1996 - 97

Services to Minnesotans with Developmental Disabilities

A Report to the Citizens and Legislature of the State of Minnesota from the Department of Human Services

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Cost of Preparing the State Plan for Services to Minnesotans with Developmental Disabilities

The cost of preparing the biennial state plan on services to Minnesotans with Developmental Disabilities is provided to comply with the requirements of Minnesota Statutes, section 3.197. The plan was prepared by staff of the Division for Persons with Developmental Disabilities. The cost in staff time for preparation is estimated at $1,507.00. The cost for printing is estimated at $1,435. Mailing costs are estimated at $2,134. The estimated total cost for preparing this report is $5,076.00.

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The Department of Human Services acknowledges the dedication of Minnesota's case managers, case management supervisors, and service providers. Because of their efforts and commitment, Minnesota has moved closer to achievement of its goals pertaining to services for persons with developmental disabilities.

The Department of Human Services is also grateful to staff of the University of Minnesota Institute on Community Integration and the Governor's Planning Council for Developmental Disabilities. Their willingness to collaborate with the Department on numerous projects has contributed to improvements in the state's service system for individuals with developmental disabilities.

TABLE OF CONTENTS

Executive Summary iii

I. Mission and Obligations 2

II. Values 3

III. Services Available for Persons with Developmental Disabilities 4

Case Management 4

Support Services 5

Facility-Based Services 12

Homes 14

IV. Trends in Services and Supports 17

V. Objectives and Priorities 19

VI. Conclusion 25

Executive Summary

This 1996-1997 Biennial State Plan for Minnesotans with Developmental Disabilities was prepared for the legislature of the State of Minnesota in accordance with Minnesota Statutes, section 252.291, subdivision 3, which requires the Commissioner of the Department of Human Services to develop a [biennial] state plan for the delivery and funding of residential support services for persons with mental retardation or a related condition. This report describes services available to Minnesotans with mental retardation or a related condition, discusses trends in services and expenditures, and specifies the values, legislation, and appropriations that help define Minnesota's objectives for the development and management of residential and support resources during the coming biennium.

Trends in Services and Expenditures

Minnesota's services for persons with developmental disabilities emphasize support for families, inclusion into community residential, vocational, and leisure environments, and involvement of families and consumers in decisions that affect them. Among the most notable trends in services to persons with developmental disabilities is Minnesota's decreasing reliance on large, congregate living arrangements and its emphasis on developing community-based homes for one to six people. Commitment to community living is demonstrated by:

(1) a decline in the number of people with developmental disabilities residing in Minnesota's regional treatment centers from nearly 3,000 in 1978 to 610 in January 1995;
(2) a dramatic increase in the number of people served by Developmental Disabilities Waivers from a few hundred in the mid-1980's when waivered services first became available to over 4,000 in January 1995;
(3) extension of service eligibility for Semi-Independent Living Services (SILS) to persons who need more than 90 days of daily intervention per year as well as provision of vouchers, cash grants, and housing allowances; and
(4) as of January 1995, moves by 90 people with developmental disabilities who had been screened and found to be placed inappropriately in nursing homes to community homes through the Alternative Community-Based Services (ACS) Waiver.

The types of support available for community living for individuals with developmental disabilities have increased throughout the past years. Programs that support families and/or individuals in their communities include:

(1) the Family Support Grant Program, which, as of January 1995, provided approximately 640 families with grants averaging $2,700 per year to help them offset the added costs of raising a child with a developmental disability;

(2) the Children's Home Care Option, authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248), that allows approximately 3,900 children with developmental disabilities who live in their parental homes to receive medical assistance benefits regardless of their parents' income;

(3) special education, including early intervention services for children age birth through 7, special education for elementary, middle-school, and secondary school-aged children, and transition planning services for adolescents;

(4) SILS, which provide approximately 1,600 adults with developmental disabilities with support and instruction to enable them to live semi-independently in houses or apartments in the community;

(5) residential habilitation services provided by Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR), which serve over 4,000 people with developmental disabilities annually;

(6) the Home and Community-Based Services Waiver, which provides approximately 4,200 individuals with developmental disabilities with case management, and additional services which may include in-home support, supervised living services, homemaker services, respite care, environmental modifications, assistive technology, specialist services, personal support, housing access coordination, 24-hour emergency assistance, day training and habilitation, supported employment, adult day care, and crisis respite;

(7) the ACS Waiver for people with developmental disabilities who were screened and found to have been placed inappropriately in nursing homes; and

(8) employment and training services for adults with developmental disabilities.

Minnesota's commitment to community living for persons with developmental disabilities is reflected in its program expenditures. In fiscal year 1994, Minnesota spent $159,106,722 on community ICFs/MR; $127,711,222 for the Developmental Disabilities Waivers; $25,300,000 for nursing home services for people with developmental disabilities; $7,857,143 on SILS services; and $1,597,923 to fund the Family Support Grant Program.

Objectives and Priorities for 1994-1995

During the 1995 legislative session, the Department of Human Services will introduce the **Life Skills Self-Sufficiency Initiative,** an effort that is intended to establish a direction for future changes toward the goals of increased consumer choices in long term care, chronic care, and social services. The Life Skills Self-Sufficiency Initiative will allow more tailoring to meet individual needs and responsiveness to the need to spend public funds in an efficient and effective way. The initiative includes several proposals that relate to supports for persons with disabilities: **1) Consumer Support Grants; 2) Developmental Disabilities Pilots; 3)** the **Developmental Disabilities Waiver Alternative Allocation Structure,** and **4)** a **Quality Assurance Support System.** Achievement of the goals of the Life Skills Self-Sufficiency Initiative will yield a service

system characterized by more equitable distribution of funds, increased consumer choice of services and supports, improved service access and coordination, and increased flexibility of services. In addition, the Department will continue participation in a three-year **Performance-Based Contracting Demonstration Project** with selected ICF/MR providers and county agencies in which those providers are located that is expected to result in services that emphasize consumer choice and achievement of positive outcomes.

Reform efforts initiated during fiscal year 1996 are anticipated to continue into fiscal years 1997, 1998, and beyond. The Department believes that changes in the service delivery system brought about by the Life Skills Self-Sufficiency Initiative and the performance-based contracting demonstration project will result in a more efficient and coordinated system that offers consumers a broader range of service options than is available currently, is more easily accessed, emphasizes achievement of positive outcomes, and is more responsive to the needs of individuals with developmental disabilities and their families than the current system.

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This 1996-1997 Biennial State Plan for Minnesotans with Developmental Disabilities was prepared for the Legislature of the State of Minnesota in accordance with Minnesota Statutes, section 252.291, subdivision 3, which requires the Commissioner of the Department of Human Services to develop a [biennial] state plan for the delivery and funding of residential and support services to persons with mental retardation or related conditions in Minnesota.

This report fulfills the obligations specified in that statute. In addition, it describes services available to Minnesotans with developmental disabilities who are diagnosed with mental retardation or determined to have a related condition, discusses trends in service use and program expenditures, and specifies the values, legislation, and appropriations that help define Minnesota's objectives for the development and management of residential, day, and support resources during the next biennium.

The report also describes the Department's proposal to the 1996 Legislature for reform of the developmental disabilities service system. During the 1996 legislative session, the Department will introduce the **Life Skills Self-Sufficiency Initiative.** Primary goals of the legislation are to ensure access to necessary services, and create greater flexibility and consumer choice in social services, long-term care, and chronic care programs so people can be as independent and self-sufficient as possible, and assure that public funds are being spent as efficiently and effectively as possible. Components of the bill that will impact services for persons with mental retardation or a related condition are: 1) Consumer Support Grants; 2) Developmental Disabilities Pilots; 3) the Developmental Disabilities Waiver Alternative Allocation Structure; and 4) a Quality Assurance Support System.

Consumer Support Grants will provide monthly grant subsidies to consumers with functional limitations to enable them to purchase needed care, services, supplies, and equipment directly from nontraditional sources for less cost than county purchased services. The program would result in consumers having increased control and decision making over services and supports. The Developmental Disabilities Pilots will test alternative purchasing and service delivery models for persons with developmental disabilities within the structure of the Minnesota health care system. Strategies to be demonstrated include: 1) shifting decisions about the purchasing of services for persons with developmental disabilities to the local level; 2) consolidating and streamlining regulatory requirements;

3) allowing efficiencies to be used to expand services to eligible participants; and 4) providing increased choices in the areas of nontraditional supports and services.

The Alternative Allocation Structure proposes combining the various state and county-managed components of the developmental disabilities waiver into a single system and implementing use of a weighted daily average reimbursement limit for counties. The development of the alternative allocation structure would improve access to funding by allocating dollars for new recipients based on their needs, provide a mechanism to allow people with high needs living in community ICFs/MR and who have chosen waivered services to leave those facilities, place decisions at the local level, and reduce state costs for state operated community services (SOCS) by transferring funds to Medical Assistance and reimbursing existing SOCS rates with federal participation through the waiver. The process of change will be initiated during the 1996-1997 biennium. System reform will continue into the 1998-1999 biennium.

The Quality Assurance Support System will test and implement alternative quality assurance approaches for persons requiring ongoing care. The approaches include: 1) peer review models for public and private providers; 2) client satisfaction and client feedback instruments; 3) advocacy and oversight for individual consumers; and 4) local quality assurance and service planning approaches. The proposal will result in a more proactive approach to ensuring quality than is possible with the current system, which relies heavily on the use of investigative and reactive approaches for correcting deficiencies. It will give consumers who have ongoing support needs a mechanism for communicating their degree of satisfaction with the services they receive, and will result in improvements in health, safety, and quality of care.

I. Mission and Obligations

The Department of Human Services, in partnership with the federal government, counties, and other public, private, and community agencies throughout Minnesota is a state agency directed by law to assist Minnesotans whose personal or family resources are not adequate to meet their basic human needs. The Department is committed to assisting individuals to access programs that provide the appropriate quantity and quality of services commensurate with their needs and those of their family in order to attain the maximum degree of self-sufficiency consistent with their capabilities.

Minnesota is one of 17 states with a county-administered, state-supervised human services delivery system. County agencies are responsible for screening individuals for eligibility for services, providing case management services for individuals with a diagnosis of mental retardation or a related condition, arranging for needed services, contracting with providers for services, and monitoring service provision to ensure that it is delivered in accordance with individuals' Individual Service Plans. The Department of Human Services assumes supervisory responsibilities over many of these county-administered services.

The Division for Persons with Developmental Disabilities and other related divisions within the Department work to ensure that Minnesotans with developmental disabilities who have been diagnosed with mental retardation or a related condition receive services which adequately and appropriately meet their needs. Specific obligations include: 1) insuring quality of care and compliance with all laws, rules, and regulations; 2) managing the growth and development of residential, and day training and habilitation services throughout Minnesota; 3) administering specific programs authorized and funded by the state Legislature; and 4) providing training and technical assistance to county case managers, county social service agency staff, and providers. The Department also monitors the quality of case management and service provision. In addition, the Department acts as the "public guardian" for 4,995 people with mental retardation or a related condition age 18 and over.

II. Values

Programs and services administered by the Department of Human Services are premised on the belief that all Minnesotans, including those with developmental disabilities, are unique, valuable individuals who can contribute in important ways to community life in Minnesota. Important principles that guide development of programs and services for Minnesotans with developmental disabilities are age-appropriateness, cultural-appropriateness, service provision within the least restrictive environment, inclusion into community activities, and support for development of ongoing relationships.

Age-appropriate services are those that are respectful of the person's chronological age and are reflected in both the type of services and the manner in which they are provided. Culturally-appropriate services are respectful of an individual's need for identification with other members of his or her cultural background. Service provision within the least restrictive environment involves offering only as much support and instruction as the individual needs in an environment which allows as much personal freedom and decision-making as the individual is capable of handling.

Inclusion of individuals with developmental disabilities in the day-to-day activities of their home communities has many benefits. It provides people with opportunities for learning new skills in the environments in which those skills are needed. Inclusion also provides opportunities for people with developmental disabilities to interact socially with their peers who do not have disabilities.

Friendships and ongoing relationships between people with developmental disabilities and their peers without disabilities are important for meeting an individual's social and interpersonal needs. Involved, supportive family members, friends, and advocates play an important role in assisting consumers to make decisions, monitor the quality of services provided, and protect individuals' rights.

III. Services Available for Persons with Developmental Disabilities

Case Management

Case management is the cornerstone of quality services for persons with mental retardation or **a** related condition and was first mandated as a required service in Minnesota in 1977. Case management is provided by county social service agencies to assist individuals to gain access to needed social, medical, educational, and other supports and services. A case manager's responsibilities include both administrative and service functions. Administrative functions consist of intake, determination of eligibility, screening, service authorization, review of eligibility, and conciliations and appeals. Case management service functions include assessment or arranging for assessments of individuals' functional skills and needs, developing individual service plans to address needs identified through the assessment process, identifying service options, identifying providers, assisting clients to access services, coordinating services, evaluating and monitoring services, and reviewing service plans annually.

Minnesota Rules, parts 9525.0004 to 9525.0036, commonly known as Rule 185, and Minnesota Statutes, section 256B.092 govern the provision of case management services to Minnesotans with mental retardation or a related condition. In 1991, legislative amendments to Minnesota Statutes, section 256B.092, which contains policies for providing case management services, were enacted. These amendments resulted in the following changes: 1) reduction of the duplication of efforts in the areas of diagnosis, assessment, and service plan development; 2) elimination of the habilitation component of the service plan and clarification of the provider's role in development of individual program plans; 3) separation of the administrative and service functions of case management; 4) provision for free choice of vendor of case management services for recipients of home and community-based services effective July 1, 1992; 5) clarification of host county concurrence requirements; 6) provision for waivered service demonstration projects; 7) clarification of discharge planning requirements for persons in regional treatment centers; and 8) technical edits to update or clarify statutory language.

Case Management

In State Fiscal Year 1994, 409 case managers provided case management services to 19,081 Minnesotans with mental retardation/ related conditions.

These amendments resulted in a need to revise Rule 185. The objectives in revising the rule were to: 1) incorporate changes in statutory authority as well as federal standards; 2) streamline and organize the rule in a more user-friendly style; 3) assure that the case management system treats the consumer with the highest degree of dignity while facilitating consumer choice, control, and autonomy; 4) balance consumer protections and rights with responsibilities; promote services that support persons in the context of their cultures and families; 5) support family system approaches to services; and 6) allow flexibility and diversity in the achievement of outcomes. The revisions to Rule 185 became effective on April 25, 1994.

A survey conducted by the Division for Persons with Developmental Disabilities in January of 1994 revealed that 19,081 people with mental retardation or a related condition received case management services. Minnesota's 87 counties employ a total of 409 case managers and 14 case aides. In addition, at least three counties contract with private individuals to provide case management services.

Issues and challenges facing Minnesota during the 1996-1997 biennium pertain to service access and availability, caseload size, persons waiting for services, training needs, turnover rates of case managers, and pragmatic barriers to implementing effective quality assurance procedures at the county and state levels. Objectives for the 1996-1997 biennium pertaining to case management include: 1) continued in-service and pre-service training for Minnesota's case managers; and 2) providing technical assistance to counties regarding conflict mediation in an effort to minimize conciliation.

Support Services

Many of the services available for persons with mental retardation or a related condition are not tied to or limited by the places in which people live. An advantage of services that are "unbundled" from housing is that the person can move from one place to another without a disruption in services. Support services administered by the Department of Human Services for persons with mental retardation or a related condition that are funded and may be provided independent of housing are: 1) the Family Support Grant Program; 2) The Children's Home Care Option, commonly known as "TEFRA; 3) the Home and Community-Based Services Waiver; 4) SILS; 5) employment and training services; and 6) community-based crisis services. Early intervention services for preschoolers with disabilities, special education for elementary and middle school students, and transition services for secondary school-age students with disabilities, while not provided or administered by the Department of Human Services, are crucial in terms of the supports they provide to children with developmental disabilities and their families.

Family Support Grant Program. Since 1976, Minnesota has provided cash grants to families with children who have mental retardation or a related condition. The Family Support Grant Program (formerly called the Family Subsidy Program) grants eligible families up to $3,000 per year, in the form of vouchers, direct cash payments from the county agency, or lump sum payments, to help defray the cost of items and services that are necessary to maintain a child with mental retardation or a related condition in the family home. Families may use the grants to cover expenses that are in excess of or different from

Family Support Grant Program - SFY 1995	
Families Served	640
Families Awaiting Grants	355
Average Yearly Grant	$2,700
Total Expenditures	$1,599,000

the costs parents of children without disabilities experience. In order to be eligible for the program, a family must have a child eligible for services to persons with mental retardation or a related condition, aged birth through 21, and an adjusted annual gross income of less than $63,778 as of July 1, 1994 (except where extreme hardship can be demonstrated). As of January 1995, 640 families received Family Support Grants. The appropriation for the program was increased by the Minnesota Legislature from $1,478,000 in state fiscal year 1993 to $1,599,000 in state fiscal years 1994 and 1995. Even with the increased appropriations, as of January 1995, approximately 355 families who had been determined eligible could not be given grants because the program's allocation was exhausted.

The Children's Home Care Option. Minnesota's Children's Home Care Option (TEFRA), authorized by the "Tax Equity and Fiscal Responsibility" Act of 1982 (Public Law 97-248), allows the provision of medical assistance benefits, up to the 19th birthday, for children with disabilities who live in their parental homes and would otherwise require out-of-home placement. Parental income is disregarded when establishing a child's eligibility for medical assistance benefits under TEFRA. Depending on their income, parents of children with disabilities may be assessed a fee for medical assistance reimbursed services provided to their child. By January of 1995, approximately 3,900 children with disabilities were receiving medical assistance benefits through TEFRA.

The Children's Home Care Option

. Authorized by the "Tax Equity and Fiscal Responsibility" Act of 1982 (P.L. 97-248)

. Provides medical assistance benefits to children with disabilities up to age 19, regardless of parental income

. Over 3,000 children with disabilities received MA benefits through TEFRA in fiscal year 1994

Developmental Disabilities Waivered Services. In 1983, Minnesota obtained a federal waiver to use medical assistance funds to purchase home and community support services for persons with mental retardation or a related condition who would otherwise require the services of **intermediate care facilities for persons with mental retardation** (ICFs/MR). The **Home and Community-Based Services** (HCBS) waiver provided a new resource to support individuals with mental retardation or a related condition in their family homes or other community settings. The waiver made possible the separation of funding for housing from funding for services and allowed creation of flexible and creative service options for eligible individuals. It provided a mechanism for using federal, state, and county funds to purchase services to prevent placements in state regional treatment centers and enabled people living in community ICFs/MR and regional treatment centers to move to neighborhood homes with individualized services.

Minnesota has two waiver programs for persons with mental retardation or a related condition who would otherwise require ICF/MR services. The first is the **Mental Retardation/Related Conditions Waiver,** which served over 4,200 persons with mental retardation or a related condition in state fiscal year 1994. Currently, about 230 of those individuals are served in state-operated community service (SOCS) waiver programs. The second is the **Alternative Community-Based Services Waiver** for persons with mental retardation or a related condition who had been placed inappropriately in nursing homes on or before January 1,1990. Together, these two programs are referred to as Developmental Disabilities (DD) waivers.

MR/RC Waiver
State Fiscal Year 1994

Total Expenditures	$124,530,091
Number of People Served	4,217

ACS Waiver
State Fiscal Year 1994

Total Expenditures	$3,181,131
Number of People Served	90

Services available through the DD waivers include case management, supported living services, in-home family support services, personal support, homemaker services, respite care, environmental modifications, assistive technology, specialist services, casegiver training and education, 24-hour emergency assistance, and housing access coordination. In addition, adults with developmental disabilities are eligible to receive day training and habilitation services, supported employment, or adult day care services. Individuals who receive waivered services live in a variety of places, including homes of parents or relatives, homes of families licensed to provide foster care, or their own homes or apartments. Some individuals live in corporate foster homes that, with a handful of exceptions, are home to no more than four people.

Services Available Through the DD Waivers

- Case Management
- Supervised Living Services
- In-Home Family Support
- Respite Care
- Homemaker Services
- Personal Support
- Environmental Modifications
- Specialist Services
- Assistive Technology
- Housing Access Coordination
- 24-Hour Emergency Assistance
- Day Training and Habilitation
- Supported Employment
- Adult Day Care
- Crisis Respite

Minnesota's DD waiver program has grown rapidly over the past 11 years. The number of persons receiving waivered services, which was less than 300 in 1984, is estimated to reach 5,000 by July 1, 1995. An independent assessment of Minnesota's Home and Community-Based Services Waiver was undertaken in state fiscal year 1992 by the Institute on Community Integration at the University of Minnesota and Systemetrics, Inc. of Lexington, Massachusetts. The purpose of the assessment was to evaluate the overall success of Minnesota's waiver program in meeting required federal standards and state goals. The assessment revealed that the waiver was a cost-effective means of providing services. Using relatively conservative estimates, the

assessment revealed that Medicaid savings to the State of Minnesota between 1987 and 1991 due to the HCBS program were approximately $14 million state dollars. The assessment also revealed that an overwhelming majority of parents and guardians of recipients in the sample rated the medical and non-medical professional services recipients received as adequate or better than adequate. Although some problems were noted, such as an inadequate supply of waivered service providers in rural areas, a scarcity of providers skilled in serving persons with severe challenging behaviors or severe physical disabilities, a shortage of respite care providers, an over-reliance on a small group, facility-based approach for serving people, and fewer recipients from racial/ethnic minorities than were expected, access to the program was found to be equitable and consistent with federal and state regulations.

Since the 1992 assessment, a number of changes have been made to the program, such as the addition of new services to increase flexibility and enhanced measures of quality assurance, including those related to health and medical needs. An alternative allocation system to address concerns with the existing system has also been proposed. An evaluation of the program is planned during 1996 and 1997 to assess the effect of these changes and provide further recommendations.

Semi-Independent Living Services SFY 1994	
Persons Served	1,600
Persons Awaiting SILS	300
Total Annual Expenditures	$7,857,143

Semi-Independent Living Services. Individuals with mental retardation or a related condition who are not at risk of ICF/MR level of placement may be eligible for **semi-independent living services (SILS).** SILS provide adults, age 18 and over, with instruction in the skills necessary for living in the community. SILS was first funded by the Legislature in 1982 with an appropriation of $425,000. In state fiscal year 1994, approximately 1,600 persons received SILS, which include instruction in budgeting, cooking, personal safety skills, home management, shopping, leisure skills, social skills, self-determination, and accessing community support services. The state appropriation for SILS in fiscal year 1994 was $5,500,000. Counties are required to fund at least 30 percent of the cost of SILS, bringing the total annual expenditures for SILS to $7,857,143.

Semi-Independent Living Services (SILS)

SILS for adults with developmental disabilities include:

Instruction in skills necessary for semi-independent living, such as budgeting, cooking, shopping, personal hygeine, etc.

Support to facilitate community adjustment and integration

One-time housing allowances of up to $1,500

Semi-independent living services were originally available only to persons who needed 90 or fewer days per year of intervention. In response to recommendations submitted by the Department of Human Services (DHS), the 1991 Minnesota Legislature modified Minnesota Statutes 252.275 pertaining to semi-independent living services to extend service eligibility to persons who needed daily intervention, but did not require a 24-hour plan of care. Changes to the statute in 1991 also permitted county social

service agencies to provide vouchers or cash grants to eligible persons to allow them to purchase their own services, and one-time housing allowances of up to $1,500 to assist SILS recipients to pay for items such as damage deposits, furniture, and appliances that could not be funded through other public sources and were necessary for securing a home.

Additional legislative changes in 1993 clarified eligibility for SILS by limiting eligibility to persons who are not at risk of ICF/MR placement in the absence of less restrictive services, and allowed counties to contract with qualified unlicensed individuals to provide SILS, as long as the individual was not related to the SILS recipient or providing SILS to anyone else. In 1993, an amendment to Minnesota Statutes, section 256B.0916 directed DHS to expand availability of HCBS by transferring eligible SILS recipients to the HCBS waiver. Legislation allowed DHS to transfer funds from the state SILS account and the state Community Social Services Act (CSSA) account to provide the state match for federal Medicaid funds for HCBS. As a result of a survey conducted by the Division for Persons with Developmental Disabilities in late 1993 and early 1994, approximately 600 SILS recipients were identified by counties as being potentially eligible for HCBS under a broader federally acceptable interpretation of need for a "24-hour plan of care." In May of 1994, counties were awarded diversion allocations for each SILS recipient identified as potentially eligible for HCBS. As of January 1995, over 200 people had transferred from SILS to the HCBS waiver. The legislation that authorized the SILS to waiver transfers also allowed people to remain in their homes without having to move into new residences to obtain HCBS, and allowed them to retain the same provider, even if the provider chose not to become licensed as a provider of HCBS, as long as the person's services did not change substantially in intensity.

Counties who transfer individuals from SILS to HCBS under this option may experience savings in CSSA funds and SILS funds. The legislation that authorized the transfers stipulated that 80 percent of the savings in SILS funds that resulted from transferring eligible individuals from SILS to HCBS be used to provide SILS to additional recipients, or increase levels of service for those already receiving SILS. It is estimated that up to 300 individuals may begin receiving SILS as a result of savings realized by transferring individuals from SILS to HCBS.

A survey conducted by the Division for Persons with Developmental Disabilities in January of 1994 revealed that over 300 people currently living in community ICFs/MR, their family homes, family foster homes, corporate foster homes, or receiving waivered services are awaiting SILS services. These individuals could live more independently if additional state and county funding for SILS was available.

Employment and Training. Day training and habilitation services provide adults with developmental disabilities with the training and support they need to obtain employment in the community as well as with opportunities to participate in employment-related and general community activities. The goal of day training and habilitation (DT & H) services is to maximize each individual's independence and participation in the community. These services strive to enhance inclusiveness in the workplace, assist individuals to become more independent as wage earners, and to empower individuals so that they may

benefit from and contribute fully to their communities. Today in Minnesota, more than 200 licensed providers of day training and habilitation services provide employment services as well as a variety of other services to more than 8,000 adults with developmental disabilities. Ten of the licensed programs are state-operated. Day training and habilitation services include community-based supported employment, center- based employment, and specialized training and assistive technology, all aimed at increasing independence and inclusion in the community. The number of individuals receiving day training and habilitation services continues to grow as students transition from public school programs into adult services, and as individuals move from RTCs and nursing homes into community homes.

Employment and training services include:

. Supported employment (full/part-time employment in integrated community settings with support of a job coach)

. Part-time work center-based work (often consisting of subcontract assembly-type tasks)

. Specialized training and adaptive technologies to increase independence in work and other settings

. Instruction in life-skills in integrated community environments

Community-Based Crisis Services. Individuals with developmental disabilities sometimes experience events in their lives that lead to crisis situations. Crisis is defined as the disruption of life patterns, activities, or events that result in restriction or termination of services within a particular setting, and sometimes places individuals at risk for being asked to leave their homes or jobs. In order to prevent admissions and readmissions of people to RTC's, state-operated **Community Support Services** projects have been developed in each of the catchments areas served by the state's regional treatment centers. Crisis services have also been developed by private sector providers in the seven county metro area, and in the northern part of Minnesota.

Private and state-operated models contain similar components. In both, teams of highly skilled professionals provide on-site technical assistance to community service providers and case managers of people whose community placements are threatened by their challenging behaviors. Technical assistance usually consists of teaching staff to: 1) identify the functions served by the challenging behavior through an assessment process; 2) modify environments to reduce the probability that challenging behaviors will occur; and 3) identify alternative behaviors to teach that will replace the challenging behavior. When on-site technical assistance is not effective or when an individual's challenging behavior is so severe it poses a threat to the individual or to others, it may be necessary to provide off-site crisis services. Off-site crisis services consist of temporarily removing the individual from the setting in which he or she is experiencing difficulties to another setting that provides added security and access to staff who are highly skilled in treating severe challenging behaviors. When the challenging behaviors that precipitated the crisis are under control, individuals return to their homes.

Crisis services appear to be effective in preventing commitment to regional treatment centers (RTCs). Data showed that in 1994, 75 percent of the individuals who were admitted to RTCs for off-site

crisis services were discharged within 90 days. This is an important change from 1992, when 80 percent of the people admitted to RTCs remained longer than 90 days. Admission rates to RTCs have also stabilized, indicating that people with challenging behaviors who have been discharged to community settings are being successfully being served in those settings. In addition, on-site crisis services appear to be effective in reducing demissions from community placements.

Plans are currently in place to create five community-based crisis service programs in the Twin City metropolitan area and in southern Minnesota and to enhance existing crisis services in RTC catchments areas. Several county collaboratives have been established to pursue service development and funding for innovative proposals, including partnerships between private and public sector providers, and development of more generic crisis services to serve the needs of a variety of individuals.

Early Intervention. Minnesota has a history of providing early intervention services for infants and toddlers with disabilities that pre-dates the federal legislation passed in 1986 mandating the provision of educational and related services to children with disabilities age three through five. The federal legislation provides incentives for states to offer educational services to children age birth through two years. In Minnesota, early intervention services are available for children age birth to seven years who have a substantial delay or disorder in development, or who have an identified physical, mental, or social-emotional condition or impairment known to hinder normal development, and who need special education. A key component in early intervention services is the Individual Family Service Plan (IFSP), a document that specifies the services a child is to receive and sets educational goals'. The IFSP is comparable to the Individual Education Plan (IEP) required for elementary, middle, and secondary school-aged students who receive special education services. An important distinguishing characteristic of the IFSP is its emphasis on a family-centered approach to intervention as well as interagency cooperation in the development and provision of multidisciplinary services. Minnesota has designated the Department of Education as the lead agency for coordination of early intervention services.

Early Intervention Services

According to Minnesota Rules, part 3525.2335, early childhood special education must be available to pupils from birth to seven years of age who have a substantial delay or disorder in development or who have an identifiable sensory, physical, or social/emotional condition or impairment known to hinder normal development and who need special education.

Special Education Services for Elementary. Middle, and Secondary School-Aged Children. Children with developmental disabilities receive education services from their local school districts. More and more, school districts are educating students with disabilities in regular classrooms instead of providing instruction in separate schools or in special classrooms within regular schools. Students in special education receive the support necessary to participate in classroom activities with their peers without disabilities, as well as specialized instruction and support to help them to acquire functional, academic, and social skills.

Transition Services for Secondary School-Age Students. Minnesota assists youth with disabilities and their families to make successful, appropriate transitions from secondary schools to living and working in the community. Minnesota Statutes, section 120.17, subdivision 3(a), requires each student's IEP address the student's need to develop skills to live and work as independently as possible within the community, and that by the ninth grade or age 14, the plan shall address transition from secondary services to post-secondary education and training, employment, community participation, recreation, leisure, and home living. Minnesota Statutes, section 120.17, subdivision 16 requires that each school district establish a Community Transition Interagency Committee (CTIC) to identify current services, programs, and funding sources; develop multi-agency teams to address transition needs of students; develop a community plan to assure that transition needs of individuals with disabilities are met; prepare a yearly summary assessing the progress of transition services in the community; recommend changes or improvements in transition services; and exchange information pertaining to exemplary programs and studies of effectiveness.

Transition Planning

MN Statutes 120.17, subd. 3(a), requires that by grade 9 or age 14, Individual Education Plans of students with disabilities must address transition from secondary public education to post-secondary education and training, employment, and community living.

CTIC members include adults with disabilities who have received transition services, parents of individuals with disabilities, regular and special educators, post-secondary educators, local business or industry representatives, and representatives from rehabilitation services, state human services, county social service agencies, health service agencies, and public or private adult service provider agencies.

Facility-Based Support Services

In addition to offering services to persons with mental retardation or a related condition that are unbundled from housing, Minnesota has three options in which funding for services and housing are combined. These are: 1) community based ICFs/MR; 2)RTCs; and 3) nursing homes. A disadvantage of these types of living arrangement is that the funding for the services and the housing does not follow the person if he or she wants to move to different type of setting in the community. Services of this type are referred to as being "bundled," or "packaged."

Community-Based ICFs/MR. Many individuals with developmental disabilities live in privately operated community group homes called ICFs/MR. Community-based ICRFs/MR began in the 1970's as an alternative to state regional treatment centers, and are facility-based residential services for persons who require 24-hour care, supervision, and active treatment to learn or retain daily living skills. Community ICFs/MR in Minnesota range in size from four to 101 beds.

In 1983 the Minnesota legislature passed a moratorium to the development of new ICFs/MR due to the increasing costs of serving people in these facilities. Implementation of the HCBS waiver in 1984 offered an alternative to facility-based ICF/MR services. As part of the waiver plan agreement with the

federal government, ICF/MR beds were to be decertified and converted to waivered services. In 1986, the average monthly census in Minnesota's community ICFs/MR was 4,988. By state fiscal year 1994, the average monthly census in Minnesota's 339 community-based ICFs/MR had dropped to 4,590. This reduction is attributable in part to decertification of ICF/MR beds that occurred as a result of implementation of the HCBS waiver.

Community-Based ICFs/MR SFY 1994	
Persons Served	4,590
Number of Facilities	339
Total Annual Expenditures	$159,106,722
Average Per Diem	$128.58

As the number of people choosing waivered services over private community ICFs/MR continues to increase, so does the number of facilities closing due to low occupancy. In 1987, Minnesota Statutes, section 252.292 gave the Department of Human Services the authority and resources it needed to work with counties and service providers to develop plans to close facilities and assist people who lived in those facilities to move to community homes with waivered services. Five ICFs/MR serving a total of 75 individuals closed in 1993, and 11 ICFs/MR serving 224 individuals closed in 1994. An additional 11 ICFs/MR serving 250 individuals are projected to close in 1995.

In addition to privately operated community-based ICFs/MR, state-operated community ICFs/MR exist. Development of the SOCS ICFs/MR was authorized by the 1988 legislature as an exception to the moratorium on development of new ICFs/MR. Between 1990 and 1994, 15 SOCS ICFs/MR serving a total of 90 people were developed and opened. The new facilities were limited to serving six individuals each, and were required to serve people from RTCs.

Regional Treatment Centers. In June of 1980, approximately 2,600 Minnesotans with developmental disabilities lived in regional treatment centers. In the 15-year period from 1980 to 1995, the population of the RTCs declined by nearly 2,000 as people moved from the state's seven RTCs that served people with mental retardation or a related condition to community-based ICFs/MR or to homes in the community with waivered services. By January 31, 1995, the census in Minnesota's RTCs had declined to 610.

Regional Treatment Centers (RTCs) SFY 1994	
Number of RTCs serving people with developmental disabilities	6
Average Daily Census	781
Total Annual Expenditures	$86,770,000
Average Daily Cost (including cost of training and habilitation services provided by RTCs)	$310.00

Moose Lake Regional Treatment Center closed in 1993. Six RTCs remained in operation as of January 1995. These are located in Brainerd, Cambridge, Faribault, Fergus Falls, St. Peter, and Willmar. The roles of the remaining RTCs are changing as individuals continue to move to smaller community homes. Community Support Services projects located at each of the RTCs have been in operation since 1993. These projects provide technical assistance and

consultation to parents, service providers, and case managers of individuals who exhibit challenging behaviors. The Community Support Services projects have been helpful in preventing placements to RTCs, hospitals, and correctional facilities. In addition, community-based clinics were established at the Faribault and Cambridge RTCs in 1990 to provide a variety of services to individuals with mental retardation or a related condition who had difficulty obtaining services from psychiatrists, psychologists, dentists, dieticians, occupational therapists, speech/language therapists, audiologists, or occupational therapists in their home communities.

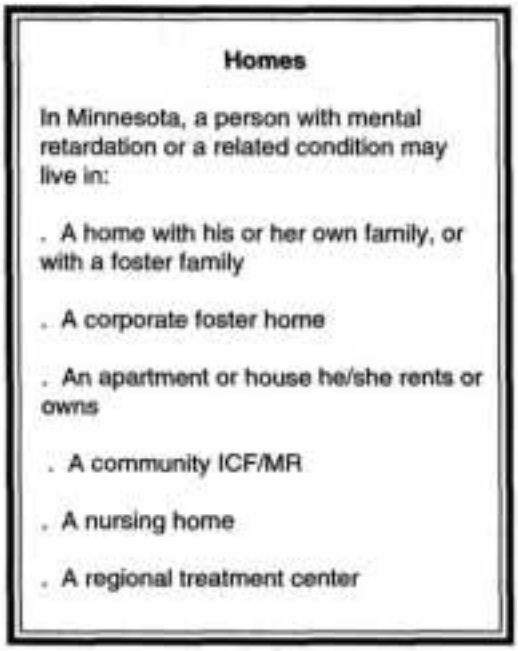
Nursing Homes. About 700 Minnesotans with mental retardation or a related condition resided in nursing homes as of January 1995. Federal legislation passed in 1987 mandated annual review of all nursing facility placements of persons with mental retardation or related conditions. If the review revealed that inappropriate placement had occurred, a more appropriate community placement had to be located, except when the individual had resided in the nursing facility for a long period of time and chose to remain there. In response to the federal legislation, Minnesota applied for and obtained an additional waiver to federal Title XIX regulations to assist in relocation of people placed inappropriately in nursing homes prior to January 1, 1990. This waiver, called the **Alternative Community-Based Services Waiver** (ACS), had resulted in the relocation of approximately 90 people screened and found to be placed in nursing homes inappropriately to community placements by January 1995.

The Department continues to pursue alternatives for serving people with developmental disabilities in less restrictive settings. The availability of enhanced federal funding through the MR/RC waiver for persons moving from regional treatment centers to the community, waiver allocations for persons moving from nursing homes, and rate adjustments for the purpose of upgrading community-based ICFs/MR have strengthened the capacity of community facilities and community-based services to meet the needs of individuals with more severe disabilities. In the coming biennium, the Department will continue to encourage the development of community-based residential programs as downsizing of regional treatment centers and as voluntary closure or voluntary decertification of private community ICFs/MR beds occurs.

Homes DHS recognizes that it has a responsibility to assist with housing for some individuals who need long-term assistance with their housing because of functional limitations. In the past, it was often assumed that individuals with mental retardation or a related condition needed to live in a specialized facility in order to receive the services they needed. Examples of living environments which also provide services are community ICFs/MR, RTCs, and nursing homes. Costs for housing in these settings are combined with costs for services. Facilities receive an operating rate that covers the combined "package" or "bundle" of room, board, and services for all people living in the facility. Over the years, DHS has moved toward unbundling the funding for services from the funding for housing in order to allow more

housing choices for people it supports.

In many of the places in which Minnesotans with mental or a related condition live, costs for housing are paid separately from the costs for any services provided to the individuals living in the settings. Housing costs for individuals with developmental disabilities who live in licensed foster homes and board and lodging facilities are paid through DHS's Group Residential Housing (GRH) program. GRH is a state-funded system of rates and payments for persons who reside in group residences who meet the eligibility criteria of the general assistance (GA) program or the Minnesota Supplemental Aid (MSA) program. By federal definition, all MSA recipients are categorically aged, blind, or disabled. Thus, GRH funding for individuals with mental retardation or a related condition comes from the MSA program. Monthly GRH rates are negotiated by counties with providers. The rate set is for room and board only, and does not include program costs or the costs of social services. Services received by individuals with developmental disabilities who live in GRH-funded programs are funded through other sources, such as the DD waiver, SILS, or county CSSA funds.



Examples of settings in which funding for housing is separate from funding for any support services the person receives are: 1) family members' homes; 2) homes or apartments licensed as adult foster care; and 3) homes that are owned or leased by individuals with mental retardation or a related condition.

Family Members' Homes. Many Minnesotans with developmental disabilities live with their families. Some of these individuals receive special education, services through the HCBS waiver, Family Support Grants, SILS, or day training and habilitation. Others do not receive services due to a lack of need for services, failure to request services, or are on waiting lists for services.

Single Family Homes or Apartments Licensed as Adult Foster Care. Some individuals with developmental disabilities live in homes that are licensed as adult foster care. Many of these homes are owned or leased by families who are licensed foster care providers. Others are owned or leased by a corporations licensed to provide foster care. Individuals who live in family or corporate foster homes sometimes receive services such as SILS or HCBS in addition to the housing and supervision which foster care provides.

Homes Owned or Leased by Consumers. A small but growing number of individuals with developmental disabilities are choosing to buy or lease their own homes. Consumers with developmental disabilities who wish to purchase homes face the same obstacles that other low income potential home buyers face. These include difficulty in saving enough money for the down payment and closing costs,

obtaining financing, locating an affordable house in a safe neighborhood, and funding ongoing maintenance and repairs. Individuals who receive medical assistance can have no more than $3,000 in cash assets, compounding their difficulty in saving the money needed to purchase and furnish a home, and maintain a cushion that can be used to fund emergency repairs. Often, the parents or relatives of individuals with developmental disabilities who wish to purchase a home provide financial assistance for the down payment and closing costs, and may help with maintenance and repairs.

In some instances, individuals who own their own homes live alone, but more often than not, it is necessary for them to have one or more roommates in order to be able to afford to live in the home. People who choose to share their homes can apply their renters' monthly contribution toward the mortgage payment. People who must remain eligible for medical assistance (MA) in order to receive services, however, may risk losing their eligibility if they have rental income. To overcome this problem, some MA eligible individuals who have purchased homes have chosen to lease their homes to a service provider, who licenses the home under adult foster care. The home is then eligible to receive GRH payments that can be used to cover the cost of room and board, of which the monthly mortgage payment is a portion. This type of arrangement may be advantageous for persons with developmental disabilities as it shifts the responsibility for ongoing maintenance and repair from the consumer to the service provider. It also protects the consumer's MA eligibility, since he or she does not receive income in the form of rent from any roommates who share the home.

A primary benefit of consumer-owned or leased housing is increased control over the home that is often not possible when living in a home owned or leased by a service provider. In addition, consumers who become dissatisfied with their services no longer need to move to obtain services from a different provider. Equity in the home also accrues to the consumer, not the service provider or private individual who owns the home.

In several instances, parents have purchased second homes in which their children with developmental disabilities live. This option is probably beyond the reach of most families, since few people can afford to make two mortgage payments. In addition, financing available for second homes is usually limited to loans with higher interest rates than loans available for first-time borrowers.

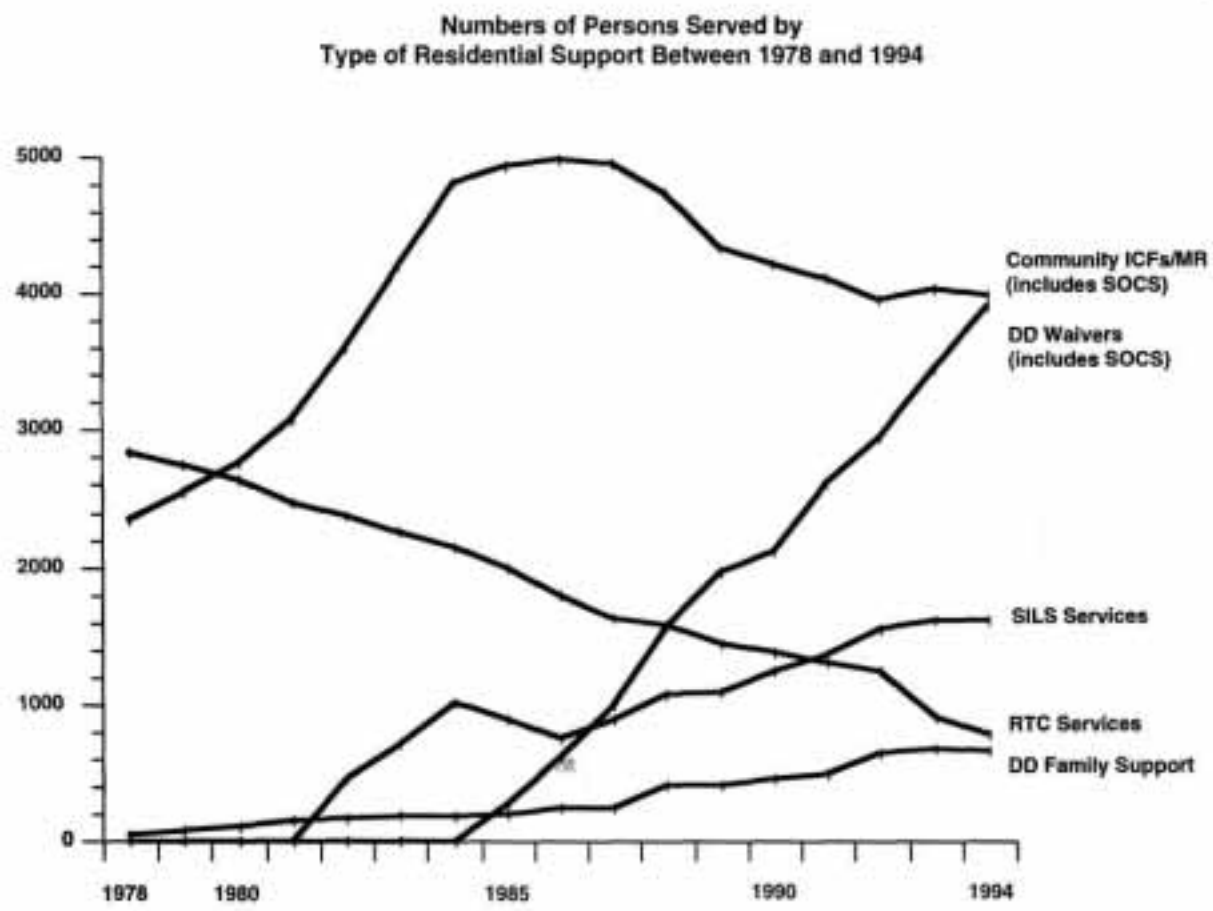
Recent legislation does remove one important disincentive to the purchase of homes by parents for their children with developmental disabilities. Minnesota Statutes, section 273.124, subdivision 1(c), enacted in 1993, allows for real estate property that is occupied and used for the purposes of a homestead by a relative of the owner to be considered as a homestead when property taxes are calculated. The statute defines a relative as a parent, stepparent, child, stepchild, spouse, grandparent, grandchild, brother, sister, uncle, or aunt, and states that relationships may be by blood or by marriage. Although neither the related occupant nor the owner of the property may claim a property tax refund for the property occupied by the relative, the obligation to pay homestead taxes, rather than non-homestead taxes at a higher rate, may make purchase of a second home for a relative with developmental disabilities a more attractive option.

IV. Trends in Services and Supports

In recent years, community integration of people with developmental disabilities has become a nation-wide focus. Services for Minnesotans with developmental disabilities have changed and improved in accordance with national trends. The most significant development in Minnesota's service delivery system in the past two decades has been its emphasis on developing community-based living options for children and adults with developmental disabilities. Providing people with developmental disabilities with the necessary instruction and support to work in community environments has also been a major focus.

The effects of Minnesota's deinstitutionalization and community integration efforts are depicted in Figure 1. As Figure 1 illustrates, the number of persons served in regional treatment centers began a steady decrease in 1978, when the population was close to 3,000. In January 31, 1995, the census of these large, congregate institutions had declined to 610 people who had been committed and another 43 admitted for temporary care of 90 days or less. Community ICFs/MR experienced a growth in population beginning in 1978, which stabilized in the mid-1980's, and is declining slowly. Other community-based

Figure 1

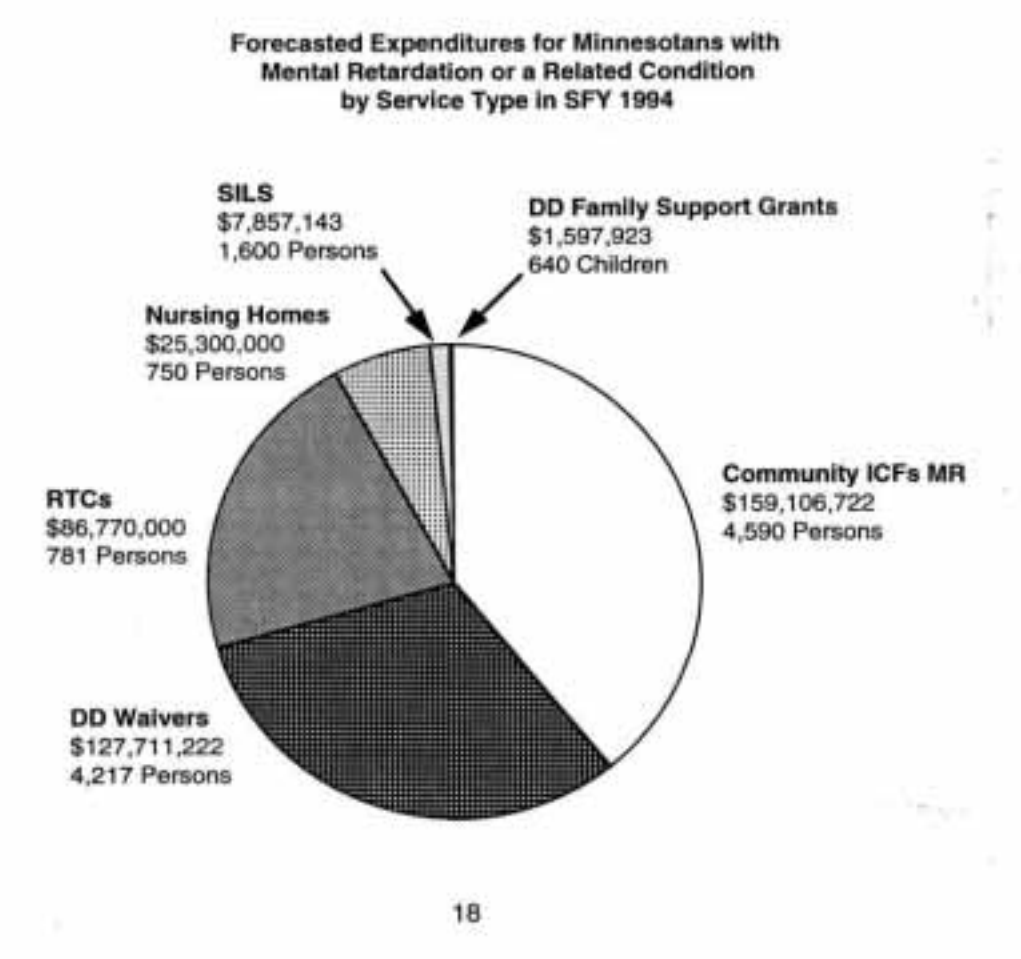


programs, most notably the Home and Community-Based Services Waiver, have grown considerably since the mid-1980's in accordance with Minnesota's emphasis on community integration and deinstitutionalization.

As the number of persons served in RTCs declined, the costs of serving the individuals who remain in these centers increased. The average daily cost of serving an individual in a RTC in state fiscal year 1982 was $85. By fiscal year 1995, the cost had risen to $324 per day. The increased daily costs are largely due to the fact that capitol costs for continuing to operate these facilities for a declining population have increased over the years.

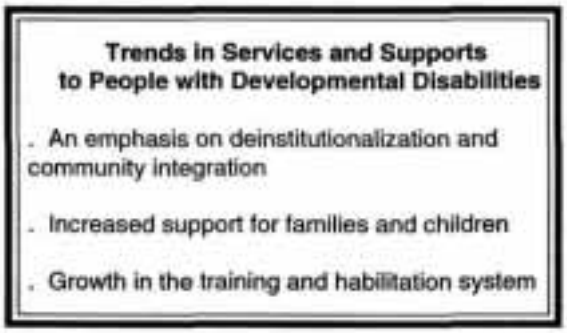
State expenditures in fiscal year 1994 are illustrated in Figure 2. Expenditures for people living in community ICFs/MR, which totaled $159,106,722, represent the largest proportion of expenditures for people with developmental disabilities. Minnesota spent $127,711,222 serving individuals through the Home and Community-Based Services Waiver in fiscal year 1994. Expenditures for individuals with developmental disabilities residing in RTCs during fiscal year 1994 were $86,770,000. Costs for nursing home services for persons with developmental disabilities during that fiscal year were estimated to be $25,300,000. SILS expenditures totaled $7,857,143. Family Support Program expenditures were $1,597, 923.

Figure 2



Many more resources are available now than in the past to support community living. Services for families and children have grown during the past decade, and are expected to become an even greater priority in future years. Both the number of families receiving Family Support Grants and the annual program expenditures has increased from 1978 to the current time. In addition, the Home Community-Based Services Waiver provides services to numerous individuals and their families. The availability of medical assistance through Minnesota's Children's Home Care Option (TEFRA) in fiscal year 1988 increased the type of support available for families and children.

Support by the Minnesota Legislature for community living for people with developmental disabilities has increased dramatically. Allocations for the Semi-Independent Living Services Grant Program, which provides adults with developmental disabilities with necessary support and instruction for living in the community, increased during the 1980's, allowing additional numbers of eligible persons to receive SILS. Expenditures for waivered services have increased at a rate, which reflects the increase in the number of persons served and in accordance with payment limits approved by the federal Health Care Financing Administration.



The number of persons receiving training and habilitation services for adults with developmental disabilities has increased yearly since 1979, the first year that data was available. This growth is due in large part to successful efforts to move people out of RTCs. According to a study conducted by the Department of Administration in 1990, expenditures for day training and habilitation services grew from $39,434,113 in 1985 to $52,814,901 in 1990, an increase of 33.9 percent. Costs for state fiscal year 1994 are estimated at $90,100,000.

V. Objectives and Priorities

DHS is committed to assisting Minnesotans with developmental disabilities to access appropriate, quality services that are commensurate with their needs and assisting them to attain the maximum degree of self-sufficiency consistent with their capabilities. Priorities for the 1996-1997 biennium include comprehensive reform efforts of the service system for persons with developmental disabilities that are intended to ensure access and create greater flexibility and consumer choice in social services, long-term care, and chronic care programs so people can be as independent and self-sufficient as possible.

In keeping with these goals, the Department has proposed changes, which will have positive long-term effects on how services are provided. During the 1995 legislative session, the Department will introduce the **Life Skills** Self-Sufficiency **Initiative.** The Life Skills Self-Sufficiency Initiate is intended to increase consumer choices in long term care, chronic care, and social services to allow more tailoring to

individual needs and physical abilities. As part of this initiative, the Department intends to: 1) implement and evaluate a **Consumer Support Grant** program; 2) implement and evaluate **Developmental Disabilities Pilots** that involve shifting the purchase of services for persons with developmental disabilities to the local level, consolidating and streamlining regulatory requirements, allowing efficiencies to be used to expand services to eligible participants; and providing increased choices to consumers of nontraditional supports and services; 3) implement an **Alternative Waiver Allocation Structure** for the Developmental Disabilities waiver; and 4) test and implement alternative **Quality Assurance Support Systems.** The Department will also continue the **Performance-Based Contracting Demonstration Project** authorized by 1993 legislation. These demonstration project allows providers of ICF/MR, SILS, and HCBS services to move toward an outcome-based approach to the delivery of services to persons with mental retardation or a related condition.

The Life Skills Self-Sufficiency Initiative is composed of:

- Consumer Support Grants
- Developmental Disabilities Pilots
- An Alternative Waiver Allocation Structure
- A Quality Assurance Support System

The proposed Consumer Support Grants will consist of monthly grants that will enable consumers to purchase their own needed supports. Persons eligible for grants will be those with functional limitations, and could include elderly persons desiring to leave nursing homes or individuals who are in need of community support to prevent nursing home placement, persons with developmental disabilities, persons with severe and ongoing mental illness or emotional disturbance, persons with hearing impairments who have other significant functional limitations, and other persons with functional limitations living in biological family settings. Family members of elderly persons or individuals with functional limitations may also be recipients on behalf of eligible consumers. Counties will be allocated funds for grants, and will distribute the grants to consumers and families. Consumer Support Grants will enable consumers to purchase needed care, services, supplies, and equipment directly, at less than the cost of county-purchased services. The grants will also allow consumers to obtain services informally from friends or neighbors rather than formally from agencies or professionals. Consumer Support Grants will also provide consumers with increased control and decision making over services.

Consumer Support Grants

Eligible persons - those with functional limitations

Purpose - allow consumers to purchase their own services, supplies, and equipment directly

Result - Increased consumers control over services

The Developmental Disabilities Pilots will test ways to improve service access, enhance consumers' choices for how their needs are met, and demonstrate innovative methods for providing services. Local participating planning groups, comprised of consumers, providers, advocates, and county agencies will work collaboratively to develop a system that distributes resources in a more efficient manner. The pilots will allow participating local entities to integrate resources that come from multiple funding streams and draw funding from this single source to flexibly provide, manage, and

purchase services. Alternative methods of assuring consumer protections will be allowed in order to reduce administrative and regulatory demands and provide services that are as flexible and responsive as possible.

The pilots are expected to benefit consumers by maximizing consumer choices and enhancing ease of access to and control over services. Barriers to service access will be reduced by individualizing the funding structure. Regulatory structures will be reduced, and administration will be localized. Consumer input into service design and consumer satisfaction with services will be an integral component of the pilots. More attention will be paid to individualizing services to meet consumers' needs, and less on providing "packaged" services that provide more than what is needed.

An evaluation of the pilots will be conducted to determine: 1) effects of the pilots on consumers and families; 2) the effect on providers of service; 3) the cost impact on governmental agencies and private payers, as applicable; 4) the extent to which "managing" an array of services has positive or negative outcomes for stakeholder groups; and 5) the impact on waiting lists. Based on the results of the evaluation, decisions to modify, expand, or abandon the model(s) tried will be made.

Plans call for the implementation of up to three pilots in State Fiscal Year 1996 and planning for three additional pilots in the coming years. County participation in the pilots will be voluntary. Several counties have already been working with local consumers, families, and providers to determine their interest in the project, and proposals from those counties have been submitted to the Department.

The Developmental Disabilities Pilots will result in:

- Cost efficiency
- Increased collaboration
- Increased consumer choice
- Individualized, responsive services
- Reduced barriers to access
- Simplification of rules and regulations
- Positive outcomes for people with developmental disabilities

In the 1995 legislative session, the Department will propose an alternative waiver allocation structure for distributing home and community-based resources to county agencies in a manner that reflects the needs of the persons who will receive them. The proposal was developed in response to issues related to the existing system. Management of costs within the current system has become complicated. Currently, costs for waivered services are managed on an aggregate basis. Each county maintains service costs within a daily average reimbursement limit. Some recipients may have service costs that are above the average while others' costs may be lower than the average. Changes made in the administration of the program in order to meet targeted initiatives have also created issues. For example, when counties were unable to serve persons with high service needs who were leaving RTCs within their average reimbursement limits, "enhanced" funding was made available in order to enable counties to purchase necessary services and continue downsizing initiatives. The Department manages the average for this group separately from the county average maintained for other recipients. In addition to introducing an additional layer of government into the administrative process, the availability of enhanced funding resulted in inequities in access. Although individuals leaving RTCs are provided with needed services, individuals with similar

needs who are living at home or leaving a community ICF/MR may not be able to access similar levels of funding for home and community-based services within the county-maintained average.

The alternative allocation structure proposes the use of a weighted daily average reimbursement limit for counties that is based on the sum of allowable funding limits for state fiscal year 1995 recipients, and funding levels for new recipients that are reflective of their needs. It will accomplish the following: 1) improve access to funding by allowing allocation of dollars to county agencies based on the need levels of persons who will be served, regardless of previous living arrangement or type of provider; and 2) place resource management and decision making at the level closest to the person receiving services. Actual funding authorizations for individuals will be decided at the local county level. This will streamline and simplify administrative procedures. Additional management and decision-making support for local agencies is also planned.

Issues with Minnesota's Current Waiver Allocation Structure

- Differences in levels of funding
- Complicated procedures for managing costs
- Layers of administration

As part of the proposal, the four state managed components of the DD waiver program projected to serve a total of 1,605 persons by June 30, 1995, will be combined with the funding for the 3,560 persons whose costs are managed by counties in a statewide average. Counties will authorize funding for individual recipients based on actual service plans developed by persons closest to the recipient.

The Alternative Waiver Allocation Structure will:

- Improve access to waivered service funding
- Transfer resource management and decision-making to county agencies
- Streamline and simplify administrative procedures

The Quality Assurance Support System component of the Life Skills Self-Sufficiency Initiative seeks to test and implement alternatives to traditional approaches for ensuring quality in the services provided to individuals who require ongoing care. The proposal includes: 1) design of a "peer review" model that can be used to examine service delivery practices within county and other service delivery organizations; 2) development of processes and instruments for measuring consumer satisfaction and providing feedback to providers and local agencies; 3) examination and development of recommendations concerning the availability of legal representation for individuals under public guardianship and need for increasing ombudsman-related functions; and 4) support for local level coordination of services and funding of services under a capitated limit.

Service delivery systems are changing as a result of consumers' demand for flexible and responsive services that meet their unique needs. Current methods for measuring quality rely heavily upon investigation by external reviewers to detect inadequacies, followed by corrective action to remedy deficiencies. The Quality Assurance Support System proposal was developed in response to a need for quality assurance mechanisms that can be used by agencies on an ongoing basis for the purposes of

self-examination and self-correction. The alternative systems will not eliminate necessary monitoring and oversight, but will address quality assurance in a more proactive manner than the methods that are employed currently. Additionally, encouraging local service agencies to collaborate in the planning and monitoring of services will result in improvements in consumers' health, safety, and quality of care.

Quality Assurance Support Systems Will Include:

- Peer review models for examination of service delivery practices
- Processes for measuring client satisfaction
- Feedback mechanisms for providers and local agencies
- Advocacy and oversight for individual consumers
- Local level quality assurance monitoring and service planning

In 1993, the Minnesota Legislature authorized the Commissioner of the Department of Human Services to establish demonstration projects to improve the efficiency and effectiveness of service provision for persons with developmental disabilities through performance-based contracting. The legislation directed the Commissioner to seek federal authority for the waiver of necessary provisions of regulations governing ICFs/MR in order to permit alternative quality assurance mechanisms to be used on a demonstration basis. The impetus for the legislation came from a recognition that traditional approaches to defining and monitoring quality of services may bear little relationship to the quality of life experienced by individuals with developmental disabilities who are recipients of those services. In addition, standards of care which govern ICFs/MR have resulted in a regulatory system that lacks the flexibility to meet consumer needs. As a result of inadequacies in the current regulatory system, interest in an outcome-based system to increase service quality has grown.

In response to that legislation, Minnesota submitted a Section 1115 Demonstration Waiver request for authority to engage in performance-based contracting and a demonstration grant application to the Health Care Financing Administration in March of 1994. Notice of award of the receipt of $800,000 in cooperative agreement funds over a three-year period for evaluation of the demonstration project and other project-related activities was received in September of 1994. Approval of the Section 1115 waiver is anticipated in June of 1995.

The performance-based contracting demonstration projects are affording five provider agencies with ICFs/MR in six counties that were selected through a request for proposal process an opportunity to provide outcome-based residential and support services that emphasize consumer choice, increased responsiveness to individual preference, and increased independence and community involvement. In each of the counties involved, local work groups consisting of representatives from each of the provider agencies, county staff, advocates, and other interested individuals have been meeting for over a year to develop each provider organization's alternative quality assurance framework and to provide a forum through which consumers and family members can become involved in the systems change process.

In order to allow implementation of alternative quality assurance mechanisms, numerous process standards currently in place that would prevent use of those approaches will be waived. Legislation authorizing the demonstrations also required that the rights and procedural protections guaranteed under certain statutes not be denied to individuals involved in the project. These protections include: 1) regulations governing the use of aversive and deprivation procedures; 2) Ombudsman's Office protections; 3) a requirement that day services and residential services be provided by separate entities; 4) appeal rights; 5) the right to case management; and 6) requirements for reporting of abuse of vulnerable adults and children. In addition, demonstration project sites will continue to be licensed as supervised living facilities by the Department of Health, county agencies must remain responsible for arranging appropriate services, and monitoring of the use of psychotropic medication must continue.

Performance-Based Contracting Demonstration Projects will:

- Allow 5 participating provider agencies to implement alternative quality assurance approaches by waiving certain process standards
- Result in services that emphasize consumer choice and achievement of positive outcomes
- Replace existing cost-based reimbursement system with contracts specifying amount and conditions of reimbursement, monitoring and evaluation requirements, and expected consumer outcomes

Payment for ICF/MR services for the participating providers will be based on their fulfillment of contractual obligations set forth in an agreement between each provider, the host county, and DHS that specifies the amount and conditions of reimbursement, requirements for monitoring and evaluation, and expected consumer outcomes. Contracts will replace the current reimbursement system that requires ICF/MR providers to undertake extensive cost reporting and document their compliance with process requirements.

Summary

Achievement of the goals of the Life Skills Self-Sufficiency Initiative will result in a service system that promotes consumer choice and is flexible and responsive to the needs of individuals with developmental disabilities and their families. Simplification of complex administrative rules and procedures is expected to improve the manner in which providers deliver services, and increase their capacity to serve more individuals with developmental disabilities. The Department believes that reform efforts brought about by the Life Skills Self-Sufficiency Initiative will result in the provision of quality services that meet or exceed customers' expectations in both an efficient and effective manner.

The performance-based contracting demonstration projects will allow evaluation of alternative means of ensuring quality of community residential services for people with developmental disabilities. Waivers of some existing rules and process requirements will result in a system that is more responsive

to consumer preference. The Department believes that the performance-based contracting demonstration projects will both increase the quality of services delivered to individuals as well as empower them to take more active roles in defining desired outcomes for their lives and achieving personal goals.

VI. Conclusion

Minnesota's commitment to people with developmental disabilities is demonstrated by the array of supports and services available to its citizens across their life span. Family Support Grants, services through the DD waivers, and SILS allow individuals to live in the community in typical single family homes and still receive needed services. Housing options that include services in addition to providing a place to live are also available. Early intervention services for children with disabilities aged birth through seven are family-focused and are aimed at remediating the effects of handicapping conditions to the greatest extent possible. Educational services for students with developmental disabilities in elementary, middle, and secondary middle schools assist them to acquire functional, age appropriate skills necessary to live within their homes and communities, and to make friends with their peers without disabilities. Transition planning services assist families and their adolescent children to prepare for entry into adult life and work. Training and habilitation services provide adults with opportunities and instruction necessary for engaging in meaningful work, either on-site at a training and habilitation center, or in a community setting with job coach support.

Minnesota's efforts to assist its citizens with developmental disabilities to live productive, meaningful lives in least restrictive environments is exemplary. Numerous problems still exist, however. Many individuals are currently without services. Aging parents whose adult children with developmental disabilities still live at home are concerned about what will happen to their children when they are no longer able to provide for them. Individuals living in ICFs/MR or with their families are on lengthy waiting lists for SILS. People with severe challenging behaviors or chronic medical conditions who live in RTCs or large community ICFs/MR are often unable to move into smaller community homes with HCBS services due to their county's inability to maintain service costs within a daily average reimbursement rate. A shortage of service providers trained to address these individuals' needs also exists. In some areas of the state, training and habilitation options that emphasize community-based supported employment, particularly for individuals with physical disabilities and/or challenging behaviors, are lacking.

During the 1996-1997 biennium, continued development of community-based support services for persons with developmental disabilities will remain a departmental priority. The Department will work with facilities that are downsizing or closing voluntarily to assist the individuals who live there to move to new homes in the community. The Department will continue to develop and oversee policies to create alternative housing options for persons with developmental disabilities as well as increase the availability of affordable community-based housing. The 1996-1997 biennium will undoubtedly contain many

challenges for people with developmental disabilities, their families, friends, advocates, service providers, and for state and county agency staff. While additional funding in the coming biennium for community-based programs and services for individuals with developmental disabilities is critically needed, changes brought about by the Life Skills Self-Sufficiency Initiative and the performance-based contracting demonstration project will result in an expanded menu of available supports, increased consumer choice, a more efficient method of delivering services, more equitable distribution of resources, and streamlining and simplification of procedural requirements for accessing services.