

SECTION III: COMPREHENSIVE REVIEW AND ANALYSIS

PART A. State Information

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Racial and Ethnic Diversity:

Based on the 2009-2013 American Community Survey 5-year population estimates, Minnesota's population is 85.6% White and 15% non-White (Black or African American, American Indian and Alaska Native, Asian, Native Hawaiian and Other Pacific, Some other race alone, two or more races). Of the total population, 5% are Hispanic or Latino (any race), and 95% are not Hispanic or Latino. For the seven-county metropolitan area, the non-White and Hispanic or Latino population account for 24% of the population and approximately 76% of the population is White.

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Poverty Rate:

Based on the 2009-2013 American Community Survey 5-year population estimates, 11.5% of Minnesota's population is below the poverty level. This is up from 10.9% in 2010.

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State Disability Characteristics/Prevalence Rate:

Prevalence of people with DD in the state

According to the ACS 2009-2013 5-year population estimates, Minnesota's population is 5,347,740. Based on an analysis conducted by University of Minnesota Senior Research Associate, Sheryl A. Larson, the estimated number of people with Intellectual or Developmental Disabilities in Minnesota is 79,681 based on a prevalence estimate of 14.9 per 1,000. This rate is based on the 1994/1995 National Health Interview Disability Supplement (NHIS-D), which is the most recent national source with sufficient information to identify people with DD. If the Galloy National Prevalence Rate of 1.8% is used, the estimated number of people with DD in Minnesota is 96,259.

Residential Settings

According to 2010 data (2010 data was used because it provided the most comprehensive data for both individualized and congregate DD settings) in the 2012 RISP (Residential Information Systems Project) report, approximately 19,085 people with DD live in individualized residential settings (home owned or leased by a person with DD; a home shared with a family members; a host home or family foster care setting with 1-3 residents, and any type of DD group home

shared by three or fewer people with DD), and 19,875 people live in congregate settings (all DD group settings in which four or more people with DD live together, state psychiatric facilities and nursing homes). There are 3,243 with DD waiting for residential services while living in the home of a family member and 28,875 people with DD served by the state DD (this is an unduplicated estimate).

According to 2012 estimates, approximately 1,719 people with DD live in ICF/IID Certified Facilities (this includes residents in state operated facilities and residents in non-state facilities). Of this total, 827 people (48%) lived in ICF/IID settings serving 6 or fewer people, 490 people (29%) lived in ICF/IID settings with 7 to 15 people, and 402 (23%) lived in settings with 16 or more people.

Source: RISP website, 2012 State Profiles

Residential settings by diagnosis, FY 2014

Number of individuals with DD who resided in other potentially segregated settings in FY2014: 16,002. Criteria for “potentially segregated settings” includes: residential settings that are controlled by a service provider (with the exception of private family settings); there are no limits to length of stay; people who are homeless (are considered not well-integrated in their community). Settings include: adult foster care, assisted living (and w/ 24 hour care), board and care, board and lodging with special services, child foster care, children’s residential care, crisis respite, homeless shelter, housing with services established, supervised living facility, and supported living services.

Source: Report on Other Segregated Settings; MN Olmstead Plan: Demographic Analysis, Segregated Settings Counts, Targets and Timelines, DHS, September 30, 2014.

Persons with DD in out-of-home residential settings, FY 2013

Percentage of people with DD who reside in 1-6 person residential setting: 93% (18,164). Minnesota ranks #12 in country. #1 is D.C., where 98% of people with DD residing in settings with 1-6 people (1,788 people). #51 is Mississippi, with only 35%. (Source: Coleman Institute, State of the State in I/DD)

Demographic and Economic Characteristics of Population with Disability Status in Minnesota

Note: This data reports on **all people with a disability** in Minnesota. *(For comparison, estimates for Minnesotans without a disability are included in parenthesis)* Sources: 2013 American Community Survey 1-year estimates (Table S1811); ACS 2009-2013 5-year estimates (Table DP02).

- Number of people with a disability in Minnesota 536,307* (10.5% of population)
- Employed: 30% (72%)
- Type of employment: 69% work in private for-profit wage and salary workers
- Type of industry: 25% work in the education services, and health care and social assistance industry
- Not in labor force: 67% (24%)
- Educational attainment for population age 25 and over:

- Less than a high school graduate: 18% (6%)
- High school graduate: 36% (24%)
- Some college or associate's degree: 29% (33%)
- Bachelor's degree or higher: 17% (37%)
- Median earnings: \$18,396 (\$33,956)
- Population age 16 and over below 100 percent of the poverty level: 19% (9%)
- Language - population 5 years and over in Minnesota: (Source: ACS 2013 1-Year Estimates, Table S1601)
 - Speak only English: 89%
 - Speak a language other than English: 11%
 - Spanish and Asian and Pacific Island languages – make up 7% of the 11%

PART B. Portrait of State Services

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Health/Health Care:

Minnesota has been a consistent leader in promoting and implementing initiatives that improve access, quality, and cost-effectiveness of services provided through publicly funded health care programs. These combined efforts have improved access to health care for low income, special need, and uninsured Minnesotans. At the same time, changes in program delivery, funding, and federal initiatives add to the complexity facing consumers.

Medical Assistance

In July 2015, Minnesota celebrated its 50th anniversary of having an established Medicaid program in the state. Minnesota was one of 31 states to adopt the full Medicaid expansion under the Affordable Care Act (ACA). In FY 2013, approximately 867,000 Minnesotans (or about 13% of the state's population) received healthcare coverage through the state's publicly funded basic health care programs (Medical Assistance and MinnesotaCare). This is up from 707,000 in FY2009. Of the 867,000 total, approximately 739,000 low-income children and parents, people with disabilities, adults without children and seniors received Medical Assistance.

Approximately 17% of the people eligible for Medical Assistance are people who are disabled or blind (125,630 people). The average monthly enrollment for MinnesotaCare in FY2013 was 125,000. Federal and state Medicaid funds were 88% of Minnesota's \$1,717,424,059 total DD spending in FY 2013. [Coleman, from AAIDD's The State of the States in Intellectual and Developmental Disabilities, 2015 report]

Children and Youth with Special Health Care Needs

Of the approximately 169,000 children and youth with special health care needs (CYSHCN) ages 2-17 in Minnesota, more than 32,000 (19%) have had a developmental delay at some point in their lives; 23,600 (14%) currently have a developmental delay. CYSHCN with developmental delays are among the more complex children with special health needs. Very few have needs

that are managed only by medications (<2%); more than half (59.7%) have functional limitations.

Measures that Matter is a joint DHS and MDH effort to identify, track and report on health indicators regarding children and youth with or at high risk for chronic illnesses and disabilities and their families. Minnesota-specific data from the Measures that Matter Compendium (2013):

- Percent of children and youth with special health care needs: 14.3% (179,000)
- Percent of youth with physical health condition: 8.8%
- Percent of youth with mental health condition: 6.4%
- Percent of youth with both physical and mental health condition: 2.9%
- Percent of children under age 18 who receive SSI: 1% (12,984)
- Percent of CYSHCH ages 5 to 17 whose health conditions often hinder school attendance (16%)
- Percent of CYSHCN with insurance: 98%
- Percent of CYSHCN who use special education services: 33%

Maternal and Child Health

The Minnesota Department of Health's Maternal and Child Health section disburses federal Title V block grants and other funds, and supports public health programs involving child and adolescent health including checkups, screenings and monitoring. Some of the programs are described in more detail here. Child and Teen Checkup (C&TC) is an early periodic screening, diagnosis and treatment program for children eligible for Medical Assistance. According to the CMS FFY2014 C&TC Participation report for Minnesota, 232,414 of the 534,218 children who were eligible for C&TC received at least one initial or periodic screen in FFY 2014. The Child Care Health program provides training to Child Care Health Consultants in the state. Consultants promote the development of children by ensuring child care environments are safe and healthy. The Family Home Visiting program provides services to families to improve pregnancy outcomes, promote school readiness, prevent child abuse and neglect and promote positive parenting. In 2012, 340 infants born in Minnesota died before their first birthday. The Infant Mortality Reduction Initiative identifies factors associated with infant deaths and aims to reduce preventable infant mortality. The Family Planning Special Projects (FPSP) is a grant program to fund family planning programs throughout the state. Grants reached 75,000 people through outreach activities, classes and health fairs. Over 43,000 people were counseled on reproductive life planning and contraceptive options. Nearly 25,000 males and females were screened for Chlamydia.

Mental Health for Children and Adults

- Percent of *school-age* children who have a serious emotional disturbance, which is a mental health problem that has become longer lasting and interferes significantly with the child's functioning at home and school: 9%
- Percent of *preschool* children who have a serious emotional disturbance: 5%

- Each year about 70,100 children and youth receive publicly funded mental health services in Minnesota. Most of services are community-and home-based services, such as case management, day treatment, home-based therapies and outpatient therapy.
- Over past 10 years, MA and MinnesotaCare funding for children’s mental health services increased from 38% to 61%; however, county funding decreased from 38% 10 years ago to 22%.

In 2015, Minnesota approved \$51 million in new funding for mental health services and treatment. This increases access to early intervention services, crisis teams and crisis beds; and access to community supports such as respite care, ACT teams and supportive housing. More beds will be available to offer intensive services at Anoka Regional Treatment Center.

Public/Private Insurance Access

Minnesotans with Health Insurance

In 2014, MNSure, Minnesota’s insurance health exchange, opened. MNSure is an online marketplace where people can shop for, compare and enroll in public and private health insurance options. Federal tax credits can be accessed through MNSure to reduce the cost of premiums. 61,874 people enrolled in a qualified health plan (QHP) through MNSure in 2015. Additionally, 120,129 people enrolled in Medicaid and 37,769 enrolled in MinnesotaCare. As of May 2014, 95% of Minnesotans have health coverage – the highest percentage in state history. The state’s uninsured rate dropped from 8.9% in fall of 2013 to just 4.9% in 2014.

Employer Insurance

About 2,375,755 Minnesota workers are employed by businesses that offered health insurance. In 2013, 49% of Minnesota private sector establishments offer health insurance to employees. This is down from 50.1% in 2012. (Source: Kaiser Family Foundation)

Children’s Health Insurance Program (CHIP)

CHIP provides insurance coverage for children in families with incomes that are too high to qualify for Medicaid, but cannot afford private coverage. Total Medicaid and CHIP enrollment (as of April 2015): 1,026,406 people. This is an 18% increase from 873,040 in 2013 (pre-ACA). Minnesota’s CHIP participation rate is 84.7% (percentage of eligible children enrolled in Medicaid and CHIP in Minnesota).

Institutional Care

MN has shifted long-term services and supports from institutional to home and community-based settings. In 2012, 5% of Medical Assistance-eligible people with disabilities lived in an institution rather than the community. A physician certifies a person’s need for a nursing facility, boarding care facility or an intermediate care facility (ICF/DD), and recertifies annually. The ICF provides health or rehabilitative services for those who require active treatment for developmental disabilities. Each recipient has an individual service plan. Several state programs – Medical Assistance and Minnesota Health Care Programs, Durable Medical Equipment program – cover health costs.

Minnesotans with Disabilities

Minnesotans with disabilities with health insurance: 95%. Of these, 57% have private insurance coverage and 73% have public health coverage (some have both types). Source: 2009-2013 ACS 5-year estimates (Table B18135).

Children and youth with special health care needs who have a current developmental delay are significantly less likely to have private insurance in comparison to those who have never had a developmental delay (37.8% v. 68.5%). CYSHCN with current developmental delay are five times more likely to have both public and private insurance than those who have never had a developmental delay.

One measure of health care quality is the extent to which CYSHCN access health services through primary care meeting the criteria of a “medical home.” Among those with a current developmental delay, 20.4% have a medical home. Among those who have never experienced a developmental delay, 53.1% have a medical home. [Source: Measures that Matter]

Home and Community-Based Services

MN has shifted long-term services and supports from institutional to home and community-based settings. In 2012, 95 percent of Medical Assistance-eligible people with disabilities lived in the community rather than an institution.

The number of MN home care providers is about 1,650, up from 1,100 in 2010. [Strib, July 2, 2014]

In FY 2013, Minnesota spent \$1,682,313,990 for DD community services, a .7% real increase over the previous year.

In FY 2013 in Minnesota, of the persons with DD in out-of-home residential settings, 18,164 (93%) were in settings of 1-6 persons; 536 (3%) were in settings of 7-15 persons; and 784 (4%) were in settings of 16+ persons.

In FY 2013 in Minnesota, home and community based services waiver spending was 73% of total DD spending (compared to 51% nationally). MN spent an average of \$63,203 per person on the waiver. [Coleman, from AAIDD’s The State of the States in Intellectual and Developmental Disabilities, 2015 report]

Of the people with developmental disabilities receiving Minnesota long-term care services, 91.9% received home and community-based services in 2013, up from 90.9% in 2009 [DHS, DHS Data Warehouse]

Long-term Services and Supports

As of 2014, MN was one of 16 states that provided assistance to people in applying for Supplemental Security Income (SSI) and Disability Insurance (DI) from the Social Security Administration. Since beginning in the early 1990s, MN DHS contracts with 55 agencies to help

people on public programs who have disabilities to increase their incomes and decrease their state health care and benefit costs. Under a pay-for-performance model, 1,112 people had SSI/DI claims approved in SFY 2013. [GAO report Dec. 2014]

Prevention and Wellness

Health reform helps Minnesotans prevent health problems rather than treating them after they arise. Prevention efforts examples: more access to preventative health screenings without copays, and community-based efforts through SHIP (Statewide Health Improvement Program). Over the past year, immunization coverage among children aged 19-35 months – increased by 12% from 66% to 74%. In the past two years, premature deaths decreased by 5%. Minnesota has the second lowest rates of premature death among states. Since 1990, infant mortality decreased 45% from 8.9 to 4.9 deaths per 1,000 live births. (Source: MDH infant mortality report)

Other

Chemical Dependency

Chemical dependency services have historically been offered as an acute model of care. More recently, there has been a transformation of chemical health services to a chronic disease model of care and recovery-oriented systems of care. A new model of care for substance abuse disorders was presented in 2012 to the Legislature which makes the shift from a chronic model of care. Since 1988, publicly-funded substance abuse treatment services in Minnesota have been state funded, county-administered through the Consolidated Chemical Dependency Treatment Fund (CCDTF). Nearly 50% of treatment admissions from 2009-2012 were paid for through the CCDTF and an additional 16% were provided through a pre-paid MA program, MinnesotaCare or MA. In 2012 there were 53,705 substance abuse treatment admissions in Minnesota. (DHS legislative report, January 2014)

Special Needs Basic Care (SNBC)

SNBC is a managed care program for persons with disabilities between the ages of 18 and 64. Some SNBC plans integrate MA with Medicare services for persons who are dually eligible. The program served 48,358 individuals as of July 2014.

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Employment:

Job Training, Job Placements, and Vocational Rehabilitation Services

According to the Minnesota State Rehabilitation Council, 18,459 people with disabilities received services from the VRS program in FFY 2014, and 4,381 applicants developed employment plans. Of the participants, 76% had three or more serious functional limitations (types of functional limitations include: communication, interpersonal skills, mobility, self-care, self-direction, work skills or work tolerance) and 18% had two serious functional limitations. And 42% of those accepted for service were transition-aged youth, age 16-24. According to

2014 VRS Comprehensive Needs Assessment report data, approximately 6% of the 6,900 (or 414 people) accepted for VRS services in 2013 were people with DD as their primary disability category. From 2007 to 2013, the percentage of people accepted for VRS services with DD as the primary disability ranged between 6 and 8 percent.

In 2014, the state VRS program reported 2,867 competitive placements; the top areas of integrated competitive employment placements were clerical and sales, service jobs, professional/technical/managerial, industrial trades and healthcare. This is an increase of 131 placements from 2013. 25% of those finding employment utilized ongoing supports, up from 20% from 2013.

For every \$1.00 VRS spends on services, case management and administration, \$8.90 goes back into Minnesota's economy through wages earned by VRS participants. The \$8.90 has a broader impact on the economy, resulting in an additional \$17.80 of economic activity. This year, the 2,869 people finding employment through Vocational Rehabilitation average earnings increased from \$28 per week to \$326 dollars per week. Individuals employed after receiving VR services earned a combined total of \$935,000 per week. This data reflects all participants of VR services.

Worksite Accommodations

Minnesota agencies work with employers to address concerns around supports and accommodations. The State Rehabilitation Council has focused on employer relationships. The state has produced media noting that: most workers with disabilities don't need accommodations, and most accommodations are low-cost.

In a study, employer intentions to grant an accommodation were predicted by a number of factors: emotional response to the requestor, characteristics of the disability and the accommodation and fairness perceptions. None of these are legal reasons to deny a request. (Carpenter, 2013). Yet another study found the top five most important items for accommodation requests for employees with disabilities, employers and service providers were: supportiveness of the employee's direct supervisor, employer's support for requesting accommodations, communication between the employee and employer, employers' understanding of disabilities and ADA eligibility and the extent to which accommodations are matched to job requirements.

A review of 15 studies across the nation in the last decade showed that employers have positive general attitudes toward workers with disabilities, however, had reservations about hiring workers with certain disabilities.

In Minnesota, some private employers, such as Wells Fargo, 3M, and United Health Group, promote their employment accessibility efforts on their websites; other employers do not.. The MN Department of Human Rights provides accessibility information and regulates discrimination in job applications, interviews and other employment practices.

Employer Worksite (Building/Property) Accommodations

In 2010, Market Response International conducted a random survey of 500 for-profit businesses in Minnesota that cater to the public. The survey was designed to measure awareness, attitudes and impact of the ADA among the businesses. Older buildings have the lowest percentage of accommodations. Six out of ten respondents report that their building or property was originally designed or later remodeled for greater accessibility. Companies with smaller annual revenue were less likely to have accommodations in their building/property than higher revenue companies (regardless of location). On average, approximately 75% of Minnesota business managers believe their businesses, buildings/property are accommodating to people with disabilities. The accessibility of businesses' websites lags far behind accessibility of their physical spaces. Of the 305 businesses with websites, 3% reported that their website has been tested for accessibility features, only 4% stated their website had accessibility features, and almost 47% of the businesses said they haven't even had the discussion of making their website accessible to people with disabilities.

Source: Awareness, Attitudes and Impact of the ADA among Minnesota Businesses: A Qualitative and Quantitative Research Study prepared for Minnesota Governor's Council on Developmental Disabilities, April 2010.

Work Incentives/Benefits – MA/EPD

Some people with disabilities fear that returning to work and earning more income will result in a loss of their Medicaid (Medical Assistance or MA) coverage. The Medical Assistance for Employed Persons with Disabilities program allows people with disabilities to earn any level of income, build more assets and keep MA coverage. From July – December 2012, MA-EPD had 8,358 enrollments and the average monthly income earned was \$582.91 (41% of enrollees were enrolled in a HCBS waiver). In December 2012, 18.4% (1,504) of MA-EPD enrollees had a developmental disability. Another option is MinnesotaCare, a health coverage program assisting people slightly over the MA income guidelines.

A program of Good Will Easter Seals called Work Incentives Connections helps people understand the effect that work has on government benefits such as Social Security Income (SSI), Medical Assistance, food support, Medicare and Social Security Disability Insurance (SSDI). Benefit analysts and staff research issues and provide reports that provide information to help people make informed choices about working. Assistance is provided to people with all types of disabilities throughout Minnesota, including family members, vocational/services providers, advocates and others assisting people with disabilities. To receive in-depth assistance, the individual must be between ages 16 and 64 and receiving either SSDI or SSI.

Transition Age Students

In a 2012 survey of state VRS staff, most said they had seen a large increase in the past two years in the amount of time spent with transition-age youth with challenging disability-related barriers to employment; the staff wanted additional training in career development services. Minnesota's 2014 comprehensive statewide needs assessment noted consistent and documented needs, including: inclusion of a career development section in transition plans; ASL interpreters for career development classes and work experiences; and parent forums or support groups for transition-age youth. An emerging need is increasing incidence of individuals

with Autism Spectrum Disorder (ASD). In FFY 2006 VRS served 175 consumers with ASD in FFY 2012, VRS served 488 consumers with ASD.

In a study of RSA-911 closure records of FY 2004-2006, Minnesota ranked in the bottom third (17 of 51) of all states in the proportion of youth with disabilities who closed from VR with employment. [T. Honeycutt et al, state differenced in the vocational rehabilitation experiences of transition-age youth with disabilities, *Journal of Vocational Rehabilitation*, Volume 42 Number1, 2015] Note: RSA evaluates all programs authorized by the *Rehabilitation Act of 1973*. The RSA 911 data include demographic and programmatic data for each person who exited the Vocational Rehabilitation program in a fiscal year. The data is designed to be used by the state VR agencies that are responsible for collecting the data.

Passed in 2014, the Workforce Innovation and Opportunity Act (WIOA) provides year-round employment and training services for transition age youth (out-of-school youth between 16 and 24 and in-school youth between 14 and 21). These youth require additional assistance to complete an educational program or secure employment (youth with disabilities, pregnant or parenting youth, homeless/run-away or foster youth, among others, would be eligible). Vocational Rehabilitation Services, in conjunction with the Department of Education, will provide these services. 42 percent (7753) of those accepted for VR services in 2014 were transition-aged youth, age 16-24.

Source: [http://mn.gov/deed/images/SRC Annual Report 2014.pdf](http://mn.gov/deed/images/SRC%20Annual%20Report%202014.pdf)

Competitive Integrated Employment, Sheltered Employment, Data about Employment

Data sets show consistent employment disparities. The 2012 American Community Survey estimates 32.5% of working age adults with disabilities were employed compared with 71.4% of people without disabilities. In 2013, 29.5% of Minnesotans with disabilities were employed, compared to 72.3% of Minnesotans without disabilities (U.S. Census) Labor force statistics for Dec. 2013 estimate that 16.5% of individuals with disabilities aged 16 and older were employed compared with 64% of those without disabilities (BLS, Jan. 2014)

For people with DD, the disparity widens further. Data from the National Core Indicators project suggest that in 2010, only 14.7% of working age adults supported by state DD agencies were employed in integrated employment (Human Services Research Institute 2012). Community rehab providers reported in 2010 that only 27% of individuals with DD supported by their organization worked in integrated jobs including both individual jobs and group supported employment and typically in limited hours and low wages. And given that participation in facility-based and non-work services has grown at the same time, there is not an apparent systemic movement toward competitive employment.

Outcomes have declined for individuals with DD served by state VR agencies with declining hours and wages. Students with DD in particular have the lowest rates of education, work, and preparation for work after high school. (Note: the Rehabilitation Services Administration RSA-911 database is a public access database that captures individual characteristics, services provided, and employment outcomes at the point of closure from VR services.

For FY 2012 in MN: Participation in day and employment services: total served, 16493; 17% in integrated employment, 34% in community-based non-work; 72% in facility-based work and 11% in facility-based non-work. (Most of this is from State Data: The National Report on Employment Services and Outcomes 2013. U of Mass-Boston.)

Public Employment

In 2014, Gov. Mark Dayton issued an executive order providing for increased state employment of individuals with disabilities. The percentage of state employees with a disability declined from about 10% in 1999 to less than 4% in 2013. The order sets a goal of at least 7% by August 2018. It requires statewide model and agency plans, revised hiring processes, greater supported work awareness and on-the-job demonstration project. This initiative builds on other, earlier state efforts such as the Seeds internship program at MnDOT, which is open to students with disabilities or from underrepresented groups.

Employment First Policy

As part of its planning process, the Olmstead Subcabinet adopted a Minnesota Employment First Policy on Sept. 29, 2014, requiring all state agencies to integrate a vision, values and guiding principles in their work, and assigning three agencies (Human Services, Education, and Employment and Economic Development) responsibility to define, operationalize and document a process to ensure a person-centered approach and informed choice are used. The three agencies must align programs, funding and policies, and develop uniform data collection and reporting procedures. The operational planning process has been initiated. The policy was the culmination of a stakeholder coalition drive since 2007. [State Olmstead Plan; APSE article]

Extended Employment

The mission of the Extended Employment (EE) services is to provide the ongoing employment support services necessary to maintain and advance the employment of persons with a most severe disability. Employment shall encompass the broad range of employment choices available to all persons and promote an individual's self-sufficiency and financial independence. (Minn. Stat. 268A.15, subd. 2.)

Nearly five thousand Minnesotans with a most severe disability were reported to have received the ongoing employment supports necessary to add nearly four million work hours to the state's productive capacity, earning nearly \$28 million in personal income. For each state dollar invested in 2014, program participants earned on average \$2.22, increasing financial independence and potentially reducing dependency on public support systems.

Persons receiving Extended Employment (EE) services have decreased by 392 persons, or 71%, since state fiscal year (SFY) 2000. One thousand three hundred thirty (1,330) people entered EE in 2000, declining to 938 entrants in 2014. 274 young people (age 22 and under) comprised 29% of the 938 EE entrants in 2014, a decrease of 14 people since 2000.

Over the last 15 years, employed persons reported with schizophrenia are declining while persons reported with depressive disorders show a mild increase in employment. Although the number of workers with other disabilities is small by comparison to persons with intellectual disabilities or mental illness, trends are noteworthy: Autism/Autism Spectrum Disorder, learning disabilities, and Attention-deficit disorders are on the rise, while persons with other disabilities are holding steady or declining. Persons with Brain Injury showed a significant increase in SFY 2014.

Supported Employment Services

Supported employment services are provided to people with disabilities who need intensive ongoing support to perform in a work setting. A person receiving services must be in a paid competitive employment setting that offers people with disabilities the same wages and benefits as workers without disabilities. Funding for supported employment is provided through state DD agencies, state vocational rehabilitation services, special education, and HCBS waivers. With many sources, specialists use braided funding strategies.

The Vocational Rehabilitation (VR) program remains the primary source of entrants to Supported Employment (SE). In 2014, VR referred 337 of the 582 individuals in need of ongoing employment support services in competitive jobs to service providers funded by the EE program, or 58% of entrants to SE; other public organizations referred 21% of the SE entrants.

For DHS (state DD agency) in FY 2013, \$19,971,991 was spent on 2,906 supported employment participants [Coleman]. Supported Employment (SE) participation increased by 338 entrants over FY 2011. SE participants represented 20% of the 14,690 total day work participants in 2013.

Community Employment (CE)

Community employment refers to work that is performed by a group of people (typically groups include a high percentage of people with disabilities) and the workers are often paid less than the customary wage for similar work performed by individuals without disabilities. Intensive job supports are provided to people who work in community employment settings. In 2014, VR referred 54 entrants (26%) to CE; other public organizations 30%; schools 8%; self-referrals 6%; other sources 19%; and 11% unreported.

Center-based Employment (CBE)

Center-based employment is typically a job in a production facility, food service or janitorial operation in a community rehabilitation program. People perform work assignments while earning wages determined by their rate of production. In 2000, entrants to CBE totaled 420 persons. However in 2014, only 150 individuals' first experience in the EE program was not in a community setting, representing a 64% decline in 15 years. Entrants are persons not previously reported in an EE program. In 2000, the Vocational Rehabilitation (VR) program referred 60% of the entrants to CBE; other public agencies referred 20%; schools 6%; other sources 4%; 1% were self-referred; and service providers did not report the referral source of 10% of the entrants. By contrast, in 2014 VR referrals to CBE were reduced to 26%; other public agencies

21%, schools 25%; other sources 19%; self-referrals 7%; and 2% unreported. CBE declined by 333 entrants (38%), and 270 entrants (36%), respectively. Entrants are persons not previously reported in an EE program. Youth entering CBE is the same as in 2000, however entrants to CE dropped by 63%, and entrants to SE increased by 142%.

Analysis of reported data suggests the strongest predictor of wage is the work setting – the highest wages correlate to work in supported employment and reflect the strongest cohesion with the program purpose: to promote individuals’ self-sufficiency and financial independence.

Day Training and Habilitation Services

DT&H provides licensed support services to people with disabilities to develop and maintain life skills, participate in community life and engage in activities of their choosing.

- FY2013 data for ICF/DD residents only – 1,398 average monthly recipients; average monthly cost per recipient is \$1,768; DT&H services received a rate increase of 1% in April 2014.

Individual Placement and Supports

As part of the overall Olmstead Plan effort to increase competitive employment for people with disabilities, agencies and stakeholders developed expansion plans for the Individual Placement and Supports (IPS), a data-driven interagency effort to increase competitive employment for people with serious mental illness. In Minnesota, people with SMI have a 59% success rate when engaged in the IPS program. For SFY 2014, 639 people worked in integrated competitive employment for an average of 16 hours per week at a \$10.27 average hourly wage – higher success rates than other programs serving this population. Because of its success, the 2015 Legislature converted former one-time allocations into baseline funding, and appropriated \$10 million more for the next biennium.

Sub-minimum Wage

Under the Fair Labor Standards Act, the Department of Labor issues certificates allowing employers to hire people with disabilities below minimum wage, with the rationale of not curtailing their employment opportunities. In Minnesota, 100 Community Rehabilitation Programs, 13 School Work Experience Programs, and 11 Businesses hold certificates. [DOL/WHD website]

In 2011, the Disability Rights Network wrote a position paper that called for an immediate end to center-based employment and the minimum wage exemptions they sometimes rely on. The Association of People in Supported Employment (APSE) also wrote a position paper that supports the elimination of subminimum wage for individuals with disabilities by the end of 2014 – under conditions that address the concerns of center-based employers.

Not all people with disabilities seek competitive employment in the community. While the state’s Olmstead Plan promotes choice, Minnesota has adopted an Employment First policy that promotes competitive, integrated employment. The Olmstead Subcabinet resolves the two perspectives by insisting on an informed choice process that ensures people are aware of their options, including an experiential understanding of their opportunities.

(iii)

Informal and Formal Services and Supports

Social Services

Minnesota has a state supervised county administered social service system. The Department of Human Services (DHS) is the primary supervisory state agency and there are 87 counties and 11 American Indian tribes that administer services. People must apply for services through their local county social service agency. There are a wide range of social services, income support, health care and long-term services available.

Child Welfare/Child Services

DHS, the county, tribes and other partners are engaged in efforts to prevent child maltreatment in the state. In 2013, over 19,000 reports of child maltreatment were addressed by the child protection system. Approximately 72% of the reports received a family assessment, while the remaining received a family investigation. In 2012, less than 1% of the 25,839 children that were subject of a child maltreatment report were children abused and neglected by locally monitored, state-licensed facilities, such as family foster care or home child care. American Indian and African-American children had the highest rates of contact with the child protection system, being six times more likely to be reported as abused or neglected. (Source: DHS

Aging

According to DHS' 2013 Status of Long-Term Services and Supports report, 74% of all MA long-term services and supports expenditures support home and community-based services (HCBS). In 2010, about 88% of long-term care services funding for people with disabilities supported HCBS, while 12% funded institutions. In 2015, this percentage has increased to 91% and 9% respectively.

Minnesota spent over \$3.6 billion on long-term services and supports in State FY2012 through MA programs.

Independent Living and other services

Independent living services are services that develop, maintain and improve the community-living skills of a person. The Minnesota Statewide Independent Living Council is a federally mandated council of community volunteers who work with the state's Centers for Independent Living, VRS, and other state agencies to develop a state plan for independent living.

Supported living services (SLS)

In FY 2013 in Minnesota, 5,231 DD participants received supported living or personal assistance support at a total cost of \$85,528,918. [Coleman, State of State]

In 2013, CMS approved Minnesota's Reform 2020 demonstration project, which includes personal care assistance services (now called Community First Services and Supports – CFSS) to

people not eligible to receive such services under a 1915(i) or 1915(k) state plan amendment. But approval is pending approval of the state's 1915(i) and 1915(k) SPAs.

In 2013, as part of its Reform 2020 (Medicare reform effort), MN established the Community First Services and Supports (CFSS) service to replace the Personal Care Assistance program, giving participants more choice and control over services, including the option to be the employer of their own support workers. This is made possible by passage of the Affordable Care Act, allowing for more flexible, self-directed services.

SLS for Children and Adults

In FY 2013 in MN, \$284,989,320 was spent on 13,711 participants (an average per family of \$20,785) for family supports, including: respite care, family counseling, home adaptations, in-home training, sibling support, education, behavioral management services, specialized equipment, and cash subsidy. Of this total, 3,164 received cash subsidies of \$13,071,304.

Semi-independent Living Services

SILS include training and assistance in managing money, preparing meals, shopping, personal appearance and hygiene and other activities needed to maintain and improve and adult with developmental disabilities' capacity to live in the community. SILS are state and county funded.

SILS data:

FY2013 total expenditures: \$7,675,000

CY 2013 total recipients: 1,560

Supervised living facility

An SLF is a facility that provides supervision, lodging, meals, counseling, developmental habilitation or rehabilitation services under a Minnesota Department of Health license to five or more adults who have a developmental disability, chemical dependency, mental illness, or a physical disability. DHS provides licensure to treatment and rehabilitation programs within SLF facilities such as detoxification programs, CD treatment programs, residential facilities for adults with mental illness, and residential intermediate care facilities for persons with DD.

Community First Services and Supports (CFSS)

CFSS was created by the 2013 Legislature, and is intended to replace Personal Care Assistance services (PCA) and consumer support grant (CSG) programs. When CFSS is implemented in the state, it will provide assistance and support to persons with disabilities, the elderly, and others with special health care needs living independently in the community. CFSS will give participants more flexibility and control over the services they receive by allowing them to act as an employer that can hire and fire their CFSS support workers. CFSS is similar to PCA in terms of eligibility. A person will complete a MnCHOICES assessment (which replaces the PCA assessment), receive a support plan with a listing of the programs and services they are eligible for, meet with a consultation services provider to select a service delivery model and develop a person-centered plan, and depending on the plan developed - seek a CFSS provider agency to hire support services, or hire their own CFSS support worker (spouses and parents of minors may be paid to provide services to eligible family members, too.). Training and other resources

will be provided to help people transition to CFSS. CFSS participants may also purchase goods to reduce the need for human assistance.

DHS has submitted a state plan amendment to the Centers for Medicare and Medicaid (CMS) to obtain approval for CFSS, but the approval process can take several months.

Family Support

- Minnesota offers the **Family Support Grant Program** to provide cash grants to families of children with disabilities to prevent or delay out-of-home placement of children and provide access to certain services and supports. Average monthly recipients: 1,810. In FY2014, \$2,483,969 in state funds was spent on the Family Support Grant Program. Currently, families receiving services under the DD, CAC, CADI, BI, Consumer Support Grant or PCA are not eligible for the Family Support Grant.
- **The Consumer Support Grant** also provides cash grants to replace fee-for-service home care services payments. These grants are an alternative funding source and are not available for people receiving Waiver services, other cash-assistance grants, or certain services through the MA Home Care Program. FY2013 – monthly average enrollees: 1,756; monthly average allocation: \$788.
- **In-home family support.** Habilitation services provided to a person and his/her family, including extended family members who are not providing licensed foster care, in the family's home and/or in the community to enable the person to remain in or return to the home. Not only does this include training of the person, but also training the family members to increase their capabilities to care for and maintain the person in their home.

Peer support

Minnesota Centers for Independent Living (CILs) provided advocacy services, independent skills training, information and referral, peer counseling and transition supports. The independent living philosophy and person-centered thinking and planning are foundational to how CILs operate. The centers coordinate with stakeholders and participants through the Council for Independent Living.

Faith-Based

Approximately eight churches in the Twin cities area have completed training on "Inclusive Congregations: The Place I Belong." The training helps faith communities create a more intentionally inclusive and welcoming environment for people DD and their families. The church ministries include individual (side-by-side) support, special needs services, and integrated, inclusive participation. Arc Greater Twin Cities has an extensive library of books, CDs and DVDs on faith and spirituality. Inclusive Innovations – supports Jewish communities and orgs to fulfil their commitment to provide meaningful inclusion and participation for people with disabilities and their families. Minnesota Grant Watch gives public alerts to disability grant opportunities for faith-based organizations.

Partners of the National Collaborative on Disability, Religion and Inclusive Spiritual Supports, including the University of Minnesota, conducted a 2013 faith-based community employment pilot project in Minnesota, funded by the Kessler Foundation. That pilot is now being scaled up in Minnesota and replicated in Tennessee, Kentucky and Texas. The project builds the capacity of congregations to expand, refine and evaluate customized processes that equip faith communities to support employment for members with disabilities. It is promoted as a low-cost way to increase employment for people with disabilities.

Volunteer Activities

- In Minnesota, 34% of people with development disabilities responding to the NCI adult consumer survey reported they were engaged in volunteer work, compared to 32% in all NCI-participating states.
- PAI – offers community volunteer opportunities for adults with autism and other disabilities. PAI connects clients who have DD, ASD or TBI to places where they can volunteer and experience satisfaction of making our community a better place to live.

Waiver Programs

Source: Coleman Institute, State of the State in I/DD, p.36

- FY2013 – 19,738 people with DD received services through a HCBS waiver.
- In FY2013 - Minnesota spent \$1,247,493,417 on HCBS Waivers (\$63,203 = waiver cost/participant).
- Waiver spending % of total DD spending = 73%

FY2013 – average of 1,350 people were served in the Brain Injury (BI) Waiver each month.

FY2013 – average of 349 people were served in the Community Alternative Care Waiver each month.

FY2013 – average of 16,547 Minnesotans were served in the Community Alternative for Disabled Individuals Waiver. The CADI Waiver provides funding for home and community-based services for children and adults who would otherwise require the level of care provided in a nursing facility.

FY2014 – average of 15,879 people were served in the Developmental Disabilities Waiver each month. The DD Waiver provides funding for home and community-based services for children and adults with developmental disabilities or related conditions who would otherwise require the level of care provided in an Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD).

New Waiver Licensing and Standards

In 2014, the State initiated new Home and Community-Based Services (HCBS) licensing and standards under Chapter 245D, to replace (among others) the provider requirements for most DD services formerly under Chapter 245B, as well as some other services. (People living in ICF DD homes have had some difference in licensing rules.) This was part of a larger initiative to improve the dignity, health and independence of program participants.

Beginning Jan. 1, 2014, MN replaced its county-based service rates system with a statewide system for continuing care providers.

On July 1, 2014, MN initiated a 5% rate increase for continuing care providers. Of that, 80% is to be used to increase employee compensation.

Limits were placed on the growth of the CADI and DD waiver programs for fiscal years 2012 to 2015.

Crisis Respite Services

Crisis respite services are short-term care and intervention services that are provided to a person due to the need for relief and support of the caregiver and/or protection of the person or others living with that person. Medical and behavioral needs are met.

Residential based habilitation services under DD Waiver

Services provided to a person who cannot live in his or her home without such services or who need outside support to remain in his or her home. Habilitation services are provided in the person’s residence and in the community, and should be directed toward increasing and maintaining the person’s physical, intellectual, emotional and social functioning.

State Medical Assistance Spending by Category (in thousands)			
	SFY 2014	SFY 2019	Ave. annual change
LTC waivers	1,242,082	1,818,891	8%
MA total	4,358,071	6,052,703	7%

Nov. 2014 Long-Term Service and Support Forecast, DHS

Also: the average monthly number of ICF/DD recipients is projected to decrease by 1.6%, from 1,646 in 2015 to 1,545 in 2019.

The average monthly persons served in Day Training and Habilitation in ICF/DD is projected to increase from 1,319 to 1,892.

Total Medical Assistance spending for DD Waiver is changing at an average annual rate of 5.2%. The average monthly number of recipients is projected to increase by 3.2% -- 16,159 in 2015 to 18,328 in 2019.

- In 2012 MN applied for and received a waiver program change establishing case management services for all waiver recipients. Case managers are provided by lead agencies (counties and tribes) or entities contracted with the lead agency. They assist participants in gaining access to needed waiver and state plan services and other services regardless of funding source. Case managers meet face-to-face with DD waiver participants every six months. DHS conduct site reviews of all lead agencies; its third round of reviews begins late in 2015.

- With the prevalence of social needs facing Medicaid populations, including housing, transportation, nutrition and other supports, accountable care organization (ACO) programs and medical providers have incentives to maximize supports. In MN, the ACO model is Integrated Health Partnerships (IHPs). IHPs are provider-led organizations that participate in shared savings arrangements with community-based organizations, social service agencies and public health resources to improve health outcomes for people with low incomes. They do this by prioritizing quality, preventative health care and rewarding providers for reaching agreed-upon health goals. [Center for Health Care Strategies brief, Feb. 2015]

Trends

Source: House Research Department, Overview of Programs for People with Disabilities, Feb. 2014 Updated. <http://www.house.leg.state.mn.us/hrd/pubs/disbprog.pdf>

- MA LTC facilities monthly average recipients have been declining over time while MA LTC waiver and home care monthly average recipients have been increasing during the same time period (from 1996- 2015).
- In 2010, the average # of recipients of MA LTC facilities was 20,000 and average Waiver/Home Care recipients was slightly over 50,000. In 2015, LTC: slightly under 20,000 and Waiver: Almost 65,000.

Residents with DD in Nursing Facilities (FY 2011-2013)

Source: Coleman Institute, State of the State in DD, p.31

- 359 people with DD are in nursing facilities in Minnesota.

State fiscal effort for DD services in Minnesota

(Fiscal effort: spending for DD services per \$1,000 of aggregate statewide personal income): Decreased 6% from \$7.13 in 2011 to \$6.73 in 2013. New York leads the nation in fiscal effort by spending \$10.11 per \$1,000.

Source: The State of the State in I/DD, Coleman Institute.

Home Care Services

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

- FY2013 – monthly average recipients: 3,668
- Average monthly cost/recipient: \$388

Disability Linkage Line

The Disability Linkage Line is a free, statewide information and referral sources for disability-related questions, staffed by certified options counselors. In 2014, the line received 65,299

inquiries, serving 29,128 people. Of these, 96% said they would recommend the line to a friend. Question topics included health insurance, public benefits, housing, financial assistance, legal, supports, and employment.

Minnesota's Aging and Disability Resource Center maintains information on over 10,000 helping agencies. The web-based service includes links to resources such as DB 101, the social security disability planner, the MA-EPD premium tool and the housing resource tool box. Specialists also are available online through the Disability Linkage Line.

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Interagency Initiatives

Olmstead Subcabinet

Minnesota's most significant interagency initiative affecting disability services at this time is the Olmstead Sub-Cabinet established by Gov. Mark Dayton in January 2012. The commissioners of eight state agencies are charged with developing a comprehensive Olmstead Plan. The executive director of the Governor's Council on Developmental Disabilities and the Ombudsman for Mental Health and Developmental Disabilities are the two *ex officio* subcabinet members. The plan has been in development for over three years. The state agreed to create the plan as part of a court settlement agreement (Jensen et al v. Minnesota Department of Human Services). Minnesota's Olmstead Plan was approved by the U.S. federal court on September 29, 2015. The plan's goal is "people with disabilities are living, learning, working, and enjoying life in the most integrated setting."

Olmstead planning is changing the landscape of interagency work. Multi-agency teams are developing measurable goals in the areas of employment, housing, transportation, supports and services, lifelong learning and education, healthcare and healthy living, and community engagement. In some cases, standing groups such as the Minnesota Council on Transportation Access are being repurposed for Olmstead; in others, new entities such as the Interagency Employment Panel, have been created. The intent is for the new initiatives to become ongoing entities for continuous Olmstead plan development. The interagency groups also have formal connections with advocates, service providers, local governments, and other stakeholders.

Ongoing initiatives

- **Assistive Technology:** The GCDD supports the Administration Department's STAR program's coordination with related programs in DHS, DEED and other state agencies.
- **Employment:** The Governor's Workforce Development Council is the state Workforce Investment Board. An initiative since 2014 is state realignment for the federal WIOA direction.
- **Youth:** the MN State Interagency Committee brings together state agencies, local agencies and other stakeholders to address education policy coordination for youth and disability issues. A current initiative is developing new measures to track interagency accountability.

- Disability collaboration: The GCDD collaborates with the State Council on Disability and other small disability agencies. A current initiative is public celebration and awareness of the ADA 25th anniversary.
- MN Disability website: The GCDD, along with eight other state agencies, councils and commissions, maintains the Disability Minnesota website (www.mndisability.gov/public/) which provides a single entry point to over 100 state programs, products and services across the range of disability issues. It also provides access to disability-related laws, statutes and regulations.

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Quality Assurance

Monitoring

Several agencies are involved with monitoring abuse, neglect and exploitation: MN Office of the Attorney General; the Ombudsman Office for Mental Health and Developmental Disabilities; the Office of Health Facility Complaints (Department of Health); and the Medicaid Fraud Unit, Surveillance and Utilization Review System and the Licensing Division, all in the Department of Human Services. The GCDD works closely with each agency.

The Ombudsman Office is responsible for promoting highest attainable standards of treatment, competence, efficiency and justice for persons receiving services for mental illness, developmental disabilities, chemical dependency or emotional disturbance in children. The office resolves concerns and complaints about services to improve the quality of care clients receive. They carry out their mission by mediating or advocating for clients; consulting with providers about policies and procedures; gathering and analyzing information; conducting investigations; reviewing death and serious injuries; reviewing records and making site visits.

Interagency coordination and systems integration efforts that result in improved and enhanced services, supports and other assistance

The Minnesota Olmstead Plan Subcabinet has been an interagency initiative responsible for developing measurable goals around improved services and supports in the areas of person-center planning, transition services, housing and services, employment, lifelong learning and education, waiting list elimination, transportation, healthcare and healthy living, positive supports, crisis services, community engagement, and other developing topics. The 2015 plan assigns interagency work groups with responsibility to carry out the measurable goals.

Other interagency efforts, noted elsewhere in this report, include: the State Interagency Council, and the MN Disability website partners. Also referenced elsewhere are advisory groups that bring together agencies and stakeholders, including: The State Rehabilitation Council, the Council for Independent Living, the State Education Advisory Panel, the State Council on Disability, and the Council on Transportation Access.

Person centered planning services

Minnesota's Olmstead Plan defines person-centered planning as an organized process of discovery and action meant to improve a person's quality of life, and considers it as foundational to overcoming system biases and supporting people's ability to engage fully in their communities. Since 2012 the State has trained and provided technical assistance to 4,655 people on person-centered thinking and planning. The State developed a person-centered organizational development tool for use by providers and trained 470 provider staff from across the state.

In 2015 the State engaged four agencies in a yearlong training and technical assistance project with the MN DHS and the University of Minnesota's Institute on Community Integration to create organizational and system change to support person-centered practices. It has adapted and tested a person-centered plan scoring criteria and checklist too to assess whether plans contain characteristics of a person-centered plan.

Minnesota also: reached 1,300 people at a two-day 2015 conference on person-centered perspectives; gave grants to 607 provider agencies to further person-centered practices; and selected and pilot tested a quality of life survey. Funding has been granted to fully implement the survey in the 2016-17 biennium.

Minnesota supports person-centered planning through ongoing training opportunities for human service workers, emphasizing both protocols and approaches to person-centered thinking. The University of Minnesota's Institute on Community Integration prepared a manual for person-centered planning professionals. The MGCDD produced "It's My Choice," a person-centered planning guide for people with developmental disabilities and has continued reprinting it; the last update was in 2014.

Legal and Human Rights

The Minnesota Department of Health licenses facilities as health care institutions (e.g., ICF/DDs and supervised living facilities) and investigates maltreatment of vulnerable adults. In all facilities in SFY 2013, 1,345 complaints were received and 380 investigated onsite with 47 substantiated. Also that year, facilities reported 19,537 incidents; 201 were investigated onsite with 72 substantiated. Department reports are requested by the GCDD and the Disability Law Center. The Disability Law Center represented people in 79 of Minnesota's 87 counties on issues related to their disabilities in 2014. Access to community services needed for independence (Medicaid waiver services, PCA, and mental health) was the largest area of need for over 60% of the clients served.

Disability Justice Resource Center

The Disability Justice Resource Center helps members of the legal community better understand complex disability justice issues for people with disabilities, and identify and eliminate biases against people with disabilities. It has an online collection of statutes, regulations, case law and commentaries. The site has been funded through a "cy pres" fund created as part of the Jensen class action suit which also has led to creation of Minnesota's Olmstead Plan. The GCDD, Twin Cities Public Television, aided by lawyers and law professors, created the site.

Restraint and Seclusion

GCDD has been instrumental in resolving a 2009 lawsuit against DHS alleging that residents of the former Minnesota Extended Treatment Options (METO) program were unlawfully and unconstitutionally secluded and restrained. The resolution, known as the Jensen Settlement Agreement, required the state to commit to a plan of action addressing the closure and replacement of the program and facility with community homes and services; the modernization of the State's Rule 40; and the development of the State's Olmstead Plan.

Rule 40 governs the use of aversive and deprivation procedures in licensed facilities that serve persons with developmental disabilities. The new rule applies to the use of positive supports, and is intended to be consistent with current best practices in the treatment field and consistent with the most integrated and person-centered planning and development of an Olmstead Plan. The GCDD and the MN Disability Law Center were represented on an advisory committee that in 2013 recommended best practices. These included positive support strategies, person-centered planning, permitted techniques, prohibited techniques, emergency use of manual restraint, temporary use of mechanical restraint for self-injurious behavior, staff training, reporting and notifications, monitoring, oversight, and implementation. A public hearing and comment process for a proposed rule revision began in January 2015; on July 7, 2015, the adopted rules were filed with the Minnesota Secretary of State.

Restrictive Procedures in Schools

In 2012 a state-convened stakeholder group developed a plan to reduce use of restrictive procedures; the state has since annually reported standard measurable results for the plan goals. In 2013, schools were trained on restrictive procedure law changes, and schools were given funds and flexibility to collaborate with mental health professionals who are not staff. In 2014, state funds (\$250K) were targeted to help students with disabilities most frequently experiencing restrictive procedures, specifically prone restraints. Annual stakeholder sessions are now held.

Compared to the 2012-2013 school year, 2013-14 had: 34% fewer incidents of prone restraint reported (942 to 644); 12% fewer students with disabilities who experienced prone restraint; 19% fewer districts reporting use of prone restraint; 18% fewer Black students with disabilities experiencing prone restraint; 9% fewer White students experiencing prone restraint; 18% fewer reported physical holding incidents (16,604 to 15,738); and 2% fewer seclusion incidents reported.

Students with Emotional or Behavioral Disorder or Autism Spectrum Disorder account for more than three-fourths of the students on whom restrictive procedures have been used. The others were students in categories including Developmental Cognitive Disability, Other Health Disabilities, and Developmental Delay.

According to a Feb. 12, 2014, majority committee staff report to the U.S. Senate Health, Education, Labor and Pensions Committee, MN's protections from dangerous restraints and

seclusion for students with disabilities have loopholes including too broad definitions. Use of prone restraints, however, is being phased out by August 2015.

On Aug. 31, 2015, with adoption of the Positive Supports Rule, prohibitions on restrictive procedures (with limited exceptions) apply to all services and facilities licensed by MN DHS when provided to a person with developmental disabilities.

Partners in Policymaking®

Since 1987 when Partners in Policymaking® was created in Minnesota, the GCDD has supported this competency- and values-based leadership training program. In FY 2015, class 32 graduated 9 self-advocates, 16 parents and one parent self-advocate. (Participants evaluated themselves on federal IPSII outcomes, before and after the course. On a 5-point scale, increases were: independence, 4.4 to 4.6; productivity, 4.1 to 4.6; self-determination, 4.2 to 4.7; and integration and inclusion, 3.3 to 4.4. Graduates rated knowledge gained at 4.8; usefulness of presentations at 4.8; and quality of the training sessions at 4.9.

One graduate workshop, “Working with the Media,” was offered, Fifteen Partners graduates attended the workshop and 13 graduates attended follow-up small group coaching sessions to refine skills. A closed listserv for graduates and coordinators had 422 subscribers. Partners online courses received 12,920 visits and 27,292 page views. The GCDD also offers a “Telling Your Story” app which had 747 free downloads. Also in 2014 a longitudinal survey and study of Partners classes found that 97% of respondents have the advocacy skills necessary to get needed services and supports some or most of the time; and 98% rate their leadership skills as good to excellent. Baseline, six-month follow-up and longitudinal surveys are administered annually.

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Education and Early Intervention

In Minnesota, Head Start served 14,898 children in FY 2012/2013, about 23 percent of income-eligible children under 5. Of these, 13 percent had a diagnosed disability. In addition to federal, state and county agencies, Head Start involves tribal governments, school districts and quasi-governmental community action agencies.

General Education

Minnesota has 328 elementary and secondary independent school districts, 168 charter schools and many specialty districts including 13 special education &/or vocational cooperative districts. In the 2013-14 school year, public schools taught 14,566 pre-K students and 837,154 K-12 students. Private schools and home schooling taught 69,012 K-12 students. Private schools must complete a standard form regarding IDEA provisions for students with disabilities.

Special Education

In the 2013-14 school year, 126,809 K-12 public school students participated in special education, supported by 9,330 FTE special education teachers. The MN Department of

Education supports special education through policy development, compliance and assistance, early learning services, data analytics, school-wide positive behavioral intervention support, personnel development, and universal design projects, and regional centers of excellence for early childhood professionals.

The annual unduplicated child count reports the number of students with disabilities under 14 general categories. During the 2014-15 school year, the total number of children in special education programs (birth to 21) was 130,886. This includes 5,529 with developmental cognitive delay (mild or moderate), 2,004 with developmental cognitive delay (severe or profound), 17,067 with autism spectrum disorder, and 15,996 with developmental delay (a category for younger children).

Early Intervention

Part C of the Individuals with Disabilities Education Act (IDEA) serves infants and toddlers through age 3 with developmental delays or diagnosed conditions with a high probability of resulting in developmental delays. In Minnesota, services are offered through Help Me Grow, an infant and toddler intervention effort involving the state departments of Human Services, Education and Health, and local government agencies. Services provided through Help Me Grow include: assistive technology devices and services; audiology; family training, counseling and home visits; medical, psychological, nursing, vision, nutritional and health services; and transportation and related costs. The number of Minnesota children receiving early intervention and special education services under IDEA reported in 2015 (2012-13 data) was 5,162, ages birth to 3.

Early Childhood

Part B of IDEA focuses on early childhood, and childhood up to age 21. Participating children are served in the least restrictive environment, which can include Head Start, school readiness programs, childcare facilities or community-based programs. The number of Minnesota children receiving early intervention and special education services under IDEA reported in 2015 (2012-13 data) was 15,175, ages 3 through 5.

IDEA reports in 2015 show that the percent of population who are children with disabilities, ages 3 through 5 are 7.1% for Minnesota and 6.2% for the nation. For ages 6 through 21, 9.5% for Minnesota, and 8.7% for the nation.

In Minnesota, Head Start served 14,898 children in FY 2012/2013, about 23 percent of income-eligible children under 5. Of these, 13 percent had a diagnosed disability. In addition to federal, state and county agencies, Head Start involves tribal governments, school districts and quasi-governmental community action agencies.

Private Schools

About 10 percent of Minnesota children attend private or independent K-12 schools. Under state statute, students with disabilities attending private schools may not be denied special instruction and services on a shared time basis through the public school district.

Transportation to and from the non-public school may be provided by the school district. Schools cannot discriminate on the basis of disability, and must ensure physical and program access for persons with disabilities.

Educational Support/Performance/Teacher Training

MDE supports educational performance by evaluating efforts to implement the Individuals with Disabilities Education Act (IDEA). The 2013-2018 Part B State Performance Plan sets state targets. As of June 30, 2015, Minnesota has met federal requirements on all data indicators.

Other support and training, include resources and consultation for educators involved with learner with low incidence disabilities, an issue in less populated rural areas. Also, administrators and educators at care and treatment facilities, including health care, shelter, correctional and other programs, receive technical assistance from MDE to help with both general and special education

Other resources for teachers include Education Minnesota's Minnesota Educator Academy, and access to parent-focused training at organizations such as Pacer.

SEAP

Governor-appointed members of the Special Education Advisory Panel advise the state's special education programs. It includes parents, legal advocates, local school staff and administrators, higher education, social work and other support staff, and state agency representatives.

Community Resources

Community resources include:

- Early Childhood Family Education (ECFE) strengthens families through the education and support of all parents in providing the best possible environment for the health growth and development of their children. Every school district provides ECFE programs.
- Minnesota Association for Children's Mental Health promotes positive mental health for all infants, children, adolescents and their families. It provides parent education and training resources, referrals, and publications and training for professionals.
- PACER Center offers parent training and an information center for families of children and youth with all disabilities from birth to young adults.
- Local universal design innovation example: In 2014 at Northeast Metro 916 Intermediate School District, a school building was designed with disabilities in mind, including extra wide hallways, curved door handles, sensory rooms, wheeled desks, natural lighting and differently designed HVAC and lighting systems.

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Housing

In 2015, Minnesota's Olmstead Plan established a person-centered, informed-decision vision in which people with disabilities will choose where they live, with whom, and in what type of housing. In this vision, supports and services will allow sufficient flexibility to support individual

choices on where they live and how they engage in their communities. With the emphasis on choice, the Plan noted its focus is not about closing potentially segregated settings.

In 2015, the Legislature authorized initial policy changes to the Group Residential Housing program, intended to increase the flexibility of housing benefits to allow more individuals to move from segregated to integrated settings.

The State received federal funding in 2014 and 2015 for 160 Section 811 housing vouchers for people with disabilities exiting out of segregated settings into their own homes. State agencies – MHFA and DHS – have begun planning to align housing and service supports.

In SFY 2014, there were an estimated 38,079 people with disabilities living in segregated settings. These include nursing facilities and a variety of state institutions including intermediate care facilities for people with developmental disabilities. Over the last 10 years, 6,017 were moved from segregated settings into integrated housing of their choice where they have a signed lease and receive financial support to pay for the cost of housing. With this number as a baseline, by 2019 the state goal is to move another 5,547 (about 92% increase) into the most integrated housing with a signed lease. There is sufficient funding authorized and forecasted to meet this target.

According to 2010 data in the 2012 RISP (Residential Information Systems Project) report, approximately 25,586 people with DD received Medicaid funded or non-Medicaid funded long term supports and services under the auspices of State programs. The numbers in state operated living arrangements were 89 (ICF), 332 (HCBS) and 218 (nursing homes). The numbers in non-state operated arrangements were 1,384 (own home), 10,332 (family home), 1,438 (host family/foster), 8,569 (group, not ICF), 1,630 (ICF), and 1,594 (other). In Minnesota, 10,322 people with DD received services while living in the home of a family member; this was 40% of the State caseload, compared to 56% nationally.

Housing Support/Services

- *Bridges Rental Assistance Program* – Is a program administered by Minnesota Housing that provides rental housing assistance for people with low-incomes who have a serious mental illness. Seven-hundred and four (704) households or units were assisted in FFY 2014; average assistance per household was \$5,444; nearly 33% of households participating in the program comprised people of color and Hispanic households. In 2015 the State legislature authorized an additional \$2.5 million to support the expansion of the program.
- *Housing Access Services* is a partnership, authorized in 2008, between Arc of MN and DHS to support people with disabilities in moving to homes of their own. Initially only part of the DD waiver, it now is open to people eligible under any waiver (whether in the waiver program or not.) Since 2009, over 1,300 people with disabilities have moved into their own homes through this program. In 2014, approximately 256 individuals were moved into a home of their own.

- *The Moving Home Minnesota* initiative was implemented in June 2013 to help people move from nursing homes or other institutions to homes in the community. This effort is under the federal Money Follows the Person Rebalancing Demonstration, a strategy for reducing the reliance of institutional care and developing opportunities for people with disabilities and older adults to fully participate in their communities. This program is expected to serve between 2,000 and 2,500 people over five years. Through Oct. 20, 2015, 103 transitions or moves have been completed.
- *Return to the Community* is an initiative of DHS to help nursing home residents who want to return to homes in the community make that transition into the community. The service provides long-term care options counseling to people who have entered a nursing home. Community living specialists offer in-person assistance for people considering a move to assisted living, help consumers and caregivers look at housing options in the community and assists with the discharge process and connecting people to resources via the Senior Linkage Line® and Disability Linkage Line®. In Q4 of 2014 241 people moved from the nursing home back to the community through the Return to Community initiative.

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Transportation

The transportation section of the state Olmstead Plan pledges that “people with disabilities will have access to reliable, cost-effective, and accessible transportation choices that support the essential elements of life such as employment, housing, education, and social connections. The U.S. District Judge asked for a more concrete description of when and how the proposed strategies will be implemented.

Public Transit

In the Twin Cities metropolitan area, all regular route buses and trains are fully accessible. Outside of the Twin Cities, where public transit is available, it is accessible but is more limited in schedule and range.

Paratransit

In the 89 communities in the jurisdiction of the Metropolitan Council, ADA paratransit service is available for people who have extreme difficulty using regular route transit service because of a disability or health condition. The service is first-door-through-first-door for people who are ADA-certified. Outside of the Twin Cities, services tend to provide curb-to-curb service and sometimes depend upon volunteer drivers.

Community Access

To advance community access, the state departments of Transportation and Human Services have partnered with local planning agencies to develop coordination plans covering all of Greater (non-Twin Cities area) Minnesota as well as the interstate Fargo-Moorhead area.

Air transit

In 2013, MSP Airport began Navigating Autism, a free monthly program to prepare and help children with autism and their families in flying. The airport's Traveler's Assistance Program offers help with disability-related needs, accessed through information booths throughout the main terminal. At the same time, self-advocates have complained the assistance program is inadequate in scope.

Council on Transportation Access

MN Council on Transportation Access includes representatives of state agencies and stakeholder groups. It provides research and advice to the legislature, encourages cooperation among members, and assisted in the development of the state Olmstead Plan. In a 2012 report it noted that while services are still inadequate, in the previous five years each region of the state had made some progress in service coordination.

Transit Gaps

In a 2013 DHS survey, 60% of MN counties reported non-medical transportation service gaps, and 58% reported medical transportation gaps. Access to transportation also was identified as a barrier to home and community relocation of people with disabilities, as well as a barrier to employment. Particularly in rural areas, low mileage reimbursement rates were reported as impacting volunteer-based transportation services. [DHS gaps study]

Light Rail Accessibility

Making Strides 2014 Accessibility Survey – provides wealth of data about the challenges faced by members of the disability community as they seek to access the Green Line.

There are heavy concentrations of people with disabilities living along the Green Line where 44% of St. Paul Public Housing Hi-Rise buildings are located. In Sept. 2014 (third month of Green Line services) 7 of 14 stations in St. Paul had more than 1,000 boardings by people with disabilities – and more than 2,000 boarded at Central Station. Link to report: <http://dcc-stpaul-mpls.org/sites/dcc-stpaul-mpls.org/files/images/MakingStrides2014AccessibilityReport.pdf>

Common issues cited were: sidewalks broken or missing, potholes, sidewalk with steep grade or uneven and train door timing.

The District Councils Collaborative of St. Paul and Minneapolis (DCC) has also studied walkway accessibility around the Twin Cities' Central Corridor light rail project and identified problems that don't get captured in standard tests, such as sidewalk potholes and debris.

Recommendations from the various reports of the DCC related to accessibility call for adding high-visibility crosswalks to increase pedestrian safety and accessibility throughout the corridor, providing longer signal times for people to cross the streets, adding more signage to identify pedestrian crossings, and removing snow on sidewalks to lessen pedestrian barriers in the winter.

Accessible Recreation Opportunities

The Minnesota Department of Natural Resources provides accessible recreational activities and opportunities for people with disabilities of all ages. The agency also maintains accessible campsites, lodging, trails, fishing piers, trout stream sites, etc., as well as hunting and fishing licenses for people with disabilities. Source:

http://www.dnr.state.mn.us/accessible_outdoors/index.html.

Private organizations also provide accessible outdoor recreation facilities and opportunities in the state. These include:

- Amherst H. Wilder Foundation (hiking, field trips, residential camps)
- Capable Partners (hunting and fishing opportunities)
- Courage Center (seasonal activities and residential summer camp)
- Wheelin' Sportsmen (hunting, fishing and shooting events)
- Wilderness Inquiry (active outdoor adventure opportunities)

The PACER Center has a compilation of accessible recreational and sports programs and activities that are available in the community for children and young adults with disabilities and their families. The website includes a wide variety of recreational programs for people with disabilities available in MN:

- Accessible playgrounds and parks
- Adaptive recreation and inclusion programs
- Sports teams (baseball, basketball, floor hockey, soccer, swimming and more)
- Special Olympics of MN
- Camps and traveling excursions
- Social activities and clubs
- Skiing

Adaptive Recreation is a program for St. Paul residents of all ages who are mentally and/or physically disabled. The program provides recreational, educational, social, and cultural activities. Since 1976 the program evolved from primarily recreation to an array of educational, social, cultural and recreational services. The program also provides skills development and opportunities for people with disabilities to be integrated into mainstream programs. Similar programs are found elsewhere in the state, including Bloomington, Eden Prairie, Edina and Richfield.

The GCDD provides a list of recreational programs on its website:
<http://www.disability.state.mn.us/resources/disability-resources/by-topic/#recreationandsports>

(iX) Child Care

Child care

All child care programs (with religious exemptions) must comply with ADA Title III. Potential discrimination is addressed by both Pacer Center, an advocacy group, and Minnesota Licensed Family Child Care Association. The Minnesota Department of Education provides guidance at www.parentsknow.state.mn.us, including encouragement to include mainstream preparation as part of a child's individualized education program. Statewide information resources include the Minnesota Online Special Needs Directory at <http://www.tc.umn.edu/~coop0001/>.

The Center for Inclusive Child Care is a comprehensive resource network for promoting and supporting inclusive early childhood and school-age programs and providers. Families of children with disabilities can receive training and consultation. The network offers family tip sheets at <http://www.inclusivechildcare.org/>, funded by MDE.

Family assistance

Minnesota provides three public child care assistance programs: (1) MFIP/DWP child care assistance is for parents who receive Minnesota Family Investment Program benefits or Diversionary Work Program benefits; (2) Basic Sliding Feed child care assistance is for parents who are working, looking for work, or going to school; (3) Transition Year child care assistance is for parents who have recently gone off MFIP or DWP benefits. Each program has income limits. While the programs can benefit families with disabilities, the State acknowledges some social workers and advocates may have limited knowledge of options. [Source: DB 101]

Part C. Analysis of State Issues and Challenges

(i)

Criteria for Eligibility for Services

The Minnesota Department of Health publishes a 250 page guidebook on eligibility for a wide range of state and federal government programs has been published and is available online at <http://www.health.state.mn.us/divs/fh/mcshn/maze/maze0910.pdf>

Special Services, Waiver Services, Long Term Services/Supports: For DHS health care programs and Medicaid, criteria include U.S. citizenship or certain immigration status, income, assets, disability determination by the Social Security Administration or through the State Medical Review Team.

Medical Assistance: Coverage requirements are: a Minnesota resident; a U.S. citizen or qualifying noncitizen; a Social Security number (or exception is met); meet the income limit and asset limit, and any other program rules. The income limit is based upon age, who lives with you, and other factors including pregnancy, blind or a disability. People not meeting the income limit may still qualify using a spenddown.

Medical Assistance for Employed People with Disabilities: Ages 16 to 65 years, employed, has a disability and is not on SSI, asset limits apply, earnings must be more than \$65.00 per month.

Home and Community Based Waiver: For people with developmental disabilities, can be any age, certified as developmentally disabled, needs an ICF/ level of care, must be on Medical Assistance, asset limits apply, residence applies.

TEFRA: Medical assistance eligibility is due to a child's disability but the income of the family exceeds Medical Assistance limits, sliding fee scale applies, must be under age 19, the child must live with a parent, the disability is certified.

MinnesotaCare: Income and asset limits apply, no disability required, sliding fee scale for health care coverage.

Home Care Services (including personal care assistance): The person must be enrolled in Medical Assistance or TEFRA and be assessed for services to assist activities of daily living; prior authorization is needed; services must be ordered by a physician and must be provided in a person's own home.

Family Support Grant: The person must be under age 21 years, certified as disabled, and live in a family home; adjusted income must be \$91,458 or less; can't be on a home and community based waiver at the same time.

Consumer Support Grant: The person must be Medical Assistance eligible and eligible for home care, able to direct own supports, lives in own home, is not on a waiver and needs ongoing supports.

Cash, food assistance programs: Eligibility is based on income. For example, Minnesota Supplemental Aid is a small extra month cash payment for adults on SSI.

Food Support (renamed from Food Stamps): Helps people to buy food and eligibility is based on income and size of household.

Group Residential Housing: A monthly payment for room and board if a person has a disability and is over age 18. Expenditures totaled \$90.8 million in 2008.

NOTE: Non-citizens can receive assistance as a refugee, asylee, Cuban, Haitian or as an individual fathered by a U.S. citizen during the Vietnam War. These individuals are referred to as “qualified immigrants” and are eligible for SSI, food supports, Medical Assistance, etc.

Early Intervention Services: Minnesota's Help Me Grow program provides services for children birth through age two (Infant/Toddler Intervention) with developmental delays, or a diagnosed physical or mental condition with a high probability of delay resulting; and children three to five years of age (Preschool Special Education) with learning, speech, or play delays.

VRS: Individuals with the most significant disabilities meaning a severe physical/mental impairment resulting in a serious functional limitation in terms of employment in three or more functional areas; and requires multiple services over an extended period of time.

Long Term Services/Supports: The Social Security Administration's PASS Program for SSI recipients allows return to work by setting aside funding to achieve a work goal.

Independent Living Services: Any individual with a significant disability, as defined in 34 CFR 364.4(b), is eligible for Independent Living services under the State Independent Living Services and Center for Independent Living programs authorized under Chapter 1 of Title VII of the Act. The determination of an individual's eligibility for IL services must meet the requirements of 34 CFR 364.51.

(ii)

Analysis of the barriers to full participation of unserved and underserved groups

For two years, some MN school districts have been required to set aside some special education funding for academic and behavioral interventions to keep students in regular education. They had been singled out for placing too many students of color in special education programs. In two years, St. Paul school district had a 40% reduction in special education referrals. Statewide, including voluntary programs, \$5.5 million were set aside to provide interventions to 2,707 students in 2012-13. In previous years, about 9% of students with interventions entered special education. [Pioneer Press July 6, 2014]

The GCDD funds a cultural outreach program. In FY 2014, 12 people in the African-American community graduated from On Eagles Wings. In FY 2013, 33 people in the African-American and Latino communities graduated. The GCDD worked with IPSII, Inc. on a training program on emergency planning and preparedness for individuals with developmental disabilities from the African American community. A half-day emergency planning and preparedness session is made available to graduates of the On Eagles Wings training program. The *Feeling Safe Being Safe* resource materials from the GCDD are provided to participants.

The reference to IPSII and the recent addition needs to be clarified. The emergency planning and preparedness project was a Project of National Significance. Grant funds were awarded to IPSII, Inc. and they created a Being Prepared Center.

Race/Ethnicity/Minority

While Minnesota continues to become more diverse in race and ethnicity, access to supports and services continues to be a problem as evidenced by the percentage of people receiving home and community based services or Medicaid funding compared to the proportion of people who are Caucasian. The only area of disproportionality is special education where students from minority backgrounds are over-identified.

A Minnesota-specific concern is that the state's refugee and immigrant populations are predominately people of color. In any given year, 25 to 50 percent of Minnesota's immigrants are refugees, compared to eight percent nationally. The Twin Cities has the world's largest Hmong population outside of Asia, and the largest Oromo population outside of Ethiopia. Minnesota has the largest Somali population in the nation. The Disabled Immigrants Association, based in Minneapolis, provides information, referrals, peer support, transportation and other services to immigrants with disabilities, with a focus on Somali immigrants

Disadvantages related to poverty

In repeated surveys conducted by the GCDD, individuals who become disabled later in life, live in poverty, and live in rural areas are least likely to have access to the Internet. In addition, poverty plays a critical role in access to health care when co-pays increase. Poverty also plays a part in the development of secondary conditions.

English as a Second Language (ESL)

One consequence of Minnesota's influx of refugees and immigrants is a growth in the number of people with limited English proficiency, but also in the diversity of primary languages. Students in Minnesota schools report speaking more than 200 languages at home. While this has long been true in the state's two major cities, the number of people speaking other languages is increasing in suburban and rural areas as well. Language courses and translation services are not as available outside the core cities.

DHS provides Multilingual Referral Lines, in ten non-English languages that help clients with limited English proficiency to be referred to appropriate state or county human services providers. There is no cost to clients. The referral agency is asked to contact the client, and provide interpretation as needed.

Rural/Urban

Unemployment is greater in the most rural parts of Minnesota. Some areas have very few supports and services options available, and transportation to access those services is often lacking or inadequate.

Attitudes

In surveys undertaken by the GCDD, individuals with developmental disabilities say they are not making key decisions about their own lives because of old attitudes. The barrier of entrenched attitudes is a key consideration in the State's Olmstead Plan deliberations, where training and program measurement are among the tools being considered for attitudinal and performance change.

Assistive Technology Users

According to one state study, the most underserved group in receiving AT is African American females in public schools. (Related information is in the following section.)

The GCDD works closely with the State Demographer's Office to determine the most unserved and underserved areas within Minnesota, and has used that data in program development. The GCDD also uses customer and market surveys with the ability to analyze results by age, severity of disability, and geographic location.

(iii)

Availability of Assistive Technology

DHS Disability Services Division administers the Assistive Technology Grants program, providing person-centered assistive technology, technical assistance and case consultation to people. (2014 DHS RFP for corporate foster care). DHS Medical Assistance funding streams for assistive technology and modifications, for SFY 2012 totaled \$75.1 million (for 158,936 people). The people are people with disabilities, older adults and people with chronic health conditions, and people with chronic health conditions.

Breakdown:

- State Plan durable medical equipment and supplies, \$57.6 million in support of 131,937 people; Fee-for-service home and community-based waivers and Alternative Care, \$15.4 million in support of 16,194 people; and Elderly Waiver managed care participants, \$2.1 million for 10,805 people.

Other AT comes from DEED, MDE and local schools, the DHS MA program provides most AT equipment. The Dept. of Administration STAR program provides information and device training. The DHS Tech4Home helps people with disabilities with AT support to help them remain in or move to homes of their own. [DHS legislative report]

Minnesota's waiver services include monitoring technology to promote community living and independence in some residential services. (Disability Waivers Rate System, DHS legislative report, Jan. 15, 2015)

STAR Program

STAR is Minnesota's assistive technology (AT) program funded under the federal AT Act of 1998. The program promotes the reutilization of AT. It offers device demonstrations allowing consumers to compare features and benefits of devices. It loans, both short-term and open-ended, devices to consumers during a time of need or to try before purchasing. A network of partner organizations around the state eases obtaining loans. STAR maintains an online device exchange to donate, sell and buy used, usable technology.

STAR offers AT training, including an online learning site, Tools for Your Future, funded by the Minnesota State Colleges and Universities system. Potential consumers are made aware of the resource through conferences, workshops, recycling events and online communications. STAR is guided by a governor-appointed Minnesota Assistive Technology Advisory Council

(iv)

Waiting Lists

Wait List Definition

Minnesota statutes set the parameters for waiting lists for the four waiver programs. For the DD waiver, counties are required to maintain a waiting list of persons with developmental disabilities specifying the services needed but not provided. The waiting list must be used by counties to assist them in developing needed services or amending their children and community service agreements.

Counties periodically reevaluate the needs, choices, and options for individuals waiting for waiver services; and prioritize the allocation of waiver resources – Children with service needs to avoid out-of-home placement; individuals affected by private sector ICF/DD closures, individuals with immediate risk of out-of-home placement; individuals with immediate risk of ICD/DD placement. Counties meet with individuals to review continuing need for/interest in DD waiver services and update screening information in MMIS at least every three years (Minn Stat Section 256B.092).

How Individuals Are Selected for the Waiting List

Minnesota traditionally selected individuals to be on the waiting list based on need data that is captured on a DD Screening document, by age, and current living arrangement. Now, the state used MnChoices, a web-based application that integrates assessment and support planning for all people who need long-term services and supports. It is used for all assessments in counties and tribes, and will extend to managed care organizations in 2016.

The DHS establishes statewide priorities for individuals needing CAC, CADI, or TBI waivers according to specific criteria – unstable living situations due to the age, incapacity, or sudden loss of the primary caregivers; moving from an institution due to bed closures; sudden closure of their current living arrangement; require protection from confirmed abuse, neglect, or exploitation; sudden change in need that can no longer be met through state plan services or

other funding resources alone; other DHS priorities. When allocating resources to counties, consideration must be given to the number of individuals waiting who meet statewide priorities, and the county's current use of waiver funds and existing service options (Minn. Stat. § 256B.49).

Wait List Litigation

Minnesota currently faces litigation contending that in recent years more than 5,000 Minnesotans with intellectual or developmental disabilities have been placed on waiting lists for waiver services – in some cases, a decade or more – while more than \$1 billion in available funds were not spent. With Minnesota's system of allocating funds to counties, some counties spend nearly their entire allocation, while others spend only 20 to 40 percent of the funds. Unspent money is returned to the state's general fund.

Minnesota efforts to address the litigation concerns, as well as Olmstead obligations include a plan to eliminate wait lists. DHS has begun providing technical assistance to counties. Beginning Feb. 1, 2016, DHS begin providing annual summary data about waiting list urgency categories. One year later, DHS intends to have an electronic record system (replacing a temporary system) to track urgency of need categories across all waivers. This is intended to introduce promising practices used in other states.

Wait List Elimination

From the DHS Report on Program Waiting Lists legislative report, Dec. 2014:
Currently, the only waiting lists in the DHS Continuing Care Administration are for the Developmental Disabilities (DD) waiver and Community Alternatives for Disabled individuals (CADI) waiver. As of Oct. 1, 2014, there are 3,501 people on the DD waiver waiting list; and 1,447 on the CADI list. Beginning July 1, 2015 there are no enrollment limits for the CADI waiver, so the cost of serving the waiting list people is included in the Medical Assistance forecast. The State Legislature has approved additional funding for the CADI waiting list elimination.

The DD waiver program has had almost continuous enrollment limits in place, with one exception in 2001, which creates pent up demand for the program. Currently, the DD waiver is limited to 180 new waiver allocations per year. In FY 2016, the forecast assumes 300 new waiver allocations per year. It is anticipated that opening enrollment for this program will add people beyond those currently on the waiting list. Based on the program growth during the 90-day open enrollment period in 2001, it is estimated that during the first year of open enrollment the number of waiver recipients would increase by 178% beyond the current waiting list. It is estimated that an additional 1,000 people will be added the second year and 600 per year after that.

The current DD waiver enrollment process allocates enrollment priority based on statutory priorities, including urgency of need, so on average the current waiver recipients require higher intensity services than the additional people who will be added to the program due to open

enrollment. This analysis projects that the average monthly cost of the additional recipients will be 80% of the current forecasted average service cost.

Many of the people on the waiting list for the DD waiver currently receive other Medical Assistance services, such as Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD), other disability waivers, and personal care. The cost of these services has been subtracted from the projected additional DD waiver costs. The average cost of these services is based on the average monthly service use of DD waiting list recipients from Oct. 2013 through March 2014.

SFY	Additional recipients	Net MA costs millions	State costs millions
2016	4,078	146.2	74.9
2017	6,897	291.8	148.9
2018	7,680	332.1	169.4
2019	8,280	363.9	185.5

Minnesota Statute 256B.092, Sub. 12 establishes the priorities for individuals on the waiting list for development disabilities (DD) waiver services as on January 1, 2010. Those statewide priorities include:

Subd. 12. Waivered services statewide priorities.

(a) The commissioner shall establish statewide priorities for individuals on the waiting list for developmental disabilities (DD) waiver services, as of January 1, 2010. The statewide priorities must include, but are not limited to, individuals who continue to have a need for waiver services after they have maximized the use of state plan services and other funding resources, including natural supports, prior to accessing waiver services, and who meet at least one of the following criteria:

- (1) no longer require the intensity of services provided where they are currently living; or
- (2) make a request to move from an institutional setting.

(b) After the priorities in paragraph (a) are met, priority must also be given to individuals who meet at least one of the following criteria:

- (1) have unstable living situations due to the age, incapacity, or sudden loss of the primary caregivers;
- (2) are moving from an institution due to bed closures;
- (3) experience a sudden closure of their current living arrangement;
- (4) require protection from confirmed abuse, neglect, or exploitation;
- (5) experience a sudden change in need that can no longer be met through state plan services or other funding resources alone; or
- (6) meet other priorities established by the department.

(c) When allocating resources to lead agencies, the commissioner must take into consideration the number of individuals waiting who meet statewide priorities and the lead agencies' current use of waiver funds and existing service options. The commissioner has the authority to transfer funds between counties, groups of counties, and tribes to accommodate statewide priorities and resource needs while accounting for a necessary base level reserve amount for each county, group of counties, and tribe.

(v)

Analysis of the adequacy of current resources and projected availability of future resources to fund services

Employment Funding/VRS

In FFY 2014, VRS reported spending \$21.5 million on services purchased for consumers and \$16.5 million on services provided by VR staff. In the year, 18,459 people with disabilities received services, down 1,076 from the previous year. Of these, 42 percent were transition-aged youth, age 16 through 24. And of these, 11.2 percent were people with developmental cognitive disabilities and 19.6 percent were people with autism.

The inadequacy of current resources is highlighted by the VRS order of selection: three of the four priority categories are closed. Current funding is mostly limited to people with a most significant disability, persons whose condition results in serious limitations in three or more functional areas. In Minnesota, category four has been closed for years. Categories two and three have been closed intermittently.

VRS assesses qualitative adequacy. Examples of needs include: adding a career development section to transition plans; alternative transition meeting locations beyond schools; more engagement between counselors and clients; more varieties of work experience; and better information for potential employers.

Transit Funding

In 2012 DHS expanded its biennial service gaps analysis to include people with disabilities. Transportation was most frequently identified as a gap (66 percent of all counties). Regional planning efforts do not include increased funding as a strategy, but do include strategies to make better use of current funding. These include: service centralization (scheduling, etc.), regional provider databases, expanded regional steering committees, new call centers or websites, and shared vehicle, facilities or other resources. More flexible funding policies has been identified as a priority.

With federal funding, the MnDOT Office of Transit funds 30 to 35 new accessible transit vehicles per year, and (with local match) innovative transit services beyond the requirements of the ADA.

Special Education

The cost of Minnesota special education continues to increase. In 2013, the StarTribune reported that the cost rose 70% in the past decade, and contended that increased services to children with mild autism was a partial cause. A legislative auditor report the same year concluded that costs are increased, in part, because 75% of state special-education rules exceed what is required by federal regulations. The same legislative auditor report said that school districts are diverting general education aid to pay for special education costs.

Waivers

Federal waiver programs, based on eligibility requirements specific to each waiver, are not an entitlement. The continuing caseload waiting lists apparently indicate inadequate funding. However, in Minnesota, another factor is that while the State manages the waivers, they are administered by lead agencies including counties, tribes and health plans (for the elderly waiver). Each year the administrative process has resulted in available funds being unspent. Recent state policy changes (noted elsewhere here) are expected to result in a reduction and then disappearance of waiver waiting lists.

Waiver service adequacy is illustrated in the National Core Indicator program. In 2013-14, the adult consumer survey showed – in every category – that Minnesota was below average (compared to all NCI-reporting states) on matters of choice. *Note: this data also is noted in sections VI and VII below.*

Independent Living Services

Minnesota continues to have 11 unserved counties (13%) meaning that no core services are available to residents. Community needs are seldom addressed, there is no designated contact or referral and no detailed information gathered about needs.

There are 47 underserved counties (54%), meaning limited access to and availability of core services. There are limited contacts with information and referral available. The independent living services centers note that they are the only programs attempting to provide core independent living services to people of all disabilities.

Notes

People feel forced to choose between Supported Employment or day (non-work) services, which typically are distinct programs with different government agency sponsors. Selecting one cuts off potential benefits of the other. TransCen in San Francisco has a small successful model called WorkLink that braids the two. [Journal of Vocational Rehabilitation 40 (2014)]

The federal Achieving a Better Life Experience (ABLE) Act became law in 2014, offering a new opportunity to set aside funds for services without impacting the SSI \$2,000 individual resource limit. It changes the tax code to allow for tax-advantaged savings accounts for qualified individuals with disabilities to save for certain expenses such as education and transportation. The Legislature authorized establishing a Minnesota ABLE plan; it was signed into law on May 22, 2015.

StarTribune, 12-29-14: of the 425 home caregivers and agencies notified of wrongful billing practices since 2008, just one in four were ultimately convicted, according to the newspaper's review of public records.

On July 1, 2015, MN initiated a 24/7 centralized common entry point for reports of suspected maltreatment of vulnerable adults.

The DHS office of inspector general's Legislative Report on maltreatment of vulnerable adults and children for FY 2013 notes increasing numbers of allegations investigated (906) and allegations substantiated (235).

The 2013 Legislature required counties to use a standardized tool in carrying out duties under the Vulnerable Adult Act. Research has shown it results in more reliable, accurate and consistent decisions than professional judgement alone. [DHS bulletin, Aug. 5, 2013]

(vi)

Analysis of the adequacy of health care and other services, supports and assistance that individuals with developmental disabilities who are in facilities receive

Nationally in 2010, 4 percent of residents with DD and chronic health conditions living in congregate care settings were 21-years-old or younger; about a third (n=7,926) were younger than 14. Olmstead requires they be provided appropriate and reasonable accommodations for community-based services. In 2000, CMS reported there were 4,886 children with special health care needs living in skilled nursing facilities; of whom 1,222 had DD. It has been postulated placement occurs when families are not able to obtain adequate community-based services, but the reasons are complex. [American Academy of Pediatrics clinical report, Sept. 29, 2014, Pediatrics vol. 134.]

[from same AAP clinical report] The care of children and youth in residential settings is driven by physician orders and nursing protocols and may be more regimented than home care. (eg, time of feeding, bathing and medication administration).

[From same AAP clinical report.] The Developmental Disabilities Assistance Bill of Rights Act defines developmental disability. Most people with DD do not have medically complex conditions or chronic illness. Medically fragile children are supported by government, educational and fiscal programs that do not apply to adults, leading to a significant step-down in services and available supports when reaching adulthood.

A GAO analysis of 2012 data showed only about 5,000 school-age children are in nursing homes (and about 42% are in just three states: CA, NY, TX). Surveyed state and local school officials report challenges including curricula development and adequate teacher training.

The National Core Indicator survey found in 2013-14 that 42% of responding Minnesota adults with disabilities reported they chose or had some input in where they live, compared to 54% in all NCI states.

(vii)

Adequacy of Home and Community Based Waivers Services (to the extent that information is available)

CHOICE: Waiver service adequacy is illustrated in the National Core Indicator program. In 2013-14, the adult consumer survey showed – in every category – that Minnesota was below average (compared to all NCI-reporting states) on matters of choice. In Minnesota 42% of respondents (compared to 51% in all NCI states) reported they chose or had some input in where they live. Also: 29% (compared to 44% in all NCI states) chose or had some input in choosing the people with whom they live or they lived alone. Among people with a paid job in the community, 67% (83%) chose or had some input in where they work. Among people with a day program or regular activity, 43% (59%) chose or had some input in where they go during the day. 37% (65%) chose or were aware they could request changing staff who help them at home, job, day program or regular activity. 72% (82%) decide or have input in choosing their daily schedule. 88% (91%) decide or have input in how to spend free time. 85% (87%) choose or have input in choosing how to spend their money. 48% (63%) chose or are aware they could request to change their case manager/service coordinator.

WORK: NCI data showed that 31% of responding Minnesotans (compared to only 16% in all NCI-reporting states) have a paid job in the community. The work was 26% (33%) in individually-supported positions, 13% (34%) in competitive positions, and 62% (34%) in group-supported positions. In a typical two-week period, people worked 31.1 (224.2) hours in individually-supported employment, 19.4 (40.5) hours in competitive positions, and 29.9 (31.9) in group-supported employment. Average gross wages in two weeks was \$235.00 (\$197.89) individually supported, NA (\$227.44) competitive, and \$108.89 (\$170.73) group supported. The average hourly wage was \$7.75 (\$8.33) in individually-supported jobs, NA (\$8.20) in competitive jobs, and \$4.05 (\$5.69) in group-supported jobs. 85% (84%) worked 10 of the last 12 months in their positions. 26% (25%) received paid vacation or sick time. The percentage of workers in the most common jobs were 12% (18%) in food preparation and service, 33% (33%) in building and grounds cleaning or maintenance, 4% (15%) in retail, 19% (9%) in assembly, manufacturing or packaging. Among people without a paid job in the community, 58% (49%) would like a paid job in the community. 40% (25%) of all respondents have integrated employment as a goal in their service plan. 58% (71%) attend a day program or regular activity; 34% (32%) do volunteer work.

SATISFACTION: NCI data showed that 89% of Minnesota respondents (90% in NCI-reporting states) said they like their home. 26% (26%) wanted to live somewhere else. 64% (65%) talk with their neighbors at least some of the time. Of those with a paid community job, 89% (93%) like where they work. Also among those with a paid community job, 37% (30%) want to work somewhere else. Among those with a day program or regular activity, 87% (88%) like their program or activity; and 42% (34%) want to go somewhere else or do something else during the day.

SERVICE COORDINATION: NCI data showed that 94% of Minnesota respondents (95% in NCI-reporting states) reported they met their case manager (or service coordinator); 83% (88%) said their case manager asks them what they want. 90% (88%) said their case manager helps them get what they need. 71% (75%) report that if they leave a message, their case manager calls back right away. 96% (94%) said their staff come when they are supposed to. 92% (92%) said they get the help they need to work out problems with their staff. 74% (87%) helped make their service plan.

HEALTH: NCI data showed that, in the past year, 62% of Minnesota respondents (88% in NCI-reporting states) had a physical exam; 72% (79%) had a dental exam; 58% (59%) had an eye exam or vision screening. In the past five years, 75% (65%) had a hearing test. Among female respondents, in the past three years 56% (67%) had a pap test; in the past two years, 85% (75%) had a mammogram. Among respondents 50 year and older, in the past year 8% (19%) had a colorectal cancer screening.

United Cerebral Palsy's 2015 state by state comparison regarding inclusion ranked Minnesota as seventh best in the nation. It noted that the state has no large facility keeping people isolated from the community but noted that (based on 2012 data) Minnesota has a waiting list that would require 17% annual program growth to accommodate the need. As of 2013, 91% of program participants were involved with HCBS, receiving 90% of program dollars.

In January 2014 Minnesota began a new Disability Waiver Rate System, following a CMS ruling that the state's disability waivers were out of compliance with federal requirements for uniform rate determination. Rate setting transferred from counties and tribes to the state. Finding one year showed minimal fiscal impact, but larger impacts are anticipated in the next five years, with some service rates going much higher or lower. [Supported employment service supports may require higher expenses than the new standard, according to Opportunity Services.] (Disability Waivers Rate System, DHS legislative report, Jan. 15, 2015)

As service rates go through a five year transition process, a provider coalition has contended that confusion has led to rate inadequacy, resulting in some providers not being able to assist people. (Dec.16, 2014 DHS letter to DWRS Provider Coalition)

In 2013, DHS surveyed counties on the availability of services for people with disabilities over the past two years. The most frequently identified service gaps were chore service, companion service, respite care, transportation and adult day care.

DHS Nov. 2014 long-term service and support forecast. State Medicaid spending projected to increase 7% from \$4,358,071 in SFY 2014 to \$6,052,703 in SFY 2019. Of this, long term care waivers and home care projected to increase 8% from \$1,242,082 in 2014 to \$1,818,891 in 2019. Of this, Medicaid DD waiver spending (and monthly persons served) projected to increase from \$1,072,666,118 (15,879 people) in 2014 to be \$1,425,4000,042 (18,328) in 2019. Total Medicaid spending for DD waiver in changing at an average annual rate of 5.2%

From same DHS 2014 forecast:

The payments to ICFs/DD, (and projected recipients) are projected to decline from \$1444,310,966 (1,646 people monthly) in 2015 to \$142,690,571 (1,545) in 2019.

Forecast also has some DT&H numbers and all the waivers.

DRAFT