Administration

MANAGEMENT
ANALYSIS DIVISION

PUBLIC EXPENDITURES FOR SERVICES TO PERSONS WITH DEVELOPMENTAL DISABILITIES IN MINNESOTA

Pursuant to 1990 Laws, Chapter 568 article 3, Section 100 -Human Services Dept

Report prepared for the Human Services Dept by the Adm Dept of Mn, Management Analysis Division

APRIL 1991

PUBLIC EXPENDITURES FOR SERVICES TO PERSONS WITH DEVELOPMENTAL DISABILITIES IN MINNESOTA

Minnesota Department of Administration
Management Analysis Division
April 1991

203 Administration Building, 50 Sherburne Avenue, St. Paul, Minnesota 55155

TABLE OF CONTENTS

TABLE OF CONTENTS, Continued

TABLE OF CONTENTS, Continued

TABLE OF CONTENTS, Continued

Services and their costs / day services and special education

Services and their costs / support services

TABLE OF CONTENTS, Continued

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

In the last two decades, the philosophy behind services to persons with developmental disabilities has shifted dramatically. While at one time disabled persons were housed in large segregated institutions, the emphasis now is on providing supports that allow them to live in the community. In an effort to reduce costs and to serve persons with developmental disabilities in less-restrictive community settings:

- the population of regional treatment centers has been progressively reduced,
- large intermediate care facilities for the mentally retarded have been downsized,
- dollars previously available only for institutional services have been freed up for home- and community-based programs through a federal Medicaid waiver, and
- new supports such as semi-independent living services and the family subsidy program have been created.

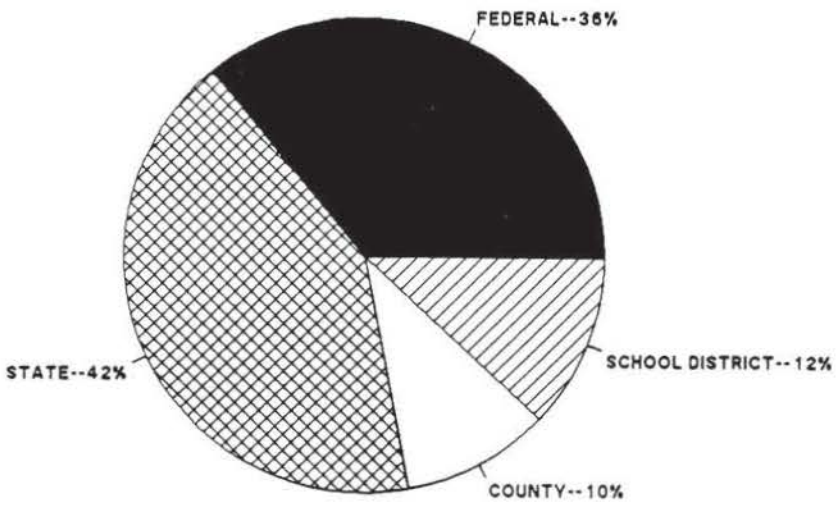
At the same time, the service delivery system has become highly fragmented:

- Services are funded by a combination of federal, state and local dollars, are regulated by federal and state governments, and are provided by private operators, state and county governments, and school districts.
- Government directly provides housing, day habilitation and medical care through regional treatment centers, provides education through the special education programs of school districts, and provides case management through county case managers.
- Private owners provide housing, day habilitation and daily activity support through intermediate care facilities for the mentally retarded, day training and habilitation facilities, and semi-independent living services.
- Counties determine the package of services to be provided to persons with developmental disabilities, but do so within constraints established by federal and state governments.

The costs associated with serving persons with developmental disabilities have increased as the number of programs and clients has grown. The 1990 Legislature directed the Department of Human Services to provide a report describing all current state spending on mental retardation services, including special education and vocational rehabilitation. The department contracted with the Department of Administration Management Analysis Division to conduct the study.

Management Analysis identified 22 services to persons with mental retardation and related conditions that are provided or funded by public dollars. For each service, this study describes the average number of persons served and the total cost of the service broken down by funding source for the five most recent fiscal years.

Figure 1. Sources of funding for developmental disabilities services, FY 90



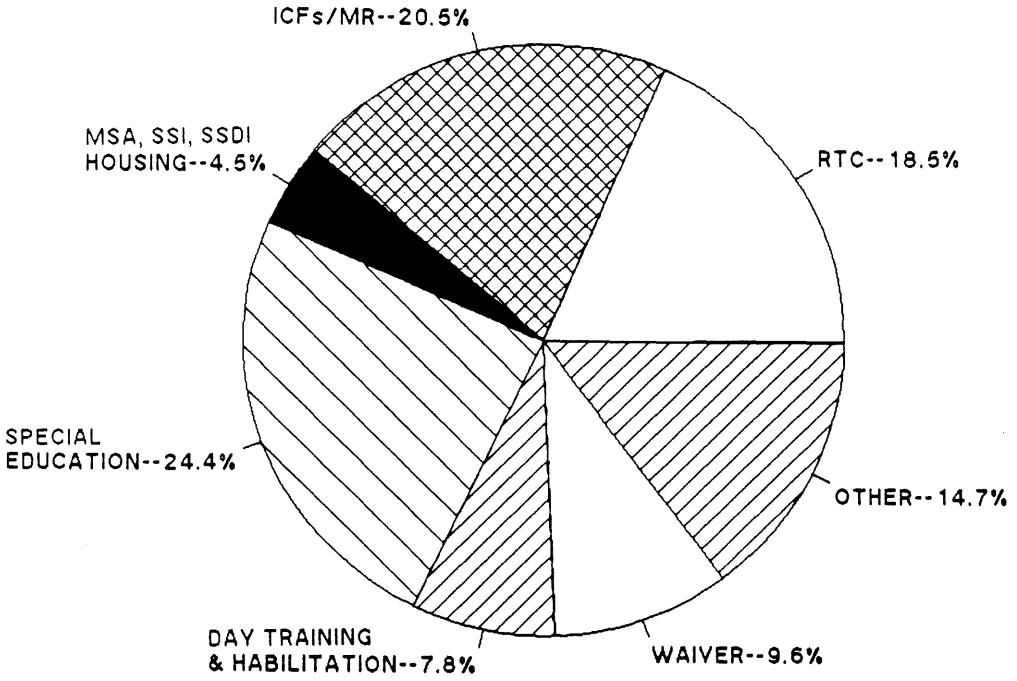
These 22 services are:

Regional treatment centers
Intermediate care facilities for the mentally retarded
Child foster care
Adult foster care (non-waiver)
Nursing homes
Board and lodging
MSA, SSI, SSDI Housing
Vocational rehabilitation
Special education
Day training and habilitation
Case management (non-waiver)
Screening
Semi-independent living
Family subsidy
Waiver services
Assessment
Respite care (non-waiver)
Counseling
Personal care
Acute care
Additional Community Social Services Act services
Children's home care option (TEFRA)

The key questions addressed in the report are:

- How much do federal, state and local governments spend on mental retardation services?
- How do residential service options compare in cost?
- How does Minnesota compare with other states?
- How does developmental disabilities spending growth compare with inflation?
- What fiscal incentives are available to counties to select the least-expensive services for persons with developmental disabilities?

Figure 2. Program expenditure shares for developmental disabilities, FY 90



Public spending on mental retardation services

Total spending

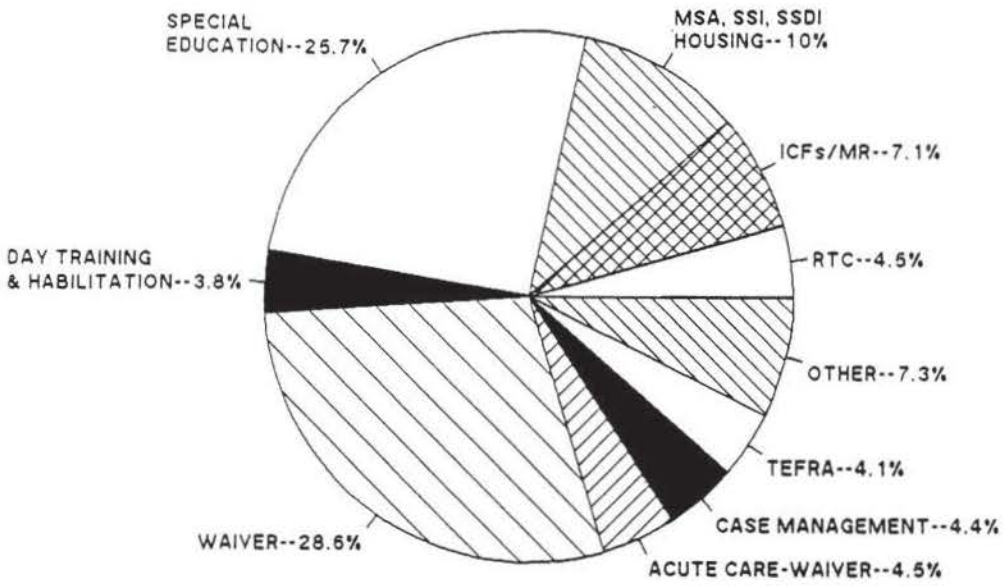
In Fiscal Year 1990, $583.1 million in federal, state, county and school district funds were spent on services to persons with mental retardation. This represents a 43 percent increase over the Fiscal Year 1986 total of $408.4 million. During these five years, state spending for these services increased from $186.6 million to $243.9 million. State spending accounted for 42 cents of every dollar spent on developmental disabilities services in FY 90 (Figure 1).

Just over 50 cents of every dollar was used to pay for residential services (including supported living arrangements under the waiver). The remainder funded day training and habilitation, special education and non-residential support services.

Regional treatment centers and intermediate care facilities for the mentally retarded accounted for almost 39 percent of total expenditures, compared with 9.6 percent for the Home- and Community-based Waiver services (not including acute care) (Figure 2).

Most of the increase in costs was accounted for by the introduction of the waiver

Figure 3. Shares of increase in service spending, FYs 86 - 90



(and waiver-related costs), and by special education, although regional treatment centers, intermediate care facilities for the mentally retarded and case management also contributed substantially to the increase (Figure 3). It is not possible to determine what the cost of services would have been in the absence of the waiver.

The largest single source of funding is the federal Medicaid program created under Title XIX of the Social Security Act. In Fiscal Year 1990, Medicaid funded 58 percent of all services. An additional 24 percent was provided by special education funding.

Average spending

Average annual expenditures increased for most services over the five years. The exceptions were semi-independent living services, family subsidy and non-waiver respite care.

The number of residents in regional treatment centers declined by 481 in the last five years. At the same time, the per diem rates for the centers increased from $152.49 to $228.75, and center expenditures increased by $7.8 million (Figure 4). The individuals discharged from regional treatment centers have required services in the community, and no treatment center campuses have been closed, requiring that fixed costs be spread over fewer residents and driving up the average cost of service in regional treatment centers.

Federal, state, county and school district shares over time

Overall spending increased by roughly 43 percent between FYs 86 and 90, as did the federal and county shares of total spending. School district expenditures increased by 118 percent, reflecting the shift in the provision of day services to the school districts. State spending increased by just 31 percent, although the state spent more than any other source in both years (Figure 5).

Figure 4: Regional treatment center expenditures and populations, FYs 86 - 90

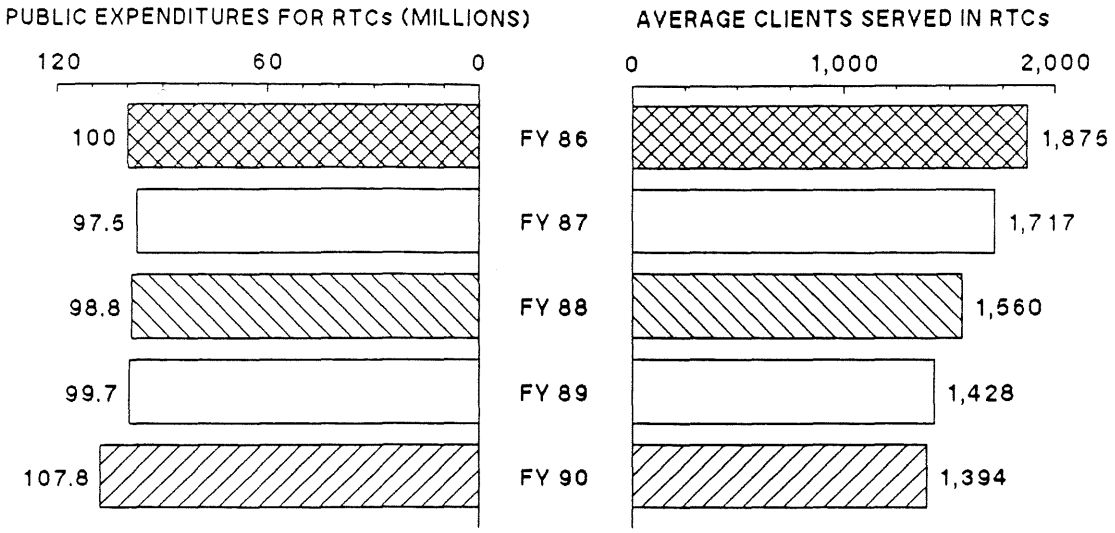


Figure 5. Federal, state, county and school district funding of developmental disabilities programs, FYs 86 and 90

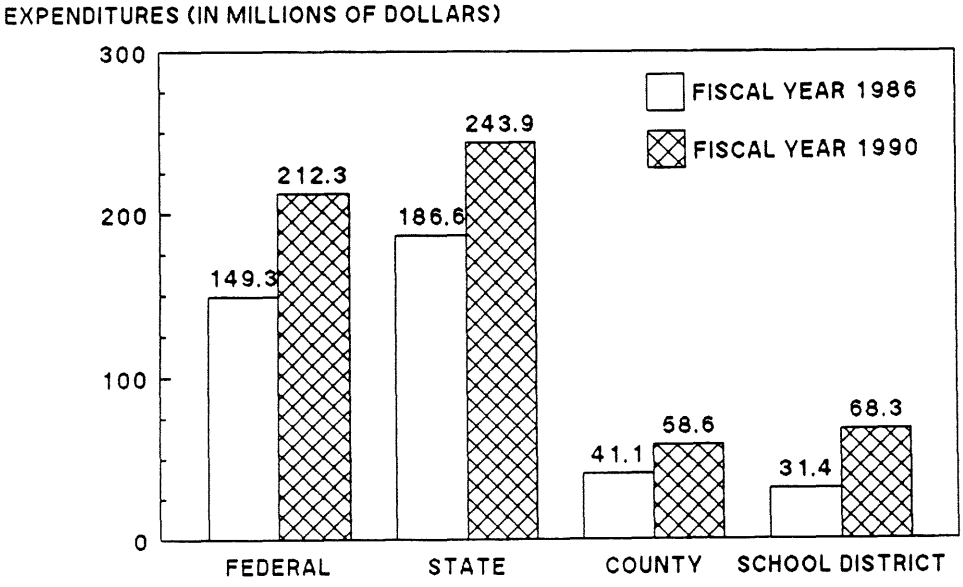
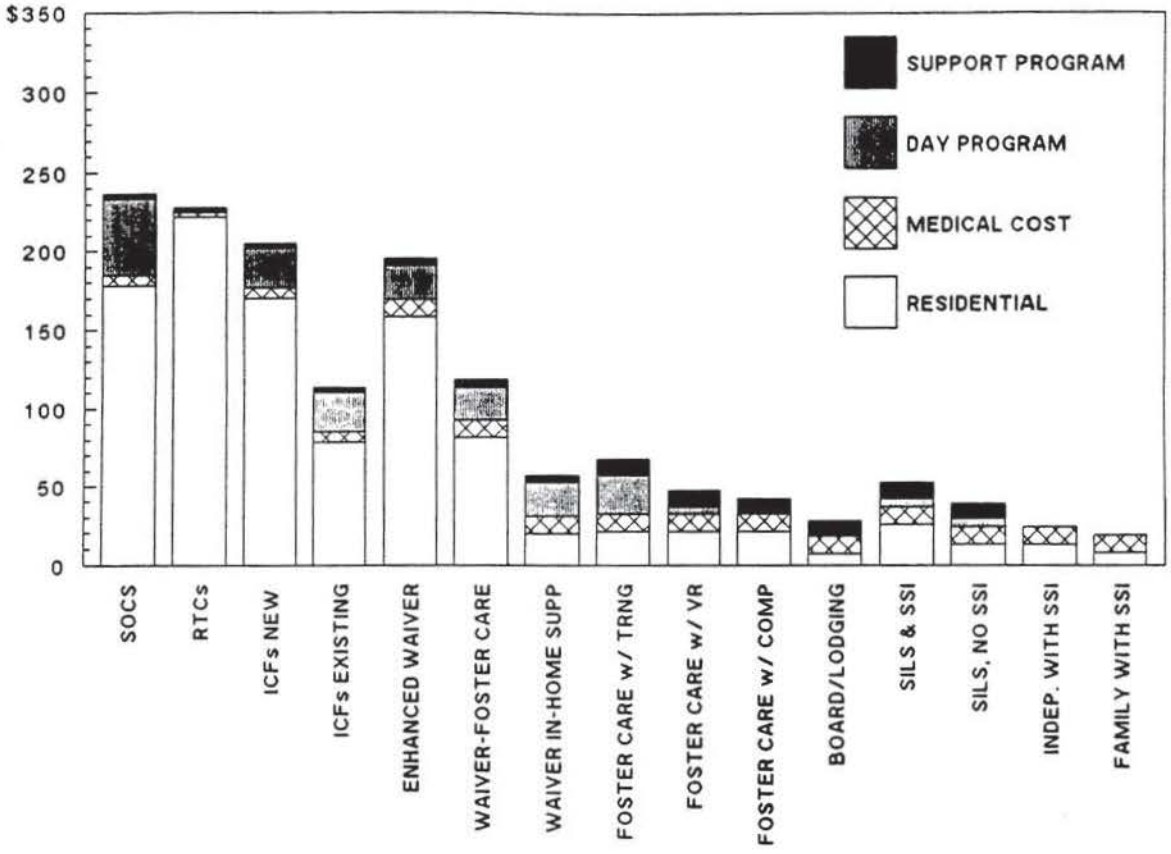


Figure 6. Average daily government expenditures for selected residential options, FY 90



Public spending by residential option

The public cost of providing a full range of services in different types of residential settings indicates which services are most costly. The average per-person per-day cost of all services (residential, medical, day and support) provided to individuals living in different settings in Fiscal Year 1990 is shown in Figure 6.

State-operated community services and regional treatment centers were the most costly ($236.18 and $227.45, respectively; $86,205.70 and $83,019.25 annually). New intermediate care facilities for the mentally retarded averaged $204.90 ($74,788.50 annually), while existing facility placements averaged just over half of that ($112.48; $41,055.20 per year). Waiver costs ranged from $57.36 for in-home support to $195.50 under the enhanced waiver ($20,936.40 to $71,357.50 annually). Services provided to persons living in their own homes, non-waiver foster care, board and lodging and semi-independent living programs tended to cost much less ($19.80 to $67.31; $7,227.00 to $24,568.15 per year).

It must be kept in mind that persons with developmental disabilities have different levels of functioning ability. In general, persons with greater needs receive a greater intensity of service, accounting for some of the difference in costs of service. For example, many persons living at home with family members or living independently have a higher functioning ability than many of those residing in regional treatment centers, state-operated community services and intermediate care facilities for the mentally retarded. However, this is not universally true. Institutional barriers prevent some persons from receiving the most appropriate care at the lowest cost. For example, some persons slated to be served in a state-operated community service could be served in group foster care under the waiver if private providers were available to serve them in the community.

Minnesota compared with other states

Fiscal effort

Minnesota devotes greater fiscal effort (spending per $1,000 of state personal income) to developmental disabilities services than do all but six of the 50 states and the District of Columbia.

Community services

When only community services are considered (that is, spending on residential facilities of 15 beds or less, and on non-residential day and support services), Minnesota ranks sixth in fiscal effort.

Minnesota ranks 14th in community services spending as a percent of total developmental disabilities spending, devoting about 55 percent of total outlays to community services. Michigan ranks first. Along with New Hampshire and Colorado, Michigan devotes more than 70 percent of its spending to community services. These three states are also able to exert less fiscal effort overall than Minnesota. Michigan, New Hampshire and Colorado are relatively low on the total fiscal effort scale (21, 18 and 40, respectively) when compared with their rankings on community spending as a percentage of total spending (1, 2 and 3, respectively).

Residential placements

Because residential services are the most expensive, states with a relatively high number of residential placements per capita would be expected to exert relatively greater fiscal effort. Residential services include both institutional (facilities with 16 or more beds, such as state institutions, large intermediate care facilities for the mentally retarded, and other large residences) and community residences (facilities with 15 or fewer beds, including small intermediate care facilities for the mentally retarded and other small residential settings).

Minnesota ranks second among the states in providing residential services to persons with developmental disabilities. The five-state Upper Midwest region accounts for five of the top six states in residential placements per 1,000 population: North Dakota ranks first with 2.43, Minnesota second with 2.18. Minnesota and North Dakota are both more than two standard deviations above the average 1.14 residents per 1,000.

Developmental disabilities growth vs. inflation

Total spending

Total spending for developmental disabilities services grew at an average annual rate of 9.31 percent from FY 86 through FY 90, compared with 7.42 percent for medical care and 9.52 percent for hospital services. The Consumer Price Index for all items grew at an average annual rate of 4.36 percent over the same period.

Average costs

Average expenditures per client -- which factor in the increasing number of clients receiving services -- increased faster than medical care and hospital inflation for regional treatment centers, case management (non-waiver), waivered services, and acute care. Average expenditures for intermediate care facilities for the mentally retarded, child foster care, nursing home residents who have developmental disabilities, and day training and habilitation grew at rates slower than health care inflation rates.

Capacity to pay for services

Total government spending on services for persons with developmental disabilities grew faster than state personal income during the last four years of the 1980s.

By contrast, state expenditures during this period grew at the same rate as state personal income. This implies that growth in spending above that warranted by growth in income was fed by federal, county and school district dollars.

When special education spending is removed from the total, however, state spending for these services grew faster than personal income and total spending. While federal and school district dollars for special education more than doubled from Fiscal Years 1986 through 1990, state special education spending grew by 10 percent. The state's share of special education spending dropped from 65 percent in state Fiscal Year 1986 to 48 percent in state Fiscal Year 1990.

Fiscal incentives

The selection of a total service package (residential, day, and support services) for a person with developmental disabilities is dependent on funding sources, total service costs, and cost-sharing formulas. These factors create fiscal incentives that can lead counties to prefer some services over others regardless of the total cost of care. Counties play the primary public role in arranging services to persons with developmental disabilities. Counties have had strong financial incentives to use Medicaid services such as regional treatment centers, intermediate care facilities for the mentally retarded or the Home- and Community-based Waiver. In recent years, the county contribution toward these Medicaid-eligible services was just under 5 percent. Effective Jan. 1, 1991, the counties no longer contribute toward the costs of Medicaid services, increasing the county incentive to use these options.

Other non-Medicaid-funded community services, such as semi-independent living services, non-waiver adult foster care or board and lodging, are paid in large part by county social service dollars. By using federally financed Medicaid services, counties save county dollars. But decisions that are financially responsible from the county perspective might not be the most appropriate choices from a client service perspective and might not be least expensive for the system overall.

A comparison of residential settings based on recent changes in Medicaid cost sharing indicates the following:

- Counties have no county fiscal incentive to prefer any Medicaid-funded service over another or to attempt to minimize total medical assistance costs.

- With no fiscal incentives to use one particular Medicaid-funded service instead of another, the county may be expected to use other criteria for service selection, such as availability, location, and appropriateness.

- Counties still have to follow state requirements to control Home- and Community-based Waiver costs according to the waiver cap, which will encourage counties to place individuals with more severe needs in regional treatment centers and newly developed intermediate care facilities for the mentally retarded.

- Counties have no fiscal incentive to use non-Medicaid-funded services, regardless of their cost or availability. The total cost for semi-independent living services, non-waiver adult foster care, and board and lodging is less in total than costs for Medicaid-funded services, but is more costly to counties.

Sometimes desired services such as beds in intermediate care facilities for the mentally retarded or Home- and Community-based Waiver openings may be unavailable. Counties may then have to choose among less-attractive alternatives: use of county-funded services, admission to a regional treatment center or letting the individual go unserved. In this situation, the county's financial interests and the client's best interests are likely to be in conflict.

INTRODUCTION

INTRODUCTION

The 1990 Minnesota Legislature directed the Department of Human Services to study current state spending on services to persons with mental retardation and to estimate growth in spending. Specifically, the legislation said:

> By January 1, 1991, the commissioner of human services, in consultation with counties, the department of education, and the state planning agency, shall provide a report to [the legislature] . . . that contains a description of all current state spending on mental retardation services, including special education services and vocational rehabilitation services . . . . The report must also identify service system alternatives, including fiscal incentives, mandates, and rule changes, that will encourage cost containment without adversely affecting quality or the provision of appropriate services. The proposals must include specific recommendations for semi-independent living services, respite care, case management, and day training and habilitation services.

The Department of Human Services Developmental Disabilities Division contracted with the Department of Administration to conduct the spending study and the service system alternatives study in the specific area of case management. The two studies were conducted concurrently, but their reports are published separately. This volume deals exclusively with spending on services for people with mental retardation.

For the purposes of this study, the Administration project team defined "mental retardation services" as services to persons with developmental disabilities, who are further defined in federal statute (Public Law 100-146) as persons with a chronic disability attributable to a mental impairment or a combination of mental and physical impairments. A developmental disability results in substantial functional limitations and calls for special care, treatment or other services. It is manifested before the age of 22 and is likely to continue indefinitely. The term "developmental disabilities" includes mental retardation and related conditions.

Overview of the report

The report is divided into four parts.

Part 1 is an overview of the sources of funding for programs serving persons with developmental disabilities. It includes a summary of costs, client numbers and average annual costs in table form.

Part 2 establishes the context for Minnesota's costs for developmental disability programs through cost comparisons between Minnesota and other states and between developmental disability programs and programs for other populations served by the Department of Human Services. It also compares changes in spending for developmental disability services with changes in the cost of health care generally.

Part 3 explains the Department of Administration project team's study methodology and discusses 22 categories of services and their annual costs from Fiscal Year 1986 through Fiscal Year 1990. Service costs are divided into residential, day and support categories and are further broken down by funding source.

Part 4 analyzes the average daily cost of a complete package of services by selected residential settings. It also discusses the counties' fiscal incentives to select certain services and avoid others.

Appendix A spells out specific methodological issues and any limitations presented by the data, and provides further documentation of service data. Appendix B lists cost-containment mechanisms used in health care and social service delivery systems. Appendix C lists cost-containment recommendations presented to the project team in the course of its work.

The report is based on the best available data as of Dec. 31, 1990.

Project team

A team of seven consultants and analysts from Administration's Management Analysis Division conducted this study. They worked in association with several Department of Human Services divisions: Children's Services, Community Social Services, Development Disabilities, Long-Term Care Management, Reimbursement, Reports and Statistics, Residential Program Management, and the Regional Treatment Center Implementation Project. The conclusions in this report reflect the views of the Management Analysis Division.

The project team members were William Clausen, Sharon Coombs, Gail Dekker, Laura Himes Iversen, Scott Nagel and Paul Schweizer, led by Kent Allin. Assistance was provided by Charlie Ball, Carol Glaser, Mary Krugerud, Jill LaFave, Karen Patterson and Mary Williams.

Part 1.

OVERVIEW OF SPENDING ON MENTAL RETARDATION SERVICES

OVERVIEW OF SPENDING ON MENTAL RETARDATION SERVICES

The public pays for a wide range of services to persons with developmental disabilities. Some services, such as regional treatment centers and special education, are delivered by government. Others, including intermediate care facilities for the mentally retarded and day training and habilitation, are privately provided. The costs of services to people with developmental disabilities are increasing in Minnesota and represent an important share of state expenditures for social, education and health services.

In Fiscal Year 1990, $583.1 million in federal, state, county and school district funds were spent on services to persons with mental retardation (Table 1). The comparable figure for Fiscal Year 1986 was $408.4 million. During these five years, state spending for mental retardation services has grown from $186.6 million to $243.9 million (Figure 7).

In Fiscal Year 1990, overall state spending for these services accounted for 1.7 percent of total state spending. The cost of services for persons with developmental disabilities was 9.5 percent of total Department of Human Services spending, while costs to the state to serve this population through special education amounted to more than 4 percent of state government education spending. Medicaid-funded services to persons with developmental disabilities accounted for 24 percent of state Medical Assistance spending.

Sources of funding: federal

Services are delivered through a public-private system supported by a combination of federal, state, county and school district funds. The largest single source is the federal Medicaid program formed under Title XIX of the Social Security Act. The dollars and requirements associated with the Medicaid program drive spending for developmental disability services. In Fiscal Year 1990, Medical Assistance paid for 58 percent of all residential, day and support services (Figure 8). Other federal sources include Social Services Block Grants under Title XX of the Social Security Act, the income maintenance programs known as Supplemental Security Income and Social Security Disability Insurance, and special education and vocational rehabilitation funds (Table 2).

Sources of funding: state

Minnesota contributes to services for persons with developmental disabilities by matching federal Medicaid and Social Services Block Grant funds and adding to Supplemental Security Income funds. Medical Assistance funding ratios varied from year to year (Table 3). In Fiscal Year 1990, the federal government paid 52.8 percent of Medical Assistance expenditures, the state 42.5 percent and the counties 4.7 percent. The state matches the Social Services Block Grant dollar for dollar, and allocates the funds to counties through the Community Social Services Block Grant program created by the Community Social Services Act. Minnesota Supplemental Aid complements federal Supplemental Security Income funds.

Table 1. Summary of estimated expenditures for persons with mental retardation or related conditions

SERVICES	DETAILED TABLE	FY 86	FY 87	FY 88	FY 89	FY 90
RESIDENTIAL						
1. Regional treatment centers	17	$100,038,680	$97,490,488	$98,758,136	$99,652,433	$107,841,437
2. ICFs–MR	18	107,332,085	108,106,739	110,854,046	112,092,311	119,676,291
3. Child foster care	19	3,276,445	3,654,592	4,016,188	4,102,599	3,978,245
4. Adult foster care (non–waiver)	20	275,562	281,011	305,175	349,163	845,740
5. Nursing homes	21	4,946,019	5,185,830	4,516,974	4,716,473	4,551,120
6. Board/lodging	22	392,902	230,130	433,469	543,282	590,443
7. MSA, SSI, SSDI housing	23	8,876,094	11,150,015	15,598,755	21,710,905	26,407,897
DAY SERVICES & SPECIAL EDUCATION						
8. Vocational rehabilitation	24	12,141,608	12,441,534	13,212,707	16,332,732	16,330,502
9. Special education	25	97,367,520	119,754,344	128,595,904	139,944,116	142,210,681
10. Day training & habilitation	26,27	39,136,783	40,894,428	41,734,971	43,417,700	45,759,735
SUPPORT						
11. Case management (non–waiver)	28	8,265,763	12,661,423	15,001,747	16,065,884	15,985,790
12. Screening	29	225,230	291,626	397,179	500,926	708,929
13. Semi–independent living	30	3,803,900	4,094,219	4,365,751	5,017,558	6,039,035
14. Family subsidy	31	705,000	701,000	1,062,700	1,062,700	1,128,700
15. Waiver support services	32,33	6,057,149	13,348,516	29,532,565	46,944,385	55,948,357
16. Assessment	34	665,536	784,610	871,245	933,804	1,233,118
17. Respite care (non–waiver)	35	268,254	599,008	583,003	588,990	976,288
18. Counseling	36	0	0	236,690	423,503	323,746
19. Personal care	37	7,635	8,833	41,593	137,581	262,249
20. Acute care services						
a. Waiver	38	735,392	1,796,914	4,783,110	6,810,026	8,601,282
b. RTC & ICF–MR	39	9,380,222	9,918,652	10,457,082	11,288,817	11,952,425
21. Additional CSSA services*	41	4,528,305	5,647,464	5,433,892	4,067,227	4,593,704
22. Children's home care option	42	0	0	0	2,004,771	7,160,211
Total		**$408,426,083**	**$449,041,374**	**$490,792,884**	**$538,707,885**	**$583,105,924**

* "Additional CSSA" services include non–waivered homemaking, non–state–administered SILS, transportation, consultation, and other CSSA services.

Figure 7. Federal, state, county and school district funding of developmental disabilities programs, FYs 86 and 90

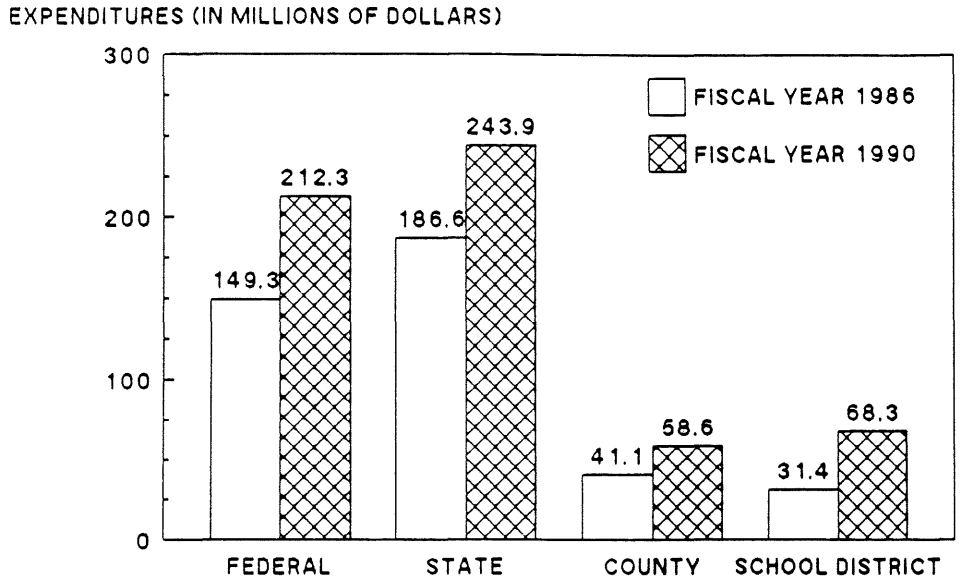


Figure 8. Revenue sources for developmental disabilities programs

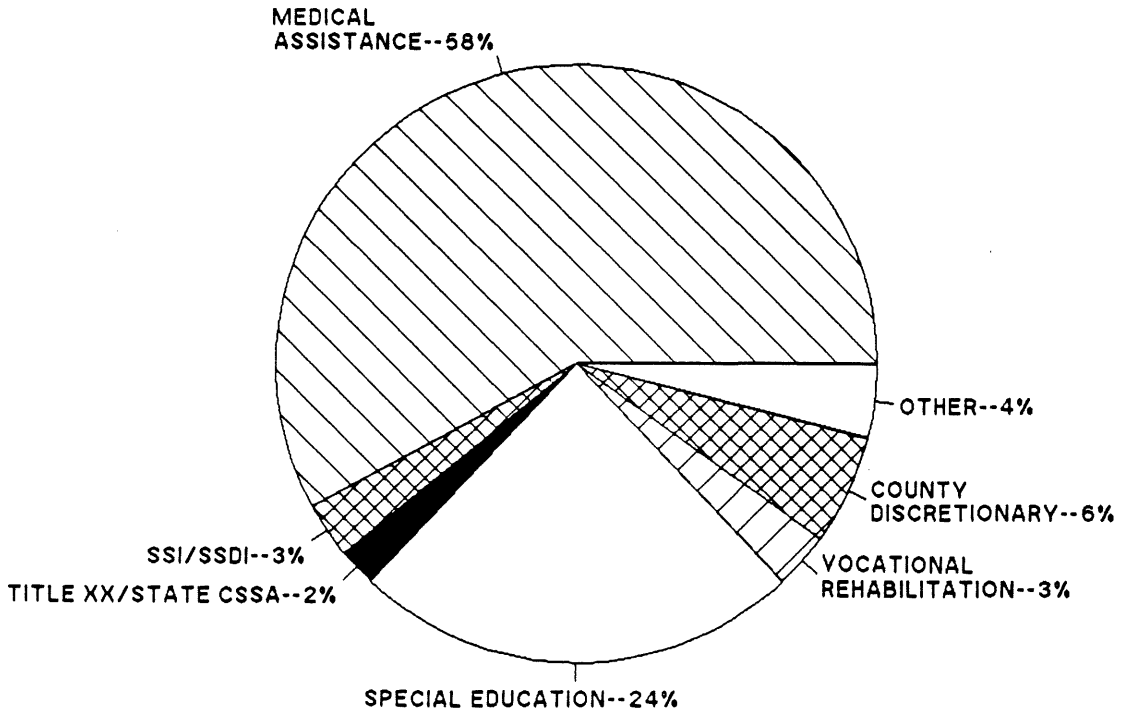


Table 2. Comparison of federal, state and county shares, FYs 86 - 90

	FY 86	FY 87	FY 88	FY 89	FY 90
FEDERAL					
Medicaid	$130,620,594	$135,801,696	$149,715,704	$162,065,541	$179,460,573
Vocational rehab	2,825,211	2,977,418	3,211,530	3,795,662	3,964,376
Special education	3,099,917	5,878,419	5,999,035	6,789,661	6,550,972
SSI/SSDI	6,594,620	7,726,013	10,760,421	13,286,842	15,433,844
Title XX	6,208,553	7,386,326	7,103,496	6,782,697	6,894,168
TOTAL	**$149,348,895**	**$159,769,872**	**$176,790,186**	**$192,720,403**	**$212,303,933**
STATE					
Medical Assistance	$103,378,051	$106,612,342	$115,543,864	$127,797,648	$144,261,567
Vocational rehab	7,559,430	7,109,586	7,276,068	7,499,728	7,850,325
Special education	62,906,827	71,061,738	68,404,097	65,882,392	67,345,607
MSA	1,939,252	2,910,401	4,112,584	7,160,453	9,327,945
CSSA block grant	6,814,621	8,232,438	7,979,594	7,221,035	6,847,143
Family subsidy / SILS	3,367,730	3,321,300	4,083,800	4,720,500	5,399,500
State RTC	634,489	901,806	2,504,144	4,436,146	2,835,268
TOTAL	**$186,600,400**	**$200,149,611**	**$209,904,151**	**$224,717,902**	**$243,867,355**
COUNTY					
Medical Assistance	$11,469,043	$11,848,651	$12,836,713	$14,199,739	$16,036,615
MSA	342,221	513,600	725,750	1,263,609	1,646,108
SILS	1,141,170	1,473,919	1,344,651	1,359,758	1,768,235
Non-entitlement	28,163,577	32,471,533	34,998,662	37,174,411	39,169,576
TOTAL	**$41,116,011**	**$46,307,703**	**$49,905,776**	**$53,997,517**	**$58,620,534**
SCHOOL DISTRICT	**$31,360,776**	**$42,814,186**	**$54,192,771**	**$67,272,064**	**$68,314,102**
GRAND TOTAL	**$408,426,082**	**$449,041,372**	**$490,792,884**	**$538,707,886**	**$583,105,924**

Table 3. Medical Assistance funding shares

	FY 86	FY 87	FY 88	FY 89	FY 90
Federal	53.23%	53.41%	53.84%	53.30%	52.82%
State	42.10	41.93	41.55	42.03	42.46
County	4.68	4.66	4.62	4.67	4.72

Minnesota supports some services solely with state or a combination of state and county dollars. The family subsidy and semi-independent living programs are funded by the state at its discretion and use no federal money. Expenditures for these programs grew from $4.5 million in FY 86 to $7.2 million in FY 90. Special education expenditures for persons with developmental disabilities were $142.2 million in FY 90, $68.3 million of it from school district funds and $67.3 million from state funds.

Sources of funding: counties

Counties receive both state and federal dollars to provide social services. This includes federal Title XX and state Community Social Services Act block grant funds. Both funds have remained relatively constant over the past five years. The fastest growing source of social service funds has been from county tax levies. In FY 86, county-financed social service funds totaled $28.1 million. This pool of funds grew to $39.2 million in FY 90.

Spending growth from FY 86 through 90

Federal funding for services to persons with developmental disabilities totaled $149.3 million in FY 86 and $212.3 million in FY 90. The largest source of federal funds in FY 90 was Medicaid, which totaled $179.5 million or 85 percent of all federal funds (Table 2). State funds totaled $186.6 million in FY 86 and $243.9 million in FY 90. The two largest sources were state funds to match Medicaid dollars ($144.3 million in FY 90), and special education appropriations ($67.3 million in FY 90). County funds grew from $41.1 million in FY 86 to $58.6 million in FY 90. The two largest sources of county funds were county non-entitlement funds ($39.2 million in FY 90) and county funds to match Medicaid dollars ($16 million in FY 90). One other source of funding was local property taxes for school districts, totaling $31.4 million in FY 86 and $68.3 million in FY 90.

The Medical Assistance program -- with contributions from federal, state and county governments -- and local special education funds experienced the largest dollar growth from FYs 86 through 90. Medical Assistance funds grew by $94.3 million, while local school district funds increased by $37 million.

State funding not related to Medical Assistance grew by $16.4 million from FYs 86 through 90.

The growth in funding was found in three areas: appropriations for education ($4.4 million), appropriations for family subsidy and semi-independent living ($2.0 million), and appropriations for Minnesota Supplemental Aid ($7.4 million). The growth in county non-entitlement funds was $11 million from FYs 86 through 90. Counties used these additional funds mostly in two areas: case management services ($6.1 million) and vocational rehabilitation services ($2.8 million).

Services and clients

Just over 50 cents of every dollar was spent on residential services, the remainder on day training and habilitation, special education and nonresidential support services.

Regional treatment centers and intermediate care facilities for the mentally retarded accounted for 39 percent of total expenditures, compared with 9.6 percent for the Home- and Community-based Waiver services (not including acute medical care) (Figure 9).

The waiver and services related to it (acute care waiver and Minnesota Supplemental Aid, Supplemental Security Income and Social Security Disability Insurance housing) showed the greatest client growth over the five years (Table 4). Other client populations, such as those at regional treatment centers and intermediate care facilities for the mentally retarded, either stabilized or declined in numbers over that time.

Dividing the expenditures for each service in Table 1 by the client populations in Table 4 identifies the average cost of service to a client, presented in Table 5.

Average annual expenditures increased for most services over the five years. The exceptions were semi-independent living services, family subsidy and non-waiver respite care. Most of the total increase in costs was accounted for by the waiver and waiver-related costs, and special education, although regional treatment centers, intermediate care facilities for the mentally retarded, case management and TEFRA also contributed substantially to the increase (Figure 10).

Figure 9. Program expenditure shares for developmental disabilities, FY 90

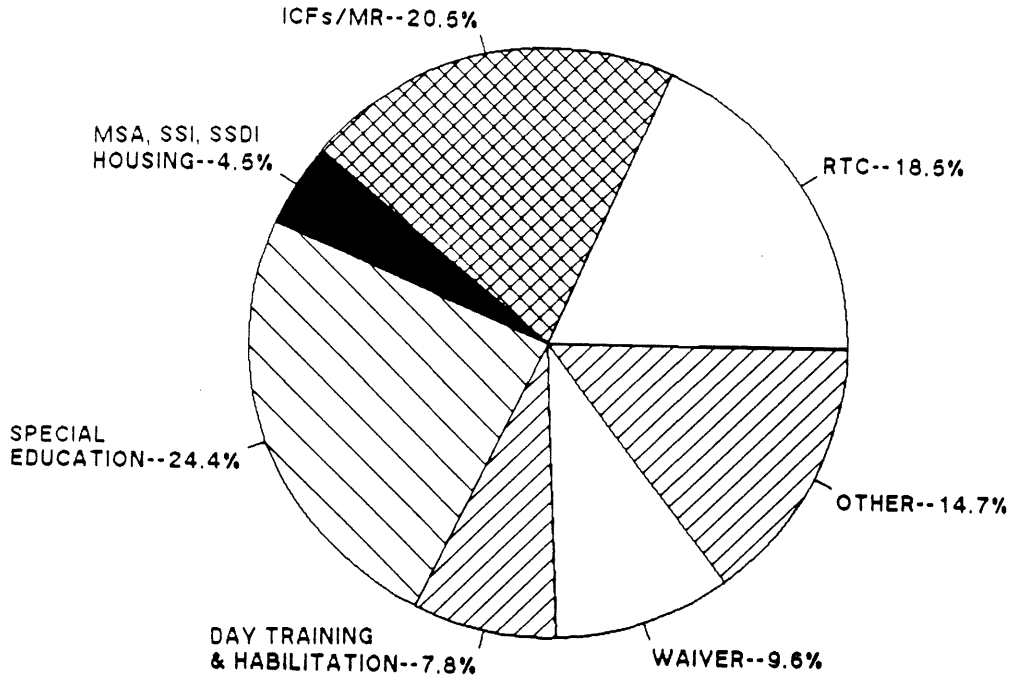


Figure 10. Shares of increase in service spending, FYs 86 - 90

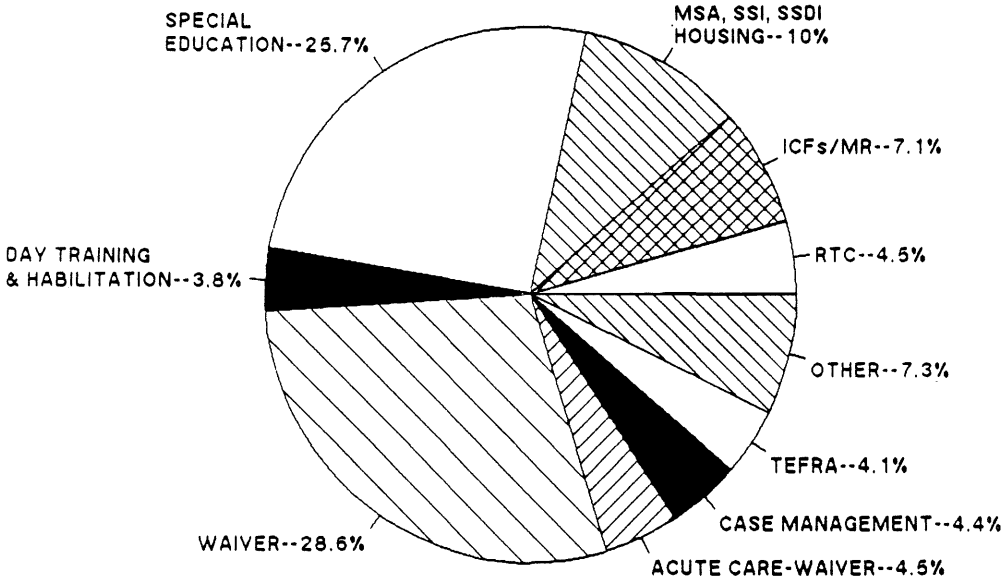


Table 4. Summary of estimated number of clients by service category

SERVICES	FY 86	FY 87	FY 88	FY 89	FY 90
RESIDENTIAL					
1. Regional treatment centers	1,875	1,717	1,560	1,428	1,394
2. ICFs–MR	4,988	4,961	4,737	4,344	4,224
3. Child foster care	759	786	831	791	721
4. Adult foster care (non–waiver)	312	134	135	145	401
5. Nursing homes	325	325	275	260	245
6. Board/lodging	333	113	177	211	238
7. MSA, SSI, SSDI housing	2,664	3,128	4,302	5,387	6,181
DAY SERVICES & SPECIAL EDUCATION					
8. Vocational rehabilitation	7,415	8,210	8,384	8,499	8,687
9. Special education	12,597	12,837	13,655	13,642	13,706
10. Day training & habilitation	6,379	6,208	5,829	4,948	5,041
SUPPORT					
11. Case management (non–waiver)	14,954	16,814	14,974	14,826	16,267
12. Screening	1,176	1,626	2,136	2,416	3,188
13. Semi–independent living	757	888	1,075	1,148	1,250
14. Family subsidy	270	269	419	432	460
15. Waiver support	614	1,000	1,666	2,055	2,273
16. Assessment	4,380	2,706	2,281	2,354	3,127
17. Respite care (non–waiver)	222	423	650	785	1,004
18. Counseling	0	0	394	765	552
19. Personal care	15	12	14	22	39
20. Acute care					
a. Waiver	539	900	1,616	2,004	2,113
b. RTC & ICF–MR	6,893	6,601	5,823	5,604	5,337
21. Additional CSSA	9,618	9,610	7,532	5,766	5,015
22. TEFRA	0	0	0	817	1,726

NOTES: 1. "Additional CSSA" includes non–waivered homemaking, non–state–administered SILS, transportation, consultation, and other CSSA services.

2. Columns cannot be summed to obtain an unduplicated count.

Table 5. Summary of estimated average annual expenditure per client

SERVICES	FY 86	FY 87	FY 88	FY 89	FY 90	Average annual Percent change FY 86–90 *
RESIDENTIAL						
1. Regional treatment centers	$53,354	$56,780	$63,306	$69,785	$77,361	9.73%
2. ICFs–MR	21,518	21,791	23,402	25,804	28,332	7.12%
3. Child foster care	4,317	4,650	4,833	5,187	5,518	6.33%
4. Adult foster care (non–waiver)	883	2,097	2,261	2,408	2,109	24.31%
5. Nursing homes	15,219	15,956	16,425	18,140	18,576	5.11%
6. Board/lodging	1,180	2,037	2,449	2,575	2,481	20.42%
7. MSA, SSI, SSDI housing	3,332	3,565	3,626	4,030	4,272	6.41%
DAY SERVICES & SPECIAL EDUCATION						
8. Vocational rehabilitation	1,637	1,515	1,567	1,878	1,880	3.51%
9. Special education	7,729	9,329	9,417	10,258	10,376	7.64%
10. Day training & habilitation	6,135	6,587	7,160	8,775	9,078	10.29%
SUPPORT						
11. Case management (non–waiver)	553	753	1,002	1,084	983	15.47%
12. Screening	192	179	186	207	222	3.80%
13. Semi–independent living	5,025	4,611	4,061	4,371	4,831	–0.98%
14. Family subsidy	2,611	2,606	2,536	2,460	2,454	–1.54%
15. Waiver support	9,865	13,349	17,727	22,844	24,614	25.68%
16. Assessment	152	290	382	397	394	26.92%
17. Respite care (non–waiver)	1,208	1,416	897	750	972	–5.29%
18. Counseling	0	0	601	554	586	–
19. Personal care	509	736	2,971	6,254	6,724	90.65%
20. Acute care						
a. Waiver	1,364	1,997	2,960	3,398	4,071	31.43%
b. RTC & ICF–MR	1,361	1,503	1,796	2,014	2,240	13.26%
21. Additional CSSA	471	588	721	705	916	18.09%
22. TEFRA	0	0	0	2,454	4,148	–

NOTE: "Additional CSSA" includes non–waivered homemaking, non–state–administered SILS, transportation, consultation, and other CSSA services.

* Single rate if applied to each of the 4 years would result in the net change from FY 86 to FY 90.

Part 2.

CONTEXT OF DEVELOPMENTAL DISABILITIES SPENDING

CONTEXT OF DEVELOPMENTAL DISABILITIES SPENDING

To establish a context for evaluating developmental disabilities expenditures, the study team looked for measures that address three questions: (1) where the state's effort on behalf of persons with developmental disabilities ranks with respect to that of other states; (2) how the growth in spending for developmental disabilities services compares with the growth in spending for health and social services generally; and (3) how the change in average costs compares with the change in costs for health care in the larger economy.

When trying to answer these questions, the team applied three measures:

- Minnesota compared with other states,
- the percent of Medical Assistance and community social services spending devoted to this population over time, and
- the growth in the cost of developmental disabilities services compared with inflation.

Although these measures do not answer specific questions about whether we're spending too much or too little on these services and whether we treat this population better or worse than other populations, they do provide some context for understanding Minnesota's aggregate effort on behalf of persons with developmental disabilities.

State comparison

The comparison of spending on developmental disabilities services among states requires a uniform methodology for collecting comparable data. A national comparison of developmental disabilities spending, conducted for state Fiscal Year 1988 by Braddock, Hemp, Fujira, Bachelder and Mitchell, provides the most recent data base. FY 88 data reported in Table 1 differs from Braddock's data because the study team relied on different data sources, examined some costs in greater detail, and included services not reported by Braddock.

The study assessed the relative commitment of state governments to persons with developmental disabilities and their families, using the magnitude of budgeted funds over a 12-year period as the primary indicator. Data presented for mental retardation/developmental disabilities expenditures includes all services associated with state institutions (regional treatment centers), intermediate care facilities for the mentally retarded, other residences, day and work programs, case management, waivered services, semi-independent living, family subsidy, and other services. Expenditures were also reported for income maintenance, special education and vocational rehabilitation. This data provides a yardstick to measure Minnesota's effort on behalf of people with developmental disabilities. The comparisons attempted to answer several questions:

How does Minnesota's fiscal effort on behalf of people with developmental disabilities compare with the fiscal effort of other states?

How much effort does Minnesota devote to community-based, as opposed to institutional, services and how does this relative effort compare with those of other states?

How do Minnesota's rates of residential and institutional placement compare with those of other states?

The idea of "fiscal effort" is to compare spending on developmental disabilities programs with a state's capacity to pay for these services. Total developmental disabilities expenditures in each state were divided by aggregate state personal income in thousands of dollars. The result, a measure of developmental disabilities spending per $1,000 of personal income, permits a direct comparison of state fiscal effort regardless of state population or total spending.

Fiscal effort data reflects spending for developmental disabilities services as defined above. Income maintenance, special education and vocational rehabilitation expenditures are not included in the fiscal effort analysis.

Total fiscal effort

Minnesota devotes greater fiscal effort to developmental disabilities services than all but six of the other 49 states and the District of Columbia (Table 6). Minnesota ranks seventh overall, behind North Dakota, four eastern seaboard states and the District of Columbia. Minnesota's fiscal effort is more than one standard deviation above the average, indicating that Minnesota is a significantly greater funder of services.

Table 6. Comparison of total developmental disabilities spending by state, FY 88

		MR/DD spending (millions)	MR/DD spending per $1,000 personal income			MR/DD spending (millions)	MR/DD spending per $1,000 personal income
1.	North Dakota	$65.00	$7.35	27.	Kansas	104.50	2.71
2.	New York	1,800.00	5.52	28.	Arkansas	74.20	2.64
3.	Connecticut	382.60	5.36	29.	Missouri	200.10	2.60
4.	Massachusetts	605.80	5.16	30.	Delaware	29.30	2.60
5.	Rhode Island	82.20	5.15	31.	Mississippi	70.40	2.54
6.	District of Columbia	66.20	4.95	32.	Maryland	214.70	2.51
7.	Minnesota	315.70	4.52	33.	Illinois	486.60	2.47
8.	Iowa	170.80	4.16	34.	Oklahoma	102.00	2.42
9.	South Dakota	35.70	3.93	35.	Washington	176.30	2.40
10.	Ohio	626.10	3.85	36.	Georgia	218.70	2.37
11.	Pennsylvania	713.20	3.78	37.	Indiana	175.70	2.21
12.	Wyoming	23.60	3.74	38.	Texas	534.10	2.21
13.	Vermont	30.00	3.67	39.	California	1,120.00	2.19
14.	South Carolina	141.90	3.32	40.	Colorado	113.80	2.16
15.	Louisiana	172.50	3.30	41.	Alaska	20.30	2.09
16.	Montana	33.70	3.29	42.	New Mexico	37.80	2.07
17.	Utah	63.90	3.26	43.	Virginia	200.20	1.97
18.	New Hampshire	63.00	3.23	44.	Alabama	94.70	1.86
19.	Maine	55.10	3.18	45.	Tennessee	119.00	1.85
20.	Wisconsin	232.80	3.17	46.	West Virginia	36.70	1.71
21.	Michigan	465.20	3.12	47.	Arizona	77.70	1.56
22.	New Jersey	476.60	2.92	48.	Kentucky	72.70	1.56
23.	Oregon	115.10	2.90	49.	Florida	302.60	1.55
24.	Nebraska	68.30	2.89	50.	Hawaii	25.60	1.44
25.	Idaho	34.60	2.83	51.	Nevada	16.80	0.97
26.	North Carolina	245.40	2.76				

SOURCE: The State of the States in Developmental Disabilities, Braddock et al. (1990).

North Dakota stands out as the leader in overall fiscal effort, motivated in part by a class-action suit. North Dakota spends one-third more, on a per-$1,000-of-personal-income basis, than the second-ranking state, New York. Its fiscal effort was almost 63 percent greater than Minnesota's. In response to the lawsuit, North Dakota is making up for a past failure to develop community services. In 1977, it ranked 15th in overall fiscal effort and last in fiscal effort for community services.

Community vs. institutional spending

"Community services" consists of spending on publicly and privately operated residential facilities of 15 beds or less, day training and habilitation, sheltered work, supported and competitive employment, family support, early intervention, and other state-assisted residential living arrangements and supports.

When considering a state's fiscal effort only on behalf of community services, Minnesota again places high (Table 7). Minnesota ranks sixth, while North Dakota again leads the nation. Both states were more than one standard deviation above the mean.

Another way to compare community spending is to consider the percentage of total spending devoted to community services. States that have *shifted* resources to the community and away from institutions (residential facilities with 16 or more beds) show the largest percent of spending on community services. States that are in transition from institution-based systems to community-based systems and those that have developed dual institutional and community systems split their funding more evenly.

Table 8 shows community services spending as a percent of total spending. Minnesota ranks 14th, spending about 55 percent of total outlays on community services.

Michigan ranks first. Along with New Hampshire and Colorado, it devotes more than 70 percent of its spending to community services. These three states, which spend a larger share of their budgets on community services than Minnesota does, are able to exert less fiscal effort overall than Minnesota. Michigan, New Hampshire and Colorado are relatively low on the total fiscal effort scale (21, 18 and 40, respectively) when compared with their ranking on community spending as a percentage of total spending (1, 2 and 3, respectively). By comparison, Minnesota ranks seventh in overall spending and 14th in community spending percentage.

Table 7. Comparison of spending on community services by state, FY 88

	Total MR/DD spending (millions)	Community spending (millions)	Community spending per $1,000 personal income
1. North Dakota	$65.00	$36.10	$4.08
2. Rhode Island	82.20	56.90	3.56
3. District of Columbia	66.20	44.10	3.30
4. Connecticut	382.60	232.40	3.26
5. New York	1,800.00	992.40	3.04
6. Minnesota	315.70	174.70	2.50
7. Michigan	465.20	359.70	2.41
8. New Hampshire	63.00	45.70	2.34
9. Massachusetts	605.80	272.60	2.32
10. South Dakota	35.70	18.70	2.06
11. Vermont	30.00	16.80	2.06
12. Ohio	626.10	324.90	2.00
13. Pennsylvania	713.20	370.40	1.96
14. Montana	33.70	19.80	1.93
15. Iowa	170.80	76.90	1.87
16. Maine	55.10	30.40	1.75
17. Nebraska	68.30	38.30	1.62
18. Colorado	113.80	80.90	1.54
19. Utah	63.90	29.20	1.49
20. Wisconsin	232.80	106.70	1.45
21. Idaho	34.60	17.60	1.44
22. Maryland	214.70	121.30	1.42
23. Alaska	20.30	13.50	1.39
24. Wyoming	23.60	8.60	1.36
25. California	1,120.00	614.20	1.20
26. New Jersey	476.60	190.50	1.17
27. South Carolina	141.90	45.80	1.07
28. Oregon	115.10	42.40	1.07
29. Louisiana	172.50	55.80	1.07
30. Indiana	175.70	81.00	1.02
31. Missouri	200.10	77.10	1.00
32. Georgia	218.70	90.80	0.98
33. Illinois	486.60	191.20	0.97
34. Arizona	77.70	45.90	0.92
35. Delaware	29.30	10.30	0.91
36. New Mexico	37.80	16.40	0.90
37. Washington	176.30	62.30	0.85
38. Kansas	104.50	32.40	0.84
39. North Carolina	245.40	72.30	0.81
40. Arkansas	74.20	20.50	0.73
41. Florida	302.60	135.70	0.70
42. West Virginia	36.70	13.80	0.64
43. Kentucky	72.70	29.90	0.64
44. Texas	534.10	150.10	0.62
45. Virginia	200.20	62.80	0.62
46. Hawaii	25.60	10.80	0.61
47. Alabama	94.70	27.50	0.54
48. Tennessee	119.00	33.30	0.52
49. Nevada	16.80	7.30	0.42
50. Oklahoma	102.00	17.50	0.42
51. Mississippi	70.40	11.10	0.40

SOURCE: The State of the States in Developmental Disabilities, Braddock et al. (1990).

Table 8. Comparison of spending shares for community services by state, FY 88

		Percent community spending			Percent community spending
1.	Michigan	77.32%	27.	Florida	44.84%
2.	New Hampshire	72.54	28.	Nevada	43.45
3.	Colorado	71.09	29.	New Mexico	43.39
4.	Rhode Island	69.22	30.	Hawaii	42.19
5.	District of Columbia	66.62	31.	Georgia	41.52
6.	Alaska	66.50	32.	Kentucky	41.13
7.	Connecticut	60.74	33.	New Jersey	39.97
8.	Arizona	59.07	34.	Illinois	39.29
9.	Montana	58.75	35.	Missouri	38.53
10.	Maryland	56.50	36.	West Virginia	37.60
11.	Nebraska	56.08	37.	Oregon	36.84
12.	Vermont	56.00	38.	Wyoming	36.44
13.	North Dakota	55.54	39.	Washington	35.34
14.	Minnesota	55.34	40.	Delaware	35.15
15.	Maine	55.17	41.	Louisiana	32.35
16.	New York	55.13	42.	South Carolina	32.28
17.	California	54.84	43.	Virginia	31.37
18.	South Dakota	52.38	44.	Kansas	31.00
19.	Pennsylvania	51.93	45.	North Carolina	29.46
20.	Ohio	51.89	46.	Alabama	29.04
21.	Idaho	50.87	47.	Texas	28.10
22.	Indiana	46.10	48.	Tennessee	27.98
23.	Wisconsin	45.83	49.	Arkansas	27.63
24.	Utah	45.70	50.	Oklahoma	17.16
25.	Iowa	45.02	51.	Mississippi	15.77
26.	Massachusetts	45.00			

SOURCE: The State of the States in Developmental Disabilities, Braddock et al. (1990)

Institutions and residential services

Because residential services are the most expensive, states with relatively high residential placements per capita would be expected to exert relatively greater fiscal effort.

Table 9 shows the number of persons receiving residential services in each state. Residential services include both institutional (facilities with 16 or more beds, such as state institutions, large intermediate care facilities for the mentally retarded, and other large residences) and community residences (facilities with 15 or fewer beds, including small intermediate care facilities for the mentally retarded and other small residential settings). It does not include nursing home services provided to persons with developmental disabilities. The states are ranked by the number of residents in all settings per 1,000 persons in the state population.

Minnesota ranks second among the states in the provision of residential services to persons with developmental disabilities. The five-state Upper Midwest region accounts for five of the top six states in residential placements per 1,000 population. North Dakota ranks first with 2.43, Minnesota second with 2.18. Minnesota and North Dakota are both more than two standard deviations above the average of 1.14 residents per 1,000.

The three states that devote the highest percentage of their budgets to community services -- Michigan, New Hampshire and Colorado -- are also relatively low in residential population per 1,000 (41, 28 and 32, respectively) and in total fiscal effort (21, 18 and 40).

Total spending and spending per $1,000 of personal income are highly correlated with total residents and residential placements per 1,000 population. The correlation coefficient for total spending and total residents is 0.88; for spending per $1,000 of personal income and residents per 1,000 population, it is 0.69. Both figures indicate that states that place the greatest number of persons per capita outside the home exert the greatest fiscal effort. They imply that a state, if it is to contain costs, must address the cost of residential services and prevent out-of-home placement whenever possible.

Table 9. Comparison of residential populations by state, FY 88

	TOTAL	State institution	Large private ICFMR	Other large residential	Small ICFMR	Other small residential	Residents/ 1,000 pop
1. North Dakota	1,634	347			495	792	2.43
2. Minnesota	9,276	1,556	1,934	73	2,726	2,987	2.18
3. South Dakota	1,452	474			216	762	2.05
4. Iowa	5,718	1,062	819	2,140	67	1,630	2.02
5. Rhode Island	1,915	283			691	941	1.94
6. Wisconsin	9,146	1,790	1,578	70	70	5,638	1.90
7. District of Columbia	1,043	257			394	392	1.68
8. Connecticut	4,959	2,157	22	234	496	2,050	1.54
9. New York	27,227	9,534	1,079	1,129	6,308	9,177	1.53
10. Wyoming	719	419				300	1.47
11. Montana	1,162	253			10	899	1.44
12. Massachusetts	8,242	3,320			472	4,450	1.41
13. Kansas	3,430	1,149	676		203	1,402	1.39
14. Nebraska	2,164	470	302		4	1,388	1.36
15. Louisiana	5,903	2,841	1,555		1,253	254	1.32
16. Oregon	3,551	1,130	199	167	22	2,033	1.30
17. Pennsylvania	14,843	4,426	1,945	1,124	815	6,533	1.24
18. New Jersey	9,307	5,236	72	981		3,018	1.21
19. Oklahoma	3,871	1,213	1,969			689	1.18
20. Utah	1,964	527	600		57	780	1.17
21. Missouri	5,873	1,888	160	1,862	118	1,845	1.15
22. Illinois	12,984	4,518	4,223	1,355	1,095	1,793	1.12
23. South Carolina	3,802	2,354	94		602	752	1.11
24. Ohio	11,746	2,990	4,004	188	1,123	3,441	1.09
25. California	29,897	6,772	2,685	4,028	1,555	14,857	1.08
26. Delaware	692	378			63	251	1.07
27. Vermont	587	191			54	342	1.07
28. New Hampshire	1,119	167	23		54	875	1.06
29. Idaho	1,042	250	48		183	561	1.04
30. Indiana	5,690	1,945	608		2,418	719	1.03
31. Washington	4,514	1,795	516		153	2,050	0.99
32. Colorado	3,200	554	333		280	2,033	0.97
33. Maine	1,140	307	144		267	422	0.96
34. Maryland	4,349	1,441		92		2,816	0.96
35. Mississippi	2,338	1,458	595			285	0.89
36. North Carolina	5,542	2,886	422	115	414	1,705	0.86
37. Arkansas	2,048	1,316	128			604	0.86
38. New Mexico	1,185	493			148	544	0.79
39. Hawaii	848	245			28	575	0.78
40. Texas	12,746	7,662	2,842		1,237	1,005	0.76
41. Michigan	6,920	1,302			2,223	3,395	0.75
42. Florida	8,818	1,993	1,293	987	639	3,906	0.73
43. Alaska	369	61			40	268	0.70
44. Tennessee	3,406	2,024	188		12	1,182	0.70
45. Virginia	4,051	2,821	126		97	1,007	0.69
46. Georgia	3,640	2,080	110			1,450	0.59
47. Arizona	1,936	388				1,548	0.57
48. West Virginia	977	508	51		156	262	0.52
49. Alabama	2,077	1,285		30	31	731	0.51
50. Kentucky	1,843	746	433			664	0.49
51. Nevada	443	178			15	250	0.44
U. S. TOTAL	263,348	91,440	31,776	14,575	27,304	98,253	1.08

Table 10. Medical Assistance spending, FYs 86 - 90

	FY 86	FY 87	FY 88	FY 89	FY 90	FYs 86–90
MR/DD	$245,467,688	$254,262,688	$278,101,212	$304,062,928	$339,758,755	
All other	774,981,914	831,368,762	893,832,562	942,976,502	1,065,862,785	
TOTAL	$1,020,449,602	$1,085,631,450	$1,171,933,774	$1,247,039,430	$1,405,621,540	
MR/DD percent of total	24%	23%	24%	24%	24%	
MR/DD annual increase	–	4	9	9	12	38%
All other annual increase	–	7	8	5	13	38
TOTAL annual increase	–	6	8	6	13	38

Medical Assistance and community social services spending comparison

Medical Assistance funded 58 percent of developmental disabilities services in Fiscal Year 1990. The percentage of Medical Assistance spending devoted to this population remained virtually unchanged over the five years considered in this study (Table 10). Total Medical Assistance spending and Medical Assistance spending for the developmentally disabled population grew at similar rates over FYs 86 through 90.

If looked at in terms of total dollars, this population was not treated any more generously in FY 90 relative to all other Medicaid-eligible populations than it was in FY 86.

While this conclusion does not tell us whether too much or too little was being spent on persons with developmental disabilities relative to other persons, it does tell us that persons with developmental disabilities did not receive any larger or smaller piece of the Medical Assistance pie than they did in Fiscal Year 1986.

Similarly, the percentage of community social services funds going to persons with developmental disabilities changed very little over the five years. Mental retardation expenditures accounted for roughly 15 percent of total community social services expenditures (Table 11).

Table 11. Change in MR/DD share of CSSA expenditures, FYs 86 - 90

	FY 86	FY 87	FY 88	FY 89	FY 90
SHARES					
Mental illness	18.40%	17.14%	15.92%	21.53%	25.35%
Child care	5.16	4.52	5.23	5.72	6.78
Vulnerable adults	11.92	13.09	13.69	12.41	10.98
MR/DD	14.32	15.85	15.05	15.04	14.98
Children	30.50	34.27	33.41	35.18	31.46
CD	8.12	7.22	7.43	8.66	8.21
"Other" target population	11.58	7.90	9.27	1.46	2.25

Source: Community Social Services Division, Department of Human Services.

Table 12. Growth in total developmental disabilities expenditures and health care inflation

Service	Average annual inflation FYs 86 - 90
Total developmental disabilities spending	9.31%
CPI - medical	7.42
CPI - hospital	9.52
CPI - all items	4.36

Source: U.S. Department of Labor, Bureau of Labor Statistics.

Table 13. Growth in average developmental disabilities expenditures and health care inflation

Service	Average annual inflation, FYs 86 - 90
Regional treatment centers	9.73%
ICFs/MR	7.12
Child foster care	6.33
Nursing homes	5.11
Day training & habilitation	10.29
Case management	15.47
Waiver	25.68
Acute care	
Waiver	31.43
RTC & ICFs/MR	13.26
CPI - all items	4.36
CPI - medical	7.42
CPI - hospital	9.52

NOTE: Inflation in services reflects growth in average annual expenditures per client, not per client/day.

Source: U.S. Department of Labor, Bureau of Labor Statistics.

Developmental disabilities cost growth and health care inflation

The cost of serving developmentally disabled persons increased from FYs 86 through 90, but so did the cost of living in general and the cost of health care in particular. Table 12 compares the change in total spending for developmental disabilities services with inflation. Two measures of health care inflation are presented for comparison: the consumer price index of medical costs for all urban consumers and the hospital portion of medical costs. The consumer price index for all items is presented for reference. Consumer price index values were reported for the 12 months ending in June of each year, corresponding to the state fiscal year.

Comparing the change in total costs with inflation does not account for increases or decreases in the number of persons served, however. Table 13 presents the average annual change in average costs.

For each year, the average cost for each of nine services was treated as the index of spending in that year. The services are regional treatment centers, intermediate care facilities for the mentally retarded, child foster care, nursing homes, day training and habilitation, case management, waiver, and acute care. The percent change in average cost from year to year becomes the measure of inflation in specific developmental disabilities services to be compared with inflation in the general economy.

Over the five fiscal years 1986 through 1990, average expenditures for regional treatment centers, case management (non-waiver), waivered services, day training and habilitation, and acute care grew at a faster annual rate than the consumer price index for medical care and for the hospital portion of health care in the general economy. Average expenditures for intermediate care facilities for the mentally retarded, child foster care, and developmentally disabled residents of nursing homes grew at rates slower than health care inflation but faster than the Consumer Price Index for all items.

Another helpful analysis is to compare the change in state spending on developmental disabilities programs with the change in the state's capacity to pay for such services. This type of analysis is similar to the fiscal effort comparison between the states for FY 88, except that it compares the change in Minnesota spending from calendar years 1986 through 1989. For each year, total developmental disabilities spending is divided by aggregate personal income (representing the capacity to pay for services) to determine fiscal effort (Table 14). The same analysis is performed for state expenditures only (Table 15) and for state expenditures except for special education (Table 16).

Total government spending on services for persons with developmental disabilities -- largely controlled by decisions of state and local governments -- grew faster than the state's capacity to pay for those services during the last four years of the 1980s. Total fiscal effort grew by 6.9 percent from calendar years 1986 through 1989.

By contrast, state fiscal effort remained the same in each of the four years. That is, state expenditures during this period grew at the same rate as state personal income. This implies that growth in spending above that warranted by growth in income was fed by federal, county and school district dollars.

State spending for developmental disabilities services other than special education, however, grew faster than personal income and total spending. While federal and school district dollars for special education more than doubled from FYs 1986 through 1990, state special education spending grew by 10 percent. The state's share of special education spending dropped from 65 percent in state FY 86 to 48 percent in state FY 90.

Table 14. Fiscal effort for developmental disabilities services, Calendar Years 86 - 89

	Personal income (thousands)	Developmental disabilities spending*	Fiscal effort (per $1000)	Percent change
1986	$62,774,000	$428,733,727	$6.83	–
1987	66,715,000	469,919,594	7.04	3.13%
1988	70,963,000	514,752,851	7.25	2.98
1989	76,861,000	560,906,905	7.30	0.60
Change 1986 – 1989	**22.44%**	**30.83%**	**6.85%**	

* Adjusted to calendar year (FY 86 + FY 87)/2 = CY 86

SOURCE: State Demographer, Minnesota State Planning Agency.

Table 15. State fiscal effort for developmental disabilities services, Calendar Years 86 - 89

	Personal income (thousands)	State developmental disabilities spending*	Fiscal effort (per $1000)	Percent change
1986	$62,774,000	$193,375,006	$3.08	–
1987	66,715,000	205,026,881	3.07	−0.24%
1988	70,963,000	217,311,027	3.06	−0.35
1989	76,861,000	234,292,629	3.05	−0.46
Change 1986 – 1989	**22.44%**	**21.16%**	**−1.05%**	

* Adjusted to calendar year (FY 86 + FY 87)/2 = CY 86

SOURCE: State Demographer, Minnesota State Planning Agency.

Table 16. State fiscal effort for developmental disabilities services except special education, Calendar Years 86 - 89

	Personal income (thousands)	State developmental disabilities spending*	Fiscal effort (per $1000)	Percent change
1986	$62,774,000	$126,390,723	$2.01	–
1987	66,715,000	135,293,964	2.03	0.72%
1988	70,963,000	150,167,782	2.12	4.35
1989	76,861,000	167,678,629	2.18	3.09
Change 1986 – 1989	22.44%	32.67%	8.35%	

* Adjusted to calendar year (FY 86 + FY 87)/2 = CY 86

SOURCE: State Demographer, Minnesota State Planning Agency.

Part 3.

SPENDING FOR STATE SERVICES

SPENDING FOR STATE SERVICES

The legislative directive for this study was to describe current state spending on services to persons with mental retardation, including special education and vocational rehabilitation services. The project team identified 22 services provided or funded by federal, state, county or school district sources. Each service was assigned to one of three categories: residential, day or support. Information on the amount spent for each service and the number of persons receiving these services for the last five years was collected and analyzed.

The data is presented according to state fiscal years. In some cases, calendar-year data was adjusted to fiscal year. Although the legislation required collection only of state spending data, this report shows the costs of government services broken down by federal, state and county sources. A description limited to state spending would not have given a complete picture of services, nor would it have shown the state's contribution to the total cost.

The project team attempted to collect all pertinent data related to each service. Some data was readily available because reporting has been required. When data was available from more than one source, the team analyzed the data and sources to determine the most accurate and consistent. In some cases, data was not available, requiring the team to use estimates and interpolations to present an accurate-as-possible picture of public spending. The project team believes that the data presented here is the best available.

This study focused on services targeted to persons with developmental disabilities. Although these persons may receive other public services, this study concentrated on services provided to this population because of its unique needs. The costs of services such as food stamps or general assistance provided to persons with developmental disabilities are not included in this report because these services are not specifically targeted to that population.

Information on sources and methodology for selected tables is presented in Appendix A.

SERVICES AND THEIR COSTS: RESIDENTIAL

REGIONAL TREATMENT CENTERS

Regional treatment centers provide comprehensive services to persons with medical and other basic human service needs, including residential, vocational rehabilitation and other support services, such as medical, therapeutic and recreational programs.

Minnesota has eight regional treatment centers, in Anoka, Brainerd, Cambridge, Faribault, Fergus Falls, Moose Lake, St. Peter and Willmar. All but Faribault and Cambridge also serve persons who are mentally ill, chemically dependent or elderly. The Anoka center does not serve persons with developmental disabilities.

In the last 20 years, several factors have shifted the emphasis away from placing persons with developmental disabilities into regional treatment centers and toward returning them to or retaining them in community settings.

One factor was the *Welsch v. Likins* legal action in 1974 that established the right to treatment in the least restrictive environment. In 1980, the Welsch Consent Decree required Minnesota to reduce the number of persons with mental retardation in regional treatment centers to improve conditions and increase staff-to-resident ratios, and to develop community service alternatives.

A second factor in this shift toward community alternatives was the Medicaid funding of community-based intermediate care facilities for persons with developmental disabilities.

As a result of these developments, the regional treatment center population of persons with developmental disabilities declined from 2,630 in 1980 to 1,394 in 1990. The population remaining at the regional treatment centers includes persons who have severe behavior problems, are medically fragile, and have multiple disabilities. In 1988, 98 percent of regional treatment center residents were 21 or older, and 59 percent were male. Sixty-four percent were profoundly retarded, 19 percent severely retarded, 7 percent moderately retarded and 9 percent mildly retarded.

In 1989, the Department of Human Services and the state employees' unions negotiated a settlement on the future of the regional treatment centers. This agreement in part calls for relocation of all but 95 of the remaining persons with mental retardation or related conditions into private or state-operated community homes over a six-year period. The 1989 Legislature adopted this agreement, which included the development of the following state-operated services in Fiscal Year 1991: 26 community homes, 5 crisis homes and 11 day programs.

In FY 90, more than 94 percent of regional treatment center costs were paid by the Medical Assistance program. Although the number of regional treatment center residents dropped by 481 between FYs 86 and 90, total annual government costs showed an overall increase of $7.8 million.

In addition to the state Medical Assistance match, the state pays the full amount of

costs not allowed by the Medical Assistance program, which grew by 347 percent from $634,489 in FY 86 to $2,835,268 in FY 90. The government cost per patient day, which includes unreimbursed state costs but not private pay contributions, increased by 51 percent, from $147.34 in FY 86 to $221.85 in FY 90.

(Additional acute care costs not funded through regional treatment center per diems are accounted for later in this report in Table 39.)

Table 17. Regional treatment centers: expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
Total cost	$103,538,680	$100,990,488	$102,258,136	$103,076,433	$111,193,437
Less private pay (est.)	3,500,000	3,500,000	3,500,000	3,424,000	3,352,000
Total gov't cost	**$100,038,680**	**$97,490,488**	**$98,758,136**	**$99,652,433**	**$107,841,437**
FUNDING SOURCE					
Federal	$52,902,910	$51,588,015	$51,813,524	$50,750,281	$55,464,258
State	42,483,653	41,401,440	42,497,678	44,455,551	47,420,887
County	4,652,116	4,501,033	4,446,934	4,446,601	4,956,291
AVERAGE COST					
No. of recipients	1,875	1,717	1,560	1,428	1,394
Patient days	678,967	611,070	566,094	509,721	486,095
Gov't cost/patient day	**$147.34**	**$159.54**	**$174.46**	**$195.50**	**$221.85**
Total cost/patient day	$152.49	$165.27	$180.64	$202.22	$228.75
Unreimbursed costs	$634,489	$901,806	$2,504,144	$4,436,146	$2,835,268

INTERMEDIATE CARE FACILITIES for the MENTALLY RETARDED

Intermediate care facilities for the mentally retarded provide active treatment, 24-hour care, lodging, food and recreation. Residents must leave the facility to receive day services -- either extended employment services or day habilitation services for adults and educational services for children. Residents are eligible for acute medical services under Medicaid. The costs of providing medical services to people in intermediate care facilities for the mentally retarded are reported in Table 39. Intermediate care facilities for the mentally retarded are dispersed throughout the state, with most counties containing at least one. Although most facilities are privately owned and operated, their funding comes from Medical Assistance for eligible residents. The Department of Human Services Reimbursements Division sets rates for each facility based on past costs.

Intermediate care facilities for the mentally retarded developed in the 1960s as the first alternative to regional treatment centers. The trend toward deinstitutionalization greatly accelerated when Title XIX Medicaid funds became available for the construction and operation of intermediate care facilities for the mentally retarded in 1971.

Between 1978 and 1986, the number of residents served in intermediate care facilities for the mentally retarded rose from 2,341 to 4,988. Some facilities had more than 100 beds; 278 of the 330 facilities in 1986 served fewer than 16 residents.

In 1981, the Minnesota Legislature imposed a 5 percent cap on the growth of rates for intermediate care facilities for the mentally retarded. The 1983 Legislature placed a moratorium on the expansion or construction of new facilities to contain Medicaid costs (M.S. 252.291). The moratorium legislation directed the Department of Human Services to reduce the number of beds in regional treatment centers' and communities' intermediate care facilities for the mentally retarded from 7,500 to 7,000 by 1986. Between July 1986 and January 1990, more than 600 beds were decertified. The 1988 Legislature, recognizing that the current bed supply was inadequate for the service needs of persons with severe physical and medical problems, authorized the development of 150 new beds in intermediate care facilities for the mentally retarded.

The average monthly population in intermediate care facilities for the mentally retarded peaked at 4,988 in FY 86, decreasing to 4,224 (including 161 children) by FY 90 as larger facilities were downsized, even though the number of facilities increased.

Although the number of residents in intermediate care facilities for the mentally retarded has decreased, the total cost has grown from $107.3 million in FY 86 to $119.7 million in FY 90. The average daily cost per person increased by 32 percent from $58.95 in FY 86 to $77.62 in FY 90. Cost increases are attributable to general inflation as reflected in the Consumer Price Index, the downsizing and closing of facilities, conversion of facilities from Class A to Class B homes, one-time rate adjustments for citations and violations, and the higher costs of new facilities.

Table 18. Intermediate care facilities for the mentally retarded: expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
FUNDING SOURCE					
Federal	$57,122,136	$57,739,809	$59,683,818	$59,745,202	$63,213,016
State	45,188,954	45,330,237	46,053,205	47,112,398	50,814,552
County	5,020,995	5,036,693	5,117,023	5,234,711	5,648,723
Total	**$107,332,085**	**$108,106,739**	**$110,854,046**	**$112,092,311**	**$119,676,291**
No. of recipients	4,988	4,961	4,737	4,344	4,224
Cost/person/day	**$58.95**	**$59.70**	**$64.11**	**$70.70**	**$77.62**

CHILD FOSTER CARE

Child foster care is substitute 24-hour-a-day family or group home care for a planned period of time. Children are placed in foster homes when they cannot be cared for in their parents' home. Eleven percent of children in foster care are identified as having developmental disabilities.

Two sources fund child foster care programs. Children from homes receiving Aid to Families with Dependent Children are eligible for funding under federal Title IV-E; other children are funded through county social services. Little reliable data exists on foster care costs for children with developmental disabilities. The only data available involves those children funded through county social services and comes from county reports to Human Services.

Between FYs 86 and 90, the number of children receiving child foster care ranged from 721 to 831. Child foster care costs grew from approximately $3.3 million in FY 86 to $4 million in FY 90. According to the reports, the average monthly cost grew from $359.73 in FY 86 to $459.81 in FY 90. A review of Human Services emergency rules (M.R. 9560.0650 - 9560.0656) suggests that these figures understate the actual cost. These rules establish a base rate, which increases according to a child's age and includes a premium based on difficulty of care. Care for a child receiving a mid-range level of care, according to the rules, would cost approximately $686 to $759 per month.

Table 19. Child foster care: expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
FUNDING SOURCE					
Federal	$568,463	$590,217	$602,428	$603,082	$576,845
State	624,163	657,827	676,728	642,057	572,867
County	2,083,819	2,406,549	2,737,032	2,857,460	2,828,532
Total	**$3,276,445**	**$3,654,592**	**$4,016,188**	**$4,102,599**	**$3,978,245**
No. of children served	759	786	831	791	721
Cost/child/month	**$359.73**	**$387.47**	**$402.75**	**$432.22**	**$459.81**
Cost/child/year	**$4,316.79**	**$4,649.61**	**$4,832.96**	**$5,186.60**	**$5,517.68**

ADULT FOSTER CARE

Adult foster care is supervised 24-hour care for up to four adults in a corporate or family setting, with access to social services and community resources. According to a report of the Human Services Social Services Division, of the 2,112 persons living in adult foster care settings in 1989, 1,733 (82 percent) had developmental disabilities.

Corporations served 1,190 persons with developmental disabilities in 1989, while families served 543. Persons living in corporate settings typically received services under the Home- and Community-based Waiver. (These costs are reported in Table 32.) The number of corporate foster care providers increased from 118 in 1987 to 417 in 1989, corresponding to the growth of recipients on the waiver.

The expenditures and clients in Table 20 reflect only county-subsidized services in family-type settings. Adult foster care funded by counties has revenues at its disposal from state Community Social Service Act block grants, federal Title XX block grants and county discretionary funds. Table 20 shows the approximate funding shares of federal, state and county sources.

These costs are in addition to individuals' room and board, which are supported by such fiscal resources as Supplemental Security Income, Social Security Disability Insurance, Minnesota Supplemental Aid, and earned and unearned income. Rates are negotiated by the county, with each individual's personal financial resources applied first and the county paying the balance of the cost. Services funded through county social services are provided at the discretion of the counties. Adult foster care is used chiefly when other residential services are unavailable under the Home- and Community-based Waiver or in institutional settings.

The best available data showed wide fluctuations in the number of clients in this setting and in average monthly costs. County social service data projections anticipated a large increase in caseload and costs for FY 90.

Table 20. Adult foster care: non-waiver expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
FUNDING SOURCE					
Federal	$47,810	$45,383	$45,776	$51,327	$122,632
State	52,495	50,582	51,422	54,644	121,787
County	175,257	185,046	207,977	243,192	601,321
Total	$275,562	$281,011	$305,175	$349,163	$845,740
No. of persons served	312	134	135	145	401
Cost/person/month	$73.60	$174.76	$188.38	$200.67	$175.76
Cost/person/year	$883.21	$2,097.10	$2,260.56	$2,408.02	$2,109.08

PERSONS INAPPROPRIATELY PLACED IN NURSING HOMES

Nursing home care is 24-hour supervised medical care in a community facility primarily for elderly persons. Public Law 100-203 (1987) required all states to assess the service needs of all persons with mental retardation or related conditions who were residing in nursing homes, to determine the appropriateness of their services and to correct inappropriate placement of persons with developmental disabilities. The law required that all nursing home residents with mental retardation or related conditions be assessed and given appropriate services and/or placements by April 1, 1990. A preadmission screening program preventing future inappropriate placements had to be in place by Jan. 1, 1989.

The law allowed states to request additional time to arrange and provide necessary services to those persons assessed as inappropriately placed. Minnesota was granted an extension to complete the assessments, and agreed to complete the relocation of inappropriately placed residents by June 30, 1992. The latter would be accomplished by moving 200 persons to services financed under a federally approved Home- and Community-based Waiver (targeted for nursing home residents), 45 persons to intermediate care facilities for the mentally retarded, and 30 to other services.

In FY 1987, Minnesota estimated that 1,200 individuals with mental retardation or related conditions were living in nursing homes. Of that number, 325 were thought to be inappropriately placed, but not all 1,200 persons had been assessed at that time. The May 1990 Human Services Management Indicator Reports for the Developmental Disabilities Division indicated that 123 persons had been relocated from community nursing homes into the community. Persons who have resided in nursing homes for more than 30 months have the option of remaining there.

The number of persons with developmental disabilities assessed as inappropriately placed in nursing homes decreased from 325 in FY 86 to 245 in FY 90. Because screening did not begin until 1988, FY 86 and 87 numbers are estimates.

The costs associated with persons inappropriately placed in nursing homes were estimated by multiplying the number of inappropriate placements by the average monthly cost of service in a community nursing home under rates approved by Human Services. The total costs increased slightly from $4.9 million in FY 86 to $5.2 million in FY 87, then decreased to $4.6 million in FY 90. Costs are shared by federal, state and county governments under the Medical Assistance program.

The total costs in Table 21 may be understated. For example, although 325 persons were listed as inappropriately placed in FY 86, that number may have been low because none of the 1,200 persons had yet been assessed.

Table 21. Inappropriate placements in nursing homes: expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
FUNDING SOURCE					
Federal	$2,632,766	$2,769,752	$2,431,939	$2,513,880	$2,403,902
State	2,082,274	2,174,419	1,876,803	1,982,334	1,932,406
County	231,474	241,660	208,684	220,259	214,813
Total	**$4,946,019**	**$5,185,830**	**$4,516,974**	**$4,716,473**	**$4,551,120**
No. of persons	325	325	275	260	245
Avg. monthly payments	$1,268	$1,330	$1,369	$1,512	$1,548

BOARD and LODGING

Board and lodging services provide supportive group living with little supervision and little or no formal program activity, for persons with developmental disabilities who have few functional impairments. They may be unable to obtain semi-independent living services or to live in their own home without support or in any other kind of group living arrangement. Providers, licensed by the Department of Health, negotiate their rates with the host county.

Table 22 shows expenditures for board and lodging reported by county social service agencies. Expenditures are usually for persons unable to pay for their total cost of care.

Costs and the number of persons served fluctuated widely between FYs 86 and 90. Possible explanations for the fluctuations include inconsistent reporting among counties and changing county reporting systems.

The costs and number of persons served do not necessarily show all costs or all persons with developmental disabilities served in board and lodging facilities throughout Minnesota. Many people receive board and lodging services paid by Supplemental Security Income, Social Security Disability Insurance, and/or Minnesota Supplemental Aid. The total number of persons with developmental disabilities in board and lodging facilities was not known. No data was available to reference these numbers.

Table 22. Board and lodging: expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
FUNDING SOURCE					
Federal	$68,168	$37,166	$65,020	$79,862	$85,614
State	74,848	41,423	73,040	85,024	85,024
County	249,886	151,541	295,409	378,396	419,805
Total	$392,902	$230,130	$433,469	$543,282	$590,443
No. of persons served	333	113	177	211	238
Cost/person/month	$98.32	$169.71	$204.08	$214.57	$206.74
Cost/person/year	$1,179.89	$2,036.55	$2,448.98	$2,574.80	$2,480.85

SUPPLEMENTAL SECURITY INCOME, SOCIAL SECURITY DISABILITY INSURANCE and MINNESOTA SUPPLEMENTAL AID

Supplemental Security Income, Social Security Disability Insurance and Minnesota Supplemental Aid provide financial resources to low-income persons with developmental disabilities, and pay for room and board.

Supplementary Security Income is payable to individuals or couples assessed by the Social Security Administration as disabled, blind or 65 or older and with limited income and resources. The Supplementary Security Income program was created under Title XVI of the Social Security Act, with the federal government paying 100 percent of the costs.

Social Security Disability Insurance eligibility is based on an individual's employment or a parent's or grandparent's contribution to Social Security. Benefits, payable to the eligible dependents of a person who is disabled, retired or deceased, are intended to replace part of the earnings lost because of a physical or mental impairment severe enough to prevent a person from working. The fully federally paid program was created under Title II of the Social Security Act.

The Minnesota Supplemental Aid Program provides additional income to recipients of Supplemental Security Income. The State of Minnesota pays 85 percent of MSA benefits, the counties 15 percent.

Table 23 information is limited to persons who reside in adult foster care, receive board and lodging, or receive waiver or semi-independent living services. These benefits usually pay for room and board in negotiated-rate facilities. No record exists of SSI, SSDI or MSA payments to people with developmental disabilities who did not reside in negotiated-rate facilities.

The estimated number of SSI recipients with developmental disabilities in these settings increased by 125 percent from 930 persons in FY 86 to 2,092 in FY 90. The total transfer payments grew 139 percent from an estimated $3.1 million in FY 86 to $7.4 million in FY 90.

SSDI benefits and the number of recipients increased steadily throughout the five-year period. Total transfer payments grew 131 percent from approximately $3.5 million in FY 86 to approximately $8.1 million in FY 90. The number of recipients increased 94 percent from 1,035 in FY 86 to 2,013 in FY 90.

Over the five years, the average monthly SSI payment increased 6 percent from $276.91 to $293.73 and the SSDI payment increased 18 percent from $282.15 to $333.67.

The number of MSA recipients increased by 197 percent from FY 86 through FY 90, beginning with 699 recipients and ending with 2,076. Estimated benefits increased by 378 percent from $2.3 million to $11 million.

The average monthly MSA payment increased by 62 percent from $271.99 in FY 86 to $440.51 in FY 90, likely due to a rate increase for persons who were deinstitutionalized and moved into community facilities and whose room-and-board costs had been paid previously with Medical Assistance funds.

Table 23. SSI, SSDI and MSA: room and board expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
FUNDING SOURCE					
Federal	$6,594,620	$7,726,013	$10,760,421	$13,286,842	$15,433,844
State	1,939,252	2,910,401	4,112,584	7,160,453	9,327,945
County	342,221	513,600	725,750	1,263,609	1,646,108
Total	**$8,876,093**	**$11,150,014**	**$15,598,755**	**$21,710,904**	**$26,407,897**
SSI TOTALS					
No. of recipients	930	1,128	1,485	1,832	2,092
Avg. payment / month	$276.91	$270.66	$275.48	$283.50	$293.73
Expenditures	$3,090,283	$3,663,594	$4,909,027	$6,232,493	$7,373,682
SSDI TOTALS					
No. of recipients	1,035	1,151	1,593	1,843	2,013
Avg. payment / month	$282.15	$294.12	$306.10	$318.97	$333.67
Expenditures	$3,504,337	$4,062,419	$5,851,393	$7,054,349	$8,060,162
MSA TOTALS					
No. of recipients	699	849	1,224	1,712	2,076
Avg. payment / month	$271.99	$336.08	$329.41	$410.05	$440.51
Expenditures	$2,281,473	$3,424,002	$4,838,334	$8,424,063	$10,974,052

SERVICES AND THEIR COSTS:

DAY SERVICES AND SPECIAL EDUCATION

VOCATIONAL REHABILITATION

Vocational rehabilitation services, administered by the Department of Jobs and Training, are categorized as basic vocational rehabilitation, extended employment, and independent living services. This report estimates the costs only for basic vocational rehabilitation and extended employment services, because relatively little data was available on the independent living program.

Basic vocational rehabilitation is provided by approximately 150 counselors in 46 Division of Rehabilitation Services field offices throughout Minnesota. The core of the rehabilitation program, these services include counseling, planning, guidance and placement. Recipients are also given transitional employment services; artificial appliances such as braces, hearing aids, limbs and glasses; college, vocational, technical, tutorial or correspondence training; transportation and income maintenance during training; rehab engineering services; and other services necessary to train for or continue employment.

Extended Employment Program services are basically of two kinds: center-based sheltered workshop and community-based supported employment. In cooperation with Minnesota's 35 rehabilitation facilities, the Division of Rehabilitation Services attempts to help individuals with severe disabilities to reach their fullest employment potential. The emphasis in recent years has been on supported employment, where individuals work in community settings alongside individuals who are not disabled.

Approximately two-thirds of the persons served in the Extended Employment Program are developmentally disabled. In this analysis, persons who were mentally retarded, or who had a primary or secondary disability of cerebral palsy, epilepsy, or autism, were included.

The number of basic services recipients remained at approximately 3,000 persons per year, while program costs increased from approximately $3.9 million in FY 86 to approximately $5.1 million in FY 90. The federal government funds more than 75 percent of this program through Title I and Title VI-C of the Vocational Rehabilitation Act.

No federal funds are provided for extended employment services. The legislature appropriates funds for the Extended Employment Program as a whole, and the Division of Rehabilitation Services allocates funds between the two service types. The number of persons with developmental disabilities in the Extended Employment Program in FY 86 was 4,462 and in FY 90 was 5,687. (The number in center-based services decreased by 102, while the number in supported employment increased by 1,327.) While the number served grew, state appropriations remained relatively constant -- between $6.1 million and $6.7 million. Additional funds were generated from county sources, and increased by 150 percent during the five years, from $1.8 million to $4.5 million.

Center-based services receive the majority of their funds from contracts, sales and charitable donations. However, only state and county funds are reported in this study. Additionally, costs of supported employment may be understated for FYs 86, 87 and 88 because counties had no category to report their expenditures to Human Services.

Table 24 shows the total of all vocational rehabilitation programs broken out by federal, state and county sources. The total cost increased from $12.1 million in FY 86 to $16.3 million in FY 90.

Vocational rehabilitation services funding is not based on a per capita rate. Total budgets are established and program administrators are allowed to provide as many services as possible within their budget. The average FY 90 expenditure per person in the basic program was $1,690. For a person receiving center-based services the average cost was $2,058; for a person in a supported employment site, $1,869.

Because funds are not allocated specifically to persons in the Extended Employment Program, records of amounts spent by type of recipient were not available. In this report the total costs associated with these services were allocated to the developmentally disabled population based on the number of persons with developmental disabilities as a percentage of the total extended employment population. Further, federal government data, based on federal fiscal year, was adjusted to state fiscal year for the purposes of this report.

Table 24. Vocational rehabilitation: expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
BASIC SERVICES					
Direct services	$1,936,184	$1,977,863	$2,197,079	$2,464,729	$2,534,770
Voc. rehab. counselor	1,944,601	2,007,971	1,979,163	2,420,293	2,534,764
Total	$3,880,785	$3,985,834	$4,176,242	$4,885,022	$5,069,534
Funding source					
Federal	$2,825,211	$2,977,418	$3,211,530	$3,795,662	$3,964,376
State	1,055,574	1,008,416	964,712	1,089,360	1,105,158
No. of recipients	2,953	2,889	2,971	2,999	3,000
EXTENDED EMPLOYMENT					
IN-HOUSE	$6,950,914	$7,070,251	$7,556,462	$7,264,330	$6,886,815
Funding source					
State	$5,193,947	$4,715,721	$4,906,308	$4,273,318	$3,945,576
County	1,756,967	2,354,530	2,725,109	3,065,966	2,941,239
No. of recipients	3,449	3,968	3,896	3,616	3,347
SUPPORTED EMPLOYMENT	$1,309,909	$1,385,449	$1,405,048	$3,808,387	$4,374,153
Funding source					
State	$1,309,909	$1,385,449	$1,405,048	$2,137,050	$2,799,591
County	0	0	0	1,971,376	1,574,562
No. of recipients	1,013	1,353	1,517	1,884	2,340
TOTAL VOCATIONAL REHABILITATION					
Federal	$2,825,211	$2,977,418	$3,211,530	$3,795,662	$3,964,376
State	7,559,430	7,109,586	7,276,068	7,499,728	7,850,325
County	1,756,967	2,354,530	2,725,109	5,037,342	4,515,801
Total	**$12,141,608**	**$12,441,534**	**$13,212,707**	**$16,332,732**	**$16,330,502**

SPECIAL EDUCATION

In the 1987-88 school year, Minnesota's 435 local school districts incurred operating expenses (excluding community service, capital and debt service expenditures) of slightly more than $3 billion for elementary and secondary education. Funding for these expenditures is through a combination of state, local and federal sources. State government provided approximately 54 percent of the districts' revenue, while local and other sources provided approximately 42 percent and the federal government approximately 4 percent.

About 10 percent of the total cost of primary and secondary education was spent on special education, which is provided by all school districts, directly or through cooperative arrangements with other school districts, to children with handicaps. Public Law 94-142 guarantees that all children ages 3 to 21 receive a free, appropriate and public education, regardless of the type or severity of their handicap. In Minnesota, this mandate has been expanded to include infants and toddlers, from birth to age 3. School districts are required by M.S. 120.17 to provide special instruction and services, through a secondary school or its equivalent, to handicapped children from birth until the child graduates or reaches the age of 21.

Minnesota law defines a child with a handicap as one who has a hearing or visual impairment, speech or language impairment, physical handicap, other health impairment, mental handicap, emotional/behavioral disorder, specific learning disability, or deaf/blind handicap and who needs special instruction and services (M.S. 120.03).

The Department of Education records by disability category the number of children receiving special education services. The categories of special education applicable to this study of persons with developmental disabilities are: mildly mentally handicapped, moderately/severely mentally handicapped, and autistic. In addition, the Department of Education estimates that half the pre-kindergarten children in early childhood special education will be diagnosed as mentally handicapped or autistic.

Approximately 15 percent of the children in special education have a primary disability that fits into one of these categories.

This report estimates the costs of providing special education services to children with mental handicaps, including all costs associated with the single disability categories discussed above, plus a pro-rata portion of the costs of early childhood special education.

Total special education expenditures for people with developmental disabilities in FYs 86 through 90 increased by 46 percent from approximately $97.4 million to $142.2 million. At the same time, the number of children with mental handicaps receiving special education services increased from 12,597 in FY 86 to 13,706 in FY 90. The majority of costs fell under the category of direct aid and spending for mentally handicapped students. In 1990, $106.3 million of the $142.2 million spent was for direct aid. Approximately $23.9 million was spent in FY 90 on non-salary personnel costs. Secondary vocational education added approximately $2.9 million to FY 90 expenditures. Finally, the general revenue aid for students with mental handicaps in special education was $9.2 million over and above the usual amount of general revenue aid.

Table 25. Special education: expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
DIRECT AID & SPENDING FOR STUDENTS					
Federal	$3,072,500	$5,578,123	$5,817,169	$6,639,026	$6,419,743
State	44,933,284	52,157,371	53,424,416	54,544,566	55,424,887
Local	24,807,574	30,854,533	36,889,225	43,678,168	44,407,396
Total	**$72,813,358**	**$88,590,027**	**$96,130,810**	**$104,861,760**	**$106,252,026**
NON-SALARY PERSONNEL COSTS					
State	$9,829,803	$7,973,102	$4,325,886	$0	$0
Local	6,553,202	11,959,654	17,303,546	23,593,896	23,906,706
Total	**$16,383,006**	**$19,932,756**	**$21,629,432**	**$23,593,896**	**$23,906,706**
SECONDARY VOCATIONAL EDUCATION					
Federal	$27,417	$300,296	$181,866	$150,635	$131,229
State	2,915,120	2,632,599	2,706,726	2,526,203	2,721,680
Total	**$2,942,537**	**$2,932,895**	**$2,888,592**	**$2,676,838**	**$2,852,909**
STATE GENERAL REVENUE AID					
ECSE	$2,260,712	$5,000,113	$4,542,220	$5,476,028	$5,639,845
Kindergarten	737,852	684,913	637,350	585,384	602,895
19- to 21-year-old students	2,230,056	2,613,640	2,767,500	2,750,211	2,956,300
Total General Revenue	**$5,228,620**	**$8,298,666**	**$7,947,069**	**$8,811,623**	**$9,199,040**
TOTAL FOR CHILDREN WITH MENTAL HANDICAPS					
Federal	$3,099,917	$5,878,419	$5,999,035	$6,789,661	$6,550,972
State	62,906,827	71,061,738	68,404,097	65,882,392	67,345,607
Local	31,360,776	42,814,186	54,192,771	67,272,064	68,314,102
Total	**$97,367,520**	**$119,754,344**	**$128,595,904**	**$139,944,116**	**$142,210,681**
Total number of children with mental handicaps receiving special education services	12,597	12,837	13,655	13,642	13,706

DAY TRAINING and HABILITATION

Day training and habilitation facilities, formerly known as developmental achievement centers, provide regular, out-of-home training, supervision, habilitation, rehabilitation and/or developmental guidance to adults with developmental disabilities. Children formerly served by these programs are now served by school districts through early childhood special education unless school districts have contracted with day training programs to continue providing services.

Clients are referred by county case managers. The programs serve individuals with a wide range of functional disabilities who may not be accepted in other day programs such as vocational rehabilitation. More than half the persons in day training and habilitation programs are severely or profoundly mentally retarded. In addition to being mentally retarded, approximately 16 percent of all participants have epilepsy, 10 percent are blind, 10 percent have cerebral palsy, and 19 percent have severe behavior problems.

A variety of services are provided to individuals, according to individual need and the availability of other resources, such as community-based employment or contracts for in-house vocational activities. In recent years, more individuals have been working in community jobs, supported by day training and habilitation job coaches. For the last quarter of 1988, 1,675 adults worked in community-based employment. They earned $422,966 in 174,385 hours of work.

Day training and habilitation service funding sources are Medical Assistance for residents of intermediate care facilities for the mentally retarded and Home- and Community-based Waiver recipients, county social service funds for persons not in a Medicaid-funded residence, and other government sources, including cities, schools and the Department of Jobs and Training.

Table 26 shows the costs of providing day training and habilitation services for the past five fiscal years. Table 27 shows the number of persons receiving these services. The approximate number of adults increased by 24 percent from 4,769 in FY 86 to 5,935 in FY 90. The costs associated with these services increased by 34 percent from $39.4 million in FY 86 to $52.8 million in FY 90.

The average monthly cost per adult client increased by 41 percent from $526.76 per recipient in FY 86 to $741.57 in FY 90. Average costs per person served increased more than the inflation index. The increases in excess of the index were caused by rate variances, special needs rates and increases in the number of days of service. Rate variances that permit increases in excess of the index are approved by the Department of Human Services, based on the recommendation of the local agency, or they may result from licensing deficiencies cited by Human Services.

Table 26. Day training and habilitation: expenditures

FUNDING SOURCE	FY 86	FY 87	FY 88	FY 89	FY 90
MA–ICF/MR	$17,275,506	$19,025,729	$21,301,334	$24,488,932	$26,862,901
Adult	17,012,292	18,584,477	20,889,618	24,336,997	26,862,901
Child	263,215	441,252	411,716	151,935	0
COUNTY SOCIAL SERVICES	18,800,707	18,907,790	18,409,213	18,133,269	18,049,539
Adult	11,184,539	12,927,601	15,026,523	17,120,462	18,049,539
Child	7,616,168	5,980,189	3,382,691	1,012,807	0
OTHER GOV'T SOURCES	3,060,570	2,960,909	2,024,425	795,500	847,295
Adult	1,608,613	1,006,098	957,768	714,221	847,295
Child	1,451,958	1,954,812	1,066,657	81,279	0
TOTAL NON–WAIVER	39,136,783	40,894,428	41,734,971	43,417,700	45,759,735
Adult	29,805,443	32,518,176	36,873,908	42,171,680	45,759,735
Child	9,331,340	8,376,252	4,861,064	1,246,020	0
Federal	12,455,947	13,215,250	14,227,890	15,718,191	16,806,167
State	10,854,523	11,380,890	11,952,656	13,130,554	14,005,121
County	15,826,313	16,298,287	15,554,425	14,568,954	14,948,446
Total	**$39,136,783**	**$40,894,428**	**$41,734,971**	**$43,417,700**	**$45,759,735**

Table 27. Day training and habilitation: recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
FUNDING SOURCE					
MA–ICF/MR					
Adult (1.)	2,872	2,961	2,872	3,013	3,033
Child (2.)	3	–	–	–	–
COUNTY SOCIAL SERVICES (3.)					
Adult	1,897	1,725	1,904	1,935	2,008
Child	1,607	–	–	–	–
TOTAL					
Adult	4,769	4,686	4,776	4,948	5,041
Child	1,610	1,522	1,053	–	–
AVERAGE MONTHLY COSTS					
Adult	**$520.82**	**$578.29**	**$643.39**	**$731.25**	**$756.46**
Child	**482.99**	**458.62**	**384.70**	–	–

1. Number of recipients as of Dec. 31 of reported fiscal year.

2. Children's numbers were not identified by funding source in FYs 87 and 88; in FY 89, children's services were transferred to the Special Education program.

3. Persons receiving CSSA services and not residing in a Medical Assistance – funded residence, reside in SILS, family foster care or their own home.

SERVICES AND THEIR COSTS: SUPPORT SERVICES

CASE MANAGEMENT

Case management, as defined in *Social Services in Minnesota* for 1987, is the arrangement, coordination and monitoring of services to meet the needs of persons with developmental disabilities and their families. Services are provided by the counties. (See the companion report, *Minnesota's Case Management System for Persons with Developmental Disabilities*, for a detailed description of case management.)

Case management is funded by three sources: county social service funds, the Home- and Community-based Waiver and Medical Assistance administrative funds. County social service funds come from federal, state and county tax dollars.

The costs for case management are included in two categories on Table 1. Line 11, Case Management, refers to county social service funding of case management and corresponds to Table 28. Case management funded under the waiver is included in Line 15, Waiver Support Services. Table 32 breaks out the costs of case management from other waiver services.

The cost of providing case management services under the waiver increased by 642 percent from approximately $.5 million in FY 86 to $3.5 million in FY 90, while the caseload increased by 308 percent. County social service funding of case management increased by 93 percent, from approximately $8.3 million in FY 86 to $16.0 million in FY 90, while caseloads increased by 9 percent. A special appropriation of $1.1 million was provided by the legislature for case management in FY 90. It was impossible to break out Medical Assistance administrative funding from county social service totals. The sum of these expenditures equals the total case management spending for persons with developmental disabilities, which grew from $8.7 million in FY 86 to $19.5 million in FY 90.

The average annual cost per person for county social service funding of case management increased by 78 percent between FYs 86 and 90. Average annual costs for case management under the waiver increased by 82 percent.

Table 28. Case management: non-waiver expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
FUNDING SOURCE					
Federal	$1,434,110	$2,044,820	$2,250,262	$2,361,685	$2,158,440
State	1,574,628	2,279,056	2,527,794	2,514,311	3,243,554
County	5,257,025	8,337,547	10,223,691	11,189,888	10,583,797
Total	**$8,265,763**	**$12,661,423**	**$15,001,747**	**$16,065,884**	**$15,985,790**
No. of persons served	14,954	16,814	14,974	14,826	16,267
Cost/person/month	**$46.06**	**$62.75**	**$83.49**	**$90.30**	**$81.89**
Cost/person/year	**$552.75**	**$753.03**	**$1,001.85**	**$1,083.63**	**$982.71**

SCREENING

Screening is a service assessment and planning process for persons who are or may be eligible for services through the Home- and Community-based Waiver, intermediate care facilities for the mentally retarded or regional treatment centers, under the Medical Assistance program. Although this is the majority of screening performed, additional screening occurs as a means to assess a person's need for county-sponsored programs. Screening for service precedes case management.

The number of persons receiving screening services increased from 1,176 in FY 86 to 3,188 in FY 90. Screening expenditures grew from $225,230 in FY 86 to $708,929 in FY 90. The average cost of screening increased from $191.52 per person in FY 86 to $222.37 in FY 90.

This program experienced significant growth because of the advent of screening for the waiver, which required persons to undergo screening in order to determine eligibility for its services. In FY 90, 2,331 persons were screened for the waiver, approximately 73 percent of all persons receiving screening services. Medical Assistance pays the cost of screening for the waiver. County social services pay for screening services not under the waiver.

Table 29. Screening: expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
FUNDING SOURCE					
Federal	$117,300	$155,233	$212,133	$269,699	$377,859
State	97,142	122,775	166,537	208,135	297,963
County	10,789	13,648	18,509	23,143	33,107
Total	**$225,230**	**$291,626**	**$397,179**	**$500,926**	**$708,929**
No. of persons served	1,176	1,626	2,136	2,416	3,188
Cost/person	**$191.52**	**$179.35**	**$185.95**	**$207.34**	**$222.37**

SEMI-INDEPENDENT LIVING

The semi-independent living program has a variety of services to help adults who need some systematic supervision, but not 24-hour or even necessarily daily supervision, to live as independently as possible.

The program was established in 1983 by the Minnesota Legislature (M.S. 252.275) to reduce the costly use of regional treatment centers and intermediate care facilities for the mentally retarded. Caseworkers, along with a screening team, have determined that these clients would return or be admitted to an intermediate care facility for the mentally retarded if semi-independent living services are not provided.

In FY 89, 76 percent of the program's clients were mildly retarded. Another 19 percent were moderately retarded and 5 percent were severely retarded or had a related condition.

Persons receiving these services may live in their own apartments or homes, with their parents, or in board and lodging facilities, but not in an intermediate care facility for the mentally retarded. In FY 89, 411 persons lived in a group living situation, while 722 lived independently or in a relative's home. The primary program goal is to promote independence and self-sufficiency with appropriate and necessary support and assistance.

Adults may receive assistance in the following areas:

- shopping, meal planning and preparation
- money management and budgeting
- home maintenance
- first aid and administration of medications
- appropriate social behavior
- recreational opportunities
- social services and transportation access

The program may be provided by counties or by private agencies licensed by the Department of Human Services.

Program costs are only for support services. Room and board is paid by other financial sources such as Supplemental Security Income, Social Security Disability Insurance, Minnesota Supplemental Aid, earned income and unearned income. The number of persons receiving semi-independent living services increased by 65 percent, from 757 in FY 86 to 1,250 in FY 90. In FY 90, the state paid almost 71 percent of the cost, with the counties paying the remainder from county social service dollars. The total cost for semi-independent living services increased by 58 percent, from $3.8 million in FY 86 to approximately $6 million in FY 90. The average monthly cost per person decreased by 4 percent from FY 86 to FY 90.

Table 30. Semi-independent living: expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
FUNDING SOURCE					
State	$2,662,730	2,620,300	3,021,100	3,657,800	4,270,800
County	1,141,170	1,473,919	1,344,651	1,359,758	1,768,235
Total	**$3,803,900**	**$4,094,219**	**$4,365,751**	**$5,017,558**	**$6,039,035**
Persons served	757	888	1,075	1,148	1,250
Waiting list		411	363	389	510
Average annual cost/person	$5,025	$4,611	$4,061	$4,371	$4,831
Average monthly cost/person	$418.75	$384.22	$338.43	$364.22	$402.60

FAMILY SUBSIDY PROGRAM

The Family Subsidy Program (M.S. 252.37) was enacted in 1976 to provide cash assistance to families in order to support children with developmental disabilities in their natural or adoptive home. The intent of the legislation was to prevent or delay placements in regional treatment centers or intermediate care facilities for the mentally retarded. To be eligible, a child must be mentally retarded or have a related condition, be under age 22, live with his or her biological or adoptive parents, and be at risk for out-of-home placement. Grants are limited to $250 per month, except in emergencies.

Subsidies can be used for services, equipment, and home or vehicle modifications as included in the child's individual service plan, as long as other health insurance or medical programs do not cover such costs. Expenditures are limited to those related to the developmental disability, and are not for the usual child-rearing expenses. These funds can be used to pay for respite care.

Families apply for grants through their county social service agency.

This program is distinct from the Children's Home Care Option under the federal TEFRA Waiver, which pays for Medical Assistance services to children with disabilities who live at home.

In FY 86, 270 families were served; by FY 90, the number had increased by 70 percent to 460. Another 192 families are on waiting lists. Total expenditures increased by 60 percent, from $705,000 to approximately $1.1 million, while the average monthly grant decreased from $238.82 in FY 86 to $225.02 in FY 90. More than half the expenditures for family subsidy in FY 90 were used by families for respite care and sitting services.

Table 31. Family subsidy: expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
State expenditures	$705,000	$701,000	$1,062,700	$1,062,700	$1,128,700
Families served	270	269	419	432	460
Families served per month	246	247	381	393	418
Waiting list	90	120	113	115	192
Average monthly grant	**$238.82**	**$236.50**	**$232.44**	**$225.34**	**$225.02**

WAIVER SUPPORT

The Home- and Community-based Waiver was established in Section 1915(c) of the Social Security Act to encourage use of less costly community services for persons residing in an intermediate care facility for the mentally retarded or regional treatment center, or at risk of placement in one of these settings. Funding is under the Medical Assistance program.

Services are defined as follows as listed in the state's waiver application to the federal government (January 1986):

Case management: locating, coordinating and monitoring social, habilitative, medical and other services to meet the needs of eligible clients and their families.

Respite care: short-term care provided to an individual due to the absence or need for relief of the persons normally providing the care. This service may be provided in the individual's home or in an out-of-home setting approved by the county and may include both day and overnight services.

Homemaker services: general household activities provided by a trained homemaker when the individuals regularly responsible for these activities are temporarily absent or unable to manage the home and care for themselves or others in the home. Services include meal preparation, cleaning, simple household repairs, laundry, shopping for food, clothing and supplies, and other routine household care. In addition, homemakers will provide ongoing monitoring of the individual's well-being, including home safety.

Day habilitation: supervision, training and assistance in the areas of self-care, communication, socialization and use of leisure and recreational time and behavior management.

Supportive living arrangements for children: the provision of rehabilitation services to children and adolescents who require daily staff intervention due to severe behavioral problems, medical conditions, physical defects, and/or lack of adequate survival skills that result in the family's inability to maintain the child in their home. Services are provided outside the biological or adoptive home in family-style settings for up to three children.

Supportive living arrangements for adults: habilitation services for adults who require daily staff intervention due to behavioral problems, medical conditions, physical defects and/or lack of adequate survival skills. Daily staff intervention means direct care by professional staff providing on-site supervision, training or assistance to the individual in self-care, sensory motor development, interpersonal skills, communication, education and elimination of maladaptive behavior, community living and mobility, health care, leisure and recreation, money management and household chores. Services are provided in the client's place of residence, specialized adult foster homes and group homes for up to six persons.

In-home family support services: habilitation services provided to children, adolescents and adults and their families in the family's home to enable the individual to remain in or return to the home. Services include training of the individual and family to increase their capabilities to care for and maintain the individual at home.

Adaptive aids: minor physical adaptations to the home, to vehicles and to equipment used to enable individuals with mobility problems, sensory deficits and/or behavior problems to live more independently. Adaptations may be made to individuals' place of residence, whether it be in their own home, their family's home or an out-of-home residential setting that provides habilitation services.

The number of persons receiving waiver services increased by 270 percent, from 614 in FY 86 to 2,273 in FY 90. The cost associated with providing the waiver services increased by 824 percent, from $6 million in FY 86 to approximately $55.9 million in FY 90. Approximately 60 percent of the total FY 90 waiver costs were spent on supported living arrangements for adults.

The average cost per day for persons on the waiver increased by 150 percent, from $27.03 in FY 86 to $67.44 in FY 90. Average daily costs for a person receiving in-home support ($33.60) were significantly lower than for an individual requiring residential and other support in a foster care site ($83.16). In FY 90, the maximum allowable average per diem was $73.76.

The waiver per diem was established by the federal government with the provision that costs would be less than those of comparable services in a regional treatment center or intermediate care facility for the mentally retarded. Per diem rates for the waivers are increased annually by an inflation adjustment based on the Consumer Price Index, but the portion of this increase that is for home care services is limited by law to 4 percent. Cost increases do not apply to the portion of the per diem rate that covers day habilitation services. The average cost per person increased at a level greater than the rate of inflation, however, because actual per diems were initially well below federal maximum levels.

The federal Health Care Financing Administration determines the maximum number of persons that can be served under the waiver, and openings are allocated to counties by the Department of Human Services.

Table 32. Waiver support: expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
CASE MANAGEMENT					
Federal	$253,959	$489,489	$906,334	$1,269,573	$1,870,586
State	200,896	384,278	699,446	1,001,129	1,503,694
County	22,332	42,708	77,772	111,237	167,156
Total	$477,187	$916,474	$1,683,384	$2,381,939	$3,541,436
No. of recipients	529	917	1,519	1,949	2,156
Avg cost/day	**$2.47**	**$2.74**	**$3.04**	**$3.35**	**$4.50**
HOMEMAKER					
Federal	$23,667	$20,000	$77,904	$78,406	$110,420
State	18,722	15,701	60,121	61,828	88,762
County	2,081	1,745	6,685	6,870	9,867
Total	$44,471	$37,446	$144,695	$147,104	$209,049
No. of recipients	109	110	116	113	125
Avg cost/day	**$1.12**	**$0.93**	**$3.42**	**$3.57**	**$4.58**
RESPITE CARE					
Federal	$210,205	$384,913	$396,629	$398,737	$419,887
State	166,284	302,179	306,091	314,426	337,532
County	18,485	33,584	34,035	34,936	37,521
Total	$394,974	$720,676	$736,681	$748,100	$794,940
No. of recipients	186	284	365	431	477
Avg cost/day	**$5.82**	**$6.95**	**$5.53**	**$4.76**	**$4.57**
DAY HABILITATION					
Federal	$394,656	$957,204	$2,189,766	$3,644,720	$4,624,461
State	312,195	751,461	1,689,911	2,874,063	3,717,429
County	34,705	83,516	187,903	319,340	413,242
Total	$741,556	$1,792,181	$4,067,174	$6,838,123	$8,755,132
No. of recipients	205	415	813	1,028	1,137
Avg cost/day	**$9.91**	**$11.83**	**$13.71**	**$18.22**	**$21.10**
SUPPORTIVE LIVING ARRANGEMENTS – CHILD					
Federal	$315,566	$707,571	$1,272,499	$1,605,893	$2,718,731
State	249,631	555,485	982,027	1,266,335	2,185,485
County	27,750	61,735	109,193	140,704	242,946
Total	$592,947	$1,324,791	$2,363,482	$3,012,932	$5,147,163
No. of recipients	82	99	129	167	185
Avg cost/day	**$19.81**	**$36.66**	**$50.20**	**$49.43**	**$76.23**

Table 32. Waiver support, continued: expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
SUPPORTIVE LIVING ARRANGEMENTS – ADULT					
Federal	$1,681,589	$3,948,058	$9,958,886	$16,310,283	$17,722,858
State	1,330,231	3,099,458	7,685,582	12,861,561	14,246,735
County	147,874	344,466	854,570	1,429,062	1,583,716
Total	$3,159,694	$7,391,982	$18,497,188	$30,600,907	$33,553,310
No. of recipients	353	650	1,236	1,535	1,698
Avg cost/day	**$24.52**	**$31.16**	**$41.00**	**$54.62**	**$54.14**
IN–HOME SUPPORT					
Federal	$320,996	$573,095	$1,041,253	$1,628,447	$1,952,318
State	253,926	449,914	803,567	1,284,121	1,569,395
County	28,227	50,002	89,350	142,680	174,459
Total	$603,150	$1,073,011	$1,933,977	$3,055,248	$3,696,172
No. of recipients	142	215	335	404	447
Avg cost/day	**$11.64**	**$13.67**	**$15.82**	**$20.72**	**$22.65**
ADAPTIVE AIDS					
Federal	$22,975	$49,113	$57,062	$85,297	$132,660
State	18,175	38,557	44,036	67,261	106,640
County	2,020	4,285	4,896	7,473	11,855
Total	$43,170	$91,955	$105,984	$160,032	$251,155
No. of recipients	27	89	118	135	149
Avg cost/day	**$4.38**	**$2.83**	**$2.46**	**$3.25**	**$4.62**
TOTAL					
Federal	$3,223,615	$7,129,442	$15,900,333	$25,021,357	$29,551,922
State	2,550,060	5,597,033	12,270,781	19,730,725	23,755,672
County	283,475	622,041	1,364,405	2,192,303	2,640,762
Total	**$6,057,149**	**$13,348,516**	**$29,532,565**	**$46,944,385**	**$55,948,357**
Unduplicated number	614	1,000	1,666	2,055	2,273
Avg cost/day	**$27.03**	**$36.57**	**$48.57**	**$62.59**	**$67.44**

Table 33. Waiver support: recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
WAIVERED SERVICES					
Case mgmt	529	917	1,519	1,949	2,156
Homemaker	109	110	116	113	125
Respite care	186	284	365	431	477
Day hab	205	415	813	1,028	1,137
SLA–hab	82	99	129	167	185
SLA–adult	353	650	1,236	1,535	1,698
In home	142	215	335	404	447
M.P. adap	27	89	118	135	149
Total undup. count	**614**	**1,000**	**1,666**	**2,055**	**2,273**
Conversions	282	475	970	1,206	1,217
Diversions	332	525	696	849	967
Maximum federally allowed waiver recipients (undup)	1,010	1,665	1,665	2,287	2,748

ASSESSMENT

Assessment is an appraisal of an individual's or family's condition involving personal problems, mental or nervous disorders, chemical abuse or other social health or behavioral problems, conducted in response to a crisis. Assessment includes investigation of child maltreatment or vulnerable adult incidents by means of client interviews, review of records and testing in order to determine need for services and an appropriate treatment plan. Assessment is performed by counties or private providers hired by the counties.

It is unclear how the counties determine the number of persons receiving assessment and the associated costs. The definition of assessment in Minnesota Rule 185 conflicts with the community social service definition, which tells the counties how to allocate costs and describe services received. This report reflects the costs and number of persons served provided by the counties to the Department of Human Services.

The costs of providing assessment increased by 85 percent, from approximately $666,000 in FY 86 to $1.2 million in FY 90. In FY 90, the average cost per person assessed was $394.

There was a potential for mixing of costs and number of persons served between assessment and other similar county social service categories, such as case management and screening. Because of this potential overlap, the reliability of this data is uncertain.

Table 34. Assessment: non-waiver expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
FUNDING SOURCE					
Federal	$115,470	$126,714	$130,687	$137,269	$178,802
State	126,785	141,230	146,805	146,140	177,569
County	423,281	516,665	593,754	650,394	876,747
Total	**$665,536**	**$784,610**	**$871,245**	**$933,804**	**$1,233,118**
No. of persons served	4,380	2,706	2,281	2,354	3,127
Cost/person/month	**$12.66**	**$24.16**	**$31.83**	**$33.06**	**$32.86**
Cost/person/year	**$151.95**	**$289.95**	**$381.96**	**$396.69**	**$394.35**

RESPITE CARE

Respite care is the short-term care provided to individuals because those normally providing the care are absent or need relief. Respite care may be provided during the day or overnight, either in the individual's home or in an out-of-home setting. Respite care was provided under both the Home- and Community-based Waiver and county social service funds. The cost of respite care reimbursed under the waiver was reported in Table 32. This section reports the cost associated with respite care provided strictly by county social service dollars.

From FY 86 through FY 90, costs reported by the counties for providing respite care increased by 264 percent, from approximately $268,000 to $976,000.

The average number of non-waiver respite care recipients increased by 352 percent, from 222 in FY 86 to more than 1,000 persons in FY 90. In FY 90 an additional 477 persons received respite care under the waiver. The total amount spent on respite care in FY 90 was the sum of the waiver respite care cost of approximately $800,000 and the respite care cost provided by county social service funds of approximately $976,000, for a total of $1.8 million. The increased expenditures for respite care indicated that counties were using their discretionary authority to spend more money on this service.

Table 35. Respite care: non-waiver expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
FUNDING SOURCE					
Federal	$46,542	$96,740	$87,450	$86,582	$141,562
State	51,102	107,821	98,236	92,177	140,585
County	170,610	394,447	397,317	410,232	694,141
Total	**$268,254**	**$599,008**	**$583,003**	**$588,990**	**$976,288**
No. of persons served	222	423	650	785	1,004
Cost/person/month	**$100.70**	**$118.01**	**$74.74**	**$62.53**	**$81.03**
Cost/person/year	**$1,208.35**	**$1,416.09**	**$896.93**	**$750.31**	**$972.40**

COUNSELING

Counseling is the application of therapeutic processes to personal, family, situational or occupational problems in order to provide positive resolution or improved acceptance in a face-to-face or telephone communication with an individual, group or family client. Counseling services are generally provided directly by the county.

Table 36 shows the estimated community social services expenditures for counseling services for FYs 88 through 90. Because the Department of Human Services did not report counseling costs separately from other county social service expenditures for FYs 86, 87 and 88, no costs are shown for those years.

Costs increased from $237,000 in FY 88 to $324,000 in FY 90. During the same time, the numbers of persons served increased from 394 to 552. The average cost per person served decreased from $601 in FY 88 to $586 in FY 90. Counseling services are also paid through Medical Assistance. It is unknown how much funding comes from each source.

Table 36. Counseling: expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
FUNDING SOURCE					
Federal	$0	$0	$35,504	$62,255	$46,943
State	0	0	39,882	66,278	46,619
County	0	0	161,305	294,970	230,184
Total	**$0**	**$0**	**$236,690**	**$423,503**	**$323,746**
No. of persons served	0	0	394	765	552
Cost/person/month	**$0.00**	**$0.00**	**$50.06**	**$46.13**	**$48.87**
Cost/person/year	**$0.00**	**$0.00**	**$600.74**	**$553.60**	**$586.50**

PERSONAL CARE

Personal care involves assistance with daily eating, walking or other activities to prevent institutional care when the person requires personal services beyond the scope of homemaker responsibilities. These services are paid with county social service funds and are provided in the home by community personal care assistance organizations. Personal care services are also eligible for reimbursement under Medicaid.

Table 37 shows the estimated county social service expenditures for personal care services for FYs 86 through 90. Costs increased from approximately $7,600 in FY 86 to more than $260,000 in FY 90. In FY 86, counties reported 15 persons receiving personal care service. This increased steadily to 39 in FY 90.

Some expenses reported here may include personal care assistance billed under Medicaid. The number of persons served may or may not reflect the number of persons receiving personal care assistance under Medicaid.

Nursing services under Medicaid include personal care assistance and private-duty nursing. Part of the dramatic increase in reported cost for personal care services may be due to a change in Medicaid reimbursement practices in 1989.

Table 37. Personal care: expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
FUNDING SOURCE					
Federal	$1,325	$1,426	$6,239	$20,224	$38,026
State	1,454	1,590	7,008	21,531	37,764
County	4,856	5,816	28,346	95,825	186,459
Total	**$7,635**	**$8,833**	**$41,593**	**$137,581**	**$262,249**
No. of persons served	15	12	14	22	39
Cost/person/month	**$42.41**	**$61.34**	**$247.58**	**$521.14**	**$560.36**
Cost/person/year	**$508.97**	**$736.04**	**$2,970.93**	**$6,253.69**	**$6,724.33**

ACUTE CARE

Acute care programs, also referred to as health care programs, include the services shown in Table 38. The primary services are inpatient hospital care, physician services, outpatient hospital and clinics, laboratory and X-ray services and prescribed drugs. Acute care services are provided to anyone eligible for Medical Assistance. Data reported here is for acute care services provided to persons under the Home- and Community-based Waiver and to residents of institutions such as regional treatment centers or intermediate care facilities for the mentally retarded. The cost of acute care for persons who do not reside in a waiver setting, regional treatment center, or intermediate care facility for the mentally retarded is not reflected in this report because Human Services and other agencies do not collect data specific to individual characteristics or disabilities.

Table 38 shows the acute care costs for waiver recipients and the number of persons receiving acute care. Costs increased from approximately $735,000 in FY 86 to more than $8.6 million in FY 90. Over the same period, the number of persons receiving acute care services increased from 539 to 2,113. The average monthly cost per person increased by 198 percent, from $113.70 in FY 86 to $339.22 in FY 90.

Table 39 shows the acute care costs and number of recipients residing in regional treatment centers and intermediate care facilities for the mentally retarded. For FYs 86 through 90, the total acute care costs increased from approximately $9.4 million to $12 million. The number of recipients decreased over the same period, and the average monthly cost per recipient increased by 65 percent.

Tables 38 and 39 also show a breakdown by major type of acute care service delivered for FYs 86 through 89. Services included in the category with the largest dollar amount, "All other acute care," are shown in Table 40 for FYs 88 and 89.

Costs are more than twice as much for residents of intermediate care facilities for the mentally retarded as for regional treatment center residents, due to many medical services being provided as part of the per diem in regional treatment centers. In FY 90, average monthly acute care costs were $86.02 in a regional treatment center and $207.42 in an intermediate care facility for the mentally retarded.

The cost of acute care for waiver recipients ($339.22 per month on average) was higher than the cost of acute care for residents of intermediate care facilities for the mentally retarded. Residents of intermediate care facilities receive some acute care services at their place of residence, the costs reported in the total operating expenses. In contrast, the cost of acute care provided to waiver recipients reflects all costs. Acute care costs are not a part of the Home- and Community-based Waiver per diem.

Table 38. Acute care (waiver clients): expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
INPATIENT HOSPITAL					
Cost	$207,028	$477,008	$1,145,622	$1,658,374	NA
No. of recipients	54	105	229	273	NA
Avg cost/month	**$319.49**	**$378.58**	**$416.89**	**$506.22**	**NA**
PHYSICIANS' SERVICES					
Cost	$98,145	$180,561	$390,322	$532,761	NA
No. of recipients	454	745	1,423	1,722	NA
Avg cost/month	**$18.01**	**$20.20**	**$22.86**	**$25.78**	**NA**
OUTPATIENT HOSP/CLINIC					
Cost	$37,951	$62,270	$148,827	$190,999	NA
No. of recipients	183	305	600	721	NA
Avg cost/month	**$17.28**	**$17.01**	**$20.67**	**$22.08**	**NA**
LAB AND X-RAY					
Cost	$1,694	$4,254	$8,383	$11,243	NA
No. of recipients	54	79	187	206	NA
Avg cost/month	**$2.61**	**$53.85**	**$44.83**	**$54.58**	**NA**
PRESCRIBED DRUGS					
Cost	$85,564	$196,949	$545,896	$732,286	NA
No. of recipients	422	728	1,389	1,768	NA
Avg cost/month	**$16.90**	**$22.54**	**$32.75**	**$34.52**	**NA**
ALL OTHER ACUTE CARE					
Cost	$305,010	$875,872	$2,544,060	$3,684,363	NA
No. of recipients	449	809	1,550	1,935	NA
Avg cost/month	**$56.61**	**$90.22**	**$136.78**	**$158.67**	**NA**
TOTAL					
Total cost	$735,392	$1,796,914	$4,783,110	$6,810,026	$8,601,282
Unduplicated count	539	900	1,616	2,004	2,113
Avg cost/month	**$113.70**	**$166.38**	**$246.65**	**$283.18**	**$339.22**
FUNDING SOURCE					
Federal	$391,449	$959,732	$2,575,226	$3,629,744	$4,543,197
State	309,600	753,446	1,987,382	2,862,254	3,652,104
County	34,343	83,736	220,501	318,028	405,981

Table 39. Acute care (RTC, ICF/MR residents): expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
TYPE OF CARE					
Inpatient hospital	$1,760,691	$1,861,755	$1,962,820	$1,936,040	NA
Physicians' services	957,066	1,012,002	1,066,938	1,168,285	NA
Outpatient hosp/clinic	374,382	395,871	417,361	524,256	NA
Lab and X-ray	40,478	42,802	45,125	65,410	NA
Prescribed drugs	1,579,309	1,669,962	1,760,615	1,969,080	NA
All other acute care	4,668,297	4,936,260	5,204,223	5,625,746	NA
TOTAL	**$9,380,222**	**$9,918,652**	**$10,457,082**	**$11,288,817**	**$11,952,425**
FUNDING SOURCE					
Federal	$4,993,092	$5,297,552	$5,630,093	$6,016,939	$6,313,271
State	3,949,073	4,158,891	4,344,918	4,744,690	5,075,000
County	438,056	462,209	482,071	527,188	564,154
AVERAGE COST					
No. of recipients	6,893	6,601	5,823	5,604	5,337
Cost/person/month	**$113.40**	**$125.22**	**$149.65**	**$167.87**	**$186.63**

Table 40. Acute care: other costs

	WAIVERED SERVICES		RTCs		ICF-MR	
	FY 88	FY 89	FY 88	FY 89	FY 88	FY 89
Comm. MHC	$161,623	$183,909	$20,837	$2,718	$358,103	$374,282
HMO	16,510	548	0	0	18,944	12,331
Rehab	536,853	541,917	18,911	54,981	1,218,701	1,209,930
NH Rehab	66,585	64,636	18,737	25,457	581,648	596,875
Home health	393,826	749,704	378	731	29,556	25,595
Crippled child	396	113	0	48	320	77
Buy-in	119,646	228,510	14,898	16,933	45,416	48,308
Recip. recs	(52,626)	(8,567)	0	0	(2,092)	(231)
Family Plan	14,100	21,820	605	492	42,097	38,058
State MICD	274	95,930	59,071	153,270	0	22,237
Supplies	405,682	551,745	238,659	190,055	545,351	764,899
Transport	289,948	484,532	54,191	35,786	680,010	779,215
EPSDT	734	1,316	0	0	3,288	1,989
Dental	104,418	120,946	10,391	7,843	300,026	269,461
Optometric	12,851	10,324	1,797	2,516	51,083	26,114
Psychology	230,928	324,794	7,596	11,919	677,653	665,762
Priv. nurse	177,696	203,512	9,478	0	20,086	29,585
Phys. Therapy	2,743	1,480	0	0	8,034	1,059
Speech Therapist	5,049	6,743	1,297	158	56,310	68,258
Podiatry	3,036	5,906	441	434	15,687	17,782
Chiropracty	1,484	1,409	0	20	752	392
Audiology	7,157	7,976	393	178	20,188	16,919
IPH OB	0	379	0	145	1,015	592
Code 66	26,529	83,241	19,615	47,604	36,422	102,429
Code 67	1,920	1,426	290	148	1,595	987
IPH-CD	0	115	0	0	0	0
Unidentified	16,698	0	8,223	703	8,222	702
Total	**$2,544,060**	**$3,684,364**	**$485,808**	**$552,139**	**$4,718,415**	**$5,073,607**

ADDITIONAL CSSA SERVICES

Other Community Social Services Act services as shown in Table 1 include several categories of costs shown in Table 41. Those services are non-waiver homemaking, non-state-administered semi-independent living services, transportation, consultation and other services. Homemaking and semi-independent living services were described earlier in this report. Transportation services include travel or escort to and from community resources and facilities. Consultation services are the sharing among professionals of information and expertise on problems encountered in a program or case situation. "Other services" include 22 miscellaneous support services provided by county social service agencies, among them aftercare, adult daycare, child care, education assistance, emergency assistance, housing services, information and referral, and money management.

The total cost associated with the additional Community Social Services Act services has remained relatively constant over the five years covered in this report. The money for these programs comes from county social service funds.

Table 41. Additional CSSA services: expenditures and recipients

	FY 86	FY 87	FY 88	FY 89	FY 90
TYPE OF CARE					
Homemaking	$256,186	$256,109	$243,955	$287,426	$234,854
SILS	26,498	999,603	1,152,478	835,812	755,484
Transportation	409,341	460,757	987,744	1,450,346	1,487,897
Consultation	0	0	180,178	304,738	193,503
Other	3,836,281	3,930,996	2,869,537	1,188,904	1,921,966
Total expenditures	**$4,528,305**	**$5,647,464**	**$5,433,892**	**$4,067,227**	**$4,593,704**
FUNDING SOURCE					
Federal	$785,661	$912,065	$815,084	$597,882	$666,087
State	862,642	1,016,543	915,611	636,521	661,493
County	2,880,002	3,718,855	3,703,198	2,832,824	3,266,124
Total expenditures	**$4,528,305**	**$5,647,464**	**$5,433,892**	**$4,067,227**	**$4,593,704**
AVERAGE COST					
Persons served	9,618	9,610	7,532	5,766	5,015
Cost/person/month	**$39.23**	**$48.97**	**$60.12**	**$58.78**	**$76.33**
Cost/person/year	**$470.82**	**$587.67**	**$721.44**	**$705.38**	**$915.99**

CHILDREN'S HOME CARE OPTION

The Children's Home Care Option of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) allows Medical Assistance coverage for certain children with disabilities who live at home with their parents and who would otherwise not be eligible because of their parents' income and assets. For a child to be eligible for Medical Assistance under TEFRA, it must be determined that:

- the child is disabled as certified by the Social Security Administration or by the state medical review team;
- the child is 18 or younger;
- the child is eligible for Medical Assistance based on his or her own income and assets;
- the child requires a level of care comparable to the care provided in a hospital, skilled nursing facility, or intermediate care facility including one for persons with mental retardation;
- it is appropriate to provide care to the child at home; and
- the expected cost to Medical Assistance to provide home- or community-based care to the child will not exceed the expected cost to Medical Assistance to provide comparable medical institutional care.

Medical Assistance will pay for medically necessary services not covered by private insurance. For example, under the Children's Home Care Option, home health services, prescribed drugs, medical transportation and insurance premiums are reimbursable.

Table 42 shows the costs for FYs 89 (the program's first year) and 90. The program is available to any child with a disability and is not restricted to children with developmental disabilities. The Department of Human Services estimated that 83 percent of children in the program have a developmental disability. Applying this percentage to the total number of children served and total expenditures under the Children's Home Care Option, the number of children with a developmental disability in the program would be 817 in FY 89 and 1,726 in FY 90. Not all children in the program receive services, as Table 42 indicates, because the program establishes eligibility rather than providing services. In FY 89, there were 83 children who did not receive services, and this number grew to 291 in FY 90.

Home care services are medically necessary services prescribed by a physician and provided in the child's home, including therapy, personal care, private-duty nursing, and medical supplies and equipment. Other Medical Assistance services include any Medical Assistance service covered by the state, including prescribed drugs, medical transportation, screening, and insurance premiums.

The majority of children do not receive home care services under the program. The average annual cost for only medical services was $1,824 in FY 89 and $2,118 in FY 90. While a smaller percentage of children receive both home care and medical services, the cost was much higher for home care, as exemplified by the average annual cost of $7,497 in FY 90. Total expenditures in FY 89 were approximately $2 million, growing to $7.2 million the next year. Cost per child increased and may continue to increase with parents' growing awareness of services offered and covered, and as services are employed for children with severe needs on a long-term basis.

Table 42. Children's home care option: expenditures and recipients

	FY 89	FY 90
NUMBER OF RECIPIENTS		
Children using no services	83	291
Children using medical services only	536	886
Children using MA services & home care	198	549
Total number of recipients	**817**	**1,726**
AVERAGE COSTS		
Home care services	$3,375	$7,497
Other MA services	1,824	2,118
Overall average cost/child/year	**$2,455**	**$4,148**
TOTAL COSTS		
Home care	$666,788	$4,119,117
Other MA services	1,337,983	3,041,093
Total costs	**$2,004,771**	**$7,160,211**
FUNDING SOURCE		
Federal	$1,068,543	$3,782,023
State	842,605	3,040,226
County	93,623	337,962

Part 4.

DAILY-COST COMPARISONS AND INCENTIVE ANALYSIS

DAILY-COST COMPARISONS

This section compares the total costs of services provided to adult persons with developmental disabilities in different types of residential settings. The analysis is based on the cost data presented in Parts 1 and 3 of this report, and on other data. The comparisons reflect FY 90 costs. For ease of comparison, only options for adult residential placements are compared.

The options shown represent the costs of typical residential settings and the related services that many persons in these residential settings would receive. These options do not represent all available options. However, a full menu of options, ranging from no government-funded service to 24-hour institutional care, is presented.

Table 43 compares the costs associated with providing services in eight types of residential settings: state-operated community services, regional treatment centers, intermediate care facilities for the mentally retarded, waiver services, family foster care, board and lodging, semi-independent living services, and living at home with family or independently.

For each residential setting, costs are shown for residential care (room and board, supervised care and personal care), medical costs, day programs, and support programs (for example, case management).

It must be kept in mind that the residential settings are home to persons with different levels of functioning ability. In general, persons with greater needs receive a greater intensity of service. This factor accounts for some of the difference in service costs shown in Table 43. For example, many persons living independently or at home with family members have a higher functioning ability than many persons residing in regional treatment centers and intermediate care facilities for the mentally retarded. However, this is not universally true. Institutional barriers exist that prevent persons from receiving the most appropriate care at the lowest cost. For example, some persons slated to be served in a state-operated community service could be served in group foster care under the waiver if private providers were available to serve them in the community.

State-operated community services

The highest cost option appears to be state-operated community services. The Department of Human Services plans to serve 108 persons in these residences in FY 91. The $178.18 per diem cost shown for FY 90 state-operated residential care is based on Human Services forecasts for FY 91. The FY 91 per diem cost of $199 was discounted backward one year at 10 percent to estimate the FY 90 cost shown here. Medical and day program costs for FY 90 were estimated in the same way. The support program cost of $2.73 per day is the average daily cost of case management services based on costs and recipient data shown in Table 28.

The estimated FY 90 cost for providing state-operated community services to persons with developmental disabilities is $236.18 per person per day. This is an annual cost of $86,206.

Table 43. Estimated average daily per capita government expenditures in typical residential settings, FY 90

SETTING	RESIDENTIAL	MEDICAL	DAY PROGRAMS	SUPPORT PROGRAMS	TOTAL	ANNUAL
SOCS	$178.18	$6.54	$48.73	$2.73	$236.18	$86,205.70
RTCs	221.85	2.87	0.00	2.73	227.45	$83,019.25
ICFs						
New facilities	170.04	6.91	25.22	2.73	204.90	$74,788.50
Existing facilities	77.62	6.91	25.22	2.73	112.48	$41,055.20
WAIVER SERVICES						
Enhanced waiver	158.59	11.31	21.10	4.50	195.50	$71,357.50
Group foster care	81.31	11.31	21.10	4.50	118.22	$43,150.30
In-home support	20.45	11.31	21.10	4.50	57.36	$20,936.40
FAMILY FOSTER CARE (non-waiver)						
Day options						
Day training and habilitation	20.70	11.31	25.22	10.08	67.31	$24,568.15
Vocational rehabilitation	20.70	11.31	5.42	10.08	47.51	$17,341.15
Competitive employment	20.70	11.31	0.00	10.08	42.09	$15,362.85
BOARD AND LODGING	6.90	11.31	0.00	10.08	28.29	$10,325.85
SILS						
Receives SSI	26.29	11.31	5.42	10.08	53.10	$19,381.50
No SSI	13.42	11.31	5.42	10.08	40.23	$14,683.95
HOME, with family or independently						
W/ family, receives SSI	8.49	11.31	0.00	0.00	19.80	$7,227.00
Indep., receives SSI	12.87	11.31	0.00	0.00	24.18	$8,825.70
No SSI	0.00	0.00	0.00	0.00	0.00	$0.00

Regional treatment centers

The next highest cost option is the provision of comprehensive services in a regional treatment center. The per diem cost of $221.85 includes day training and rehabilitation provided on site, as well as some on-site medical care. The remaining medical care costs are $2.87 per person per day, based on the costs and recipient data shown in the footnote to Table 39 in Appendix A. Case management support costs of $2.73 are also included in the total costs.

As shown in Table 43, the estimated cost per person per day for providing these services to persons with developmental disabilities in a regional treatment center is $227.45. This is an annual cost of $83,019.

Intermediate care facilities for the mentally retarded

Caring for persons with developmental disabilities in newly developed intermediate care facilities for the mentally retarded is the next highest cost option. There is a significant difference between the cost of serving persons in new intermediate care facilities for the mentally retarded and the cost in existing facilities. The cost of providing residential service -- $170.04 in new facilities -- is based on data provided by the Long-Term Care Division of Human Services. The residential cost for providing services in existing facilities is $77.62. Medical costs of $6.91 per person per day are based on data in the footnote to Table 39 in Appendix A. Day program costs of $25.22 are based on Table 27. Support program costs of $2.73 reflect case management costs. The total cost per person per day in a new facility is $204.90 ($74,789 per year), and in an existing facility, $112.48 ($41,055 per year).

Waiver services

The Department of Human Services projected that 100 persons would receive enhanced waivered services in FY 91 at a per diem cost of $164.09. Discounting this cost backward one year determines a FY 90 cost of $157.02. This cost includes day program costs of $21.10 and support program costs of $4.50, resulting in a residential cost of $131.42. However, a room and board cost of $27.17 must be added to determine a full residential cost of $158.59. This is the residential amount shown in Table 43. Adding back the day program and support program costs and including the medical cost produces a total cost per person of $195.50 per day or $71,358 per year.

Approximately 1,700 persons reside in group foster care settings and receive supportive living arrangement services paid for under the regular waiver program. The estimated residential expense of $81.31 per person per day is based on supportive living arrangement expenses from Table 32 of $54.14 and estimated room and board costs of $27.17. Medical costs of $11.31 per person per day are based on Table 38. Day program costs of $21.10 per person per day are based on Table 32. Support program costs of $4.50 represent case management costs to persons on the waiver as shown in Table 32. The total cost per day for a person receiving supportive living arrangement waivered services and residing in group foster care is an estimated $118.22. The annual cost is $43,105.

Approximately 130 persons live at home and receive in-home support under the waiver at a residential cost of $20.45 per person per day. Adding the medical, day program and support program (case management) costs produces a total per diem cost of $57.36 ($20,936 yearly).

Family foster care

An estimated 543 adults with developmental disabilities live in family foster care residential sites. These persons may participate in one of three types of day programs -- day training and habilitation, vocational rehabilitation, or competitive employment. Table 43 shows the estimated costs for each of these options.

The residential costs for persons living in family foster care are estimated at $20.70 per person per day. This rate -- the average foster care rate for non-waiver recipients -- is based on the negotiated-rate facility survey undertaken by the Department of Human Services. It may include a combination of government and private sources.

Medical costs are estimated at $11.31, the same rate estimated for persons receiving Medical Assistance services under the waiver. The $25.22 average cost of day training and habilitation for persons residing in family foster care settings is the average monthly cost for day training and habilitation shown in Table 26 divided by 30.

The $5.42 cost of vocational rehabilitation is based on the FY 90 costs shown in Table 24 for extended employment.

The support program cost of $10.08 per person per day is the estimated cost of support programs provided by the counties through the Community Social Services Act. This estimate assumes the provision to a person living in a family foster care setting of the following services: case management $2.73, assessment $1.10, respite care $2.70, counseling $1.63, and transportation $1.92. These services and costs are taken from Tables 28, 34, 35, 36 and 41.

The total cost is $67.31 per person per day (or $24,568 per year) for a person residing in family foster care and receiving day training and habilitation. If the person receives vocational rehabilitation, the total cost per person per day is $47.51 ($17,341 per year). If the person is competitively employed, the total cost is $42.09 per person per day (or $15,363 per year).

Board and lodging

Table 43 shows the average cost of board and lodging residential expenses paid for under Community Social Service Act programs at $6.90 per day. Adding medical costs of $11.31 and support program costs of $10.08 results in a total per day cost of $28.29. The annual cost is $10,326.

Semi-independent living services

Table 43 shows that approximately 1,250 persons received semi-independent living services in FY 90. Of these, 500 received Supplemental Security Income payments and 750 did not. For persons not receiving those payments, the residential cost per day was $13.42 (taken from Table 30). Adding medical costs of $11.31, day program costs of $5.42 and support program costs of $10.08, as shown on Table 43, results in a total cost per day of $40.23 or $14,684 per year. For persons receiving Supplemental Security Income, average payments of $12.87 must be added. This results in a total cost of $53.10 per person per day or $19,382 per year.

Home, living with family or independently

A person living independently was eligible for Supplemental Security Income payments of $12.87 per day and could incur Medical Assistance costs of, on average, $11.31 per day. The total government cost was $24.18 per person per day or $8,826 per year. An estimated 4,000 persons with development disabilities received these services.

A person living in the house of a friend or family member was eligible for two-thirds of the $12.87 payment, or $8.49 per day. Adding this amount to the estimated Medical Assistance cost of $11.31 resulted in a cost to the government of $19.80 per person per day, or $7,227 annually.

ANALYSIS OF FISCAL INCENTIVES

The selection of a total service package (residential, day, and support services) for a person with developmental disabilities is dependent on funding sources, total service costs, and cost-sharing formulas. These factors considered in unison create fiscal incentives to prefer some services over others regardless of the total cost of care.

The most significant incentives relate to the availability of federal Medicaid money. This report's companion, *Minnesota's Case Management System for Persons with Developmental Disabilities,* describes the impact of federal dollars:

> Minnesota has historically attempted to maximize federal financial participation in providing services to persons with developmental disabilities. Because federal dollars are most readily available for institutional care, Minnesota relies heavily on these settings. For example, a 1988 report by Human Services states, "Minnesota has consistently had the highest rate of utilization of ICF/MR services in the United States. In 1986 Minnesota's utilization rate was over two and one-half times the national average" .... Dollars, not needs, often determine what services people will receive.

When Medicaid money became available for in-home support and other community services, use of these options expanded rapidly. Costs of the Home- and Community-based Waiver increased from $6 million in FY 86 to $56 million in FY 90.

Counties play the primary public role in arranging services to persons with developmental disabilities. Counties have had strong financial incentives to use Medicaid services such as regional treatment centers, intermediate care facilities for the mentally retarded or the Home- and Community-based Waiver. In recent years, the county contribution toward these Medicaid-eligible services was just under 5 percent. Effective Jan. 1, 1991, the counties no longer contribute toward the costs of Medicaid services, increasing the county incentive to use these options.

Other non-Medicaid-funded community services, such as semi-independent living services, non-waiver adult foster care or board and lodging, are paid in large part by county social service dollars. By using federally financed services, counties save county dollars. But decisions that are financially responsible from the county perspective might not be the most appropriate choices from a client-service perspective and might not be least expensive for the system overall.

A comparison of residential settings based on recent changes in Medicaid cost sharing indicates the following:

- Counties have no county fiscal incentive to prefer any of the Medicaid-funded services over another or to attempt to minimize total costs (for example, regional treatment centers are the most expensive in total costs, but the county has no fiscal incentive to minimize use of these services vs. a less costly option such as an intermediate care facility for the mentally retarded or waivered services).

- With no fiscal incentives to use one particular Medicaid-funded service instead of another, the county may be expected to use other criteria for service utilization, such as availability, location, and appropriateness.

- Counties still have to follow state requirements to control Home- and Community-based Waiver costs according to the waiver cap, which will encourage counties to place individuals with more severe needs in regional treatment centers and newly developed intermediate care facilities for the mentally retarded.

- Counties have no fiscal incentive to use non-Medicaid-funded services, regardless of their cost or availability. The total cost for semi-independent living services, non-waiver adult foster care, and board and lodging are less in total than Medicaid-funded services, but are more costly to counties.

Sometimes desired services such as beds in an intermediate care facility for the mentally retarded or Home- and Community-based Waiver openings may be unavailable. Counties may then have to choose among less-attractive alternatives: use of county-funded services, admission to a regional treatment center or letting the individual go unserved. In this situation, the county's financial interests and the client's best interests are likely to be in conflict.

CONCLUDING COMMENTS

Detailing how government spends more than a half-billion dollars annually on services to Minnesotans with developmental disabilities proved to be a difficult and time-consuming task. Due in part to the fragmented delivery system, basic data is not routinely available on spending and clients being served. Even with this study's comprehensive effort to identify costs and clients, it was impossible to arrive at an unduplicated count of clients across programs.

Much of the information contained in this report has never been compiled and published before. We hope that this new information will assist policy makers as they struggle with the complex human and fiscal issues involved in providing services to this vulnerable group of Minnesota's citizens.

APPENDICES

Appendix A.

SOURCES AND METHODOLOGY FOR SELECTED TABLES

Table 1. Summary of estimated expenditures by service categories for persons with mental retardation or related conditions

This table summarizes federal, state, county and local expenditures for services to persons with developmental disabilities for FYs 86 through 90. Expenditures are service specific, and may or may not include costs that are identified in other services. For example, waiver support services include case management, respite care, day training and habilitation, and homemaking. The expenditures for these services funded through the Home- and Community-based Waiver are reported in the waiver support services area and not under that identified service. To account for total expenditures for these four services, regardless of program or funding source, would require the addition of waiver support services costs to reported service expenditures.

Supplemental Security Income, Social Security Disability Insurance and Minnesota Supplemental Aid expenditures are identified only for those individuals who use these funds for room and board in foster care, board and lodging, and other group living arrangements. These expenditures do not include all persons who receive these benefits.

County social services spending in Minnesota

Counties in Minnesota are the principal government agencies responsible for coordinating and arranging for services to people in need. Under the Community Social Services Act (M.S. 256E), Minnesota operates a state-supervised county-administered system of social services. Community social services are distinct from social insurance programs (for example, Social Security and unemployment compensation) and income maintenance programs (for example, Minnesota Supplemental Aid and General Assistance).

Minnesota Statute 256E identifies eight target programs: programs for persons with developmental disabilities, programs for emotionally disturbed children, adult mental health programs, chemical dependency programs, children's programs, child care subsidies, adult programs, and "other" programs. Although these are the eight identified program groups, a variety of services is offered through county social services. For persons with developmental disabilities, the counties reported expenditures for many services, including assessment, case management, day training services, extended and supported employment, adult and children's foster care, board and lodging, semi-independent living services, respite care, and services identified in the Home- and Community-based Waiver.

Counties report social services spending to the Department of Human Services, Community Social Services Division, as both projected and actual expenditures at the close of the calendar year. The department provides each county a list of services as a means to report costs to each program group. This discussion on county social services spending in Minnesota applies to the information in Tables 19, 20, 22, 28, 29, 34 through 37 and 41.

Data sources: Social services data available for this project included the following:

1. Actual revenues, expenditures and number of clients served for Calendar Years 1985, 1986 and 1987.

2. Actual revenues, expenditures and number of clients served for Calendar Year 1988 for 75 counties and an allocation formula for expenditures and client count for 12 counties based on spending in Calendar Year 1987.

3. Projected expenditure data for Calendar Year 1989 in summary form.

4. Projected expenditure, revenue and client data for Calendar Years 1990 and 1991.

Additional revenue, expenditure and client count data was available for services that are not discretionary but that require county contributions: the Home- and Community-based Waiver and semi-independent living services.

Methodology: The first step in using the county social service data was to identify a list of services to account for in each year. After creation of the list, Calendar Year 1989 data had to be estimated. Projected 1989 social services expenditures for persons with developmental disabilities listed only one service -- case management -- of the 10 services relevant to this discussion, lumping the rest into an "other" category. Where service expenditures and client counts had to be estimated, they were based on the expenditure patterns and service utilization of Calendar Years 1988 and 1990.

Expenditures, revenues and program participant counts for the other services in this report were collected on a state fiscal year basis. County social service data -- reported in a calendar year format -- was converted to fiscal year by assuming that the number of clients served and expenditures occurred on an equal basis throughout the year. Calendar year data was allocated between two fiscal years, because Minnesota's fiscal year runs from July through June.

Once data was converted to fiscal years, program expenditures and client count data accounted for in other service areas of the report had to be subtracted or removed from county social service expenditures. This was done to avoid duplication of expenditures and number of persons served when totalling all data for this population.

After completion of the above procedures, the next step was to estimate the amount of funds attributed to non-discretionary funding sources. With the lack of growth in Federal Title XX and state Community Social Services Act funds, the counties have been funding a greater share of social services (see table). Percentages of total revenues from these three sources were estimated based on the total social service funds available from these three sources for each of the five years.

Data reliability and service interpretation: Examination of five county reports for two calendar years indicated a wide latitude in reporting of social services data and interpretation of service categories. One example is the change in the number of adult foster care recipients for Calendar Years 1985 and 1986. In 1985, the counties reported 497 recipients, and in 1986, 128. Data from two surveys made by the Department of Human Services on adult foster care indicated that the number of

Allocation factors for estimating CSSA program fund sources

Source	FY 86	FY 87	FY 88	FY 89	FY 90
Federal	17.35%	16.15%	15.00%	14.70%	14.50%
State	19.05	18.00	16.85	15.65	14.40
County	63.60	65.85	68.15	69.65	71.10
Total	100%	100%	100%	100%	100%

persons with developmental disabilities, not on the Home- and Community-based Waiver, in adult foster care settings was 487 in 1987. There probably was no drop of 370 adults in 1986 and a similar gain in 1987. One possible explanation is that the counties reported adult foster care numbers differently in 1985 and 1986. In 1985, it would appear that counties reported all persons in adult foster care, while in 1986 they reported only those individuals who were supported with county social services dollars. Many of the services for persons with developmental disabilities may be paid for through income maintenance accounts (Supplemental Security Income, Social Security Disability Insurance, and Minnesota Supplemental Aid). County social services dollars often are used to supplement these and other funds. This is true for such services as board and lodging, foster care, day training and habilitation, extended and supported employment, screening, and personal care services. Where other data was available to corroborate social services data or where data was available to suggest total expenditures or number of persons served, it was used.

The second type of problem with this data is inconsistent reporting across counties. An example can be found in the average expenditure per person for respite care. Average yearly respite care expenditures per person showed a variation of as much as 600 percent from county to county. The same was true for child foster care average monthly expenditures in the metropolitan area. There was no method available to verify these differences short of surveying and questioning in each county.

The nature of services and funding sources, reporting variances and definition changes from year to year, and inter-county differences in reporting make it imperative that these factors be considered when examining county social services data for this population. While reported county social services expenditures for persons with developmental disabilities increased by $68.7 million from FY 86 through FY 90, the waiver accounted for 74 percent of that growth, with county-administered programs accounting for 23 percent. Overall, federally funded programs increased by $28.1 million, state-funded by $23.7 million, and county-funded by $16.9 million.

Table 3. Medical Assistance funding shares

The source of information was the Reports and Statistics Division of the Department of Human Services.

Table 17. Regional treatment centers

Sources of fiscal and recipient data were the Reports and Statistics Division and the Reimbursements Division of the Department of Human Services.

Costs for regional treatment centers are inclusive, that is, they include residential, day habilitation, support services, and some medical costs. Medical costs not associated with per diems are shown in Table 39.

Total costs include expenditures reimbursed through Medical Assistance, private pay, and state dollars for unreimbursed expenses. The state dollars include both Medical Assistance dollars and dollars for unreimbursed expenses. Total unreimbursed costs paid by the state were:

FY 86	**$ 634,489**
FY 87	**901,806**
FY 88	**2,504,144**
FY 89	**4,436,146**
FY 90	**2,835,268**

Cost per patient day was calculated by dividing total expenditures by patient days.

Table 18. Intermediate care facilities for the mentally retarded

The source of both fiscal and recipient data was the Reports and Statistics Division of the Department of Human Services.

Costs for intermediate care facilities for the mentally retarded are for active treatment provided by the residence and for room and board. The day training and habilitative costs for these persons are reported separately. Medical costs not associated with the per diem for the intermediate care facility for the mentally retarded are shown in Table 39.

Average cost per day was calculated by dividing total expenditures by 365 days and average number of recipients.

Average daily facility costs were provided by the Audits Division of the Department of Human Services. The average rate at an intermediate care facility for the mentally retarded was:

Effective date	Number of facilities	Average rate	Range
10/1/86	345	$65.31	$33.65 - 142.65
10/1/87	335	65.09	32.55 - 144.41
10/1/88	336	69.82	37.45 - 158.28
10/1/89	328	73.65	40.14 - 173.93
10/1/90	308	81.20	36.53 - 197.75

These numbers do not include facilities in an appeal process, those being downsized or closed, or new facilities authorized by the 1989 Legislature.

The 1989 Legislature authorized 150 new beds, which allowed for the development of 37 facilities with an average per diem of $170.04 and a range from $106.58 to $268.42.

Thirty-nine facilities were targeted for downsizing or closure, affecting 862 persons. As of May 1990, 748 persons had been relocated to the Home- and Community-based Waiver or other intermediate care facilities for the mentally retarded.

Table 19. Child foster care

Information about county social services spending in Minnesota, which partially supports the child foster care program, can be found in the Table 1 discussion in this appendix.

Information about county social services spending and recipient count was provided by the Community Social Services Division in its annual reports titled *Social Services in Minnesota: Revenues, Expenditures and Clients Under the Community Social Services Act* for Calendar Years 1985 through 1988; projected data was available for 1989, 1990 and 1991 from county reports to the state. The only data available, it may not reflect total expenditures or total number of children served. Given the physical, medical and emotional needs of many children with developmental disabilities, costs per month could be considerably more than $460 in FY 90.

A review of five county reports for Calendar Year 1988 indicated that average monthly child foster care rates ranged from $251.00 to $878.85.

It is unknown what portion of total expenditures is paid through the federal Title IV-E child foster care program. The eligibility requirements are based on income and resources.

Table 20. Adult foster care

Information about county social services spending in Minnesota, which partially supports the adult foster care program, can be found in the Table 1 discussion in this appendix.

Data was provided by the Department of Human Services Developmental Disabilities Division, and was available for the number of persons in adult foster care for Calendar Years 1987 and 1989. Other information was gathered from county social service reports to the Community Social Services Division of Human Services. It was unknown if all expenditures represented supplements to other available income maintenance funds.

Table 21. Inappropriate placements in nursing homes

Data for the number of persons inappropriately placed in nursing homes was provided by the Developmental Disabilities Division of the Department of Human Services. The number of persons inappropriately placed was identified for 1988 through 1990. Data was estimated for 1986 and 1987 because the screening process to identify individuals had not been established in those years.

Average monthly payments were from nursing home data published in *Minnesota Family Support and Medical Programs* (March 1990) and provided by the Reports and Statistics Division. No attempt was made to discern average costs for a skilled nursing facility vs. an intermediate care facility. The figure used was the average cost across all nursing homes.

Table 22. Board and lodging

Information about county social services spending in Minnesota, which partially supports the board and lodging program, can be found in the Table 1 discussion in this appendix.

Data was provided by counties and reported by the Department of Human Services in summary form in the 1985, 1986, 1987 and 1988 reports titled, "Social Services in Minnesota, Revenues, Expenditures and Clients Under the Community Social Services Act." The data for 1989 and 1990 was based on county estimates submitted to the department. Board and lodging facilities are usually used by persons who are elderly or who have mental health concerns. No reports are available to verify the number of persons in these settings.

As with adult foster care, resources of Supplemental Security Income, Social Security Disability Insurance, and Minnesota Supplemental Aid would be employed before counties would provide additional funding.

Table 23. SSI, SSDI and MSA

Supplemental Security Income

The Supplemental Security Income program was enacted by Congress in 1974 as a federally financed and administered public assistance program for needy people who are age 65 or older, blind, or disabled. This is a means-tested program, meaning that an individual's income and resources must be below a certain limit to qualify for benefits.

This analysis is only for persons who have been identified as recipients of adult foster care or board and lodging, or those receiving services from the Home- and Community-based Waiver or a semi-independent living services provider.

Sources of data: Data was available about benefits received, percentage of a service group that received benefits, and cost of services in a residential setting. Rarely were all three of these pieces of data available for each residential setting. Average benefits for adults on the Home- and Community-based Waiver were available from the Developmental Disabilities Division of the Department of Human Services. Percentage of population receiving benefits for semi-independent living services recipients was available from the same source. Data about the average cost of services in different residential settings was provided by the Long-Term Care Division of Human Services from a 1989 survey of 920 negotiated-rate facilities.

Supplemental Security Income benefits were capped at $386 per month for an individual in 1990. The maximum benefit increases are based on Consumer Price Index changes.

Methodology: The methodology for calculating average Supplemental Security Income benefits was based on examining relevant data for each residential option.

Supported living arrangement under the Home- and Community-based Waiver: Data provided from the Reports and Statistics Division of Human Services indicated an average of 1,112 persons receiving Supplemental Security Income benefits during FY 90. This represented 49 percent of all Home- and Community-based Waiver recipients. The division provided quarterly data for FYs 86 through 89, which was averaged for a yearly total.

The average monthly Supplemental Security Income benefits were also provided by the Reports and Statistics Division. Average monthly Supplemental Security Income benefits for persons who also receive Home- and Community-based Waiver services were $258.07. Average monthly benefits for previous fiscal years were also calculated from quarterly summaries.

Residential support for semi-independent living services recipients: Information from the Developmental Disabilities Division of Human Services indicated that 38.1 percent of semi-independent living services recipients were also Supplemental Security Income recipients in FY 90. There would then be 476 persons who received semi-independent living services and Supplemental Security Income benefits that year. This same percentage was applied to previous fiscal years to arrive at the number of beneficiaries.

Conversations with persons in the Developmental Disabilities Division indicated there was no reason to assume that benefits would be less than the maximum, which was $386

SSI housing assistance for people with developmental disabilities

	FY 86	FY 87	FY 88	FY 89	FY 90
HCB WAIVER					
No. of recipients	192	447	676	957	1,112
Avg. payment/month	$230.15	$235.79	$237.11	$248.36	$258.07
Total cost	**$530,266**	**$1,264,778**	**$1,923,436**	**$2,852,166**	**$3,443,686**
SILS					
No. of recipients	288	338	410	438	476
Avg. payment/month	$326	$340	$354	$369	$386
Total cost	**$1,126,656**	**$1,379,040**	**$1,741,680**	**$1,939,464**	**$2,204,832**
ADULT FOSTER CARE					
No. of recipients	260	279	298	316	368
Avg. payment/month	$221	$227	$228	$239	$248
Total cost	**$690,082**	**$758,657**	**$814,863**	**$905,075**	**$1,095,212**
BOARD/LODGING					
No. of recipients	190	64	101	121	136
Avg. payment/month	$326	$340	$354	$369	$386
Total cost	**$743,280**	**$261,120**	**$429,048**	**$535,788**	**$629,952**
TOTAL					
No. of recipients	930	1,128	1,485	1,832	2,092
Avg. payment/month	$276.91	$270.66	$275.48	$283.50	$293.73
Total cost	**$3,090,283**	**$3,663,594**	**$4,909,027**	**$6,232,493**	**$7,373,682**

per month in FY 90. The same assumption was applied to previous fiscal years.

Adult foster care: Persons in adult foster care settings who received Supplemental Security Income were assumed to be similar to adults in foster care settings through the Home- and Community-based Waiver. In FY 90, according to data gathered from the Developmental Disabilities Division, 57.2 percent of adults living in the community under the Home- and Community-based Waiver received Supplemental Security Income benefits. This percentage was applied to total adult foster care recipients for each fiscal year. The total number of adult foster care recipients for each fiscal year beginning in FY 86 was 454, 487, 521, 553, and 643. The percentage was applied to these numbers to determine Supplemental Security Income recipients.

Adults in adult foster care settings and under the Home- and Community-based Waiver received average monthly Supplemental Security Income benefits of $248.01 in FY 90. This same amount was used for persons not on the Home- and Community-based Waiver

and residing in adult foster care settings. Average benefits were calculated for the previous fiscal years, adjusted for Consumer Price Index changes in the maximum Supplemental Security Income monthly benefit.

Board and lodging: The number of persons who reside in board and lodging facilities was available only from summarized county social service reports. This probably does not represent all persons in these settings.

The number of these persons who received Supplemental Security Income benefits was estimated by using the same percentage of Supplemental Security Income recipients that received Home- and Community-based Waiver services. In FY 90, it was estimated that 144 persons in board and lodging facilities received Supplemental Security Income benefits.

The average monthly Supplemental Security Income benefit was also estimated to be the maximum allowed per month, $386 in FY 90. This was adjusted for previous fiscal years by changes in the Consumer Price Index.

Social Security Disability Insurance

Social Security Disability Insurance is an income maintenance program sponsored by the federal government to support people who have become disabled and are no longer able to work, and their spouse and children. Unlike other income maintenance programs, this program is not means-tested. Persons with developmental disabilities may receive benefits beginning at age 18 if their parents or grandparents paid into the social security system and they are now retired or deceased.

Social Security Disability Insurance was examined to determine the amount of these benefits received and used by persons with developmental disabilities. Benefits are applied toward residential room and board costs. No attempt was made to determine total Social Security Disability Insurance benefits to all persons with developmental disabilities. For purposes of this study, residential options considered were supported living arrangements under the Home- and Community-based Waiver, living options for persons who receive semi-independent living services, adult foster care, and board and lodging.

Sources of data: Data was available about benefits received, percentage of a service group that receives benefits, and cost of services in a residential setting. Rarely were all three pieces of data available for each residential setting. Average benefits for adults on the Home- and Community-based Waiver were available from the Developmental Disabilities Division. Percentage of population receiving benefits was available for semi-independent living services recipients from the same division. Data about the average cost of services in different residential settings was provided by the Long-Term Care Division from a 1989 survey of 920 negotiated-rate facilities.

The maximum Social Security Disability Insurance benefit per month in December 1988 was $264 for children of a disabled worker, $358 for a dependent of a deceased worker, and $208 for a former wage earner with a disability.

Methodology: The methodology for calculating average Social Security Disability Insurance benefits was based on examining relevant data for each residential option.

Supported living arrangement under the Home- and Community-based Waiver: Data provided from the Developmental Disabilities Division indicated that 1,038 persons

SSDI housing assistance for people with developmental disabilities

	FY 86	FY 87	FY 88	FY 89	FY 90
HCB WAIVER					
No. of recipients	292	475	791	976	1,038
Avg. payment/month	$281.32	$293.40	$305.48	$318.42	$333.09
Total cost	**$985,745**	**$1,672,380**	**$2,899,616**	**$3,729,335**	**$4,148,969**
SILS					
No. of recipients	268	314	381	406	443
Avg. payment/month	$282.48	$294.63	$306.71	$319.59	$334.29
Total cost	**$908,456**	**$1,110,166**	**$1,402,278**	**$1,557,042**	**$1,777,086**
ADULT FOSTER CARE					
No. of recipients	274	294	314	334	388
Avg. payment/month	$282.48	$294.63	$306.71	$319.59	$334.29
Total cost	**$928,794**	**$1,039,455**	**$1,155,683**	**$1,280,917**	**$1,556,454**
BOARD/LODGING					
No. of recipients	201	68	107	127	144
Avg. payment/month	$282.48	$294.63	$306.71	$319.59	$334.29
Total cost	**$681,342**	**$240,418**	**$393,816**	**$487,055**	**$577,653**
TOTAL					
No. of recipients	1,035	1,151	1,593	1,843	2,013
Avg. payment/month	$282.15	$294.12	$306.10	$318.97	$333.67
Total cost	**$3,504,337**	**$4,062,419**	**$5,851,393**	**$7,054,349**	**$8,060,162**

were receiving Social Security Disability Insurance benefits at the end of FY 90. This represented 47.5 percent of all Home- and Community-based Waiver recipients. This same percentage was applied to waiver recipients for FYs 86 through 89 to determine the number of Social Security Disability Insurance recipients who received waiver services. The average payment was $333.09 per month. Average Social Security Disability Insurance monthly payments for FYs 86 through 89 were determined by using the same inflation factor applied to changes in Supplemental Security Income benefits:

FY 87 4.3 percent

FY 88 4.1 percent

FY 89 4.2 percent

FY 90 4.6 percent

Semi-independent living services to persons in community settings: A survey of counties that negotiate and allocate semi-independent living services through various vendors indicated that 35.4 percent of the recipients received Social Security Disability Insurance benefits. This percentage was applied to semi-independent living services clients to determine the annual number of Social Security Disability Insurance beneficiaries.

The average monthly Social Security Disability Insurance benefit was established using the average received by adults who lived in community settings under the waiver. The average monthly benefit in FY 90 was $333.09, but this was across all settings, including children and adults on the waiver who received home support. The average benefit used for the semi-independent living services population was $334.29 for FY 90 based on adults living in community residences. It was revised downward for each preceding fiscal year to FY 86, using the same percentages as above.

Adult foster care: Data about recipients in adult foster care came from two sources: the adult foster care survey made by the Department of Human Services and county social services plans. The adult foster care survey results showed 487 adults with developmental disabilities, not on the Home- and Community-based Waiver, in foster care settings in 1987. A similar 1989 survey showed 553 adults. County-projected social services data for 1990 indicated that 643 adults would be served. County data for preceding years seemed to account only for those persons who received assistance above and beyond the cost of room and board not reimbursed through income maintenance programs. Consequently, 1986 and 1988 recipients were estimated at 454 and 521, respectively.

The number of persons who received benefits was determined by the percent of persons who received benefits in adult foster care settings under the Home- and Community-based Waiver -- 60.3 percent in FY 90. This same share was applied each year to the above number of persons in adult foster care.

The average monthly Social Security Disability Insurance benefit was estimated to be the same for adults in foster care settings under the Home- and Community-based Waiver for FY 90 -- $334.29. This figure was adjusted for preceding years by the same percentages employed for Home- and Community-based Waiver recipients.

Board and lodging: The only source of data on persons with developmental disabilities who received services in board and lodging facilities was the summary of county social service reports. The recipients in board and lodging are listed in the table on Page 10. At first it was hypothesized that persons in board and lodging facilities would be like persons who receive semi-independent living services -- that very few (35.4 percent) would receive Social Security Disability Insurance benefits. This seemed possible until it was considered that the average negotiated rate for board and lodging facilities was $663.74 (according to the negotiated-rate facility survey), more than $160 more than group living under a semi-independent living services provider. The effect would be to force Minnesota Supplemental Aid benefit rates far beyond conceiveable limits.

Given the negotiated rates for this type of facility, it was assumed that Social Security Disability Insurance beneficiaries as a percentage of the population were apt to be like other adults in corporate and family foster care settings. The share of adult beneficiaries in these settings was 60.3 percent, which was used to estimate the number of Social Security Disability Insurance recipients who lived in board and lodging facilities.

The average monthly benefit was calculated in a way similar to calculating average benefits for adult foster care and semi-independent living services recipients.

Minnesota Supplemental Aid

Minnesota Supplemental Aid is the state's cash assistance supplement to the federal Social Security program. State and county agencies share in the cost of benefits -- 85 percent state and 15 percent county. For persons with developmental disabilities, Minnesota Supplemental Aid is most often used in negotiated-rate facilities to pay for room and board. The benefit is determined by looking at the negotiated rate, subtracting funds that can be applied from earned income and other income maintenance programs to arrive at the necessary benefit, and adding a personal needs allowance of $49 per month. As negotiated-rate facilities vary in per diems, so will the amount of monthly Minnesota Supplemental Aid benefits. The maximum rate allowed for negotiated-rate facilities is $918 per month, with some exemptions.

Minnesota Supplemental Aid was examined to determine the amount of these benefits received and used by persons with developmental disabilities to pay for their room and board costs. No attempt was made to determine total Minnesota Supplemental Aid benefits to all persons with developmental disabilities. For purposes of this study, residential options considered were supported living arrangements under the Home- and Community-based Waiver, living options for persons who received semi-independent living services, adult foster care, and board and lodging.

Data sources: Data was gathered for Home- and Community-based Waiver recipients from quarterly data for FYs 86 through 90, provided by the Reports and Statistics Division of Human Services. Additional waiver data was gathered from the Developmental Disabilities Division for waiver recipients in FY 90. Data on semi-independent living services recipients was also provided by that division. The negotiated-rate facility survey also provided valuable information about room and board rates in this type of facility.

Methodology: Minnesota Supplemental Aid average monthly benefits were the most difficult to determine, especially for facilities where no specific data was available. Since Minnesota Supplemental Aid rates in negotiated rate facilities were dependent on the availability of other earned and unearned income sources, those sources had to be considered in determining average monthly Minnesota Supplemental Aid payments. The negotiated-rate facility survey was used to determine average monthly room and board rates for adult foster care and board and lodging facilities. These average rates plus benefits from Supplemental Security Income and Social Security Disability Insurance became the basis for determining Minnesota Supplemental Aid average monthly rates.

Supported living arrangement under the Home- and Community-based Waiver: Data about Minnesota Supplemental Aid benefits to Home- and Community-based Waiver recipients was provided by the Reports and Statistics Division. Its data suggested that the average number of persons with developmental disabilities receiving Minnesota Supplemental Aid benefits in FY 90 was 1,284. This represented 58.8 percent of all Home- and Community-based Waiver recipients.

The average monthly benefit in FY 90 was $542.32. Average benefits and number of recipients for earlier years were also provided based on quarterly data.

Recipients of semi-independent living services: Data from the Developmental Disabilities Division suggested that 16.8 percent of semi-independent living services recipients received Minnesota Supplemental Aid, based on a 1990 survey of counties. This percentage was applied to semi-independent living services recipients for each

MSA housing assistance for people with developmental disabilities

	FY 86	FY 87	FY 88	FY 89	FY 90
HCB WAIVER					
No. of recipients	171	396	656	1,043	1,284
Avg. payment/month	$422.16	$459.17	$404.68	$502.98	$542.32
Total cost	**$866,272**	**$2,181,976**	**$3,185,641**	**$6,295,298**	**$8,356,067**
SILS					
No. of recipients	127	149	181	193	210
Avg. payment/month	$155.04	$166.30	$180.60	$214.76	$220.08
Total cost	**$236,281**	**$297,344**	**$392,263**	**$497,384**	**$554,602**
ADULT FOSTER CARE					
No. of recipients	232	247	289	344	425
Avg. payment/month	$264.61	$267.79	$284.12	$300.32	$310.23
Total cost	**$736,674**	**$793,730**	**$985,328**	**$1,239,721**	**$1,582,173**
BOARD/LODGING					
No. of recipients	169	57	98	132	157
Avg. payment/month	$218.07	$220.69	$233.93	$247.26	$255.42
Total cost	**$442,246**	**$150,952**	**$275,102**	**$391,660**	**$481,211**
TOTAL					
No. of recipients	699	849	1,224	1,712	2,076
Avg. payment/month	$271.99	$336.08	$329.41	$410.05	$440.51
Total cost	**$2,281,473**	**$3,424,002**	**$4,838,334**	**$8,424,063**	**$10,974,052**
FUNDING SOURCE					
State	$1,939,252	$2,910,401	$4,112,584	$7,160,453	$9,327,945
County	342,221	513,600	725,750	1,263,609	1,646,108
Total	$2,281,473	$3,424,002	$4,838,334	$8,424,063	$10,974,052

year to determine the number of Minnesota Supplemental Aid recipients.

The average monthly grant was determined by using the average monthly room and board rate for semi-independent living services -- $487.68 -- as taken from the negotiated-rate facility survey, and adjusting for other income sources. If Social Security Disability Insurance and Supplemental Security Income had been averaged across all recipients, the average monthly grant would have been $118.47 for Social Security Disability Insurance and $146.99 for Supplemental Security Income. The difference between these amounts summed and $487.68, was $222.22. If 210 persons

received Minnesota Supplemental Aid in FY 90, then their average monthly benefit would have been $1,322 -- an unlikely figure. What had to be factored into this analysis was the amount of earned and unearned income that could be applied to the rate. Data about semi-independent living services recipients indicated that more than 90 percent were in some kind of vocational activity that could earn income. Home- and Community-based Waiver data indicated that adults had average adjusted earned income of $33.00 per month and unearned income of $39.42 per month. Given the high functioning level of persons in the semi-independent living services program, it was probable that they could be earning more per month. If Minnesota Supplemental Aid benefits were to approximate overall Minnesota Supplemental Aid average monthly benefits, earned and unearned income would have to average $185.25 per month. This would require 55 hours of work per month at minimum wage.

Using this background, it was hypothesized that many semi-independent living services recipients would be working and that the average grant would approximate overall Minnesota Supplemental Aid grants. For FY 90, this was determined to be $220.08 per month, with previous years adjusted according to the changes in overall Minnesota Supplemental Aid average payments.

Adult foster care: The number of persons in adult foster care who received Minnesota Supplemental Aid can be estimated in one of two ways: (1) use of a percentage of recipients based on the number of adults in foster care settings under the Home- and Community-based Waiver -- 83.5 percent -- or (2) use of a modified percentage based on the ratio of Minnesota Supplemental Aid recipients to Supplemental Security Income recipients under the Home- and Community-based Waiver. The former method would potentially overestimate recipients. It is unlikely that 83.5 percent of adults in adult foster care (not Home- and Community-based Waiver recipients as well) would be receiving Minnesota Supplemental Aid when only 60 percent receive Supplemental Security Income. Minnesota Supplemental Aid and Supplemental Security Income are closely related, but Supplemental Security Income is not required for Minnesota Supplemental Aid benefits in all cases.

The latter method would allow for considering the interplay of Supplemental Security Income and Minnesota Supplemental Aid by applying a ratio based on evidence seen for Home- and Community-based Waiver recipients. The ratio of Minnesota Supplemental Aid recipients to Supplemental Security Income recipients for Home- and Community-based Waiver recipients by fiscal year was:

FY 86	**0.8906**
FY 87	**0.8859**
FY 88	**0.9704**
FY 89	**1.0898**
FY 90	**1.1546**

These ratios were applied to adult foster care Supplemental Security Income recipients to determine Minnesota Supplemental Aid recipients for persons residing in adult foster care settings. The number of Minnesota Supplemental Aid recipients in FY 90 was estimated at 425.

The average Minnesota Supplemental Aid benefit per month would depend on receipt of other earned and unearned income. The average monthly rate for adult foster care settings, based on analysis of the negotiated-rate facility survey, was $621.13.

The average income from other financial sources, averaged across all adult foster care persons, was:

SSDI	**$201.72**
SSI	**141.94**
Earned income	**33.00**
Unearned income	**39.42**

The average earned and unearned income amounts were based on data regarding adults on the Home- and Community-based Waiver. It was assumed that amounts would be similar for this population.

The difference between the total for the above amounts and the average room and board rate of $621.13 is $205.05. This amount in the analysis would be the average Minnesota Supplemental Aid benefit across all adult foster care recipients. With 425 persons receiving Minnesota Supplemental Aid, the average benefit per month to these individuals would then be $310.23.

Amounts for earlier fiscal years were adjusted by changes in the average adult foster care rate as provided by rate changes in the Department of Human Services adult foster care survey. The year-to-year changes were:

1986 to 1987:	**1.2 percent**
1987 to 1988:	**6.1 percent**
1988 to 1989:	**5.7 percent**
1989 to 1990:	**3.3 percent**

Board and lodging: The number of persons residing in board and lodging facilities and receiving Minnesota Supplemental Aid benefits was determined in the same fashion as for adult foster care recipients. There was no data available to determine the exact recipients, but the assumption was that recipients should be similar to Supplemental Security Income recipients based on the nature of Minnesota Supplemental Aid and the average cost for board and lodging.

The number of recipients was determined by applying the same ratio of Minnesota Supplemental Aid recipients to Supplemental Security Income recipients, based on the ratio established by Home- and Community-based Waiver recipients. Using those ratios, as outlined earlier, would indicate that the number of Minnesota Supplemental Aid recipients living in board and lodging facilities was 157 in FY 90.

The average monthly Minnesota Supplemental Aid benefit was determined based on other income sources and the average monthly rate for board and lodging. The average monthly rate was $663.74, according to analysis of the negotiated-rate facility survey. Other earned and unearned income sources averaged across all recipients per month were:

SSDI	**$202.26**
SSI	**220.57**
Earned income	**33.00**
Unearned income	**39.42**

Figures for the last two income sources were taken from similar amounts for recipients of Home- and Community-based Waiver services.

The difference between the above amounts and $663.74 per month was $158.49. This figure represented average monthly Minnesota Supplemental Aid benefits across all board and lodging recipients. Recalculating the amount only for the Minnesota Supplemental Aid recipients would result in average monthly Minnesota Supplemental Aid benefits of $255.42 in FY 90. Average monthly benefits were adjusted for earlier years, using changes in average monthly foster care rates as stated previously.

Table 24. Vocational rehabilitation

Three types of vocational rehabilitation services are available to persons with developmental disabilities: basic services, extended employment, and independent living services. Basic services are used to assess and evaluate a person's needs for vocational training, adaptations to a work environment, or time-limited support on a job site. Information about these services was provided by the Department of Jobs and Training for each person who had a primary or secondary disability of mental retardation, epilepsy, cerebral palsy or autism.

Sources of data: Basic services data included costs and number of persons served for each identified service. Additional information was gathered about vocational rehabilitation counselor costs. Funding sources are a mixture of Federal Title I and Title VI-C, and state appropriations. Dollars had to be converted from federal fiscal year to state fiscal year.

Extended employment program data could not be tracked directly to each individual. These programs are run by 35 non-profit providers throughout Minnesota and derive their funds primarily through work contracts, sales and contributions. They are not funded on a per-person basis or through per diems. Data available from the Department of Jobs and Training Division of Rehabilitation Services included total state appropriations provided for in-house and supported employment programs. The department also made available the number of people in each of these programs who were mentally retarded or had a related condition, based on where an individual spent the most time during the year. Counties also fund extended employment programs as reported in Department of Human Services social services reports. The categories for reporting social service expenditures and number of persons served did not include supported employment until 1989. The Department of Jobs and Training does not regularly audit extended employment programs and therefore did not know total expenditures and revenues for these programs, nor was it able to verify county expenditures. The exception was for FY 90. During 1990, a Department of Jobs and Training review of extended employment programs documented that total county expenditures for in-house services were $4,287,520, and for supported employment services $2,374,562.

Methodology

Basic services: The methodology for calculating total expenditures for basic services was straightforward. Persons with a primary or secondary developmental disability were identified and costs were matched.

Adjustments had to be made for the federal fiscal year (October through September). This was done for both expenditures and number of persons served by using ratios of 3/4 and 1/4. The 3/4 ratio was used in the same federal fiscal year as state fiscal year, while the 1/4 ratio was applied to the prior federal fiscal year. Application of these ratios to expenditures and number of clients provided data for basic services.

One final calculation had to be made for allocating expenditures between federal and state dollars. An analysis of total basic revenue (federal Title I and Title VI-C, and state appropriations), showed the percentage of dollars from these sources:

	Federal		State
	Title I	Title VI-C	
FFY 86	71.8%	0.0%	27.2%
FFY 87	73.4	1.3	25.3
FFY 88	75.4	1.5	23.1
FFY 89	76.4	1.3	22.3
FFY 90	76.9	1.3	21.8

These percentages were applied to total annual expenditures to calculate federal and state shares.

Extended employment: Two types of services are offered through extended employment: in-house programs (long-term employment, work component, and work activity) and supported employment (formerly known as community-based employment). The Division of Vocational Rehabilitation provided the number of persons with developmental disabilities in each of these programs for each fiscal year, based on where the person spent the majority of the time.

Funding for extended employment programs comes from state appropriations and county social services. The department makes the policy decision on how it will allocate dollars between in-house and supported employment services. Over the past five years, while state appropriations for extended employment programs increased by $373,000, the department reduced allocation of state dollars to in-house programs by $1.82 million and increased the supported employment allocation by $2.19 million.

The method employed for allocating state dollars to each of these services was by examining the total hours of service across all populations served rather than solely persons with developmental disabilities served in each program.

The percentages were:

	FY 86	FY 87	FY 88	FY 89	FY 90
In-house	**68.6%**	**66.9%**	**68.9%**	**67.4%**	**68.6%**
Supported employment	**73.9**	**70.6**	**68.7**	**70.6**	**70.6**

These percentages were applied to total expenditures for each service to arrive at total state appropriations for persons with developmental disabilities.

Although this methodology determined state dollars for each extended employment service, there was no similar methodology available for calculating county expenditures. The Department of Jobs and Training does not annually require audits of extended employment programs for funding allocations. Extended employment programs receive about 20 percent of their funds from government sources, with the bulk of the balance coming from contracts, sales, and contributions.

The only data available for county funding of extended employment programs was in social service expenditure and client count reports from the Department of Human Services. As the Department of Jobs and Training allocated fewer dollars to in-house services, more dollars were provided by counties to stabilize funding. The data from actual social service reports for 1985 through 1988 indicated county funding increasing by about $1 million. During this time there was no category for allocating county dollars to supported employment services. Data provided for 1989 was projected and indicated continual growth in in-house county dollars and first reported expenditures for supported employment of nearly $2 million. Available data for 1990 also was projected, but the Department of Jobs and Training did have some data for county funding of each for these services. The results for 1990 were:

	Voc rehab	Social services
In-house	**$2,941,239**	**$4,022,506**
Supported employment	**1,574,562**	**3,451,198**

Projected social services data seemed to overstate the contribution to each service. Projected vs. actual data, as reviewed for 1988, indicated that, while total expenditures were more than projected, they were often not in the primary service areas. The vocational rehabilitation numbers were actual figures provided by all extended employment programs, and therefore seemed to be better data.

The implication is that county projected data for 1989 may have been overstated, especially for supported employment services.

Table 25. Special education

State spending for special education for persons with mental handicaps can be put into four categories for estimating total expenditures: direct aid and spending, non-salary personnel costs, secondary vocational education aid for handicapped children, and state general revenue aid.

Direct aid and spending

The state provides financial aid to school districts to compensate their costs of providing special education to handicapped children. The share of the total cost of special education paid by the state varies by category. This aid is provided in addition to general education revenue given to all school districts for the education of all students. M.S. 124.32 (1988) requires that state reimbursement be provided in the following categories:

Teachers' salaries (Subdivision 1b, 1989 supplement) A portion of the salary of essential personnel providing services to handicapped children is paid by the state. For a full-time person, the state pays $16,727 or 60 percent of the person's salary, whichever is less. This is a decrease from 1988 law, which provided a maximum reimbursement of $18,400 or 66 percent.

Contract services (Subdivision 1d) The cost of contract services for special instruction and services provided to any pupil is paid by the state at the rate of 52 percent of the difference between the contract cost and the basic revenue amount paid by the state for that pupil.

Supply and equipment aid (Subdivision 2) The state pays 47 percent of the cost of purchased or rented supplies and equipment for use in instructing handicapped children, up to $47 per pupil per year.

Travel aid (Subdivision 2b) The state pays half a district's expenses for necessary travel of essential personnel providing home-based service to handicapped children under age 5.

Residential aid (Subdivision 5) Under certain conditions, the state will pay 57 percent of the difference between the instructional cost charged to the district for a child placed in a residential facility and the basic revenue paid by the state for that child.

Special pupil (Subdivision 6) The state will pay all costs of educating a handicapped child who has no home district because its parents' rights have been terminated or the parent or guardian lives outside the state, less the general education basic revenue allowance and any other aid earned on behalf of that child.

Summer school (Subdivision 10) The state pays aid for summer school programs for handicapped children based on the previous year's teachers' salaries, contract services and residential aid.

Non-salary personnel expenditures

The direct aids do not cover the cost of benefits paid to personnel of the school district. It is estimated that 90 percent of the cost of special education was personnel cost. Benefits include health insurance (8 percent), FICA (7.65 percent), Teacher's Retirement Association (8.98 percent) and life, disability and dental coverage. Not all these benefits are provided by all districts.

The state share of this expense has decreased to zero over the last five years. In FY 86, the state paid all employer obligations to the teacher retirement funds and Social Security. In FYs 87 and 88, the state required school districts to make employer contributions for amounts exceeding the state aid payments. In FYs 89 and 90, the school districts paid the full amount of the cost of benefits.

Secondary vocational education aid for handicapped children

The state provides funds to school districts for secondary vocational education for handicapped children. This funding category was created by the 1978 Legislature (M.S. 124.574).

The vocational education services provided include support service facilitation and vocational evaluation and assessment. A support service facilitator works with students and arranges math and reading skill support, technical tutoring, job coaching and curriculum modification. Vocational evaluation and assessment is a process to identify a student's interests and abilities.

State aid for this program increased by 44 percent from FYs 86 through 90.

This program serves all handicapped children. The districts report only the total number of students receiving vocational education services, not the disability category of the students receiving services. Consequently, this report shows only estimated costs of vocational education to mentally handicapped children because actual data was not available. The Department of Education estimates that 80 percent of the handicapped children receiving services in 1986 were mentally handicapped. This percentage had probably fallen to between 50 and 60 percent by 1990, a reduction of approximately seven percentage points per year. While there was no quantifiable data to support these estimates, the Department of Education perceives that the population being served was changing from mostly mentally handicapped children to those with more severe and multi-handicapping conditions, such as emotional disorders.

General revenue aid

In addition to the direct aid for special education discussed above, the state provides general revenue aid to school districts (formerly called foundation aid) on a weighted average daily membership basis. The 1990 weighted average daily membership formula allowance was $2,838.

Each school district receives this general education revenue based on the number of children attending its schools, including both handicapped and non-handicapped children. The general education revenue was not included in this summary of special education expenditures, with three exceptions: (1) the general education revenue

applied to children in early childhood special education (these costs are included because these children would not have been enrolled in schools if not for their diagnosis of mental handicaps); (2) handicapped kindergarten general revenue aid, to the extent that the foundation aid for handicapped kindergarten students exceeded the aid for other kindergarten students; and (3) general revenue aid for students 19 to 21 years old (these costs are included because it was assumed in this study that children 19 to 21 years of age would have already graduated had it not been for their mental handicap).

The total direct aid and spending amounts were provided by the Department of Education. The total includes residential aid and summer school for children with handicaps. Actual amounts for these two categories were not available for FY 90; therefore, FY 89 cost levels were assumed for these categories.

The breakdown between federal, state and local contributions was made as follows:

The federal contribution was reported separately by the Department of Education. The remainder was allocated between state and local contributions based on estimated contribution levels. Using funding amounts and formulas in Minnesota statutes, the Department of Education estimated that the percentages of total costs paid by the state in FYs 86 through 90 were:

FY 86 - 64.43%

FY 87 - 62.83

FY 88 - 59.15

FY 89 - 55.53

FY 90 - 55.52

These estimated contributions include an underallocation amount (pro-rata allocation) that effectively reduced the amount of state aid to local school districts. The percentages were applied to the total expenditures for each year to determine the state contribution amounts shown.

Total non-salary personnel costs were estimated to be 25 percent for direct aid and spending. The state contribution for this category of spending decreased from approximately 60 percent in FY 86 to zero in FY 89. The state contribution amounts of 40 percent in FY 87 and 20 percent in FY 88 were estimated because actual contribution amounts were not available.

General revenue aid to children in Early Childhood Special Education, to kindergartners who were handicapped, and to 19- to 21-year-old students was estimated by the Department of Education. The amounts for children in Early Childhood Special Education and kindergarten were reduced by 50 percent because it is estimated that 50 percent of these children will be diagnosed as having mental retardation. The amount of funding for kindergarten for children with disabilities was reduced by another 50 percent because aid for children with disabilities is increased by one-half of a pupil unit due to their disabilities (that is, regular kindergarten receives funding for one-half of a pupil unit, but kindergarten for children with disabilities receives funding for one pupil unit, a difference of one-half of a pupil unit).

Table 26. Day training and habilitation: expenditures

The source of data for expenditures of day training and habilitation services for Calendar Year 1985 was a report from the Developmental Disabilities Division of the Department of Human Services. For Calendar Years 1986, 1987 and 1988 the source was data from the Governor's Planning Council on Developmental Disabilities, published in Policy Analysis Papers 25, 28, and 29. Calendar Years 1989 and 1990 data was forecasted by the Long-term Care Division of Human Services.

Data was adjusted from calendar to state fiscal year.

Expenditures were based on actual and forecasted numbers provided in a survey of all day training and habilitation providers. Day training and habilitation services are financed according to several criteria -- a person's place of residence (in the case of an intermediate care facility for the mentally retarded, Medical Assistance funds), other services received (Home- and Community-based Waiver recipients have services paid by Medical Assistance), and other criteria (people not in one of the above programs have services paid through county social service funds).

Other government funding sources include schools, cities, state or federal grants, and the Department of Jobs and Training.

Waiver expenditures are reported in total on a separate table. Numbers transferred to the summary table (Table 1) are the day training and habilitation expenditures excluding costs attributed to waiver recipients.

The total expenditures attributed to different jurisdictions were calculated in two ways and summed. The first method examined the source of funds for persons who resided in an intermediate care facility for the mentally retarded. The source of funds for these persons was based on the matching requirements of Medical Assistance (Table 3). For persons who received funding through county social services, these funds were a mixture of federal Title XX block grant, state Community Services Social Act block grant, and county levies. The estimated percentage from each of these sources by year was shown in the discussion of Table 1 in this appendix. These percentages were applied to each total to arrive at a total cost by government body. Other costs were attributed to county sources. An example for 1990 would show:

	Federal	State	County
MA - ICF/MR	**$14,188,984**	**$11,405,988**	**$ 1,267,929**
County social services	**2,617,183**	**2,599,134**	**12,833,222**
Other	**0**	**0**	**847,295**
Total	**$16,806,167**	**$14,005,122**	**$14,948,446**

Table 27. Day training and habilitation: recipients

The number of persons receiving services in a day training and habilitation program as of Dec. 31 of each fiscal year was used as the base number of clients for this analysis.

Changes in federal law allowed for children ages 3 to 5 to be served by school districts, beginning in 1986. Minnesota legislation further extended educational services to children from birth to age 2. This shift in children's services from day training and habilitation to local school districts was completed in fall 1988.

Persons by place of residence for those funded through county social services included those living independently, living with natural family or relatives, receiving residential support through the semi-independent living program, or in foster care (not related to the Home- and Community-based Waiver), board and care facilities, nursing homes, or other group living facilities.

Average monthly costs per person were calculated by dividing total expenditures by 12 and the total number of persons served.

Average approved statewide per diems (including transportation per diems) by calendar year were:

1986	**$31.69**
1987	**34.19**
1988	**35.73**
1989	**38.72**
1990	**41.78**

Table 28. Case management

Information about county social services spending in Minnesota, which partially supports case management, can be found in the Table 1 discussion in this appendix.

In FY 90, case management expenditures from state sources included a state Community Social Services Act block grant of $2,143,554, and a state appropriation from the regional treatment center negotiated agreement of $1,100,000.

Data for recipients of case management supported by county funds was taken from social service expenditure and service recipient reports submitted to Human Services. Total costs of case management, reported by the counties to the department's Social Services Division, are reflected in annual department reports: *Social Services in Minnesota* for 1985 through 1988. Waiver case management data was reflected in the department's report No. 372 to the Health Care Finance Administration. The cost of case management under the waiver shown in the federal reports was subtracted from the case management expenditures reported in the county social service reports to calculate only county social service funding of case management.

There was no way to verify the accuracy of the number of persons receiving case management services or the expenditures on case management services reported by the counties to Human Services. The county data was reported on a calendar year basis and adjusted to fiscal year for this report.

Table 29. Screening

Screening services are usually funded by Medical Assistance and are related to qualifying for a Medical Assistance program. Data was available regarding Medical Assistance funding for screening for FYs 89 and 90. It was assumed that previous years' data represented Medical Assistance reimbursement for screening costs. It was unknown how much of reported screening costs for the previous years was paid by counties.

Data was from county social service reports to the Human Services Social Services Division for Calendar Years 1985 through 1988 and from projected data for 1989 and 1990. Information on Medical Assistance expenditures for screening was provided by the Reports and Statistics Division of Human Services.

Table 30. Semi-independent living services

Data on expenditures and persons served was provided by the Developmental Disabilities Division of the Department of Human Services.

State and county governments share in the cost of semi-independent living services at a predetermined rate readjusted at year's end. An initial rate is established for each year based on the availability of dollars and the expected cost of care. The state determines this rate of allocation and later adjusts it based on unused appropriations and the number of persons served. In FY 90, the initial rate was 62.5 percent state and 37.5 percent county. It was adjusted to the final rate of 70.7 percent state and 29.3 percent county. The final rate was used in allocating state and county expenditures for each fiscal year.

The average annual and monthly costs were calculated by dividing total expenditures by the number of persons served and the applicable time period. Rates for services are by the hour and ranged between $6.99 and $25.95 in FY 90. A total of 248,295 hours of service were provided in FY 89.

Table 31. Family subsidy program

Data was provided by the Developmental Disabilities Division of the Department of Human Services.

The average monthly grant was calculated by dividing total expenditures by 12 and the average number of families served per month. Grants are not issued on a first-come, first-served basis. The likelihood of a family receiving a grant is based on an assessment of an individual situation compared with that of other families.

Table 32. Waiver support: expenditures and recipients

Data on waiver expenditures for FYs 86 through 89 was from the Reports and Statistics Division of the Department of Human Services No. 372 reports to the Federal Health Care Financing Administration. These reports are filed six and 18 months after the close of the fiscal year. The six-month reports are known as initial reports, the 18-month reports as lag reports. Lag reports were used for FYs 86, 87 and 88. An initial report was used for FY 89.

FY 90 data was provided by the Developmental Disabilities Division of Human Services from county encumbrance data.

Average daily costs were calculated by dividing total expenditures by the number of recipients and 365 days. No attempt was made to try to account for different intensity of service use. Average costs would be significantly different for actual service units per person.

Waiver per diems are capped, that is, counties must spend at or below the per diem averaged across all recipients. The approved per diems for each fiscal year were $58.92 for FY 86 (estimated), $61.46 for FY 87, $63.67 for FY 88, $66.79 for FY 89 and $71.50 for FY 90. The approved rate for FY 91 is $76.50.

Table 33. Waiver support: recipients

The unduplicated number of persons served was derived from the Health Care Financing Administration No. 372 reports submitted by the Reports and Statistics Division of Human Services for FYs 86 through 89. Data for FY 90 was provided by the Developmental Disabilities Division.

Table 34. Assessment

Information about county social services spending in Minnesota, which partially supports the assessment program, can be found in the Table 1 discussion in this appendix.

Allocation of expenditures by government sources assumed that all assessment costs were paid with social services dollars. Medical Assistance dollars do reimburse for assessment, but there is no means to determine these costs.

Table 35. Respite care

Expenditures in Table 35 are for that portion of respite care funded by county social services spending. Information about county social services spending in Minnesota, which partially supports respite care, can be found in the Table 1 discussion in this appendix.

Data was from two sources: Department of Human Services waiver reports to the federal government and county social service reports to the Department of Human Services.

Respite care can also be paid for with Medical Assistance funds for services under the Home- and Community-based Waiver and through use of family subsidy funds. Nearly half of all family subsidy expenditures are for respite care. The expenditures in Table 32 account for Home- and Community-based Waiver respite care expenditures, but not for potential family subsidy costs. The degree of overlap there might be with family subsidy expenditures was unknown.

Table 36. Counseling

Data was provided by the Department of Human Services Social Services Division, via the summary of county social service expenditures and recipients.

Information about county social services spending in Minnesota, which partially supports counseling, can be found in the Table 1 discussion in this appendix.

Table 37. Personal care services

All data for these costs and recipients was from county social service reports to the Department of Human Services.

Information on county social services spending in Minnesota, which partially supports personal care services, can be found in the Table 1 discussion in this appendix.

The large jump in personal care expenditures was likely due to a change in state Medicaid practices regarding personal care services. Personal care beginning in FY 89 was paid through provider organizations rather than to individuals. Counties would use Medical Assistance funds for a Medical Assistance-eligible person before using county funds. However, it was unknown what percent or amount came from Medical Assistance dollars.

Table 38. Acute care (waiver clients)

Acute care cost and recipient data for FYs 86 through 89 was provided by the Reports and Statistics Division of Human Services based on Health Care Financing Administration No. 372 reports. The breakdown among services was not available for FY 90.

The large increase in average monthly acute care costs may be due to two factors: In the initial years of the waiver, persons were placed on the waiver toward the end of the fiscal year, which resulted in underestimating the total costs of acute care needs throughout the year; and second, as persons became stabilized in community settings, utilization increased.

Table 39. Acute care (RTC, ICF/MR residents)

Acute care costs were provided by the Reports and Statistics Division of the Department of Human Services for FYs 88 and 89. Because no accurate data was available for FYs 86 and 87, estimates were based on FYs 85 and 88 data. FY 90 data, not broken down across services, was derived from budget figures for the FY 92-93 biennium.

Average costs per month grew by an average of 10.5 percent per year. Although no figures were available for all five years to distinguish between acute care costs for regional treatment centers and intermediate care facilities for the mentally retarded, data was available for FYs 88, 89 and 90. Data for FYs 89 and 90 was provided from Human Services' FYs 92-93 budget preparations.

Table 40. Acute care: other costs

This data was provided by the Reports and Statistics Division of Human Services.

"Other" costs account for the largest dollar amount and percent of the total. For persons on the Home- and Community-based Waiver, the share from other acute care costs grew from 41.5 to 54.1 percent from FY 86 through FY 89. For persons in regional treatment centers, the share remained at about 49.8 percent. For waiver recipients, the largest "other" expenditures were for home health services, medical supplies, and rehabilitation. For persons in regional treatment centers, the largest groups were medical supplies and state mental illness or chemical dependency services. For persons from intermediate care facilities for the mentally retarded, the largest group was from rehabilitation, medical transportation, medical supplies, and psychological services.

Table 41. Additional CSSA services

This data was from the county social service reports submitted to and summarized by the Department of Human Services. Information about county social services spending in Minnesota, which partially supports personal care services, can be found in the Table 1 discussion in this appendix.

Homemaking service expenditures are in addition to spending for such services under the Home- and Community-based Waiver. Semi-independent living program expenditures are in addition to the state-administered semi-independent living program. Many of these expenditures would be for individuals not served under the state programs.

Table 42. Children's home care option

Expenditures and number of persons served were estimated based on a percentage of children who would be at risk of placement in intermediate care facilities for the mentally retarded. Total children served and total children's home care option expenditures were provided by the Long-Term Care Division of Human Services. The percentage of children at risk of placement in intermediate care facilities for the mentally retarded was used to determine the total number of children with developmental disabilities and corresponding expenditures.

Appendix B.

COST-CONTAINMENT MECHANISMS

COST-CONTAINMENT MECHANISMS

This appendix describes a variety of cost-containment mechanisms used in health care and social service delivery systems. Descriptions include examples of the mechanisms' uses in the developmental disability system and others, as well as a brief discussion of advantages and disadvantages associated with each strategy. Cost-containment mechanisms described include:

Prior authorization

Utilization review

Limits on supply

Cost sharing

Affecting consumer demand and choice

Setting caps on costs

Transferring risk to providers

Case management

The selected bibliography at the end of this appendix provides sources for additional information on these cost-containment mechanisms.

Prior authorization

With *prior authorization,* the funding source requires that it pre-approve the spending of its funds in order for the provider to receive payment for services.

Prior authorization is used to ensure that the services to be delivered are included in the list of services covered by the funding source, that the prescribed services will meet the needs of the client, and/or that least-expensive alternatives are selected where appropriate.

Examples of use In most health maintenance organizations (HMOs), a primary care physician must authorize the use of plan and specialty services. In the Medicaid program, all services must receive prior authorization in order to be reimbursed.

Examples of use in the developmental disability service system include those funded under a state's Medicaid plan or through waivers of Medicaid, both of which must receive prior authorization by the state Medicaid agency. Any Medical Assistance service to be provided to a client must be included in the individual service plan developed and approved by the client's case manager.

Pros and cons An advantage of prior authorization is that it prevents providers from expending funds for which it won't be reimbursed, which in turn can limit the overall cost of care. It can also assist in ensuring quality, because both the provider and the funding source must agree on the appropriateness of services before they are provided.

A disadvantage of prior authorization is that it does not take into account whether services have actually been provided as expected. Also, prior authorization is required under Medicaid primarily to ensure that the services are covered by Medicaid, rather than to ensure that services are appropriate for the client or cost effective. Prior authorization also may have relatively little affect when dealing with entitled services, since the funding source cannot deny the provision of services to which an individual is entitled. Further, when services are denied through prior authorization, access is decreased.

Utilization review

With *utilization review,* the funding source reviews the services after they have been provided, and decides whether to reimburse the provider.

Narrowly defined, utilization review is an auditing procedure on costs to ensure that the provider of services has met its contractual obligations to the funding source.

At its broadest, utilization review is used to accomplish the same basic goals as prior authorization -- to ensure that services are covered by the funding source's plan, are of reasonable cost given the alternatives, and/or are appropriate to meet client needs. Utilization review is also used to ensure that services have been delivered in accordance with the funding source's expectations and regulations.

Examples of use Nearly all public and private payers monitor the provision of services and related payments through utilization review. Minnesota Medical Assistance rules authorize a "post-payment review process" to ensure compliance with Medical Assistance requirements by monitoring "both the use of health services by recipients and the delivery of health services by providers" (Minnesota Department of Human Services, 1990*).

An example of use in the developmental disability services system is those developmental disability services funded by Medicaid, which are subject to utilization review.

Pros and cons A major benefit of utilization review is that it allows the funding source to evaluate how services were actually provided and received, not just how their provision and reception was intended. Utilization review can be important in controlling abuse and fraud, and in ensuring appropriateness of care. Further, if the funding source requires utilization review -- which focuses on outcomes -- the funding source may then allow the provider more flexibility in deciding how services are provided, as long as certain outcomes are achieved. The state could subject the procedural aspects of case management to less regulation, for example, as long as the utilization reivew process demonstrated acceptable client outcomes (for example, increased client satisfaction and independence).

A problem with utilization review is that it can create tremendous tension between providers and funding sources if payment for services is disallowed after the services have been provided. Reviewing procedures and outcomes can also require a significant commitment of the funding source's time and staff. Further, outcome measures to be used in utilization review may be difficult to agree upon and develop.

---

*Complete references can be found on Page 11 of this appendix.

Limits on supply

With *limits on supply*, the funding source restricts the number of facilities or services that may be developed and/or funded.

Examples of use Minnesota and other states have limited the supply of skilled and intermediate care facilities by placing a moratorium on new bed construction. Certificate-of-need regulations attempt to limit "the number of institutions and services, such as hospitals and nursing homes, to services that are certified as necessary by regulatory agencies" (Iversen, 1988). Medicare and private insurers set limits on the number of days (or hours or other units of service) that they will fund hospital, home health or nursing home care.

An example of use in the developmental disability system is the moratorium on intermediate care facility construction in Minnesota, which applies to intermediate care facilities for the mentally retarded. Some states set annual limits on the number of hours of case management or respite care that can be provided to clients with developmental disabilities or their families. In the Home- and Community-based Waiver, there are a limited number of waiver openings reserved for persons who are being deinstitutionalized or diverted from institutionalization.

Pros and cons One advantage often associated with limiting supply is its directness and simplicity. A moratorium on institutional bed construction sends a clear message to providers and consumers about what services can be expanded and what services are likely to be available. Presetting limits on the number of units of service covered by an insurer lets consumers know what will or will not be covered. Another advantage of limiting the supply of a service that is viewed as costly, inappropriate or overused is that it can encourage the development of alternatives to that service.

A disadvantage to limiting supply is that it can restrict access to care for persons who need it. Moratoriums, for example, may limit institutional care, even when the need for beds is great and community-based services are not available. Also, decreasing access is not always a good idea, even from a purely financial standpoint. Persons discouraged from seeking relatively inexpensive preventive care or services may later need a more intensive level of services that could have been avoided. A disabled child's parents who are under stress and unable to obtain respite care, for example, may later feel it necessary to place their child in a group home. Also, universally-applied limits on the number of units of service a person can receive do not take into account individual differences in need. A 30-hour limit on case management, for example, may be sufficient for some persons, and inadequate for others.

Cost sharing

With *cost sharing,* funding sources attempt to share the cost of care with clients or other funders.

Cost sharing is a cost-containment mechanism used by most private and public funding sources. Client contributions may come in the form of premiums, deductibles or copayments. Funding sources may also reduce their liability by requiring that they be the funder of last resort.

Examples of use Medicare and private insurance policies typically include large deductibles, premiums and copayments. Minnesota Medical Assistance rules state that private accident and health care coverage, including HMO coverage, is considered the primary source of payment. Medical Assistance requires individuals who do not meet income eligibility criteria to "spend down" their personal income and assets until they do.

Examples of use in the developmental disability system include new provisions for cost sharing of developmental disability services recently passed or on the horizon. In the past, for example, the Tax Equity and Fiscal Responsibility Act (TEFRA) deemed children with developmental disabilities eligible for Medicaid, regardless of parental income. Now, however, parents are expected to contribute to the cost of care, based on their ability to pay. The Health Care Financing Administration, which administers Medicaid at the federal level, has indicated that states should incorporate other types of user fees into their developmental disability case management systems.

Pros and cons The advantages of using cost sharing are at least threefold. First, payments made on behalf of the client, whether out-of-pocket or made by other insurers, can substantially reduce the amount of money the funder must expend to meet client needs. Often, one funder is simply unable to bear the full cost of providing care. Second, if clients must pay a portion of the services themselves, they may be more likely to carefully evaluate their need for care, and generally less likely to seek care. Third, cost sharing may be seen as a way to more equitably finance care. Cost sharing based on service use, for example, may be viewed as an equitable cost-containment mechanism because persons who use the services pay a greater proportion of the cost. Cost sharing based on ability to pay also is often seen as a "fair" way to allocate resources.

However, cost-sharing mechanisms can be difficult to administer and costly to implement (for example, developing user fees and developing methods for fairly measuring ability to pay). Also, cost sharing may reduce access to services. As previously discussed, reducing access can both decrease client well-being and increase overall costs of care. Further, cost sharing based on service use may place a significant financial burden on persons who need many services. Finally, cost sharing between fiscal bodies can create incentives that may increase the overall cost of care. In the developmental disability system, for example, county case managers may have incentives to steer clients to institutional care (which is paid entirely by state and federal government) rather than noninstitutional care (for example, Semi-independent Living arrangements, which are paid in part by counties), even though the noninstitutional alternative is much less expensive overall.

Affecting consumer demand and choice

When *affecting consumer demand and choice,* costs are contained by decreasing or directing consumer demand for certain services. Such strategies include restricting eligibility for services, limiting a client's choice of providers, limiting outreach efforts, and (as previously discussed) cost sharing.

Examples of use HMOs generally are closed systems, requiring members to obtain standard plan services from providers selected by the HMO. Case managers may direct clients from institutional care to less-expensive community-based alternatives. Advocates have claimed that participation in the Supplemental Security Income program is low because the administrative process for applying for benefits is difficult and sufficient efforts are not taken to let persons know they are eligible for benefits (Minnesota Board on Aging, 1990).

Examples of use in the developmental disability system include Minnesota's case management system, where case managers are expected to assist individuals in choosing less-expensive and more-appropriate alternatives to institutional care. Generally, client choice in case managers is limited to case managers who are employees of the county in which the client resides. Also, eligibility for services provided through Medicaid's Home- and Community-based Waiver is limited to persons at risk of institutionalization.

Other changes in the developmental disability system have worked to expand rather than decrease consumer choice and accessibility to services. Since 1977, all Minnesotans diagnosed as having a developmental disability have had a case manager available to assist them in accessing services. Eligibility criteria for system services were expanded in 1985 when the definition of "developmental disability" was expanded from mental retardation to mental retardation and related conditions.

Pros and cons Directing clients' choice of services in the developmental disability system often means assisting clients in understanding and selecting alternatives to institutionalization. This can be advantageous by both containing costs and improving clients' quality of life. Also, when funding sources limit the number of types of providers a client can choose from, clients usually have some choices within those limits. Thus, limits on choice can be relatively painless for clients.

On the other hand, limiting choice can adversely affect quality of care if clients cannot choose a new provider when they are dissatisfied. Limiting eligibility, limiting outreach efforts and implementing cost-sharing strategies can all serve to reduce access to services, which can have an adverse affect on both clients and overall costs.

Setting caps on costs

When *setting caps on costs,* funding sources may limit the cost of the service or set of services to be provided.

Examples of use Rates paid to Minnesota nursing homes are capped through a case-mix system containing 11 levels of reimbursement. Specifically, patient needs are categorized on a scale ranging from A to K, where K includes clients who need the greatest amount of care.

Medicare's reimbursement to hospitals is another example of capped rates. In this case, providers receive a specified amount per patient with a particular diagnosis. This amount, which varies by hospital, is set in advance. Thus, hospitals have "an incentive to search for efficiency and to conserve resources, since the amount (they) receive per diagnosis will be fixed in advance" (Fein, 1989).

Examples of use in the developmental disability system include the capping of service rates in Minnesota for intermediate care facilities for the mentally retarded and day habilitation. Developmental disability services paid through the Home- and Community-based Waiver are also subject to caps. Average per capita expenditures are not to exceed the "average per capita expenditures for the level of care provided in an intermediate care facility for the mentally retarded that would have been made had the waiver not been granted "(Minnesota Department of Human Services, 1987). Service costs can exceed the average rate of an intermediate care facility for the mentally retarded as long as aggregate Medical Assistance costs under the waiver are less than the aggregate cost of Medical Assistance without the waiver.

In several states, including Minnesota, the legislature allocates a limited amount of money to fund a service such as semi-independent living arrangements, and when the money runs out, no additional services are provided.

Pros and cons Caps are a clear way of pointing out acceptable costs to providers, giving them incentives to control costs. These limits can allow funding sources to adequately plan, prioritize and anticipate expenditures.

However, one disadvantage in setting caps is that it requires a reimbursement formula that adequately reflects real differences in provider costs and client needs, if providers are to be appropriately reimbursed. Accurate allocation formulas can be difficult to develop, so that providers may be overpaid or underpaid for the services they provide.

Limited appropriations can also result in a first-come, first-served policy, so that people who need services after the money is expended cannot receive them, regardless of their level of need. By giving providers incentive to provide services below the caps, capped rates may also be an incentive to reduce the scope of services. Medicare patients, for example, have complained that they leave hospitals "sicker and quicker" due to hospital reimbursement policies.

Transferring risk to providers

In *transferring risk to providers,* the funder sets a cap on the cost of the service package, and then holds the provider "at risk" for the cost of the services used. If costs exceed the cap, the provider absorbs the loss. If costs are below the cap, the organization keeps all or some portion of the savings.

Examples of use Medicare and Medicaid HMOs are prepaid a fixed amount per enrollee, and are at risk for the cost of services provided. Generally, the Health Care Financing Administration pays the HMOs 95 percent of the expected cost of services had the enrollee not been an HMO member, theoretically saving 5 percent for each Medicare or Medicaid recipient enrolled.

Examples of use in the developmental disability system include the right of persons with developmental disabilities to be enrolled in HMOs. HMOs may be designed to serve a general population and/or specifically tailored to address the needs of Medicare beneficiaries, Medicaid recipients or persons with mental illness (Scheffer and Rossiter, 1989).

It does not appear that there are any HMOs or other risk-sharing plans developed exclusively to serve persons with developmental disabilities. However, the development of these types of organizations has been proposed on the grounds that they could provide well coordinated, less-expensive services to persons with a developmental disability (Friswold et al., 1987; Cole, 1987).

Pros and cons An advantage to shifting the risk of the cost of care to providers is that it allows the funder to plan and limit liability. Also, risk sharing gives providers significant incentive to control costs, since they save money when the cost of care is below the capped rate and lose money when the cost of care exceeds the cap. Further, because of these incentives, providers may be more likely to provide preventive care as well as community-based alternatives to institutionalization, if that is viewed as a way to contain costs. Last, risk sharing gives providers much more flexibility to meet individual needs than do traditional funding mechanisms -- providers generally are free to provide any type of service to the client to meet needs, rather than being restricted to certain types of approved care.

A major concern with risk sharing is that incentives to contain costs may also be incentives to reduce access to services. This is a particular concern when serving a vulnerable population such as persons with developmental disabilities. Also, risk sharing requires the development of a capitation formula that reflects actual costs and risks. This has been a problem with Medicare HMOs.

Case management

With *case management,* clients are assigned a case manager who plans, coordinates and monitors the services used.

Definitions of case management vary widely. Generally speaking, case management is a process of linking clients to services. This process includes intake, needs assessment, individualized planning, coordination of services, monitoring, advocacy, and cost containment (see companion report, *Minnesota's Case Management System for Persons with Developmental Disabilities*). Case management may be developed to meet various, sometimes conflicting goals. Sometimes, cost control is not mentioned as a case management function. In other cases, cost control is case management's primary function.

Examples of use Numerous demonstration projects have involved case management for the elderly as a means of saving money by diverting seniors from nursing home care. These demonstration projects have emphasized the role of case management in assisting persons to obtain the care they need, as well as containing costs.

HMOs frequently use case management as a means of cost containment, as described in this excerpt from an article on Medicaid HMOs:

> The notion of managed care -- sometimes called case management or gatekeeping -- is a coordinating and rationing strategy designed to exploit the unique role of the primary care physician and key to cost containment (Freund et al., 1989).

An example of use in the developmental disabilities system includes the fact that all persons with developmental disabilities in Minnesota have access to a county case manager. Policies and opinions affecting Minnesota's system vary regarding the role the case manager should play in containing costs (Minnesota Department of Administration, 1991).

Pros and cons Case management can improve access by helping clients navigate the service system, and can help clients obtain appropriate, quality care by assessing needs and monitoring services. Case management has the potential to reduce costs in several ways. First, case managers are often expected to develop a package of noninstitutional services for clients that can substitute for costly institutional care. Second, the coordination of services can save money by eliminating services that are duplicative or that work at cross purposes. Further, case management may help to contain costs if the case manager can assist the client in obtaining preventive care and services that obviate the later need for more expensive and intensive care. Last, the total cost of the service package developed by the case manager may be capped (see companion report).

One disadvantage of case management is that it is often developed to meet unclear and/or conflicting goals such as improving access and controlling costs. This can result in conflicts of interests for case managers, and hostile relationships among the providers, funding sources, administrators and recipients of case management services. Unclear cost vs. access goals can also result in service plans being

required even though there is no money to fund them. Consequently, case managers may spend considerable time developing plans that are never used (leaving them less time to assist other clients), client expectations may be falsely raised, and long waiting lists for services may result.

Also, case management systems vary tremendously from state to state and among service systems, with no clear indication of what type of model is best at meeting various system goals. Problems with case management systems for persons with developmental disabilities often cited in the literature include heavy caseloads, ineffective leadership, inadequate training, and lack of role clarification (McAnally and Linz, 1988). Noted problems with Minnesota's system include: Individual services are difficult for case managers to provide; there are no formal cost-containment mechanisms tied to case management; and simplicity and common sense are missing in the system (Minnesota Department of Administration, 1991).

As noted, case management systems for persons with developmental disabilities have not generally been used to control costs. Demonstration projects of case management for elderly persons, in which individuals at risk of institutionalization were to be diverted to the community, have indicated that case management actually increases costs by increasing the demand for community-based services without decreasing nursing home utilization (Iversen, 1988). The cost-effectiveness of other models of case management is largely unknown.

REFERENCES / SELECTED BIBLIOGRAPHY

Cole, R., "Community-based Prepaid Medical Care for Adults With Mental Retardation: A Proposal for a Pilot Project," *Mental Retardation,* Vol. 25:223-225, August 1987.

Fein, Rashi, *Medical Care, Medical Costs: The Search for a Health Insurance Policy,* Harvard University Press, Cambridge, Mass., 1989.

Freund, D.A., R.E. Hurly, J.E. Paul, C. Grubb, L.F. Rossiter, and K.W. Adamache, "Interim Findings from the Medicaid Competition Demonstrations," *Advances in Health Economics and Health Services Research: Risk-based Payments Under Public Programs,* R. Scheffer and L. Rossiter, eds., Vol. 10, JAI Press, Greenwich, Conn., 1989.

Friswold, K., M. Msall and R. Cooke, "A University-based HMO for Persons with Development Disabilities: An Editorial," *Mental Retardation*, Vol. 25:233-235, August 1987.

Iversen, L.H., "Utilization Control: What's Appropriate for Long-term Care?" *InterStudy's Long-term Care Expansion Program: Issue Papers,* InterStudy, Excelsior, Minn., 1988.

McAnnally, P., and M.H. Linz, *Minnesota Case Management Study,* University of Minnesota, Minneapolis, 1988.

Minnesota Board on Aging, Interagency Board for Quality Assurance, *Seniors Agenda for Independent Living*, prepared for Gov. Rudy Perpich, St. Paul, 1990.

Minnesota Department of Administration, Management Analysis Division, *Minnesota's Case Management System for Persons with Developmental Disabilities*, St. Paul, 1991.

Minnesota Department of Human Services, "Home- and Community-based Services Waiver Renewal Request Pursuant to Section 1915 (c) of the Social Security Act for the Period July 1, 1987, to June 30, 1992, submitted March 1987, amended with additional information, May 15, 1987."

Minnesota Department of Human Services, *Medical Assistance and General Assistance Medicare Care Provider Manual*, Fiscal Year 1990 edition, St. Paul, 1990.

National Association of State Mental Retardation Program Directors, *Medicaid Home- and Community-based Services for Persons with Developmental Disabilities: The Home- and Community-based Waiver Experience,* NASMRPD, Alexandria, Va., 1989.

Scheffer, R., and L. Rossiter, eds., *Advances in Health Economics and Health Services Research: Risk-based Payments Under Public Programs,* Vol. 10, JAI Press, Greenwich, Conn., 1989.

Appendix C.

INVENTORY OF SUGGESTED COST-CONTAINMENT ALTERNATIVES

INVENTORY OF SUGGESTED COST-CONTAINMENT ALTERNATIVES

This appendix lists various cost-containment recommendations that were presented to the Management Analysis Division project team in the course of its work. The proposals were made by a variety of sources described below.

No attempt has been made to analyze these recommendations or to assess whether they would in fact have positive impacts on costs. All suggestions that directly or indirectly aim to contain costs or promote efficiency have been included. This list should be used as a discussion piece and should not be seen as recommendations of the Management Analysis Division.

Items are listed within the following topical categories:

Allocation of resources
Case management enhancements
Case management funding
Case management roles
Case management rule (Rule 185)
Day programs
Delivery models and service philosophy
Department of Human Services' role
Family supports
Home- and Community-based Waiver
Intermediate care facilities for the mentally retarded
Local role
Regional treatment centers
Rules, licensing and quality controls
Semi-independent living services
Special education
State-operated community services

The numbers in parentheses after each item indicate its source:

1-21 -- Individual interviews with legislators, other state and county officials, advocates and system experts.

22-34 -- Focus group discussions and brainstorming. Groups included people with developmental disabilities, parents, public and private-sector service providers, Greater Minnesota residents and standing advisory committees. (The focus group code number should not suggest that the entire group endorsed the recommendation.)

35-52 -- Officials from other states and the federal Health Care Financing Administration.

53 -- Project advisory group selected by the Developmental Disabilities Division of the Department of Human Services.

54-60 -- Private-sector providers informally interviewed during site visits.

Allocation of resources

Provide services subject to appropriations only. Eligibility for services should not create an entitlement to services (8, 37, 38, 41, 42, 43, 44).

Build service priorities into the system (11, 15, 16, 22, 23, 26).

The state cannot afford two systems: the public-sector system (regional treatment centers, state-operated community services) and the private-sector system (intermediate care facilities for the mentally retarded, waivered services, etc.) There should be only one system and it should be community-based (1, 5, 24, 29).

Consolidate funding and have it follow the clients (23, 26, 53).

Provide services subject to the availability of "slots" for particular services (39, 50, 53).

Consider the use of fixed-price contracts or capitation approaches (11, 12).

Society cannot maximize everyone's full human potential. Acknowledge a point of diminishing returns. Design a model to allocate services accordingly (11, 33).

Put dollar caps on expensive cases (18, 23).

Eliminate the priority status that regional treatment center residents receive. They use up an inequitable share of resources and could be served less expensively in the community (24, 56).

Develop a managed-care model of service delivery (a social service "HMO") on a pilot basis (52, 53).

Do not require that service levels be "optimal." Meet basic needs, but beyond that, consider costs and other service populations' needs (2).

The challenge is to reorganize the dollars now being spent (4).

KEY

1-21 -- Individual interviews with legislators, other state and county officials, advocates and system experts.

22-34 -- Focus group discussions and brainstorming. Groups included people with developmental disabilities, parents, public and private-sector service providers, Greater Minnesota residents and standing advisory committees. (The focus group code number should not suggest that the entire group endorsed the recommendation.)

35-52 -- Officials from other states and the federal Health Care Financing Administration.

53 -- Project advisory group selected by the Developmental Disabilities Division of the Minnesota Department of Human Services.

54-60 -- Private-sector providers informally interviewed during site visits.

Make the same level of legislatively mandated services available to all service populations (7).

Stakeholders must be involved in the implications of rising costs in order to slow the increases (15).

Identify the minimum acceptable standards (standard of living and service standards) that will not be compromised, and recognize that one is dealing with options beyond that (15).

Build market forces and constraints into the service delivery system (15).

Use selected Medical Assistance copayments (15).

Consider the applicability of a consolidated fund approach, as is used in chemical dependency (15).

Cap developmental disabilities program costs (with adjustments for inflation only), and force prioritizing of services (19).

Minnesota should look for new types of federal waivers, including "HMO" approaches (21).

Move toward regional providers and package bidding (21).

Allow counties to encumber funds so they do not have to spend money just because they have it (22).

Do not build a community-based system without downsizing the state system (23).

Individuals allocating resources must learn to say "no" (23).

Continue to fund existing programs, rather than developing a new focus every year (27).

Develop the case management case-mix approach as a demonstration waiver under Medicaid; include people who are in intermediate care facilities for the mentally retarded (52).

Counties need to develop criteria to prioritize who receives in-home services, because demand is phenomenal (59).

Case management enhancements

Improve training (4, 5, 34).

Conduct case management pilots and experiments (5, 10).

Add laptop computers and expand computerized recordkeeping for case managers (5, 29).

Improve information access to case managers and across systems (20, 25).

Examine the use of technology to decrease paperwork and increase efficiency (26).

Case management funding

Separate administrative and service functions and pursue separate funding sources for each (1, 10, 16, 21, 47, 52).

Allow private-sector vendors to compete with the county case managers (1, 21, 24, 26, 27, 29).

Private-sector case management vendors should contract with the state (1).

Do not separate administrative and service functions; it will cost more (18).

Improve the system for capturing federal administrative funds for case management (53).

Case management roles

Do not require the full case management process if respite care is all that is needed (10, 18, 20, 22, 43).

Clarify roles and responsibilities (1, 22, 24, 29).

Parents should be able to be their child's case manager or co-case manager (5, 9, 10, 29).

Replace multiple case managers with a single case manager whose jurisdiction covers all disciplines and services (24, 29, 32, 33).

Eliminate duplicate client assessments, such as completed by the educational system, residential provider, day provider, Rehabilitation Services and county case manager (29, 31, 32, 33).

KEY

1-21 -- Individual interviews with legislators, other state and county officials, advocates and system experts.

22-34 -- Focus group discussions and brainstorming. Groups included people with developmental disabilities, parents, public and private-sector service providers, Greater Minnesota residents and standing advisory committees. (The focus group code number should not suggest that the entire group endorsed the recommendation.)

35-52 -- Officials from other states and the federal Health Care Financing Administration.

53 -- Project advisory group selected by the Developmental Disabilities Division of the Minnesota Department of Human Services.

54-60 -- Private-sector providers informally interviewed during site visits.

Allow family members or other interested parties to monitor service provision on behalf of a client. Case managers would monitor services only if a client has no interested family member to do so (37, 42, 45).

Train parents to be case managers (20, 42).

County boards, not case managers, should determine if discretionary services will be provided (7).

Provide different levels of service to those under guardianship and those with active families (10).

Case managers should do more initial planning, but less ongoing routine work (10).

Eliminate case managers; they are an extra layer, although you need somebody taking responsibility for programs and allocating resources (11).

Eliminate case managers for children with families and provide vouchers to the families (12).

Case managers should provide help when needed, but move away from being a dictator or paid friend (17).

Acknowledge that case managers cannot meet all needs (22).

Do not require case management for individuals living with their families or other relatives, high-functioning individuals living alone, clients in nursing homes or clients needing no services beyond respite care or day programs (22).

Use case aides instead of case managers for some clients (22).

Do not pay for case management when the parent is doing the real work (29).

Eliminate duplicate counseling provided by multiple sources (32).

Case managers' requests for services for their clients should be reviewed by a district review committee to look at need and appropriateness of services recommended (35).

Develop clients' individual service plans biennially instead of annually (36).

Develop different types of individual service plans with varying levels of detail for people with different levels of need (42).

Allocate and limit frequency of contact with the case manager based on client need (42).

Categorize clients according to severity of need and provide services to them according to the category they fall in. If funds are limited, offer case management to the most needy clients according to the availability of funds (43).

Cap the number of hours of case management services a client can receive in one year (46).

Ensure greater uniformity and consistency in case manager duties (55).

Use paraprofessionals to deal with phone calls, paperwork and meeting logistics (58).

Eliminate case management services that are duplicated by some private in-home service providers (59).

Case management rule (Rule 185)

Reduce the paperwork associated with case management (5, 16, 22, 23, 24, 28).

Reduce the burdens of Rule 185 (7, 18, 34).

Eliminate duplication and redundancy between Rules 185, 4 and 160 (23, 32, 34).

Make Rule 185 less process-oriented and more outcome-oriented. Develop better measures (12, 18).

Put teeth in the rule and require counties to comply (20, 21).

Simplify and standardize the individual service plan (22, 34).

The state should provide samples of acceptable documents, such as individual service plans (5).

Turn many of Rule 185's "shalls" into "mays" (18).

Reduce case management paperwork for Rules 185, 40, 203, etc. (22).

Simplify Rule 185. It's getting more complicated all the time and the training is repetitious (22).

Eliminate duplications and conflicts between Rule 34 and Rule 185 (22).

Do not routinely require case managers to redo individual plans and assessments done by providers (22).

KEY

1-21 -- Individual interviews with legislators, other state and county officials, advocates and system experts.

22-34 -- Focus group discussions and brainstorming. Groups included people with developmental disabilities, parents, public and private-sector service providers, Greater Minnesota residents and standing advisory committees. (The focus group code number should not suggest that the entire group endorsed the recommendation.)

35-52 -- Officials from other states and the federal Health Care Financing Administration.

53 -- Project advisory group selected by the Developmental Disabilities Division of the Minnesota Department of Human Services.

54-60 -- Private-sector providers informally interviewed during site visits.

Reduce monitoring by case managers consistent with monitoring already done by Health or Human Services (22).

Scrap Rule 185 and start over. It gets worse as it is revised. Include outcome goals in a new rule (23).

Eliminate different case management rules for different service populations (23).

Reduce the number of prescribed deadlines in Rule 185 (34).

Reduce the intrusiveness of the rule so that clients do not get programmed for life whether they want it or not (34).

Spell out the basic conceptual assurances of case management in Rule 185 and eliminate the rest (34).

Day programs

Older people with developmental disabilities should be allowed to "retire" from day programs (8, 22, 23, 27, 28, 33).

Eliminate the duplication of services between Jobs and Training and Human Services day programs; stop the duplicate funding (2, 29, 32, 33, 60).

Eliminate duplicate assessments and job placement services (29, 32, 33, 60).

Eliminate day training centers and give the money to intermediate care facilities for the mentally retarded (14, 28).

Weigh costs and benefits of supported employment and other vocational activities on a case-by-case basis. Don't expend resources, for example, on a client whose job coach is manipulating the client's hands to perform the task (22, 24).

Revoke the rules that mandate day activities for clients that cannot benefit from it (23, 26).

Revoke the rules that allow clients almost no unstructured time (24, 30).

Do not require all clients (medically fragile clients, for example) to go to off-site day programs or to programs that are so structured or lengthy (29, 30).

End county disincentives to place people out of family homes in order to get funding for day program services (10).

Revise funding policies to recognize different levels of need in supported employment (10).

Paying for supported employment will require cutting an entrenched system of day programs (23).

Give money directly to parents rather than to day programs that provide "baby-sitting" (29).

Reduce duplication and overlap between day training and habilitation facilities and sheltered workshops (29).

Involve businesses in supported employment efforts (29).

Provide in-unit activities including recreational activities for some regional treatment center residents (30).

Put more emphasis on volunteer programs in the regional treatment centers, such as the Foster Grandparents program. Revoke the rule prohibiting employees from volunteering the same care to clients (30).

Institute sunset clauses for activities that do not yield results over time (34).

Maximize federal money for day services (53).

Delivery models and service philosophy

Crisis programs need to be developed in the community that would be less expensive than regional treatment centers or psychiatric wards (1, 4, 23, 28, 53).

Expand use of foster care homes (15, 18, 21).

Require state-run facilities to compete on an even playing field with private-sector facilities (24, 26, 28).

The state needs more community-based services, such as the waiver and semi-independent living services, that are not tied to property (1, 53).

Define the vision and identify how to get there in stages. Stick with incremental changes (7, 10).

Emphasize preventive efforts such as prenatal care and service to children at risk (10, 53).

KEY

1-21 -- Individual interviews with legislators, other state and county officials, advocates and system experts.

22-34 -- Focus group discussions and brainstorming. Groups included people with developmental disabilities, parents, public and private-sector service providers, Greater Minnesota residents and standing advisory committees. (The focus group code number should not suggest that the entire group endorsed the recommendation.)

35-52 -- Officials from other states and the federal Health Care Financing Administration.

53 -- Project advisory group selected by the Developmental Disabilities Division of the Minnesota Department of Human Services.

54-60 -- Private-sector providers informally interviewed during site visits.

The state needs alternative delivery models that share the risks and are not dependent on the counties (11, 12).

Limit the growth of personal care attendants paid for by Medical Assistance (16, 52).

Reconsider whether the community is always the least restrictive environment; a rural campus might be less restrictive than an urban environment (23, 30).

Tap private resources such as the United Way and religious organizations (26, 29).

Equalize the county share for various programs to reduce financial incentives and disincentives to use particular programs (26, 53).

Continue community placements and reasonable mainstreaming (2).

Minnesota should encourage private development of services and competition (9).

Develop a mix of service strategies that test various interventions and hypotheses (11).

The state should contract with large, stable nonprofit organizations for the administration of developmental disability services (11).

The first priority should be keeping people out of regional treatment centers and group homes; deinstitutionalization should occur to the extent that additional money is available (13).

Shift from the medical model to a support model (17).

Combine programs so that a family is eligible for one, rather than four or five (16).

The state needs to do a detailed analysis of when it is cost effective to use Medicaid and when it is not (19).

Coordination and accountability are needed at the regional level in order to serve low-incidence populations coming out of regional treatment centers (21).

Increase flexibility to provide service levels between semi-independent living services and the waiver (22).

Do not do costly screenings for clients who will only be told that there is no money available for services (22).

Reduce the levels of bureaucracy (22).

Shift the emphasis from making people "normal" to helping them have a good life; no amount of programing can make a person "normal" (22).

Do not require reviews every six months for children in out-of-home placements; this time frame is more appropriate for neglected children (22).

Make crisis services available at regional treatment centers (22).

Shift the emphasis from quantity of services to efficiency (23).

Develop financial incentives for counties to use semi-independent living services rather than the waiver (23).

Reassess the responsibility of parents in paying for developmental disability services (23).

Funding sources should get together and develop a simple, comprehensive billing form (24).

Quit pushing clients to constantly improve, regardless of age or disability; constant programing is costly and stressful (24).

Maximize use of federal Medicaid money (24).

Reduce service monopolies to increase competition and lower costs, especially with semi-independent living services and waivered services (29).

Reduce administrative costs (29).

Society should pay full costs of developmental disability services because society will benefit when the person with the developmental disability pays taxes later (29).

Increase the use of HMOs for health care (29).

Eliminate the for-profit sector of providers (30).

Recognize cost effectiveness of congregate care (30).

Eliminate duplication within the service system; case management and day programs provide examples (53).

KEY

1-21 -- Individual interviews with legislators, other state and county officials, advocates and system experts.

22-34 -- Focus group discussions and brainstorming. Groups included people with developmental disabilities, parents, public and private-sector service providers, Greater Minnesota residents and standing advisory committees. (The focus group code number should not suggest that the entire group endorsed the recommendation.)

35-52 -- Officials from other states and the federal Health Care Financing Administration.

53 -- Project advisory group selected by the Developmental Disabilities Division of the Minnesota Department of Human Services.

54-60 -- Private-sector providers informally interviewed during site visits.

Department of Human Services' role

Offer consultation and support to providers and counties in problem-solving and implementation of department rules (24, 26, 27, 31).

Develop a memo of understanding with other involved state agencies regarding roles and responsibilities (32, 33).

Be more active at the federal level to ensure that Minnesota benefits from Medicaid waivers and modifications (4).

Develop better evaluation techniques and conduct more longitudinal studies (8).

Provide good data and summary reports to policy makers, including the numbers of clients served, program expenditures, and eligibility requirements (19).

Determine whether regional services specialists are needed; issues could go directly to Human Services (22).

Provide more timely training on implementation of rule and policy changes (22).

Provide automated data on placement resources (24).

Provide clear and consistent responses to questions (27).

Reduce inter-division conflicts and develop an integrated departmental policy (28).

Eliminate redundant staff positions (31).

Facilitate cooperation between counties, especially when issues arise with host county concurrence (34).

Establish specific, concrete expectations with providers, so they don't get caught in "Gotcha!" games (55).

Family supports

Support families; develop more individualized and flexible community supports (1, 4, 10, 16, 19, 21, 56).

Eliminate or revise parental fees for TEFRA to reduce risks of institutionalizations. This could also motivate parents to use public resources more conservatively (10, 29, 52).

There is a need for more individual supports in people's natural homes (1, 18).

Offer cash stipends to families to enable them to keep a family member with developmental disabilities at home and reduce the number of people institutionalized (5, 40).

Be careful with financial commitments to respite care, because the demand cannot be met (2).

Eliminate family recordkeeping requirements for the family subsidy program (10).

Offer respite care as an unlicensed service (29).

Give parents money and let them choose services; they will select less costly services (29).

Expand the voucher program statewide (see the Dakota County pilot) (29).

Use money more wisely and utilize natural supports (33).

Home- and Community-based Waiver

Use the waiver to offer more in-home support, more family support and less residential service (1, 10).

Look for ways to lower waiver start-up costs and then pass on learnings so that there will be less developmental overhead (19).

Do not require annual waivered services screenings (22).

Allow contracting for waiver development (23).

Use the waiver as the major funding source (28).

Do not turn waiver sites into mini-institutions with overregulation (28).

Examine whether it makes sense for residents in a waiver program to receive the renters' credit (55).

Resolve funding issues more equitably between waivered residential services and day programs, so that residential programs get a fair share of the per diem (55).

Make in-home services contracts more flexible. Now families are afraid to request the minimal needed services for fear that if they require more services later they won't be able to get them (59).

KEY

1-21 -- Individual interviews with legislators, other state and county officials, advocates and system experts.

22-34 -- Focus group discussions and brainstorming. Groups included people with developmental disabilities, parents, public and private-sector service providers, Greater Minnesota residents and standing advisory committees. (The focus group code number should not suggest that the entire group endorsed the recommendation.)

35-52 -- Officials from other states and the federal Health Care Financing Administration.

53 -- Project advisory group selected by the Developmental Disabilities Division of the Minnesota Department of Human Services.

54-60 -- Private-sector providers informally interviewed during site visits.

Intermediate care facilities for the mentally retarded

Adjust reimbursement procedures to avoid private providers' going out of business (23, 28, 56, 58).

Implement a client-based reimbursement system (14, 26, 28).

Separate program costs from property costs (10).

Establish a logical, orderly process for group home placements with clear roles and authority. Consider the Wisconsin model (28).

Residential and other systems duplicate Activities in Daily Living (31).

Have the state agency determine the number of beds in intermediate care facilities for the mentally retarded that will be funded and allocate beds to providers (48).

Reduce the reimbursement incentives for providers to sell buildings to other providers (57).

Local role

Mandate local planning and coordination (23, 27).

The appeals process should give the benefit of the doubt to county professionals, not advocates (7).

Retain host county concurrence (24).

Allow local units of government to raise their own funds for social services, including case management for people with developmental disabilities (37).

Regional treatment centers

Close the regional treatment centers (19, 28, 31, 53).

Reduce supervisory staff and add direct care staff (29, 30).

Close the developmental disabilities units at the regional treatment centers (5).

Make better use of existing resources, including the regional treatment centers (7).

Maintain regional treatment centers as an acute care setting (8).

Consolidate some regional treatment centers and close others. Faribault and Moose Lake could be converted to corrections facilities (21).

Maintain regional treatment centers as a provider of last resort for clients that private-sector providers cannot handle (22).

Close the regional treatment centers or downsize them (23).

Consider use of regional treatment centers as prisons (28).

Have regional treatment centers provide consulting to the private sector on a regional basis (28).

Reduce use of staff overtime (29).

Lay off workers with seniority and hire less-expensive new workers (29).

Maintain the regional treatment centers as a safety net for individuals who cannot be served in the community or who are too costly to serve in the community (30).

Reduce understaffing. Understaffing ultimately costs more because of increased use of overtime and sick leave and additional workers' compensation claims (30).

Phase out the regional treatment centers over five years (31).

Rules, licensing and quality controls

Shift to an outcome focus (4, 10, 12, 16, 23, 24, 26, 33, 53).

Reduce the paperwork (5, 16, 22, 29, 31, 32, 57, 60).

Coordinate licensing activities and combine all licensing standards in one comprehensive, functional rule. Conduct joint Human Services and Health Department licensing inspections (22, 24, 26, 27, 31, 33, 53, 57).

Minnesota should consider direct contracts with providers instead of relying on rules so much. Services should be audited against contract specifications (1, 12).

Eliminate redundant rules such as Rule 34 (23, 28).

Eliminate time-consuming documentation and accountability requirements that reduce service efficiency (24, 27).

Develop one master rule for providers, combining all existing rules and regulations affecting service delivery (28, 31).

KEY

1-21 -- Individual interviews with legislators, other state and county officials, advocates and system experts.

22-34 -- Focus group discussions and brainstorming. Groups included people with developmental disabilities, parents, public and private-sector service providers, Greater Minnesota residents and standing advisory committees. (The focus group code number should not suggest that the entire group endorsed the recommendation.)

35-52 -- Officials from other states and the federal Health Care Financing Administration.

53 -- Project advisory group selected by the Developmental Disabilities Division of the Minnesota Department of Human Services.

54-60 -- Private-sector providers informally interviewed during site visits.

Eliminate the duplication of Rule 42 and foster care licensing requirements for overnight respite care providers (28, 54).

Modify the adult foster care rule to allow less than 24-hour care; this would fill the gap between intermediate care facilities for the mentally retarded and semi-independent living services (4).

Stop letting the focus on process supersede the mission (12).

Eliminate excessive paperwork associated with Rule 40 and Rule 186 (22).

Shorten excessively long rules (22).

Reduce the level of detail in rules; they should be realistic, rather than trying to mandate the ideal (23).

Look at outcomes, not process. Let people with developmental disabilities live like other people. Overregulation creates an abnormal situation (24).

Eliminate licensing and free up money for programs (24).

Eliminate Big Brother-like Rule 11 background checks; the payoff is not worth the expense (24).

Eliminate factors driving up costs in Rules 10, 11, 38, 40 and 75 (24).

Eliminate duplication from Rule 42 and Rule 403 (27).

Eliminate duplicative assessments such as quarterly psychological assessments for children who will always be profoundly retarded (29).

Verify Medical Assistance eligibility less frequently (29).

Evaluate service providers on the basis of performance; do not just pay them for their time (29).

Reduce data privacy constraints that result in duplication of paperwork (32).

Fix the pertinent rules (33).

Conduct audits on a sampling basis; do not review every record (53).

Revise Rule 42 to accommodate individuals living with their families. For example, the family and not the in-home service provider should be monitoring psychiatric medications (54).

Eliminate redundant, intrusive paperwork; consider any paperwork's contributions to service quality (54).

Measure quality by developing an environment conducive to good social functioning and integration, rather than a provider's ability to provide extensive, expensive and perhaps unnecessary services (57).

Semi-independent living services

Provide more semi-independent living service programs and give the counties financial incentives to use them (1, 16).

Minnesota should reimburse counties for semi-independent living services use at the same rate as intermediate care facilities for the mentally retarded (4).

End the county fiscal incentive to use waivered services over semi-independent living services (10).

Modify Rule 18 to allow for reduction in documentation and paperwork when the service level of a client is reduced (31).

Develop maintenance services for fairly self-sufficient clients who still need some support (31).

Eliminate duplication of casework services between the semi-independent living services provider and the county case manager (31).

Attempt to secure federal funding for semi-independent living services (31).

Special education

Reduce the number of administrators in the schools. Have one person follow the child through school rather than having a different person for each age group (29).

State agencies need to collaborate and clarify responsibilities (32).

Eliminate duplication of services for young children provided by Human Services and the Department of Education (32).

Public schools should not be serving the most severely handicapped children (32).

KEY

1-21 -- Individual interviews with legislators, other state and county officials, advocates and system experts.

22-34 -- Focus group discussions and brainstorming. Groups included people with developmental disabilities, parents, public and private-sector service providers, Greater Minnesota residents and standing advisory committees. (The focus group code number should not suggest that the entire group endorsed the recommendation.)

35-52 -- Officials from other states and the federal Health Care Financing Administration.

53 -- Project advisory group selected by the Developmental Disabilities Division of the Minnesota Department of Human Services.

54-60 -- Private-sector providers informally interviewed during site visits.

Reconsider whether children need occupational therapy and physical therapy in both their residential and school settings (32).

Involve business in the financing of public education (32).

State-operated community services

Stop state-operated community services development; let private-sector providers offer needed services (22, 24, 26, 28, 31).

Reconsider the decision to go from three-bedroom facilities with two residents per bedroom to six-bedroom facilities with one resident each (2).

Access to state-operated community services should be limited or the private sector should be funded over time to compete with state-operated community services (7).

The state should rent, not buy, state-operated community service facilities so that it is not encumbered with these houses away from population centers when the residents die (9).

Put state-operated community service funding into a consolidated fund that would follow clients; allow counties flexibility in spending that money (23).

Don't set up new training for state-operated community service employees when other institutions have the potential to train; this is duplication (24).

Stop hiring additional state employees to staff the state-operated community services (29).

Buy existing houses at local market rates (30).

Construct new homes for state-operated community services because remodeling existing houses would be just as costly (30).

Review how the state has set up rules and regulations for real estate acquisition to see if the process can be made easier or faster for state-operated community services (30).


GREAT SEAL OF
L'ETO