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DEPARTMENT OF HUMAN SERVICES

Legislative Report

Status of Long-Term Services and Support

Aging and Adult Services, Disability Services, Behavioral Health, Nursing Facility Rates and Policy

August 2019

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $12,000.

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Contents

I. Executive summary

Long-term services and supports (LTSS) are a spectrum of health and social services that support Minnesotans who need help with daily living. LTSS enable people to lead meaningful lives at all stages, according to their own goals, with opportunities to make meaningful contributions and build upon what is important to them. People can access LTSS in institutional settings, such as hospitals and nursing homes, or in their homes and other community settings. This report summarizes the status of Department of Human Services (DHS) efforts to manage the LTSS system, in particular, how we are adapting to current conditions and emerging trends and pressures.

For decades, Minnesota has been working to rebalance the LTSS system from primarily institution-based services to primarily home and community-based services (HCBS). In 1995, we crossed the threshold where more people received LTSS services in their homes and community. Today, 87 percent of all people receiving LTSS get them through HCBS.

This report describes the status of the LTSS system today. The report provides context for understanding the current status and future directions of LTSS in Minnesota. This includes key developments of the last 25 years in the evolution of the LTSS system.

Although a small percent of the people who use LTSS receive them in nursing facilities, these are still an important part of our system. Information about nursing facilities is included in the report. The advent of the Medicaid HCBS waiver option in 1981 enabled Minnesota to build a robust non-institutional service system.

Most of these HCBS programs have been in place for decades and the services successfully meet people's needs every day. The demand for them continues, and the service system responds to those demands. At the same time, there are emerging trends and challenges to which the system must adapt. The report discusses these five pressing issues:

- Workforce pressures
- Program and population growth and changes
- New technologies
- Changing preferences
- Federal directives

Our focus is on improving the quality of people's lives and ensuring the sustainability of the LTSS system.

DHS uses data to measure the effectiveness of the service system and to inform decision-making. The report identifies, describes and provides links to several of these data sources. The report incorporates data from these sources throughout. The Measuring our progress section of the report is devoted to showing some of the ways we measure our progress along with what those measures show. The section covers these six goals:

- Increased flexibility to better meet the needs of each individual
- Increased stability in the community
- Better-informed individual decision-making about LTSS options

- Promotion of person-centered practices – life-long and in crisis situations
- Recognize and address the social determinants of health care need and cost

The Policy directions section of the report describes the work that DHS is doing to improve the LTSS system. In particular, we address key efforts to adapt to the changing environment while improving the quality of people's lives and ensuring the sustainability of the LTSS system. This section has six themes:

- Addressing workforce challenges
- Data-driven decision-making
- Supporting people to have more choice and control
- Rights and protections
- Innovation and quality
- Rates and payment reform

The report concludes with recommendations for future action. These are:

- Redesign Vulnerable Adult Act
- Establish standards for crisis response
- Improve value-based purchasing of nursing facility services
- Improve disability waiver system to give people who receive services more choice and control while streamlining service administration
- Fully implement 2017 Elderly Waiver rate reforms
- Support efforts to end HIV in Minnesota

II. Legislation

Minnesota Statutes 2016, section 144A.351 BALANCING LONG-TERM CARE SERVICES AND SUPPORTS: REPORT AND STUDY REQUIRED.

Subdivision 1.Report requirements. The commissioners of health and human services, with the cooperation of counties and in consultation with stakeholders, including persons who need or are using long-term care services and supports, lead agencies, regional entities, senior, disability, and mental health organization representatives, service providers, and community members shall prepare a report to the legislature by August 15, 2013, and biennially thereafter, regarding the status of the full range of long-term care services and supports for the elderly and children and adults with disabilities and mental illnesses in Minnesota. The report shall address:

(1) demographics and need for long-term care services and supports in Minnesota;

(2) summary of county and regional reports on long-term care gaps, surpluses, imbalances, and corrective action plans;

(3) status of long-term care services and related mental health services, housing options, and supports by county and region including:

(i) changes in availability of the range of long-term care services and housing options;

(ii) access problems, including access to the least restrictive and most integrated services and settings, regarding long-term care services; and

(iii) comparative measures of long-term care services availability, including serving people in their home areas near family, and changes over time; and

(4) recommendations regarding goals for the future of long-term care services and supports, policy and fiscal changes, and resource development and transition needs.

Minnesota Statutes 2016, section 245A.03, subd. 7 (e)

(e) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity required under paragraph (c) will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet long-term care service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long term care services reports and statewide data and information. By February 1, 2013, and August 1, 2014, and each following year, the commissioner shall provide information and data on the overall capacity of licensed long-term care services, actions taken under this subdivision to manage statewide long-term care services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over health and human services budget.

III. Introduction

Long-term services and supports (LTSS) are a spectrum of health and social services that support Minnesotans who need help with daily living. LTSS enable people to lead meaningful lives at all stages, according to their own goals, with opportunities to make meaningful contributions and build upon what is important to them. People can access LTSS in institutional settings, such as hospitals and nursing homes, or in their homes and other community settings.

In recent decades, Minnesota has shifted the LTSS system from institutional-based services to home and community-based services (HCBS). In 1995, the balance changed from the majority of services provided in institutional settings to the majority of services provided in home and community-based settings. Today, 87 percent of the people receiving LTSS get them through HCBS.

The shift towards HCBS mirrors changing personal preferences. In general, people report they have a higher quality of life when living in the community. HCBS, on average, are less costly than institutional care. Minnesota's success in rebalancing the LTSS system has resulted in higher quality of life for the people who use services and cost savings, compared to what the state would have spent on services provided in institutional settings.

While the demand for HCBS continues, emerging trends and pressures challenge the sustainability of the service system while also offering new opportunities. These include:

- Workforce pressures
- Changes in program participation and utilization
- New technologies
- Changes in preferences
- System gaps
- Federal directives

The Department of Human Services (DHS) is working to evolve the LTSS system to adapt accordingly, maintaining Minnesota's commitment to the quality of life and system sustainability. It is unrealistic to believe that Minnesota will achieve solutions which address both quality and sustainability within one biennial budget cycle. The report lays out DHS's long-term strategies for achieving these goals and concludes with recommendations for action.

Purpose of report

This report summarizes the status of DHS efforts to manage the LTSS system, in particular, how we are adapting to current conditions and emerging trends and pressures. The report includes recommendations on additional action to bolster quality and system sustainability. The four divisions of DHS primarily responsible for administering the LTSS system jointly developed this report: Aging and Adult Services, Behavioral Health, Disability Services and Nursing Facility Rates and Policy.

DHS is submitting this report to the Minnesota Legislature pursuant to Minnesota Statutes 2016, section 144A.351.

IV. System change

For decades, Minnesota has been working to rebalance the long-term services and supports (LTSS) system from primarily institution-based services to primarily home and community-based services (HCBS). In 1995, we crossed the threshold where more people received LTSS services in their homes and community.

Over time, as institutions closed and the vast majority of funding was dedicated to supporting HCBS, the Department of Human Services (DHS) increased its focus on meaningful community participation and the quality of life of people who use services. When people have more choice and flexibility in how they access and use supports and services, they also have more opportunity to lead lives that are personally meaningful and fulfilling. Other policy priorities have been creating a quality-driven system and ensuring the sustainability of the system.

Generational changes

By the 2000's, DHS embarked on a new set of significant reforms. These can be thought of as 'generational changes' in that they will take many years to achieve and will result in a system that is fundamentally different. Some of these changes are fully-implemented, some are still in the process and some DHS is just being to launch. Initiatives that DHS has implemented include the following.

- 1994 and 2005. The Senior Linkage Line (1994) and Disability Linkage Line (2005) launched. These free, statewide resource networks help people solve problems, navigate the system and plan for the future. Putting information and resources in the hands of people gives them more choice and control of their lives. These resources also help people and families maximize their natural supports and reduce or delay the need for formal services. In 2017, the Disability Linkage Line and other related tools and resources came together under one brand, Disability Hub MN.
- 2001. The Legislature adopted a number of recommendations from the Long-Term Care Task Force which set a new vision for LTSS for older adults and people with disabilities. These included proactive long-term care consultation, increased availability of information and assistance, shorter nursing home stays, and relocation assistance for people to move to community settings.
- 2005. DHS's partnership with managed care plans expanded to coordinate and integrate health and LTSS through Minnesota Senior Health Options and Minnesota Senior Care Plus.
- 2006. The Minnesota Nursing Home Report Card website launched, helping people who need nursing home care understand their options and make choices. The Nursing Facility Performance-Based Incentive Payment Program began. It was the first of several pay for performance efforts aimed at improving quality of life and quality of care in nursing homes statewide, as well as rebalancing the LTSS system.
- 2009. Moratorium on new corporate foster care beds (PDF) instituted. By limiting capacity of more expensive group settings, the system is expanding towards services and supports delivered in people's own homes.

- 2009. Legislature authorized reforms of assessment and support planning (MnCHOICES) processes, provider standards (245D), rate-setting (Disability Waiver Rate System) and personal care assistance services.
- 2010 and 2011. Return to Community Initiative (2010) and Moving Home Minnesota (2011) began. These programs help people who are living in nursing homes or other institutions and want to move home or to a new setting in their community.
- 2013. MnCHOICES launched. This is a person-centered, comprehensive assessment tool. Lead agency assessors use the application to assess people's needs and preferences, determine eligibility and provide information and service options. People can use the information from the assessment to make informed choices about services and supports. MnCHOICES has improved the consistency and equitability of access to available services across the state.
- 2014 and 2015. 245D licensure (2014) and Minnesota Rule, Chapter 9544 (Positive Supports Rule) (2015) implemented. Together these created statewide standards, prohibited restrictive interventions including restraint, seclusion and aversive practices and required the use of positive support strategies and person-centered planning with people who receive services.
- 2014 and 2017. Disability waiver rate system (2014) and elderly waiver rate reforms (2017) launched. These new rate-setting methodologies reflect service standards and providers' reasonable costs to deliver services. The implementation of the disability waiver rate system included stabilization adjustments (referred to as banding) to manage the pace of the rate changes. The period of banding ends in 2020. DHS has partially implemented the Elderly Waiver rate reforms.
- 2015. Minnesota Adult Abuse Reporting Center (PDF) (MAARC) launched. The MAARC is a state system for centralized reporting for suspected abuse, neglect and financial exploitation of vulnerable adults. Moving from a county-based to a state reporting system simplified reporting for mandated reporters and members of the public concerned about the welfare of vulnerable adults. The MAARC covers all vulnerable adults, regardless of the person's service use. The MAARC enables improved data collection and reporting which helps with remediation, prevention and system management.

Reform 2020

Bipartisan legislation enacted by the 2011 Minnesota Legislature sought to reform the Medical Assistance program with an effort called *Reform 2020*. The legislation identified the following outcomes for the reform effort:

- Achieve better health outcomes
- Increase and support independence and recovery
- Increase community integration
- Reduce reliance on institutional care
- Simplify the administration of the program and access to the program
- Create a program that is more fiscally sustainable

Parts of the plan submitted to the Centers for Medicare and Medicaid Services (CMS) received approval in 2013 and work has moved forward on those. Other elements have moved forward, as possible, without additional funding from CMS. The Reform 2020 values and goals continue to define our efforts to reform the LTSS system.

To advance this work, in the context of today's trends and challenges, we focus on:

1. Better individual outcomes, including:

    - Increased flexibility to better meet the needs of each person
    - Increased stability in the community
    - Better-informed, individual decision-making about LTSS options
    - Use of person-centered planning
    - Improved transitions between settings and programs, preventing avoidable health crises
    - Recognition of and action on the social determinants of health care need and cost

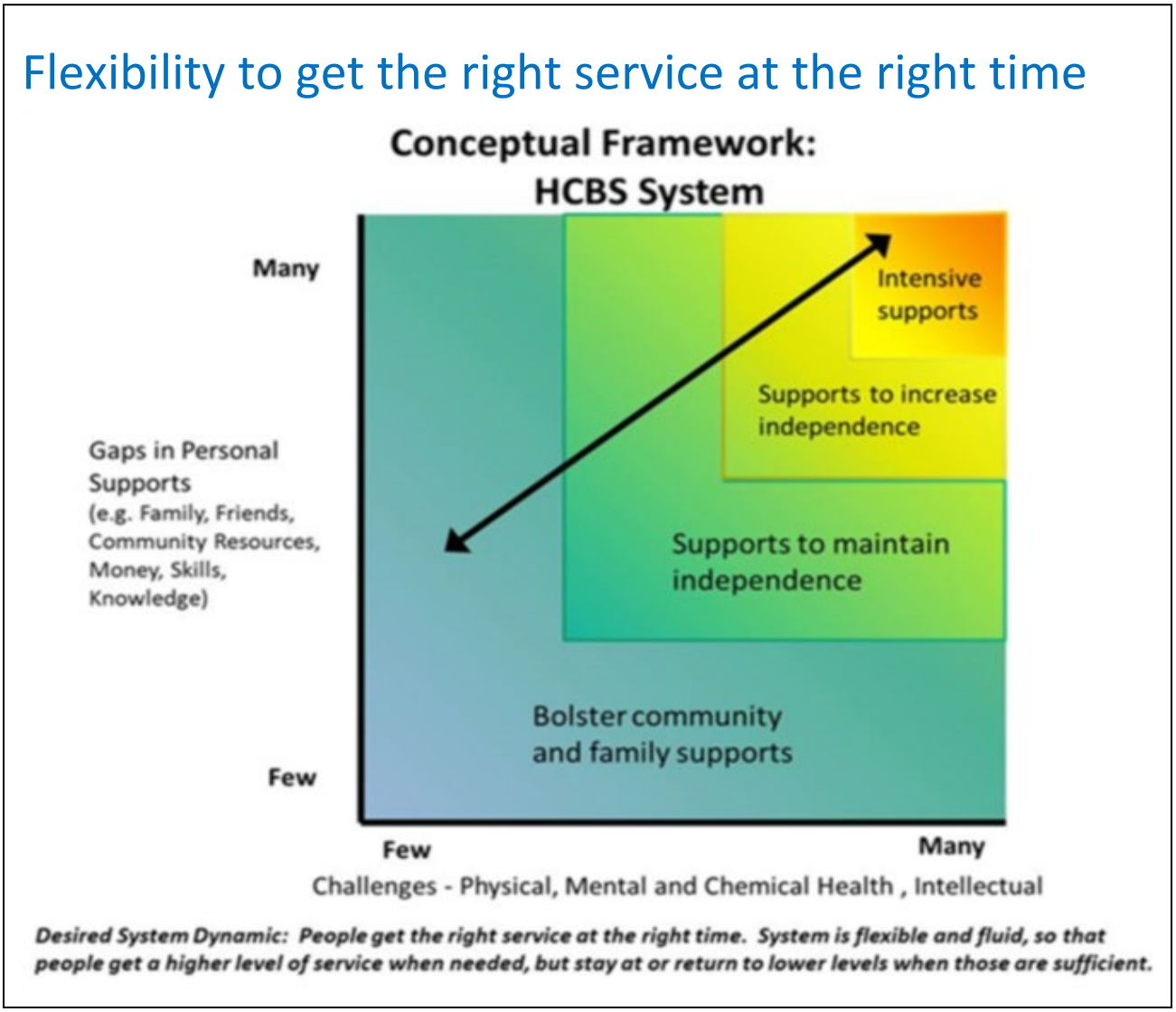
2. Right services at the right time, including:

    - Low-cost, high-impact services that reach people sooner
    - Decreased reliance on more costly services
    - HCBS, not institutional care, as a preferred option

3. Ensuring the future of LTSS, including:

    - Increased sustainability of the LTSS system
    - Increased efficiency in the use of public LTSS resources.

Figure 1: Conceptual framework for the home and community-based services system



Using data

To support our efforts to achieve better outcomes for people, provide the right service at the same time and sustain the system, we are strengthening our data systems. Data enables us to monitor how the progress towards our goals. It also helps us understand what is and isn't working well in the system. Data informs our decisions about how to prioritize our efforts and resources. Data from several sources appear in this report.

- National Core Indicators and National Core Indicators- Aging and Disabilities initiative

  This initiative measures and tracks how well HCBS support people with intellectual or developmental disabilities and their families, physical disabilities, and people who are older. The goal is to learn about how well the services and supports people use help them to live, learn, work and enjoy life in their community.

- Nursing home resident quality of life interviews

  Each year, trained staff employed by an independent contractor of DHS interview people living in nursing homes about their quality of life. DHS uses this feedback to help people choose the right facility for them, pay facilities for excellent service and for quality improvement, and to better understand people's daily experience in nursing homes.

- HCBS lead agency reviews

  DHS designs and sets the standards for the HCBS system. Lead agencies, including counties, tribal nations and managed care organizations under contract with DHS, administer the programs on a local level. DHS initiated the lead agency review of counties and tribes managing and administering HCBS programs in 2006 and has completed three full rounds of reviews for each lead agency. It examines all five Medicaid waiver programs and the Alternative Care program in each lead agency.

- Managed Care Organization care plan audits

  The contracts between DHS and managed care organizations require those organizations to audit annually a sample of care plans for all enrollees, including those who receive waiver services. The audits follow established protocols and include review of delegated administrative functions, required waiver case management tasks, and person-centered planning. If managed care organizations use a care system model where entities such as clinics, counties, and tribes provide care coordination for enrollees, DHS requires managed care organizations to audit the care systems that provide contracted services. DHS reviews and approves corrective action plans related to care plan audit findings and care system audit findings.

- Performance dashboards

  DHS makes data on home and community-bases service delivery available to the public to ensure transparency and accountability and to inform decision-making. The HCBS dashboards provide statewide data related to certain DHS program goals. The lead agency review team uses the Results-Based Accountability™ model to develop and share best practices in performance measurement. In addition, HCBS dashboard reports provide summary data on county and statewide operations and performance measures.

- Employment First Data Dashboards

  These dashboards track employment outcomes in Minnesota's disability service system in line with Minnesota's Employment First policy. This policy sets the expectation that all working-age people with disabilities in Minnesota can work, want to work and can achieve competitive, integrated employment.

V. Trends and challenges

The advent of the Medicaid home and community-based services (HCBS) waiver option in 1981 enabled Minnesota to build a robust non-institutional service system. Most of our programs have been in place for decades and the services successfully meet people's needs every day. The demand for these services continues, and the service system responds to those demands. At the same time, there are emerging trends and challenges to which the system must adapt.

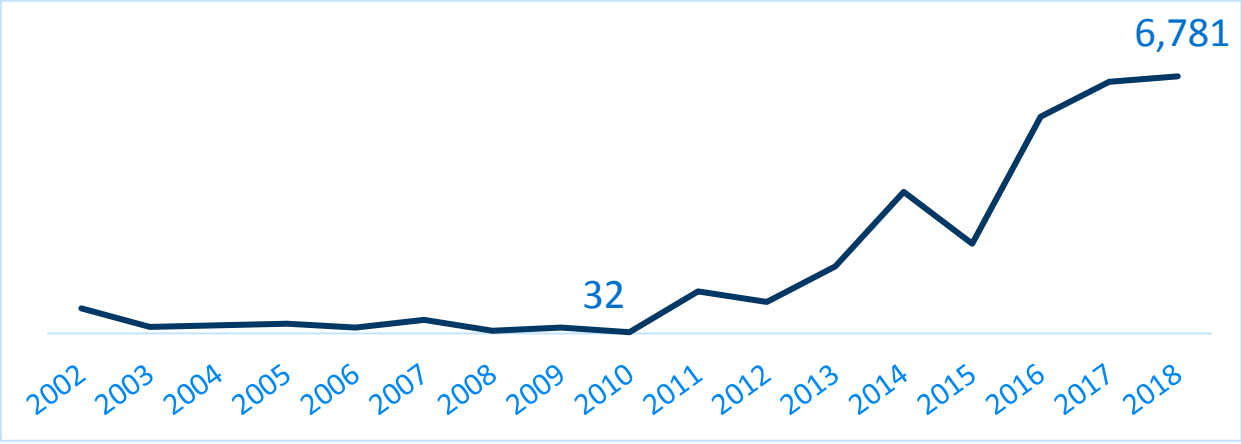
Workforce pressures

The low-wage, long-term services and supports (LTSS) field is especially impacted by the statewide workforce shortages that affect all Minnesota industries. This shortage coincides with increased demand and a need for increased skills to support more people in the community and a more diverse population. People already have trouble finding workers to provide these services. This is an urgent issue because these critical services enable people to live in the community. Economic forecasts project that the labor market will tighten considerably in the future.

The 2018-2019 Direct Support Workforce Survey showed that the direct support workers are low-paid, generally earning below a livable wage. They are more likely to work part-time. The survey found that there was a 39 percent annual turnover rate. The majority of those who left their positions left within six months of hire. A related worker survey showed that many direct support workers rely on government subsidies for health benefits, energy and food assistance.

The study shows that vacancies in personal care aide jobs, a classification used for direct are workers, have grown dramatically since the end of the Great Recession. The study projects the vacancy rate to stay high due to increasing demand and high turnover.

Figure 2: Personal care aide vacancies in Minnesota, 2002 to 2018



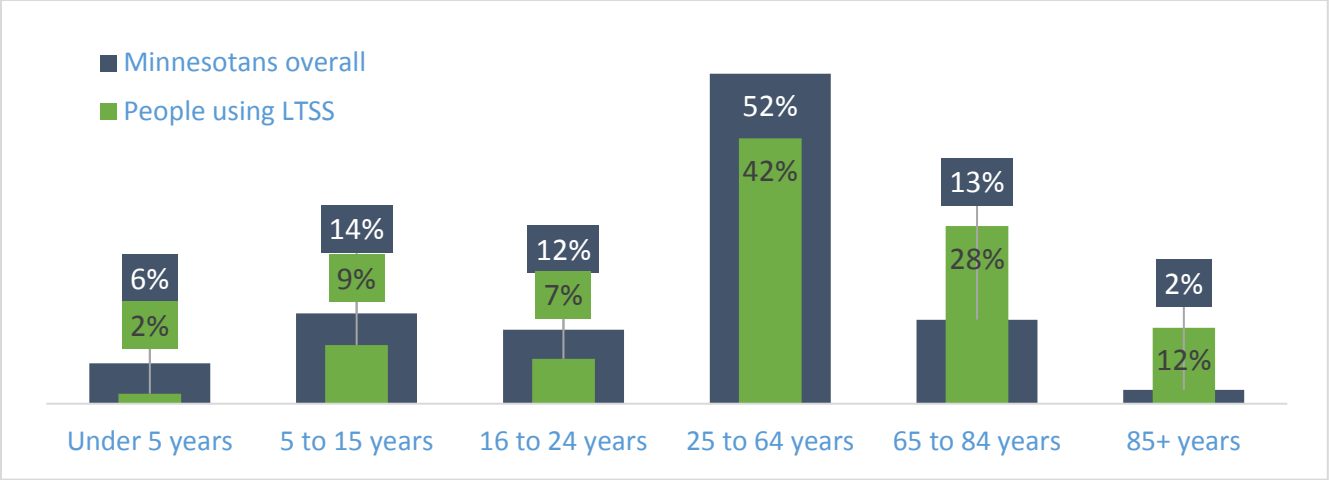
Program and population growth and changes

Minnesotans are living longer than ever before. By 2030, approximately one in five Minnesotans will be age 65 or older. Not only is the overall number of older adults increasing, but those born with or who acquired disabilities, and with chronic conditions live longer as well. People who historically would not have lived to be very old, are reaching older adulthood.

The proportion of Minnesotans who are 65 years or older is growing. The Minnesota State Demographic Center projects that part of the population to grow from 14.8 percent in 2015 to 21.2 percent by 2030. About 40 percent of people who use LTSS are 65 years or older.

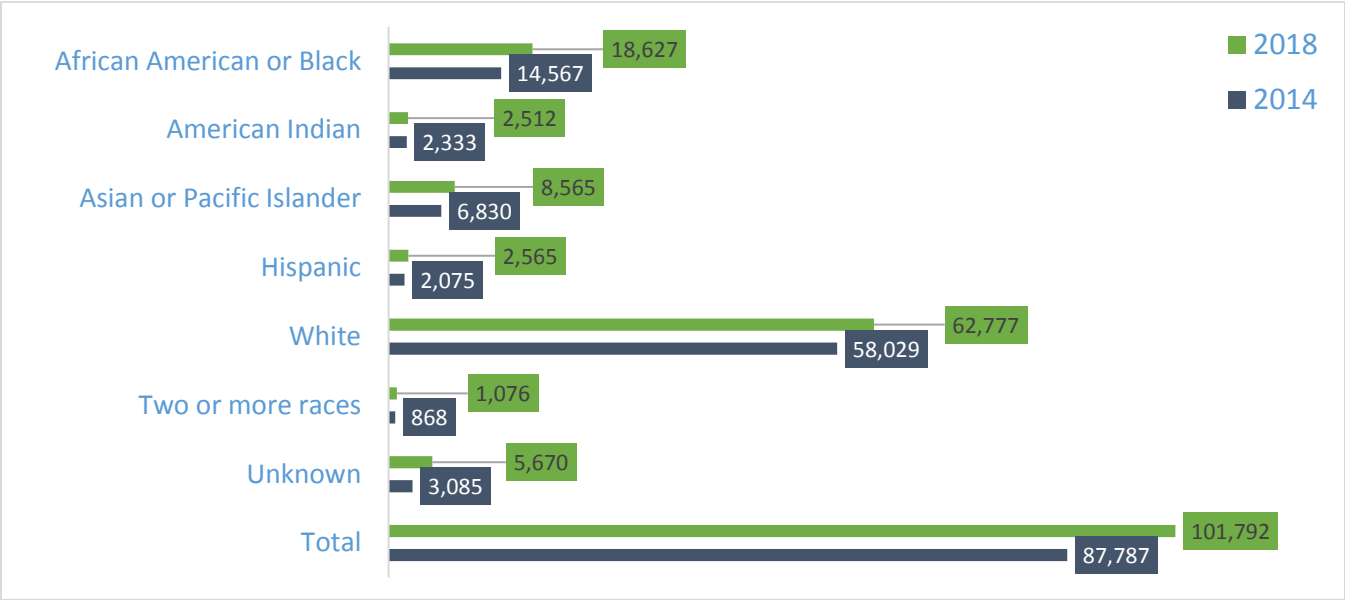
HCBS programs are growing faster than the state's population. Between 2014 and 2018, the HCBS population grew by 16 percent. In comparison, the state's population grew by 3 percent. This outpaced growth occurred in people 64 years old and older.

Figure 3: People using LTSS by age compared to Minnesotans overall, 2018



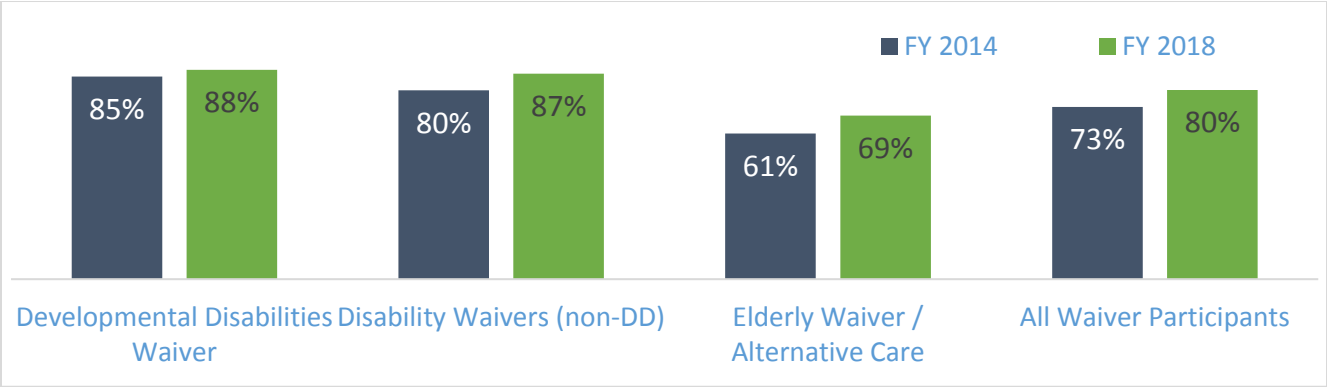
Between 2014 and 2018, the number of people receiving HCBS services grew by over 14,000 people, or 16 percent. Not only are these programs growing, but they are also growing more diverse. During the same time period, the number of people of color served grew by nearly 6,700 people. As of January 2018, about one-third of people using HCBS services identified as a race or ethnicity other than white.

Figure 4: Change in HCBS use over time by race and ethnicity, 2014 to 2018



The proportion of people using waiver services who have high needs grew from 73 percent in FY14 to 80 percent in FY18. The growing proportion of people with higher needs indicates that the HCBS system has a robust array of services that are able to serve those acute needs.[1]

Figure 5: Percent of people on an HCBS waiver with higher needs, 2014 to 2018

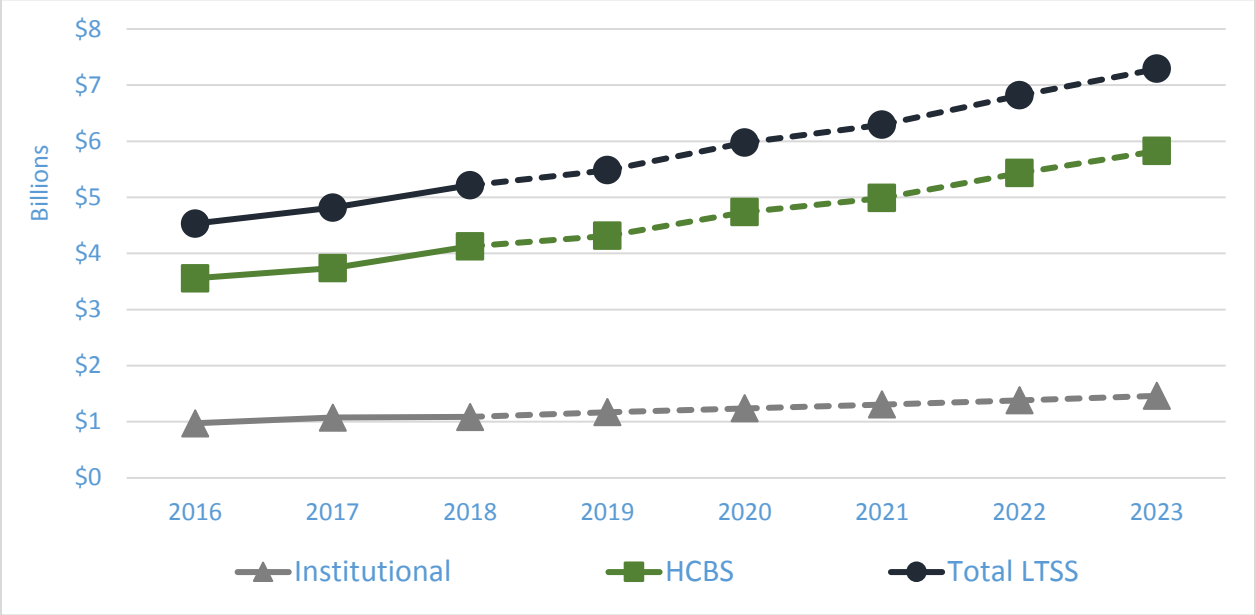


In FY18, the Department of Human Services (DHS) spent $5.2 billion on LTSS. The majority of the spending was on services provided in the community. Over 85,000 people received waiver services. Over 43,000 used personal care assistance services and approximately 1,400 people received home care nursing services. In FY18, an average of 1,367 people received services in intermediate care facilities for people with developmental disabilities (ICFs/DD). Over 1,600 people received family support grants and over 3,400 received consumer

[1] Higher needs defined as profile numbers 1 – 3 for people on DD waivers and case mix B-K for all other people

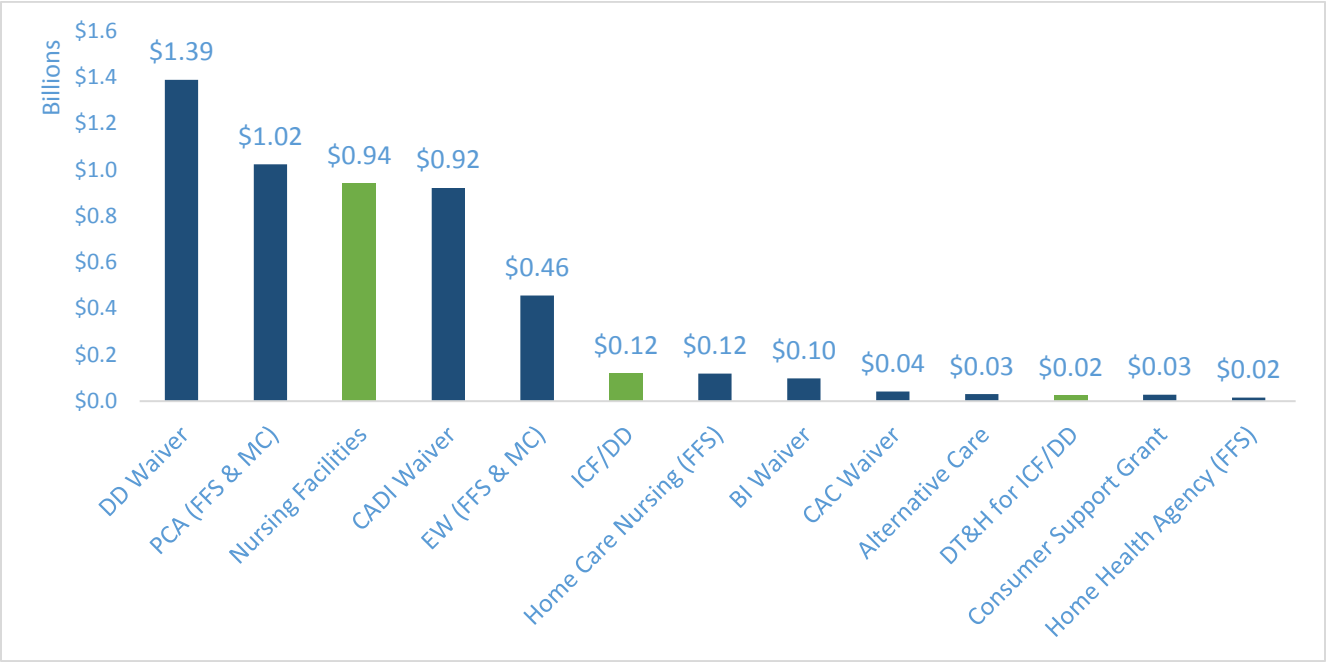
support grants. Semi-Independent Living Services served another 1,500 people. HIV/AIDS programs served over 2,600.

Figure 6: Total spending for LTSS (in billions), by state fiscal year[2]



[2] Source: February 2019 Forecast. These projections are as of February 2019 and do not take into account changes passed during the 2019 legislative session. HCBS spending includes fee-for-service payments as well as managed care payments under the Elderly Waiver. However, managed care payments for state plan home care services, including PCA, are not included.

Figure 7: FY 2018 total LTSS spending[3] (HCBS and Institutional), $5.2 Billion[4]



New technologies

The world of technology is expanding at an astounding rate. Seemingly every day, there are new products on the market that can help people with long-term support needs. In some cases, technology can reduce or replace the need for a person to provide support. For example, there are various levels of response and monitoring systems that make it safer for people to live alone. There is 'smart technology' that can operate appliances, windows, doors, shades, lights and more. People can operate these devices from on or off-site. Technology can prompt people to do tasks and monitor if certain tasks are completed. There is a wide array of solutions that make it easier for people to communicate.

On the business side, technology is available that can make it easier for service providers to manage their operations, from providing service remotely to increasing documentation efficiency.

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[3] LTSS in the chart includes Developmental Disabilities waiver, personal care assistance paid through fee-for-service and managed care, nursing facilities, Community Access for Disability Inclusion (CADI), Elderly Waiver (EW) (fee-for-service and managed care), intermediate care facilities for persons with developmental disabilities (ICF/DD), home care nursing (fee-for-service), Brain Injury (BI) waiver, Community Alternative Care (CAC) waiver, day training & habilitation (DT&H) for ICF/DD residents, Alternative Care, Consumer Support Grants, and home health (fee-for-service).

[4] Source: February 2018 Forecast (FFS: Fee for service; MC: Managed care)

While new technologies provide us with opportunities, they also provide a challenge. Keeping up with technology is difficult and can require new investments in equipment, training and maintenance. People and families may not be comfortable with the perceived risk associated with using technology rather than direct support workers.

As people with disabilities pursue their goals and dreams, technology can play a role in supporting safety and increasing independence and autonomy. Technology has the potential to lessen a person's use of paid staff, as well as deploy available workers to support more people through innovative approaches. This can help alleviate some workforce pressure.

Public policy needs to keep up with the quickly evolving technology environment.

Changing preferences

People who come into the service system now have different expectations and goals than those who came into the service system years ago. People want to have more choices, more control over their services and more opportunity to be fully contributing members of their communities. The service system has to adapt to support people differently, while maintaining stable services for those who have been in the system for years.

This includes:

- Individualized support plans that incorporate natural, technology and paid supports
- Expanded options to support people where they want to live and work
- Use of technology to reduce use of direct support workforce, where appropriate, and to increase or maintain autonomy
- Service design to achieve outcomes that are important to the person
- Choices about who delivers services.

It is vital to have a robust provider network able to adapt successfully to new demands.

Increasingly, people who use LTSS and are of working age, want to work at regular jobs at competitive wages and the opportunity to contribute to their communities. While average earned income for some is rising, most people with disabilities still are not working or are working for non-livable wages (often sub-minimum wage). The service system needs to align with the presumption that competitive employment is the first option for people. These changes require significant effort. (For more information, see the National Core Indicator survey section in this report.)

Federal directives

Home and Community-Based Services (HCBS) Rule

In 2014, the federal Centers for Medicare and Medicaid Services (CMS) published regulations[5] that made a number of changes, including changes to the definition of home and community-based settings for the Medicaid HCBS waivers. CMS granted states until March 2022 to bring their systems into compliance with the HCBS settings requirements. States are required to develop a transition plan for the HCBS waivers in order to comply with the rule. (See discussion of HCBS Rule transition plan in the Innovation and quality section of this report.)

The purpose of the rule is to maximize opportunities for people who use HCBS. It raises expectations around what is possible for older adults and people with disabilities. It requires that all people:

- Have information and experiences with which they can make informed decisions
- Are treated with respect and empowered to make decisions about how, when and where to receive services
- Have opportunities to be involved in the community, including living and working in integrated settings.

The HCBS Rule might mean significant changes for some providers in how they deliver services, and for some people, in how they receive services. After almost 30 years of diverse and inconsistent policies across the country, the HCBS Rule sets the standard for the next generation of services. It raises hopes and expectations for changes in the lives of older adults and people with disabilities.

Americans with Disabilities Act (ADA) and the Olmstead decision

The Americans with Disabilities Act, and subsequent Supreme Court Olmstead decision, affirm the right of people with disabilities to live in the most inclusive environment appropriate to their needs. The United States Department of Justice has challenged some service models across the country that are considered segregated. These include large congregate living arrangements or day service settings for people with disabilities. The Department of Justice also challenges states on policies/programs that do not provide adequate assistance to people who wish to leave a nursing home or other institutional setting and move into the community. States must modify their policies, procedures or practices to avoid discrimination.

Minnesota's Olmstead Plan[6] ensures people with disabilities in Minnesota have opportunities to live fully in their communities. Thirteen state agencies have representatives on the Olmstead Subcabinet, which oversees

[5] Transition plan for home and community-based settings webpage

[6] Minnesota Olmstead Plan website

implementation of the plan. The federal court also has jurisdiction over the plan as a result of the settlement of a class action lawsuit, *Jensen v. Department of Human Services*[7].

[7] Jensen settlement agreement webpage

VI. Measuring our progress

As stewards of the long-term services and supports (LTSS) system, we need to know if the investments we make are resulting in the desired outcomes. The Department of Human Services (DHS) uses multiple data sources to help us understand how much we did, how well we did it and is anyone better off because of it. These sources include the nursing home quality of life survey, National Core Indicators surveys, the Employment First Dashboard, and program data.

DHS uses survey tools to ask people directly about their experiences using services with the goal of understanding how certain aspects of people's experiences are changing as we are making changes to the system that supports them. The data also helps guides us as we make further changes in an effort to meet individuals' preferences and needs more successfully. The survey initiatives discussed in this section are:

- **Nursing home quality of life survey (NH QOL)**
  This is an in-person interview that allows people with differing cognitive and communication abilities to participate. DHS conducts the NH QOL in every certified facility in the state annually.

- Suite of National Core Indicators (NCI) surveys
  These surveys ask people and families about their quality of life and quality of services.

    - **NCI-Aging and Disabilities survey (NCI-AD)**
      This survey interviews older adults and people with physical disabilities.

    - **NCI-In Person Survey (NCI-IPS)**
      This survey interviews people with intellectual or developmental disabilities.

    - **NCI- Adult Family Survey (NCI-AFS)**
      This survey interviews families of adults with intellectual or developmental disabilities living at home.

In NCI results, the term "people in the community" refers to people who receive services through one of the follow programs:

- Alternative Care (AC)
- Brain Injury (BI) Waiver
- Developmental Disabilities (DD) Waiver
- Elderly Waiver (EW)
- Community Alternative Care (CAC) Waiver
- Community Alternatives for Disabled Individuals (CADI) Waiver
- State plan home care, for example, personal care assistance (PCA).

All survey data reported here is from 2018 unless otherwise noted.

Goal 1: Increased flexibility to better meet the needs of each individual

Increased flexibility of LTSS helps people meet their needs and goals in the way that works best for them.

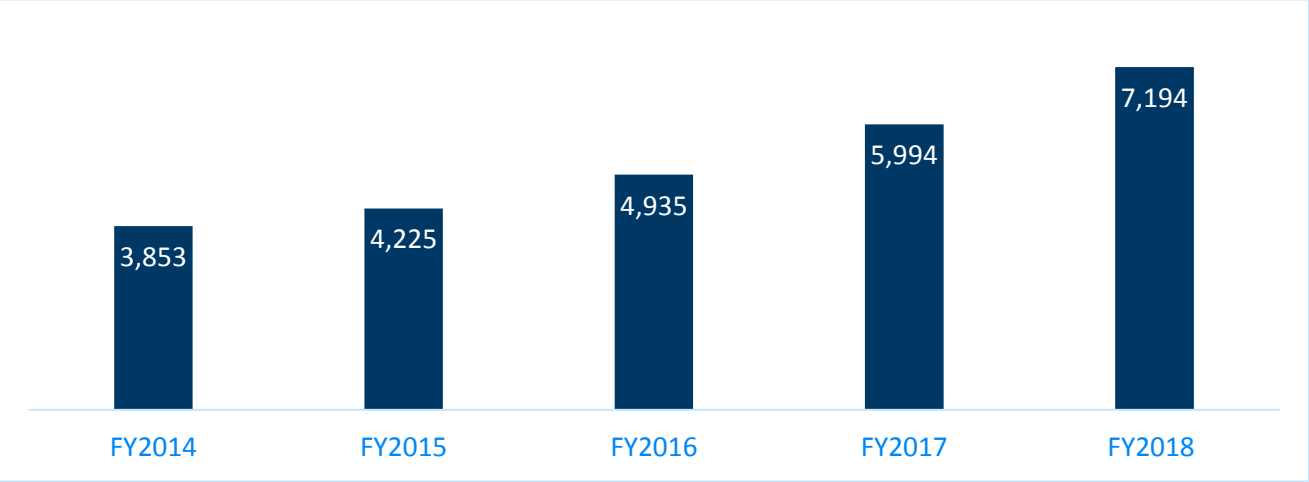
- 76 percent of respondents say services meet all their needs and goals (NCI-AD)
- 71 percent of respondents say they can choose or change the kind of services they receive (NCI-AD)
- 81 percent of people in nursing homes say they are encouraged to speak up about things they don't like in the facility (NH QOL).

Although 94 percent of people in the community interviewed told us services and supports help them live a good life, there are unmet service needs we work to address. The follow is a list of the top five service needs by the percent of NCI-IPS respondents that indicated the service was an unmet need.

1. Transportation (21 percent) and assistance finding, maintaining or changing jobs (21 percent)
2. Support for social engagement, relationship issues, and/or meeting people (19 percent)
3. Education or training (17 percent)
4. Dental care (13 percent)
5. Respite or family support (12 percent)

The consumer-directed community supports (CDCS) program is one example of how DHS supports flexible services. CDCS put people in charge of their service budgets. Through this program, people can choose or design the services and supports that fit their needs. This program has seen growth. The average annual change in number of people enrolled in the program since FY14 is 17 percent.

Figure 8: Total number of people receiving consumer-directed community supports, 2014 to 2018



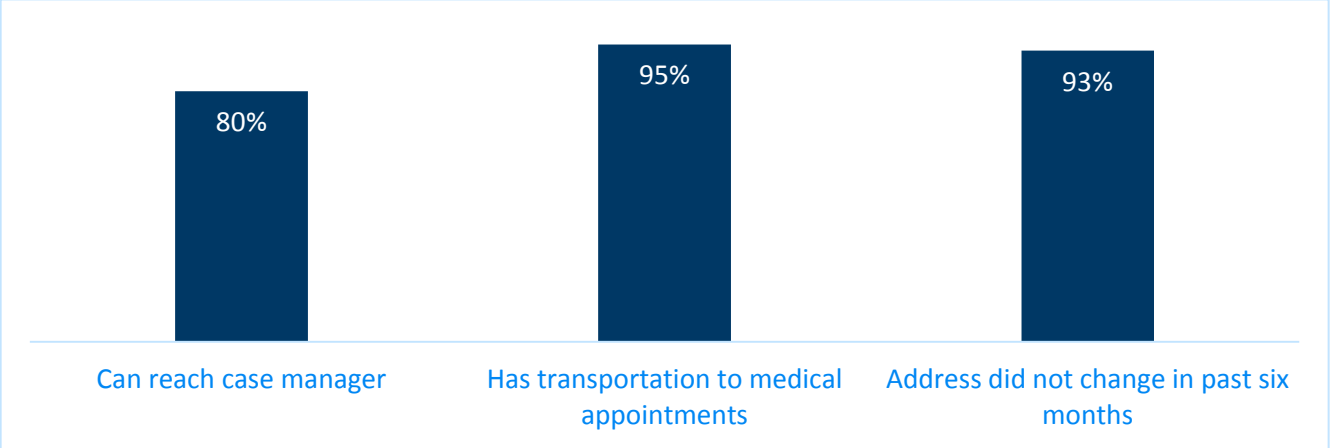
Goal 2: Increased stability in the community

Consistent housing, access to services, and adequate support help improve people's stability in the community. Two ways we have looked at people's stability are monitoring data about how well crisis and HCBS services are supporting people.

Minnesota's Olmstead Plan is the State's plan for ensuring people with disabilities in Minnesota have opportunities for to live fully in their communities. One of the aims of the plan is for people who experience a crisis to connect with community services in a timely fashion. The goal was by, June 30, 2018, the percent of people who receive appropriate community services within 30-days from a hospital discharge will increase to 91 percent. In FY18, of the 15,237 individuals hospitalized due to a crisis, 14,343 (94.1 percent) received community services within 30 days after discharge.

We also look to the NCI-AD for indicators of people's stability in the community. The large majority of people in the community report they can reach their case managers, have transportation to get to medical appointments, and their address did not change in the past six months.

Figure 9: Percentages of people reporting they can reach their case manager, have transportation to medical appointments and have not had a change of address in the past six months



Goal 3: Better-informed individual decision-making about LTSS options

The LTSS system is complex. When people are able to find information and resources important to them, they are able to make better decisions about the services and supports they receive.

People who receive services through a waiver have a case manager or care coordinator that helps them navigate the system and connect with services and supports.

- 77 percent of survey respondents say they usually or always get enough information to help them participate in planning services for their family member (2017 NCI-AFS)

- 80 percent of survey respondents say they can reach their case manager/care coordinator when they need to (NCI-AD).

DHS helps all Minnesotans and their caregivers navigate the LTSS system by providing information and resources through different platforms. This may be in-person, over-the-phone, or online. Some issues require multiple contacts to resolve. Also, some people return with additional inquires. These resources and the annual number of site visits or contacts include:

- Senior Linkage Line was contacted by phone, chat, email or in-person 378,507 times and provided assistance to 222,116 people (CY18)
- Disability Hub was contacted by phone, chat, and email 76,939 times and provided assistance to 26,616 people (FY18)
- Disability Hub MN recorded 22,507 visits to the website (FY18)
- MinnesotaHelp.info had 727,589 visits (FY18)
- Housing Benefits 101 (HB101) had 125,529 visits (FY18)
- Disability Benefits 101 (DB101) had 219,638 visits (FY18).

The number of visits to website resources increased from approximately 860,569 in 2016 to 1,095,263 in 2018. That is a 27 percent increase.

Goal 4: Promotion of person-centered practices

We work to create and foster a culture that aims to understand, respect, and honor the things that are important to each person. The goal is for people to lead lives that have purpose and are meaningful to them. To do this, the system must be person-centered and help people:

- Build or maintain relationships with their families and friends
- Live as independently as possible
- Engage in productive activities, such as employment
- Participate in community life.

Most people in the community interviewed report that they are able to see friends and family, have transportation to go where they want to, and like where they live (NCI-AD).

- 88 percent of survey respondents say they can always or almost always see or talk to friends and family when they want to (if there are friends and family who do not live with the person)
- 79 percent of survey respondents say they have transportation when they want to do things outside of their home
- 86 percent of survey respondents say they like where they live.

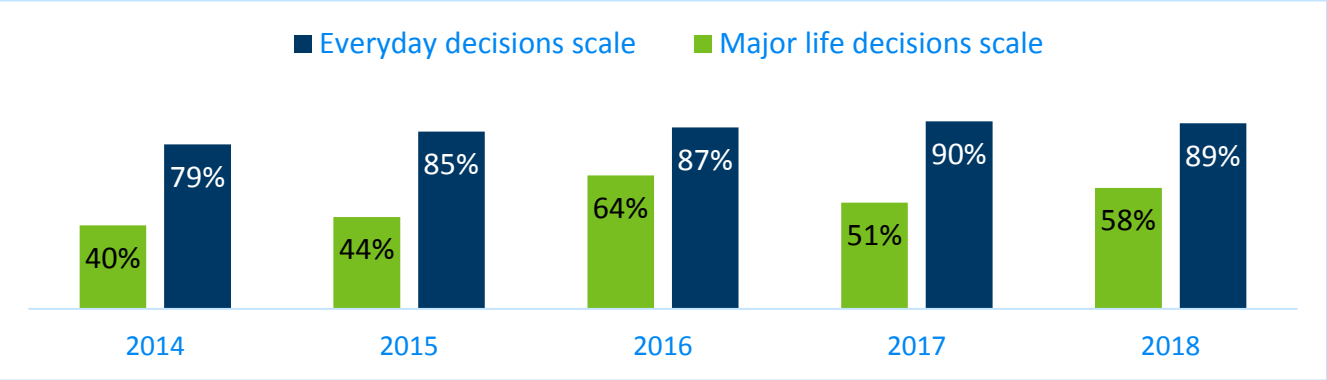
People living in nursing homes feel less positive about their ability to do meaningful things with their time and about their connections to other people (2018 NH QOL). Nursing homes have taken notice. Almost half of DHS-funded quality improvement projects focus on improving psychosocial outcomes.

- 76 percent have something to look forward to most days
- 62 percent report that staff stop by just to talk

- 70 percent say another resident is a friend.

Informed choice is a hallmark of person-centered planning. The chart below shows two scales that look at survey respondents' reported involvement in major life and everyday decisions. The percent is an indicator of the level of the involvement in decision-making among the survey respondents.

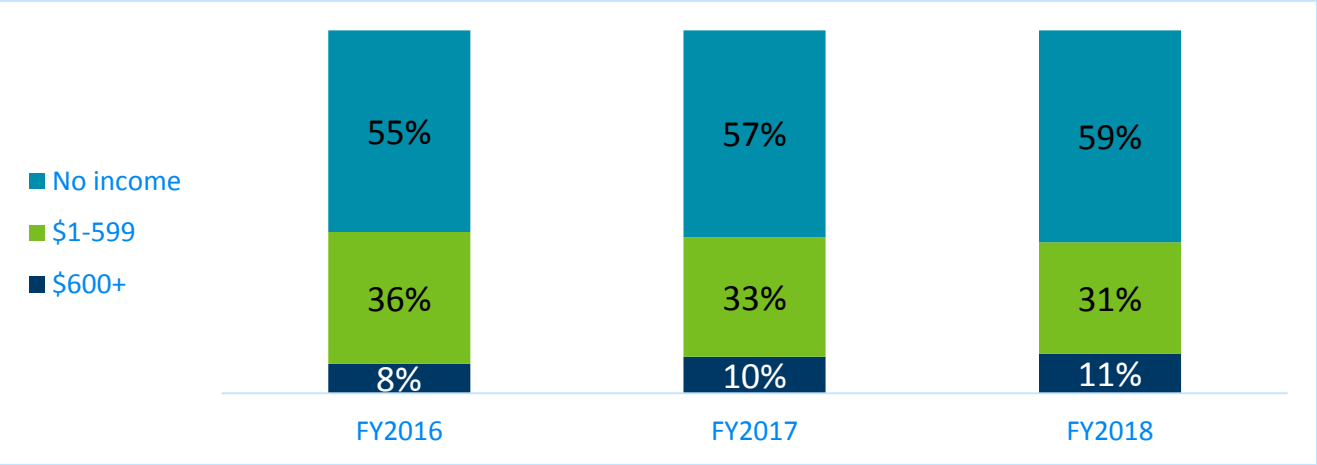
Figure 10: Level of involvement in major and everyday decisions (NCI-IPS, 2014 to 2018)



Increasingly, people with disabilities say they are interested in having jobs in the competitive workforce. At the same time, there is increased concern about the rights of people with disabilities and service models where they receive sub-minimum wage. DHS monitors the income of people with disabilities as an indicator that services support and utilize individuals' interests, strengths, and skills. This does not mean that every person with a disability has to work at a competitive job. It does mean that everyone, regardless of ability, deserves the opportunity to pursue work that is meaningful and fulfilling to them.

DHS tracks progress toward fulfilling Minnesota's Employment First policy and shares results through the Employment First dashboards. Since FY16, we have seen an increase in the percent of people in the community age 18-64 who are earning $600 or more per month.

Figure 11: Percent of people in the community by monthly income, FY 2016 to FY 2018



Goal 5: Improved transitions between settings and programs, preventing avoidable health crises

Improving transitions between settings and programs is key to preventing avoidable health crises and improving the quality of care received. Case managers and care coordinators play a key role in helping to facilitate these transitions.

- 84 percent of survey respondents report someone followed-up with them after discharge from a hospital or rehabilitation facility (if it occurred in the past year) (NCI-AD)
- 90 percent of survey respondents report feeling comfortable and supported enough to go home after discharge from a hospital or rehabilitation facility (if it occurred in the past year) (NCI-AD).

The first 30 days of a person's nursing home stay are crucial. DHS tracks hospitalization and community discharge rates during this period and shares the information on the Nursing Home Report Card and with providers.

- 13 percent of people admitted to a nursing home go to the hospital in their first 30 days
- 38 percent of people admitted to a nursing home return home in 30 days.

DHS supports initiatives to help people transition from and live in the most integrated setting. Moving Home Minnesota helps people transition from institutional settings to homes in the community. The program served 567 people from 2013 – June 2019. Return to Community helps people who are privately paying and not on public programs transition from nursing homes in the community. This program served 6,946 people with 8,143 transitions from 2010 – June 2019.

Goal 6: Recognize and address the need and costs of the social determinants of health care

The need and costs of the social determinants of health care are broad and complex. They include indicators such as health status, chronic conditions, food security, housing, access to transportation, and social connectedness. We see that people who use LTSS also experience factors that correlate with poor health outcomes and higher health care costs.

- 16 percent of older adults and people with physical disabilities (NCI-AD) and 3 percent of adults with an intellectual or developmental disability (I/DD) who were interviewed describe overall health as poor (NCI-IPS)
- 83 percent of older adults and people with physical disabilities interviewed report having chronic health condition(s) (NCI-AD)
- 10 percent of people with I/DD interviewed have diabetes (NCI-IPS)
- 8 percent of older adults and people with a physical disability interview report ever skipping a meal due to financial worries (NCI-AD)

- 87 percent of older adults and people with physical disabilities interviewed report being able to get an appointment to see their primary care doctor when they need to (NCI-AD)
- 26 percent of people with I/DD interviewed report there is at least one place where the person feels afraid or scared (in home, day program, work, walking in the community, in transportation, or other place) (NCI-IPS)
- 13 percent of older adults and people with physical disabilities interviewed report often feeling sad or depressed (NCI-AD) and 12 percent of people with I/DD interview report often feeling lonely (NCI-IPS)
- 12 percent of older adults and people with physical disabilities interviewed report never feeling in control of their lives (NCI-AD).

People in nursing homes vary in their feelings of well-being. Research by the University of Minnesota (*Quality of life for long-term care residents: predictors, disparities, and directions for the future*) has found that people of different races and ethnicities report significantly lower overall quality of life in nursing homes than people who are white.

- 38 percent of people sometimes or often feel lonely, sad or depressed (2018 NH QOL)
- 18 percent of people report that staff at the facility get angry at them (2018 NH QOL)
- People of different races and ethnicities rate their quality of life two to five percent lower than people who are white (UMN).

One of the aims of the Olmstead Plan is to increase access to affordable housing. We track the number of people with disabilities who live in the most integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of their housing. From 2014 to 2018, this number increase by 64 percent.

DHS promotes the use of person-centered practices across the state. One intended outcome is people living lives in the community where they are able to participate and contribute. Part of having a community life is having unpaid relationships with others. These efforts address the social determinant of social connectedness. For measures related to these outcomes, see the discussion under Goal 4: Promotion of person-centered practices.

VII. Policy directions

The Department of Human Services (DHS) uses multiple strategic approaches to move the long-term services and supports (LTSS) system in towards specific goals:

1. **Access -** People who need supports and services have access to them.
2. **Equity -** They benefits of the system are shared equitably among the people who use it.
3. **Quality -** High quality services and supports help people lead meaningful lives as they choose
4. **Sustainability -** The system is available for those who need it in the future.

Addressing the workforce challenges

In order to provide LTSS to all those who need them, we need to address the workforce shortage through several initiatives.

Support planning

There is a significant pressure on the direct service professional workforce. Support and assistance that come through unpaid relationships people naturally develop in daily environments such as home, school, work and community places are commonly referred to as natural supports. Innovative approaches leveraging natural supports and technology have the potential to lessen a person's dependence on paid staff, as well as to deploy available staff capacity where there is the greatest need. Minnesota is using several strategies to expand the integration of natural supports and technology with formal services, where appropriate, to support people to live and participate in the community. Natural supports and technology that address safety concerns and provide back-up support when things do not go as planned, can reduce the need for constant direct support staff that some people would otherwise require to be in the community.

These efforts include:

- Training for certified MnCHOICES assessors on opportunities during assessments and support planning to consider technology
- Supporting innovative approaches, such as the Technology for Home program, which offer an individualized team approach to assistive technology consultation and technical assistance
- Providing consultation on technology supports with teams to reduce the use of restrictive procedures
- Training for case managers and providers on supportive technology and integrating technology, natural supports and paid services in their planning.

Rates

In 2018, DHS conducted research on differences between direct support professional wages and wages paid to workers in similar occupations. This research compared all Bureau of Labor Statistics occupation codes that have the same education, experience and training requirements as direct support professionals in home and community based services. The analysis found that the average direct support professional wage is 17.31 percent lower than the average wage for all occupations with the same classifications. This research suggests that competing industries may have modified compensation to align with inflation over time, whereas the direct care service industry has had slower growth in compensation.

One upcoming approach to addressing wages paid to direct support professionals of disability waiver services is incorporating a new competitive workforce factor to disability waiver rate formulas, which will reduce the gap between the wages paid to direct support professionals and the average wage paid to employees in other competing industries.

Flexible services

In Minnesota and elsewhere, disability services are evolving to meet people's preferences. In addition to residential models in which providers have responsibility and control over housing and services, there are flexible approaches to supporting people in their own homes or in the homes of their families. Flexible services can help reduce the reliance on staff, be cost-effective and result in reports of higher quality of life and increased consumer satisfaction. DHS is undertaking efforts to simplify and streamline home and community-based services (HCBS) to ensure all people have equitable access to and flexible use of waiver services. The 2019 Minnesota Legislature passed the Disability Waiver Reconfiguration (Article 5 Section 86) which will

- Create a more equitable and predictable experience for people
- Incentivize person-centered supports
- Put more control in the hands of people who use services
- Allow people to see the range of funding available to them
- Align services across waivers
- Involve people in making decisions about how to invest funds to meet their specific circumstances.

By January 2021, DHS will develop a proposal for the reconfiguration, including how Minnesota could move from four to two disability waivers. The public will have an opportunity to provide additional feedback. The Disability Waiver Reconfiguration is the result of the Waiver Reimagine Project. To read more in-depth about the findings of the project, view the 2019 Waiver Reimagine Project Legislative Report.

Workforce workgroup

DHS and the Minnesota Department of Employment and Economic Development assembled a cross-agency workgroup that includes people with disabilities, the Office of Higher Education and colleges and universities in the Minnesota state system which has been meeting since May 2017. They analyzed existing data and developed recommendations on ways to expand, diversify and improve Minnesota's direct care and support workforce. The Olmstead Subcabinet incorporated those recommendations into the Minnesota Olmstead Plan workplan that the different state agencies are implementing. (See the Direct Care and Support Services section of the Olmstead Plan.) The workgroup continues to meet to monitor and support the work of the plan.

Data-driven decision-making

Promoting access to and use of data is a cornerstone of DHS' agency-wide strategic plan. DHS supports data-driven decision-making by ensuring data is accessible to and usable by program staff and our partners.

DHS monitors key performance measures and trends to understand how well our system is able to serve people in the setting of their choice and ensure sustainability to meet growing demand. We also know that as the demographics of our state change over time, the programs and services will need to evolve continually to meet people's needs and preferences. These performance and demographic trends guide policy and program development.

Quality and sustainability in LTSS programs depend on partnerships between lead agencies, providers, people using services, and other stakeholders. In order to ensure that our partners have the information they need to make strategic decisions, DHS shares performance and demographic data on our website. Our goal is to provide transparent and interactive data to help people better understand the trends in their own communities.

Examples of these data resources include:

1. Public Performance Dashboards

   These interactive dashboards allow users to explore key performance trends by county, age groups, and race/ethnicity of people served by HCBS. This will give counties and other stakeholders performance measure information at their fingertips.

2. Demographic Dashboards

   Demographic trends can tell counties and providers about how the population of their community is changing over time and ensure they are developing the services to meet those needs. These dashboards provide county-level information about the demographics of HCBS programs over time.

3. Aging Data Profiles

   The Aging Data Profiles include statewide, regional and county-level demographic and service data. The profiles provide information on the variation and differences about our aging society to inform those developing programs, services and supports that help older adults live, work and engage in their communities. All data is about Minnesotans age 65 and older.

4. Employment First Dashboards

   Employment outcome information is available by county, program area, age, and service providers. These dashboards are not only helpful for making strategic decisions and improvements, but they also empower people who receive services to understand typical employment outcomes, including average earning among programs and providers.

5. Vulnerable Adult Protection Dashboard

   The Vulnerable Adult Protection Dashboard explains what happens after people report suspected maltreatment of a vulnerable adult to the Minnesota Adult Abuse Reporting Center (MAARC).

6. Nursing Facility Report Card

   The State launched the Nursing Home Report Card in 2006 after calls from the legislature for greater transparency about nursing home quality. The site strives to include only information that is important to people who use services and their families, grounded in research, trustworthy, and actionable. Minnesota plans to introduce a companion report card for assisted living facilities in 2021.

We continue to build resources to share performance data. Currently, the DHS Aging and Adult Services Division is developing an assisted living report card to measure and report on the quality of individual assisted living

settings across Minnesota, for housing and services paid for privately and through public programs. Once DHS fully implements the report card, we will share the results with the public through a website. We will update the report card over-time as new data on quality are available.

Supporting people to have more choice and control

People have the most expertise about their own needs. DHS promotes people having control over their choices by providing them with information and tools to understand their options and make informed decisions. In addition, we are adapting services to have more options for flexibility and directing the person's own services. This gives people more control over their services.

People have the ability to control their services

DHS is developing new service options and redesigning existing service options to create more opportunities for people to have greater control over their own services.

Consumer directed community supports (CDCS) is a unique service option available through the HCBS waivers. This option can give people greater control, flexibility and responsibility to manage and direct their services and supports. An increasing number of people choose CDCS so they can do things such as:

- Customize their services
- Hire and fire staff
- Purchase goods and services.

People who participate in CDCS are willing to assume greater responsibility for the implementation of their plan because of its increased flexibility.

While consumer directed community supports is one self-directed service option, other options exist as well.

People across Minnesota use personal care assistance (PCA) services for help with day-to-day activities in their home and community to help them maximize their independence. People who use this service can choose between two service options based on the amount of control they wish to exercise over staffing decisions.

In the traditional PCA option, the person chooses an agency, which provides the workers or hires worker(s) the person would like to bring to the agency. The agency finds, hires, trains and supervises the support workers. The agency also is responsible for maintaining the care plan specific to the needs of each person. The person works with the agency to choose and schedule workers.

With the PCA Choice option, the person still selects an agency, but he or she finds his/her own support workers. The person trains and supervises workers and creates a care plan. The person can get assistance from the agency for these activities, if desired. The person hires, fires and manages the schedules for their workers, including any back-up staff.

The Minnesota Legislature authorized DHS to develop an alternative to PCA, called, community first services and supports (CFSS). With extensive stakeholder engagement, DHS is progressing with the development of this new option.

People will have more choice and control over their services with CFSS. Like PCA, this service will allow people to have support in activities of daily living, instrumental activities of daily living and complex health-related needs. However, CFSS also will include:

- Helping people acquire, maintain or enhance the skills necessary to accomplish activities of daily living, instrumental activities of daily living or functions related to health
- Purchasing goods that either replace the need for human assistance or increase people's independence.

In CFSS, people will have a range of control over their services based on their choices. This includes two service delivery options. One is to be the employers of their own support workers with assistance by a financial management services provider. The other is to receive services through agency providers that employ the support workers.

Information and tools for planning and decision-making

MnCHOICES Assessment and Support Plan application

Both people who use publicly funded services and those who do not can benefit from a comprehensive assessment and support-planning process. People who have any type of disability or are in need of LTSS can request to go through the assessment and planning process through a lead agency (their county or tribal nation).

Lead agencies increasingly use MnCHOICES, an electronic web-based application, to conduct a comprehensive assessment for people of all ages with all types of disabilities in the state. The MnCHOICES process includes discovery of people's goals, interests and preferences, as well as health, welfare and safety concerns. It seeks to balance what is important to the person with what is important for the person.

MnCHOICES supports people to make informed choices about all aspects of their life. Its assessment and support planning system also determines eligibility and captures important data for ongoing service planning and evaluation. Certified assessors have reported that the MnCHOICES process has led to more thorough and comprehensive service planning that result in people exploring work or living in a different location and accessing services that they may not have known to ask for in the past.

Minnesota Information Technology (MNIT) team, in partnership with DHS, built the MnCHOICES Assessment and Support Plan application and continues to develop and improve it in a project known as MnCHOICES Assessment 2.0. After an in-depth review of the project in February 2019, to ensure it was on track and would meet the needs of users, the project was modified to obtain a quality, vendor that will work with DHS to develop a product that will meet user's needs.

The delay allows MNIT and DHS to perform an external review through a request for proposal process of new vendors and technology solutions that may meet the needs of MnCHOICES.

Senior LinkAge Line

The Senior LinkAge Line® is a service of the Minnesota Board on Aging in partnership with Minnesota's Area Agencies on Aging. It provides free, objective information and assistance to help older Minnesotans and their families. The Senior LinkAge Line can help with Medicare, long-term care planning, care transitions, prescription drug costs and help Minnesotans connect to local services. The Senior LinkAge line works in tandem with the Disability Hub and LinkVet to help people navigate services, find answers and get the help they need.

Minnesotahelp.info

Minnesotahelp.info is a tool that helps Minnesotans find services such as housing, homemaking services, transportation, food and community support. The site provides access to the Nursing Home Report Card and will provide access to the assisted living facility licensure and the Assisted Living Report Card approved by the 2019 legislature.

The next phase for the Senior LinkAge Line and Minnesotahelp.info is to

- Provide more self-service options
- Improve search capabilities, data collection and reporting

Disability Hub MN

Disability Hub MN, a free statewide resource network, helps people solve problems, navigate the system and plan for the future. The Hub focuses on people's needs and goals—helping them understand their options, find solutions, set goals, and build paths toward creating the lives they want. The Hub also supports a suite of online tools including:

- Direct Support Connect helps people who self-direct their own care and direct support workers, such as personal care assistants (PCAs), find each other
- Disability Benefits 101 gives people information and tools about health coverage, benefits and employment so they can learn how work and benefits go together
- Housing Benefits 101 offers information and tools to help people explore housing options, discover what makes sense for them and make a plan to get there.

In 2018, the Hub handled 84,234 contacts, serving 28,336 people

Rights and protections

People receiving services have the right to live in dignity, free from harm, and to receive high-quality care. DHS has several initiatives underway to strengthen the quality assurances throughout the HCBS system. Efforts

include adding licensing standards for certain services, redesigning the vulnerable adult system and adopting a culture of accountability, learning and continuous improvement in response to critical incidents.

Assisted living facility licensure and additional dementia care requirements

The 2019 Legislature passed new licensure requirements for assisted living facilities, in an effort to enhance the rights of and protections for people who live in assisted living facilities, and to enhance the state's ability to monitor and enforce these requirements. The Minnesota Department of Health will administer the license, which will be effective August 1, 2021. There are a number of significant elements in the new assisted living licensure law, including the following:

- Designation of a single entity that is responsible for both the housing and the services delivered in the assisted living facility, and a single assisted living contract between the resident and facility that includes both housing and, if applicable, services
- Two categories of licensure: assisted living facility and assisted living facility with dementia care
- Consumer bill of rights designed specifically for assisted living facilities
- Requirements to utilize a person-centered planning and service delivery process
- Requirements that ensure providers will meet the federal HCBS settings rule standards
- Requirements to disclose information to residents including:
    - Uniform checklist disclosure of services
    - Information about costs and billing
    - Description of the facility's policies regarding public programs
    - Description of the complaint resolution process
- Minimum staffing requirements and staff training requirements
- Protections for consumers regarding termination of services or housing, including:
    - Limited allowable grounds for termination
    - Process for a resident to appeal a termination
    - Planning required by the facility for a move or transition in services
    - Requirements to notify the ombudsman for long-term care
    - Requirements to notify case managers for people who receive public programs
- Protections from retaliation
- Preservation of the resident's right to choose alternative service providers
- Enhanced physical plant requirements.

A significant number of people in assisted living facilities have some form of dementia. Therefore, the law gives special consideration to meeting the needs of people with dementia. For example, all assisted living facilities must meet dementia care training standards. Facilities with an assisted living with dementia care license must meet additional standards, including:

- Demonstrated capacity to provide dementia care services
- Administrator training requirements
- Policies and requirements related to delivery of dementia care services
- Additional staff training and supervisory requirements

- Higher standards for on-site staffing
- Higher physical plant requirements for assisted living facilities with dementia care licenses that have a secured dementia care unit.

Some consumer protections will become effective prior to August 2021. Others are now in effect as of August 2019. The protections currently in effect include retaliation protections for residents of existing registered housing with services settings operating under chapter 144G. Electronic monitoring protections will also apply to these settings for all agreements in effect, entered into, or renewed on or after January 1, 2020.

There are also current interim consumer protections now in effect for residents of assisted living settings that will sunset once assisted living licensure comes into effect in August 2021. First, under chapter 144A, licensed home care providers who provide care to clients in assisted living settings may be subject to immediate fines with no opportunity to correct the violation first during an initial survey, follow-up survey, or complaint investigation. Second, a Maltreatment Compensation Fund was also established to provide compensation for cases of maltreatment where the licensee was determined to be responsible to home care clients and assisted living residents who receive home care. Finally, the Minnesota Department of Health will prioritize complaints related to service terminations in assisted living settings.

Adult Protection

The state's vulnerable adult protection reporting and response system provides a safety net for people who use services, or who are vulnerable based on an impairment in their ability to meet their own necessary needs. The state strives to ensure safe environments and services for vulnerable adults. When there is suspected maltreatment of a person who is vulnerable, the state encourages good faith reporting to the Minnesota Adult Abuse Reporting Center (MAARC) the centralized reporting system, operated by DHS.

Every report made to MAARC is accepted. The MAARC immediately referred to a county social service agency when they assess the need for emergency adult protective services. The MAARC also refers a report to law enforcement if criminal acts may be involved, and to the medical examiner if death is alleged. The MAARC also refers every report to the lead investigative agency responsible to assess the allegation and respond. This may be a county or the state departments of Health or Human Services.

Investigation of the alleged incident of maltreatment and service offerings to the person who is vulnerable is required in appropriate cases. County agencies use standardized tools to support person-centered assessment and safety planning. Counties and tribal nations offer adult protective services to remediate harm to the vulnerable adult and prevent reoccurrence of maltreatment. DHS provides policy guidance, training, consultation, tools and a data system to support county and tribal adult protective services for vulnerable adults.

Long-Term Care Ombudsman

Title VII Chapter 2 of the Older Americans Act establishes the Office of Ombudsman for Long-Term Care. This office is separate from agencies that administer funding or services, regulate, license or certify long-term care services and from associations of long-term care facilities. This independence allows the office to represent long-

term care consumer interests and remain an independent voice. A full-time state long-term care Ombudsman heads the office and is responsible for the statewide program.

The Office of Ombudsman for Long-Term Care advocates for individuals receiving long-term care services. The staff members investigate and resolve complaints, provide information and consultations, advocate for systemic change, and inform public agencies about issues facing residents in long-term care settings.

Ombudsmen for long-term care have a unique role in prevention and promoting quality of life. They empower people to exercise their right to live in the least restrictive living environments and work to ensure access to LTSS when needed. The office not only does complaint investigations but also conducts training and provides consultations, including consultations with providers. They work to resolve issues as early and at the lowest level possible. The Office of Ombudsman for Long-Term Care determines systemic problems that affect many and works collaboratively to resolve them.

Collaborative Safety model pilot

Collaborative Safety is an approach that intends to move a critical incident system away from a culture of blame and toward a culture of accountability. Years of research have shown that assigning blame in response to adverse events might actually decrease accountability because it inhibits the ability of an organization to learn and improve.

The model draws from the same sciences that safety-critical industries, such as aviation and nuclear power, use to improve systems and develop a culture of safety. Advanced models engage employees in safety efforts, establish comprehensive approaches to analyzing adverse events and promptly act upon identified areas of improvement.

When it addresses typical underlying systemic factors, an agency can begin to make critical advancements in promoting safe outcomes for children, adults, families and employees.

DHS's Child Safety and Permanency division uses this model. Now, we are piloting this model with disability services. Through the pilot, we will test using the Collaborative Safety model for investigating critical incidents, such as medication errors and wheel chair safety incidents. The project will take place during 2019. Case reviews began in May. The pilot is exploring the use of the Collaborative Safety model to:

- Improve the quality of life and community participation/contribution of people with disabilities
- Develop a robust and proactive response to critical incidents dedicated to accountability, learning and improvement of Minnesota's systems, rather than assessing blame
- Move beyond surface level understandings of how systems fail to an understanding of how various parts of a system worked together to cause the failure
- Develop recommendations about whether Minnesota should adopt this model and how to do so.

Innovation and quality

While existing services are successful, we need to be innovative to keep up with emerging trends and challenges. Additionally, traditional practices have not served all people with equal success. When we do better, people will do better. We need to learn what is working and what is not working, and develop new approaches accordingly.

New approaches, coupled with evaluation and learning, may uncover new promising practices.

Home and Community-Based Services (HCBS) Rule transition plan

In 2014, the federal Centers for Medicare & Medicaid Services (CMS) published regulations that included a change in the definition of home and community-based settings for the Medicaid HCBS waivers. CMS granted states until March 2022, to bring their systems into compliance with the new requirements. On Feb. 12, 2019, CMS gave its final approval to Minnesota's Home and Community-Based Services Rule Statewide Transition Plan (PDF) to bring settings into compliance with the federal HCBS regulations. We continue to work the plan and we are on track to meet the federal March 2022 compliance deadline.

By working intensively over the last several years with providers to implement the HCBS settings rule, DHS has gained an in-depth understanding of provider practices in these settings. Many providers are doing excellent work to ensure their services are person-centered, that people have opportunities to engage in their communities, and people are supported to have the highest possible quality of life. Other providers are meeting the minimum requirements, but have opportunity for growth and improvement.

(Also, see discussion of the rule in the Federal direction section of this report.)

DHS is committed to providing on-going information and updates about the transition to people who use services and their families. Minnesota has a strong network of partners willing to make the necessary changes to improve experiences for people and to comply with the rule's requirements. DHS has and will continue to work with providers to enhance HCBS practices. Planned efforts for 2019-2021, include:

- **Promote promising practices**
  Many providers are doing creative and excellent work to deliver personalized services in settings where people live together in a group. We will create short videos that share the stories of these high-performing providers.
- **Develop an HCBS provider toolkit**
  Providers identified four areas that they find most challenging:
  - Person-centered practices
  - Community engagement/partnerships
  - Transportation
  - Employment.

  This toolkit will contain frequently asked questions, examples of promising practices and resources specific to these topics.

- **Provide support to providers:** We recognize some providers, especially smaller providers, would benefit from in-person, one-to-one support focused on improving service quality and overcoming barriers. Providers will apply to receive this technical assistance. As part of the application, they will identify goals and barriers. DHS will tailor the individual provider support to each provider.
- **On-line training modules**: DHS will develop on-line content on person-centered practices geared primarily towards small provider organizations and family providers. The intent is to extend access to person-centered tools and training to providers for whom time and travel needed to participate in in-person training is a barrier.

Safeguards against fraud, waste and abuse

DHS recognizes its responsibility to ensure proper use of public funds. As a good steward of these funds, DHS ensures the appropriate checks are in place to prevent, identify and stop fraud, waste, and abuse in its programs. The DHS Office of Inspector General manages financial fraud and abuse investigations; licensing programs such as family child care, adult foster care and mental health centers; and conducts background studies on people who apply to work in these settings.

In 2019, the Minnesota Legislature passed a robust program integrity package which includes significant changes to combat fraud, waste, and abuse. Among the key changes are:

- Established documentation and billing requirements for HCBS
- Strengthened standards for sanctioning and/or removing providers
- Required published Minnesota exclusion list that, as a condition of payment, vendors must check monthly
- Immunity and anonymity granted for people who report fraud or abuse.

One key initiative to combat fraud, waste, and abuse is the implementation of electronic visit verification (EVV). Passed by Congress in 2016, the 21st Century Cures Act requires Minnesota and other states to verify Medicaid-funded personal care services. Service providers electronically report the identities of the people providing and receiving the service, the type of service, and the location of the service.

In Minnesota, personal care assistance visits will be subject to EVV, as well as visits for certain waiver services. DHS is planning the implementation of EVV by working across business areas and engaging with people that use services and providers. DHS will use the data collected through EVV to analyze utilization of personal care services and track trends. We will also use the data to identify areas where DHS should make changes to policy, training, or investigation to prevent and address fraud, waste, and abuse.

DHS grant programs

Live Well at Home Grants

Living Well at Home grants aim to strengthen a community's ability to provide affordable LTSS for older persons. They are available to public, private for-profit and non-profit agencies. The funds are for projects that expand, integrate and sustain the services and infrastructure that enable older adults to remain in their own homes and

communities. Grantees may use the funds to support family, friends and neighbors in caregiving. Grants can also support integration of medical services and LTSS in local communities.

Grants promote the development of services that are available to people of all income levels, in particular to those who are eligible for public programs. They expand the options that are available through the private market by increasing affordable options. Grants aim to contribute to the LTSS system in conjunction with a variety of federal, state, local and private funding sources for long-term services and support such as, Older Americans Act funds, Medical Assistance, foundation grants and private pay resources.

Within the program are the following three general categories:

- LTSS development grants provide $350,000 or less to help develop, expand and sustain services that are critical to maintaining community living for older adults and their family and other natural caregivers, such as friends and neighbors.
- Core HCBS grants provide $30,000 and $50,000 to strengthen and develop additional HCBS and alternatives to nursing homes and other residential services.
- Capital and renovation grants provide $350,000 or less to cover the capital costs of new construction, renovation, retrofitting, or remodeling of existing buildings or making accessibility modifications in individuals' homes. This includes transportation (e.g. purchase of a vehicle) or technology. The intent of the grants is to increase the options people have for how and where they want to age in the community.

Disability services innovation grants

Disability services innovation grants promote new ideas to achieve positive outcomes for people with disabilities. All of them require grantees to use new ways to help people with disabilities in Minnesota:

- Achieve integrated, competitive employment
- Live in the most integrated setting
- Connect with others in their communities.

With funding authorized by the 2015 Minnesota Legislature, DHS issues the following types of grants:

- Large innovation grants are multi-year grants for more than $50,000 per year to people and organizations that work with people with disabilities.
- Small innovation grants are single- and multi-year grants between $2,000 and $50,000 per year to people and organizations that work with people with disabilities in Minnesota.
- Microgrants are grants up to $500 to people with disabilities to help them achieve their personal goals for competitive, integrated employment, living in the most integrated settings or increased community integration.

Streamlining and simplifying disability waiver services

The four disability waivers have different eligibility criteria, different services, distinct administrative requirements, and different resource allocation methods. While the programs provide critical supports, people

with disabilities and other stakeholders agree that the disability waiver system is complex and could be easier to understand and use. The 2019 Legislature passed legislation beginning a process to simplify these programs.

First, this effort streamlines services available across the four waivers, clearly defines services based on the service setting, adds innovative new service options, and makes service choices easier to understand. This will decrease the number of services that provide similar types of support and make the programs easier for people with disabilities, their families, service providers, and lead agencies to understand.

Second, the legislation provided resources to plan the transition of resource allocation methodology from a lead agency budget model to an individualized budget model across all waiver programs. This approach promotes transparent and flexible budgeting. This will provide valuable information to people with disabilities and, as appropriate, their families, about their budget range as they plan for services.

END HIV MN

In the 2017 legislative session, Minnesota directed the Commissioner of Health, in coordination with the Commissioner of Human Services and in consultation with community stakeholders, to develop a strategic statewide comprehensive plan to end HIV in Minnesota. This legislation coincided with work on a statewide HIV strategy already started by the Minnesota Department of Health and DHS. In January 2019, the two agencies unveiled END HIV MN, Minnesota's strategy to end HIV by 2025. This strategy identifies priority tactics including provider education, awareness campaigns, community outreach, wraparound supports and more. Implementation of these tactics will support key goals that will lead to better health outcomes for people living with HIV and a reduction in new HIV infections, eventually ending the HIV epidemic in our state. DHS leads coordination of the implementation of END HIV MN. Successful implementation will decrease the need for ongoing support services and, by eliminating new infections, will reduce and eventually end the need for HIV services in our state.

Report card for assisted living

The Aging and Adult Services Division at DHS is taking important steps to measure and report on the quality of assisted living services for all payers. Our work on the development of an assisted living report card will lay the foundation for future efforts to extend quality measures to additional HCBS provider types. Minnesota is focusing on measuring and reporting on quality in assisted living for the following reasons:

- DHS' Nursing Home Report Card is a national model. We can apply our knowledge and experience measuring quality in that setting to assisted living.
- The quality of assisted living matters so much to people and families, because it is not only about their experience of a specific service; people live in the setting, and call the setting their home.
- Assisted living is a growing industry, and a relatively expensive service, whether it is paid for privately or publicly. For example, through Minnesota's Elderly Waiver program, 4 out of 10 participants utilize assisted living (i.e. customized living), and 6 out of 10 dollars are spent on assisted living.
- Finally, in the past several years, there has been growing concern about quality, transparency, and consumer experiences in assisted living settings.

The 2019 Minnesota Legislature provided funding to support the development of an assisted living report card, including resident and family surveys. These funds will help accelerate the work that is already underway. For example, the Aging and Adult Services Division just concluded a project under contract with the University of Minnesota to summarize existing research on quality measurement in assisted living across the nation. As we develop an Assisted Living Report Card for Minnesota, in partnership with stakeholders, we will also evaluate how we can approach quality measurement for services beyond assisted living.

Mobile crisis services

County mobile mental health crisis services are teams of mental health professionals, practitioners and peers who provide mental health services to individuals within their own homes and at other places in the community outside of a clinical setting. Emergency mental health services are available 24 hours a day, seven days a week, for both children and adults.

When someone calls for mobile mental health crisis services, a mental health professional talks with the caller, assesses the situation and offers help. Sometimes the mental health crisis can be resolved over the phone. The crisis service provider can easily handle some calls by giving information and referral. Other times, face-to face, short-term, intensive mental health services are required.

Minnesota currently has 33 crisis teams located throughout the state providing 24-hour, seven days a week, crisis lines and face to face assessments. A list of county and tribal crisis line numbers is available on-line.

Crisis teams are available at no out-of-pocket cost to those who utilize the service. If an individual has insurance the crisis team will bill the insurance for the cost. State grant funds are available for those who are uninsured and underinsured.

Rates and payment reform

Across LTSS, payment reforms are helping the state address service access and program sustainability by setting rates that reflect provider's reasonable costs. At the same time, the state is developing and implementing pay for performance strategies to incent and pay for higher quality services across the state.

Disability rates reform

Beginning in January 2014, Minnesota began implementing the Disability Waiver Rate System (DWRS), which transferred the responsibility of setting service rates from counties and tribal nations to the state. Previously, counties and tribes negotiated rates with providers. Now, DHS sets rates using statutory formulas informed by complex and extensive research on the cost of providing disability waiver services in Minnesota. This research has involved multiple reviews of national and local independent data sources as well as disability service provider cost and wage surveys.

In 2017, the Legislature authorized DHS to conduct annual cost reporting by providers of DWRS services. Once implemented, providers will submit data on the cost of providing disability waiver services to DHS once every five years. This new information will allow DHS to make rate modification recommendations informed by provider-reported costs.

Aging and adult services rates reform

To help ensure that providers are available to serve the needs of older Minnesotans, the 2017 Minnesota Legislature passed significant rate-setting reforms for a wide array of HCBS delivered through Elderly Waiver, Alternative Care, and Essential Community Supports. Like DWRS, DHS designed the aging program rate-setting methods to reflect providers' reasonable costs to deliver HBCS.

The 2017 aging program rate reforms required a study of the new methods, as well as current aging program HCBS rates. DHS conducted this study in 2018. In a report to the legislature, DHS recommended that the rate-setting methods in statute be refined based on the results of the study, and that the rates be fully funded. By fully funding the new aging program rate-setting methods, we can help ensure that the service rates are "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers," as required by the federal government, and that critical services are available for public program participants into the future.[8]

Nursing facility rates reform

Value-based reimbursement (VBR) is a major change to the way the state sets Medicaid and private-pay daily rates for nursing homes. Enacted by the 2015 Legislature and effective January 1, 2016, VBR sets rates based on facilities' reported costs. It sets nursing home payment rates for direct care services based on their quality, and sets one statewide price for other costs.

VBR aims to:

- Improve quality of care and quality of life for residents
- Improve employees' standard of living
- Address workforce needs
- Improve facility environments
- Support nursing facility access throughout the state
- Make the payment system more understandable.

VBR has dramatically increased payments to nursing homes while also improving direct-care staff salaries and benefits. However, a 2019 independent evaluation requested by the Legislature found that VBR does not provide effective financial incentives for facilities to improve quality. The 2019 Legislature made no changes to the payment formula. DHS is monitoring VBR to determine its effect on nursing home quality, cost to people needing care and to the state, workforce stability, and statewide access to care.

[8] Social Security Act, Title XIX, Section 1902(a)30(A)

VIII. Report recommendations

The Policy directions section of the report describes the work that the Department of Human Services (DHS) is doing to improve the LTSS system. In particular, we describe key efforts to adapt to the changing environment while improving the quality of people's lives and ensuring the sustainability of the LTSS system. To continue this work, DHS recommends that the state take the following actions.

Redesign Vulnerable Adult Act

DHS has initiated a multi-year project for review of the state's Vulnerable Adult Act. The Act redesign researches best practices and engages stakeholders in policy development. The redesign will address challenges in the statute to better support goals of prevention, align with person-centered practices and improve the balance between investigative and service response to self and caregiver neglect.

Establish standards for crisis response

In 2015, the legislature mandated that DHS work to develop crisis standards. In 2016, DHS worked with stakeholders to develop crisis standards that would provide clarify and improve access to crisis services. While these standards have not passed as of yet, we recommend the next legislature passes them. Implementing these new proposed standards will ensure a more coordinated and consistent response to individuals in crisis across the state and result in more individuals having access to crisis services.

Improve value-based purchasing of nursing facility services

Value-based reimbursement (VBR) payment has increased the average cost of a nursing home stay by 46 percent, from $65,678 per year in 2014 to $95,670 per year in 2019. DHS projects state payments to nursing homes to increase by 76 percent, from $361 million in 2015 to $638 million in 2023 (forecasted), while the number of people served is projected to decrease by 12 percent. An independent evaluation of VBR found no evidence to date that the payment formula has improved statewide nursing facility quality.

We recommend adopting improvements to VBR laid out in the independent evaluation. This includes modifying VBR to pay more for higher quality and less for low-quality care, with extensive financial and educational resources available to nursing homes to assist them in quality improvement. VBR will continue to reimburse nursing homes for all care-related costs, up to a limit based on their quality scores. VBR will continue to reimburse fully workers' health benefits.

We also recommend a three percent inflation cap on the annual growth of other operating costs in nursing homes. Under VBR, other operating costs have increased significantly. Administrative costs have driven this change, growing by $7 per resident day from 2013 to 2017, greater than dietary, housekeeping, laundry, maintenance and plant operations combined.

These recommended improvements to nursing home reimbursement aim to preserve access to and ensure better value for facility-based LTSS in Minnesota.

Increase people's choice and control while streamlining service administration

Reduce differences in the type and amount of services available and creating models for individualized budgeting:

- Creates a more equitable and predictable experience for people
- Encourages person-centered supports
- Puts more control in the hands of people who use services
- Allows people to see the range of funding available to them
- Gets people more involved in making decisions about how to invest those funds to meet their specific circumstances.

By January 15, 2021, DHS will develop a proposal to reconfigure the Medical Assistance waivers, pursuant to Disability Waiver Reconfiguration (Article 5 Section 86), passed by the 2019 Minnesota Legislature. The Disability Waiver Reconfiguration is the result of the Waiver Reimagine Project.

Fully implement 2017 Elderly Waiver rate reforms

The 2017 Minnesota Legislature enacted new rate-setting methods for a wide array of services provided under Elderly Waiver, Alternative Care, and Essential Community Supports, and for customized living services provided through the Brain Injury and Community Alternatives for Disability Inclusion waivers (See Minnesota Statutes, section 256B.0915, subdivision 11-17). As directed by statute, DHS partially implemented the reforms on January 1, 2019.

Full implementation of the new rate-setting methods will help ensure that people have access to critical home and community-based services (HCBS) across the state. A 2018 evaluation of the new rate-setting methods found that the reforms need only minor adjustments, and that full implementation of the methods would yield appropriate rates that align with providers' reasonable costs to deliver services. The study found that existing rates for many service rates were not adequate to cover providers' costs. For example, if the state fully implements and funds the rate-setting methods, the rate for chore services would increase 81 percent and the rate for homemaker cleaning services would increase 39 percent. The evaluation findings and DHS' recommendations are available in a report to the legislature.

Support efforts to end HIV in Minnesota

The work on END HIV MN will result in a policy recommendation for the 2020 session. We will be seeking authority to convene and compensate an advisory board. Authority to compensate members will support meaningful engagement by people living with and at risk for HIV who are not employed in the HIV sector. The

HIV section at DHS is working with the partner unit at the Minnesota Department of Health to identify additional policy needs in 2021 to advance the work to end HIV in our state.

IX. Appendix A

Corporate foster care annual needs determination report

Introduction

Minn. Stat. §245A.03, subd. 7h requires the Minnesota Department of Human Services (DHS) commissioner to annually report to state legislative committees that have jurisdiction over the health and human services budget on the:

- Licensed corporate foster care capacity of the state
- DHS actions taken to manage the licensing moratorium
- Recommendations for changes.

DHS has incorporated the 2019 Corporate Foster Care Needs Determination report into the LTSS report as an appendix.

This report begins with defining corporate foster care and providing background information on the licensing moratorium. We discuss data regarding statewide and regional corporate foster care capacity, as well as DHS's key activities during the past year related to managing the moratorium. Current legislative changes and recommendations for future action conclude the appendix.

Definitions and background

Minnesota statute defines corporate foster care as a setting where the license holder does not live in the home (Minn. Stat. §245D.02, subd. 4d) and is either:

- A child foster residence setting licensed according to Minn. R. 2960.3000 to Minn. R. 2960.3340; or
- An adult foster care home licensed according to Minn. R. 9555.5105 to Minn. R. 9555.6265.

A Community Residential Setting (CRS), is a residential program as identified in (Minn. Stat. §245A.11, subd. 8) where:

- Residential supports and services are provided (Minn. Stat. §245D.03, subd. 1c, 3i-ii)
- The license holder is the owner, lessor or tenant of the facility
- The license holder does not reside in the facility (Minn. Stat. §245D.02 subd. 4a).

Both corporate foster care and CRS settings typically use a shift-staff model of support. For this report, we will use the term "corporate foster care" to refer to both types of settings.

In Minnesota, there is a licensing moratorium on the development of new corporate foster care beds. The statewide baseline (set July 1, 2013) is 13,700 corporate adult and child foster care beds. The legislature tasked the DHS Disability Services Division (DSD) to manage and track changes in capacity in relation to the cap. In doing so, DSD works with the other DHS divisions (i.e., licensing, behavioral health, aging/adult services and housing) to manage statewide resources and capacity.

Exceptions to the moratorium do not count toward the statewide corporate foster care capacity. License exceptions can apply to:

- People who require hospital level of care
- Settings that require Chapter 144D housing with services registration
- People who need new corporate foster care development because of the closure of a nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DD), regional treatment center or because of a restructuring of state-operated facilities
- People who no longer require the level of care provided by state-operated facilities (e.g., Minnesota State Security Hospital, Anoka Regional Treatment Center)
- People who need new corporate foster care development because of the discontinuation of the residential care waiver service
- People who receive Chapter 245D services and live in an unlicensed setting that requires a license (Note: This exception ended June 30, 2018).

Information and data on corporate foster care capacity

This section will discuss the current corporate foster care capacity, including the number of beds by region and the number of exceptions in this state fiscal year and the last state fiscal year.

Current statewide capacity

In 2014, the maximum number of allowable beds was 13,700. As of June 30, 2019, there are 14,276 total licensed corporate foster care beds in Minnesota. This is a 305-bed increase over FY18 (2 percent).

The increase in FY19 is primarily due to the 228 exceptions to the moratorium that DHS approved for people who needed new corporate foster care development and who met the exception category criteria. By removing the total number of exceptions granted during the period of the moratorium (836), the capacity count for FY19 was 13,440, which is within the maximum allowed under the moratorium[9].

The FY19 moratorium capacity count was higher than the FY18 moratorium capacity count by less than one percent.

The most common exception approval in FY19 was for people who needed new corporate foster care development due to the closure of their ICF/DD facility (123 approvals). This represented a 35 percent increase from the 91 approvals in FY18 because of an ICF/DD closure.

The second most common exception approval was for people receiving Chapter 245D services and living in an unlicensed setting that required a license (83 approvals). This represented a 51 percent decrease from the 168 approvals for this exception type in FY18. DHS expected the decrease in the number of this type of exception

[9] DHS calculates the moratorium capacity count by subtracting the cumulative approved exceptions from the number of licensed beds.

approval because entities needed to contact DHS about the setting before June 30, 2018 to be eligible for the exception in FY19.

The decrease in the number of unlicensed setting exception approvals also contributed to a 20 percent decrease in the total number of exception approvals from FY18 (286) to FY19 (228). If there is not an increase in requests for other types of moratorium exceptions, we expect a continued decrease in the total number of exceptions requested in FY 2020 due to the unlicensed setting exception no longer being available.

For the number of exceptions approved by type in FY19 and how approvals compare to FY18, refer to Table 1.

Table 1: Number of licensing moratorium exceptions by type (FY 2018 - FY 2019)

Exception description	SFY 2018 Exceptions approved	SFY 2019 Exceptions approved
People who require hospital level of care	2	1
People who needed new corporate foster care development because of the closure of an ICF/DD facility	91	123
People who no longer require the level of care provided by state-operated facilities (i.e., Minnesota State Security Hospital or Anoka Regional Treatment Center)[10]	22	21
People who need new corporate foster care development due to the discontinuation of the residential care waiver service	3	0
People who receive Chapter 245D services and live in an unlicensed setting that requires a license (note: This exception ended June 30, 2018)	168	83
Total approved exceptions	**286**	**228**

[10] Includes Jensen Settlement class members.

Capacity by region

In addition to calculating statewide capacity changes from year to year, DHS calculates the corporate foster care bed-capacity changes by region (see Table 2). In FY19, six regions had a decrease in licensed corporate foster beds and six had an increase. Both decreases and increases in beds were modest, ranging from -2 to -5 percent. Region 8, the Southwest Corner, showed the largest percentage increase, with 23 more beds in FY19 (5 percent).

Table 2: Current number of DHS licensed beds by region (FY 2018 - FY 2019)

Region[11]	Region name	Largest county	SFY 2018[12] licensed bed count	SFY 2019[13] licensed bed count	Difference
1	Northwest Corner	Polk	237	236	0%
2	North Central	Beltrami	263	257	-2%
3	Northeast Corner	St. Louis	1,565	1567	0%
4	North West	Clay	919	926	1%
5	Central	Crow Wing	595	602	1%
6	West	Kandiyohi	825	819	-1%
7E	Central East	Chisago	545	543	0%
7W	Central West	Stearns	874	900	3%

[11] These regions are the regional resource specialist areas. See referenced Regional Resource Specialist (RRS) Geographic Area Map, DHS-4850B (PDF) for the regional boundaries.

[12] Licensed bed count was calculated on last day of FY18.

[13] Licensed bed count was calculated on last day of FY19. In FY19, four licensed beds were categorized under "Other" county and were not included in a region.

Region[11]	Region name	Largest county	SFY 2018[12] licensed bed count	SFY 2019[13] licensed bed count	Difference
8	Southwest Corner	Lyon	453	476	5%
9	South Central	Blue Earth	972	957	-2%
10	Southeast Corner	Olmsted	1,581	1,630	3%
11	Metro	Hennepin	5,142	5,359	4%

Table 3: Licensed capacity summary (FY 2018 - FY 2019)

Category	SFY 2018 licensed bed count	SFY 2019 licensed bed count	Difference
Statewide licensed capacity	13,971	14,276	2%
Approved exceptions this fiscal year	286	228	-20%
Cumulative approved exceptions	608	836	38%
Moratorium capacity count[14]	13,363	13,440	1%

Key activities during fiscal year 2019

During the past year, DHS worked to improve the corporate foster care service-delivery system by managing the moratorium, administering grants and supporting services that provide person-centered, integrated living options for people.

[14] The moratorium capacity count is calculated by subtracting the cumulative approved exceptions from the number of licensed beds.

Managing the moratorium

DHS approves exception requests to the extent the moratorium allows while maintaining the ability to approve requests that are critical to people's health and safety. In FY19, DHS approved new corporate foster care development for 61 people who did not meet exception to the moratorium criteria. These approvals were for people with complex needs (i.e., urgent health and safety needs), who were unable to remain in their current setting and could not be served within the current corporate foster care capacity of the county/region.

Note: An example of "an urgent health and safety need" is when a provider gives a notice of service termination to a person from a residential setting and that person does not have options for another home.

Grants

Local Planning Grants

State fiscal year 2019 marks the sixth year of the renewable Local Planning Grant for Corporate Foster Care Alternatives. It is a DHS-awarded grant for developing alternatives to corporate foster care.

The current two grantees are:

- St. Louis County
- Washington County

During the current grant period, grantees have focused on person-centered activities to aid people in exploring alternatives to corporate foster care. Activities include:

- Providing access and opportunity to Person Centered trainings for case managers and supervisors
- Developing and delivering trainings to parents and guardians
- consulting with and including people with disabilities in the implementation of grant activities
- Implementing programs designed to encourage independent living
- Creating a pool of peer mentors for people seeking to move from corporate foster care
- Creating a pool of peer mentors for case managers to support people in moving from corporate foster care.

From July 1, 2018 to March 31, 2019, these grants helped 20 people move out of corporate foster care.

Technology for home grant program

The DHS-funded Technology for Home program offers at-home, in-person assistive technology (AT) consultation and technical assistance to help people with disabilities live more independently. Expert consultants work in teams to provide cost-effective solutions and to communicate with the lead agency to develop a plan for people who receive home care or home and community-based waiver services.

As part of their work, Technology for Home:

- Consults with eligible people in their own homes, workplaces or public locations
- Connects people to resources that will help them live in their own homes

- Conducts follow up to ensure effective training, set up and installation
- Serves on the person's team to develop a plan to meet AT goals.

Between March 2013 and March 2019, the program provided 13,638 instances of service to help people with assistive-technology needs.

Innovation grants

The DHS-managed Disability Services Innovation Grant program promotes innovative ideas to improve outcomes for people with disabilities in Minnesota. Five grantees are working with adults and youth in transition with disabilities to secure independent housing using innovation approaches such as:

- Using person-centered planning and the discovery process to identify housing preferences and match individuals with host homes and job placements
- Collaborating with public schools to provide transitional support, housing and vocational services
- Finding a roommate-caregiver through a web-based program to enable people to move out of a group home or family home.

One result of grant activities is that 63 people have moved into more independent housing, on their own or with a roommate or host home of their choice.

Local infrastructure grants

In 2017, the Minnesota Legislature directed the Department of Human Services' Housing & Support Services Division to create the Community Living Infrastructure Grant Program. The grant, which targets counties, tribal nations, and tribal/county collaboratives, aims to create housing stability for people with disabilities who want to live in the community. DHS awarded the first round of grant funding in 2018. We are currently in the process of negotiating contracts with successful applicants for the second round of funding. Grant applicants applied for funding in one, two, or all three of the following categories:

- Outreach efforts to help people understand their housing options
- Hiring, training, and supporting housing resource specialists
- Funding for counties, tribal nations and collaboratives to administer and monitor the Housing Support[15] program.

Eligible responders from all over the state responded to the proposal request published in March 2019.

Housing Access Services grant program

The Housing Access Services Grant program helps people with disabilities access housing in the community. This program aims to support an alternative to institutional and facility care, and has reduced demand for potential

[15] In 2017, the Minnesota Legislature approved a change that renamed the state's Group Residential Housing (GRH) program. Effective July 1, 2017, the name of the program is now Housing Support.

moves into corporate foster care and also moved people out of homelessness. From July 2009 through March 2019, the program has helped 2,255 people.

Services to help people access and maintain housing

Moving Home Minnesota program

Moving Home Minnesota is an initiative started in 2013 to help people move from nursing facilities or other institutions to their own homes in the community. It is Minnesota's effort under the federal Money Follows the Person Rebalancing Demonstration, which is a strategy for reducing reliance on institutional care and developing opportunities for people with disabilities and older adults to fully participate in their communities.

The initiative closed to new enrollment on August 31, 2018 in anticipation of the final year of the demonstration. However, in January 2019, Congress authorized a one-year extension of the program. Because Minnesota had funds left from its original authorization, CMS approved the program to re-open to new enrollment on March 1, 2019.

In FY19, Moving Home Minnesota helped 111 people move out of institutions and into the community.

Housing access coordination services

Housing access coordination is a waiver service that became available in 2016. It offers support similar to the grant program, but it is a service available under the disability waivers:

- Brain Injury (BI)
- Community Alternative Care (CAC)
- Community Access for Disability Inclusion (CADI)
- Developmental Disability (DD).

Like the grant program, the service helps people plan for, find and move to homes of their own that are not owned, leased or controlled by disability services providers. It is a pay-for-performance, person-centered service that pays for staff assistance based on the results achieved. The service reimburses providers for actual time spent helping a person get housing.

The service also has a follow-up stage that aims to help the person retain that housing.

During the FY18, 1,661 people used housing access coordination services from 35 providers. The total amount spent for these service agreements was $2,525,121 (Note: This total may rise as DHS pays claims up to one year from the date of service delivery).

Services to support people living in their own home

Individualized home supports

In the spring of 2017, DHS received CMS approval for a waiver amendment that authorized the new individualized home supports service. The option was effective as of July 1, 2018. One year later, as of July 1,

2019, 112 people had the individualized home support service authorized. A person may receive individualized home supports when they are eligible for the following disability waivers:

- Brain Injury
- Community Alternative Care
- Community Access for Disability Inclusion.

The individualized home support service holistically supports a person in his or her own home and within his or her community by providing support (e.g., supervision, cuing) and training as a single, comprehensive service. With multiple service-delivery methods, both in-person or via remote support, this new service increases a person's choices and options for how and where services are delivered to meet his or her service needs. A person can receive support or training in four broad community-living service areas of:

- Community participation
- Health, safety and wellness
- Household management
- Adaptive skills.

The service uses a person-centered approach to support what is important both to and for a person. For example, an individualized home-support staff member can ride along with someone who receives services as he or she learns to navigate the local bus system. This is helps the person get to his or her job, as well to get to community activities. If the person misses the bus one day or gets lost, he or she also can use this service to call someone to help reduce anxiety and solve the problem.

In that way, this service recognizes that each person interacts with his/her world differently. For example, one person may have neighbors who are noisy at night. To deal with it, the person may prefer to receive coaching from his or her staff over the phone before approaching the neighbor with a complaint. Or, the person might prefer staff to come along to talk to the landlord about the loud neighbors.

By combining training and support functions into a single, comprehensive service, the service:

- Is more responsive and individually tailored to a person's needs
- Has greater flexibility
- Increases service efficiency.

Assistive technology

Throughout FY18 DHS worked in collaboration with the Minnesota Star Program, State Services for the Blind, Vocational Rehabilitation Services and Minnesota Department of Education to develop the Minnesota's Guide to Assistive Technology website. The website went public at the end of the fiscal year through a press release on June 27, 2018 a posting on the Governor's Facebook page. Since then, throughout FY19, our focus has been on increasing marketing efforts for this comprehensive online resource for the public that contains helpful information about:

- The number of people who may pay for assistive technology

- Assistive technology resources by region
- Descriptions of how people can use assistive technology to support themselves in education
- Employment
- Community environments.

DHS also worked to develop an online module in the MnCHOICES Certified Assessor Training focused on technology. DHS developed this training based on the assistive technology training in June 2018 and incorporated feedback from participants. This is a required training for MnCHOICES assessors and is scheduled for released in the summer of 2019.

Learning outcomes for assessors include:

- Intentionally considering technology during assessment and planning for individuals being assessed through MnCHOICES
- Knowing that talking to the person about assistive technology is their responsibility
- Using the SETT process (Someone, Environment, Task and Tools) when considering assistive technology as part of the assessment process
- Being knowledgeable about the Minnesota STAR Program and the State Services for the Blind assistive technology services and resources
- How to accurately transfer assessment information about technology to the support plan and how to indicate the need for an assistive technology referral.

Throughout the second half of FY19 DHS has worked in collaboration with the Association of Residential Resources in Minnesota (ARRM) on developing a Supportive Technology Training Series. We piloted the training series with the Anoka County case managers and case manager supervisor. The four-part series helps case managers navigate the world of supportive technology, including

- What supportive technology is
- Relevant policy
- Available funding and resources
- Practice through a series of case scenario exercises.

We will use what we learn from the pilot to adapt the training to a format that we can offer to all of Minnesota's counties and tribes.

Conclusions

In FY19, DHS increased the number of corporate foster care beds to:

- Meet the needs of people living in ICF/DD facilities that were closing
- Support people who were receiving Chapter 245D services and living in an unlicensed setting that required a license
- Retain access to services for individuals with complex behavioral and/or medical needs who could not remain in their current setting and existing corporate foster care capacity did not meet their needs.

As required by statute, DHS must manage statewide capacity to the moratorium threshold. People with complex needs who do not meet moratorium exception criteria continues to need new foster care capacity; as a result, DHS needs to reserve available capacity for these situations. This situation limits DHS's strategic ability to use available capacity to develop needed out-of-home crisis respite/respite options.

X. Appendix B

On-going programs and services

Community first services and supports

Community first services and supports (CFSS) is a new self-directed home and community-based service being developed by the Minnesota Department of Human Services.

For more information, see the Community first services and supports webpage.

Consumer directed community supports

Consumer directed community supports (CDCS) is a unique service option that gives people flexibility and responsibility to direct their services and supports. CDCS may include services, supports and items currently available through the Medical Assistance waivers, as well as additional services.

For more information, see the Consumer directed community supports webpage.

Consumer Support Grant

The Consumer Support Grant (CSG) program is a state-funded alternative to Medicaid home care services of home health aide, personal care assistance and/or home care nursing. Through cash grants, the CSG program provides consumers with greater flexibility and freedom of choice in service selection, payment rates, service delivery specifications and employment of service providers.

For more information, see the Consumer Support Grant (CSG) program webpage.

Day training and habilitation

Day training and habilitation services include the supervision, training or assistance of a person to develop and maintain life skills, engage in productive/satisfying activities of their own choosing and participate in community life. Services are designed and implemented in accordance with the person's Coordinated Services and Supports Plan. The service helps people reach and maintain their highest level of independence, productivity and integration into the community.

For more information, see the Day training and habilitation webpage.

Employment First (Minnesota's plan for competitive, integrated employment)

Minnesota is committed to ensuring people with disabilities have opportunities and support to work in competitive, integrated employment. DHS supports an employment first approach, with employment being the preferred outcome for people with disabilities.

For more information, see the Employment First webpage.

Essential Community Supports

Essential Community Supports (ECS) is a program of services and supports that may be available to people who need services to live in the community, but who do not need the level of care provided in a nursing facility.

For more information, see the Essential Community Supports program webpage.

Family Support Grant

The Family Support Grant (FSG) program provides state cash grants to families of children with disabilities. The goal of the program is to prevent or delay the out-of-home placement of children and promote family health and social wellbeing by facilitating access to family-centered services and supports.

For more information, see the Family Support Grant webpage.

Financial management services

Financial management services (FMS) providers help people who employ their own service workers directly. For a list of approved and enrolled financial management service providers, including contact information and fee schedules, see the Financial management services provider information webpage.

Home and community-based services (HCBS) waivers

Medicaid home and community-based services (HCBS) waivers afford states the flexibility to develop and implement community alternatives for Medicaid-eligible people with disabilities and chronic health care needs who would otherwise receive services in a hospital, nursing facility or Intermediate Care Facility for Persons with Developmental Disabilities.

For more information, see the home and community-based services waivers webpage.

Home care services

Home care services offer medical and health-related services and assistance with day-to-day activities to people in their home. Home care can provide short-term care for people moving from a hospital or nursing home back to their home or continuing care to people who have ongoing needs.

For more information, see the home care services webpage.

Intermediate Care Facilities for Persons with Developmental Disabilities

Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD) are residential facilities licensed to provide services to people who require active treatment for developmental disabilities or related conditions. ICFs/DD are located in 62 counties in Minnesota and each serve from four to 64 people.

For more information, see the ICFs/DD webpage.

Long-term care consultation

Long-term care consultation (LTCC) services provide information, assessment and support planning to help people with disabilities and older adults remain in or move to community living.

For more information, see the long-term care consultation webpage.

Medical Assistance for Employed Persons with Disabilities

Medical Assistance for Employed Persons with Disabilities (MA-EPD) allows working people with disabilities to qualify for MA under higher income and asset limits than regular MA. The goal of the program is to encourage people with disabilities to work and enjoy the benefits of employment.

For more information, see the Medical Assistance for Employed Persons with Disabilities webpage.

Medical Assistance Rehabilitation Option

The Medical Assistance rehabilitation option consists of two types of mental health services to enhance existing mental health services in Minnesota. This is done through expanded support and intervention services in the community.

For more information, see the Medical Assistance rehabilitation option webpage.

MnCHOICES

MnCHOICES is an assessment and support planning tool used by Minnesota counties and tribal nations (managed care organizations are scheduled to begin using MnCHOICES in 2020). A MnCHOICES assessment uses a person-centered planning approach to help people make decisions about their long-term services and supports, and determine eligibility so people can receive the right service at the right time.

For more information, see the MnCHOICES assessments webpage.

Personal care assistance

Personal care assistance (PCA) services provide help for a person with his/her day-to-day activities in the home and community. Assistants (PCAs) help people with activities of daily living, health-related procedures/tasks, observation/redirection of behaviors and instrumental activities of daily living for adults. PCA services are available to eligible people enrolled in a Minnesota Health Care Program.

For more information, see the personal care assistance services webpage.

Relocation service coordination

Relocation service coordination is a type of case management to help people who currently reside in eligible institutions and who want to move into the community. Relocation service coordination – targeted case management helps people plan and arrange for the services and supports they need to live in the community.

For more information, see the relocation service coordination webpage.

Self-directed service options

Self-directed service options give people more control over the services and supports they receive. Options include personal care assistance (PCA/PCA Choice), consumer directed community supports (CDCS) and the Consumer Support Grant (CSG).

For more information, see the self-directed service options webpage.

Semi-independent living services

Semi-independent living services (SILS) include training and assistance to people with developmental disabilities so they can manage money, prepare meals, shop, keep up personal appearance/hygiene and other activities needed to live in the community. A goal of SILS is to support people in ways that will enable them to achieve personally desired outcomes and lead self-directed lives.

For more information, see the semi-independent living services webpage.