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Funding of Services for Mental Retardation in Minnesota

MN Dept of Public Welfare
1983

FORWARD

The administration of Governor Rudy Perpich has reaffirmed Minnesota's committment to implement its long-standing policy of deinstitutionalization of mentally handicapped persons and to develop less restrictive, more normalized services in community-based settings- Toward this end, Welfare Commissioner Len Levine has articulated this committment to lead the Minnesota Department of Public Welfare to a position of national prominence in the development and delivery of program and cost effective human services. As he stated before the House Appropriations Committee on February 7, 1983,

> "Institutionalization is poor fiscal policy and even worse social policy. We can and will establish a system in Minnesota which insures, through effective case management at the county level, that the aging, the mentally retarded, the mentally ill and the chemically dependent live in the most normal environment which their individual capabilities permit."

He further stated that we must fulfill our responsibilities to people in state institutions. They are entitled to decent physical facilities, the sensitive care of well trained staff and effective programs. Institution staff must perform the crucial role in the deinstitutionalization program by preparing their patients to live outside institutions.

This Plan of Action follows the preliminary report on Developmental Achievement Centers and Semi-Independent Living Services, submitted on February 15 to the 1983 Legislature, and represents a major effort of a special Task Force appointed on January 19, 1983, made up of representatives of the Medical Assistance Unit, Office of Policy Analysis, Support Services Bureau, Social Services Bureau and the Mental Retardation Program Division. The major redirection of the scope and funding of mental retardation programs and services this Plan offers will require substantial further effort. It is expected to result in a vastly broadened, cost-effective program of services that will facilitate the aggressive implementation of Minnesota's policy of Deinstitutionalization through the prudent use of the Title XIX Medical Assistance Program.

A PLAN FOR THE REDESIGN OF THE SCOPE AND FUNDINGS OF SERVICES FOR THE MENTALLY RETARDED IN MINNESOTA

BACKGROUND

Over the past two decades, Minnesota has witnessed a major shift in the design and scope of services to the mentally retarded. From a primary reliance on large, state operated institutions in the 1960s, Minnesota began to develop community-based residential settings in the mid-sixties as an alternative to the large "state schools" for the retarded. In many instances, those residences were quite large in size, some exceeding 100 beds.

The advent of the 1970s was marked with a major shift in the philosophy of care of the mentally retarded. That "shift" was from large congregate care facilities to smaller, home-like settings in the community, typically from six to fifteen beds in size. The development of this system of residential services was facilitated by the availability of significant federal financial support under the Title XIX Medical Assistance Program.

From the early 1970s through 1982, Minnesota aggressively implemented the small group home model to the extent it was considered the undisputed leader nationally in its provision of services to the mentally retarded, and in keeping with contemporary philosophy.

The 1980s have introduced two major factors that require a re-examination of manner in which we provide for the care and training of the mentally retarded. Those factors are first, the "technology" we have developed in the humane and effective care of the retarded and, secondly, the economy. These factors taken together with the recent report of the Legislative Audit Commission, the Welsch v. Levine Consent Decree and a Minnesota Supreme Court Decision dictate a redesign of the methods, scope and financing of Mental Retardation services in Minnesota.

Several recent developments have underscored the need for a new direction in the Mental Retardation Program in Minnesota. Those developments include a recessive economic trend nationally and in Minnesota, changes in federal law, court actions affecting services to the mentally retarded, changes in professional thinking about how and where the mentally retarded can best be served, and finally, the results of two recent major studies of the issues central to delivery and management of services to the mentally retarded in Minnesota. This Plan takes into account those developments and offers a new direction consistent with the best "contemporary" thinking available to the Department.

DEPARTMENT PLAN OF ACTION

INTRODUCTION

The 1982 Legislature charged the Department of Public Welfare to conduct a study of the feasibility of using the Title XIX Medical Assistance Program as a funding source for Developmental Achievement Centers and Semi-Independent Living Services, two major components of the larger Mental Retardation Program in Minnesota. The results of that study were submitted to the 1983 Legislature on February 15 and was entitled, "A Preliminary Report on Developmental Achievement Centers and Semi-Independent Living Services".

The conduct of that study has led to a much broader examination of the entire Mental Retardation Program with special attention given to the role the Medical Assistance Program plays in the operation and funding of that program.

Simultaneous to this effort, the Legislative Audit Commission conducted an "Evaluation of Community Residential Programs for Mentally Retarded Persons." A report of that study offered numerous recommendations in the areas of planning, control and funding of residential programs. This Plan has attempted to address those recommendations to every extent possible within the time frame available.

This document is organized into six sections, three of which deal with the major categories of program services for the mentally retarded, and three that detail management, legislative and fiscal issues. While this Plan does not offer the total sum of actions planned, it does list some immediate activities, scheduled for this legislative session and an overall direction for subsequent years.

The preparation of this Plan included an evaluation of the progress made in meeting the ten objectives in the Department's original "Six-Year Plan for the Mentally Retarded in Minnesota" that was developed late in 1980. As will be pointed out in the sections that follow, the results of that evaluation underscore the need to make several "mid-course" adjustments in the original objectives and the means proposed to achieve them.

This Plan lists several "actions" across several program and service components. Few, if any, stand alone as independent functions that are not affected by or, do not affect other actions. In other words, the proposed actions all have a degree of interdependence on each other. The Plan should be read and considered as a "whole" since it treats the total Mental Retardation program as a manageable whole. That, in essence, is the goal: to manage the Mental Retardation Program in Minnesota.

SECTION I. RESIDENTIAL SERVICES FOR THE MENTALLY RETARDED

Minnesota has two major ways in which it provides residential training and treatment services to those persons requiring out-of-home placement: state hospitals and community-based intermediate care facilities for the mentally retarded (ICF/MR).

The Six-Year Plan projected a total number of certified ICF/MR beds needed in 1987 at 6,500. This Plan proposes a cap of no more than 7,500 ICF/MR certified beds including state hospitals and community-based residential facilities.

A. STATE HOSPITALS. Minnesota has eight state hospitals that were serving 2,328 mentally retarded persons as of January 1, 1983. The F.Y. 1982 costs for that service were at $97.98 per day for a total expenditure of $70,781,000. The F.Y. '83 per diem is projected $109.50.

ISSUE (1): WELSCH V. LEVINE CONSENT DECREE. That decree, signed on September 15, 1980, details several stipulations regarding the level (number) and quality (type) of services provided in the state hospitals . A review of the department's performance since the signing of that decree revealed several areas of non-compliance.

Action (1): The department has adopted a policy that it will do everything necessary to achieve full compliance with the Welsch v. Levine Consent Decree. Toward that end, a special Task Force has been appointed to work with the Court Monitor and the attorneys for the plaintiffs to develop a "compliance plan" for the state hospital system. (?)

Rationale: This action is is consistent with this administration's philosophy of deinstitutionalization which includes the provision of quality services to those persons residing in state hospitals while simultaneously developing less restrictive alternatives for them in the community.

Administrative and Legislative Impacts: The administrative impact of this action is an increased control over, and accountability for the delivery of quality services in the state hospitals. Some realignment of functions and responsibilities will be necessary to the extent that full compliance with the Consent Decree can be guaranteed.

Fiscal Impacts: Appropriation requests to enable compliance have been included in the department's biennial budget request. No significant increases are necessary. Full compliance will result in a reduction and/or elimination of expensive compliance hearings before the court monitor and the Federal District Court.

ISSUE (2): CONSOLIDATION OF STATE HOSPITAL SERVICES. At the present time, six of the eight state hospitals are multi-purpose, that is, they serve three separate disability groups. Faribault and Cambridge

State Hospitals serve only mentally retarded persons. Preliminary cost analyses suggest that continued reductions in the total number of persons served by the state hospital systems requires some consolidation (i.e., closure of whole units serving the mentally retarded) if cost savings are to be realized. Further, as deinstitutionalization efforts significantly reduce the overall hospitalized population, entire institutions may need to be closed.

Action A (2): No specific action has been identified at this time. It is expected, however, that at least one mental retardation unit in one of the six multi-purpose institutions will be phased out within the next biennium with that population being consolidated with some combination of an existing state hospital program and community-based programs.

Rationale: As stated in the Issue section, only through whole unit-closures can maximum cost savings be realized when reducing populations. This factor is critical to the development of community alternatives under the Medical Assistance Waiver (Section III) since new alternative services can only be developed with dollars saved with long-term care bed reductions.

Administrative and Legislative Impacts: The major administrative impact of this action will require a comprehensive consolidation plan that accommodates both the residents and employees of a unit targeted for consolidation. The department has demonstrated its ability to effect such actions in the past with the closure of the Hastings and Rochestgr facilities. Legislative action will be required for any total facility closure when such is identified in the future.

Fiscal Impact: No detailed fiscal impact analysis has been done since no specific unit has been identified for consolidation. Generally, it is estimated that approximately 60-70% of the average per diem costs are saved by population reductions and 95-100% savings can be realized with unit closures. Typically, these estimates assume personnel reductions proportional to resident reductions primarily through attrition and transfer.

ISSUE (3): STANDARDIZED ADMISSION AND DISCHARGE CRITERIA. In order to successfully implement subsequent sections detailed in this Plan, several administrative actions will be necessary including the development and monitoring of a statewide set of criteria for admission to state hospital programs with a priority of reducing or eliminating the admission of children to state hospitals and, an accelerated return of all currently placed children to the community. Equal priority will be given to procedures that assure that no inappropriate placements are made when community alternatives are available to persons needing residential treatment services.

Action A (3): The department will establish standardized admission and release criteria for state hospitals (initially) and other components of the mental retardation service system (subsequently) so as to assure appropriate placements in the

least restrictive settings appropriate to mentally retarded persons in need of service. These criteria will be monitored by county level screening committees established as a part of the Mental Retardation/Medical Assistance Program.

Rationale: This action follows the recommendation offered in the LAC report that pointed to the department's general lack of control over systemwide service utilization. In the absence of such criteria and the attendant monitoring of those criteria, it is unlikely that the reductions necessary under the Consent Decree and the MA Waiver formula will be realized.

Administrative and Legislative Impacts: This action will require a coordinated authority within the department to assure systemwide compliance with this policy. Legislative approval of an appropriation sufficient to fund a client-based management information system will be necessary. A description of that system appears in Section IV, Program Control and Cost Containment.

Fiscal Impact: The fiscal impact of this action appears in Section D of this Plan, Program Control and Cost Containment.

ISSUE (4): COUNTY UTILIZATION TARGETS. To assure that the department meets its objective of reducing the number of mentally retarded persons residing in state hospitals as required under the Consent Decree and, to assure the requisite movement of persons into community alternatives planned under the Medical Assistance Waiver (Section III), the Commissioner proposes the establishment of county-based quotas on long-term care bed utilization. There is currently wide variation in county by county utilization of state hospitals for their mentally retarded clients. That variation ranges from a low utilization of 2.2 persons per 10,000 general population to a high of 18.3 per 10,000 with the statewide average being 5.4/10,000. In most instances, the variation reflects the degree to which counties have succeeded in developing community-based alternatives to state hospitals. The absence of incentives to develop those alternatives has typically resulted in utilization of state hospitals when a less restrictive, less expensive alternative would have been more appropriate.

Action A (4): The Commissioner will seek authority to establish reasonable utilization targets that limit the number of persons each county will be able to place in a state hospital. The formula establishing targets will consider current utilization levels, population and statewide goals in such a manner that no county will be unduly penalized for past performance.

Rationale: This action represents one component of a larger effort to establish a statewide plan for the distribution of residential services to the mentally retarded. This action recognizes that statewide controls must be emplaced if the department is to assure that service development and utilization continues within the available fiscal resources. Continued reliance on an open-ended "supply and demand" Medical Assistance model will undoubtedly result in increased deficits and inefficient use of scarce resources.

Administrative and Legislative Impact: This action will be implemented under the authority sought in Action A(3) above, involving the establishment of specific admission and release criteria for state hospitals. Additionally, counties identified as an "over utilizer" of state hospitals will be targeted for technical assistance in developing community-based alternatives. Specific procedures to be employed will be detailed in the comprehensive statewide plan for the equitable distribution of residential and alternative services No legislative impact beyond that described in ActionA(3) is anticipated.

Fiscal Impact: As less expensive alternative settings are developed to serve those persons discharged from the state hospitals and as those reductions permit the consolidation/closure of whole MR units, a net state savings will be realized. The actual cost impacts of this transition are discussed in the last sections of this Plan.

B. COMMUNITY-BASED INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR). The second major component of Minnesota's residential system for the mentally retarded is the ICF/MR program. As of January 1, 1, 1983, Minnesota had 313 separate facilities serving a total population of 4,920 persons. An additional 218 beds have been approved and i are scheduled to open within the next eighteen months bringing the total capacity to 5,138. The F.Y. 1982 costs for this program averaged $50.90 per day for a total expenditure of $68,745,000.

ISSUE (1): LIMITATIONS ON THE CONTINUED EXPANSION OF ICF/MR FACILITIES. The Six-Year Plan estimated a need for a total of 4,650 beds by 1987, a goal that was realized less than two years after the writing of that plan. Development has occurred at a much higher rate than anticipated, and with major differences in utilization of these programs among the eighty-seven counties. Those differences range from a low of 3.1 persons placed in an ICF/MR per 10,000 general population to a high of 26.9 per 10,000 with the statewide average being 8.9 per 10,000. Estimates of persons currently residing in ICFs/MR who could function in a much lower level of care range as high as 20%, or nearly 1,000 persons. The LAC Report offered several specific recommendations that would severely restrict any further development of ICF/MR facilities except for those that are targeted to an area of low development and/or for very specific populations of high need.

ACTION B(l): The department is proposing an absolute limitation of 7,500 certified intermediate care beds for the mentally retarded including state Hospitals and community-based ICF/MR facilities. That proposal seeks legislative authority to restrict any future development of ICF/MR beds except in areas of high need, for specific populations, and only as the number of beds are reduced in the state hospitals or existing community facilities. In no instance will the total number of beds statewide

two years. Existing authority under DPW Rule 185 has not been effective in controlling the growth of beds, nor does it address regional and county differences in the level of development and utilization. A second rationale for this action is the requirement for absolute state control of ICF/MR bed utilization under the Medical Assistance Waiver (Section III) so as to permit the development of less restrictive community alternatives.

Administrative and Legislative Impact: This action will enable the department to frame the necessary cost containment initiatives that will set the stage for: 1) the successful implementation of the Title XIX Waiver, 2) that further over-development of ICF/MR beds does not occur, 3) that all future development will occur only in those areas of highest need and for those specific populations identified as being in highest need. This action will require the department to develop and implement a statewide plan for the distribution and utilization of residential and alternative services for the mentally retarded.

Fiscal Impact: One major fiscal impact of this action will be the establishment of an absolute cap on the number of dollars expanded for all ICF/MR beds. Expenditures will no longer exceed projections since new beds in the community must be matched with comparable bed reductions in the state hospitals or existing ICF/MR beds in the community. In addition, certain MA formula incentives could encourage a county to develop alternative services to long-term care for mentally retarded.

ISSUE (2): THE FINANCING OF ICF/MR FACILITIES UNDER DPW RULE 52. The LAC Report detailed several areas of deficiencies in the way ICF/MR services are financed through the department's reimbursement rule. Those deficiencies have resulted in disincentives to efficient management of programs, vast differences in certain cost categories among programs, and the lack of limits on such things as interest expense and property related costs. Changes were also recommended in administrative procedures that would reduce the amount of time for the setting of rates and the resolutions of a large backlog of appeals.

ACTION B(2): The department is proposing legislation that amends DPW Rule 52 in each of the areas identified as deficient in the LAC Report.

Rationale: The rationale for this action is cost-containment and better management control over the ICF/MR system. Legislative action is requested that gives the department immediate authority to implement specific procedures in the reimbursement process that resolve those deficiencies.

Administrative and Legislative Impacts: The impact of this action will significantly change the administration of DPW Rule 52, both In the area of rate setting and in more equitable levels of reimbursement for ICF/MR services.

Fiscal Impact: The fiscal impact analysis of the proposed changes in Rule 52 have not been completed. The results of those analyses will accompany the legislative proposal when it is finalized.

SECTION II. DAY PROGRAM SERVICES

The day program service at issue in this plan are those services-provided to the approximately 5,399 mentally retarded persons attending the 107 Developmental Achievement Centers (DACs) in Minnesota. The issue of the funding of these services was studied and reported in a document submitted to the 1983 legislature on February 15, 1983. That document was entitled, "A Preliminary Report on the Funding of Developmental Achievement Centers and Semi-Independent Living Services in Minnesota." That document should be read for a detailed discussion of the issues presented below.

ISSUE (1): THE FINANCING OF DACs FOR RESIDENTS OF ICF/MR FACILITIES. This issue was examined and detailed in the Preliminary Report on Developmental Achievement Centers and Semi-Independent Living previously submitted. Several developments have surfaced over the past two years that have made the funding of DACs a major issue confronting the department. The most important of those developments was declining county resources resulting in service cutbacks in certain counties. Actions at both the Minnesota Supreme Court level and the U.S. Federal District Court level have dictated the need for a solution to this problem. Given the complex and interdependent nature of this Plan of Action that focuses on the use of the Medical Assistance Program, the action proposed represents the "best solution" to the problem.

ACTION II (1): The Department is proposing to increase the Medical Assistance appropriation sufficient to fund training and habilitation services (DAC), required by residents of ICFs/MR, through the Medical Assistance Program.

Rationale: This action removes the fiscal disincentive to counties to place persons in need of residential care and treatment in less restrictive community-based ICF/MR programs. It does so by equalizing the costs to counties for community-based and state hospital ICF/MR level of care. It further assures the provision of "active treatment," as required in federal regulations and, assures that this service will be provided outside the residential facility as required in state rule. Since service reductions are no longer permissible under the 1982 Minnesota Supreme Court Ruling (Swanson v. Noot), and since the use of Title XX for habilitation services to residents of ICFs/MR is prohibited by Social Security regulations, this action will relieve a major burden on limited county resources.

Administrative and Legislative Impact: This action requires an amendment to the Medical Assistance state plan to authorize payment for habilitation services to residents of ICF/MR facilities under the Medical Assistance Program. A procedure under consideration by the department involves the development of a three-party agreement among the county board. DAC and ICF/MR facility for the provision of such services. In addition, the county case manager must sign off and approve the provision of these services on an individual contract basis. Legislative action is required to authorize the Commissioner to reduce each

county's CSSA appropriation for transfer to the Medical Assistance account for state match. Those reductions will be proportional to the number of ICF/MR residents each county has in an ICF/MR and who attend a DAC. The rate of payment for DAC participants will be computed according to the formula detailed in the proposed legislation.

Fiscal Impact; The total costs of daytime training and habilitative services for clients from community residential facilities are estimated at 16.9 million in F.Y. '84 and 19.7 million in F.Y. '85. The amount of state dollars needed to match the Medical Assistance budget is 7.5 million in F.Y. '85 and 8.5 million in F.Y. '85, totalling 16.0 million for the next biennium.

If the entire 16.0 million were taken from the proposed CSSA appropriation, the following amounts of Title XX and local tax dollars would be "reallocated" for use by county boards: 8.6 million in F.Y. '84 and 10.3 million in F.Y. '85.

ISSUE (2): THE FINANCING OF DAC SERVICES TO NON-ICF/MR PARTICIPANTS. The actions recommended below for this group of DAC participants are necessary for several reasons and are discussed in the rationale section. These actions relate directly to the requirements under the Title XIX Waiver proposal discussed in Section III.

ACTION II(2): To fund habilitation services under a Medical Assistance Waiver for all persons placed from a state hospital or community-based ICF/MR into a community-based alternative waivered service and to continue funding all other DAC participants with CSSA appropriations as a social service.

Rationale: Funding training and habilitation as a waivered service for persons leaving the more expensive residential settings will encourage counties to develop and use less expensive community alternatives. The array of those services are briefly described in the next section of this Plan.

Furthermore, since the services currently provided by DACs do not meet the federal definition of rehabilitative services, it is not considered possible to certify DACs as medical vendors. Secondly, since eligibility for waivered services must include MA eligibility and "at risk of imminent placement into a long-term ~ care facility," a case would have to be made that the termination of DAC services would result in placement into an ICF/MR. Finally, since waivered services must be funded with savings generated either from projected ICF/MR diversions or from a reduction of certified beds, insufficient savings would be generated to meet the total costs of this latter group.

Fiscal Impacts: The fiscal impact of funding DAC services under the Waiver for dischargees of ICFs/MR and state hospitals are presented in Section III. The fiscal projections of continued funding of all other DAC participants under CSSA are:

F.Y. 1984 = 19.3 million
F.Y. 1985 = 18.1 million
Biennial Total = 37.4 million

These costs include serving adult clients not from an ICF/MR or in a waivered service and all preschool children. CSSA costs for developmental achievement services are reduced as the use of waivered services are accelerated in F.Y. '85 for clients from state hospitals and community residential facilities.

SECTION III. COMMUNITY-BASED ALTERNATIVE SERVICES

There are currently only two types of state-subsidized community-based alternatives to ICF/MR placement administered by DPW; semi—independent living services (SILS) and the Family Subsidy Program for up to 200 children. This section of the Plan describes a proposal which represents a major departure in the way services have been provided to the mentally retarded over the past several decades. It does so by proposing a broad array of services as alternatives to ICF/MR placement. It is the cornerstone of this Plan of Action and as a result, is given the majority of treatment in this document.

ISSUE (1): HOME AND COMMUNITY-BASED SERVICES WAIVER. Congress, as part of the Omnibus Budget Reconciliation Act of 1981 (P. L. 97-35) under Section 2176 enacted a provision giving states the opportunity to apply for a waiver of certain Medicaid statutory limitations in order to allow states to develop home and community-based services for eligible persons who would otherwise require placement in Intermediate Care Facilities and other costly long-term care facilities. The legislation responded to at least two factors: an attempt to address the funding bias toward institutional care under Title XIX and to achieve cost containment in the long-term care by encouraging the development of an array of home and community-based service options. Under the Home and Community-Based Services Waiver, Medicaid funds may be expended for case management services, homemaker services, home health aide services, personal care services, adult day care services, habilitation services, respite care services, and other select services as defined by the states.

Minnesota has the highest number of out-of-home placements in ICF/MR facilities in the nation, both institutional and community-based. This waiver will assist Minnesota in reducing its rate of out-of-home placements, as well as controlling its long-term care costs for the mentally retarded. Cost containment is integral to the waiver process and costs are specifically contained within three areas. First, to apply for the waiver, particular numbers of eligible individuals are to be targeted for services from the array of permitted services. Once the indicated number of individuals have been served and the allocated dollars have been expended, no further expenditures are made and further potential service recipients are wait-listed. Second, the waiver request requires careful screening of potential service recipients according to objective criteria in order for services to be provided. This screening mechanism can lessen the probability of serving individuals not appropriate for services and can identify for eligible individuals those options which are less costly but which meet their individual needs. Third, the waiver request requires the state to demonstrate that the use of the waiver would not result in greater overall expenditures than would be projected under the existing narrower array of services for mentally retarded persons. In addition, costs under the waiver may be contained by limiting the geographic area within a state for which the waiver is sought.

In addition to cost containment, another important consideration is the integration of the waivered services within the social and human

services administrative system in Minnesota. A review of mechanisms for implementing waivered services reveals that the decentralized county-based system of human and social services administration can be meshed with the requirements of the waiver process and that the waiver can be properly employed to strengthen the capacity of counties to identify, plan for, and ensure the provision of services to individuals in need.

ACTION (1): To apply for the Home and Community-Based Waiver under Section 1915(c) of Title XIX of the Social Security Act for mentally retarded persons currently residing in ICF/MR programs or determined to be at imminent risk of institutional placement in the next biennium.

Rationale: The purpose of this action is to provide an array of alternative community-based services appropriate to the needs of mentally retarded persons residing in or "at risk" of residing in a state hospital or a community-based ICF/MR, and to provide those alternative services at a rate less than the cost of ICF/MR placement. The aggressive development and provision of these alternative services will result in an accelerated reduction of the mentally retarded population in state hospitals and reductions in the number of ICF/MR beds in community-based programs. This action also responds to a primary recommendation in the LAC Report that strongly suggests the development of such services.

The proposed array of alternative home and community-based services to be funded under the waiver include:

1. Case Management. This most critical service involves client identification, needs assessment, individual service planning, arrangement for provision of ser vices, and supervision of implementation of the plan of service. This service will be integrated into the existing county case management function.

2. Comprehensive Family Training and Support. This program is provided according to a Family Service Plan prepared under the leadership of a county case manager, for the purposes of maintaining a child in his/her natural family home. This is accomplished through the provision of services of varying intensities and durations including homemaking and in-home training to parents and siblings, respite services in and out of the family home, and specialized services and therapies. When necessary, an additional deeming waiver (Katie Beckett) could be used to assure that the necessary level of medical service is provided to the child in his/her home.

3. Developmental Training Homes. This program involves provision of habilitative services to children and adolescents with special needs in the areas of medical/nursing care or behavioral excesses in settings

of up to three clients with adjunct services of specialized training, respite, and support staff. This program is targeted to address the needs of children and adolescents who would otherwise require ICF/MR or state hospital placement.

4. Supervised Living Arrangements. This program offers intensive habilitative services to mentally retarded adults with specialized needs in the areas of medical/nursing care or behavioral excesses in settings up to six clients with adjunct services of specialized training, respite, and support staff. Similar to the Developmental Training Home for Chil dren, this program is targeted to address the needs of adults who would otherwise require ICF/MR or state hospital placement.

5. Semi-Independent Living Services. This program provides habilitative, homemaker, and home health services as indicated in an individual service plan to enable individuals to be placed or remain in a variety of independent community settings. As a waivered service, this program will be targeted to individuals currently placed in an ICF/MR or a state hospital.

6. Adult Day Habilitative Services. This service is provided to an individual for the development of independent living skills and community survival skills for mentally retarded adults. Individuals eligible for this service are those who have been placed from an ICF/MR facility or a state hospital into a waivered alternative service funded through the waiver provision.

ADMINISTRATIVE AND LEGISLATIVE IMPACTS: The major administrative impact of this action involves the development of a comprehensive implementation and management plan for the Mental Retardation/Medical Assistance Program. That plan will combine all management functions affecting Medical Assistance expenditures into a centralized planning and management authority. The requisite component of that implementation and management plan are described in Section IV of this document. Legislative authority to apply for and implement a home and community-based services waiver is requested in the attendant legislation.

Fiscal Impact: Table 1 shows the number of clients served and the total costs of serving them without the waiver. Table 2 shows the number of clients served and the total costs of serving them with the waiver. Table 3 shows the differences between serving clients with and without the waiver.

Preliminary fiscal projections indicate that the aggressive development of alternative service to intermediate care could save substantial dollars when compared to historical growth patterns

in long-term care. Estimates indicate the following savings by year.

F.Y. 1984	=	$1,167,000
F.Y. 1985	=	$8,476,300
F.Y. 1986	=	$19,081,900
F.Y. 1987	=	$31,505,500

These savings are specifically "tied" to the movement out of long-term care into alternative services. If such movement does not take place or if beds are immediately refilled, there is no savings generated by the waiver.

The savings under the waiver increase at an accelerating rate. For the first year and one half, one should not expect significant saving.

Therefore, it should be noted that these cost projections are preliminary projections and highly dependent upon the legislative controls sought and listed in the previous sections.

In addition to the cost of the waivered services, the impacts of other state and/or county funded programs needs to be considered. The additional cost to MSA budget is estimated at 156,000 in F.Y. 1984 and l.2 million in F.Y. 1985. Additional out-patient medical services are projected at $112.300 in F.Y. 1984 and $469,820 in F.Y. 1985.

ISSUE (2): THE FUNDING OF SEMI-INDEPENDENT LIVING SERVICES (SILS)

ACTION 1. To fund SILS as a waivered service for all persons transferred out of a state hospital or community-based ICF/MR, to continue funding existing "at risk" SILS clients under the state/county SILS appropriation and to transfer funding of non-MA eligible SILS clients to CSSA as proposed in Department's Biennial Budget.

Rationale: This action is taken to encourage placement of long-term care residents into a less restrictive community alternative. To attempt to fund existing SILS clients under a waivered service would constitute a refinancing of an existing state supported program, a funding shift prohibited by federal regulations. Given the rate of turnover in SILS, it can be expected the vast majority of SILS clients will be covered under the waiver with three years from the inception of this Plan.

Finally, since non-MA eligible clients would not qualify for either long-term care or a waivered service, funding services for this group is a logical function of CSSA.

Administrative and Legislative Impacts: The administration of the state appropriated SILS program will continue as in the past. Legislative action is required to appropriate the request in the department proposed biennial budget.

Fiscal Impact: The fiscal projection of costs for this group are included in Tables 1 and 2. No additional state costs are under the waiver. Proposed budgets for the state grant program remain the 6ame as in the department's biennial budget.

Table 1

March 1983
Preliminary Cost Projections

Number of Clients Served and Total Costs by Service
Without Home and Community-Based Waiver Funded
Under Medical Assistance*
(In Thousands of Dollars)

	F.Y. 1983		F.Y. 1984		F.Y. 1985		F.Y. 1986		F.Y. 1987	
	Number of Clients	Total Costs	Number of Clients	Total Costs	Number of Clients	Total Costs	Number of Clients	Total Costs	Number of Clients	Total Costs
I. RESIDENTIAL										
A. State Hospitals[1]	2,262	$ 86,411.0	2,128 (-134)	$ 87,584.0	2,015 (-113)	$ 89,353.0	1,948 (-67)	$ 93,668.0	1,880 (-68)	$ 96,771.0
B. Community Residential[2] Facilities	4,570	$ 86,532.0	4,850 (+280)	$103,396.0	5,130 (+280)	$123,785.0	5,410 (+280)	$140,985.0	5,690(+280)	$160,145.0
C. Developmental Training Homes	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
D. Supervised Living Arrangements	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
II. DAY PROGRAMS										
A. Day Habilitation for ICF/MR Clients[3]			2,300 ~~2,863**~~	500 too many 16,919.0	3,088**	19,711.0	3,425**	23,944.0	3,537**	26,704.0
B. Day Habilitation for Clients Not From ICFs/MR			-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
III. SUPPORTIVE SERVICES										
A. In-Home Family Supports			-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
B. Case Management			-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
C. Semi-Independent Living			-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
IV. TOTAL COSTS	6,832	$172,943.0	6,978	$207,889.0	7,145	$232,849.0	7,358	$257,997.0	7,570	$283,620.0
ADJUSTED CLIENT TOTALS[4]	7,166		7,312		7,479		7,692		7,904	

*Consult the back of this table for specific methodologies.
**Day habilitation client counts are included in the counts specified on line I.B.

DISCUSSION OF TABLE 1

1. State hospital fiscal projections were estimated by the Income Maintenance Bureau, for F.Y. 1983 through F.Y. 1985. For F.Y. 1986 and 1987, 8% increases were made to the average monthly cost per client for each year. The projections were as follows:

	Numbers of Clients	Average Monthly Cost/Client	Total Cost
F.Y. 1983	2262	$3,183.44	$86,411,000
F.Y. 1984	2168	$3,429.84	$87,584,000
F.Y. 1985	2015	$3,695.31	$89,353,000
F.Y. 1986	1948	$3,981.33	$93,668,000
F.Y. 1987	1880	$4,289.78	$96,771,000

2. Fiscal projection for community-based residential facilities were based on an updating of the current forecast published by the Income Maintenance Bureau. An adjustment of the client count was made in F.Y. 1983 (from 4,344 to 4,570 clients). The projections are:

	Numbers of Clients	Average Monthly Cost/Client	Total Cost
F.Y. 1983	4570	1,577.90	86,532,000
F.Y. 1984	4850	1,776.56	103,396,000
F.Y. 1985	5130	2,010.81	123,785,000
F.Y. 1986	5410	2,171.67	140,985,000
F.Y. 1987	5690	2,345.41	160,145,000

For F.Y. 1986 and 1987, the average monthly cost per client was increased by 8% each year. The above projection will be updated by April 15, 1983 by the Income Maintenance Bureau.

3. Inclusion of the costs for day training and habilitation for clients from community residential facilities is consistent with Action II(1) page 19.

4. Adjusted Client Total - The client totals have been adjusted upward to reflect occupancy rates (97.8%) and the number of billing processed each month. For example, in December 1982 there were 4,896 beds certified as ICF/MR in the community (in 309 facilities). The number of MA eligibles in those beds were 4,738 or 97.8% of the total number of beds. Of the 4,738 MA eligibles, 4,568 payments were processed or 94.3 percent of the total number of certified beds. Eighty-six beds licensed under Rule 34 are not certified as ICF/MR beds.

.60 X = 2300 3830
X = .60) 230000.
180
500
480
200

3830
2300
1530

Table 2

March 1983
Preliminary Cost Projections

Number of Clients Served and Total Costs by Service
With Home and Community-Based Waiver Funded
Under Medical Assistance
(In Thousands of Dollars)

	F.Y. 1983 Number of Clients	F.Y. 1983 Total Costs	F.Y. 1984 Number of Clients	F.Y. 1984 Total Costs	F.Y. 1985 Number of Clients	F.Y. 1985 Total Costs	F.Y. 1986 Number of Clients	F.Y. 1986 Total Costs	F.Y. 1987 Number of Clients	F.Y. 1987 Total Costs
I. RESIDENTIAL										
A. State Hospitals	2,262	$ 86,411.0	2,096 (-168)	$ 86,267.0	1,856 (-240)	$ 82,302.0	1,600 (-256)	$ 76,442.0	1,320 (-280)	$ 67,950.0
B. Community Residential Facilities	4,570	$ 86,532.0	4,790 (+220)	$102,117.0	4,590 (-200)	$110,775.0	4,384 (-206)	$114,247.0	4,164 (-220)	$117,195.0
C. Developmental Training Homes	-0-	-0-	14	$ 165.6	105	$ 1341.1	206	$ 2,841.6	313	$ 4,663.1
D. Supervised Living Arrangements	-0-	-0-	37	$ 656.3	280	$ 5,364.2	540	$ 11,173.1	834	$ 18,636.6
II. DAY PROGRAMS										
A. Day Habilitation for ICF/MR Clients	-0-	-0-	2,863*	16,919.0	3,088*	19,711.0	3,425*	23,944.0	3,537*	26,704.0
B. Day Habilitation for Clients Not From ICFs/MR (All SLA + 33% SICS)	-0-	-0-	46	$ 286.2	350	$ 2,351.7	677	$ 4,908.9	1,043	$ 8,175.0
III. SUPPORTIVE SERVICES										
A. In-Home Family Supports	-0-	-0-	14	$ 82.8	105	$ 670.5	206	$ 1,420.8	313	$ 2,331.5
B. Case Management	-0-	-0-	92	$ 92.0	699	$ 754.9	1,374	$ 1,602.1	2,086	$ 2,626.3
C. Semi-Independent Living	-0-	-0-	28	$ 136.1	210	$ 1,102.3	412	$ 2,335.6	626	$ 3,833.0
IV. TOTAL COSTS	6,832	$172,943.0	6,978 (+146)	$206,722.0	7,358 (+167)	$224,372.7	7,358 (+213)	$238,915.1	7,570 (+212)	$252,114.5
ADJUSTED CLIENT TOTALS	7,166		7,312		7,479		7,692		7,904	

Discussion of Table 2

What are the ways that adm/readm. will be stopped?

1. State Hospitals

An accelerated reduction of the state hospital population is required under the waiver to achieve 1,856 by July, 1985. This requires averting most admissions to state hospitals and increasing the current rate of demissions from state hospitals. The average annual net reductions for the state hospitals currently are 100 clients per year. This number would be increased to 125 clients in F.Y. 84 and 240 clients in F.Y. 85 under the waiver.

Since state hospitals are currently 95% in compliance with court-ordered staffing levels, a reduction in the client population can result in a reduction in staffing. Staffing constitutes approximately 85% of the state hospital budget. The "fixed" cost constitutes 15% of state hospital budget.

Since consolidation of state hospital units will be taking place, it was assumed that most of the per diem would transfer into community-based programs.

2. Community-Based ICF/MRs

Through the aggressive provision of developmental training homes services, in-home family supports services and supportive living services, the projected increases of ICF/MR beds can be averted and the total number of ICF/MR beds reduced. However, the following is needed to accomplish this:

a. A moratorium on new development unless demonstrated that such development is needed for the placement of state hospital clients; for example, specialized Class B beds.

b. Any ICF/MR development be offset by a comparable number of ICF/MR beds which would be decertified.

c. Commissioner and County must redetermine the need, location and program for community residential facilities and determine programs that would be decertified.

d. Developing and enforcing specific long-term care targets for mentally retarded by county of responsibility.

3. The rates of growth projected for developmental training homes and in-home family supports were based on averting all ICF/MR admissions, as well as serving clients from the community imminently "at risk" of ICF/MR placement. Supervised living arrangements have been dramatically increased over current projections to prevent placements into ICF/MR for adults and place clients from ICFs/MR into supervised living arrangements. The residential program mix was determined by using the following percentages:

Developmental Training Homes	- 15%
In-home Family Support	- 15%
Supervised Living Arrangements	- 40%
Semi-Independent Living	- 30%
	100%

Case management was projected for each client participating in waivered services. The amount of day habilitation need was determined by assuming 100% of the clients placed into supervised living arrangements and 33% of the clients placed into SILS would need DAC services.

4. In F.Y. 84, placements under waiver were projected to begin in January, 1984.

Case management was projected to be available for 100% of the clients participating in waivered services. The amount of day habilitation needed was determined by assuming 100% of the clients placed into supervised living arrangements and 33% of the clients placed into semi-independent living services would need day program services.

Table 3

March 1983
Preliminary Cost Projections

The Difference from the Number of Clients Served and Total Costs by Service
With and Without the Home and Community-Based Waiver Funded
Under Medical Assistance
(In Thousands of Dollars)

	F.Y. 1983		F.Y. 1984		F.Y. 1985		F.Y. 1986		F.Y. 1987	
	Number of Clients	Total Costs	Number of Clients	Total Costs	Number of Clients	Total Costs	Number of Clients	Total Costs	Number of Clients	Total Costs
I. RESIDENTIAL										
A. State Hospitals	-	-	-34	-$1,317.0	-127	-$ 7,051.0	-189	-$16,626.0	-212	-$28,821.0
B. Community Residential Facilities	-	-	-20	-$1,279.0	-480	-$13,010.0	-486	-$26,738.0	-500	-$42,950.0
C. Developmental Training Homes	-	-	14	165.6	105	$ 1,341.1	206	$ 2,841.6	313	$ 4,663.1
D. Supervised Living Arrangements	-	-	37	656.3	280	$ 5,364.2	540	$11,173.1	834	$18,636.6
II. DAY PROGRAMS										
A. Day Habilitation for ICF/MR Clients	-	-	46	$ 286.2	350	$ 2,351.7	677	$ 4,908.9	1,043	$ 8,175.5
B. Day Habilitation for Clients Not From ICFs/MR	-	-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
III. SUPPORTIVE SERVICES										
A. In-Home Support	-	-	14	$ 82.8	105	$ 670,5	206	$ 1,420.8	313	$ 2,331.5
B. Case Management	-	-	92	$ 92.0	699	$ 754.9	1,374	$ 1,602.1	2,086	$ 2,626.3
C. Semi-Independent Living	-	-	28	$ 136.1	210	$ 1,102.3	412	$ 2,335.6	626	$ 3,833.0
IV. TOTAL COSTS	-	-	-	$1,167.0	-	$ 8,476.3	-	$19,081.9	-	$31,505.5

Table 4

March 1983
Preliminary Cost Projections

Projected Service Cost Under Medical Assistance
Under Medical Assistance*
(In Thousands of Dollars)

RESIDENTIAL	F.Y. 1983 Annual Costs Per Client	F.Y. 1984 Annual Costs Per Client	F.Y. 1985 Annual Costs Per Client	F.Y. 1986 Annual Costs Per Client	F.Y. 1987 Annual Costs Per Client
A. State Hospitals	$38,201	$41,158	$44,344	$47,776	$51,477
B. Community Residential Facilities	$18,935	$21,319	$24,130	$26,060	$28,145
C. Developmental Training Homes	-	$11,826	$12,772	$13,794	$14,898
D. Supervised Living Arrangements	-	$17,739	$19,158	$20,691	$22,346
DAY PROGRAMS					
A. Day Habilitation for ICF/MR Clients	$ 5,760	$ 6,221	$ 6,719	$ 7,257	$ 7,838
B. Day Habilitation for Clients Not From ICFs/MR	$ 5,760	$ 6,221	$ 6,719	$ 7,257	$ 7,838
SUPPORTIVE SERVICES					
A. In-Home Support	-	$ 5,913	$ 6,386	$ 6,897	$ 7,449
B. Case Management	-	$ 1,000	$ 1,080	$ 1,166	$ 1,259
C. Semi-Independent Living	$ 4,500	$ 4,860	$ 5,249	$ 5,669	$ 6,123
OUTPATIENT MEDICAL	$ 2,949	$ 3,304	$ 3,700	$ 4,144	$ 4,641

*All costs were projected at an 8% increase per year except for outpatient medical costs (projected at 12% per year) and state hospital and community residential facility costs.
*Consult the back of this page for further methodologies.

DISCUSSION OF TABLE 4

PROJECTED SERVICE COSTS

1. Of total State Hospital costs for mentally retarded, in F.Y. 1983, 91.5% is estimated to be reimbursed by Medical Assistance.

2. Costs for Developmental Training Homes and In-home family supports were determined by surveying three existing operators operating these types of services in F.Y. 1983. Cost increases were inflated at 8% per year in F.Y. 1984 through 1987.

3. The F.Y. 1983 costs for case management were projected based on the cost of $25,000 per case worker having a case load of 25 persons. The 25,000 included the worker's salary, benefits and travel.

4. Projections for semi-independent living services has been increased from current projections to account for serving more clients with greater need from ICF/MR programs.

5. Developmental Achievement costs are based upon 8% per diem increases and the increased demands defined in Funding Options Paper (January, 1983).

Table 5

March 1983
Preliminary Cost Projections

A Summary of the Costs of Developmental Achievement and Semi-Independent Living Services
By Source of Funding
(In Thousands of Dollars)

	F.Y. 1984		F.Y. 1985		F.Y. 1986		F.Y. 1987	
	Number of Clients	Total Costs	Number of Clients	Total Costs	Number of Clients	Total Costs	Number of Clients	Total Costs
I. DEVELOPMENTAL ACHIEVEMENT SERVICES								
A. Medical Assistance								
1. For ICF/MR Clients	2,863	$16,919.0	3,088	$19,711.0	3,425	$23,944.0	3,537	$26,704.0
2. For clients placed from ICF/MR (waivered)	46	$ 286.2	350	$ 2,351.7	677	$ 4,908.9	1,043	$ 8,175.0
B. CSSA								
1. For remaining adults	1,662	$10,339.3	1,295	$ 8,701.1	791	$ 5,740.3	473	$ 3,707.4
2. For preschool children*	1,400	8,943.7	1,400	9,479.4	1,400	10,048.3	1,400	10,651.1
C. TOTAL	5,971	$36,487.7	6,133	$40,243.2	6,293	$44,641.5	6,453	49,237.5
II. SEMI-INDEPENDENT LIVING SERVICES								
A. Medical Assistance for Clients from a state hospital-based or community-based ICF/MR	28	136,1	210	1,102.3	412	2,335.6	626	3,833.0
B. State grant for clients at risk of institutional placement**	696	2,342.0	724	2,557.2	675	2,573.1	600	2,470.2
C. CSSA for clients not at risk of institutional placement to be transferred on 1/1/84	247	593.9	247	555.0	-	-	-	-
D. TOTAL	971	3,072.0	1,081	4,214.5	1,087	4,908.7	1,226	6,303.2

*Preschool DAC budgets projected at 6% increase
**Projection for SILS under the state grant program is consistent with budget projections.

SECTION IV. PROGRAM CONTROL AND COST CONTAINMENT

The redesign of the mental retardation service system proposed in this Plan will require management control strategies different than those exercised in the past. Several factors underscore the need for sophisticated planning and control of the various components of an increasingly complex and distributive system of human services.

Not only was this need identified in the Legislative Audit Commission study, but also by an extensive examination of the management requirements of implementing a home and community-based services waiver under the Medical Assistance Program. Administrative resources in the department do not currently exist in sufficient quantity to accomplish this task.

Congress, in its enactment of the legislation permitting states to modify its long-term care system recognized this need. And, as a result has authorized significant federal resource match to administer this program. This Plan advocates the maximum utilization of those federal resources to design an administrative unit to manage the Mental Retardation/Medical Assistance Program in Minnesota.

ISSUE (1): THE MANAGEMENT OF THE MENTAL RETARDATION/MEDICAL ASSISTANCE PROGRAM. This Plan will not be implemented before the requisite management strategies it demands are in place. No part of this plan was developed without lengthy discussions on the management requirements it entailed. This administration is committed to sound management practices and will institute those changes considered necessary to assure the successful implementation of all actions described herein.

Action V(1): The department, as a part of a comprehensive implementation plan will constitute a Mental Retardation/Medical Assistance unit with centralized planning and control authority. The functions of this unit will be clearly delineated and will include at least the following:

1. Development of a client information system that includes client tracking, evaluation, and identification of unmet needs.

2. Development of standardized rate structures for all community services. This may include a scaling system within the particular service.

3. Development of admission and placement criteria for all services including state hospitals. This criteria will then be monitored by the State and county for enforcement.

4. Prior authorization by the MR/MA unit for any **admissions** to state hospitals or ICF/MRs.

5. Development of an array of cost-effective alternative to community ICF/MRs and state hospitals utilizing the Title XIX Waiver Authority.

6. Analysis, and subsequent removal, of any fiscal disincentives to community (non-ICF/MR) placement.

7. Transfer of administrative and financial responsibility for Title XIX services for MR clients to the MR/MA unit.

8. Establishment and reinforcement of county case managers as the point of entry into the community system.

9. Coordination of and assistance with the billing and reimbursement systems under the MMIS.

10. Development and delivery of **training systems** for providers of various MA funded services.

11. Development and promulgation of rules and standards of performance for all new services including case management and quality assurance.

12. Provide consultation and technical assistance to county agencies and service providers on the implementation of this Plan.

Rationale: This rationale for this action goes beyond a commitment to cost containment in an era of limited resources. It is absolutely mandatory if the provisions required under the MA Waiver Authority are to be met. Not only do the projections for service levels need to be as accurate as possible, they must also be monitored to assure they are not exceeded. The arguments for efficiencies, economies and programmatic benefits of a distributive system of services can be won only if the implementation of such a system is predicated on the availability of an effective management plan. This Plan of Action was developed with a full awareness of that fact.

Administrative and Legislative Impact: The administrative impact of this action is significant in that several realignments of control functions will be necessary. Also, new reporting control functions will be designed in those service areas where nothing currently exists. Legislative authorization for case management screening teams, and additional line items for administrative personnel will be necessary.

Fiscal Impact: The fiscal impact of this administrative action will be computed in the implementation plan. As stated above, maximum federal reimbursement will be sought for all administrative costs associated with the implementation of this program.

SECTION V. LEGISLATION

Legislation is being drafted to implement the actions identified in each of the above sections.

A. Actions in Section I. A. needing legislation include: (1) a cap of 7,500 certified beds, (2) establishment of a standardized admission and release criteria, (3) appropriation for a client-based information system, and (4) county-based targets for the utilization of long-term care beds.

Legislation:

Amend Minnesota Statutes 252.28 to accomplish above.

B. Actions in Section II. B. needing legislation include: (1) cost containment measures, (2) rate setting and reimbursement for ICF/MR ser vices.

Legislation:

Amend Minnesota Statutes 252.28 to include the authorization of new beds only to replace decertified beds in those regions of the state that are substantially short of community-based alternatives needed to reduce utilization of state hospitals.

Amend Chapter 256B to establish procedures for determining reasonable rates for care in ICF/MR facilities.

C. Actions in Section III. needing legislation include: (1) increase in Medical Assistance appropriation to fund training and habilitation services for residents of ICF/MR facilities, (2) transfer CSSA appropriations to MA, and (3) establish rate setting for reimbursement to DACs.

Legislation:

Amend Minnesota Statutes 256E.06 to authorize transfer of up to $16 million from the biennial CSSA appropriation beginning July 1, 1983.

Amend Minnesota Statutes 252.24 to clarify that county board responsibilities for the administration of developmental achievement services includes training and habilitation services provided by DACs to residents of ICF/MR facilities.

Amend Minnesota Statutes 256B.02, Subd. 8, to include training and habilitation services for payment under the Medical Assistance Program.

Amend Chapter 256B to establish method of rate setting for training and habilitation services.

D. Actions in Section III. needing legislation includes authority to apply for and implement a home and community-based waiver.

Legislation:

Amend Minnesota Statutes 256B.02, Subd. 8, to include: (1) case management services, (2) comprehensive family training and support services, (3) developmental training homes, (4) supervised living arrangements, (5) semi-independent living services, and (6) training and habilitative services, for payment under the Medical Assistance Program.

E. Actions in Section IV. needing legislation include: (1) establishment of case management screening teams, and (2) additional line item positions for administration of the Mental Retardation Program.

Legislation:

Amend Chapter 256B to combine county case management with that of screening MA eligible mentally retarded persons, and establish case manager responsibility for the authorization and termination of services in accordance with individual service plans.

Summary:

This Plan involves major changes in the manner in which programs and services are developed and managed in Minnesota. It was developed out of recognition and belief that such changes are needed. With the support of the Legislature, it is expected that the changes proposed will improve Minnesota's service system for the mentally retarded in a cost-effective, program accountable manner.