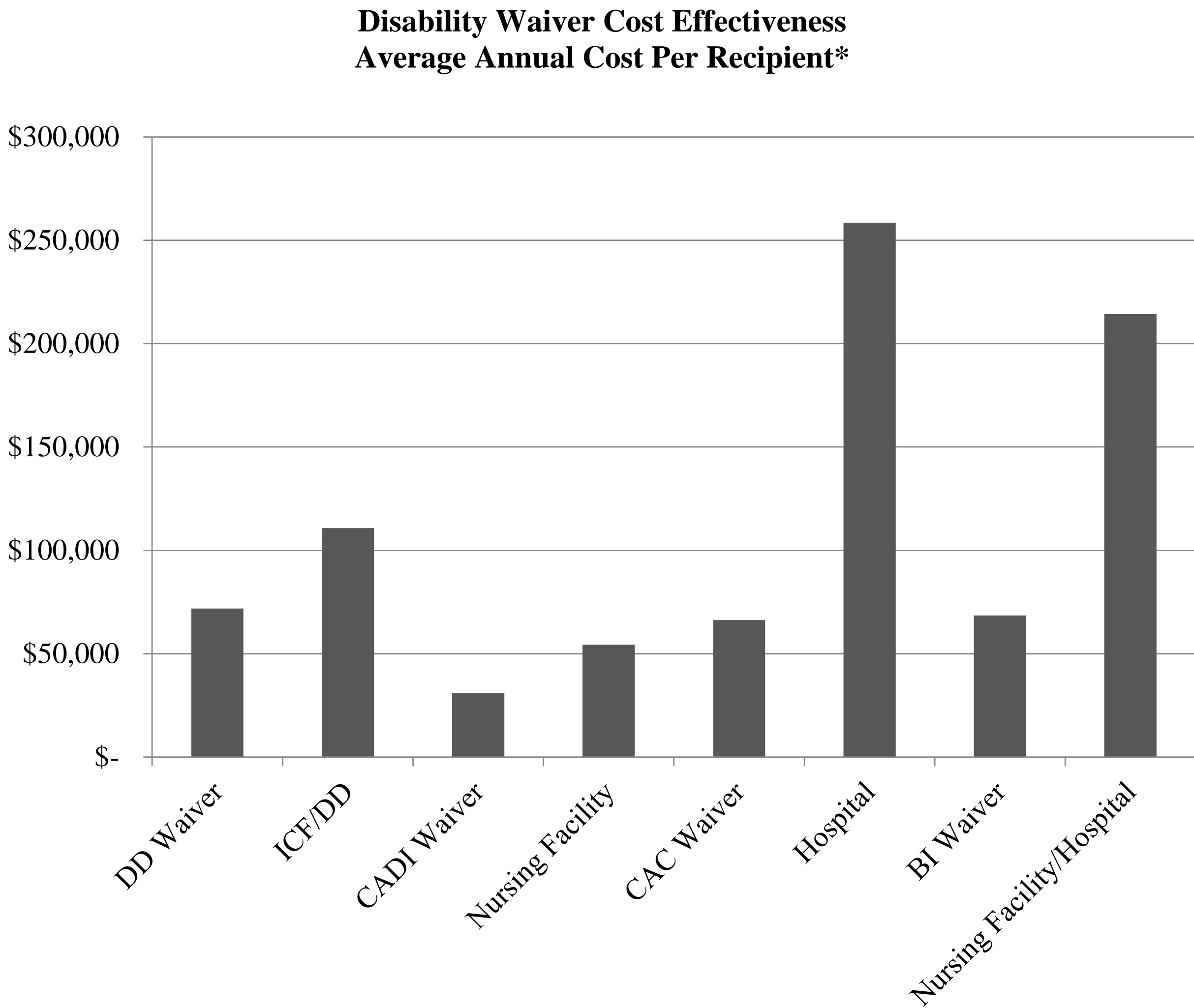
Figure 7



Source: November 2017 DHS Forecast Data

Finally, figure 8 shows disability 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



Source: November 2017 DHS Forecast Data

*The comparison periods are:
DD waiver: July 1, 2014, to June 30, 2015
CADI waiver: October 1, 2014, to September 30, 2015
CAC waiver: April 1, 2014, to March 31, 2015
BI waiver: April 1, 2014, to March 31, 2015

Acronyms

AGI: Adjusted Gross Income
BI: Brain Injury
CAC: Community Alternative Care
CADI: Community Access for Disability Inclusion
CDCS: Consumer-directed Community Supports
CFSS: Community First Services and Supports
DD: Developmental Disabilities
DHS: Minnesota Department of Human Services
DT&H: Day Training and Habilitation
EW: Elderly Waiver
FMAP: Federal Medical Assistance Percentage
FPG: Federal Poverty Guidelines
HCBS: Home and Community-Based Waiver Services
ICF/DD: Intermediate Care Facility for Persons with Developmental Disabilities
ISP: Individual Service Plan
LTC: Long-Term Care
MA: Medical Assistance
MA-EPD: Medical Assistance Employed Persons with Disabilities
PCA: Personal Care Assistant
RUGs: Resource Utilization Groups
SILS: Semi-Independent Living Skills
SMRT: State Medical Review Team
SSA: Social Security Administration
SSI: Supplemental Security Income
TEFRA: Tax Equity and Fiscal Responsibility Act of 1982
VCAA: Minnesota Vulnerable Children and Adults Act

For more information about assistance programs, visit the health and human services area of our website, www.house.mn/hrd/.