

A Preliminary Report to the Minnesota State  
Legislature  
on  
Developmental Achievement Centers  
and Semi-Independent Living Services  
in Minnesota

Minnesota Department of Public Welfare  
Leonard W. Levine, Commissioner  
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## EXECUTIVE SUMMARY

This paper examines the major issues that have created the need for a careful study of the manner by which the state funds Developmental Achievement Services for the mentally retarded in Minnesota. It further examines a relatively new service in this state entitled SILS, or Semi-Independent Living Services. Due to declining resources at the state and local levels, it examined the policy, program and fiscal impacts of using the federal Title XIX Medical Assistance (MA) Program to partially fund these programs. Finally, it explores the advantages of applying for a Home and Community-Based Services Waiver under the Title XIX program.

Extensive study and consideration of the issues presented in this paper within the broader context of the scope and direction of the entire service delivery system over the past several weeks have resulted in the following recommendations:

1. DEVELOPMENTAL ACHIEVEMENT CENTERS (DACs)
  - To fund Developmental Achievement Center services for all ICF/MR residents under the Medical Assistance Program.
  - To fund Developmental Achievement Center services as a waived service to those individuals placed from an ICF/MR or state hospital into a non-ICF/MR alternative service.
  - To continue to fund all other DAC clients under CSSA.
2. SEMI-INDEPENDENT LIVING SERVICES (SILS)
  - To fund SILS as a waived service to those individuals placed from an ICF/MR or state hospital into a non-ICF/MR alternative service.
  - To continue funding existing SILS clients at risk of ICF/MR placement under the state/county SILS appropriation.
  - To fund all non-MA eligible persons in need of SILS under CSSA.
3. HOME AND COMMUNITY-BASED SERVICES WAIVER
  - To apply for a Home and Community-Based Services Waiver to provide a broad array of community and home-based services.

The text of this paper offers the programmatic, administrative, and fiscal impacts of these recommendations.

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## I. INTRODUCTION AND PURPOSE OF THE STUDY

This report was prepared in response to legislation from the Third Special Session of the 1981 Legislature, Chapter 2, Article 1, Section 2, Subd. 4a stating, "The Commissioner of Public Welfare shall study the fiscal and programmatic impact, the number of persons who would be affected, problems and benefits to persons who would be affected, and any other effects, if the costs of providing developmental achievement services and semi-independent living services were paid through Title XIX of the Social Security Act and Minnesota Statutes, Chapter 256B. The study shall be completed and submitted to the Legislature not later than two months following final enactment of federal appropriation amounts."

Some of the factors that led to this study include:

- 1) CPU's Six Year Plan of Action calls for the development and expansion of services in the community continuum of care (See Appendix A), so that the number of state hospital residents can be reduced;
- 2) In the Welsch vs. Noot Consent Decree, DPW has agreed to propose to the Governor for submission to the Legislature, all measures necessary for implementation of the provisions of the Decree, including the elimination of financial incentive currently encouraging counties to place mentally retarded in state hospitals. This meant equalizing the percentage of the costs paid by counties for placement in state hospitals and in community-based facilities;
- 3) Increased community alternatives to institutional care are needed at a time of reduced resources available to counties and uncertainty about federal actions on Titles XIX and XX;
- 4) The Omnibus Budget Reconciliation Act of 1961, allows waivers to the Title XIX program so that home and community based services may be covered for certain individuals who would otherwise require institutional (state hospital or ICF/MR) care.

Therefore, the purposes this report intends to serve include:

- 1) To identify and describe the major programmatic and fiscal issues facing the Department that created the need for this study.
- 2) To present background information, programmatic and fiscal data on Developmental Achievement Centers (DACs) and Semi-Independent Living Services (SILS);
- 3) To explore various funding options including the utilization of the Title XIX Medical Assistance Program;
- 4) To present the respective fiscal, programmatic and administrative impacts of identified options;
- 5) To examine each option in relation to the major issues and problems, and;
- 6) To identify means to minimize state and local expenditures by maximizing federal financial participation.

Some general recommendations are offered in this report. An attempt has been made to present all facts relevant to the issues that will facilitate legislative action.

## II. MAJOR ISSUES

- A. Financial Disincentives Exist for County Boards to Utilize More Cost Efficient and Effective Service Alternatives. The need for and the costs of community-based human services is increasing, yet the level of federal and state financial participation continues to be reduced. As a result, the fiscal impact of providing services has become a major criterion for local government in determining what services a client receives and where those services are to be delivered. Federal and state financial participation continues to encourage local governments to place clients into more restrictive service settings than is appropriate. As a client becomes more independent and is placed into less restrictive community settings, local governments find themselves paying more to provide the appropriate services even though the total unit cost of the service is lower. For example, a county agency must pay more (10 times more) for community-based developmental achievement services than for state hospital-based developmental achievement services, and, pay more for maintaining a client in semi-independent living setting than in a community-based residential program setting. As a result, mentally retarded persons who need and can benefit from less restrictive (and usually less expensive) community environments are often not provided those services due to perverse historical funding models.

Pursuant to Part VII of the Welsch vs. Moot Consent Decree and Memorandum Order Dumber 4-72-Civ. 451, the Commissioner of Public Welfare was ordered to submit a proposal to the 1982 Legislature that would "eliminate the remaining financial incentives encouraging counties to place mentally retarded persons in state hospitals by equalizing the percentage of the costs paid by the counties for DAC services in state hospitals and in community-based facilities."

In the 1982 Legislature, Bouse Pile 1465 and Senate File 1365 were supported by the Department as its proposal to comply with Para. 89F. These legislative proposals were considered by the Department as the best of three options to eliminate the fiscal incentive encouraging counties to place clients into state hospitals. The options were:

1. To ask the legislature for an appropriation for grants to counties to assist them in paying for developmental achievement services;
2. To propose legislation requiring counties to pay more for developmental achievement services in state hospitals; or
3. To pay for community-based developmental achievement services under Medical Assistance, thus reducing the county share of the cost to 10% of the non-federal share and maximizing federal financial participation.

The first option was rejected because new state funds were not considered available. The second option was rejected because it would substantially increase the burden on property taxes and cause problems with levy limits. Hence, the third option was chosen as the best option. Neither bill was passed by the full legislature.

- B. Federal and State Court Mandates on DAC Services. Resource deficits in current funding model have resulted in delays and waiting lists, and in a few instances, termination of services. Due primarily to cuts in CSSA (state) and Title XX (federal) social service appropriations, counties found it increasingly difficult to meet the needs for DAC services.

Counties with severe budget constraints were authorized to reduce the amount of services to all clients, irrespective of interdisciplinary team determinations that a full time DAC program is needed on a case-by-case basis. Commissioner Hoot determined (Instructional Bulletin #81-35) that general reductions from a five day per week program to three days or five half days, was less detrimental than denials of services to some clients.

This issue was sued out, appealed to the Minnesota Supreme Court and heard in the fall of 1982. On January 21, 1983, that Court ruled that such reductions were not permissible under existing state rule.

An additional number of social service appeals have been filed as a result of service reductions in relation to Welsch v. Moot class members. On hearing this matter, the U.S. Federal District Court ordered, by specific cases, that a full time, full day program of services be provided in accordance with determinations made by the interdisciplinary team. These Court Orders were appealed by the Department but were subsequently withdrawn after the Minnesota Supreme Court decision.

Although the Department attempted steps that would allow counties some flexibility in their budgeting DAC services, the above court actions have firmly established that the programs in question must be provided in accordance with individual service plan recommendations.

- C. Reduction in the Rate of State Hospital Discharges and increase of readmissions to state hospitals are occurring due to difficulties in securing adequate and appropriate DAC services in the community. While the reduction of state hospital populations is currently within the quotas established in the Consent Decree, it is expected that continued reductions will become increasingly difficult unless a solution to the funding of DAC services is found. Further, given a federal court order that day services must be provided on a full-time (five day) basis to all persons leaving the state hospital, several counties will be faced with providing differential levels of service for their clients based on previous residency. It can be expected that such differential service provision will also result in continued appeals and hearings as counties are forced into making service reductions from the full time or five day service level to four days, three days or five one-half day levels.

- D. Potential Decertification of Community-Based Residential Facilities due to lack of adequate and appropriate day programs prior to the January 21, 1983 court order posed a serious threat to the residential service program in Minnesota. Pursuant to federal regulations (42 CFR 442.463), a community residential facility (certified as an intermediate care facility for mentally retarded, or ICF/MR) must provide active training and habilitative services to all residents regardless of age, degree of retardation, or accompanying disabilities or handicaps. The provision of training and habilitative services must be based on the goals and objectives of each resident's habilitation plan. The ICF/MR must provide evidence of provision of adequate habilitative and training services and have a sufficient number of qualified staff supervised by a Qualified Mental Retardation Professional.

In Minnesota, the above requirement for habilitation/training has been interpreted to mean that residents attend a day developmental program (typically a DAC) on a regular basis if the resident is unable to participate in sheltered work settings or is ineligible for public education. Although both community-based and state hospital-based day developmental programs are required by the federal regulations (ICF/MR) to fulfill the provisions of active treatment, only state hospital day developmental programs are funded through Medical Assistance (Title XIX). Community-based day developmental programs are funded primarily through the Community Social Services Act (CSSA), Title XX and county dollars. This has resulted in a basic administrative and funding inconsistency between state hospital and community-based day developmental programs.

Recent investigation of the Title XX issue has revealed that these funds, according to federal opinion, are not to be used for residents of ICF/MR facilities.

- E. Federal Financial Participation has not been sought for the semi-independent living services (SILS) component of Minnesota's continuum of service system. At issue is the decision to apply for a Home and Community-Based Care Waiver under Title XIX Medical Assistance Program made possible under the Omnibus Budget Reconciliation Act of 1981. This federal legislation permits states to provide home and community based services under the MA program as a less expensive alternative to long-term care placement. The SILS program in Minnesota represents such an alternative but is currently funded totally with state and county dollars. By applying for the MA Waiver and securing federal approval, 55% of the costs of the SILS program would be eligible for federal reimbursement for persons who would otherwise be placed in an ICF/MR facility or a state hospital. Without federal participation, it is unlikely this program will be expanded given its reliance on scarce state and county dollars. As a result, the counties will continue to rely on the more expensive state hospital or ICF/MR programs due to the lower costs to the counties.

- F. Summary of Issues. The above constitutes five major issues facing the state and the overriding impetus for the study at hand. The balance of this document explores the alternatives identified to address these issues and their respective policy, program and fiscal impacts.



### III. PART ONE: A DESCRIPTION OF DEVELOPMENTAL ACHIEVEMENT SERVICES

#### A. Background:

Prior to 1961, there were very few programs in Minnesota resembling the current Developmental Achievement Center programs. In 1961, the legislature funded a pilot project to develop nine DACs. Funding continued and by 1965, 23 DACs in Minnesota were operating with state grants totaling \$155,000 in appropriations for the 1963-1965 biennium. Prior to January, 1980, DAC's received state grants from the Department of Public Welfare. Those grants, which covered up to 60 percent of the costs of providing services, were legislative appropriations earmarked for that purpose. Beginning in 1975, the legislature also appropriated funds to cover transportation costs for DAC participants.

Table I shows the funding history and number of persons served from F.Y. 1973 through F.Y. 1980:

TABLE 1  
HISTORICAL FISCAL AND CLIENT DATA ON DACS FROM 1973-1980

YEAR	DAC BUDGET	STATE GRANT-IN AID	PERCENT STATE FUNDS	LOCAL FUNDS	SCHOOL CONTRACTS	TOTAL CLIENTS
FY 1973	\$4,388,609*	\$1,851,025	49 %**	\$1,909,125	\$628,432	2,423
FY 1974	5,426,907*	1,999,971	42%	2,795,266	604,670	2,792
FY 1975	7,536,681*	2,817,191	41%	3,973,780	745,710	3,178
FY 1976	10,691,893	6,210,702	61%	3,965,305	515,886	3,679
FY 1977	13,428,260	7,133,600	55%	5,833,635	437,984	4,114
FY 1978	15,426,032	7,878,535	53%	7,063,380	484,117	4,446
FY 1979	17,353,101	8,484,088	50%	8,279,825	474,687	4,679
FY 1980***	19,753,382	9,683,446	49%	9,808,792	355,697	4,902

\* Approximately 46% of DAC transportation costs were funded by the Department of Education.

\*\* Percent of state funds pertains to the percentage after school contracts have been subtracted from DAC budgets. Percentage include\* program and transportation funding.

\*\*\* In F.Y. 1980, DACs were funded for six months under state grant-in-aid and six months under CSSA.

#### B. The Purpose of DACs and the Rules and Regulations Governing Them.

Developmental achievement services are designed to assist in the development of sensory motor, communication, sociobehavioral, prevocational, home-living, and leisure skills for individuals who are mentally retarded or have cerebral palsy. In Minnesota, these services are currently provided in the community by state licensed facilities called developmental achievement centers (DACs). A DAC, formerly

termed a daytime activity center, is a facility operated by a nonprofit corporation or local government agency which provides developmental programming of less than 24 hours per day for five or more individuals who are mentally retarded or have cerebral palsy. The DAC's provide services in-center to clients from ICF/MR<sup>1</sup>\*, nursing homes, board and care homes, foster homes and their own homes. Some DAC's may also provide in-home services to certain home-bound individuals. Those enrolled for in-center services are transported to and from the DAC to their residence in the community. State hospitals also provide developmental achievement services as a part of its total program for all non-school-age residents.

In Minnesota, developmental achievement services are provided to mentally retarded individuals and those with cerebral palsy up to the age of four as well as for those 21 years of age and older. Since 1971, school-age children, four to 21 years of age, attend public school classes unless specifically excluded by the school district. The education costs are the responsibility of the school boards and the Department of Education regardless of where or by whom those services are provided.

The costs of DAC services in the community are currently covered by a combination of federal Title XX funds, state Community Social Services Act (CSSA) appropriations, and county tax levy funds for social services. DAC services in the state hospitals are funded as a part of the Medical Assistance Program.

Two principles impacting on the DAC's and their programs are "deinstitutionalization" and "normalization". Deinstitutionalization has been defined as the prevention of inappropriate hospital admissions, discharge of individuals appropriately prepared, and the establishment of community based services for those placed in the community. DAC's offer one community service in the community continuum of care. The normalization principle basically means that the daily life of the retarded individual is as close as possible to that of society in general. The combined influences of the deinstitutionalization and normalization processes and the parallel growth of community residential facilities have contributed to the development of community-based services, such as DAC's.

Developmental achievement services for adults are generally provided ten months per year, six hours per day, five days per week, from the age of 21 years and on.

A major source of clients enrolled in DAC's is the intermediate care facility for the mentally retarded (ICF/MR). Federal regulations pertaining to ICF/MR's (42 CFR 442.463) state, "The ICF/MR must provide training and habilitation services to all residents, regardless of age, degree of retardation, or accompanying disabilities or handicaps." The regulations define "training and habilitation services" as those "intended to aid the intellectual, sensorimotor, and emotional development of a resident." (42 CFR 442.401). In addition, federal regulations require that "individual evaluations of residents must...provide

the basis for prescribing an appropriate program of training experiences for the resident. The ICF/MR must have written training and habilitation objectives for each resident that are based upon complete and relevant diagnostic and prognostic data; and stated in specific behavioral terms that permit the progress of each resident to be assessed, The ICF/MR must provide evidence of services designed to meet the training and habilitation objectives for each resident." (42 CFR 442.463). As stated earlier, in Minnesota, these regulations have been interpreted to mean that all residents of ICF/MR's must attend DACs on a regular basis.

The Department of Public Welfare Rule 34, pertaining to standards for the operation of ICF/MR's and services for the mentally retarded, states that "all developmental and remedial services...shall be rendered outside of the facility, whenever possible, and when rendered in the facility, such services must be at least comparable to those provided in the community.

Both federal regulations and state rules require that there be a pre-admission evaluation, a review of that evaluation within one month of admission, and an annual review of the resident's status. The developmental progress of each resident is reviewed at least at these times if not on a more frequent basis.

DPW Rule 185 pertains to the minimum service standards for county boards and human service boards and therefore the local agencies providing case management, planning, coordination and development of services for all individuals who are or may be mentally retarded. The responsibilities of local social service agencies include securing diagnostic information, assessing the client needs and developing the individual service plan, and making placements in day and residential facilities. All of these regulations are to assure appropriate individualized training, education, and treatment of the mentally retarded client.

The DACs, in order to be licensed by DPW, must meet the standards for group day care of preschool and school age children. These standards include facility requirements, staff requirements and program requirements. The program/service standards are minimal and very general, allowing for great variation in programs of licensed DAC's. DPW is currently working toward the promulgation of DPW Rule 38 which will govern the operation of facilities providing developmental achievement services.

The issue of decreasing levels of DAC service because of county budget constraints has been raised. In response to this, DPW established the minimum level of service as three full days or five half days. The issue of the Department's authority to authorize reductions was sued out, appealed, and heard in the Minnesota Supreme Court. That court ruled on January 21, 1983 that such reductions were not permissible, and that levels of service needs must be established through the individual service plan development process.

C. Preschool Program Transfer to Department of Education.

There is currently under consideration a proposal to transfer all preschool programs currently provided in DACs to the Department of Education. At the writing of this report, a September 3, 1982 Inter-Agency memorandum, signed by the Commissioners of Health, Education and Welfare, outline a set of recommendations to study this proposal. The Department of Education has been assigned the lead in this study to occur in 1983.

D. Current DAC Funding System.

In 1979, the Minnesota Legislature enacted the Community Social Services Act (CSSA) which changed the funding of social services to a block grant model. County Boards of Commissioners were given the major responsibility for planning, coordinating, and implementing social services. The CSSA required counties to maintain the same level of expenditures as in 1979 during the 1980 and 1981 period for certain social services, including developmental achievement services as well as all other services for the mentally retarded. Beginning in 1980, the grants-in-aid for developmental achievement services were included in the block grant appropriation and the county boards, with citizen participation, began exercising authority and responsibility for determining the distribution of funds for social services. The term "social service funds" as used in this report includes Title XX federal funds, state CSSA appropriations and local funds for social services.

A study by the Office of Policy Analysis reveals that DAC expenditures increased;

From	To	Percent
1979	1980	25.5 (actual)
1980	1981	14.1 (actual)
1981	1982	3.0 (projected)
1982	1983	8.0 (projected)
1983	1984	5.0 (projected)

It should be noted that the 1983-84 projections were made from a sample of county CSSA plans filed prior to the \$312,000,000 revenue shortfall announced in November 1982, and subsequent legislative reductions. As apparent from the data above, expenditure increase rates have dropped sharply while client demands continue to increase. (See table 2, page 11.)

Reviews of each county's actual expenditures for developmental achievement services for the period January through June, 1982 indicated that the six month expenditures, including transportation, were \$12,922,262. To the degree the last half of 1982 is similar to the first six month period, the annual expenditures would be \$25,844,524. (This figure does not reflect non-county/state revenues or waiting list reductions.) These figures are approximations because (1) the transportation expenditures reported were not solely for developmental achievement services, (2) the 1981 expenditures used were with one county not reporting, and (3) direct service costs are excluded.

In 1980, the total revenue of 106 DAC's at 146 sites was \$22,890,077; CSSA accounted for \$20,395,616 or 89.1 percent of all DAC revenue. During 1981, the total revenue for DAC's was \$25,976,788 – an increase of 13.5 percent over 1980. CSSA accounted for \$23,293,614 or 89.7 percent of the total DAC revenue in 1981. The remaining sources of revenue are other government funds, family, and "other" support. (These data exclude state hospital DAC's and one DAC receiving no public funds.)

Sixty-three percent of DAC expenditures were for personnel costs. The second largest expenditure category was for transportation of clients to and from the DAC's. In 1981, transportation costs were \$3,940,000 or 15.2 percent of all expenditures. Occupancy costs were \$2.2 million or 8.4 percent of total expenditures. Supplies, postage, travel and other program costs were \$3.4 million or 13.1 percent of total DAC expenditures.

Various programs are provided by the DAC's: adult programs, school-age programs, preschool programs, infant programs, and/or homebound programs for the above age categories. Combining transportation with program per diems results in the following statewide average in-center DAC per diems in 1981:

Adult	\$25.33
School Age	\$32.17
Preschool	\$37.92
Infant	\$43.07

The statewide or regional averages do not indicate the variation in program and transportation per diems. For example, the range of adult in-center per diems is \$15.47 to \$53.37. In addition, approximately 43 percent of all clients received DAC services in the seven county metropolitan area. The 1981 regional average per diem for adults in the metropolitan area was \$27.26 while the 1981 statewide average amounted to \$25.33.

Another area of variation among DAC's is program days per year. While the statewide average number of program days for adults was 211, the average regional range was 196 to 255 per year. The actual range in program days for adults in 1981 was 175 to 244 days. The variation in number of program days per year also occurs in the infant, preschool, and school age program. In 1981, the average regional range of infant program days was 37 to 134 with the statewide average being 92 days.

The preschool average regional range was 123 to 215 days with a statewide average of 184 days. The school age average regional range was 164 to 219 days with a statewide average of 186 days.

The statewide average number of program days per week and the statewide average number of program hours per day in 1981 is as follows:

Adult Program	– 5.0 days per week and 6.1 hours per day
School Age Program	– 4.9 days per week and 5.5 hours per day
Preschool Program	– 4.6 days per week and 4.8 hours per day
Infant Program	– 2.0 days per week and 2.2 hours per day.

Under the current system of social service funding for developmental achievement services, the counties play a crucial role retarding provision of and payment for services. The fiscal planning process occurs prior to the provision of and payment for services. The county board and the DAC negotiate an annual budget and a program per diem for services based on projected units of service and service costs. Generally the DAC receives an advance from the county and additional services are based on the negotiated per diem. The counties, even when faced with fiscal constraints, may not reduce services unless determined appropriate for an individual and so documented in the individual service plan (ISP). Faced with this dilemma, counties must now consider DAC services as mandatory over all other optional services.

Table 2 summarizes the projected demands and costs for DAC services through F.Y. 1965. A more detailed analysis appears as Table B1 in Appendix B.

TABLE 2  
ACTUAL ADD PROJECTED DEMANDS AND COSTS FOR DEVELOPMENTAL  
ACHIEVEMENT SERVICES - F.Y. 1981-1985

<u>F.Y. 1981</u>	Children	Adults	Total
No. of Clients	1,250	3,614	4,864 (Actual)
Annual Client Costs	\$5,217	\$5,108	-0-
Total Cost	96,521,071	\$17,575,286	\$24,096,357
<hr/>			
<u>F.Y. 1982</u>			
No. of Clients	1,400	4,155	5,555 (Projected)
Annual Client Costs	\$5,671	\$5,420	-0-
Total Cost	\$7,939,400	\$20,722,094	\$28,661,494
<hr/>			
<u>F.Y. 1983</u>			
No. of Clients	1,400	4,383	5,783 (Projected)
Annual Client Costs	\$6,027	\$5,760	-0-
Total Cost	\$8,437,800	\$23,985,889	\$32,423,689
<hr/>			
<u>F.Y. 1984</u>	Children	Adults	Total
No. of Clients	1,400	4,571	5,971 (Projected)
Annual Client Costs	\$6,388	\$6,106	-0-
Total Cost	\$8,943,200	\$26,513,728	\$35,456,928
<hr/>			
<u>F.Y. 1985</u>			
No. of Clients	1,400	4,733	6,133 (Projected)
Annual Client Costs	\$6,771	\$6,473	-0-
Total Cost	\$9,479,400	\$29,104,766	\$38,584,166

Assumptions used in Developing Table 2:

1. Demand includes clients discharged from state hospitals, new admissions to ICF/MR's, and admissions from the community (i.e., public school graduates, etc)
2. DAC demissions are occurring and have been accounted for, on a regular basis due to development of new and additional slot\* in the community continuum of care such as sheltered workshop slots and work activity slots.
3. The 1961 waiting list of 262 adults and 146 children are eliminated; these clients are projected as having been admitted to DACs in F.Y. 1982 at existing per diem rates and are provided full services.
4. The number of infants and preschoolers requiring services will remain constant in the future.
5. The statewide average adult per diem increases six percent annually.
6. The statewide average preschool annual costs increase six percent annually.
7. There is no increase in number of days of service for preschoolers ever the years.
8. The number of days of service for adults remains stable at 211 day per year.
9. Figures exclude school age clients and costs.

NOTE: See Appendix C for fiscal impacts of meeting these demands under current funding system.

IV. ALTERNATIVE PROPOSALS FOR FUNDING DEVELOPMENTAL ACHIEVEMENT SERVICES FOR THE MENTALLY RETARDED

A. The Utilization of Title XIX.

The proposed Title XIX coverage of services for the mentally retarded is multi-faceted. In addition to Title XIX coverage of developmental achievement services for residents of ICF/MR residents, it is now possible due to recent federal regulations to cover the following services, under certain circumstances, for the mentally retarded: training and habilitation, semi-independent living services, foster care, case management, homemaker and home health aide, personal care, and respite care services. Although previous proposals usually recommend coverage of both developmental achievement services and semi-independent living services, for purposes of analysis, each part will be treated separately in this report. Each alternative will be explained and analyzed as to its impact on state policy, programming for the mentally retarded, and the financing of those alternatives.

Under Title XIX, services provided are based on individual need. All eligible individuals requiring developmental achievement services could receive the services and reimbursement would be made. However, under the HA Waiver option, services can now be targeted to specific groups under the "non-statewide waiver" if they meet the criteria for, and are at risk of being placed with a long-term care facility.

There are only two possible methods of funding Developmental Achievement Center services under Title XIX in Minnesota. One is to pay for these services under the regular Medical Assistance program as a component of the ICF/MR program under the "active treatment" requirement in the Title XIX ICF/MR regulations. The other method is to pay for DACs as a "habilitation services\*" component of a Home and Community-Based Services Waiver for HA eligible persons who, without such service, would likely be placed into an ICF/MR.

(It has been suggested that the DACs be enrolled as certified Medical Vendors; however, the Department has recently learned that the service currently provided by DACs would not meet the definition of rehabilitation services and as such, would not be certifiable.)

B. Two Proposals.

Two proposals for using Title XIX are offered regarding the funding of developmental achievement services. They are:

1. Title XIX coverage of residents in ICF/MR's as a component of the Medical Assistance program.
2. Title XIX coverage of "Waivered" eligible adults under a Home and Community-Based Services Waiver.

Proposal 1. Training and habilitation services required by residents of ICF/MR's be reimbursed under Title XIX. This proposal would require modification of the HA State Plan, legislative action and rule change under the administrative procedures act; a federal waiver is not



required. The rationale for this proposal is grounded in the requirement for training and habilitation services as required for Title XIX certification of ICF/MR's, the services would be funded under Title XIX as they are currently funded in the state hospitals.

This proposal is directed only at those individuals in ICF/MRs and who are in need of DAC services and does not include the approximately 40% who are receiving educational and vocational services funded under other service programs.

#### Policy Impact

1. Removes incentives for state hospital placement. The proposal will remove any fiscal incentive to counties for placement of mentally retarded persons in state hospitals. This is consistent with the state's policies of deinstitutionalization and normalization. It is also a major stipulation of the Welsch vs. Levine Consent Decree and resolves Major Issues A and D.
2. Standardization of developmental achievement services. Some services currently provided may not be eligible for coverage. All developmental achievement services covered by Title XIX would have to comply with the same standards whether provided by the state hospital or in the community. Federal regulations define training and habilitation services as "those intended to aid the intellectual, sensory motor, and emotional development of a resident." (42 CFR 442.401), These services are to be prescribed, based on individual need, and progress of each resident is to be assessed on a regular basis.
3. Potential incentive for residential placement. The proposal (i.e., ICF/MR residents only) creates the potential for differential treatment based on client's place of residence, perhaps providing an incentive for residential placement and forcing counties to provide a different level of services to non-residents. To the extent the proposal may provide an incentive to place and keep clients in ICF/MR's, it becomes inconsistent with the policy of normalization. At the same time, the provision of developmental achievement services for clients not in ICF/MR's would continue to be a function of the counties' priority setting and subject to fiscal constraints.
4. MA Cost Containment measures will place development achievement services in the broader category of human services. By removing a portion of DAC services from CSSA, this proposal will dictate that priority setting of all HA programs consider the services for the mentally retarded along with other covered medical services such as dental care, nursing care, home health aides and all other long-term care services. Given the stipulations in the Consent Decree and Minnesota Supreme Court decision, those priorities may require transfer of state CSSA appropriations to MA to assure state match.

### Program Impact

1. As an entitlement, services cannot be cut. The proposal will assure that counties cannot cut back services because the services would become an entitlement, however, the legislature may still impose a cap on the total MA program and specific services under it thereby controlling program expansion. This impact would eliminate the numerous appeals and hearings as described in Major Issues B. This applies most directly to the "Welsch clients" since most are placed in ICF/MR facilities and also need DAC services. Given the Supreme Court ruling, DAC services cannot be cut regardless of Title XIX funding.
2. The potential for decertification of ICF/MR programs would be eliminated. Residents of the ICF/MR facilities in need of DAC services would be assured of receiving those services. This impact directly related to Major Issue D.
3. State Hospital reduction rates will no longer be adversely affected by lack of day services in the community. Reduction quotas specified in the Consent Decree can be achieved. This impact addresses Major Issue C.
4. Non-ICF/MR residents may receive a lower priority in competing for services. The funding of day services under CSSA for non-MA residents may be reduced in favor of other community social services placing those individuals in jeopardy of receiving less than needed services.
5. Possible incentive to expand to 12 month program. The proposal may provide an incentive to increase to a full year program unless limited in State MA Plan.

### Fiscal Impact

1. County costs for state hospitals and ICF/MR's equalized. The percentage of costs to the counties for training and habilitation services would be equalized between the state hospitals and ICF/MR's resulting in removal of any fiscal incentive for state hospital placement. This addresses Major Issue A.
2. Cost control over DAC expenditures will be more equally shared between the state Medical Assistance authority (for ICF/MR residents) and the counties (for non-ICF/MR residents). However, given the court mandates on DAC services, the control function will now focus more on the negotiated rates than on the level of service. The level of service will necessarily be determined in the individual service plan process.
3. Fiscal uncertainty due to decisions in Congress. Both administrative and funding decisions by Congress in regard to Title XIX create fiscal uncertainty. That uncertainty also exists with the Title XX program. Both will have fiscal impacts on this program.
4. Costs would increase with 12 month program. Unless the state plan stipulates that the DAC program remain at 211 days per year, the change to a 12 month program would be proportionately higher.

FISCAL ANALYSIS OF PROPOSAL 1

Option 1: Fund 60% of adult DAC clients with Medical Assistance (Title XIX) as part of the residential treatment; and continue to fund the other 40% of DAC adults and all children through CSSA.

NOTE: The costs compared in this table reflect the costs for the adult DAC clients residing in ICF/MR only.

	Number of DAC clients Residing in ICF/MRs	Projected Budget	Funded Under Medical Assistance				Funded Under CSSA <sup>1</sup>		
			Federal	State	County	v.	Federal	State	County
F.Y. 83	2,604	\$14,151,675	\$ 7,426,799	\$ 6,052,671	\$ 672,205		\$2,787,880	\$2,886,942	\$ 8,476,853
F.Y. 84	2,863	16,703,649	8,482,113	7,399,716	821,820		3,006,656	3,307,322	10,389,671
F.Y. 85	3,088	18,918,097	9,852,545	8,159,375	906,177		3,121,486	3,651,193	12,145,418
F.Y. 84 & 85 Biennium		35,621,746	18,334,658	15,559,091	1,727,997		6,128,142	6,958,515	22,535,089

COST IMPACTS USING TITLE XIX COMPARED WITH CSSA		
	Federal	State
F.Y. 83	increases 7,426,799	increases 3,165,729
F.Y. 84	increases 8,482,113	increases 4,092,394
F.Y. 85	increases 9,852,545	increases 4,508,182
F.Y. 84 & 85 Biennium	increases 18,334,658	increases 8,600,576
		decreases 10,592,582
		decreases 12,574,507
		decreases 14,360,727
		decreases 26,935,234

1. See Appendix C for method used to determine federal, state and county financial participation under CSSA.
2. County savings reflects savings in Title XX and local funds.
3. An inflation factor of 6% was used in these projections.

Proposal 2. Fund DAC services as a habilitative service under a Home and Community-Based Services Waiver for those individuals placed out of a state hospital or ICF/MR into a community alternative waived service.

This proposal would require submission of a Home and Community-Based Care Waiver under section 1915(C). of the Title XIX Medical Assistance program.

#### Policy Impact

1. Program Redirection. This proposal's major impact would be to change the direction of the state's Mental Retardation program from one of heavy reliance on long-term care to less restrictive, less costly living arrangements.
2. Deinstitutionalization Encouraged. It would encourage deinstitutionalization of persons from both state hospitals and ICF/MRs.
3. Consistent with LAC Recommendations. This proposal would create the impetus for development of a broad array of community-based alternatives to the sore expensive ICF/MR program.
4. Increased Heed for Case Management and Quality Assurance mechanisms will require a more active management role for both the state and the counties.

#### Program Impact

1. ICF/MR Bed Reduction, Since a "waivered" service can only be provided with savings generated by reductions in the long-term care budget, ICF/MR beds in both the state hospitals and the community will be reduced.
2. Aggressive Pre-Placement Screening Procedures will be necessary to better assure that placement decisions are consistent with individual service needs and that incentives to place persons into ICF/MRs do not develop.
3. Reorganization of Department Functions will be necessary to implement stringent cost control measures so as to assure that budgets under the waiver are not exceeded.
4. A Client Tracking and Evaluation System will need to be developed and implemented to meet federal requirements under the provisions of the Home and Community-Based Services Waiver.

#### Fiscal Impact

1. Cost Containment will be assured since no federal reimbursement in excess of the projected budget is possible under the MA waiver.
2. Incentive to Pee Least Restrictive and least Costly Alternative will result in counties choosing waived services over the more expansive ICF/MR options.

3. Medical Assistance Savings Will Be Generated as more ICF/MR (including state hospital) beds are replaced with community-based waived alternatives. As more savings accrue, more persons can be served at less cost.

Actual fiscal impacts of implementing a Home and Community-Based Services Waiver have not been computed here. However, under the Medical Assistance Waiver provision, the state must assure that overall Medical Assistance costs will not exceed the projected expenditure levels without a waiver.

## V. PART TWO: SEMI-INDEPENDENT LIVING SERVICES

### A. Background

Semi-independent living services (SILS) represent a system of community-based support services that include counseling, instruction, supervision and assistance provided based on the individual needs of mentally retarded persons, as defined by an individual program plan. Services may include assistance in budgeting, meal planning and preparation, shopping, personal appearance, counseling and related community support services needed to maintain and improve a client's functioning in less than a 24 hour supervised setting.

As early as 1976, several counties and private providers initiated the development of semi-independent living services. The primary reason for the development of these services was to assist clients no longer in need of residential placement (i.e., 24 hour supervision) in a community or ICF/MR state hospital settings, but were not yet capable of being fully independent. At the local level, the SILS program became a key service component in the continuum of care, which bridged the gap between 24 hour supervision in community ICF/MR residential programs and independent living.

By 1980, approximately 300 clients were served in semi-independent living settings. Most of the clients were mildly and moderately retarded; a few clients were severely retarded. Over half of the clients had been placed from community residential or state hospital residential settings, and the other clients were placed directly from their parental or foster home. The service costs for SILS were paid by the county using Title XX and local tax revenues. The board and lodging costs for clients were frequently paid from the client's earnings or with his/her social security benefit payments.

On September 15, 1980, the Welsch v. Noot Consent Decree was signed. That Decree required the reduction of the number of mentally retarded residents in state hospitals to no more than 1850 by June 30, 1987. Simultaneously, the Department of Welfare developed a six year plan of services for mentally retarded persons. The plan was finalized in January, 1981 and sent to the 1981 Legislature as part of the F.Y. 82 and 83 Biennial Budget Request.

The major goal of the six year plan was the deliberate and systematic reduction of the number of mentally retarded persons residing in state hospitals to no more than 1650 by June 30, 1987; and the simultaneous development of sufficient and appropriate community-based residential program, day program and community support services in a manner as cost effective and efficient as possible. The SILS program was seen as a critical component of the service continuum to enable mentally retarded persons to master skills needed for more independent living; and thereby, reducing the demand for unnecessary and inappropriate development of community-based residential facilities by "freeing up" beds in community residential facilities for clients coming from state hospitals.

B. Purpose

The primary purpose of the SILS program is to provide a system of support services that will enable mentally retarded persons currently residing in community-based residential facilities or "at risk" of placement into community residential facilities to be served in more independent living and service settings.

The expected outcome of the program is the placement of mentally retarded persons into independent living or the maintenance of mentally retarded persons in semi-independent living arrangements, who otherwise would reside in a ICF/MR facility. As a result, SILS provide a less costly service alternative to placement into residential programs and minimize the unnecessary and inappropriate development of community ICF/MR residential facilities.

C. Current System Status

Consistent with the Six Year Plan, the 1981 Legislature appropriated monies for additional SILS development. For the F.Y. 82-83 Biennium, the Legislature appropriated an additional 1.5 million for SILS development and 842,800 for the continuation of DPW Rule 23, Deinstitutionalization Aid to the Counties. In order to establish a single source of funding for SILS, the Department decided to use Rule 23 monies exclusively to fund existing (prior to July 1, 1981) SILS clients, which supplemented the biennial appropriation for additional SILS capacities.

Individuals are eligible for SILS if they are adults (18 years and older), determined to be mentally retarded and in need of SILS by the local social service agency in accordance with DPW Rule 185.

Semi-independent living services are provided in various community settings such as the client's own home, foster home, apartment or rooming house. These services are not provided to individuals while residing in ICF/MR's. There are three major types of settings in which SILS are provided:

- a) Self contained or structured site: SILS are provided at one building where all clients live and the SILS agency may own the building.
- b) Clustered site: SILS are provided at more than one apartment with four to eight clients at each site.
- c) Scattered site: SILS are provided at various locations throughout the community.

County boards may provide SILS directly or they may contract with private vendors for provision of service\*. A person or an agency is an approved vendor or provider of SILS when the provider has received a letter of recommendation from the host county and Determination of Need from the Commissioner of the Department of Public Welfare in accordance with DPW Rule 185; and, has been licensed under the provisions of DPW Rule 16.

In July, 1981, SILS proposals were solicited by DPW; SILS were to be developed and expanded as another service in the community continuum of care for the mentally retarded so that ultimately the state hospital population could be reduced as planned by DPW. The emphasis we\* placed on individuals residing in ICF/MR facilities who could live in the open community if the support services provided under SILS were made available. The vacancies created in the ICF/Ms were to be filled by persons coming from the state hospitals. The continuum then looked thus: State hospitals ----> ICF/MR --- > SILS ----> fully independent.

Proposals were received, reviewed and evaluated by the MR program staff. When SILS are authorized, county and human service boards are reimbursed by the State on a quarterly basis for their actual expenditures for SILS. The actual percentage of total cost paid by the state is based on budgeted expenditures for SILS up to a maximum of 90 percent of actual cost. Factors taken into account by the MR program staff when awarding grants include:

- 1) the number and types of clients to be served
- 2) the projected service costs
- 3) the program and service plan
- 4) statewide rates of reimbursement.

The MR program staff's plan and priorities for state funding in fiscal year 1983 are as follows:

- 1) 81% state reimbursement of SILS for:
  - a) clients discharged from an ICF/MR since July 1, 1981
  - b) proposed clients from an ICF/MR
  - c) current and proposed clients with SSI eligibility
- 2) 50% state reimbursement of SILS for clients not eligible for SSI or not from an ICF/MR facility.
- 3) no state reimbursement of SILS for clients not eligible for SSI unless it can be demonstrated the individual will be placed in an ICF/MR if SILS are not provided. Adjustments to grants will be made in January, 1983 per availability of funds.

The Department's Budget Proposals for SILS in fiscal year 1984 and 1985 involve 80 to 85 percent state reimbursement of SILS costs for all clients discharged from ICF/MR's, or at risk of being pieced into an ICF/MR.

A detailed analysis of the demands and costs of the SILS program is provided in Appendix E from F.Y. 81 through F.Y. 85. A review of that information reveals:



1. The number of counties participating in the SILS program has increased in F.T. 82 and is expected to continue to increase in F.Y. 83 through F.Y. 85. In F.Y. 85, over 80% of the 87 counties are expected to participate in the SILS program.
2. The number of licensed vendors for SILS is expected to increase to 55 in F.Y. 83. The number of licensed vendors is expected to increase by 9% in F.Y. 84 and remain at that level in F.Y. 85. As of January 1983, there were 40 licensed SILS vendors. The number of vendors by type of agency is as follows:

Type of Agency	Number of Vendors	
County Boards	4	(10%)
Affiliated with Residential Program	20	(50%)
Affiliated with DAC	4	(10%)
Other agencies		
- non-profit corporations	1	(2.5%)
- proprietary/individual	4	(10%)
- proprietary/corporation	7	(17.5%)
	40	

3. The number of clients served in SILS has increased by approximately 500 clients in F.Y. 82 and 83. The number of clients is expected to increase by 100 clients in F.Y. 84 and 100 clients in F.Y. 85 if not major policy changes occur, and, the original appropriation request is granted.

Of the total clients served, the percentage of clients coming from ICF/MRs or at risk of being placed into ICF/MR has increased and is expected to continue to increase.

	Percent of clients from ICF/MR or eligible for ICF/MR placement	Percent of clients not eligible for ICF/MR placement
F.Y. 81	65.9%	34.1%
F.Y. 82	63.9%	36.1%
F.Y. 83	71.6%	28.4%
F.Y. 84	74.6%	25.4%
F.Y. 85	76.9%	23.1%

4. The average annual cost per clients in SILS has increased on the average of 8.2% per year in F.Y. 82 and 83. The average annual cost per client is projected to increase at 7% in F.Y. 84 and 7% in F.Y. 85. From F.Y. 81 through F.Y. 85, the average annual cost per client is expected to increase an average of 7.6% per year.
5. The total SILS budget is increasing at a decelerating rate. The total budget increased on the average of 52.9% per year in the first two years (F.Y. 82 and 83) of the state grant program. The SILS Budget is expected to increase on the average of 41.7% per year in F.Y. 84 and 85. In F.Y. 85 the increase is projected at 22.6%.

An increasing proportion of the total budget has been directed and is expected to continue to be directed toward clients who have come from ICF/MR facilities or are eligible for placement in an ICF/MR.

	% of Budget for ICF/MR Eligible	% of Budget for Clients not Eligible for ICF/MR Placement
F.Y. 83	73%	27%
F.Y. 84	81%	19%
F.Y. 85	83%	17%

## VI. A PROPOSAL TO FUND SILS USING THE TITLE XIX MA WAIVER

### A. MA Waiver - National Status

The Omnibus Budget Reconciliation Act of 1981 allows waivers to the Title XIX program so that home and community-based services not previously covered may be made available. For the mentally retarded population, the waiver may allow Title XIX coverage of the following services for any eligible client who would otherwise require ICF/MR care: habilitation, case management, homemaker and home health aide, personal care, respite care, foster care, and other services. The services to be provided must be cost effective and necessary to prevent the institutionalization of clients. Waivered services cannot be provided to clients who are inpatients of a hospital, SNF, ICF, or ICF/MR. For each individual covered under the waiver request, an objective method must be used to evaluate the need for the level of care provided in an ICF/MR. When clients are determined to require the ICF/MR level of care, they must be informed of feasible service alternatives and given a choice regarding services they want to receive. In the waiver request, a state must assure that average per capita expenditures under the waiver will not exceed average per capita expenditures that would have been incurred by the MA program without the waiver.

Since the regulations became available in October 1981, a number of policy issues have been raised, two of which follow: 1) Refinancing, the issue involves the extent to which state will be allowed to expand eligibility for Title XIX reimbursable long term care services by adding persons currently served in state supported non-medical care facilities who have been found to require the level of care of a Title XIX certified institution. HCFA is now carefully examining waiver requests to determine whether the net effect is to transfer state costs to the federal-state Title XIX program. One of the federal government's policy objectives involves limiting the growth in future federal funding of Title XIX long term care services. California had submitted two waivers involving the refinancing of long term care services which were disapproved because the intent was to replace state revenues with federal medicaid reimbursements. 2) The issue of covering infant and preschool services under the waiver has arisen. The major question is whether these children, in the absence of the services, would have to be institutionalized in an ICF/MR. In general, the number of preschoolers admitted to ICF/MR's is low as a result, it is unlikely a case could be made for those children unless a clear potential for their placement exists.

As of November 18, 1982, a total of 46 waiver requests had been submitted by 33 states. These 46 waiver requests pertain to provision of services to the aged, disabled, mentally retarded, developmentally disabled and/or mentally ill population. The present status of these waivers is as follows: 24 approved, 3 disapproved, 1 withdrawn, and 18 pending.

A total of 22 states have submitted 24 waivers including service(s) for the mentally retarded population. One waiver request was disapproved, nine are pending and fourteen have been approved.

B. Proposal

To fund SILS as a waived MA service for those clients discharged from an ICF/MR or state hospital, to continue to fund persons at risk of ICF/MR placement under the state/county SILS appropriation and to transfer non-MA eligible persons needing SILS to CSSA.

Note: The funding of SILS by three different sources is necessary due to formula requirements of the Medical Assistance Waiver. Since all waived services must be funded out of savings generated by reductions in ICF/MR (including state hospital) expenditures, it is not possible to finance all existing SILS programs under the waiver without exceeding the projected savings. Additionally, the funding of all existing SILS would likely be considered as a refinancing move by federal authorities.

Policy Impact

1. Without an aggressive pre-admission screening mechanism, the proposal may encourage admissions to community ICF/MR residential facilities.
2. The deinstitutionalization process as required under the Welsch v. Levine Consent Decree will be assisted by this proposal by "freeing up" additional community-based ICF/MR beds for clients from state hospitals or at risk of placement into state hospitals.
3. The proposal creates a less costly alternative to ICF/MR care for clients not needing 24 hour supervision, which will result in a decreased demand for community-based ICF/MR beds.

Program Impact

1. The proposal would provide additional SILS programs to reduce current ICF/MR placements of persons for whom a SILS level of service would be programtically more effective.
2. Waivers under the Home and Community-based Services Program are available for three year periods; there is no future guarantee regarding service coverage.

Fiscal Impact

- 1) The proposal will reduce the additional costs for ICF/MR care.
- 2) County Boards would pay for SILS at the same rate as they pay for ICF/MR care; and thereby, creating incentive to place capable ICF/MR clients into SILS.
- 3) The proposal would increase federal financial participation in the provision of community-based services, and reduce state and county financial participation for those persons leaving the ICF/MR level of care.

Actual fiscal impacts of this proposal have not been computed here. However, under the Medical Assistance Waiver provision, the state must assure that overall Medical Assistance costs will not exceed the projected expenditure levels without a waiver.

C. Alternative Proposals.

As pointed out in Major Issue A, there are two other alternative proposals to eliminate the fiscal incentive encouraging counties to place clients into state hospitals. These proposals were: to require counties to pay for developmental achievement services as a CSSA social service in state hospitals, or to request an appropriation for grants to counties to assist them in paying for community-based developmental achievement services.

The first alternative proposal involves the counties funding the same percentage of developmental achievement services costs provided in state hospitals as they do for these services in the community. It is estimated that counties reimburse approximately 44.9 percent of costs of developmental achievement services provided in the community and approximately 4.8 percent of the costs of these services provided through the state hospitals. Therefore, if counties reimbursed approximately 44.9 percent of state hospital developmental achievement costs, an additional 40.1 percent over current reimbursement is necessary if any fiscal incentive for state hospital placement will be eliminated. The total state hospital developmental achievement service costs for fiscal year 1982 (the most recent figure available) were \$10,618,104. Appendix D displays the fiscal impact of this proposal and the respective cost changes at the federal, state and county level. A major assumption of this analysis is that if the county and state share the state hospital DAC costs at the same rate as the community-based ICF/MS, then federal reimbursement under Title XIX would not be claimed.

The second alternative proposal involves requesting an appropriation for grants to counties to assist them in paying for community-based developmental achievement services. This proposal would require an "ear-marking" of state dollars for developmental achievement service within the CSSA appropriation. The special state appropriation would need to be sufficient to assure that county boards paid for community-based developmental achievement services at the same rate they pay for state hospital services. Under this proposal, the state share for developmental achievement services for adults would be approximately 95% of the total budget and the county share would be approximately 5%.

D. Fiscal Impact of Alternative Proposals.

A fiscal analysis was done on the three major policy alternatives described on page 2. The results of that analysis appear in Table 4.

A potential negative impact exists with policy alternative 2. If counties are charged for state hospital based DAC services and no additional funds are appropriated for these charges in CSSA or other accounts, the probable effect would be an accelerated reduction in the level of support county given to existing community-based services.

TABLE 4

The Fiscal Impact of Three Policy Alternatives to Remove  
Fiscal Incentives for Counties to Utilize State Hospitals  
In the F.Y. 83 and 84 Biennium

<u>Policy Alternative 1</u>	<u>Federal</u>	<u>State</u>	<u>County</u>
<u>Use Medical Assistance For</u> <u>Community-base Developmental</u> <u>Achievement Services for Adult</u> <u>Clients</u>			
Option I	+18,334,658	+ 8,600,576*	-26,935,234
 Policy Alternative 2			
<u>County Boards Pay for State</u> <u>Hospital Day Program Services</u> <u>at the Same Rate as Services</u> <u>Under CSSA</u>			
	-13,400,000	+ 2,966,000	+10,430,000
 Policy Alternative 3**			
<u>Request Additional State</u> <u>Appropriation for Grants to</u> <u>Counties to Assist Them in</u> <u>Paying for DAC Services</u>			
Option I	no change	+26,935,234	-26,935,234

\* Assumes the entire state share for this option would not be taken from the CSSA appropriation.

\*\* Additional appropriations needed above the projected 6% state increase under CSSA is F.Y. 84 and 85 biennium.

## VII. SUMMARY AND RECOMMENDATIONS

This paper has examined the major issues that have created the need for a careful study of the manner by which the state funds Developmental Achievement Services for the mentally retarded in Minnesota. It further examined a relatively new service in this state entitled SILS, or Semi-Independent Living Services. Due to declining resources at the state and local levels, it examined the policy, program and fiscal impacts of using the federal Title XIX Medical Assistance (MA) Program to partially fund these programs. Finally, it explored the advantages of applying for a Home and Community-Based Services Waiver under the Title XIX program.

The conclusions that can be derived from this study are many, and due to projected deficits in the Medical Assistance account, controversial.

Extensive study and consideration of the issues presented in this paper within the broader context of the scope and direction of the entire service delivery system over the past several weeks have resulted in the following recommendations:

### Re: Developmental Achievement Centers (DACs)

1. To fund Developmental Achievement Center services for all ICF/MR residents under the Medical Assistance Program.
2. To fund Developmental Achievement Center services as a waived service to those individuals placed from an ICF/MR or state hospital into a non-ICF/MR alternative service.
3. To continue to fund all other DAC clients under CSSA.

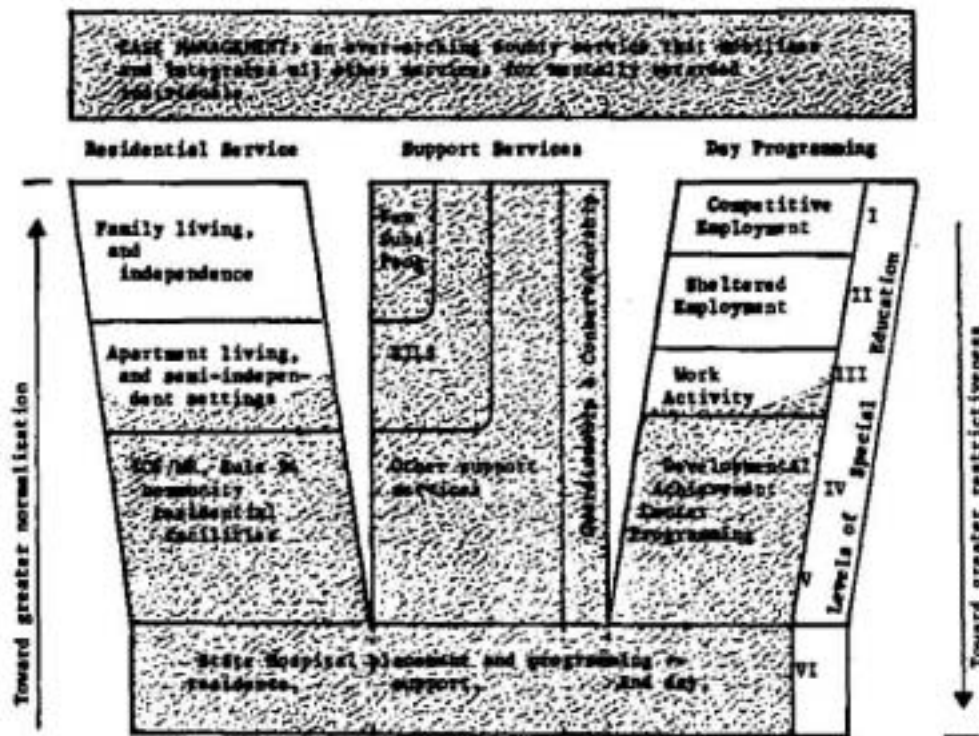
### Re: Semi-Independent Living Services (SILS)

1. To fund SILS as a waived service to those individuals placed from an ICF/MR or state hospital into a non-ICF/MR alternative service.
2. To continue funding existing SILS clients at risk of ICF/MR placement under the state/county SILS appropriation.
3. To fund all non-MA eligible persons in need of SILS under CSSA.

### Re: Home and Community-Based Services Waiver

1. To apply for a Home and Community-Based Services Waiver to provide a broad array of community and home-based services.

## APPENDIX A



Minnesota's System of Services to  
Mentally Retarded People

Minnesota has a system of services to mentally retarded people which is quite comprehensive in its general framework. These services have developed over time in response to well-perceived needs and to dialogue on proper public policy. All parts of the framework are in place to some extent, although not all are adequate in amount or development.

The system of services is diagrammed in Figure 1. The shaded portions of the figure are regulated, funded, or provided by the Department of Public Welfare (DPW). Other portions are under the responsibility of other state agencies: special education, of the Department of Education; and work activity, sheltered employment (and to some extent, competitive employment), of the Division of Vocational Rehabilitation, Department of Economic Security.

In DPW, basic authority regarding the system is provided by Minn. Stat. \*8\*8\*81252. Regulatory rules apply to specific portions, as described below.

Case management is the mobilization and integration of all services to mentally retarded individuals, charged to the county boards by DPW Rule 1S5. This rule sets standards for case management.



The other services, it will be noted, are divided into three branches: residential service, support services, and day programming. The three branches are all provided under one administration in the most restrictive level of service provision, that of state hospital service. In less restrictive settings in the community, the three branches are provided to individuals by separate service providers, many of them in the non-profit or proprietary private sector. Program standards in the shaded areas are set by DPW rules, and county case management provides the integration and assurance of service.

#### Residential circumstances:

Family living, and independence are normal family living for children, in natural or foster homes, with or without external helping services. For adults, this may be continued family living or the same kind of independent housing used by age peers.

Apartment living and housing in semi-independent settings is partially funded in some instances by county-administered monies from state and federal sources. Apart from that, this setting is not under DPW responsibility.

ICF/MR (Intermediate Care Facilities for the Mentally Retarded) residence is certified under ICF/MR regulations, and is funded under DPW Rule 52. The program standards for residential licensing are set by DPW Rule 34. This level provides 24-hour care or supervision.

#### Support Services:

Family subsidy program is a program of DPW grants to families, as applied for by the counties, to enable families to care for mentally retarded children at home and thereby avoid out-of-home placement.

SILS (Semi-Independent Living Services) consist of supportive and/or Training services for mentally retarded people who live more independently than in ICF/MRs, for the purpose of enabling that semi-independent or fully independent status. It is purchased or provided by the counties, under program standards of DPW licensing Rule 18, and partially reimbursed by state funds.

Guardianship and conservatorship is provided to wards of the Commissioner of Public Welfare, numbering about 7000, by delegation of DPW authority to the counties.

Other support services are the responsibility of the counties under standards set by DPW Rule 185. They include provision for transportation, medical care, counseling, special recreation, etc. as needed by some mentally retarded individuals.

#### Pay Programming:

Competitive employment is regular work for regular pay, in competition with all other job seekers. It is not a service of government, except as job placement is assisted by the Department of Economic Security.

Sheltered employment is employment of a handicapped worker, under circumstances that allow for the disability, at a wage of one half or more of the federal minimum. It is usually provided in private sector rehabilitation facilities with partial subsidy by the Division of Vocational Rehabilitation, Department of Iconic Security.

Work activity is specially-provided work, primarily for therapeutic purposes, which is adapted to people whose productivity is inconsequential. When it is provided in a developmental achievement center, it is subject to the program standards of DPW Rule 3 (proposed Rule 38).

Developmental achievement center (DAC) programming is provided to men-tally retarded and/or cerebral palsied persons who cannot participate in ordinary community occupation and activities. It is provided under program license and standards of DPW Rule 3 (proposed Rule 38).

State hospital programming is directly provided by DPW. It is subject to federal certification and licensing standards of DPW Rule 34, similar to community ICF/MR.

In Figure 1, the upward direction of the main diagram is in the direction of normalization of service. One purpose of the services in the continuum is to enable upward movement for all clients for which this is possible. In particular, DPW has a commitment to enable a movement of 30% upward from state hospital programming in the six years 1980-1987.

APPENDIX C  
ESTIMATED FEDERAL, STATE, COUNTY FINANCIAL PARTICIPATION  
ORDER THE COMMUNITY SOCIAL SERVICES ACT  
(TOTAL SERVICE DEMANDS MET)

	Total DAC Costs	Federal % <sup>1</sup>	State % <sup>2</sup>	County % <sup>3</sup>
F.T. 81	\$24,096,357	\$ 6,385,535(26.5%)	\$ 5,879,511(24.4%)	\$11,831,311(49.1%)
F.Y. 82	\$28,661,494	\$ 6,385,535(22.3%)	\$ 6,232,282(21.7%)	\$16,043,677 (56%)
F.Y. 83	\$32,423,689	\$ 6,385,535(19.7%)	\$ 6,606,219(20.4%)	\$19,431,935(59.9%)
F.Y. 84	\$35,456,928	\$ 6,385,535(18.0%)	\$ 7,002,592(19.8%)	\$22,068,801(62.2%)
F.Y. 85	\$38,584,166	\$ 6,385,535(16.5%)	\$ 7,422,748(19.3%)	\$24,775,883(64.2%)
F.Y. 84 & 85 Biennium	\$74,041,094	\$12,771,070	\$14,425,340	\$46,844,664

1. Federal dollars were not projected to increase over time due to the significant reductions in federal appropriations.
2. State dollar were projected to increase to 6% per year consistent with base CSSA Budget increases.
3. For F.Y. 81, federal, state end county financial participation was based on actual governmental financial participation rates for all social services in calendar years 1980 and 1981.

**STATE HOSPITAL DAY PROGRAM BUDGETS  
FOR MENTALLY RETARDED FISCAL IMPACT ANALYSIS**

**I. COSTS UNDER MEDICAL ASSISTANCE PROGRAM**

	<u>Total MR Budget (Day &amp; Residential)</u>	<u>Estimated Day, Program Costs<sup>1</sup></u>	<u>Federal</u>	<u>State</u>	<u>County</u>
F.Y. 82	\$70,787,361 <sup>2</sup>	\$10,618,104	\$5,722,096	\$4,406,513	\$489,495
F.Y. 83	85,171,000 <sup>2</sup>	12,775,650	6,704,661	5,464,146	606,843
F.Y. 84	86,384,000 <sup>2</sup>	12,957,600	6,579,869	5,740,217	637,514
F.Y. 85	87,269,000 <sup>2</sup>	13,090,350	6,817,454	5,645,868	627,028

**II. COSTS UNDER CSSA**

F.Y. 82	10,618,104	- 0 - <sup>3</sup>	5,850,575 <sup>4</sup>	4,767,529 <sup>4</sup>
F.Y. 83	12,775,650	- 0 - <sup>3</sup>	7,039,383 <sup>4</sup>	5,736,267 <sup>4</sup>
F.Y. 84	12,957,600	- 0 - <sup>3</sup>	7,139,636 <sup>4</sup>	5,817,962 <sup>4</sup>
F.Y. 85	13,090,350	- 0 - <sup>3</sup>	7,212,783 <sup>4</sup>	5,877,567 <sup>4</sup>

**III. FISCAL IMPACT BY SOURCE OF FUNDING**

	<u>Federal</u>	<u>State</u>	<u>County</u>
F.Y. 82	Decreases 5,722,096	Increases 1,444,062	Increases 4,278,034
F.Y. 83	Decreases 6,704,661	Increases 1,575,237	Increases 5,129,424
F.Y. 84	Decreases 6,579,869	Increases 1,399,419	Increases 5,180,448
F.Y. 85	Decreases 6,817,454	Increases 1,566,915	Increases 5,250,539
F.Y. 84 & 85 Biennium	Decreases 13,397,323	Increases 2,966,334	Increases 10,430,987

1. Day Program Costs in State Hospitals have been estimated at 15% of the total state hospital budget for mentally retarded. The 15% estimation was a result of a study conducted in February, 1981 by the Mental Retardation Division.
2. Budgets for serving mental retarded in state hospitals were projected by Income Maintenance. These budgets (F.Y. 83, 84 and 85) are expected to be adjusted upward 2-3 million dollars in the near future.
3. Assumes that Title XX allocations will not increase to accommodate the increased fiscal demands on the counties in funding state hospital day programs and therefore the increased cost of this policy will be borne by the State and County.
4. The State share is estimated at 55.1%, the County share at 44.9%.

APPENDIX E

SUMMARY STATISTICS FOR SEMI-INDEPENDENT LIVING SERVICES

	Number of Counties	Number of Licensed Vendors	Number of Clients <sup>3</sup>			Average Annual Actual	Cost Per Client <sup>4</sup> Adjusted	Number of Client in Need of SILS but not receiving <sup>5</sup>	Total Expenditure/ Budget	State	County
			Total	Eligible	Other						
F.Y. 81	43 <sup>1</sup>	-0- <sup>2</sup>	311	205	106	\$2628	\$2628	700	\$ 817,309	\$ 421,400	\$395,909
F.Y. 82	51	30	552	353	199	2167	2854	489	1,196,371 <sup>6</sup>	570,000 <sup>6</sup>	626,371 <sup>6</sup>
F.Y. 83	61	55	871	624	247	2364	3080	297	2,059,327	1,496,400	562,927
F.Y. 84	70	60	971	724	247	3164	3296	---	3,071,966	2,406,800	665,166
F.Y. 85	70	60	1071	824	247	3487	3527	---	3,734,386	2,951,800	782,582

F.Y. 84 & 85  
Biennium

1. In F.Y. 81, 43 counties contracted for or provided directly SILS services for 311 client prior the state aid available in F.Y. 82.
2. Vendor were not being licensed prior to F.Y. 82 since Rule 18 had not yet been promulgated.
3. Clients eligible for ICF/MR placement includes clients who have come from an ICF/MR and clients who are eligible for Social Security Income (SSI) or Social Security Disability Benefits (RSDI) and eligible for medical assistance and determined to be at risk of placement into an ICF/MR. The "Other" clients have been proposed to be funded under CSSA in January, 1984.
4. The adjusted average annual cost per client is the adjusted cost for serving a client a full twelve months per year.
5. Taken from county plans and client projections.
6. Includes 9 counties who did not receive state reimbursement in F.Y. 82.

BUDGET ANALYSIS OF SILS FUNDED UNDER STATE GRANT-IN-AID

	BUDGET					
	<u>Total</u>	<u>For MA Eligibles</u>	<u>For Non-MA Eligibles</u>	<u>Total</u>	<u>For MA Eligibles</u>	<u>For Non-MA Eligibles</u>
F.Y. 83	2,059,327	1,504,270	555,057	1,496,400	1,218,271(81%)	277,529(50%)
F.Y. 84	3,071,966	2,478,055	593,911	2,406,800	2,109,844(85%)	296,956(50%)
F.Y. 85	3,734,386	3,098,846	635,540	2,951,800	2,634,030(85%)	317,770(50%)
F.Y. 84 & 85 Biennium	6,806,352	5,576,901	1,229,451	5,358,600	4,743,874	614,726