Analysis of
Funding Options
for

Developmental Achievement Centers and Semi-Independent Living Services

In Minnesota

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Mental Retardation Programs Division

Department of Public Welfare

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I. INTRODUCTION AND PURPOSE OF THE STUDY

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

Some of the factors that led to this study include:

1) DPW's Six Year Plan of Action calls for the development and expansion of services in the community continuum of care (See Appendix A), so that the number of state Hospital residents can be reduced;

2) In the Welsch vs. Root Consent Decree, DPW has agreed to propose to the Governor for submission to the Legislature, all measures necessary for implementation of the provisions of the Decree, including the elimination of financial incentive currently encouraging counties to place mentally retarded in state hospitals. This means equalizing the percentage of the costs paid by counties for placement in state hospitals and in community-based facilities;

3) Increased community alternatives to institutional care are needed at a time of reduced resources available to counties and uncertainty about federal actions on Titles XIX and XX;

4) The Omnibus Budget Reconciliation Act of 1981, allows waivers to the Title XIX program so that home and community based services may be covered for certain individuals who would otherwise require institutional (state hospital or ICF/MR) care.

Therefore, the purposes this report: intends to serve include:

1) To identify and describe the major programmatic and fiscal issues facing the Department that created the need for this study.

2) To present background information, programmatic and fiscal data on Developmental Achievement Centers (DACs) and Semi-Independent Living Services (SILS);

3} To explore various funding options including the utilization of the Title XIX Medical Assistance Program;

4) To present the respective fiscal, programmatic and administrative impacts of identified options;

5) To examine each option in relation to the major issues and problems, and;

6) To identify means to minimize state and local expenditures by maximizing federal financial participation.

Recommendations are not offered in this report. Rather, an attempt has been made to present all facts relevant to the issues that will facilitate legislative action.

II. MAJOR ISSUES

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

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

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

1. To ask the legislature for an appropriation for grants to counties to assist them in paying for developmental achievement services;

2. To propose legislation requiring counties to pay more for develop mental achievement services in state hospitals; or

3. To pay for community-based developmental achievement services under Medical Assistance, thus reducing the county share of the cost to 10% of the non-federal share and maximizing federal financial participation.

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

B. Resource Deficits in Current Funding Model have resulted in delays and waiting lists, and in a few instances, termination of services. Due primarily to cuts in CSSA (state) and Title XX (federal) social service appropriations, counties found it increasingly difficult to meet the needs for DAC services.

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

A significant number of social service appeals have been filed as a result of service reductions. In the case of Welsch v. Soot class members, U.S. Federal District Court Orders require, by specific cases, that a full time, full day program of services be provided in accordance with determinations made by the interdisciplinary team. These Court Orders are being appealed by the Department.

Although the Department has taken steps to allow county flexibility in managing their budgets, Commissioner Hoot directed counties to assure that any clients in need of DAC services not be arbitrarily denied service. The authorized reductions for budget deficit and constraint reasons, however, conflicts with Federal Court Orders for class members (discharged from state hospitals since September, 1980), because the requirement to pay for a full five day per week program conflicts with county authority to manage its budget.

It is likely that this situation will continue, if not worsen, as long as Minnesota faces a recessive economy. (See Appendix D for projected reductions in service levels under current funding model.)

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

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

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

As reductions in community-based day programs for mentally retarded continue, the state's compliance with the active treatment provisions in the ICF/MR Regulations becomes more in jeopardy.

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

F. Summary of Issues.

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

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

Background:

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

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

TABLE 1

HISTORICAL FISCAL AND CLIENT DATA ON
DACS FROM 1973-1980

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The issue of decreasing levels of DAC service because of county budget constraints has been raised. In response to this, DPW has established the minimum level of service as three full days or five half days. The issue has not yet been resolved, and the question of reduced levels of service is currently before the Minnesota Supreme Court.

C. Preschool Program Transfer to Department of Education.

There is currently under consideration a proposal to transfer all preschool programs currently provided in DACs to the Department of Education. At the writing of this report, a September 3, 1982

Inter-Agency memorandum, signed by the Commissioners of Health, Education and Welfare, outline a set of recommendations to study this proposal. The Department of Education has been assigned the lead in this study to occur in 1983.

D. Current DAC Funding System.

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

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

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

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

With the expiration of the maintenance of fiscal effort requirement, counties may now modify or reduce the level of funding for developmental achievement services for their clients. As indicated in DPW Instructional Bulletin #81-35, dated April .30, 1982, "Developmental achievement services are mandatory, within the fiscal resources made available by the county board. If fiscal constraints make it

impossible for the county Co meet the level of services indicated in its needs assessment, a county board may modify or reduce the level of developmental achievement services in a manner which is least detrimental to the individual client served. These modifications may result in a reduction of the number of days of services and/or delays for a reasonable period of time in the delivery of services to new clients. The provision of developmental achievement services is not an absolute requirement, but is mandatory only within budgeted funds."

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

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

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

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

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

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

Another area of variation among DAC's is program days per year. While the statewide average number of program days for adults was 211, the average regional range was 196 to 255 per year. The actual range in program days for adults in 19S1 was 175 to 244 days. The variation in number of program days per year also occurs in the infant, preschool, and school age program. In 1981, the average regional range of infant program days was 37 to 134 with the statewide average being 92 days.

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

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

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

Under the current system of social service funding for developmental achievement services, the counties play a crucial role regarding provision of and payment for services. The fiscal planning process occurs prior to the provision of and payment for services. The county board and the DAC negotiate an annual budget and a program per diem for services based on projected units of service and service costs. Generally the DAC receives an advance from the county and additional services are based on the negotiated per diem. The counties, when faced with fiscal constraints, may reduce services; waiting lists may develop, and programs may not be able to meet the identified needs of the counties clients. As indicated in Major Issues B. this is precisely what has begun to occur with DAC services in Minnesota under the current funding system.

Table 2 summarizes the projected demands and costs for DAC services through F.Y. 1985. A more detailed analysis appears as Table B1 in Appendix B.

TABLE 2

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

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

Assumptions used in Developing Table 2:

1. Demand includes clients discharged from state hospitals, new admissions to ICF/MR's, and admissions from the community (i.e. public school graduates, etc)
2. DAC demissions are occurring and have been accounted for, on a regular basis due to development of new and additional slots in the community continuum of care such as sheltered workshop slots and work activity slots.
3. The 1981 waiting list of 262 adults and 146 children are eliminated; these clients are projected as having been admitted to DAC's in F.Y. 1982 at existing per diem rates and are provided full services.
4. The number of infants and preschoolers requiring services will remain constant in the future.
5. The statewide average adult per diem increases six percent annually.
6. The statewide average preschool annual costs increase six percent annually.
7. There is no increase in number of days of service for preschoolers over the years.
8. The number of days of service for adults remains stable at 211 day per year.
9. Figures exclude school age clients and costs.

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

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

A. The Utilization of Title XIX.

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

Title XIX reimbursement is based on invoices submitted by providers for services already provided. The reimbursement is generally the provider's usual and customary charge for services. Any "controls" or "limitations" on developmental achievement services or SILS under Title XIX must be specified in the State Plan and submitted to the Social Security Administration for approval.

Under Title XIX, services provided are based on individual need. All eligible individuals requiring developmental achievement services could receive the services and reimbursement would be made. However, under the MA Waiver option, services can now be targeted to specific groups under the "non-statewideness waiver".

There are two possible methods for Title XIX reimbursement of training and habilitation services of ICF/MR residents. One method involves enrollment of each eligible provider of training and habilitation services. The providers would bill the MA program for services provided to each eligible client and the appropriate reimbursement would be made directly to the provider. Advantages of this method are that the state agency would know who is providing services, the total charges for those services, and the number of clients receiving services. Potential providers would be required to meet program standards prior to being enrolled as HA providers and would be directly accountable for their services provided. It may be possible by means of a waiver that MA eligible preschoolers and adults not residing in ICF/MR's may be eligible to receive training and habilitation services as provided by individually enrolled providers. This method could also allow for consistency in provision of and reimbursement for training and habilitation services for individuals not in ICF/MR's but requiring such services.

The other method involves the ICF/MR's contracting with training and habilitation service providers and passing through the MA reimbursement received to the providers of those services. This method would allow for greater ICF/MR control of developmental achievement services and would also foster greater coordination of program planning between the two service provider groups. Training and habilitation service providers would be accountable more to the ICF/MR than the Medical Assistance Program. This model would not allow for provision of day services under MA for non ICF/MR residents.

B. Three Proposals.

Three alternative proposals for using Title XIX have been developed regarding the funding of developmental achievement services. They are:

1. Title XIX coverage of all residents in ICF/MR's.

2. Title XIX coverage of all eligible adults.

3. Title XIX coverage of all eligible adults and children.

Proposal 1. Training and habilitation services required by residents of ICF/MR's be reimbursed under Title XIX. This proposal would require modification of the MA State Plan legislative action and rule change under the administrative procedures act; a federal waiver is not required. The rational for this proposal is grounded in the requirement for training and habilitation services as required for Title XIX certification of ICF/MR's, the services would be funded under Title XIX as they are currently funded in the state hospitals.

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

Policy Impact

1. Removes incentives for state hospital placement. The proposal will remove any fiscal incentive to counties for placement of men tally retarded persons in state hospitals. This is consistent with the state's policies of deinstitutionalization and normalization. It is also a major stipulation of the Welsch vs. Hoot Consent Decree and resolve Major Issue A.

2. Standardization of developmental achievement services. Some services currently provided may not be eligible for coverage. All developmental achievement services covered by Title XIX would have to comply with the same standards whether provided by the state hospital or in the community. The standardization of services may involve revision of the State Plan and rule-making through the administrative procedures act. The result may be that some of the current services provided by DAC's may not meet federal standards. Federal regulations define training and habilitation services as "those intended to aid the intellectual, sensory motor, and emotional development of a resident." (42 CFR 442.401). These services are to be prescribed, based on individual need, and progress of each resident is to be assessed on a regular basis.

3. Potential incentive for residential placement. The proposal (i.e., ICF/ME residents only) creates the potential for differential treatment based on client's place of residence, perhaps providing an incentive for residential placement and forcing counties to provide a different level of services to non-residents. To the extent the proposal may provide an incentive to place and keep clients in ICF/MR's, it become inconsistent with the policy of normalization. At the sane time, the provision of developmental achievement services for clients not in ICF/MR's would continue to be a function of the counties' priority setting and subject to fiscal constraints. While this potential exists, evidence that counties will move in this direction does not. For example, over 2,000 persons have been placed into community facilities from state hospitals over the past ten years despite a greater cost to the counties over that of state hospital placement.

4. MA Cost Containment measures will place development achievement services in the broader category of human services. By removing a portion of DAC services from CSSA, this proposal will dictate that priority setting of all MA programs consider the services for the mentally retarded along with other covered services such as basic medical services such as dental care, nursing care, home health aides and all long-term care services. Given the stipulations in the Consent Decree and its service requirements, those priorities will be more difficult to balance.

Program Impact

1. As an entitlement, services cannot be cut. The proposal will assure that counties cannot cut back services because the services would become an entitlement, however, the legislature may still impose a cap on the total MA program and specific services under it thereby controlling program expansion. This impact would eliminate the numerous appeals and hearings as described in Major Issues B. This applies most directly to the "Welsch clients" since most are placed in ICF/MR facilities and also need DAC services .

2. The potential for decertification of ICF/MR programs would be eliminated. Residents of the ICF/MR facilities in need of DAC services would be assured of receiving those services. This impact directly related to Major Issue D.

3. State Hospital redaction rates will no longer be adversely affected by lack of day services in the community. Reduction quotas specified in the Consent Decree can be achieved. This impact addresses Major Issue C.

4. Non-ICF/MR residents may receive a lower priority in competing for services. The funding of day services under CSSA for non-MA residents may be reduced in favor of other community social services placing those individuals in jeopardy of receiving less than needed services.

5. Possible incentive to expand to 12 month program. The proposal may provide an incentive to increase to a full year program unless limited in State HA Plan, (See Appendix G for fiscal impact analysis.)

Fiscal Impact

1. County costs for state hospitals and ICF/MR's equalized. The percentage of costs to the counties for training and habilitating services would be equalized between the state hospitals and ICF/MR's resulting in removal of any fiscal incentive for state hospital placement. This addresses Major Issue A.

2. Cost control may be more difficult. Cost control will rest more with the state in its definition and scope of services specified in the State MA Plan. Counties would cot have the same level of control they currently do under CSSA.

3. Fiscal uncertainty due to decisions in Congress. Both administrative and funding decisions by Congress in regard to Title XIX create fiscal uncertainty. That uncertainty also exists with the Title XX program. Both will have fiscal impacts on this program.

4. Costs would increase with 12 month program. Unless the state plan stipulates that the DAC program remain at 211 days per year, the change to a 12 month program would be proportionately higher.

Actual fiscal impacts are reflected in Table 3 below:

TABLE 3
FISCAL ANALYSIS OF OPTION 1

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

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

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

COST IMPACTS USING TITLE XIX COMPARED WITH CSSA

	Federal	State	County[2]
F.Y. 83	increases 7,426,799	increases 3,165,729	decreases 10,592,582
F.Y. 84	increases 8,482,113	increases 4,092,394	decreases 12,574,507
F.Y. 85	increases 9,852,545	increases 4,508,182	decreases 14,360,727
F.Y. 84 & 85 Biennium	increases 18,334,658	increases 8,600,576	decreases 26,935,234

1. See Appendix C for method used to determine federal, state and county financial participation under CSSA.

2. County savings reflects savings in Title XX and local funds.

Proposal 2. Training and habilitation services for all MA eligible adults regardless of residence should be eligible for Title XIX reimbursement. This proposal would require a legislative change on services covered by 256B, rule-making through the administrative procedures act, and a waiver for non-ICF/MR clients.

Impacts repeated from Proposal 1 are listed by title only.

Policy Impact

1. Deinstitutionalization encouraged. Deinstitutionalization would be encouraged by funding an equal level of services for all adults by removing disincentives to community placement.

2. Standardization of developmental achievement services.

3. MA cost containment places DAC services in broader category.

Program Impact

1. Services cannot be cut.

2. Standardization of developmental achievement services.

3. State Hospital Reduction Rates will be met.

4. Possible incentive to expand to 12 month program.

5. Possible incentive to not advance through continuum. The proposal may provide an incentive to stay at the developmental achievement level of the continuum longer than the individual program plan indicates rather than moving on to higher day program levels such as sheltered work settings.

6. This proposal may result in an increase in the total MA program. Without targeting a specific population, it would be difficult to predict the total number of MA eligible parsons in need of DAC services.

Fiscal Impact

1. County costs for state hospitals and ICF/MR's equalized.

2. Cost control more difficult.

3. Fiscal uncertainty due to decisions in Congress.

4. Costs would increase with 12 month program.

Actual fiscal impacts are reflected in Table 4 below:

TABLE 4

FISCAL ANALYSIS OF OPTION 2

Option 1: Fund 100% of the adult DAC Clients with Medical Assistance (Title XIX), and continue to fund the children through CSSA.

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

	Number of DAC Adult Clients	Projected Budget	Funded Under Medical Assistance			v.	Funded Under CSSA[1]		
			Federal	State	County		Federal	State	County
F.Y. 83	4,385	$23,985,889	$12,587,794	$10,258,765	$1,139,330		$4,725,220	$ 4,893,121	$14,367,548
F.Y. 84	4,571	26,513,728	13,463,671	11,745,582	1,304,475		4,772,471	5,249,718	16,491,539
F.Y. 85	4,733	29,104,766	15,157,762	12,552,886	1,394,118		4,802,286	5,617,220	18,685,260
F.Y. 84 & 85 Biennium		55,618,494	28,621,433	24,298,468	2,698,593		9,574,757	10,866,938	35,176,799

COST IMPACTS USING TITLE XIX COMPARED WITH CSSA

	Federal	State	County[2]
F.Y. 83	increases 12,587,794	increases 5,365,644	decrease 17,953,438
F.Y. 84	increases 13,463,671	increases 6,495,864	decrease 19,959,535
F.Y. 85	increases 15,157,762	increases 6,935,666	decrease 22,093,428
F.Y. 84 & 85 Biennium	increases 28,621,433	increases 13,431,530	decrease 42,052,963

1. See Appendix C for methods used to determine federal, state and county financial participation under CSSA.

2. County savings reflects savings in Title XX and local funds.

Proposal 3. Training and habilitation services for all eligible adults and preschool children should be eligible for Title XIX reimbursement. This proposal would require legislation, rule-making through the administrative procedures act, and a waiver for non-ICF/MR clients. The school age mentally retarded are covered by school boards now. The Department has proposed that preschool children also be served by schools.

Impacts repeated from Proposals 1 and 2 are listed by title only.

Policy Impact

1. Covering MR children raises questions about other disabled children. Covering MR children raises questions about coverage of services for other "disabled" children, for example, learning disabled and emotionally disturbed.

2. Removes incentives for state hospital placement.

3. Standardization of developmental achievement services.

4. Inconsistent with counties balancing needs of many populations.

5. MA cost containment places DAC services in broader category.

Program Impact

1. As an entitlement, services cannot be cut.

2. Decertification of ICF/MR eliminated.

3. State Hospital Reduction rate will be met.

4. May result in increase of total MA program.

Fiscal Impact

1. Early intervention may reduce future costs. Reliable funding for early intervention could reduce later service costs.

2. County costs for state hospitals and ICF/MR's equalized.

3. Cost control more difficult.

4. Fiscal uncertainty due to decisions in Congress.

5. Costs would increase with 12 month program.

Actual fiscal impacts are reflected in Table 5 below:

TABLE 5
FISCAL ANALYSIS OF OPTION 3

Option 3: Fund 100% of the adult DAC clients and 10% of the children DAC clients with Medical Assistance (Title XIX), and continue to fund the other 90% of the children clients through CSSA.

NOTE: The costs compared in this table reflect the cost to serve 100% adult clients and 10% of the children clients.

	Number of Adult and 10% Children Clients	Projected Budget	Funded Under Medical Assistance			v.	Funded Under CSSA[1]		
			Federal	State	County		Federal	State	County
F.Y. 83	4,525	$24,829,670	$13,030,611	$10,619,650	$1,179,409		$4,891,445	$ 5,065,253	$14,872,972
F.Y. 84	4,711	27,408,048	13,917,807	12,141,765	1,348,476		4,933,449	5,426,794	17,047,805
F.Y. 85	4,873	30,052,706	15,651,449	12,961,732	1,439,525		4,958,696	5,800,173	19,293,837
F.Y. 84 & 85 Biennium		57,460,754	29,569,256	25,103,497	2,788,001		9,892,145	11,226,967	36,341,642

COST IMPACTS USING TITLE XIX COMPARED WITH CSSA

	Federal	State	County[2]
F.Y. 83	increases 13,030,611	increases 5,554,397	decreases 18,585,008
F.Y. 84	increases 13,917,807	increases 6,714,971	decreases 20,632,778
F.Y. 85	increases 15,651,449	increases 7,161,559	decreases 22,813,008
F.Y. 84 & 85 Biennium	increases 29,569,256	increases 13,876,530	decreases 43,445,786

1. See Appendix C for methods used to determine federal, state and county financial participation under CSSA.

2. County savings reflects savings in Title XX and local funds.

Comparison of Impacts on Major Issues by each of the three HA proposals and CSSA

	Major Issue	Proposal No. 1	2	3	Status Quo CSSA
A.	Fiscal Disincentives	+	+	+	-
B.	Resource Deficits	-	-	+	-
C.	State Hospital Reduction	+	+	+	-
D.	ICF/MR Decertification	+	+	+	-
E.	Federal Financial Participation	+	+	+	-

Comparison of Policy, Program and Fiscal impacts by each of the three HA Proposals and CSSA

Policy Impacts				
o Remove fiscal disincentive	+	+	+	-
o Consistent with Deinstitutionalization	+	+	+	-
o Standardization of DAC Services	*	+	+	-
o Potential for different levels of service for non-ICF/MR clients	+	+	-	*
o Possible incentive for residential placement	+	-	-	+
o Early intervention could reduce later cost	-	-	+	-
o MA cost containment measures include DAC	+	+	+	-
o Services cannot be cut	*	*	+	-
o Possible incentive to expand to 12 month	+	+	+	-
o State Hospital reduction rates met	+	+	+	-
o Non-ICF residents receive lover priority	+	*	-	+
o Fiscal uncertainty at federal level	+	+	+	+
o May result in MA program increase	-	+	+	-

Key:

+ equals positive impact
- equals negative or no impact
* equals partial positive impact

Proposal Key:

1. Title XIX for ICF/MR residents only
2. Title XIX for all eligible adults
3. Title XIX for all eligible adults and preschool children

Status Quo. Continue under CSSA and do not use Title XIX

TABLE 6

Comparison of Fiscal Impacts of Title XIX Proposals Contrasted with Maintaining the Status Quo Funding System Under CSSA (See Appendix F for breakdown of costs for each option.)

OPTION 1

Fund 60% of the adult DAC clients with Medical Assistance as part of their residential treatment, and continue to fund the other 40% of DAC adults and all children through CSSA.

	Costs Under Medical Assistance[1]	Costs Under CSSA[1]	Impacts[2]
Federal	24,955,149	12,771,070	+18,334,658
State	23,067,792	14,425,340	+ 8,600,576
County	26,018,153	46,844,684	-26,935,234
Total	74,041,094	74,041,094	

OPTION 2

Fund 100% of the adult DAC clients with Medical Assistance, and continue to fund the children through CSSA.

	Costs Under Medical Assistance[1]	Costs Under CSSA[1]	Impacts[2]
Federal	31,795,310	12,771,070	+28,621,433
State	27,898,746	14,425,340	+13,431,530
County	14,347,038	46,844,684	-42,052,963
Total	74,041,094	74,041,094	

OPTION 3

Fund 100% of the adult DAC clients and 10% of the children DAC clients with Medical Assistance, and continue to fund the other 90% of the children clients through CSSA.

	Costs Under Medical Assistance[1]	Costs Under CSSA[1]	Impacts[2]
Federal	32,425,746	12,771,070	+29,569,256
State	28,343,748	14,425,340	+13,876,530
County	13,271,600	46,844,684	-43,445,786
Total	74,041,094	74,041,094	

1. Inclues the total costs of DAC services funded under combination of MA and CSSA.
2. Title XX savings are reflected the "County" line.

NOTE: If the state share for each DAC option were taken from CSSA appropriations in the F.Y. 84 and 85 Biennium, the fiscal impact on expenditure levels by each governmental unit would then be as follows:

	Federal	State	County
Option 1	+18,334,658	no change	-18,334,658
Option 2	+28,621,433	no change	-28,621,433
Option 3	+29,569,256	no change	-29,569,256

C. Alternative Proposals.

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

The first alternative proposal involves the counties funding the same percentage of developmental achievement services costs provided in state hospitals as they do for these services in the community. It is estimated that counties reimburse approximately 44.9 percent of costs of developmental achievement services provided in the community and approximately 4.8 percent of the costs of these services provided through the state hospitals. Therefore, if counties reimbursed approximately 44.9 percent of state hospital developmental achievement costs, an additional 40.1 percent over current reimbursement is necessary if any fiscal incentive for state hospital placement will be eliminated. The total state hospital developmental achievement service costs for fiscal year 1982 (the most recent figure available) were $10,618,104. Appendix E displays the fiscal impact of this proposal and the respective cost changes at the federal, state and county level. A major assumption of this analysis, based on information from the Income Maintenance Bureau, is that if the county and state pick up the state hospital DAC costs, federal reimbursement under Title XIX will no longer be possible.

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

D. Fiscal Impact of Alternative Proposals.

A fiscal analysis was done on the three major policy alternatives described on page 2. The results of that analysis appear in Table 7.

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

TABLE 7

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

	Federal	State	County
Policy Alternative 1 Use Medical Assistance For Community-base Developmental Achievement Services for Adult Clients			
Option I	+18,334,658	+ 8,600,576*	-26,935,234
Option II	+28,621,433	+13,431,530*	-42,052,963
Policy Alternative 2 County Boards Pay for State Hospital Day Program Services at the Same Rate as Services Under CSSA	-13,400,000	+ 2,966,000	+10,430,000
Policy Alternative 3* Request Additional State Appropriation for Grants to Counties to Assist Them in Paying for DAC Services			
Option I	no change	+26,935,234	-26,935,234
Option II	no change	+42,052,963	-42,052,963

* Assumes the entire state share for these options would not be taken from the CSSA appropriation. See the "Note" on Table 6, page 22.

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

V. PART TWO: SEMI-INDEPENDENT LIVING SERVICES

A. Background

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

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

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

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

The major goal of the six year plan was the deliberate and systematic reduction of the number of mentally retarded persons residing in state hospitals to no more than 1850 by June 30, 1987; and the simultaneous development of sufficient and appropriate community-based residential program, day program and community support services in a manner as cost effective and efficient as possible. The SILS program was seen as a critical component of the service continuum to enable mentally retarded persons to master skills needed for more independent living; and thereby, reducing the demand for unnecessary and inappropriate development of community-based residential facilities by "freeing up" beds in community residential facilities for clients coming from state hospitals.

B. Purpose

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

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

C. Current System Status

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

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

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

a) Self contained or structured site: SILS are provided at one building where all clients live and the SILS agency may own the building.

b) Clustered site: SILS are provided at more than one apartment with four to eight clients at each site.

c) Scattered site: SILS are provided at various locations throughout the community.

County boards may provide SILS directly or they may contract with private vendors for provision of services. A person or an agency is an approved vendor or provider of SILS when the provider has received a letter of recommendation from the host county and Determination of Need from the Commissioner of the Department of Public Welfare in accordance with DPW Rule 185; and, has been licensed under the provisions of DPW Rule 18.

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

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

1) the number and types of clients to be served

2) the projected service costs

3) the program and service plan

4) statewide rates of reimbursement.

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

1) 81Z state reimbursement of SILS for:

   a) clients discharged from an ICF/MR since July 1, 1981

   b) proposed clients from an ICF/MR

   c) current and proposed clients with SSI eligibility

2) 50% state reimbursement of SILS for clients not eligible for SSI or not from an ICF/MR facility.

3) no state reimbursement of SILS for clients not eligible for SSI unless it can be demonstrated the individual will be placed in an ICF/MR if SILS are not provided. Adjustments to grants will be made in January, 1983 per availability of funds.

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

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

1. The number of counties participating in the SILS program has increased in F.Y. 82 and is expected to continue to increase in F.Y. 83 through F.Y. 85. In F.Y. 85, over 80% of the 87 counties are expected to participate in the SILS program.

2. The number of licensed vendors for SILS is expected to increase to 55 in F.Y. 83. The number of licensed vendors are expected to increase by 9% in F.Y. 84 and remain at that level in F.Y. 85. As of January 1983, there were 40 licensed SILS vendors. The number of vendors by type of agency is as follows:

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

3. The number of clients served in SILS has increased by approximately 500 clients in F.Y. 82 and 83. The number of clients is expected to increase by 100 clients in F.Y. 84 and 100 clients in F.Y. 85.

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

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

4. The average annual cost per client in SILS has increased on the average of 8.22 per year in F.Y. 82 and 83. The average annual cost per client is projected to increase at 7% in F.Y. 84 and 7% in F.Y. 85. From F.Y. 81 through F.Y. 85, the average annual cost per client is expected to increase an average of 7.6% per year.

5. The total SILS budget is increasing at a decelerating rate. The total budget increased on the average of 52.9% per year in the first two years (F.Y. 82 end 83) of the state grant program. The SILS Budget is expected to increase on the average of 41.7% per year in F.Y. 84 and 85. In F.Y. 85 the increase is projected at 22.6%.

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

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

VI. A Proposal to Fund SILS Using the Title XIX MA Waiver A.

MA Waiver - National Status

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

Since the regulations became available in October 1981, a number of policy issues have been raised, two of which follow:

The refinancing issue involves the extent to which state will be allowed to expand eligibility for Title XIX reimbursable long term care services by adding persons currently served in state supported non-medical care facilities who have been found to require the level of care of a Title XIX certified institution. HCFA is now carefully examining waiver requests to determine whether the net effect is to transfer state costs to the federal-state Title XIX program. One of the federal government's policy objectives involves limiting the growth in future federal funding of Title XIX long term care services. California had submitted two waivers involving the refinancing of long term care services which were disapproved because the intent was to replace state revenues with federal medicaid reimbursements.

The issue of covering infant and preschool services under the waiver has arisen. The major question is whether these children, in the absence of the services, would have to be institutionalized in an ICF/MR. In general, the number of preschoolers admitted to ICF/MR's is low.

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

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

B. Proposal

To fund semi-independent living services for clients from ICF/MR's or eligible for ICF/MR placement under Medical Assistance (Title XIX), and fund other clients not eligible for placement into ICF/MR placement under CSSA as proposed in the Department Biennial Budget Request.

Policy Impact

1. The proposal will discourage inappropriate and unnecessary admissions to community residential facilities.

2. The deinstitutionalization process as required under the Welsch v. Hoot Consent Decree will be assisted by this proposed by "freeing up" additional community-baaed ICF/MR beds for clients from state hospitals or at risk of placement into state hospitals.

3. The proposal creates a less costly alternative to ICF/MR care for clients not needing 24 hour supervision, which will result in a decreased demand for community-based ICF/MR beds.

Program Impact

1. The proposal would assure an adequate level of SILS programs to prevent inappropriate and unnecessary ICF/MR placements, based upon the demands and costs for SILS submitted be part of the Community and Home Services.

2. Waivers under the Home and Community-based Services Program are available for three year periods; there is not future guarantee regarding service coverage.

C. Fiscal Impact

1) The proposal will reduce the additional costs for ICF/MR care.

2) County Boards would pay for SILS at the same rate as they pay for ICF/MR care; and thereby, creating incentive to place capable ICF/MR clients into SILS.

3) The proposal would increase federal financial participation in the provision of community-based services, and reduce state and county financial participation.

D. Fiscal Analysis of Funding SILS.

Table 7 displays the actual fiscal impact of funding SILS under the Title XIX HA Waiver contrasted with current funding model. Funding SILS under MA would increase federal financial participation and reduce the state and county level of costs.

TABLE 7

FISCAL ANALYSIS OF THE FUNDING OF SEMI-INDEPENDENT LIVING SERVICES
FOR CLIENTS ELIGIBLE FOR ICF/MR PLACEMENT

Option: To fund semi-independent living services for clients eligible for ICF/MR placement under Medical Assistance (Title XIX) and fund other clients under CSSA as already proposed in Department's Budget Request

NOTE: The costs compared in this table reflect the SILS cost to serve clients eligible for ICF/MR placement only.

	Number of Clients Eligible for ICF/MR	Total Budget for Eligible Clients	Funded Under Medical Assistance			v.	Funded Under State Grants-in-aid		
			Federal	State	County		Federal	State	County
F.Y. 83	624	$1,504,270	789,441	643,376	71,453		- 0 -	1,218,871	285,399
F.Y. 84	724	2,478,055	1,258,356	1,097,779	121,920		- 0 -	2,109,844	368,211
F.Y. 85	824	3,098,846	1,613,879	1,336,532	148,435		- 0 -	2,634,030	474,816
F.Y. 84 & 85 Biennium		5,576,901	2,872,235	2,434,311	270,335		- 0 -	4,743,874	843,027

COST IMPACTS USING TITLE XIX AS COMPARED WITH STATE GRANT-IN-AID

	Federal	State	County
F.Y. 83	increases 789,441	decreases 575,495	decrease 213,946
F.Y. 84	increases 1,258,356	decreases 1,012,065	decrease 246,291
F.Y. 85	increases 1,613,879	decreases 1,297,498	decrease 326,381
F.Y. 84 & 85 Biennium	increases 2,872,235	decreases 2,309,563	decrease 572,672

Table 8 summarize the changes in federal state and county financial participation which take place when SILS are funded under Medical Assistance and state grant in aid for the F.Y. 84 and 85 Biennium.

TABLE 8

COMPARISON OF FUNDING SEMI-INDEPENDENT LIVING SERVICES UNDER MEDICAL ASSISTANCE OR STATE GRANT-IN-AID IN THE F.Y. 84 AND 85 BIENNIUM

	Costs Under Medical Assistance	Costs Under State Grant-in-[1]	Difference
Federal	2,872,325	- 0 -	+2,872,235
State	3,049,037	5,358,589	-2,309,552
County	885,081	1,447,764	- 562,683
Total	6,806,353	6,806,353	

1. Costs include the service costs to serve all clients receiving SILS, including those clients proposed to be transferred to CSSA in January 1984.

VII. Summary

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

The conclusions derived from this examination are many, and due to projected deficits in the MA account, controversial. The data presented in this paper will support informed decisions but may not remove all controversies. If the philosophy of the existing administration is to maximize federal financial participation so as to meet service demands and, to do so at the least cost to the state and the counties, a decision to use Title XIX for these programs will be made.

Every attempt has been made to present a balanced picture of the issues, the impacts of the various options and, as detailed and accurate presentation of fiscal projections as possible. Forecasting is an imperfect science. The forecasts offered in this paper are necessarily subject to that imperfection but represent the "best effort" possible,

APPENDIX A

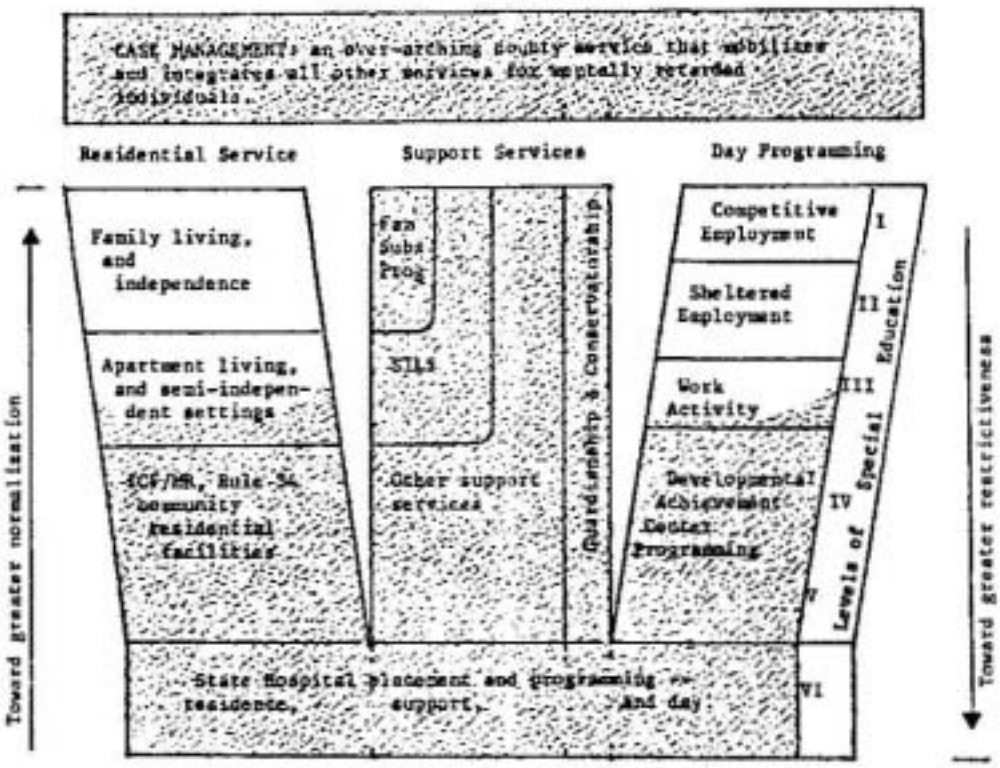

Figure 1

Minnesota's System of Services to Mentally Retarded People

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

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

In DPW, basic authority regarding the system is provided by Minn. Stat. S252. Regulatory rules apply to specific portions, as described below.

Case management is the mobilization and integration of all services to mentally retarded individuals, charged to the county boards by DPW Rule 185. This rule sets standards for case management.

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

Residential circumstances:

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

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

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

Support Services:

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

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

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

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

Day Programming:

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

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

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

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

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

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

APPENDIX B

TABLE B1
THE DEMANDS AND COSTS OF DEVELOPMENTAL ACHIEVEMENT SERVICES

	F.Y. 81	F.Y. 82	F.Y. 83	F.Y. 84	F.Y. 85
ADULT CLIENTS					
A. Clients Served	3,614	3,893			
Clients Needing Services	3,614	4,155	4,385	4,571	4,733
1981 Waiting List	262				
Clients from ICF/MR Settings	2,040(56%)	2,294(55%)	2,604(59%)	2,863(63%)	3,088(65%)
Clients from Other Settings	1,574(44%)	1,861(45%)	1,779(41%)	1,708(37%)	1,645(35%)
Avg. Daily Attendance	3,441(95%)	3,823(92%)	4,164(95%)	4,342(95%)	4,496(95%)
B. Avg. Per Diem	24.38(+6%)	25.75(+6%)	27.30(+6%)	28.94(+6%)	30.68(+6%)
Program Per Diem	20.16	21.52			
Transportation Per Diem	4.22	4.23			
C. Budgets-Total	17,575,286	20,722,094	23,985,889	26,513,728	29,104,766
Increase	1,932,643(11%)	4,477,960(23%)	2,527,839(11%)	2,591,038(10%)	
Budget for ICF/MR Clients	9,842,160	10,729,361	14,151,675	16,703,649	18,918,097
Budget for Other Clients	7,733,126	8,778,568	9,834,214	9,810,079	10,186,669
D. Avg. Days Per Year	209.5	210.5	211	211	211
Avg. Number of Days Needed to Increase to 220 days	224	224	224	224	224
E. Costs to Increase to 220 days	18,791,714	20,759,032	25,463,693	28,147,276	30,897,951
Increase	1,216,428 (6.9%)	1,251,103(6.4%)	1,477,804(6.2%)	1,633,548(6.2%)	1,793,185(6.2%)
CHILDREN CLIENTS					
A. Clients Served	1,250	1,254			
Clients Needing Service	1,250	1,400	1,400	1,400	1,400
1981 Waiting List	146				
Clients Eligible for MA	125	140	140	140	140
Clients Served In-Center (65%)	813	910	910	910	910
Clients Served at Home (35%)	437	490	490	490	490
B. Avg. Annual Cost Per Client	5,217(+6%)	5,671(+6%)	6,027(+6%)	6,388(+6%)	6,771(+6%)
C. Budget-Total	6,521,071	7,939,400	8,437,800	8,943,200	9,479,400
Budget for Clients Not MA	5,868,964	7,145,460	7,594,019	8,048,880	8,531,460
Budget for MA Eligibles	652,107	793,940	843,781	894,320	947,940
TOTAL					
A. Total Budget	24,096,357	28,661,494	32,423,689	35,456,928	38,584,166
Adult	17,575,286	20,722,094	23,985,889	26,513,728	29,104,766
Children	6,521,071	7,939,400	8,437,800	8,943,200	9,479,400
B. Clients Needing Services	4,864	5,555	5,783	5,971	6,133
Adult	3,614	4,155	4,383	4,571	4,733
Children	1,250	1,400	1,400	1,400	1,400

APPENDIX C

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

	Total DAC Costs	Federal%[1]	State%[2]	County%[3]
F.Y. 81	$24,096,357	$ 6,385,535(26.5%)	$ 5,879,511(24.4%)	$11,831,311(49.1%)
F.Y. 82	$28,661,494	$ 6,385,535(22.3%)	$ 6,232,282(21.7%)	$16,043,677(56%)
F.Y. 83	$32,423,689	$ 6,385,535(19.7%)	$ 6,606,219(20.4%)	$19,431,935(59.9%)
F.Y. 84	$35,456,928	$ 6,385,535(18.0%)	$ 7,002,592(19.8%)	$22,068,801(62.2%)
F.Y. 85	$38,584,166	$ 6,385,535(16.5%)	$ 7,422,748(19.3%)	$24,775,883(64.2%)
F.Y. 84 & 85 Biennium	$74,041,094	$12,771,070	$14,425,340	$46,844,684

1. Federal dollars were not projected to increase over time due to the significant reductions in federal appropriations.

2. State dollar were projected to increase to 6% per year consistent with base CSSA Budget increases.

3. For F.Y. 81, federal, state and county financial participation was based on actual governmental financial participation rates for all social services in calendar years 1980 and 1981.

APPENDIX D

PROJECTED DAC SERVICE REDUCTIONS UNDER CURRENT FUNDING MODEL

I. ASSUMING COUNTY EXPENDITURES FOR DAC SERVICES INCREASE AS INDICATED IN THE 1983 and 1984 COUNTY PLANS

	Projected DAC Costs	Projected County Revenue	Difference[1] (Adjusted)	Reduction Impacts will be: Clients on Waiting Lists or	Number of Days Reduced[3]
F.Y. 1982	$28,661,494	$23,637,283	$2,158,062	381 Children or 419 Adults	- 21.5 days
F.Y. 1983	32,423,689	24,917,622	4,263,698	707 Children or 779 Adults	- 38.0 days
F.Y. 1984	35,456,928	26,548,905	5,362,330	839 Children or 924 Adults	- 43.0 days
F.Y. 1985	38,584,166	28,071,117	6,654,632	983 Children or 1,082 Adults	- 48.0 days

II. ASSUMING COUNTY EXPENDITURES FOR DAC SERVICES INCREASE AT 11% PER YEAR

	Projected DAC Costs	Projected County Revenue	Difference[1] (Adjusted)	Reduction Impacts will be: Clients on Waiting Lists or	Number of Days Reduced
F.Y. 1982	$28,961,494	$26,619,363	$2,042,131	360 Children or 397 Adults[2]	- 20.5 days
F.Y. 1983	32,423,689	29,547,493	2,876,196	477 Children or 526 Adults	- 25 days
F.Y. 1984	35,456,928	32,797,717	2,659,211	416 Children or 458 Adults	- 21 days
F.Y. 1985	38,584,166	36,405,466	2,178,700	322 Children or 354 Adults	- 16 days

[1] Difference column has been adjusted to account for other DAC revenues at 10% of total budget.

[2] Actual waiting list in 1981 was 262 adults and 149 children

[3] Base for reduction of days is 211 days per year

APPENDIX E

STATE HOSPITAL DAY PROGRAM BUDGETS FOR
MENTALLY RETARDED FISCAL IMPACT ANALYSIS

I. COSTS UNDER MEDICAL ASSISTANCE PROGRAM

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

II. COSTS UNDER CSSA

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

III. FISCAL IMPACT BY SOURCE OF FUNDING

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

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

PROJECTED FEDERAL, STATE AND COUNTY REVENUES FOR DEVELOPMENTAL ACHIEVEMENT SERVICES FOR EACH TITLE XIX FUNDING OPTION

tion 1 fund 60% DAC adult clients der MA, and fund the other % adult and all children C clients under CSSA.	MA Portion of Budget	plus	CSSA Portion of Budget	equals	Total DAC Budget	Federal	State	County
F.Y. 83	$14,151,675		$18,272,014		$32,423,689	$11,026,386	$ 9,780,162	$11,617,141
F.Y. 84	16,703,649		18,753,279		35,456,928	11,857,703	11,112,865	12,486,360
F.Y. 85	18,918,097		19,666,069		38,584,166	13,097,446	11,954,927	13,531,793
F.Y. 84 & 85 Biennium	35,621,746		38,419,348		74,041,094	24,955,149	23,067,792	26,018,153
tion 2 fund 100% DAC adult clients der MA, and fund 100% pre- hool clients under CSSA.								
F.Y. 83	23,985,889		8,437,800		32,423,689	14,250,041	11,980,076	6,193,572
F.Y. 84	26,513,728		8,943,200		35,456,928	15,073,447	13,516,336	6,867,145
F.Y. 85	29,104,766		9,479,400		38,584,166	16,721,863	14,382,410	7,479,893
F.Y. 84 & 85 Biennium	55,618,494		18,422,600		74,041,094	31,795,310	27,898,746	14,347,038
tion 3 fund 100 adult and 10% ildren DAC clients under MA, d fund 90% preschool clients der CSSA.								
F.Y. 83	24,829,670		7,594,019		32,423,689	14,526,633	12,168,830	5,728,226
F.Y. 84	27,408,048		8,048,880		35,456,928	15,366,606	13,735,444	6,354,878
F.Y. 85	30,052,706		8,531,460		38,584,166	17,059,140	14,608,304	6,916,722
F.Y. 84 & 85 Biennium	57,460,754		16,580,340		74,041,094	32,425,746	28,343,748	13,271,600

APPENDIX G

Potential Additional DAC Cost Increases Under Medical Assistance

There exists the potential of additional cost increases for adult DAC services if funded under Medical Assistance, if not controlled at the legislative or departmental level. The two areas of potential cost increase and their fiscal impacts are:

1. Adult DAC per diems are increased at a rate of 8% per year rather than 6% per year. Increasing per diems for adult DAC clients by 8% per year would result in the following additional costs.

   F.Y. 84 - $ 494,728
   F.Y. 85 - $1,100,441
   Total - $1,595,169

2. The number of days of service is expanded to assure that all DAC adult clients are served a minimum of 220 days per year. This would increase the amount of days of services provided to adult clients in 64 DAC programs. The fiscal impact of expanding the number of days of service is as follows:

   F.Y. 84 - $1,633,548
   F.Y. 85 - $1,793,185
   Total - $3,426,733

APPENDIX H

SUMMARY STATISTICS FOR SEMI-INDEPENDENT LIVING SERVICES

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

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

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

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