DHS-7841A-ENG 01-19

Legislative Report

Waiver Reimagine Project

Waiver Reconfiguration and Individual Budgeting

Disability Services Division

January 2019

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I. Executive summary

Introduction

The Minnesota Department of Human Services' Disability Services Division (DHS) seeks to improve its system of supports for people with disabilities who live in Minnesota and their families. In 2017, DHS commissioned two studies to provide recommendations to:

1. Reconfigure the state's four Medicaid home and community-based services (HCBS) waivers—the Brain Injury (BI), Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC) and Developmental Disabilities (DD) waivers
2. Develop an individual budget model for people who receive HCBS services.

DHS contracted with the Human Services Research Institute (HSRI) and a team of HSRI partners to complete both studies. These efforts build on a number of DHS' previous initiatives, including development of the consumer directed community supports (CDCS) option, implementation of the MnCHOICES Assessment application and implementation of the Disability Waiver Rate Service (DWRS) framework, among others.

The project team's approach to develop the reconfiguration and provisional individual budget recommendations involved:

- Extensive stakeholder involvement, including statewide focus groups and an expert panel convened specifically for the project
- In-depth research and analysis completed by a multidisciplinary project team
- Activities and recommendations aligned with the identified goals of the project.

Stakeholder engagement

To kick off the work, the project team conducted 14 focus groups across Minnesota with people who have disabilities, family members, caregivers, providers, counties and tribal nations. In total, 265 Minnesotans contributed insights about how they experience the service system.

In addition to the project team's efforts, DHS met extensively with stakeholders throughout the state to share project information, offer opportunities for feedback and speak directly with people who receive services about their expectations for the changes. Based on these activities, DHS outlined several goals for the project:

- Offer flexibility to encourage person-centered supports
- Enhance personal authority of service choice

- Simplify waiver program information and administration
- Provide equity across waiver programs and participants
- Align benefits across waivers
- Ensure a smooth transition
- Offer the opportunity to monitor and improve programs to achieve greater sustainability.

Stakeholders were vital to the development of these goals, and they helped shape the course of the project overall. The project team also included stakeholders in an expert panel who completed several activities related to the development of the individual budget methodology. Finally, the project team met with a consistent group of stakeholders—including people with disabilities, families, advocates, providers, lead agency staff and state staff (some of whom were also members of the expert panel)—throughout the project to gain contextual understanding and offer opportunities for feedback.

Research activities

To establish opportunities for thoughtful change, the project team comprehensively researched Minnesota's current service system and the efforts of other states. Specifically, the project team reviewed:

- Minnesota's waivers
- Other states' efforts and actions to combine waivers
- How self-direction in Minnesota is applied
- How other states implemented individual budgets
- MnCHOICES assessments
- Service use and spending in Minnesota.

In the first part of this study, the project team reviewed Minnesota's four current disability waivers,[1] focusing on enrollment information, eligibility criteria, service arrays, performance measures, guiding policies and statutes and other external considerations. The project team also reviewed other states' efforts to combine or otherwise strategically reconfigure waivers. During that review, the project team focused on specific home and community-based services (HCBS) statutory authority types with widespread use around the country that might potentially align with Minnesota's project goals.[2] These reviews allowed the project team to consider possible options for reconfiguration.

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1 B. Taylor, Y. Kardell and J. Agosta, "Analysis of Minnesota disability waivers," 2018 (Prepared for Minnesota Department of Human Services Disability Services Division).

2 B. Taylor et al., "Analysis of federal funding authorities & Research Into other state activities," 2018 (Prepared for Minnesota Department of Human Services Disability Services Division).

The project team reviewed the current CDCS budget methodology, as well as individual budget methodologies used in other states.[3] The team found 31 states were using some form of an assessment-informed, prospective budget methodology for one or more target HCBS populations, and that most of the 31 states were using a level-based methodology. This review provided information about the risks and benefits of each approach and informed the development of the team's proposed budget methodology, which is designed to be sustainable over time.

Finally, the project team reviewed people's MnCHOICES assessments[4] and service use.[5] From this review, the team determined:

- DHS can use the MnCHOICES assessment to develop a budget methodology
- Service use differs according to people's needs and differences in living setting and age.

Recommendations

The project team's research led to following set of recommendations.

Two waivers: Individual Support and Residential Support waivers

The project team recommends a waiver reconfiguration that combines the populations served through the four existing HCBS waivers—BI, CADI, CAC and DD—and reduces the number of waivers to two, defined by living setting instead of level of care or diagnostic classification.[6] The resulting waiver strategy includes:

- An Individual Support Waiver that will serve people living independently or at home with their family
- A Residential Support Waiver that will serve people living in paid residential settings.

The Individual Support Waiver will include a dynamic, consumer-directed option that will give people the flexibility to self-direct all or a portion of their services. An important feature of the recommended

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3 J. Petner-Arrey et al., "Analysis of budget methodologies & research into other state activities," 2018 (Prepared for Minnesota Department of Human Services Disability Services Division).

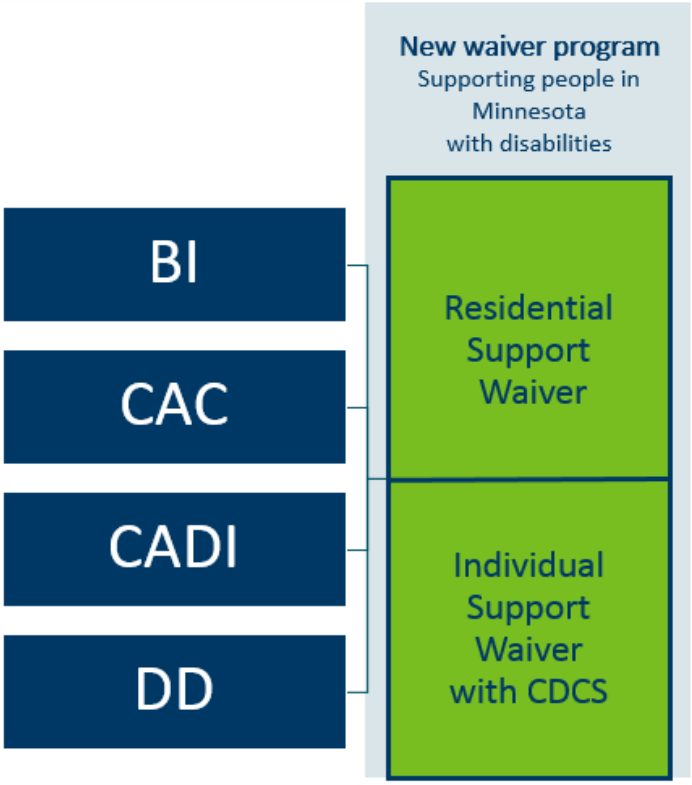
4 C. Kidney, J. Petner-Arrey and J. Agosta, "Analysis of MnCHOICES," 2018 (Prepared for Minnesota Department of Human Services Disability Services Division).

5 S. Pawlowski, J. Petner-Arrey and B. Taylor, "Analysis of service use and spending," 2018, (Prepared for Minnesota Department of Human Services Disability Services Division).

6 B. Taylor et al, "Waiver Reimagine: Feasibility & Recommendation Report," 2018 (Prepared for Minnesota Department of Human Services Disability Services Division).

reconfiguration is the identification of the new structure as a singular, identifiable program within the state. The two waivers will provide the operational structure behind this singular program (see figure 1).

Figure 1: Transition to new waiver program



Both the Individual and Residential Support waivers encompass the four levels of care and other eligibility criteria associated with the four current waivers. As a result, eligibility requirements will remain essentially unchanged for people who use services. This is intended to create unity between the two waivers and make them easier to understand and navigate.

Building on DHS' efforts to align services across the four current waivers, DHS anticipates a common set of services will be made available across the two proposed waivers, except for limitations based on living setting (e.g., foster care services [paid residential services]). These services will be available only on the Residential Support Waiver.

In both the Individual and Residential Support waivers, people will receive supports aligned with their needs indicated during their MnCHOICES assessment. In other words, each person will receive an amount of funding to pay for home and community-based services based on a score of their MnCHOICES assessment. DHS will manage budgetary allocations through a unified, individual budget

model (described below) rather than an overall aggregate authorization or spending budget limit. The methodology will be applied to all adults served on either waiver. During this study, HSRI was unable to incorporate children into the support range framework due to data lags resulting from the rollout schedule of MnCHOICES. To address this, DHS will modify the support range frameworks using updated and more complete MnCHOICES data to include children during the recalibration phase before implementation. Recalibration will allow DHS to make a number of updates to the model before implementation to incorporate new data, policy and rate changes.

Individual budget model

DHS currently operates two different budget methodologies:

1. **Consumer directed community supports (CDCS) budget methodology:** People who self-direct their services receive their budget through the CDCS methodology that DHS consistently applies across the state but differs depending on the person's waiver.
2. **Lead agency budgets:** People who choose to use traditional services receive service authorizations from their lead agencies. Lead agencies do not use a unified framework to guide authorization decisions.

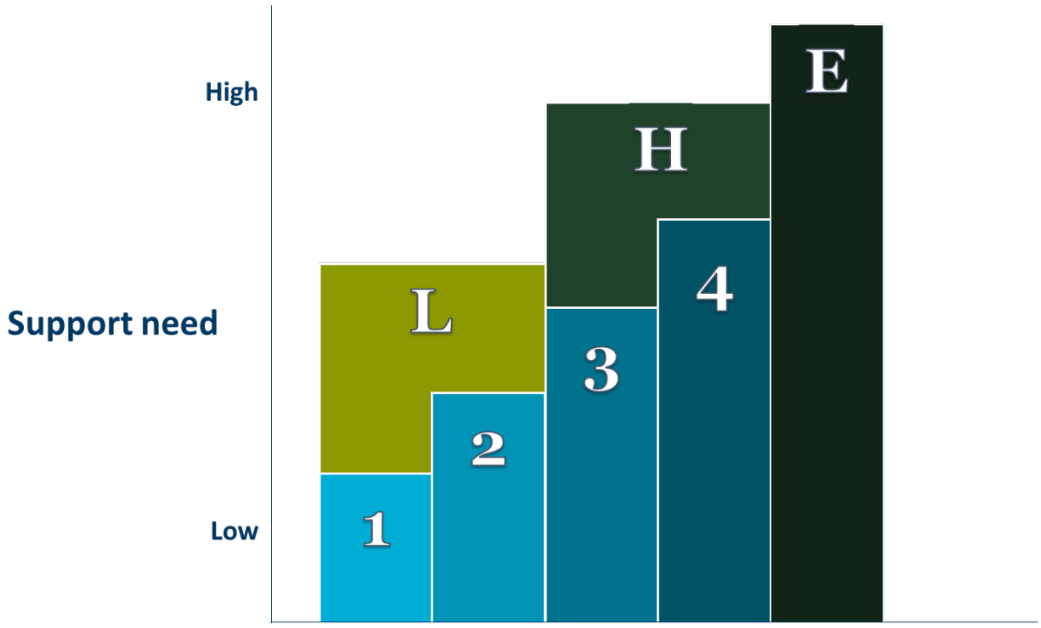
The CDCS budget methodology has remained largely unchanged since its inception in 2004, aside from cost-of-living adjustments. Meanwhile, the traditional budget methodologies vary by lead agency. As a result, DHS seeks to develop a unified, consistent budget methodology for all people who self-direct and who use traditional services. Additionally, DHS wants a methodology that can be applied consistently across people who receive services and that can offer sustainability over time.

The project team recommends an individual budget model that is composed of three different provisional frameworks:

- Support range descriptions, which help describe the framework overall so stakeholders can understand it better
- Support range criteria, which describe how MnCHOICES data are used to group people with similar support needs into a support range
- Service mixes, which are used to develop funding amounts that differ based on where people live and their support range determinations.

The individual budget model includes seven unique support ranges that are assigned to people with similar support needs (see figure 2).

Figure 2: Provisional support range framework



This framework encompasses support ranges for people with a range of general support needs (ranges 1-4) and support ranges for people with high or extraordinary health and/or psychosocial support needs (ranges L, H and E). Figure 3 describes each support range.

Figure 3: Provisional support range framework brief descriptions

1	Low general support need, typical health and psychosocial support needs
2	Moderate general support need, typical health and psychosocial support needs
L	Low to moderate general support need, high health and/or high psychosocial support needs
3	High general support need, typical health and psychosocial support needs
4	Extensive general support need, typical health and psychosocial support needs
H	High to extensive general support need, high health and/or high psychosocial support needs
E	Extraordinary health and/or psychosocial support needs as determined by an additional process

After a person is assigned a support range, he/she can receive a budget range. The budget ranges are defined based on the support range determined from a person's MnCHOICES assessment information and living setting. The project team only developed provisional budgets for adults, though the budget model is intended to include children before implementation. DHS will have to analyze updated MnCHOICES data during the support range recalibration to incorporate children.

In total, there are 35 possible budget ranges for adults who use HCBS, since there are seven support ranges and five living settings. To develop these budget ranges, the project team composed model service mixes that accounted for the type and amount of services adults in each living setting and support range typically used in the past year. Along with an average rate for those services, the team calculated the total cost of the model service mixes. The team made several adjustments to these service mixes to advance state specific policy goals and built the ranges directly from the model service mixes. Taking this approach ensures the budgets are likely to cover the types and amounts of services most people will need. People who choose the consumer directed community supports (CDCS) option will have the same budgets as those who choose to use traditional services. Table 1 explains the breakout of provisional budgets.

Table 1: Provisional individual budgets for adults by living setting and support range

	Support range						
Living setting	**1**	**2**	**L**	**3**	**4**	**H**	**E**
Corporate foster care	$81,248 to $111,248	$83,978 to $113,978	$92,903 to $122,903	$92,903 to $122,903	$111,908 to $141,908	$117,656 to $147,656	$132,225 to $162,225
Family foster care	$44,839 to $74,839	$57,150 to $87,150	$66,075 to $96,075	$66,075 to $96,075	$88,913 to $118,913	$88,913 to $118,913	$97,733 to $127,733
Other residential	$31,425 to $61,425	$34,155 to $64,155	$43,080 to $73,080	$52,661 to $82,661	$77,415 to $107,415	$77,415 to $107,415	$86,235 to $116,235
Living with family	$0 to $27,220	$0 to $27,745	$16,379 to $46,379	$16,379 to $46,379	$33,523 to $63,523	$40,071 to $70,071	$45,321 to $75,321
Living independently	$5,328 to $35,328	$5,853 to $35,853	$22,874 to $52,874	$22,874 to $52,874	$37,135 to $67,135	$43,330 to $73,330	$48,580 to $78,580

The provisional budget ranges developed through this process are meant to be used flexibly. The intent is that each person can purchase the services he/she wants and needs within his/her budget. The budget is not intended to replace the important work that occurs in planning meetings to decide which services and service amounts each person will need. Instead, it will offer guidelines to support decision-making. In addition, DHS will develop a robust exceptions process with clear criteria to allow people to request more funding when their budget may be insufficient to meet their needs. Finally, the support ranges and budgets included are provisional—DHS will need to alter the support ranges and budgets after data from the MnCHOICES 2.0 Assessment is available, and it will have to include children in the support ranges before implementation.

Alignment with goals

These recommendations align with the specific goals identified by DHS:

1. Offer flexibility to encourage person-centered supports.

The proposed, unified budget methodology approach is prospective, which means people will know their budget as they plan for their preferred services. The approach maximizes flexibility and choice for people who use services by providing them an overall budget to help guide their decisions. Both waivers can support people who have a full spectrum of support needs, no matter their living setting.

2. Enhance personal authority over service choice.

Changing CDCS to an a-la-carte approach enhances the consumer-directed option. In the current system, people must select either entirely traditional waiver services or entirely self-directed services. By creating opportunities for people on the Individual Support Waiver to self-direct a portion of their waiver services, more people will be able to use self-direction without having to adopt it for all services.

In addition, access to a budget increases the opportunity for people on both waivers to make choices about the services they need and prefer within their budget. Having this information will place greater decision-making power in the hands of people themselves. People can spend their budgets on a streamlined service menu that is easier to understand and navigate. They can make informed choices about their services

3. Simplify waiver program information and administration.

The Individual and Residential Support waivers will be operated as one program. This will simplify Minnesota's Medicaid long-term services and supports system for stakeholders at all levels. In this unified program, the difference between waivers allows for more precise targeting of services to each population's support needs.

Further, the unified budget methodology will simplify the waiver program significantly for people who receive services and lead agencies by generating a transparent budget for each person and replacing the current lead-agency-allocation management structure that varies by waiver and by use of CDCS or traditional services.

4. Provide equity across waiver programs and participants.

People with any level of support need and/or diagnosis will be able to access the program if they meet eligibility criteria. By introducing an individual budget model to manage the allocation of resources within these waivers, DHS will be able to match the services available on each waiver with people's

assessed needs rather than with specific diagnostic labels. The budget model will provide a statewide, unified resource allocation method that promotes equitable access to resources across the state, regardless of where a person lives.

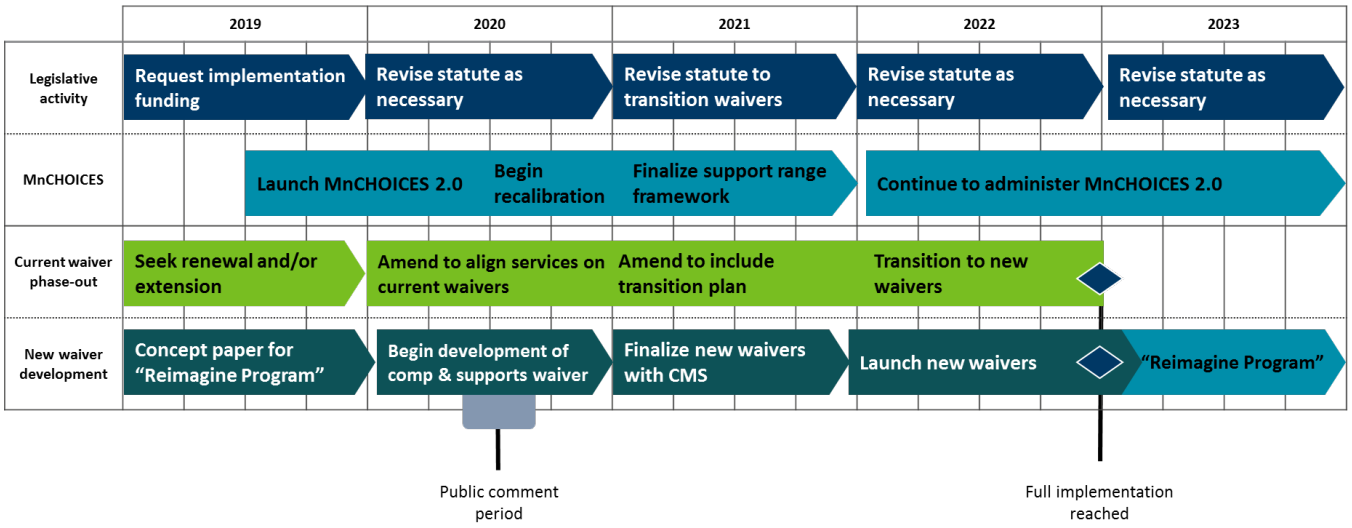
5. Align benefits across waivers.

In the proposed configuration, services from the four current waivers are combined (and in some cases, reimagined) to meet individual needs better and reduce confusion in instances when services overlap. This structure is complemented by the proposed, unified budget methodology, which is based on a person's objective support needs and is aligned across waivers.

6. Ensure a smooth transition.

A pathway to the new program must strive to lessen undesirable disruptions in services and supports for all involved—including people and their families, providers, lead agencies and system administrators. After considerable work necessary to prepare for implementation, DHS anticipates it will transition people to the new program over a 12-month period (starting in 2022) based on individual service plan dates. This will allow for the service planning process to address the unique service needs of each person on a waiver as he/she transitions to a new waiver and budget. Figure 4 shows different tasks and the proposed time each will be completed, beginning with work in 2019.

Figure 4: Proposed recommendation implementation timeline



7. Offer the opportunity to monitor and improve programs to achieve greater sustainability.

The proposed reconfiguration strategy offers the legislature and DHS the ability to make strategic adjustments to the waivers based on specific needs and use improvements to create a more sustainable system. The support range framework and the budget model will give the state "eyes on

the system," allowing it to monitor and assess individual funding in the program and make strategic adjustments over time.

Taken as a whole, the changes proposed meet the many goals DHS and stakeholders held for this work and will result in a more streamlined, simplified and person-centered service system for people with disabilities in Minnesota.

II. Legislation

This report fulfills two legislative requirements.

Minnesota Laws of 2017, First Special Session, Chapter 6, Article 18, Section 2, subdivision 7, paragraph c:

"**Consumer-Directed Community Supports Revised Budget Methodology Report.** $435,000 in fiscal year 2018 and $65,000 in fiscal year 2019 are from the general fund to study and develop an individual budgeting model for disability waiver recipients and those accessing services through consumer-directed community supports. The commissioner shall submit recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over these programs by December 15, 2018. This is a onetime appropriation."

Minnesota Laws of 2017, First Special Session, Chapter 6, Article 18, Section 2, subdivision 7, paragraph h:

"**Waiver Consolidation Study.** $110,000 in fiscal year 2018 and $140,000 in fiscal year 2019 are to conduct a study on consolidating the four disability home and community-based services waivers into one program. The commissioner of human services shall submit recommendations to the chairs and ranking minority members of the legislative committees with oversight over health and human services by January 15, 2019. This is a onetime appropriation."

III. Project recommendations

Project aims

In early 2018, the Minnesota Department of Human Services' Disability Services Division (DHS) contracted with the Human Services Research Institute (HSRI) and a team of HSRI partners to complete two studies. The aim was to develop recommendations related to DHS' goals for improving the system of supports available to people with disabilities who live in Minnesota and their families. These studies focus on four Medicaid-funded programs that offer home and community-based services (HCBS) through a waiver of certain aspects of Section 1915(c) of the Social Security Act and Minn. Stat. §256B.49 and §256B.092. The four HCBS waiver programs include:

- **Brain Injury (BI) Waiver** for people younger than age 65 with acquired or traumatic brain injuries who need the level of care provided in a nursing facility that provides specialized services (e.g., cognitive and behavioral supports) or the level of care provided in a neurobehavioral hospital
- **Community Access for Disability Inclusion (CADI) Waiver** for people with disabilities younger than age 65 who need the level of care provided in a nursing facility
- **Community Alternative Care (CAC) Waiver** for chronically ill and medically fragile people younger than age 65 who need the level of care provided in a hospital
- **Developmental Disabilities (DD) Waiver** for people with developmental disabilities or related conditions of any age who need the level of care provided in an intermediate care facility for persons with developmental disabilities (ICF/DD).

The two studies are summarized as follows:

- **Study 1** provides recommendations on reconfiguring the program structures associated with the four waivers, including the potential for consolidation to achieve efficiencies, simplifications and improvements in design and service delivery, as well as potential impacts.
- **Study 2** provides recommendations to establish an individual budgeting model for people who receive HCBS based on factors related to the person's support needs, living circumstances and other potential factors to enhance the personal authority people have over choosing the type and amount of HCBS they receive.

Background

Over the past six decades, the country's state support systems for people with disabilities have evolved significantly. Fifty years ago, there were few, if any, community-based services. While most people with disabilities lived in their families' homes without the services they or their families needed, a

significant number of people lived in state-run facilities. For decades, these facilities comprised Minnesota's primary service response to people with disabilities.

Informed by decades of legislative action, court decisions and evolving thought, current best-practice guidance emphasizes community integration and principles to promote self-determination. Further, over this time, people with disabilities increasingly have expressed their want and resolve to live lives of their own choosing in the community.

Based on these actions and demands, the changes emerging in service systems in Minnesota and elsewhere are part of a continuing evolution that began decades ago. Along the way, words like 'normalization,' 'dignity of risk,' 'inclusion,' 'participation' and 'natural supports' served as rallying points to push along change. More recently, Minnesota and other states have embraced the concepts of self-determination and supported decision-making, carrying great implications for states as they reform how systems are managed and to what end. In self-directed systems, each person who receives services has considerable authority over the services he/she receives, how he/she receives them and from whom—beginning with substantial control of his/her allocated budget for services.

At issue is how best to offer community-based services. An equal challenge to policymakers is deciding what to do with legacy services that have persisted over the years.

Within the larger national context, the Minnesota disability system has also evolved. In its 2017 Biennial Report on Long-Term Services and Supports for People with Disabilities,[7] DHS states:

> Minnesota is on a continuing journey to transform services for people with disabilities. We once had large, state-operated regional treatment centers. As they have closed, Minnesotans with disabilities have moved into communities across the state. However, living in the community may not be the same as being part of the community. Some Minnesotans with disabilities remain isolated from meaningful relationships with people who are not family or paid staff (p.6).

7 Minnesota Department of Human Services Disability Services Division, "2017 Biennial Report on Long-Term Services and Supports for People with Disabilities (PDF)," 2017.

DHS aims to tackle a challenge common to most states. This challenge is not only about efficient system management, but also about ensuring people with disabilities can live in, participate in and contribute to their communities—just as others do. To guide the way, DHS commits to achieving six fundamental outcomes related to the people it serves. These outcomes can be summed up with the acronym CHOICE:

- **C**ommunity membership
- **H**ealth, wellness and safety
- **O**wn place to live
- **I**mportant long-term relationships
- **C**ontrol over supports
- **E**mployment earnings and stable income.

DHS also recognizes that, in the context of promoting community life, people must have access to and participate in social networks to complement paid public services. These include natural, informal supports and networks that exist outside of what Medical Assistance covers. From the person's perspective, having friends and supports outside the system promotes a greater sense of community belonging. From a systems perspective, it is essential that alternative resources be maximized to complement publicly financed services to address individual needs, make the most efficient use of public resources and ensure the overall wellbeing of people with disabilities.

Regarding this overall trajectory, the state also is taking affirmative steps to achieve each intended outcome.

Olmstead Plan implementation

The state has acted with principle and attention to implement its Olmstead Plan. The U.S. District Court approved the plan in 2015. This plan presents a series of activities the state must perform to the satisfaction of the court to ensure people with disabilities:

- Live close to their families and friends
- Live more independently
- Engage in productive employment
- Participate in community life.

Transition plan for federal Centers for Medicare & Medicaid Services (CMS) requirements

DHS has worked proactively to align policy with new rules issued by CMS to guide delivery of home and community-based services (HCBS).[8] In March 2014, CMS issued new requirements for the delivery of HCBS. These rules emphasize community integration, person-centered planning and services and choice/self-direction over services. These rules provide assurances that people who use home and community-based services:

- Receive supports in the most integrated setting
- Have full access to the benefits of community living (including employment)
- Have the ability to engage with people who do not have disabilities.

The rule also promotes person-centered planning and conflict-free case management. DHS submitted a transition plan to CMS to describe how it will comply with the new rule. Given these circumstances, DHS has articulated policy intentions over time and taken steps to ensure people with disabilities receive the supports they need in ways that are consistent with these ideals.

MnCHOICES

DHS seeks to gather accurate and reliable information about the support needs of each person. MnCHOICES is an assessment and support-planning tool developed in collaboration with internal and external stakeholders in a multi-year process. DHS launched MnCHOICES in fall 2013, and all counties and participating tribal nations now use MnCHOICES for new assessments. According to DHS, the tool:

- Standardizes in-person assessments for long-term services and supports
- Promotes timely consideration of support options reimbursed through Medical Assistance long-term services and supports programs
- Provides more data than was previously available to evaluate outcomes and inform future policy decisions
- Streamlines support plan development
- Determines eligibility for publicly funded programs and services for people of all ages and disabilities—including the four current HCBS waivers.

Data generated through the comprehensive MnCHOICES assessment plays a foundational role for establishing individual budgets for each person who receives services. For more information, see the Budget methodologies research: MnCHOICES section of this report.

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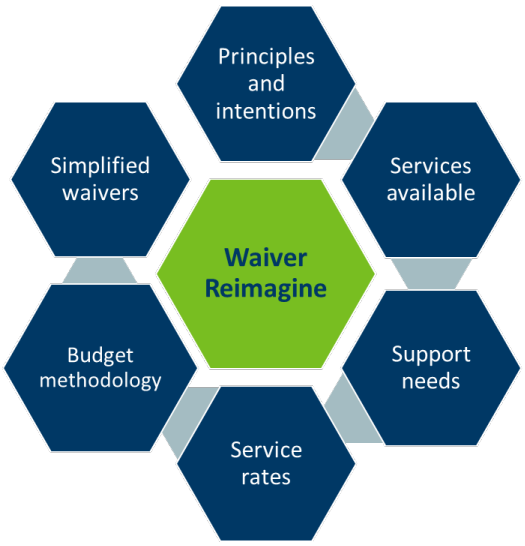
8 Medicaid.gov, "Home & Community-Based Services Guidance," n.d.

Service array development

Figure 5: The Waiver Reimagine recommendation development process



DHS has developed a well-formed service array that facilitates improved access to the community. People who participate in each of the four waivers have access to a range of services. In fact, many services are available across all waivers. As demonstrated in the Implementation considerations: Service array section of this report, these services have the potential to be offered in a streamlined and simplified way across the waivers.

People may choose to receive services through the consumer directed community supports (CDCS) option so they can self-direct their services. Across the four waivers, more than ten percent of people currently choose the CDCS option. While opportunities exist for improving service access across the waivers, opportunities also exist to expand the CDCS option and adjust the methodology so it is a viable option over time.

Disability Waiver Rate System (DWRS)

DHS is implementing a systematic way to pay for services. In response to a federal Centers for Medicare & Medicaid Services (CMS) corrective action plan, DHS began work to establish a Disability Waiver Rate System (DWRS) for "traditional" (i.e., agency-provided) services. DHS examined the cost of providing waiver services and sought stakeholder input. The 2013 Legislature finalized the DWRS, and in 2014, DHS began to implement the system. Though still in implementation, this new structure represents a significant change in rate setting in Minnesota because the responsibility of setting service rates was transferred from counties and tribal nations to DHS. This unified rate framework enables DHS to offer a consistent financing structure across counties and tribal nations. The framework also involves variables the legislature and DHS can adjust over time to account for changing costs in services, and it offers a transparent and accessible way for people, providers and others to calculate the costs of services.

Commitment to continued improvement

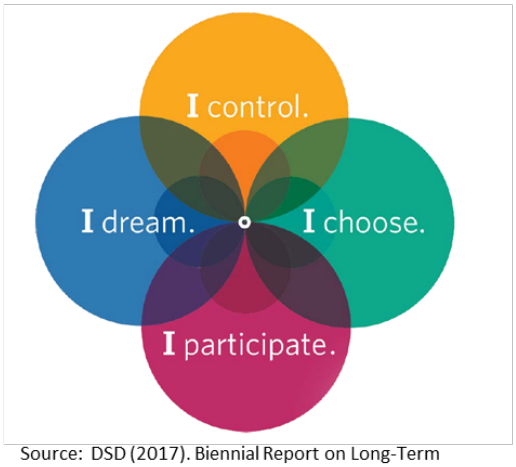
Overall, much of DHS' recent efforts to improve its service response to people with disabilities are focused on two primary commitments:

1. **To organize and deliver waiver services to people within a streamlined and unified construct in which:**
   - Administration is simplified and services are more accessible
   - The services or benefits available are well-aligned across populations, regardless of diagnosis
   - All people who receive services are treated equitably and have access to the same service-planning practices and services
   - All people have the services they need when they need them.

   People who need home and community-based services (HCBS) have a range of conditions, needs and preferences that require varying service responses. In the past, these differences resulted in dividing services into categories tied to diagnostic labels (e.g., brain injury, intellectual disability, medical fragility, mental health). However, a unified approach to HCBS seeks to de-compartmentalize the service response by bringing all those who need HCBS under the same organizing framework to assess need and deliver services.

2. **To organize and deliver HCBS to people with disabilities in ways to promote person-centered practices.** Person-centered practices seek to accommodate individual preferences, considering what is important to the person and for the person to live a healthy and safe life. As illustrated by figure 6, from the person's perspective, this ideal means each person can expect to be in control of his/her life to the extent he/she can, to pursue his/her dreams and aspirations and to live a life of his/her own making supplemented with supports he/she chooses. To achieve this, a reconfigured system must incorporate flexibility into its design to accommodate the varied choices people inevitably will make across the state.
   In this regard, DHS notes:

Figure 6: What person-centered practices mean to a person with disabilities



Source: DSD (2017). Biennial Report on Long-Term Services and Supports for People with Disabilities.(p. 29)

> A key part of our approach has been the focus on using person-centered practices in everything we do. Using person-centered practices is a fundamental part to overcoming system bias. It allows us to support people so that they can

engage fully in community activities. To achieve that, we strive to align policy, regulations, funding and practices to reach better outcomes for people. (p. 9)[9]

As DHS presses forward with these commitments, the Medicaid HCBS statutory waiver authority will provide the primary means for financing these services. As a result, it is essential that DHS' eventual strategy for using this authority be consistent with its policy intentions, provide efficient ways to manage the service system and ensure people get the services they need while exercising the opportunity to direct their own lives to the extent they can. Ensuring a smooth transition from present circumstances to a reconfigured system, however, will require careful planning and disciplined, purposed action.

Waiver reconfiguration recommendation

Two waivers: Individual Support and Residential Support waivers

After engaging in a thorough research-and-review period and discussion with stakeholders and DHS, the project team recommends combining the populations currently served through the four existing HCBS waivers (Brain Injury [BI], Community Access for Disability Inclusion [CADI], Community Alternative Care [CAC] and Developmental Disabilities [DD]) and reducing the number of waivers to two. These combined waivers will be defined by living setting instead of level of care or diagnostic classification.

The resulting waiver strategy includes:

- An Individual Support Waiver that will serve people living independently or at home with their family
- A Residential Support Waiver that will serve people living in paid residential settings.

An important feature of the recommended reconfiguration is that the new structure is a singular, identifiable program within the state. The two waivers will provide the operational structure behind this singular program. These new waivers will allow DHS to launch a program that is not connected to historical, diagnostic-specific waivers.

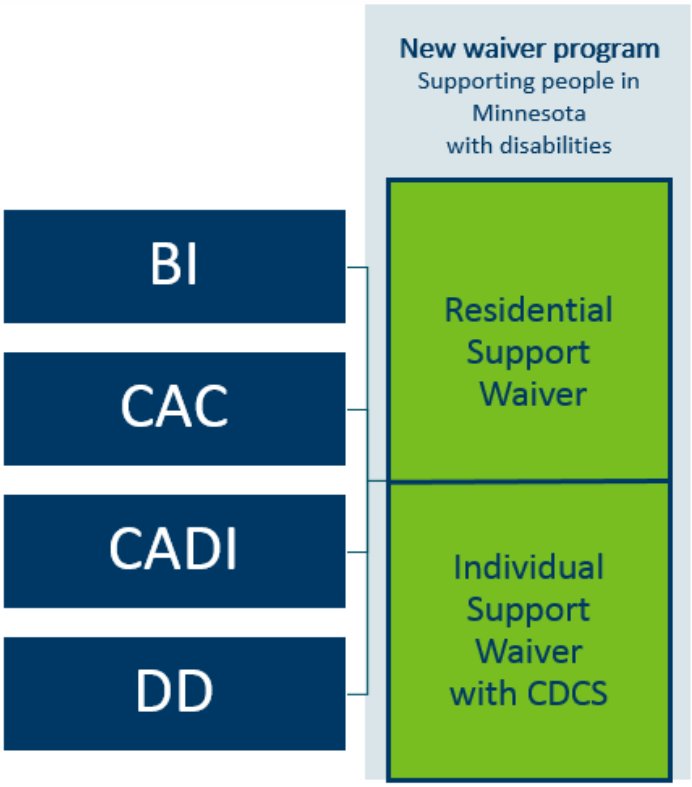
In both the Individual and Residential Support waivers, the project team proposes people receive services proportionate to their assessed support need. These services will be allocated through a budget model discussed in the Individual budget model recommendations section of this report. DHS

9 Minnesota Department of Human Services, Disability Services Division, "2017 Biennial Report on Long-Term Services and Supports for People with Disabilities (PDF)," 2017.

will manage budget allocations through individual budgets rather than county or tribal aggregate budgets. Only the Individual Support Waiver will include the consumer directed community supports (CDCS) option that allows people to self-direct all or a portion of their services.

These waivers will exist in the larger context of Minnesota's Medical Assistance program, which serves as the basis for people accessing Medicaid-paid disability services. Figure 7 shows the movement from the current system to the proposed reconfiguration.

Figure 7: Transition to new waiver program



Eligibility and target groups

Both waivers (Individual and Residential) encompass the four levels of care, as well as other eligibility criteria associated with the four current waivers (see table 2). As a result, waiver level-of-care eligibility requirements will remain essentially unchanged for people who use services. This will maximize the opportunity for people to continue to meet their existing eligibility criteria and create unity between the two waivers, which DHS will operate as a singular program.

Table 2: Level of care determinations crosswalk to proposed waivers

Current configuration levels of care	Proposed Individual and Residential Support waivers
BI: Neurobehavioral or specialized nursing facility	• Neurobehavioral hospital or specialized nursing facility • Hospital • Nursing facility • ICF/DD
CAC: Hospital	
CADI: Nursing facility	
DD: Intermediate care facility for persons with developmental disabilities (ICF/DD)	

Similarly, target groups will encompass all target groups distributed across the four current waivers (see table 3).

Table 3: Target groups crosswalk to proposed waivers

Current configuration target groups	Proposed Individual and Residential Support waivers
BI: • Primary: Aged or disabled, or both • Subgroup: Brain injury	• Primary: Aged or disabled, or both Subgroup: Brain injury • Primary: Aged or disabled, or both, general Subgroup: Disabled (other) • Primary: Aged or disabled, or both, general Subgroups: Disabled (physical) and disabled (other) • Primary: Intellectual disability or developmental disability, or both Subgroups: Intellectual disability and developmental disability
CAC: • Primary: Aged or disabled, or both, general • Subgroup: Disabled (other)	
CADI: • Primary: Aged or disabled, or both, general • Subgroups: Disabled (physical) and disabled (other)	
DD: • Primary: Intellectual disability or developmental disability, or both • Subgroups: Intellectual disability and developmental disability	

Under the proposed configuration, DHS will have the ability to target services and supports for people based on where they live. For example, the state can choose to implement services, policies or procedures specific to people who live in a family's home while also taking into consideration the unique needs and dynamics of the family unit.

Building on DHS' efforts to align services across the four current waivers, the project team anticipates a common set of services will be made available across the two proposed waivers to the degree possible given the different groups to be served on each waiver. Any differences in service arrays between the two waivers will be due to service limitations based on living setting. For example, foster care services and other paid residential services will be available only on the Residential Support Waiver, and the CDCS option will only available on the Individual Support Waiver. See the Transition plan section of this report for a description of potential service arrays under the new configuration.

Alignment with goals

The project team selected this waiver configuration because it demonstrated the best fit with DHS' overall policy goals. Chief among those goals are:

1. **Offer flexibility to encourage person-centered supports.** This configuration offers the greatest flexibility for people who use services while DHS maintains the ability to manage people's movement into paid residential settings based on criteria established through the implementation-planning phase. Both waivers can support people with a full spectrum of support needs, no matter their living setting.
2. **Enhance personal authority over service choice.** In the current system, people must select either entirely traditional waiver services or entirely self-directed services. Creating opportunities for people on the individual support waiver to self-direct a portion of traditional waiver services will allow more people to use self-direction for a portion of their support plan without having to adopt it across the board for all services.
3. **Simplify waiver program information and administration.** Reducing the number of waivers and aligning the two new waivers as mechanisms under one program is intended to simplify the supports system for stakeholders at all levels, from people who receive services to lead agency staff who administer them. Aside from services and eligibility based on residential setting, these two waivers will be as closely aligned as possible to ease administrative operation and be presented as a single program. For example, the waivers will share eligibility criteria, which will allow people to work with service planners to determine the array of supports that will meet their needs best rather than having to decide which waiver will offer the richest financial and service benefit.
4. **Provide equity across waiver programs and participants.** People with varying support needs and/or diagnosis will be able to access the reconfigured waiver programs if they meet level-of-care eligibility criteria. By introducing an individual budget model to manage the allocation of resources within these waivers, DHS will be able to match the services available on each waiver with the assessed needs of people who use services.
5. **Align benefits across waivers.** In the proposed configuration, services from the four current waivers are combined (and in some cases, reimagined) to meet individual needs better and

reduce confusion in instances when services overlap. The proposed configuration creates considerable similarity in waiver structures, and the two waivers share many services. Operating both as a singular program drives home the similarities between these two waivers in terms of structure and standards.

6. **Ensure a smooth transition.** A pathway to the new program must lessen undesirable disruptions in services and supports for all involved—including people and their families, providers, lead agencies and system administrators. While a more detailed description of the transition plan is provided in the Implementation considerations section of this report, the project team anticipates DHS will transition people to the new program over the course of a 12-month period based on individual service plan dates. This will allow for the support planning process to address the unique service needs of each person as they transition to one of the new waivers.
7. **Offer the opportunity to monitor and improve programs to achieve greater sustainability.** The proposed strategy offers the legislature and DHS the ability to make targeted adjustments to the waivers based on feedback and learning. DHS also has an opportunity to use the recommendations to create a more sustainable system. DHS might achieve this through several ways—from meeting people's support needs earlier and with less-costly services to incentivizing services that support greater independence or advance the use of natural supports. This not only fits with DHS' desire to support families and promote independence, but it also fits with overall system sustainability.

A two-waiver configuration also offers DHS the opportunity for greater control over the system. Offering different services on these waivers specific to residential settings allows DHS to observe demand for movement into costlier residential service settings. Learning more about this demand might help DHS learn how it can meet the needs better of people who live with family or independently.

Currently, counties and tribal nations make determinations about the amount of funding for each person through service authorizations. In the proposed model, DHS will apply a single, transparent method to make these determinations. This will decrease variation across counties and tribal nations in what is made available to people, making a more equitable allocation system based on people's individual needs measured by the MnCHOICES assessment.

Control is necessary to maintain fiscal responsibility. To meet this need, the budget model assigns a supports range to people with an associated budget designed to meet their needs. While promoting choice and flexibility, this model allows people to have their support needs met and still offers the legislature and DHS a mechanism by which to monitor and manage overall cost.

Individual budget model recommendations

In addition to the variation across counties and tribal nations in budget allocations mentioned above, DHS currently operates two different budget methodologies:

1. **Consumer directed community supports (CDCS) budget methodology:** People who self-direct their services receive their budget through the CDCS methodology that is applied consistently across the state but differs depending on the person's waiver.
2. **Lead agency budgets:** People who choose to use traditional services receive service authorizations from their lead agencies. Lead agencies do not use a unified framework to guide authorization decisions.

The CDCS budget methodology has remained largely unchanged since its inception in 2004, aside from cost-of-living adjustments. Meanwhile, the traditional budget methodologies vary by lead agency. As a result, DHS seeks to develop a unified, consistent budget methodology for all people who self-direct and who use traditional services. Additionally, DHS wants a methodology that can be applied consistently across people who receive services and that can offer sustainability over time.

To advance the goals outlined by DHS, the project team developed a provisional individual budget model using multiple methods, data sources and stakeholder feedback. The purpose of the budget model is to assign a budget range to each person based on needs identified by his/her MnCHOICES assessment. In conjunction with the project team's waiver reconfiguration recommendations, this unified framework is intended to meet several of the goals envisioned for the Waiver Reimagine project. DHS envisioned an individual budget model would enhance personal authority and promote greater equity among people who receive services. (See the Alignment with goals section of this report for more benefits.) The team selected this approach after conducting extensive research in both Minnesota and elsewhere. (See the Budget methodologies research section of this report for more information.)

The project team proposes a unified individual budget model for adults who receive waiver services. This approach is unified because the methodology will be applied to all adults, no matter the waiver they use. At this time, the project team does not propose including children in this particular model. Differences in the assessment for children will require the development of a distinct model for children. During this study, HSRI was unable to incorporate children into the support range framework due to data lags resulting from the rollout schedule of MnCHOICES. To address this, DHS will modify the support range frameworks using updated and more complete MnCHOICES data to include children during the recalibration phase, before implementation. Recalibration will allow DHS to make a number of updates to the model before implementation to incorporate new data, policy and rate changes. The analyses and proposals that follow pertain only to adults, defined as people age 18 or older at the time of their MnCHOICES assessment.

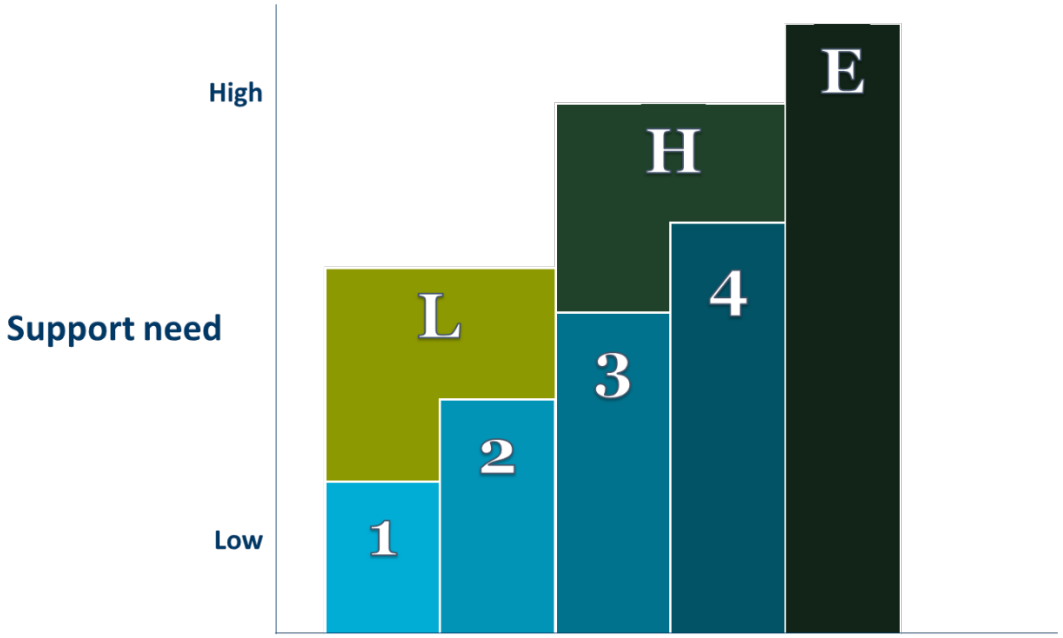
Three major provisional frameworks compose the individual budget model:

- Support range descriptions
- Criteria
- Service mixes.

First, HSRI coordinated with DHS to develop support range descriptions that describe the support needs of people in each of the ranges. Next, the project team finalized the support range criteria used to assign people to a support range. Finally, the project team developed model service mixes that indicate the budget range each person at each support range can access. More information about how the project team completed this work is described in the following sections below and also can be found in the Development of the Individual Budget Model report.[10]

The support range framework includes seven unique support ranges (see figure 8).

Figure 4: Provisional support range framework



Support ranges 1–4 are assigned to people who have general support needs that range from low (support range 1) to extensive (support range 4) and have typical (i.e., low to moderate) psychosocial and health support needs. Two support ranges are assigned to people with high health and/or high

10 C. Kidney, J. Petner-Arrey and S. Pawlowski, "Development of the Individual Budget Model," 2018 (Prepared for Minnesota Department of Human Services Disability Services Division).

psychosocial support needs and low-to-moderate general support needs (support range L) or high-to-extensive general support needs (support range H). The final support range is assigned to people with extraordinary psychosocial and/or health support needs (support range E). See figure 9 for brief descriptions of each support range.

Figure 5: Provisional support range framework brief descriptions

1	Low general support need, typical health and psychosocial support needs
2	Moderate general support need, typical health and psychosocial support needs
L	Low to moderate general support need, high health and/or high psychosocial support needs
3	High general support need, typical health and psychosocial support needs
4	Extensive general support need, typical health and psychosocial support needs
H	High to extensive general support need, high health and/or high psychosocial support needs
E	Extraordinary health and/or psychosocial support needs as determined by an additional process

Provisional support range descriptions

Support range descriptions help describe the model and show the differences in the needs of the people who receive services in Minnesota. While figure 9 provides brief descriptions, Appendix B includes more detailed descriptions developed in coordination with stakeholders.

Provisional support range criteria

The support range criteria are the scores from the MnCHOICES assessment associated with each support range. These scores are based on MnCHOICES assessment data and consider:

- General support needs (GSN): The support people need for activities of daily living (ADLs) and instrumental activities of daily living (IADLs) (e.g., eating, bathing, dressing, housework, shopping). General support needs are composed of items from the ADL and IADL sections of the MnCHOICES Assessment application.
- Health support needs: The support people need to manage health conditions (e.g., cardiac conditions, therapies, diabetes). Health support needs are composed of items from the health section of the MnCHOICES Assessment application.

- Psychosocial support needs: The support people need to manage psychosocial conditions (e.g., anxiety, verbal aggression, socially unacceptable behavior). Psychosocial support needs are composed of items from the psychosocial section of the MnCHOICES Assessment application and are broken out into three scores: psychosocial behavior (PS behavior), psychosocial emotions (PS emotion) and psychosocial mania psychosis (PS mania/psychosis).

To determine the support range, scores in each area are compared to the support range criteria in table 4.

Table 4: Provisional support range criteria

Support range	General support needs (GSN)	Psychosocial behavior	Psychosocial emotions	Psychosocial mania/psychosis	Health
1	7 or less	16 or less	5 or less	0 or 1	5 or less
2	8 to 19				
3	20 to 29				
4	30 or higher				
L	19 or less	17 to 29	6 to 11	2 to 4	6 to 19
H	20 or higher				
E	Any score	30 or higher	12 or higher	5 or higher	20 or higher

Provisional service mix

To develop the budgets associated with the support ranges, the project team proposes model service mixes that were used as the basis to calculate dollar values included in each budget range. The service mixes are broken out by different living settings that have access to different kinds of services (service mixes). Table 5 shows the living settings and service groups included in the service mix.

Table 5: Service mix by living setting and service groups

Service groups	Corporate foster care	Family foster care	Residential other	Living with family	Living independently
Residential	Yes	Yes	Yes	N/A	N/A
Personal supports	N/A	N/A	N/A	Yes	Yes
Personal care	N/A	N/A	N/A	Yes	Yes
Day and employment	Yes	Yes	Yes	Yes	Yes
Respite	N/A	N/A	N/A	Yes	N/A
CDCS*	N/A	N/A	N/A	Yes	Yes
Medical and professional	N/A	N/A	N/A	N/A	N/A
Other services	N/A	N/A	N/A	N/A	N/A

Note: CDCS will not be included as a specific service in the packages, but it will be available to people on the Individual Support Waiver.

As table 5 shows, not all services are included in each service mix. There are a couple of reasons for this. Many services are allowable only in certain residential settings and, therefore, are not included in those residential settings where they cannot be used. There are other services that are better authorized and accessed separately as needed. For example:

- Respite can be used only by people who live in their caregiver's or family's home. For this reason, respite is included only in the service mixes for people who live with family.
- Certain health, professional and other services are not included because people do not use them universally and need them only in specific circumstances.
- Not every person on a waiver needs home modifications, but those modifications are necessary for some people.

As a result, existing service definitions provide mechanisms to account for both access to these services and their costs. CDCS, though a current service grouping, will not be included in the budgets because the CDCS budgets are modeled from the budgets developed for traditional services.

The project team developed a unique provisional budget range for adults in each living setting and for each support range. The project team based these provisional budget ranges on the model service mixes shown in table 5. (See Appendix C for complete model service mixes.) Then, the project team transformed each of these model service mixes into budget ranges for each support range and by each living setting. Since there are five possible living settings available within seven support ranges, there are 35 budget ranges possible. See table 6 for the proposed budgets.

Table 6: Provisional individual budgets for adults by living setting and support range

	Support range						
Living setting	**1**	**2**	**L**	**3**	**4**	**H**	**E**
Corporate foster care	$81,248 to $111,248	$83,978 to $113,978	$92,903 to $122,903	$92,903 to $122,903	$111,908 to $141,908	$117,656 to $147,656	$132,225 to $162,225
Family foster care	$44,839 to $74,839	$57,150 to $87,150	$66,075 to $96,075	$66,075 to $96,075	$88,913 to $118,913	$88,913 to $118,913	$97,733 to $127,733
Other residential	$31,425 to $61,425	$34,155 to $64,155	$43,080 to $73,080	$52,661 to $82,661	$77,415 to $107,415	$77,415 to $107,415	$86,235 to $116,235
Living with family	$0 to $27,220	$0 to $27,745	$16,379 to $46,379	$16,379 to $46,379	$33,523 to $63,523	$40,071 to $70,071	$45,321 to $75,321
Living independently	$5,328 to $35,328	$5,853 to $35,853	$22,874 to $52,874	$22,874 to $52,874	$37,135 to $67,135	$43,330 to $73,330	$48,580 to $78,580

Note: CDCS budgets are modeled on service mixes developed for traditional services.

The following figures show the provisional budget ranges for each of the living settings. Figure 10 shows the provisional budget ranges for people who live in corporate foster care.

Figure 10: Provisional individual budget ranges for adults in corporate foster care

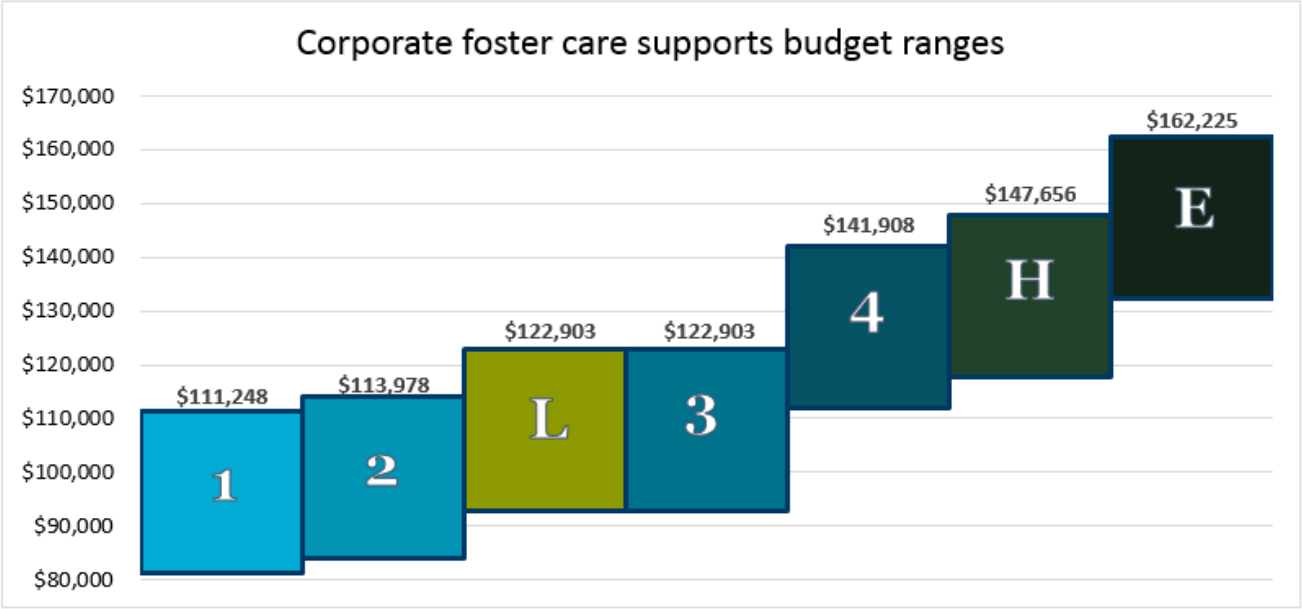


Figure 11 shows the provisional budget ranges for people who live in family foster care.

Figure 11: Provisional individual budget ranges for adults in family foster care

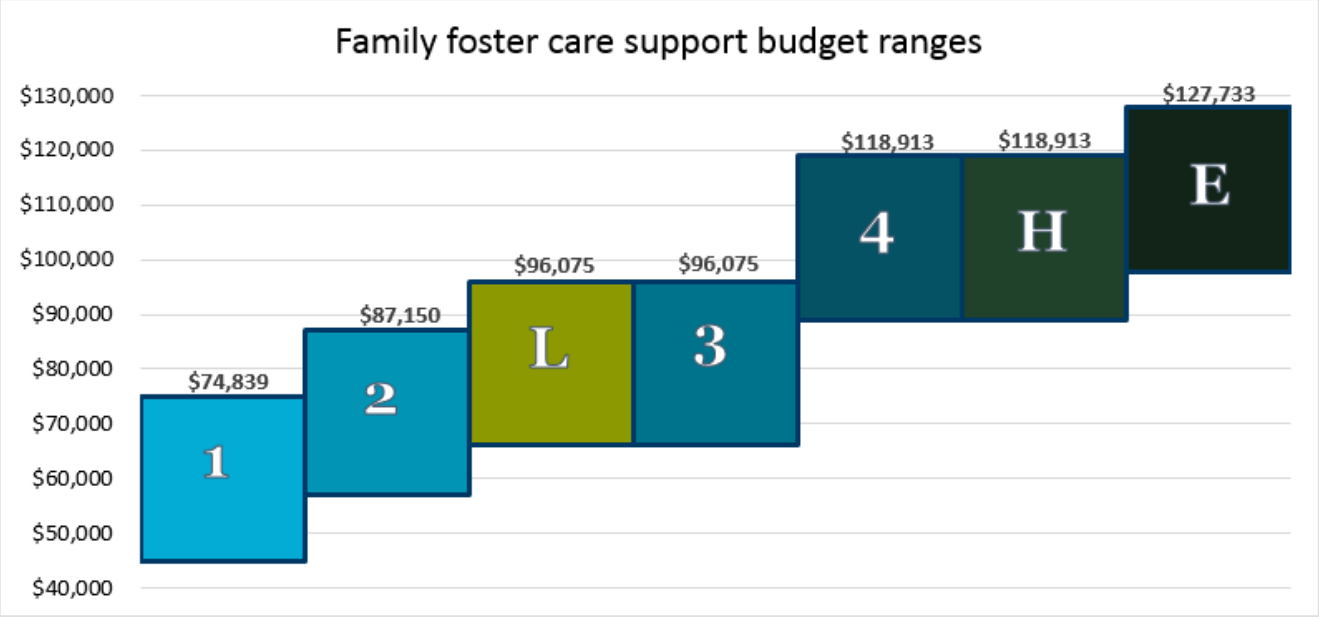


Figure 12 shows the provisional budget ranges for people who live in other residential settings.

Figure 12: Provisional individual budget ranges for adults in other residential settings

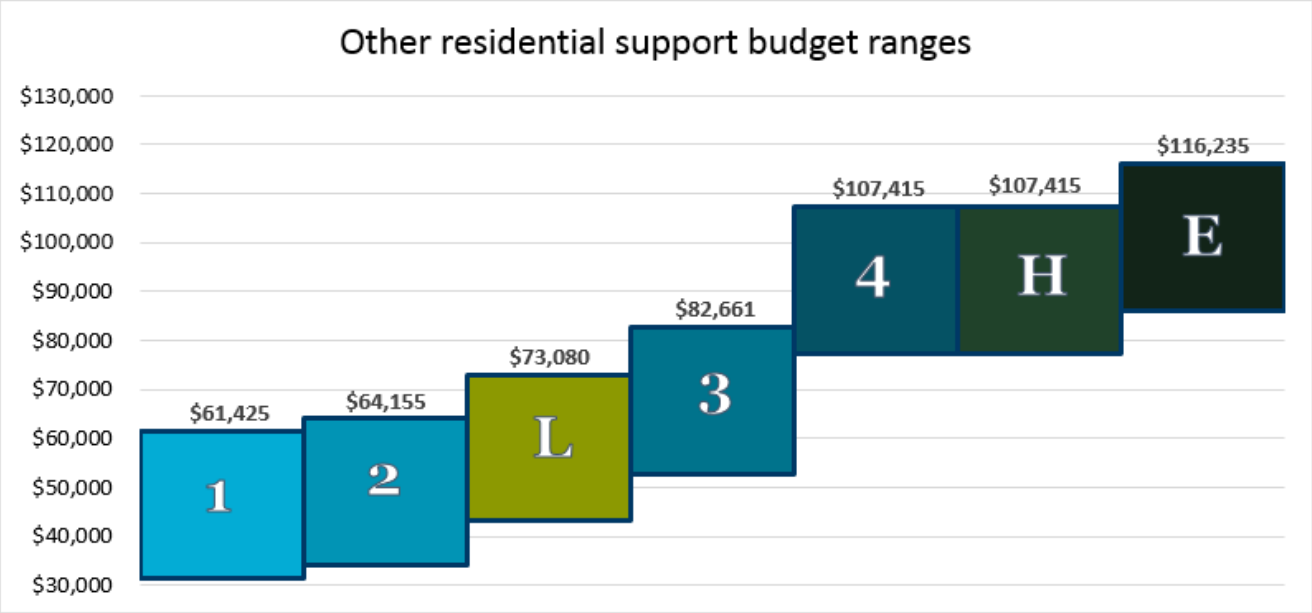


Figure 13 shows the provisional budget ranges for people who live with family, both for people who use CDCS and people who use traditional services.

Figure 13: Provisional individual budget ranges for adults living with family, with and without CDCS

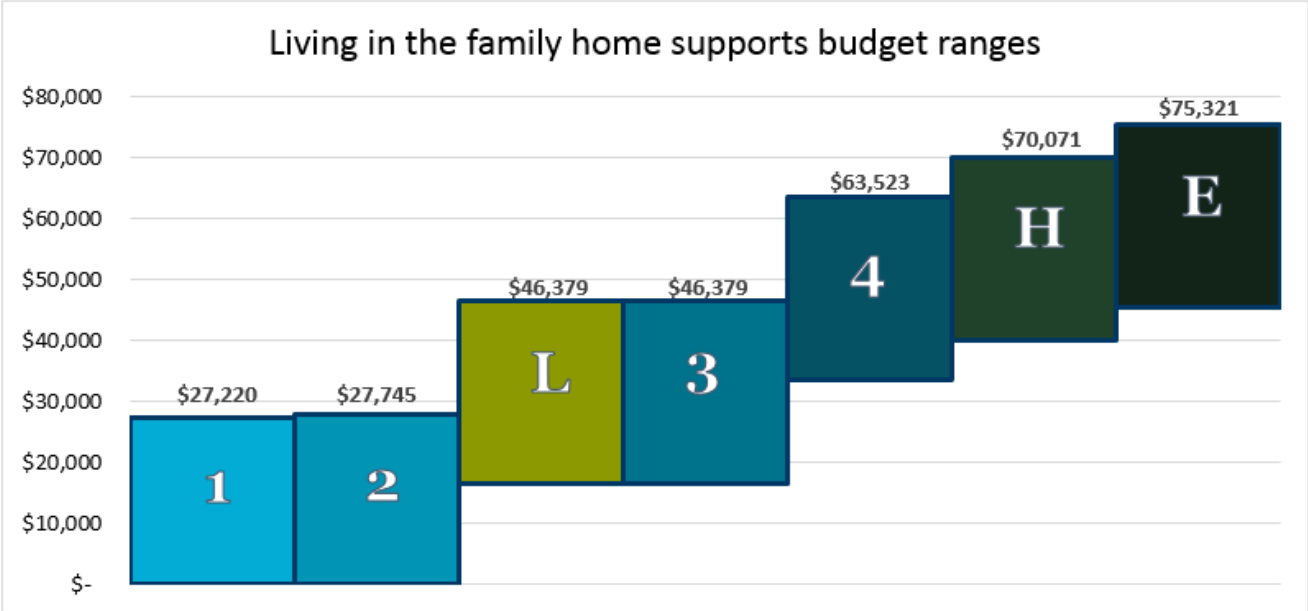
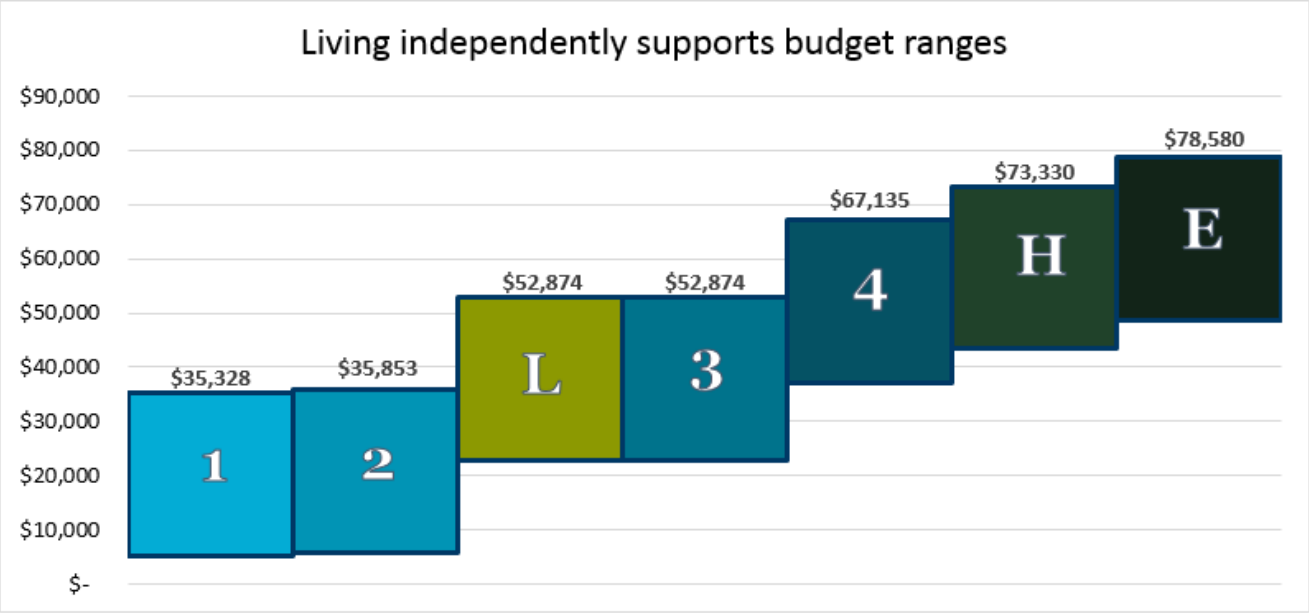


Figure 14 shows the provisional budget ranges for people who live independently, both for people who use CDCS and people who use traditional services.

Figure 14: Provisional individual budget ranges for adults living independently, with and without CDCS

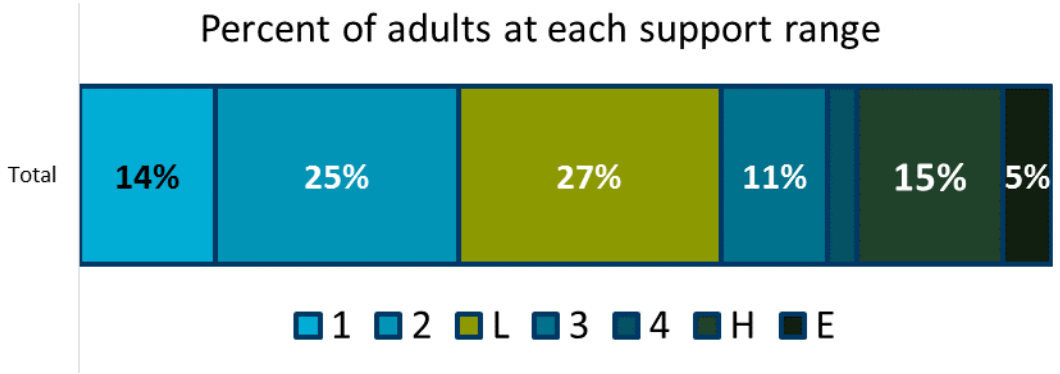


People who receive services can use these budgets flexibly to purchase the services and supports they want and need. The service mixes and specific service costs only are used in the methodology to determine the total dollar range for the budget. During the support planning process, each person will have the discretion to decide how best to use his/her budget to purchase the services and supports he/she wants and needs. For example, if a person is interested in getting a job, he/she might use funds associated with day services in the service mix to purchase employment services. In addition to promoting flexibility for people who use traditional services, people served on the Individual Support Waiver will be able to self-direct all or some of their services. It is important to note that the support ranges and budgets are provisional. Before implementation, DHS will recalculate them based on MnCHOICES 2.0 Assessment data.

Now that the project team provisionally has developed the individual budget model, DHS can use it to view the population of people served among the waivers and consider their needs in relation to overall system planning. For example, DHS can use the support range framework and budget model to illustrate differences among people served by living setting or CDCS usage. In the following figures, HSRI provides specific analyses it conducted using the proposed model.

Figure 15 shows the composition of the adults served in Minnesota by their support ranges. Support Ranges 1, 2 and L are assigned to over half of the population, indicating that most people have low general support needs.

Figure 15: Percent of adults at each support range



Note: Percentage values under four percent are too small to display a value. Three percent of the population of people who receive services are assigned to support range H.

Figure 16 displays the percent of people in each support range by whether they use CDCS or traditional services. More than half of people who use CDCS are in support ranges L, H and E. This indicates CDCS users are more likely to have high health or psychosocial support needs.

Figure 16: Percent of adults in each support range by CDCS

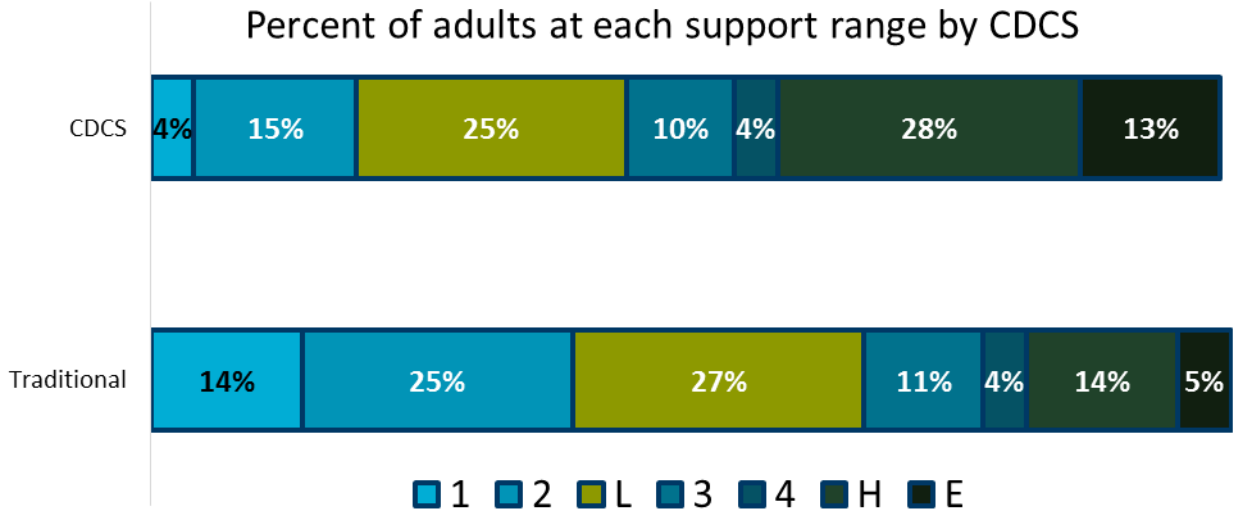
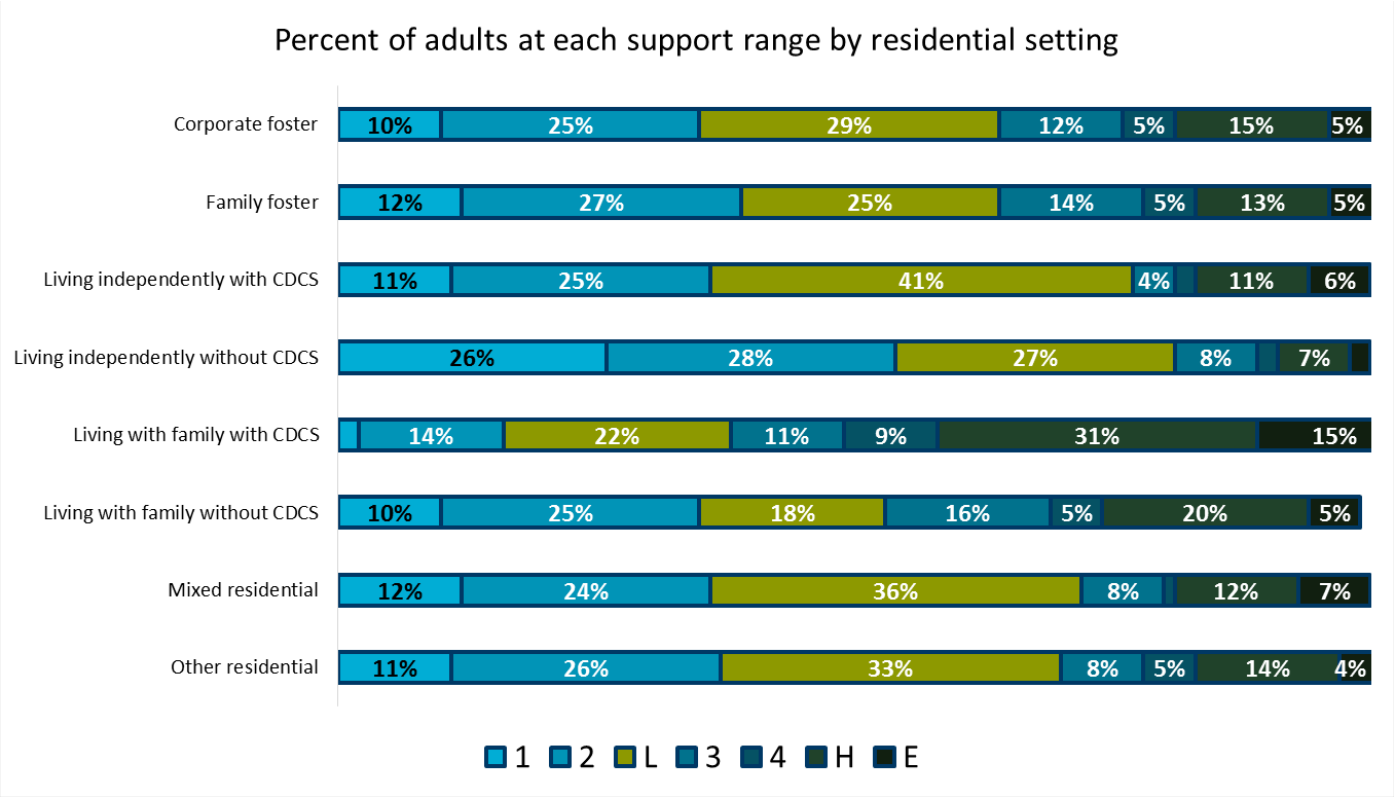


Figure 17 displays the percent of adults in each support range by residential setting. As anticipated, most people living independently have low general support needs. This is indicated by over three quarters of people who live independently being assigned to support ranges 1, 2 and L.

Figure 17: Percent of adults in each support range by residential setting



Overall, based on the assumptions DHS outlined, the project team expects the total fiscal impacts of implementing these budgets to be modest. HSRI anticipates the impact of these changes to be in the range of a savings of $16.3 million to a cost of $19.1 million. For more information about these impacts, see the Fiscal impact section of this report and review the Fiscal Impact Analysis report.[11] DHS will provide final analysis using MnCHOICES 2.0 Assessment data for adults, as well as children, to the 2021 Legislature as part of the implementation plan.

11 S. Pawlowski, J. Petner-Arrey and Y. Kardell, "Fiscal Impact Report," 2018 (Prepared for Minnesota Department of Health Disability Services Division).

Alignment with goals

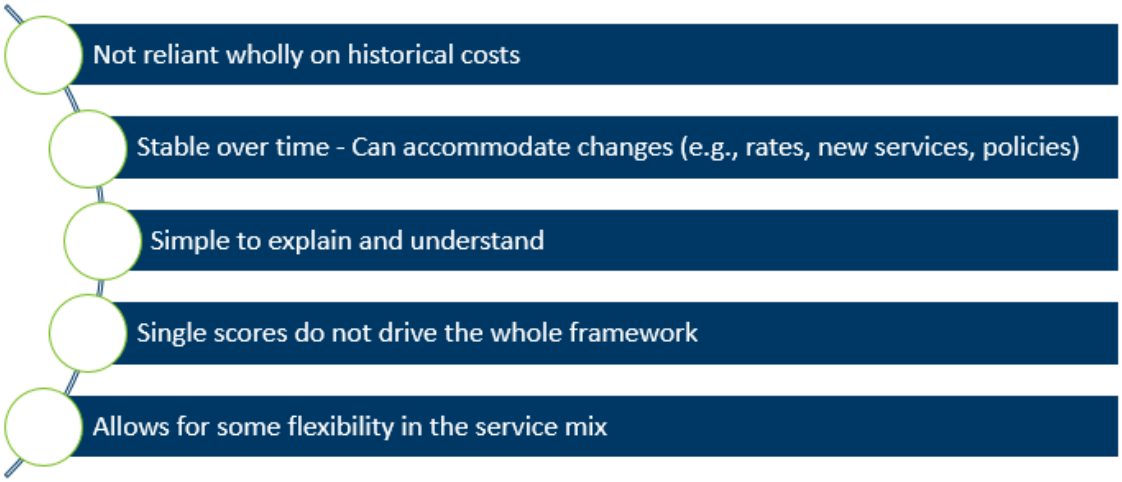
Throughout the development of the budget model, the project team revisited DHS' specific goals for this project and outlined additional benefits of the support range budget model approach:

1. **Offer flexibility to encourage person-centered supports.** Person-centered supports occur when people have information and can plan in a way that is meaningful to them. The project team intends the proposed approach to be prospective so people can know their budget well before their planning meeting. The team also intends for DHS to use this approach in a way that allows each person the flexibility to choose the services and supports he/she desires within an overall budget to help guide the planning process.
2. **Enhance personal authority over service choice.** The proposed budget methodology will enhance personal authority over service choices. People will be able to self-direct all or some of their services using the CDCS option, and they will have a budget that is consistent with those who do not self-direct. All people will know their prospective budgets, and that important information places decision-making power squarely in the hands of the people who receive services.
3. **Simplify waiver program information and administration**. The unified budget methodology will simplify the waiver program significantly for people who receive services, lead agencies and DHS. Since the process is transparent and applied uniformly, it can ease decisions for people and streamline administration for lead agencies and DHS.
4. **Provide equity across waiver programs and participants.** Using this unified budget methodology will ensure all people, regardless of their diagnosis or the specific county/tribal nation in which they live, can access similar budgets based on their objectively assessed needs and not based on differences between lead agencies or waivers.
5. **Align benefits across waivers.** The project team proposes a unified budget methodology based on objective support needs measured with a uniform assessment. Waiver type is not a factor used to determine the budget amount. People in each living setting will have access to the same budget range associated with their level of need.
6. **Ensure a smooth transition.** The project team proposes a phase-in strategy that will support people with disabilities as they transition to the individual budgets. The intent is to minimize any negative impacts to people who currently receive services. The project team also has provided a multitude of implementation recommendations to support DHS to implement the proposed recommendations. (See the Transition plan section of this report.)
7. **Offer the opportunity to monitor and improve programs to achieve greater sustainability.** The support range framework and the budget methodology will give the legislature and DHS 'eyes on the system', allowing them to monitor and assess individual funding in the program and support numerous areas of inquiry. For example, it might give DHS improved ability to predict

spending over time, since DHS will be able to understand better people's support needs and the spending required to address those support needs in different living settings.

Figure 18 shows several additional benefits of this approach.

Figure 18: Additional benefits of the individual budget methodology



First, this approach is not reliant wholly on historical costs. While the project team considered historical costs to develop the service mixes, those costs do not drive the budget as they do in other methodologies. Using service mixes allows DHS to keep an eye toward the future and the specific policy intentions it hopes to achieve so it can invest in desired outcomes. For example, employment is accounted for in all service mixes to encourage DHS' employment objectives, even though only a small portion of people use these services. Creating the service mixes in this way allows DHS to work toward resolving any inequitable practices that might exist.

The budget model is more stable than some alternatives, including the current CDCS approach. For the current CDCS approach to keep pace with the changes made to services and rates, DHS would need to update it regularly, potentially on an annual basis. Each time DHS would update the methodology, it essentially would generate an entirely new methodology based on more recent historical spending and MnCHOICES responses. In other words, DHS cannot recalibrate the current CDCS approach to account for the specific changes made to rates or services. Therefore, updates result in an entirely new methodology that might be disruptive to people who receive services. Updates also could lock in past service use and spending patterns, whether they were equitable or not.

The proposed approach offers the ability to recalibrate different parts of the framework independently of one another, and it can accommodate changes (e.g., new services, rate changes, enhanced policy intentions). For example, if DHS adds a new service, it can add this service to the budget easily and

make funding available to each person during his/her planning meeting so he/she can choose the new service. The person's budget is not dependent on what he/she spent in the past, and it is future-focused so improvements made to the service system filter easily to the people who need them most. This ability to recalibrate allows the proposed model to be somewhat malleable. DHS can adjust it when necessary with minimal disruption to people who receive services, and people who receive services can access improvements quickly.

The framework is simple to understand. Assessment data adds to a sum score, which is compiled into a support range and a corresponding budget range. Using this approach allows a person to have multiple assessed needs count toward his/her support range and the resulting budget. In some alternative approaches used by other states, a single assessment question might drive the entire budget, which prevents many people from getting the amount of support they need if they do not respond precisely and consistently to a specific question.

Given that the budget model allows for new understanding of the service system, DHS' use of this model over time will help DHS consider the way support is provided by using data, and address any problems thoughtfully and creatively as they arise.

IV. Implementation considerations

Transition plan

DHS is recommending a transition plan that involves moving from the four current waivers to two entirely new waivers. Part of the implementation strategy will include the launch of the individual budget model within the two new waivers. Currently, 2023 is the target date for full implementation of the waiver reconfiguration and budget model. To achieve this milestone while maintaining and optimizing individual outcomes and ensuring system stability, DHS will plan for the transition across multiple years. If the legislature grants DHS the authority to proceed, DHS will prepare a full implementation plan with updated data and projections for the 2021 Legislature that will incorporate the planning with stakeholders and additional analysis with MnCHOICES 2.0 Assessment data necessary to move forward with the transition.

People served through the four current waivers will transition to the two new waivers based on their living setting and their service agreement renewal date. This approach allows a full year for statewide transition, which DHS anticipates to take place from Jan. 1, 2022, through Dec. 31, 2022.

DHS might recommend an extended period for people to transition their support plans, similar what Pennsylvania used. This will make this transition easier on people who use services by allowing a period for adjustment and change to new services. This also might help with the transition for people whose budgets undergo a significant change by offering them a longer period to make arrangements. This extended transition period aims to lessen the impacts on people who currently receive services because the annual service plan meeting provides an opportunity to plan for services needed in the upcoming year and implement any changes to the planning process as necessary under the new waiver and budget structure. This also provides a logical start-date for an annual authorization for each person under a new waiver. This will be important, particularly for implementation of the budget model since it will allow people to make choices about the type and amount of services they receive at their annual planning meeting.

Reconfiguration elements

The project team presents the following considerations DHS should keep in mind as it pursues reconfiguration. As referenced in previous sections, DHS already has done considerable work to align its four current waivers, much of which is reflected in the Analysis of Minnesota Disability Waivers

report.[12] DHS will need to finalize different aspects of the waivers to continue unifying them (e.g., service definitions, provider qualifications and performance measures). DHS has developed strategies to align services in the four current waivers before the transition to the new waivers to ensure minimal disruption. Then, DHS can review and change minor differences to achieve maximum similarity within the two waivers of the new program. Related to the transition plan, the project team discusses:

- Eligibility and targeting
- Service array
- Reserved capacity
- Consumer-directed community supports
- Waiver determination.

Eligibility and targeting

Currently, three of the four waivers (BI, CAC and CADI waivers) have target age groups of 0–64 for people entering the waivers, although they can continue receiving services past their 65th birthday once they are on the program. The DD Waiver allows people of any age to enter. DHS can keep these criteria on both waivers in the Individual Support Waiver and Residential Support Waiver solution, or DHS can alter the target group age ranges as desired to create uniformity or advance other future policy objectives. Based on changing demographics of people with traumatic brain injuries on a national scale,[13] and in consultation with project team consultant Dr. John Corrigan, the project team recommends DHS consider lifting the age restriction on people who meet neurobehavioral hospital or specialized nursing facility levels of care. People who meet these criteria are living longer than ever and likely will continue to need services more specific to their needs than what currently is available on the Elderly Waiver.

Post-eligibility and regular post-eligibility treatment of income are the same across all four current waivers, so DHS will not need to make changes in a reconfiguration to an individual support waiver and residential support waiver. However, DHS can adjust these if it wishes to better align with its strategic goals. Over time, DHS might wish to evaluate its eligibility and post-eligibility processes continually to ensure continued alignment with its overarching policy objectives.

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12 B. Taylor et al., "Analysis of Minnesota's Disability Waivers," 2018 (Prepared for Minnesota Department of Human Services Disability Services Division).

13 J. P. Cuthbert et al., "Extension of the Representativeness of the Traumatic Brain Injury Model Systems National Database: 2001 to 2010," *Journal of Head Trauma Rehabilitation*, November-December, (2012): E15-27, doi 10.1097/HTR.0b013e31826da983

DHS likely will want to consider adding language to the targeting criteria for the Residential Support Waiver to ensure people who access this waiver do so because they demonstrate the need to receive services in paid residential settings (based on criteria DHS will recommend to the 2021 Legislature in the implementation plan). DHS has made clear its desire to serve people with appropriate services to meet their needs, but also to promote the ability of people to have these needs met in the most independent settings possible. DHS can achieve this by specifying within the waiver that a person's need should drive access of the Residential Support Waiver.

Service array

A considerable amount of time and consideration was given to selection of the services that will be made available in the recommended reconfigured waivers. In many cases, services were the same across the existing waivers and will continue to be available in the reconfiguration. There are differences in service definitions identified in the Analysis of Minnesota Disability Waivers report,[14] and DHS should make determinations about how to create singular definitions for use with these services on both proposed waivers.

Table 7 lists the services as they appear on the current waivers and as they will be named and aligned under the proposed waivers. Two additional services, life sharing and integrated community supports, are included in figure 18 because DHS anticipates it will add them to the array. However, their addition is not part of the project team's reconfiguration study.

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14 B. Taylor et al., "Analysis of Minnesota's Disability Waivers," 2018 (Prepared for Minnesota Department of Human Services Disability Services Division).

Table 7: Services crosswalk to the proposed waivers

Current waiver services	Individual Support Waiver	Residential Support Waiver
24-hour emergency assistance	24-hour emergency assistance	N/A
Adult day and family adult day	Adult day services (targeted to people older than age 55 and people currently enrolled)	Adult day services (targeted to people older than age 55 and people currently enrolled)
Assistive technology	Assistive technology	Assistive technology
Caregiver living expenses	Caregiver living expenses	N/A
Waiver case management	Waiver case management	Waiver case management
Chore service	Chore service	N/A
Consumer directed community supports (CDCS)	CDCS	N/A
Corporate foster care/residential habilitation: Supported living services for adults and children	N/A	Community residential services
Crisis respite	Crisis respite	Crisis respite
Customized living (billed as 24-hour customized living and customized living)	N/A	Customized living (single billing code)
Day training and habilitation/structured day program	Day support services	Day support services
Employment development	Employment development	Employment development
Employment exploration	Employment exploration	Employment exploration

Current waiver services	Individual Support Waiver	Residential Support Waiver
Employment support	Employment support	Employment support
Environmental accessibility adaptations	Environmental accessibility adaptations	Environmental accessibility adaptations
Extended home health care	Extended home health care	Extended home health care
Extended personal care assistance (PCA)	Extended PCA	N/A
Extended state plan nursing	Extended state plan nursing	Extended state plan nursing
Family foster care/residential habilitation: Supported living services for adults and children	N/A	Family residential services
Family training and counseling	Family training and counseling	Family training and counseling
Home-delivered meals	Home-delivered meals	N/A
Homemaker (excluding PCA option)	Homemaker (excluding PCA option)	N/A
Housing access coordination	Housing access coordination	Housing access coordination
Independent living skills training, supported living services (billed at 15-min), individualized home supports	Individualized home supports with training	N/A
In-home family supports	Individualized home supports with individual and family training	N/A
Night supervision	Night supervision	N/A

Current waiver services	Individual Support Waiver	Residential Support Waiver
Personal support, adult companion	Individualized home supports	N/A
Positive support	Positive support	Positive support
Prevocational services	Prevocational services	Prevocational services
Respite	Respite	N/A
Specialist services	Specialist services	Specialist services
Specialized equipment and supplies	Specialized equipment and supplies	Specialized equipment and supplies
Transitional services	Transitional services	Transitional services
Transportation	Transportation	Transportation
N/A	N/A	Life sharing
N/A	N/A	Integrated community supports

HSRI discusses the fiscal implications related to this service array briefly in the Waiver Reimagine: Feasibility & Recommendations report.[15] Of the 35 total services available through the recommended structure, 19 services are available through both waivers. Services unique to the Individual Support Waiver and to the Residential Support Waiver are based on current restrictions on how people receive those services. For example, 24-hour emergency assistance, caregiver living expenses, chore services, home-delivered meals, homemaker and several of the independent personal supports services currently are only available to people living independently or at home with family or caregivers. Consequently, these services will be offered only on the Individual Support Waiver because people who live in paid residential settings will be ineligible for and will not use these services. Additionally, the project team proposes extended PCA only be offered on the Individual Support Waiver because people who live in paid residential settings should have their personal support needs met through other services specifically available as a part of that living arrangement. Likewise, the project team proposes services currently only available to people who live in paid residential settings only be offered on the Residential Support Waiver because people who do not live in these settings cannot access these services.

Reserved capacity

This reconfiguration creates a barrier to people who might wish to move into paid residential settings because that option is available only on the Residential Support Waiver. Therefore, DHS will have to manage some amount of anticipated demand by using the reserved capacity function available through the 1915(c) authorities. States can use reserved capacity to ensure waiver access for people in specific circumstances. DHS currently uses reserved capacity for:

- Conversions on the CADI Waiver that provide access to the waiver for people served in nursing facilities
- Lack of local capacity for new people who enroll in the CADI Waiver
- People moving to DD Waiver services from intermediate care facilities for persons with developmental disabilities (ICFs/DD)
- Legislatively authorized emergency enrollments.

As it pursues this reconfiguration, DHS may continue existing reserved capacity policies, but it should also consider reserving additional reserved capacity for people who need to move from independent or family living settings to paid residential settings. Maintaining reserved capacity for this population is

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15 B. Taylor et al., "Waiver Reimagine: Feasibility & Recommendation Report," *2018* (Prepared for Minnesota Department of Human Services Disability Services Division).

one way DHS can help manage need and create a simple and fluid path for people to move into these settings if they need residential services.

It will be up to the legislature to determine how much movement onto the Residential Support Waiver it can afford and that it wishes to offer through reserved capacity. If the spaces set aside through reserved capacity are filled completely, there is a potential for a waitlist to form for the Residential Support Waiver. Therefore, DHS should monitor demand for such movement and adjust reserved capacity accordingly. This might require legislative authority to manage resources effectively.

However, HSRI anticipates that by allowing people at all support ranges to access the Individual Support Waiver and receive resources appropriate for their needs, demand for movement into paid residential service settings will not change dramatically from current levels.

Consumer-directed community supports (CDCS)

CDCS currently is available only to people who live independently or with family. Because the project team proposes CDCS only be offered on the Individual Support Waiver, this will continue to be the case. The only tangible change is the waiver on which it will be offered.

One of DHS' goals was to strengthen CDCS, so the project team proposes, as part of the reconfiguration, DHS makes certain services available for self-direction through a "participant-directed" option for individual services. Currently, DHS intends to base CDCS budgets on the same budget methodology as traditional services. This might allow DHS to gather better data about the services people choose to self-direct.

Offering self-direction for individual services can encourage expansion of self-direction in Minnesota. Currently, if a person wishes to self-direct, he/she must do so for all his/her services (excluding case management and several time-limited services). Allowing people to self-direct some services might attract those who are unsure, providing them a path to try self-direction without having to make a wholesale change. Because self-direction allows people to hire whom they want to deliver their services, expanding self-direction also might enable more people to access services not otherwise available to them based on provider shortages or distance from the service.

Waiver determination

Because of the service arrays available on both new waivers, the project team anticipates assigning people to a waiver will happen rather naturally as long as DHS creates clear protocols for making such determinations. People who live independently and at home with family will be supported on the Individual Support Waiver, while people who live in paid residential settings will be supported on the Residential Support Waiver.

It will be important for DHS to explain expectations within the additional targeting criteria of the Residential Support Waiver to ensure people's needs are driving the access to out-of-home services. Additionally, DHS will need to review how people are using the Individual Support Waiver continuously and engage with people using these supports. It will be particularly useful to engage with people who might wish to move from the Individual Support Waiver to the Residential Support Waiver. This could help DHS determine if there are additional services or changes it can make on the Individual Support Waiver to enable those people to continue to live independently. Likewise, it will be important for DHS to communicate with people on the Residential Support Waiver who might wish to move into unpaid residential settings. This could help DHS learn how best to design these waivers and the related policy to facilitate such movement.

The project team created the recommended reconfiguration to allow DHS to serve people best based on their needs. It provides DHS an opportunity to leverage these two waivers to target services and learn how to serve both populations better. It is essential for DHS to ensure case managers and support planners understand this intent and can communicate it effectively so people who receive services understand how the program works and which waiver will best meet their needs. Table 8 lists particular areas DHS should consider reviewing in relation to the transition plan.

Table 8: Waiver areas requiring review

Function
Participant waiver enrollment
Waiver enrollment managed against approved limits
Waiver expenditures managed against approved levels
Level of care evaluation
Review of participant service plans
Prior authorization of waiver services
Utilization management
Qualified provider enrollment
Execution of Medicaid provider agreements
Establishment of a statewide rate methodology
Rules, policies, procedures and information development governing the waiver program
Quality assurance and quality improvement activities

Implementation readiness

With a firm transition plan to the reconfigured waivers in place, DHS now can consider how it might implement the individual budget model that is embedded firmly in this new waiver structure. (See the Implementation Readiness report for more details about implementation.[16])

DHS expects to implement the waiver reconfiguration and the budget model concurrently between January 2022 and December 2022. To implement in a timely manner, DHS should complete several tasks before and throughout implementation. (See the Implementation Needs report for more information.[17]) These tasks are common among states choosing to implement a budget model and/or engage in waiver reconfiguration. The tasks span four unique areas:

- Communication
- Policy and procedure
- Data
- System.

Some of the tasks described are essential, and implementation cannot move forward without their completion (e.g., receiving federal Centers for Medicare & Medicaid Services [CMS] approval). Other tasks encourage a healthy implementation that is supportive of key players and allows DHS to monitor and make real-time adjustments if needed. These tasks are incorporated into the timeline indicated by DHS for implementation.

When considered as a whole, these tasks create a formal, implementation work plan DHS can use to structure the various implementation efforts, ensure it makes sufficient progress and make changes as needed. That said, the project team cannot anticipate unexpected developments during implementation; some might emerge as implementation progresses. For these reasons, DHS should consider the tasks outlined below as elements it may include in a formal implementation plan. Ideally, DHS would revisit such a plan frequently to monitor progress and revise it as needed.

Communication

Communication is the backbone of any systemic change. It conveys DHS' intentions about the planned change and allows people in the system to be ready for the proposed changes. When done early, often

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16 J. Petner-Arrey and J. Agosta, "Implementation Readiness," 2018. (Prepared for Minnesota Department of Health Disability Services Division).

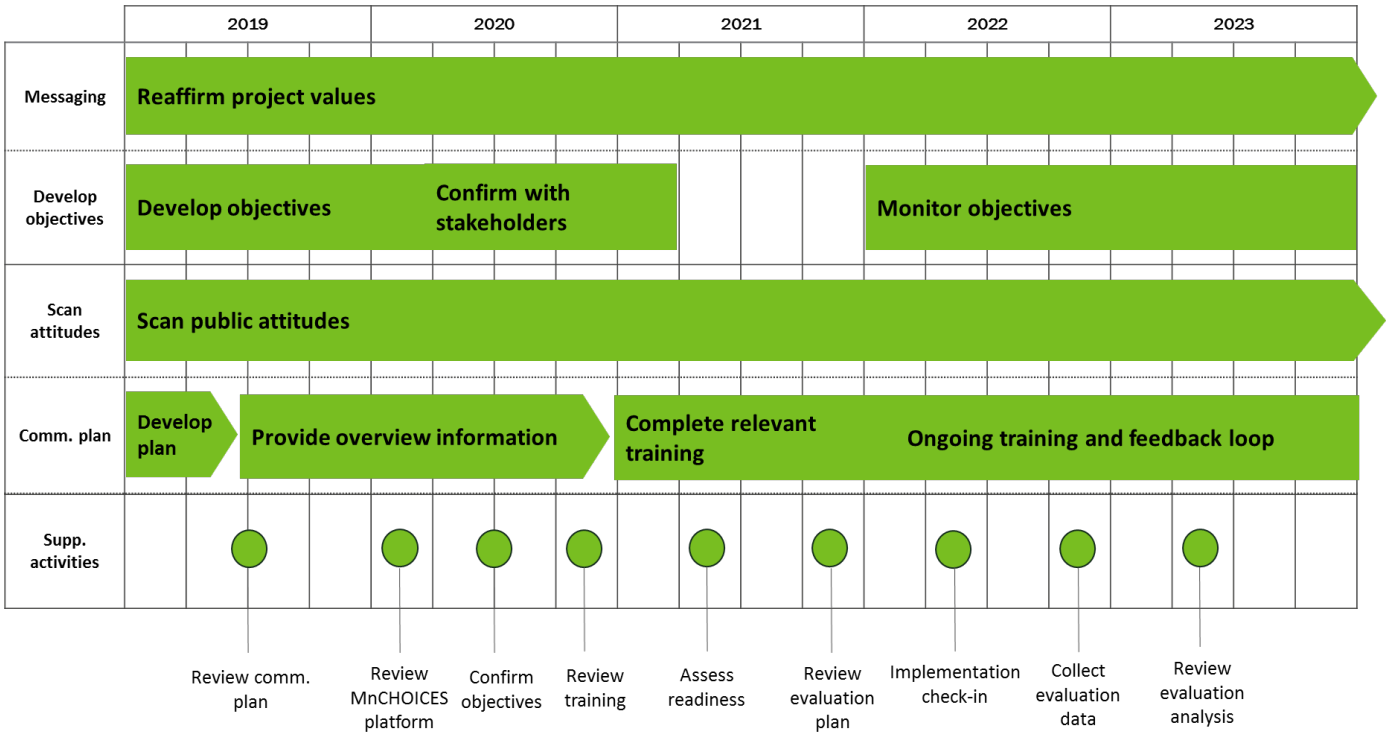
17 .J. Petner-Arrey and J. Agosta, "Implementation Needs," 2018. (Prepared for Minnesota Department of Health Disability Services Division).

and well, communication allows DHS to predict potential obstacles to implementation and make mid-course corrections to the implementation plan when needed. The project team proposes five distinct communication tasks:

1. **Outline clear and consistent messaging about the project.** To date, DHS has discussed with stakeholders its reasons for pursing this work and has developed a solid set of principles used to shape project activities and share messages about the work. These values align well with the vision and mission DHS shared at the outset of this project. The recommendations the project team provides are a natural expression of these values.
2. **Develop precise objectives for the project.** DHS should be prepared to describe the explicit outcomes it expects of the Waiver Reimagine Project. The more precise the expectations, the more likely DHS can measure and show progress toward those objectives.
3. **Scan prevailing attitudes.** DHS and HSRI have engaged in expansive stakeholder engagement throughout the project, and many of the proposed recommendations are consistent with the desired changes stakeholders expressed. This scan of stakeholder opinions should continue throughout implementation to ensure DHS is achieving the goals it set and to make any course corrections as necessary. Ideally, there will be routine opportunities to interact with stakeholders throughout implementation to stay informed of how the project is unfolding for people who receive services.
4. **Develop a communication strategy/plan.** Well before implementation, DHS should develop a formal and detailed communication plan to guide all information-sharing efforts related to the Waiver Reimagine project. This plan should include what information DHS needs to convey and to whom, how products are distributed, the content of the products and the timed distribution of different communication components. This plan also should specify communication strategies with people with disabilities, families or other caregivers, providers, county and tribal nation staff, DHS staff and the legislature.
5. **Engage in supplementary activities.** DHS should consider any supplementary communication activities, including an advisory committee and possibly a learning community. These activities will allow DHS to inform stakeholders about the project, obtain additional feedback on the project, test ideas about implementation on a small scale and ensure DHS' plans are reasonable and practical.

Figure 19 offers a timeline for potential activities related to the communication tasks that might support implementation efforts, as well as potential meeting topics for supplementary activities.

Figure 19: Communication timeline



Policy and procedure

Clear policies and procedures help all stakeholders act consistently and in accordance with the intended implementation plan. DHS has the MnCHOICES Assessment and Support Planning application in place, and it has developed robust policies for its administration. DHS also has developed detailed procedures and protocols for using consumer directed community supports (CDCS) budgets that, though requiring significant changes, will support the work of this endeavor. Because of the project team's recommendations, several existing policies will require changes. In some cases, DHS will need to establish new policies and procedures. The project team proposes the following tasks:

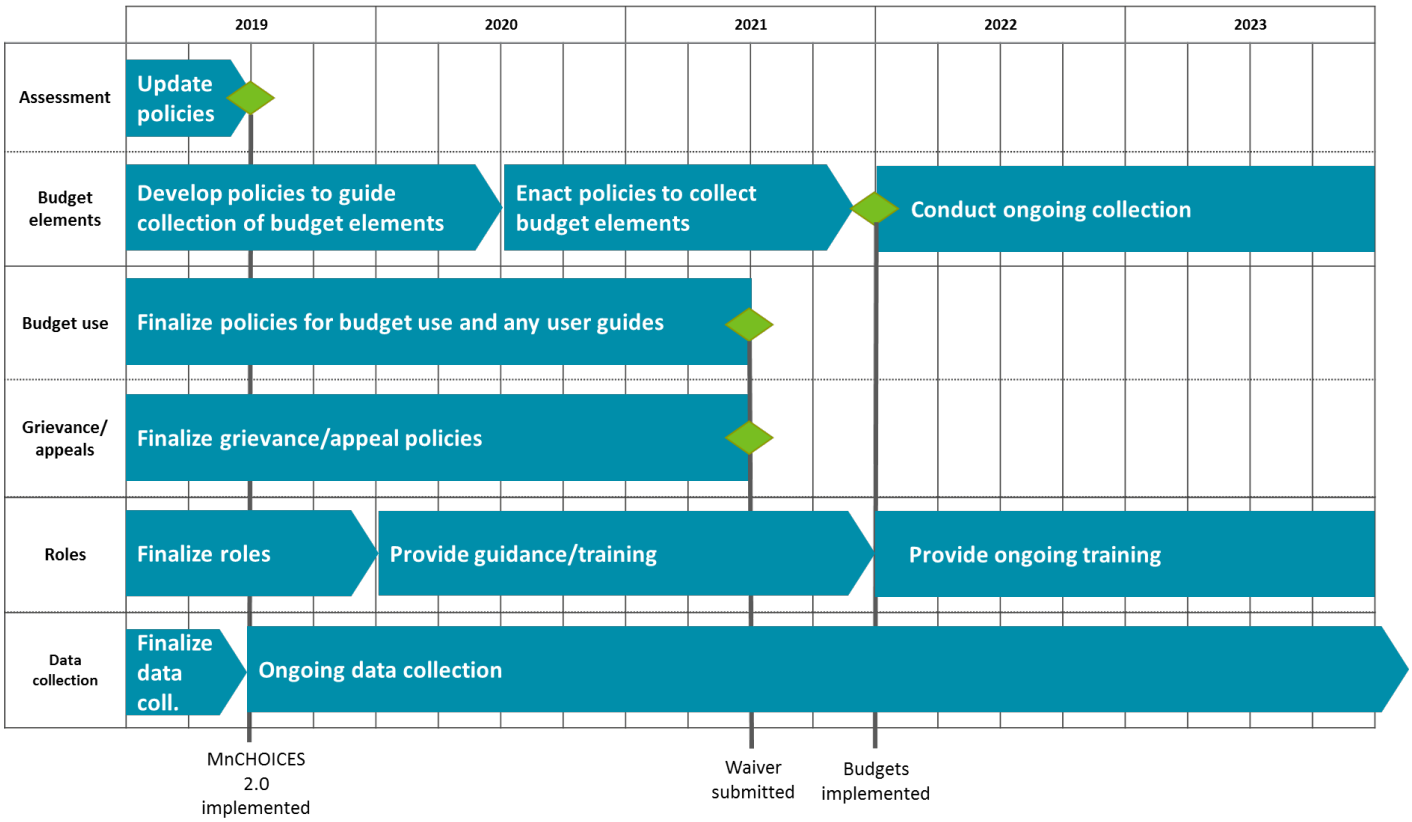
1. **Develop assessment policies.** DHS has in place robust policies and procedures that might, in some cases, require only minimal adjustments. DHS also will need to develop several new policies to support the implementation of this project. These new policies will be related to assessment data collection, assessor training and assessment requirements.
2. **Develop policies to guide essential budget elements.** DHS has considered many necessary aspects for development of the budget and now will need to develop the corresponding policies and procedures to guide these decisions. Specifically, DHS will need to decide how best to determine living setting, age cut-offs for defining adults and children and geographical

setting if DHS expects these specific determinations to impact the waiver reconfiguration effort as well as the budget model.

3. **Develop policies to guide budget use.** The project team has identified many of the decisions DHS needs to make about how to calculate the budgets. DHS will need to determine how best to make those decisions. Specifically, DHS will need to determine how to:
    - Allow for funding above the budget
    - Engage in a phased-in approach to implementation
    - Notify people of their budgets consistently
    - Manage exceptions of stakeholders
    - Structure committees related to this project.
4. **Determine grievance and appeals procedures.** DHS will want to ensure grievance and appeal procedures are clear, accessible and aligned with legal requirements.
5. **Define new roles and responsibilities.** The implementation of both the waiver reconfiguration and the budget framework will require changes in the roles and responsibilities of many key players in the system. DHS will need to take stock of all necessary administrative support functions to determine which elements need modifications to transition effectively and sustain the new waivers and budget model.
6. **Develop data collection procedures.** DHS must collect new, streamlined data to support the work of this project. DHS will use some of this data directly to inform the reconfiguration transition and budget methodology. DHS can use other data to help evaluate the transition to identify and document any needed changes.

Figure 20 offers a timeline for potential activities related to the policy and procedure tasks that might support implementation efforts.

Figure 20: Policy and procedure timeline



Data

Data are key to the implementation of any systems-change effort. Related to the budget methodology, data are necessary to determine the budget (including any unique characteristics), track changes to the budget and allow for accurate use of the budget. DHS also will use data to assess the initial and ongoing impacts of implementing the budget methodology. Related to the reconfiguration effort, DHS will use data to determine the waiver a person will transition to and when his/her transition occurs, and also to monitor and assess individual and system impacts. Due to this extensive need for data, the project team proposes the following tasks:

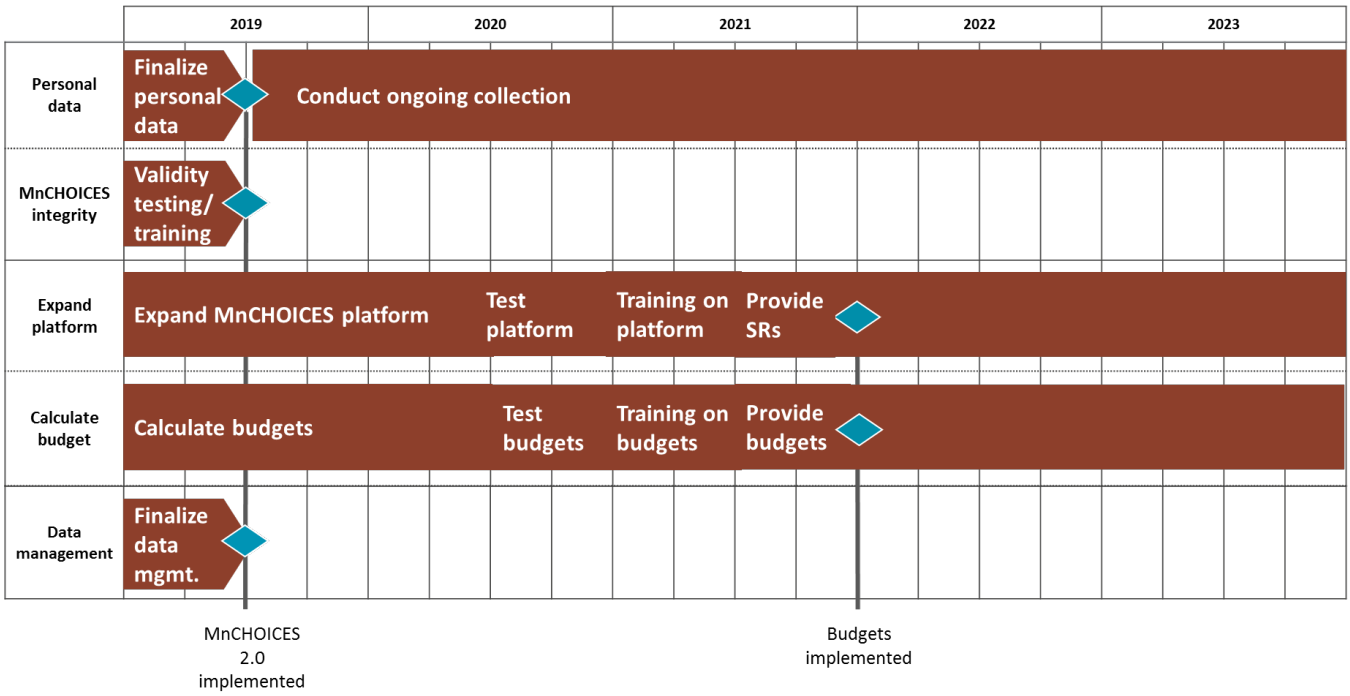
1. **Collect personal information.** Currently, DHS collects a wealth of personal information through the MnCHOICES assessment and support planning processes. However, for implementation of the budget methodology to work, DHS will update the platform to capture additional information to assign individual budgets (e.g., living setting aligned with budget development, graduation status).
2. **Protect MnCHOICES integrity.** The MnCHOICES Assessment and Support Plan application will need to continue to undergo rigorous validity and reliability testing. DHS will need to develop

enhanced training protocols and review assessor capacity. This is particularly relevant as DHS implements MnCHOICES 2.0, since the implementation of both the reconfiguration and the budget model rely heavily on results generated from the assessment. Any delays in the MnCHOICES 2.0 launch could delay the overarching transition plan.

3. **Expand the MnCHOICES platform.** DHS is making significant changes to the MnCHOICES Assessment application through the launch of MnCHOICES 2.0, and the MnCHOICES Support Plan application will need to reflect those changes. Additionally, DHS might want to use the platform to record which waiver a person uses, generate a score for the MnCHOICES assessment, calculate the budget or collect information related to exceptions.
4. **Conduct recalibration.** DHS will need to recalibrate the individual budget model using new assessment information after the launch of MnCHOICES 2.0 using current fiscal data and updated analyses. DHS will also use the recalibration period to include children in the support ranges. Planning for this recalibration well in advance will help DHS ensure a quick and smooth process. Going forward, DHS will need to consider future recalibration efforts because seemingly minor changes to the tool might require a reevaluation of the framework or changes to the algorithm used to assign a person to a support range.
5. **Calculate and distribute the individual budget.** DHS will need to develop a way to calculate the budget and share the budget with people who receive services. DHS will need to test an algorithm thoroughly and then apply it to compute budgets. DHS also will have to store budget information quick retrieval.
6. **Confirm general data management needs.** DHS will want to consider thoughtfully its various needs for data collection and, as much as possible, merge these data collection activities.

Figure 21 offers a timeline for potential activities related to the data tasks that might support implementation efforts.

Figure 21: Data timeline



System

Since this proposed work fundamentally will alter the way in which the current system functions, it will be worthwhile for DHS to consider the many needed changes, plan for implementation milestones and consider globally the best timing of related activities. The project team proposes the following tasks:

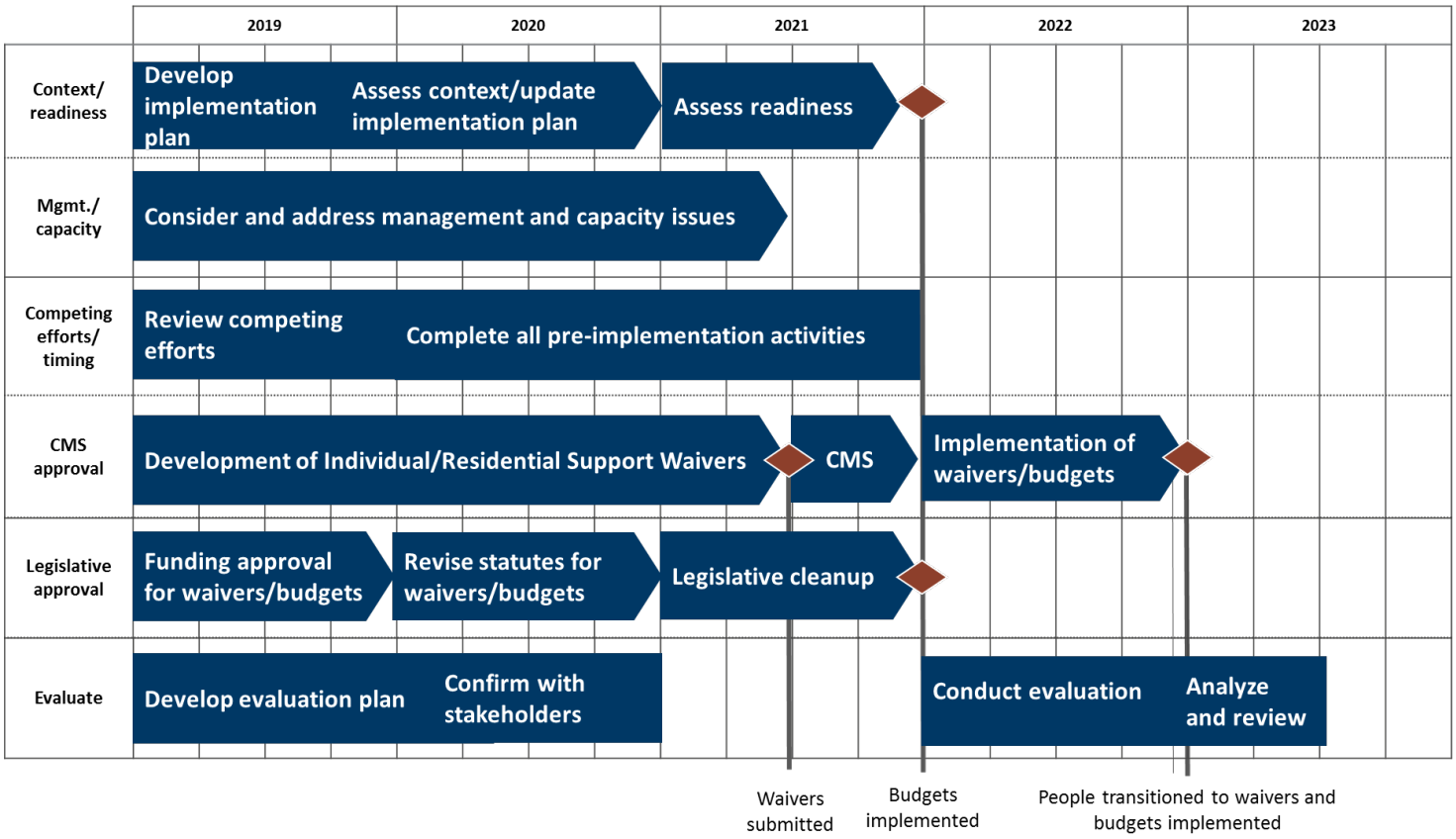
1. **Assess context.** DHS will need to meet with many stakeholders in the system to begin considering how the implementation is likely to affect them and make any specific preparations necessary. This project will simplify the process to administer the waivers and manage lead agency budgets. Implementing this level of change across the existing service structures will require close collaboration and communication with lead agencies and other stakeholders.
2. **Assess readiness.** Due to implementation timelines, many of the proposed activities will occur in 2019 and beyond. As a result, DHS might want to assess readiness for implementation by engaging in a formal readiness review as transition nears.
3. **Address management capacity issues.** Given the scope of the proposed activities, DHS will need to have a capable team of staff to lead the implementation. This team will be in charge of monitoring all related efforts.
4. **Consider competing efforts.** While DHS has planned thoughtfully for the implementation—accounting for competing efforts such as the waiver reconfiguration effort, implementation of the Disability Waiver Rates System (DRWS) framework and the launch of MnCHOICES 2.0—it

will be important for DHS also to consider any additional projects that might impact this specific implementation. The case management redesign effort and the implementation of the community first services and supports (CFSS) service are likely to have significant impacts on this project. DHS should measure those impacts thoroughly.

5. **Gain federal Centers for Medicare & Medicaid Services (CMS) approval.** DHS will need to prepare to request extensions on waivers, complete waiver applications and report the budget methodology to CMS. It is sensible for DHS to consider mapping current administrative activities and administrative activities in the proposed structure. This will help DHS ensure all claimable activities are identified and also might help DHS understand any potential areas of gap or overlap that require remediation. DHS will need to complete this work before the transition because it could lead to delays in implementation. The timing of this work is key.
6. **Plan for legislative/legal approval.** DHS has considered the elements that require legislative approval and has developed a timeline included in this report. In addition, it will be advantageous for DHS to do a detailed review of statutes, regulations, finances, policies and procedures to map any changes necessary to implement this proposed approach.
7. **Pace timing.** DHS will need to ensure the proposed tasks occur on the timeline specified in table 9 since there are many moving parts that need to occur in tandem.
8. **Evaluate the transition.** DHS should plan to conduct a formal evaluation of the transition and budget methodology implementation to determine how well the new structure is meeting the needs of people who receive services and make changes if needed.

Figure 22 offers a timeline for potential activities related to the system tasks that might support implementation efforts.

Figure 22: System timeline



Timeline

Undertaking a redesign of this magnitude will require DHS to develop a multi-year, detailed work plan with a comprehensive strategy. In addition to identifying and tracking major milestones, the work plan will need to provide the operational detail necessary for DHS staff to manage and anticipate the workload related to each major task toward transition.

DHS has identified key activity areas necessary to achieve the planned systems redesign, including legislative requirements, updates to MnCHOICES, recalibration of the individual budget model to include children, updated rates and policy based on the new version of the assessment, administration and expiration of the current waivers and development of two new waivers. Table 9 outlines the major activities in each category by year.

Table 9: Major activities by year

Category	2019	2020	2021	2022	2023
Legislative	Request funding to implement supports budgets and new waivers, and request changes to services to align across waivers	Revise statute as necessary	Revise statute to transition the four waivers to the two new waivers	Revise statute as necessary	Revise statute as necessary
Individual budget methodology	Launch MnCHOICES 2.0, and identify and begin work on a recipient portal where people will be able to access their budget and plan	Begin recalibration of the framework with MnCHOICES 2.0 data and incorporate children into the framework	Finalize recalibration with MnCHOICES 2.0 data for FY 2020/21 and other rate/service changes	Integrate individual budgets with MnCHOICES annual assessments	Continue to administer individual budgets with MnCHOICES accordingly
Current waivers	Assess need and timeline for renewal and/or extension of current waivers, and amend waivers to align services and rates	Align services across all four waivers	Amend waivers to include transition plan, and begin planning waiver sunsets	Transfer into new waiver options with annual service planning	Allow waivers to expire
New waivers	Begin writing concept paper for waiver plans and outreach to CMS	Begin waiver plan submission process, and convene public comment period	Finalize new waivers with CMS	Jan. 1, 2022: Launch supports budgets and waiver enrollment on rolling basis	Jan. 1, 2023: Reach full implementation of new budget and new waivers

In 2019, DHS should engage in work to align waiver services across the four current waivers with the services that will be offered on the Individual Support and Residential Support waivers. Offering the same array of services across the four current waivers before the transition will:

- Help DHS gain momentum toward its overall change effort
- Give people who use services time to adjust to changes in the services available to them.

Service alignment will require DHS to finalize the service array, service definitions, provider qualifications and any rate adjustments; seek legislative approval; and map the amendments necessary for each waiver to result in the same service array across all four waivers.

In 2019, DHS plans to implement MnCHOICES 2.0. The project team recommends DHS develop a sampling plan to reflect the composition of the service population closely so it can use assessment data to recalibrate the individual budget methodology as early as possible. The recalibration period also will allow DHS to use data from MnCHOICES 2.0 to incorporate children into the methodology. DHS will collect assessment data over a one-year period. DHS then will start reviewing and analyzing the new assessment data against the recommended framework to update and finalize the supports budget methodology by 2021 to include in the two new waivers. Since both the waiver reconfiguration and the budget model depend on this data, DHS must take precautions to ensure recalibration can occur as early as possible.

The four current waivers have different expiration dates. Therefore, DHS must create a strategy to extend the waivers through 2022. This will accommodate the transition period of the new waivers. Some of the options might coincide with amending the current waivers in 2019 to achieve service alignment. Table 10 presents options for DHS to consider. The feasibility of these options will depend largely on negotiations with the Centers for Medicare & Medicaid Services (CMS). CMS' early guidance on viable renewal/extension options will be essential for DHS to finalized planning. In addition, DHS' assurances related to efforts to ensure health, welfare and due process during this transition will be essential communication components.

Table 10: Waiver expiration dates and options for extension

Waiver	Expiration date	Options
CADI	9/30/2020	1. Renew in 2019 when amending all waivers for service alignment 2. Amend to align services in 2019 and request streamlined renewal in 2020 Note: CMS has discussed in the past the potential for a streamlined renewal process when there are no substantive changes to the operations or content of the waiver and when the waiver assurances are in good standing.
BI	3/31/2021	1. Request a series of temporary extensions to allow DHS to operate under current renewal authority through 12/31/2022 (21 months in total) 2. Renew as scheduled, with an included phase-out schedule ending the waiver in 2023

DD	6/30/2022	Request a series of temporary extensions to allow DHS to operate under current renewal authority through 12/31/2022 (6 months in total)
CAC	3/31/2023	No action needed as expiration date occurs after 12/31/2022 Advise CMS of intent to allow the waiver to expire at end of renewal period and include any necessary phase-out procedures during the 2019 amendment to align services.

It is important for DHS to consider data collection and submission to CMS on the statutory assurances in the timing of any renewals and extensions and as DHS moves toward waiver closeout. These elements should be a key point of discussion with CMS early in the strategy negotiation to ensure DHS' methods for data collection, analysis and aggregation will be aligned within the established timelines of the recommended reconfiguration.

DHS also will need to develop a transition plan to include in Attachment #1 during the waiver amendment process for the four current waivers. According to the CMS Instructions, Technical Guide and Review Criteria, when a new waiver replaces an existing waiver, the state is required to prepare a transition plan to describe how it will accomplish the transition between the existing and the new waiver.[18]

DHS should consult with CMS about the short- and long-term plans to reconfigure the waiver programs. In 2019, it would be important for DHS to begin articulating the overall vision for the system and operational components of the transition to CMS representatives and stakeholders. To do this, DHS will create a concept paper that includes a simple, visual representation of the systems change.

Building on the extensive and ongoing stakeholder engagement started in 2018, DHS will build the new waivers with information from meaningful and ongoing stakeholder engagement and learn from the service alignment effort that will be underway in 2020. Once the legislature reviews and approves the overall concept, DHS will begin the waiver development phase, including completing the 1915(c) waiver application templates for each new waiver. DHS will need to include the budget guidelines for the budget model in each of these new waiver plans.

In 2021, DHS expects to receive CMS approval for the new waivers with enough time to begin education and outreach for the transition from the four waivers to the new, cohesive program before the waivers become effective in January 2022.

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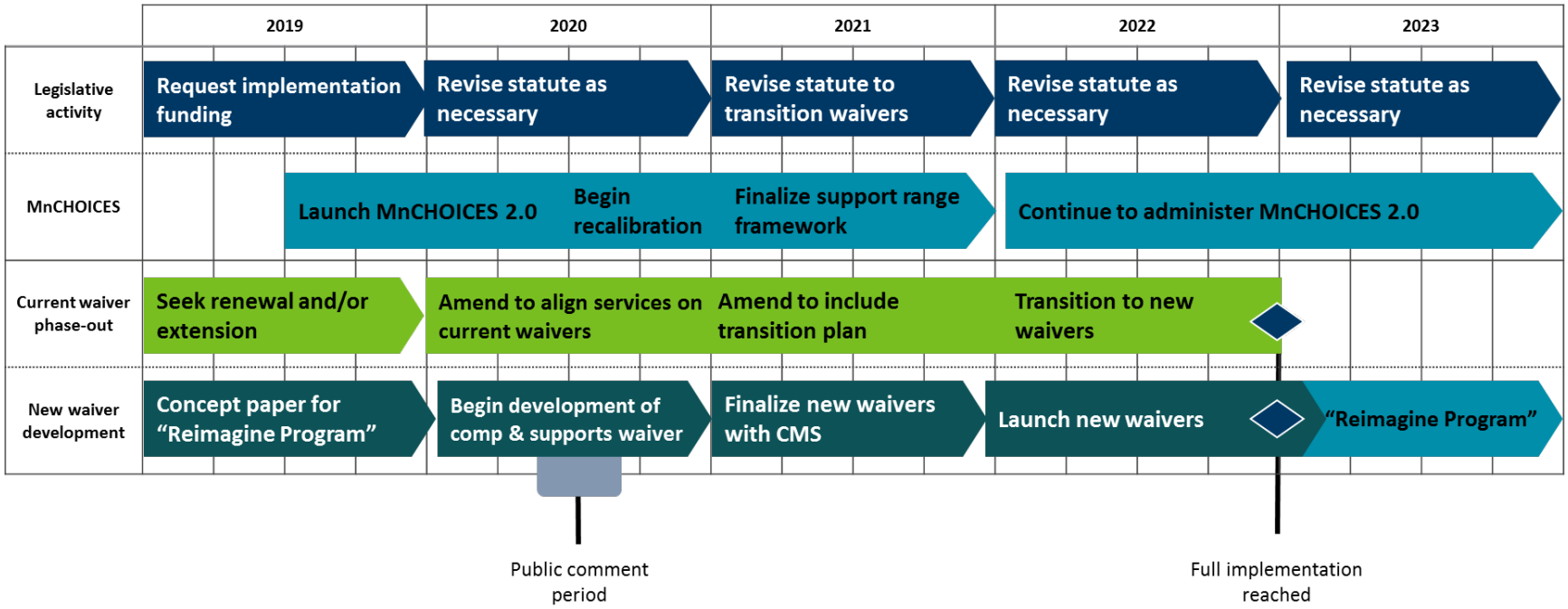
18 Centers for Medicare & Medicaid Services, "Application for a §1915 (c) Home and Community Based Waiver, Version 3.5 Instructions, Technical Guide and Review Criteria (.ZIP)," 2015.

As DHS will have included phase-out plans for the four current waivers during the amendment and/or renewal process, all people new to receiving waiver services will be enrolled directly in the reconfigured programs as of January 2022. DHS will help people who currently receive services transition to the new waivers on a rolling basis, according to plan dates, over a one-year period. This puts DHS on target to achieve full enrollment of the new waivers in 2023, enabling the final closeout of the four current waivers and leaving the two waivers.

Even though there is sufficient time to complete all the project activities outlined, the phase-in timeline in figure 23 still is fairly aggressive because there are many tasks DHS must complete over the next few years. As such, DHS will want to keep pace with the efforts in the manner outlined in this report and revisit the overall implementation plan if any specific areas hinder the transition.

Figure 23: Phase-in timeline by year



V. Background and approach

Background

Focus groups

When the project began, the project team began by trying to understand Minnesota's current situation and how people served by the four current waivers experience their services. To that end, the project team conducted 14 focus group across Minnesota to collect qualitative feedback and input from 265 people with disabilities, family members, caregivers, providers and staff from counties. Across these groups, the team identified several common issues, which are summarized in figure 24.

"**Different services across the waivers; different eligibility; it's confusing.** The needs for people are generally the same—home living, employment, transportation, medical. Eligibility is deficit-based, so you have to say all that's wrong with you to qualify. No navigation services. Once eligible there is an entitlement for all services offered so it creates over-dependencies, unbalanced expenditures, and a trend towards segregation which is not truly needs-based."

-County staff

First, there are several barriers to accessing information about waiver programs and services. Many people and their families use home and community-based services (HCBS) waiver services to provide essential supports to meet health and safety needs. People also use waivers to get supports that enable them to live in their communities through services such as in-home supports, residential supports and employment supports. However, the waivers are complex, and learning about available services is a challenge for people, their families and their caregivers. Many people learn about supports and services through word-of-mouth and networking rather than from the various systems that touch their lives. People also reported they have to know what to ask for—they need to know the right words to get the services they need.

Focus group participants indicated current programs are siloed and create many barriers for people and families to receive the supports they need and for which they are eligible. Even within counties, respondents were frustrated that case management and fiscal staff do not seem to communicate. This results in supports and services being held up because of the lack of communication and coordination.

People and their families value flexible supports and services to meet their support needs. People and their families expressed their wishes for more opportunities to be creative without reducing services or assuming people are trying to take advantage of the system. People expressed frustration over the

limitations on where they can purchase goods and services. While they recognized services come from taxpayer money and they need to be good stewards of it, they described a need for more balance. People who receive services believe some decisions by counties appeared to be based on short-term budget decisions, while alternative decisions might have had better long-term financial outcomes and greater benefit for the person and his/her family (e.g., Hoyer lift vs. ceiling lift system).

People who receive services expressed that access and availability is not consistent across counties, and people in rural counties report a greater disadvantage. If services technically are available, the staff shortage might be so severe that it is unlikely people will be able to use them. Transportation, recreation opportunities and parent support also were identified as needs in rural areas. Common national, state and system-level barriers were identified as conditions that affect waiver services in rural communities and beyond, including direct support workforce shortages, lack of transportation, insufficient affordable housing and a lack of quality service providers.

Figure 24: Key focus group themes about support

How can people best be supported?

People who receive services/families

- Streamline and simplify eligibility and renewal process
- Address the workforce crisis
- Provide useful information and resources
- Improve county/tribal staff training and competency
- More person-centered supports
- More support for specialized and other services in the rural areas
- More culturally competent services
- More opportunities to provide feedback

Providers

- Combine waivers and simplify service choices
- Reimbursement rates need to reflect the cost of services
- Improve county/tribal staff training and competency

Lead agencies

- One waiver with clearly defined guidelines
- Address MnCHOICES and planning process
- Address the workforce crisis
- Maintain a strong "safety net" system

This early engagement with stakeholders gave the project team a good understanding of the issues Minnesota is facing and allowed the project team to consider the different ways this project might address specific stakeholder concerns.

Waiver reconfiguration research

The project team conducted research to understand the different waiver reconfiguration efforts other states had undertaken. The team focused this review on statutes, regulations and sub-regulatory guidance for four Medicaid state plan and waiver authorities—chosen because of their widespread use around the country for the delivery of home and community-based services (HCBS) and their potential alignment with Minnesota's project objectives:

- 1915(c) HCBS Waivers
- 1915(i) HCBS State Plan Option
- 1915(k) Community First Choice Option
- 1115 Research and Demonstration Waivers.

When reviewing these authorities, the project team explored the following operational elements:

- Authority overview
- Target population requirements/opportunities
- Clinical eligibility parameters/level-of-care considerations
- Financial eligibility parameters
- Potential service array
- Availability of self-direction
- Geographic limitations, if any
- Limitation on number of people served
- Renewal requirements
- Cost/financial tests
- Administrative and reporting requirements and public notice requirements
- Quality assurance/quality improvement.

Additional criteria, reviewed where applicable, included:

- Extent to which populations with different diagnostic criteria are addressed
- Potential for incorporating varying level-of-care criteria
- Limitations or specific regulations related to services or providers
- Financial tests, if any
- Guidance on quality assurance or performance expectations
- Administrative or reporting requirements.

Based on a review of the available authorities and given Minnesota's current use of the 1915(c) authority, the project team determined the most feasible option at this time is to consolidate into two 1915(c) waivers.

Research into other state activities

The review of other states' activities included three steps:

1. The project team compiled a waiver review matrix. This matrix (table 11) illustrates key informational areas within and related to waivers and reconfiguration efforts, and it provides a mechanism for comparison between states. The waivers themselves served as the primary resource for the data. In some cases, however, the project team examined other available materials, such as publications made available by the state or news articles. Some information requested through the matrix, however, was not possible to find through research (e.g., reasons for change, contextual issues and public reaction).

Table 11: Waiver review matrix areas

Waiver areas
Waiver authority converting from
Waiver authority converting to
Stated reason for change
Target groups
Eligibility
Effective date of proposed waiver
Change effort timeframe
Administration and operation
Services—Summary of services before and after change effort
Self-directed (yes/no and narrative, if applicable)
Caps on individual resource allocations or budgets
Limits on numbers served
Summary of public reaction/change communication
Contextual (e.g., systemic, political) hurdles or opportunities for change
Change complete? If no, state reason

2. The project team selected states for in-depth review. After developing this matrix, the team selected six states for further review: Delaware, Kansas, New Mexico (selected for two different efforts), New York, Pennsylvania and Tennessee (see table 12). Kansas, New Mexico, New York, Pennsylvania and Tennessee all provide examples of waiver consolidation efforts—some completed, some not. New Mexico's Mi Via waiver also offered an opportunity to look at an

entirely self-directed waiver, which was relevant to Minnesota's interest in strengthening the use of the consumer directed community supports (CDCS) option. Finally, Delaware was included to provide an example of how alternative funding authorities can be used strategically—in this case, to provide employment services.

Table 12: Waiver efforts reviewed

State	Waiver effort	Funding authority
Delaware	Pathways to Employment	1915(i)
Kansas	Unnamed KanCare expansion	1115
New Mexico	Centennial Care	1115
New Mexico	Mi Via	1915(c)
New York	Bridges to Health	1915(c)
Pennsylvania	Community Health Choices	1915(b/c)
Tennessee	TennCare II	1155

With states selected and the matrix prepared, the project team conducted online research on each of the selected efforts. Information the team could not gather through this method was set aside for key informant interviews (see step 3). Interview questions differed by state based on the online availability of information. This information also informed the narrative for each effort presented in the project team's findings.

3. The project team identified and interviewed key informants within each state. To obtain information not available through research, HSRI identified key informants who had in-depth knowledge of the operational details necessary to implement the states' strategies.

   The following themes arose from these interviews:

   - States have several Medicaid funding authorities available to them that can facilitate delivery of long-term services and supports. Each authority carries with it different opportunities and hurdles, and there is no prescription for which authority a state must or should use to meet its goals.
   - States use a variety of waiver and state plan authorities to achieve desired outcomes. The type of waiver authority a state selected was based not only on the state's overall goals but also on contextual factors. The process often begins by defining the target population and the state's priorities related to serving that population.
   - States recognize efforts to reorganize long-term services and supports structures can cause some amount of disruption, and so they work to mitigate impacts on end-users of the system. The strategies they used included making incremental changes over time,

working to ensure no group would be disenfranchised under a new configuration by understanding key differences in service needs by population, developing a phase-in strategy and, if necessary, responding to the concerns of stakeholders by changing course or adjusting.

- States invest significant time and effort to prepare for consolidation or reconfiguration by aligning system components prior to implementation. This requires work to coordinate components of a program, assess differences and develop a plan to adjust accordingly. The timeframe necessary to conduct this type of evaluation and make incremental changes to policy and practice took, on average, at least 2–5 years before rollout.
- States stress the importance of developing an effective communication strategy. Many states described significant efforts related to statewide listening tours, meeting with key stakeholder organizations (e.g., provider associations, disability rights and other advocacy groups) and providing means for ongoing communication. Related to this, some states provide training on new technology solutions, services and policies and procedures for state staff at all levels, managed care organizations, service providers and others.
- States design mechanisms to track system performance to evaluate the degree to which the state met its overall goals by the selected strategy and make course corrections as necessary.

Research into Minnesota's waivers

Between January and June 2018, the project team researched and reviewed Minnesota's four current disability waivers—Brain Injury (BI), Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC) and Developmental Disabilities (DD). The project team applied a similar methodological approach to the review of these waivers as to its review of other states' waiver reconfiguration efforts. Then, the team determined additional points of inquiry within the waiver documents to get a sense of their similarities and differences. The final list included:

- Administration
- Target groups
- Numbers enrolled
- Most recent approval date
- Expiration date
- Eligibility:
  - Clinical
  - Financial
- Post-eligibility:

    - Level of care
    - Waiver services
- Caps on individual resource allocations or budgets:
    - Limits on numbers served
    - Performance measures.

Through this review, the project team found, in general, the waivers present more similarity than dissimilarity. They use the same eligibility groups and post-eligibility criteria, contain 28 of the same services with little-to-no difference in service definition, contain many of the same performance measures and generally point to the same governing rules and policies. The primary differences between the waivers are their target groups and their level of care requirements, as well as some performance measures.

A key finding is the need to consider additional existing Medical Assistance work, beyond the waivers, that will impact any proposal to reconfigure their structures. This includes:

- Case management redesign
- State plan (personal care assistance [PCA], home health, early and periodic screening, diagnosis and treatment [EPSDT])
- State- and county-funded grants or services (i.e., Family support grant, consumer support grant and semi-independent living services)
- Minnesota's Olmstead Plan
- Community first services and supports implementation.

Budget methodologies research

Consumer directed community supports (CDCS) review

To support the development of the budget methodology, the project team began its work with several research activities to understand the available options better—and to understand the current budget approach in Minnesota. This research phase greatly supported the shape of the team's recommended budget methodology. First, the team conducted a review of the CDCS methodology Minnesota currently uses. Next, the team thoroughly reviewed budget methodologies of waivers used in other states. The team also conducted research on data from MnCHOICES and on service use by people who use the four waivers.

First, to determine the benefits and risks of the CDCS approach, the project team reviewed the current CDCS methodology and how it works.[19] The team also sought to identify whether the methodology, or any part of the approach, should be preserved in the work going forward. From this review, the team learned CDCS uses a methodology tied to its two legacy assessments: The Long-Term Care (LTC) Screening Document[20] and the Developmental Disabilities (DD) Screening Document[21]. The applicable waiver plan uses both assessments to indicate a "case mix" classification that uses a documented algorithm. There are different algorithms for people on the BI, CAC and CADI waivers than for people on the DD Waiver. For the BI, CAC and CADI waivers, there are 13 case mixes: A-L and V (see table 13).

Table 13: Case mix classification summary

Classification
A – Low ADL
B – Low ADL behavior
C – Low ADL special nursing
D – Medium ADL
E – Medium ADL behavior
F – Medium ADL special nursing
G – High ADL
I – Very high ADL (eating 3-4)
J – High ADL, severe neurological impairment/3+ behavior
K – High ADL special nursing
L – Very low ADL/age 65 or older
V – Ventilator dependent

Adapted from: AC, BI, CADI, EW Case Mix Classification Worksheet, DHS-3428B (PDF).

19 J. Petner-Arrey et al., "Analysis of budget methodologies & Research into other state activities," 2018 (Prepared for Minnesota Department of Health Disability Services Division).

20 Minnesota Department of Human Services, "LTC Screening Document, DHS-3427 (PDF)," July 2018.

21 Minnesota Department of Human Services, "DD Screening Document, DHS-3067 (PDF)," February 2018.

To arrive at a case mix classification, the methodology described in the waiver plan applies a series of steps.[22] After all the considerations are applied, the county/tribal nation assigns a case mix. Once the case mix is established, the methodology calculates a daily rate [23] that later is multiplied by 365 to derive the total annual budget.

The process is similar for the DD Waiver, though the case mixes are established differently. The methodology determines a total daily weight multiplied by specific factors, and then the county/tribal nation uses a series of steps to generate the final case mix.[24] The county/tribal nation determines a total daily weight and multiplies it by 365 to produce the total annual budget.

There also are several established exceptions to allow for additional funding in certain circumstances for CDCS. The project team's review determined DHS should replace the current CDCS methodology since it does not meet many of DHS' future goals.

Research from other states

Next, the project team reviewed waivers and other sources to find information about methodologies used in other states. This review helped the project team determine whether any specific methodologies would be useful for Minnesota.[25] First, the team conducted a thorough review of 261 Medicaid waivers around the country to identify those that use an assessment-informed prospective budget. An assessment-informed prospective budget is a methodology that ties an assessment meaningfully to a budget. It is prospective because the lead agency can provide the information to the person before to his/her planning meeting. The team chose this criterion since DHS identified this approach as preferable. From the team's initial review, it determined many states were implementing some sort of budget or budget limits, but only a portion of these waivers met DHS' criteria. Thirty-one states implement an approach that meets DHS' criteria with one or more HCBS service populations.

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22 Minnesota Department of Human Services, "AC, BI, CADI, EW Case Mix Classification Worksheet, DHS-3428B (PDF)," January 2018.

23 Minnesota Department of Human Services, "CDCS Budget Methodology for the BI, CAC and CADI Waivers," June 2017.

24 Minnesota Department of Human Services, "CDCS Budget Methodology for the DD Waiver," June 2017.

25 J. Petner-Arrey et al., "Analysis of Budget Methodologies & Research into Other State Activities," 2018 (Prepared for Minnesota Department of Human Services Disability Services Division)

A standardized assessment is used and is linked directly to the resulting budgets. The budget is known before the plan to estimate needed services over the coming year and is not developed by tallying services.

The project team identified 43 waivers in 31 states that applied an assessment-informed prospective budget methodology. The team also selected example states to provide additional context and interviewed key informants in nearly all those states. The team categorized each methodology and considered the strengths and weaknesses of each.

In each of the 43 selected methodologies, the assessment was key to the budget—that is, the assessment meaningfully affected the resulting budget amount. Typically, core assessments are combined with other variables to produce a budget. As a result, a person can know his/her budget before support planning and might be able to use it as an estimate to guide support planning for the coming plan year. In each of the 43 selected methodologies, the states did not calculate the budgets by selecting needed services, adding units together and multiplying by cost.

Then, the project team categorized the selected methodologies as either an individual methodology or a level methodology:

An individual methodology results in each person having a unique budget.

A level methodology results in a group of people sharing a budget amount.

- An individual methodology results in each person having a unique and distinct budget. For this budget to be used, a person's circumstances (e.g., specific needs indicated on an assessment, his/her previous year's budget) are required to calculate the budget, so every person can have his/her own budget. For instance, if a state serves 20,000 people in its waiver, theoretically there could be 20,000 unique budgets.
- A level methodology establishes groups, and each group is defined according to common features of their needs determined from the assessment and other selected variables (e.g., age and living setting). Generally, all people who fall within a level are assigned the same budget allocation (unless finer distinctions are made within levels, such as by creating sub-levels). For example, the state may choose to assign people to one of three levels based on needs identified in an assessment. They may choose to break out the levels further based on whether a person is a child or an adult. As a result, the state could establish a three-by-two matrix to display the six budgets a person could be assigned.

Categorizing the findings by these two primary approaches provided an important distinction because each approach is designed uniquely and involves different obstacles and opportunities. The project team's review of these budgets found states more commonly used level methodologies. Of the 43 states reviewed, 32 (74 percent) used a level methodology, and only 11 (26 percent) used an individual methodology.

HSRI also interviewed key informants in six states who provided detailed information about their states' methodologies, as well as the lessons they learned from implementation. See table 14 for an overview of selected states.

Table 14: States interviewed for budget research

State	Example
Oregon	Oregon uses an individual budget methodology through its K-plan waiver using the Adult Needs Assessment and the Children's Needs Assessment to determine hours of services that are calculated by adding together time values related to different responses on the assessment. The resulting budget accounts for the total hours of needed support.
Idaho	Idaho uses an individual budget methodology through a 1915(c) waiver by using the Scales for Independent Behavior-Revised and an Inventory for Individual Needs to apply a regression equation that calculates a total annual budget amount.
Florida	Florida uses an individual budget methodology through a 1915(c) waiver by using the Questionnaire for Situational Information to apply an algorithm through the EZ iBudget Calculator that serves as starting point for the final budget.
West Virginia	West Virginia uses a level methodology using the Inventory of Client and Agency Planning tool to determine whether an individual qualifies for an add-on amount after a base budget has been determined.
North Carolina	North Carolina uses a level methodology using the Supports Intensity Scale to assign an individual to a level, which, in combination with living setting and age, determines a person's budget.
Wyoming	Wyoming uses a level methodology using the Inventory of Client and Agency Planning tool and determines a service level, and then adds any medical or behavioral needs, then uses the resulting level to determine the final budget.

There are risks and benefits associated with each type of methodology. The benefits of individual budget approaches include:

- Typically considered highly personalized
- Often based on sound statistical modeling.

The risks of individual budget approaches include:

- Difficult for most people to understand
- Require regular recalibration to account for changes in service spending that can change the entire model and may be disruptive for people who use services.

The benefits of level methodologies include:

- More easily understood
- The model can be recalibrated without much disruption.

The risks of level methodologies include:

- Tend to be thought of as less individualized
- Sometimes require additional information outside of the data collection.

From speaking with other states, the project team gathered important lessons other states' staff learned from implementing budgets (see figure 26).

Figure 26: Lessons from budget methodology review

The project team decided its proposed approach should adhere to some of these important lessons—in particular, using an understandable methodology DHS can communicate transparently to stakeholders and recalibrate easily in the future. Through this research, the team determined to include an expert panel in the development of the methodology and to use their efforts meaningfully to shape the resulting support range framework. (See the Individual budget methodology development section of this report for more information about these activities.)

MnCHOICES analysis

To consider how best to develop the budget methodology, the project team started with a thorough examination and analysis of the MnCHOICES Assessment application. DHS developed MnCHOICES to replace several assessments and provide greater consistency in eligibility determinations across programs, streamline support plans across programs, determine needs for support planning and provide for the evaluation of individual outcomes. DHS began implementing the MnCHOICES Assessment in 2014, and it continues the implementation process today.

MnCHOICES is a comprehensive, assessment and support planning, web-based application composed of 14 domains:

- Personal information
- Quality of life
- Activities of daily living (ADLs)
- Instrumental activities of daily living (IADLs)
- Health
- Psychosocial
- Memory and cognition
- Sensory and communication
- Safety/self-preservation
- Employment, volunteering and training
- Housing and environment
- Self-direction
- Caregiver
- Assessor conclusions.

The project team reviewed MnCHOICES data from 27,808 people to inform its analysis (see table 15). The team provided descriptive statistics for people included in this analysis.

Table 15: Analysis group by waiver and CDCS

Group	BI	CAC	CADI	DD	Total
Non-CDCS	835	201	15,794	7,834	24,664
CDCS	55	188	1,565	1,336	3,144
Total	890	389	17,359	9,170	27,808

Table 16 shows the percent of people who required assistance for activities of daily living (ADLs) and the kind of assistance they required.

Table 16: Support required for activities of daily living (ADLs)

Activity of daily living	None	Setup/prep	Limited or intermittent	Extensive or constant
Eating	14,203 (57 percent)	3,132 (13 percent)	4,235 (17 percent)	3,287 (13 percent)
Bathing	7,912 (32 percent)	4,093 (17 percent)	5,917 (24 percent)	6,935 (28 percent)
Dressing	9,996 (40 percent)	3,403 (14 percent)	6,830 (27 percent)	4,628 (19 percent)
Hygiene	8,027 (32 percent)	4,457 (18 percent)	7,514 (30 percent)	4,859 (20 percent)
Toilet use	15,218 (62 percent)	1,085 (4 percent)	4,607 (19 percent)	3,947 (16 percent)
Mobility	14,585 (59 percent)	1,100 (4 percent)	5,362 (22 percent)	3,810 (15 percent)
Positioning	20,603 (83 percent)	299 (1 percent)	1,812 (7 percent)	2,143 (9 percent)
Transferring	18,173 (73 percent)	386 (2 percent)	2,983 (12 percent)	3,315 (13 percent)

Table 17 shows the percent of people who required assistance for instrumental activities of daily living (IADLs) and the frequency.

Table 17: Support required for instrumental activities of daily living (IADLs)

Instrumental activity of daily living	None	Sometimes	Often	Always
Meal prep	2,723 (11 percent)	4,746 (19 percent)	7,293 (29 percent)	10,095 (41 percent)
Transportation	4,584 (18 percent)	3,601 (15 percent)	4,148 (17 percent)	12,524 (50 percent)
Housework – heavy	1,932 (8 percent)	3,424 (14 percent)	6,038 (24 percent)	13,463 (54 percent)
Housework – light	2,515 (10 percent)	6,180 (25 percent)	7,480 (30 percent)	8,682 (35 percent)
Laundry	3,582 (14 percent)	4,612 (19 percent)	5,832 (24 percent)	10,831 (44 percent)
Phone – call	13,130 (57 percent)	3,590 (14 percent)	2,474 (10 percent)	4,663 (19 percent)
Phone – answer	16,031 (65 percent)	2,772 (11 percent)	1,810 (7 percent)	4,244 (17 percent)
Shopping	2,255 (9 percent)	4,176 (17 percent)	7,257 (29 percent)	11,169 (45 percent)
Finances	4,319 (17 percent)	2,664 (11 percent)	5,625 (23 percent)	12,249 (49 percent)

Table 18 shows the health support needs of all people served who received a MnCHOICES assessment.

Table 18: Support required for health needs

Treatments and monitoring		Performed daily by support person	
		Number	Percent of all adults
Cardiac	Blood pressure	602	2 percent
	Cardioverter-defibrillator	12	Less than 1 percent
	Pacemaker	17	Less than 1 percent
	Vital signs	380	2 percent
	Weight	192	1 percent
Elimination	Bladder	138	1 percent
	Bowel program	0	0 percent
	Enemas	47	Less than 1 percent
	Sterile catheter change	0	0 percent
	Clean self-catheter	154	1 percent
	Intermittent catheter	70	Less than 1 percent
	Colostomy	104	Less than 1 percent
	Ileostomy	52	Less than 1 percent
	Scheduled toileting program	215	1 percent
Feeding and nutrition	GJtube	242	1 percent
	Gastrostomy	267	1 percent
	Jejunostomy	28	Less than 1 percent
	Nasogastric	2	Less than 1 percent
	Oral stimulation program	36	Less than 1 percent
	Other swallowing disorders	306	1 percent
	Special diet management	371	2 percent
Neurological	Seizure assist	715	3 percent
	Apnea	59	Less than 1 percent
	CPAP	450	2 percent
	Nebulizer	329	1 percent
	Oxygen therapy	475	2 percent
	Pulse oximeter	196	1 percent
Bronchial drainage	Postural drainage	63	Less than 1 percent
	Respiratory vest	159	1 percent
	Bi-level	167	1 percent
Suctioning	Nasopharyngeal	14	Less than 1 percent
	Oral	138	1 percent
	Trach care	117	1 percent
	Trach change	9	Less than 1 percent
Ventilator	Ventilator	107	Less than 1 percent

Vascular	Blood Glucose	625	3 percent
	Protime/INR	0	0 percent
	Other blood draw	26	Less than 1 percent
	Dialysis	16	Less than 1 percent
IV therapy	Blood transfusions	0	0 percent
	Chemotherapy	0	0 percent
	Medications	0	0 percent
	Total parenteral nutrition	15	Less than 1 percent
Wounds	Burn	12	Less than 1 percent
	Dressing changes	406	2 percent
	Lesions	297	1 percent
	Open surgical site	38	Less than 1 percent
	Ulcer	102	Less than 1 percent
	Wound vac	39	Less than 1 percent
Skin care	Application ointment	1,595	6 percent
	Dry bandage change	179	1 percent
	Pressure relieving device	293	1 percent
	Turning/repositioning program	626	3 percent
Other	Dialectical behavior therapy	10	Less than 1 percent
	Electroconvulsive therapy	0	0 percent
	Input/output measurements	103	Less than 1 percent
	Isolation precautions	22	Less than 1 percent
	Telemedicine	4	Less than 1 percent
	Other therapy	129	1 percent
Therapies	Alternative therapies	22	Less than 1 percent
	Occupational therapy	206	1 percent
	Pain management	86	Less than 1 percent
	Physical therapy	471	2 percent
	Range of motion	786	3 percent
	Respiratory therapy	118	1 percent
	Speech therapy	88	Less than 1 percent

Table 19 shows the psychosocial support needs and type of support of people served among the waivers.

Table 19: Support required for psychosocial needs

Challenging behavior	None or less than weekly	Weekly+, responds to intervention	Weekly+, resists intervention
Injurious to self	21,283 (85 percent)	1,924 (8 percent)	1,750 (7 percent)
Physically aggressive	22,114 (89 percent)	1,162 (5 percent)	1,581 (6 percent)
Verbally aggressive	17,177 (69 percent)	4,133 (17 percent)	3,547 (14 percent)
Socially unacceptable behavior	20,400 (82 percent)	2,564 (10 percent)	1,893 (8 percent)
Property destruction	23,075 (93 percent)	776 (3 percent)	1,006 (4 percent)
Wandering	22,933 (92 percent)	1,031 (4 percent)	893 (4 percent)
Legal involvement	24,369 (98 percent)	222 (1 percent)	266 (1 percent)
Pica	24,293 (98 percent)	314 (1 percent)	250 (1 percent)
Difficulties regulating emotion	15,790 (64 percent)	5,582 (23 percent)	3,485 (14 percent)
Susceptibility to victimization	14,546 (59 percent)	7,589 (31 percent)	2,722 (11 percent)
Withdrawal	16,119 (65 percent)	6,040 (24 percent)	2698 (11 percent)
Agitation	16,539 (67 percent)	5,023 (20 percent)	3,295 (13 percent)
Impulsivity	18,597 (75 percent)	3,77 (15 percent)	2,483 (10 percent)
Intrusiveness	21,437 (86 percent)	2,148 (9 percent)	1,272 (5 percent)
Injury to others	23,680 (95 percent)	484 (2 percent)	693 (3 percent)
Anxiety	12,901 (52 percent)	8,468 (34 percent)	3,488 (14 percent)
Psychotic behaviors	21,422 (86 percent)	1,905 (8 percent)	1,530 (6 percent)
Manic behaviors	23,523 (95 percent)	724 (3 percent)	610 (3 percent)

Conducting this analysis of the MnCHOICES assessment provided the confidence needed to move forward in the development of the methodology. This analysis assured the project team there were a sufficient number of assessments, the assessment includes the most important information required to develop a budget methodology and the assessment can show variation in support needs.

Through this analysis, the project team also produced preliminary test levels to confirm whether such an approach will work. These preliminary test levels somewhat confirmed the team's assumptions because they showed expected differences by waiver and living setting. For example, people on the CAC Waiver were nearly all assigned to the two highest preliminary levels, which is expected since this waiver serves people with high support needs. Alternatively, people living independently were more likely to be assigned to the two lowest support levels, with more than half the people who live in their

own homes assigned to these levels. Seeing the MnCHOICES data through this lens enabled the project team to move forward with developing a level methodology. These preliminary support levels provided the project team with a starting point from which to build the resulting support ranges (discussed in the Individual budget methodology development section of this report) and to complete the service use and spending analysis.

Service use and spending analysis

The last activity in the research portion of the project team's work was to analyze the service use and spending among people who use waivers to ensure the team understood the current spending patterns and considered these patterns in relation to the assessment—and in relation to how the team should develop budgets for people going forward.

The project team started by grouping people in a few key ways:

- Waiver
- Living setting (different than those indicated on the MnCHOICES assessment)
- Age
- Preliminary support level.

Then, the project team calculated average costs per member, per year.[26] The team created service groups (e.g., residential services, day and employment supports) and considered differences in the types of services used, the amounts of service used and the rates paid for services. From this analysis, the project team found the waiver a person uses influences his/her spending, which could be due to either historic practices or differences in needs of people served among waivers. Table 20 compares the average annual costs in fiscal year 2017 (FY 17) by waiver for adults.

26 Analysis were limited to individuals who received a full-year of service (at least one unit of service in each of the 12 months of fiscal year 2017) and who did not change residential placement (for example, moving from a family home to a foster home).

Table 20: Per-member, per-year cost for adults, by waiver, FY 17

Waiver	Cost per member, per year
BI	$84,185
CAC	$202,942
CADI	$45,824
DD	$79,717

People on the CAC Waiver had the highest average per-person cost for adults, more than double the cost of people on the other waivers.

As expected, a person's living setting has one of the most significant impacts on service use and associated costs. Some impacts are obvious. For example, paying for 24-hour care (e.g., corporate or family foster care or supported living) is costlier than paying for intermittent supports for a person who lives in his/her own home or family home. Others are less obvious. For example, people who live in full-time residential placements tend to use more day services compared to those who live with family or independently. Table 21 shows the per member, per year cost in FY 17 for living settings.

Table 21: Per-member, per-year cost for adults, by living setting, FY 17

Living situation	Cost per member, per year
Corporate foster care	$103,988
Family foster care	$77,038
Other residential	$53,441
With family, with CDCS	$46,927
With family, without CDCS	$41,564
Independent with CDCS	$26,882
Independent without CDCS	$25,012

People who live in paid residential settings have the highest per member, per year costs. About 60 percent of people on the DD Waiver live in a full-time, paid residential setting. In contrast, only one-

third of people on the CADI Waiver and one-fifth of people on the CAC Waiver live in paid residential settings. Additionally, people on the DD Waiver use more day services than the averages for all waivers, with amounts ranging from $5,500 per year for those living independently without CDCS (compared to a $1,200 average across the other three waivers) to $15,300 for those living in corporate foster care (compared to $4,600).

Table 21 also shows there are differences between people living with family and people living independently. The project team found the group of people living independently had overall lower support needs than those living in other settings, including with families. Using preliminary levels, more than 75 percent of those living independently were assigned to the two lowest support levels.

As mentioned previously, the project team developed preliminary support levels to review these data. This consisted of three support levels to account of increasing general support needs:

- Preliminary support levels 1-3
- Preliminary support level 4, a support level to account for people with extensive medical needs
- Preliminary support level 5, a support level to account for people with extensive behavioral needs.

The project team considered the data in table 21 through the lens of the preliminary test levels. The team observed people's preliminary support levels affect the costs of supporting them in several ways:

- Where they live (e.g., people with higher needs are more likely to receive costly full-time residential services)
- Types and amounts of other supports they receive (e.g., people with medical needs will be more likely to access nursing services)
- Rates paid for services.

Table 22 shows the per member, per year costs associated with the preliminary levels. In general, people with greater needs receive more services.

Table 22: Per-member, per-year cost for adults by preliminary support level, FY 17

Preliminary support level	Cost per member, per year
Support level 1	$31,611
Support level 2	$43,003
Support level 3	$68,560
Support level 4	$94,854
Support level 5	$82,780

The project team's additional findings related to the preliminary support levels included:

- People in the medical support level (preliminary support level 4) used far more medical and professional services—primarily nursing—than those in the other support levels
- People's use of personal care and other in-home services increases as their support levels increase
- People's use of employment services decreases as their support levels increase
- Average service rates increase as people's support levels increase.

Age also influences the amount of services a person is likely to use. Adults generally are costlier to serve because they might no longer have parental involvement or receive public education, and they more frequently live in paid residences. Table 23 shows the differences between children and adults who are living with families.

Among people who do not use consumer directed community supports (CDCS), children use considerably more services than adults. This difference is due primarily to much greater use of medical and professional services, especially nursing. Children who used medical and professional services used an average of $15,200 per year compared to $2,600 for adults. Children also used somewhat more personal assistance and respite services than adults did. This analysis examined total waiver and state plan service costs.

Table 23: Per-member, per-year cost for adults and children living with family, FY 17

Age group	With family, without CDCS	With family, with CDCS
Adults	$41,564	$46,927
Children	$50,908	$43,870

Spending amounts within adults and children who use CDCS are comparable, which is likely influenced by the fact that the calculations through which CDCS budgets are established are the same for adults and children.

Conducting these analyses showed there were clear differences in the way different types of people have used and needed services in the past. As a result, this analysis was useful to show which specific variations the project team will need accounted for within the budget methodology (e.g., children vs. adults, living setting).

Having completed all these analyses, the team began development of the individual budget methodology to complement waiver reconfiguration efforts.

Approach

Waiver reconfiguration plan development

To evaluate reconfiguration options, the project team categorized and prioritized the numerous goals through ongoing discussions with DHS staff and stakeholders in Minnesota. In discussing project goals, a handful stood out as the most critical to achieve and the most commonly identified across all stakeholders, including DHS. These important goals included:

- Offering flexibility to encourage person-centered supports
- Enhancing personal authority over service choice
- Simplifying waiver program information and administration
- Providing equity across waiver programs and participants
- Aligning benefits across waivers
- Ensuring a smooth transition
- Offering the opportunity to monitor and improve programs to achieve greater sustainability.

The project team and DHS developed evaluation criteria that incorporated these goals and other operational components. These criteria included:

- **Adherence to system goals.** How well does the option promote the intended policy and system goals? How well does the option balance competing priorities?
- **Adherence to stakeholder goals.** How well does the option address the concerns and desires of stakeholders identified during the statewide focus groups?
- **Impacts on people who receive services.** How well does the option promote equity across populations? Does the option produce minimal disruption in service for end-users? How well does the option consider the varied needs of the waiver populations? Will the option likely result in service reductions for one or more groups?
- **Impacts on the system.** Are there aspects of the option that will be difficult to predict or assess the impact on the system overall? Will the option create any undesired consequences? What are the anticipated high-level fiscal impacts?
- **Transition considerations.** Can DHS achieve the option in a reasonable timeframe? What is the level of effort required to change and/or design regulatory structures necessary to implement the option?
- **Communication considerations.** How well do stakeholders understand the option? Are there aspects of the option that will be difficult to explain? Are there aspects of the option that could be unpopular? Are there aspects of the option that will require extensive training for system administrators, case managers, providers and others?

Using these criteria, the team evaluated the benefits of the various funding authorities and structures available.

To begin, the team considered all reconfiguration models, including creating additional waivers, moving to a consolidated waiver, using a state plan configuration and more. The team eliminated options that did not perform well against the criteria. For example, stakeholders' consistent requests for a more simplified system suggested that adding additional waivers will not make the system easily navigable. Use of an 1115 demonstration similar to what Tennessee used (which essentially contains other programs within it) also appeared not to help simplify administration. (For more information about other states' efforts, see the Background and approach: Research into other states' activities section of this report.) Additionally, DHS did not identify it wanted to consider managed care options at this time.

While considering options, the team produced a service-use analysis report. The team used the results from this analysis to make determinations and projections about which services will be included in a reconfigured waiver structure. This allowed the team to produce fiscal impact projections for its recommended reconfiguration.

Individual budget methodology development

Guided by the project team's initial research, the proposed approach for developing individual budgets involved nine distinct steps (see table 23). In the following sections, the project team provides a description of each step. For additional details, see the Development of the Individual Budget Model report.[27]

Involving stakeholders

The project team's first task was to determine how to include stakeholders meaningfully in the development of the budget methodology. Stakeholders were vital to the research portion of the work, and the team heard from people in focus groups and other stakeholder engagements that people wanted an opportunity to contribute and offer feedback to the process. As a result, the team developed several opportunities for stakeholder participation. First, the team met with stakeholders to present information about the proposed plan and to gather their feedback. From this meeting there were no recommended changes, so the team proceeded with the plan as proposed. Second, the team planned for several stakeholder activities through an expert panel that directly influenced the development of the budget methodology. The expert panel was composed of stakeholders in

27 C. Kidney, J. Petner-Arrey and S. Pawlowski, "Development of the Individual Budget Model," 2018 (Prepared for Minnesota Department of Human Services Disability Services Division)

Minnesota who were knowledgeable about the service system. The expert panel had opportunities to participate in the development of each of the three frameworks that compose the model. These activities are described in greater detail in the following sections.

DHS itself also engaged in many stakeholder engagement activities related to the work, talking with people throughout the state about the proposed plan at each stage of its development. The involvement of key stakeholders who will be affected by this methodology lends credibility to the methodology and has been instrumental in its development.

Determine preliminary support ranges

The project team's next activity was to develop preliminary support ranges. The intent of these preliminary support ranges was to offer a starting place that DHS can then refine. To determine the ranges, the team began by identifying MnCHOICES assessment items the team could use to develop a scoring framework. Then, HSRI conducted an analysis to determine how the items worked together. HSRI used items from several domains in the MnCHOICES assessment (see table 23).

Table 23: MnCHOICES items included in scoring

Category	Items used for scoring
ADL items	Eating, bathing, dressing, grooming, toileting, mobility, transfer, positioning
IADL items	Shopping, meal preparation, transportation, housework (heavy), phone (calling)
Psychosocial—behavior	Aggressive to others, physical; property destruction; injury to others; socially unacceptable behavior; aggressive to others, verbal; intrusiveness; injury to self; wandering/elopement; impulsivity; susceptibility to victimization; pica
Psychosocial--emotion	Difficulty regulating emotions, anxiety, agitation, withdrawal
Health	Cardiac, elimination, catheter, ostomy, feeding tube, swallowing disorder, neurological, respiratory, bronchial draining, suctioning, ventilator, blood draw, IV, wounds, skin care, other, therapies

For each item included in the preliminary support ranges, the team included specific questions to determine whether the person did or did not need support. For some questions, the type of support needed was included, and for others, the frequency of the support was included.

The project team performed analysis to determine:

1. The items that can be combined to determine sum scores for different assessment domains (e.g., ADLs, IADLs, psychosocial and health)
2. The most appropriate number of support ranges for the support range framework

3. The sum scores that create support ranges that contain people similar to one another and different from people in other support ranges.

The team determined:

1. ADLs and IADLs can be combined to form a general support needs (GSN) score; psychosocial should be broken into psychosocial—behavior, psychosocial—emotion and psychosocial—mania/psychosis; and health should remain as-is.
2. The most appropriate number of support ranges included four GSN support ranges. HSRI came to this conclusion after testing 21 models against a series of criteria (e.g., statistical fit, measures from low to high support need). HSRI also created two support ranges for psychosocial and/or health support needs.
3. Scoring criteria for each of the four GSN support ranges and the psychosocial and/or health support ranges. HSRI reserved a support range for people who have extraordinary health and/or psychosocial support needs—with specific criteria that DHS will determine following additional data collection.

As a preliminary test, the project team assigned each person to a support range and conducted descriptive analyses to describe his/her support needs. The team used these preliminary support ranges and descriptive analyses to develop descriptions.

Develop support range descriptions

Next, the team developed support range descriptions to provide context for the model. The team shared the analyses it conducted to determine the preliminary ranges with 16 expert panel members. Expert panelists participated in a training that described the goals for the activity and walked through the descriptive data for each support range. They reviewed this data and answered many questions about the kinds of support people assigned to each support range might need. The team used Charting the LifeCourse (CtLC)[28] as a lens to consider support needs in a variety of life domains.

The team merged the panelists' responses to form the support range descriptions (see Appendix B for full descriptions) and adjusted specific wording for consistency. The team also opted to use first-person voice for the support ranges based on the recommendation of one of the panelists. Then, the team used the support range descriptions for the support range membership survey.

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28 University of Missouri – Kansas City Institute for Human Development, "Charting the LifeCourse™," n.d.

Conduct support range membership survey

When the support range descriptions were complete, the project team used the descriptions to survey the expert panel members about the support needs of people receiving services in Minnesota. First, the team developed MnCHOICES profiles for a stratified random sample of 800 people who receive services. The team generated profiles using items from each person's MnCHOICES assessment. Then, each profile was anonymized. The team provided a customized workbook to 29 expert panelists and asked them to review the data for each person's profile included in their workbook. After they reviewed the workbook, the project team asked panelists to indicate whether the GSN (ADLs and IADLs) was none, moderate, high, extensive or extraordinary; whether psychosocial support needs were none/typical, high or extraordinary; and whether health support needs were none/typical, high or extraordinary. The team also asked, "What support range should be assigned to the person?" and allowed panelists to respond by choosing among all support ranges, including the 'extraordinary needs' range, which, at this point in development, had no criteria.

Conduct support range membership survey analysis

Next, the project team collected all the responses to the survey and compared them to the preliminary support range framework. Specifically, the team compared the preliminary support range assignments to those of the expert panel members and considered differences and similarities. The team also compared responses for each of the GSN, psychosocial and health areas to the team's scores for each of those areas. The findings suggested:

1. Revisions to the criteria were needed to determined assignment to support ranges L and H for both psychosocial and health needs (i.e., more people should be assigned to support ranges L and H)
2. The addition of an extraordinary support range was needed, since some people should be assigned to support range E.

Overall, support ranges 1-4 were consistent with those of the expert panel members. The project team tested revisions by calculating a new support range assignment and comparing it to the reviewer-based assignment. The team evaluated the appropriateness of the new criteria by improvements made in the overall alignment between the final range assignment and the assignments the panelists provided. The team also saw decreases in the percentages of misalignment.

This iterative process resulted in changes to the criteria for each of the psychosocial and health areas and more people assigned to support ranges L and H. It also resulted in the addition of criteria for support range E, allowing many of the people that the expert panel deemed as needing assignment to support range E to be assigned to that range. These changes better aligned the final support range criteria with those determined by the expert panelists, and it supported more people getting into the

support ranges meant to accommodate people with more intense psychosocial and health needs. Overall, this additional analysis resulted in deliberate refinements that also aligned with stakeholders' visions for the support ranges.

Determine framework criteria

Using the analysis described in the previous section, the project team revised the support range criteria. The team reviewed the support ranges across the entire population, by waiver, CDCS usage and living setting. This review showed the support ranges are valid since the framework aligned well with what the team knows about the service system. For example, the CAC Waiver overwhelmingly is composed of people assigned to the two highest support ranges (i.e., support ranges H and E), which makes sense since this waiver is intended for people with significant health needs. Similarly, people living independently were far more likely to be assigned to the lowest three support ranges (i.e., support ranges 1, 2 and L), which makes sense since people who live independently frequently have lower support needs.

With the support range criteria finalized, the team was able to develop model service mixes based on the kinds and amounts of services people will require at each support range.

Develop model service mixes

After the support range criteria was finalized, the project team developed the model service mixes. When the team applied the support range criteria to each person, it reviewed service use by living setting for each of the five living settings:

- Adults living in corporate foster care
- Adults living in family foster care
- Adults living in other residential settings
- Adults living with family
- Adults living independently.

The project team reviewed eight service groupings to determine the proportion of people who used services and how much they used. These groupings include:

- Residential
- Personal supports
- Personal care
- Day and employment
- Respite
- Consumer directed community supports (CDCS)
- Medical and professional services

- Other services.

The team determined which services were applicable to each service mix by living setting and support range, and how much of each service typically was used by people who used each service. From this exercise, the team set an hourly amount for each service and used average rates by support range to calculate the cost of services and price each service mix. The project team discussed service mixes with the expert panel and DHS to adjust them before testing out the adequacy of these draft service mixes in a record review.

The team chose to remove medical and professional and other services from the budgets, since people do not use these services universally, and there are already clear limitations for these services. The process for determining the CDCS mix mirrored that of traditional services and also used the same budgets.

Record review

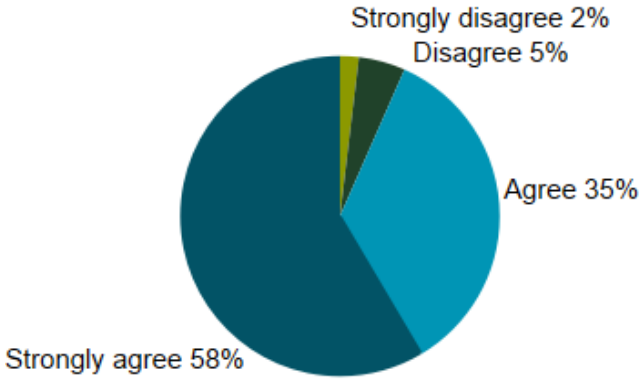
When the project team drafted the model service mixes, it considered how well they met the needs of people who receive services in Minnesota. To do this, the team collected and reviewed case records and coordinated services and supports plans for 135 people. The record review was to determine whether:

- Each support range is appropriate for each person to whom it would be assigned
- People in each support range all have similar needs
- The service mixes offer adequate support to meet each person's needs.

Overall, the team found the support range framework places people in support ranges appropriate with their support needs, and people in each of these support ranges all have similar support needs.

The team asked the record review participants whether the service mix adequately or more than adequately meet the need of the person. For adults, the team found the service mixes were adequate or more than adequate for most people considered in the record review. Figure 27 shows these results.

Figure 27: Adequacy of service mixes



DHS record reviewers either agreed or strongly agreed the service mixes were adequate or more than adequate for 93 percent of the adults whose records were reviewed. For each record reviewed, the project considered the amount of service hours that would support the people adequately. The team used results from the record review to modify the draft service packages. Notably, the team added residential services to the service mix, since it found many people did not use any other services. Additionally, the team altered several of the service mixes to align with hours indicated in the record review and to accommodate DHS' specific budgetary goals.

The project team also added:

- A five percent budgetary overage allowance (calculated by level) to each service mix to create the upper budgetary end of the support range
- A $30,000 lower budgetary band (when applicable) to create the lower end of the support range.

See Appendix C for the provisional service mixes.

Recalibration

DHS will be making several changes in its service system before it will implement the individual budget model in 2022. To prepare for the waiver reconfiguration, DHS will align services across the four current waivers, which will bring all people into a unified service framework. DHS also will launch MnCHOICES 2.0 in 2019. As such, DHS will need to recalibrate the individual budget model to account for changes to the assessment and update the service mixes with service use data from a more current year. This recalibration will begin in 2020, and it will involve repeating several important tasks used to develop the provisional methodology using updated data. (For more information, see the Development of the Individual Budget Model report.[29]) Recalibration also will provide DHS an opportunity to incorporate children into the support range framework.

Fiscal analysis

To ensure the reconfiguration effort and individual budget model are sound and can achieve necessary fiscal objectives, the project team conducted fiscal testing several times throughout the development of the individual budget model and considered the resulting findings in the development of the model. (See the Fiscal Impact report for more information about the fiscal impacts.[30])

Fiscal impact

To determine the fiscal impacts of the reconfiguration effort, the project team considered proposed changes in services within the reconfigured waivers that would result in differences in services use compared to services and use within the current waivers. Overall, the team noted the proposed reconfiguration has a relatively minimal fiscal impact. This is because DHS and HSRI do not expect

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29 C. Kidney, J. Petner-Arrey and S. Pawlowski, “Development of the Individual Budget Model,” 2018 (Prepared for Minnesota Department of Human Services Disability Services Division).

30 S. Pawlowski, J. Petner-Arrey and Y. Kardell, “Fiscal Impact of Waiver Reimagine Recommendations,”2018 (Prepared for Minnesota Department of Human Services Disability Services Division).

service use patterns to change significantly due to DHS' recent efforts to align services across the four current waivers. The estimated fiscal impact of the waiver reconfiguration (independent of the fiscal impact projected for introduction of the individual budget model) is $4.6 million. This estimate is largely associated with increased rates for supported living billed in 15-minute increments and in-home family support services as these services merge into new, higher-cost individualized home supports with training services.

Budget usage and future spending

To determine the fiscal impact of the individual budget model, the project team made several assumptions about future service use by using past authorizations and spending as an indicator of future spending (e.g., how many people were likely to spend their entire budget, how many people might spend over their budget). The team then created a model to test these assumptions. This testing resulted in specific changes to the draft service mixes that align with DHS' fiscal goals. If these assumptions remain the same, HSRI expects the overall fiscal impact to be modest, ranging from a savings of $16.3 million to a cost of $19.1 million when fully implemented.

Given the assumptions the project team used to complete these fiscal projections, the analysis shows about 12 percent of the people included are expected to experience budget reductions. About half of these are people living in corporate foster care settings with approved provider rates that exceed the rates assumed in the model. More than half the adults included in the analysis are not expected to use their entire budget since they had a substantial unused capacity available in their previous authorization. Based on past spending, the team expects just over a third of the people in the analysis will increase their spending once given an increase in their budget.

The project team developed these estimates to reflect only the impacts of the proposed reconfiguration and individual budget model. The estimates do not attempt to account for systems changes that will occur if DHS implements either of these proposals. For example, the estimates do not account for caseload growth or the end of banding as DHS implements the disability waiver rates system.

The project team based these analyses on specific assumptions related to how people's behavior will change in response to the reconfiguration and individual budget model. Given the difficulty in modeling behavioral changes, these assumptions are subject to some degree of error. With these assumptions, the team strongly encourages DHS to monitor changes in utilization patterns as implementation begins to determine whether any of the assumptions require adjustment. For example, the estimated fiscal impacts of the individual budget model assume many people will continue to under-utilize their authorizations, but if people (and their providers) want to maximize the use of their budget amounts—which will be known to all parties—costs could be substantially higher than projected.

VI. Conclusion

The process of moving to the recommended waiver structure and individual budgets will involve considerable time, attention to detail and planning. The Implementation Readiness[31] and Waiver Transition[32] reports outline many of the activities DHS will need to undertake, and the timelines by which DHS will need to accomplish those tasks. Many people within DHS likely will have roles to play in accomplishing these tasks. DHS also should build on the considerable stakeholder engagement it began to do with these studies to gather continuous feedback and insight as it moves closer to implementation.

While this work will not be without difficulty, HSRI feels these recommendations will allow DHS to run its Medical Assistance program for people with disabilities in Minnesota in a smoother, more predictable and equitable manner. In turn, people who receive services, or who otherwise are impacted by this system, will benefit from these changes.

While HSRI makes these recommendations with an eye toward the system DHS wants to achieve, any system built today will likely require refreshing and rethinking at some point in the future as best practices, stakeholder desires, political context and other factors change. Continuous monitoring post-implementation will help DHS understand how changes affect its system. Beyond that, it will be wise to continue to engage with stakeholders and legislators to determine if these systems can still meet needs in the many years to come.

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31 J. Petner-Arrey and J. Agosta, "Implementation Readiness," 2018 (Prepared for Minnesota Department of Human Services Disability Services Division).

32 B. Taylor, Y. Kardell and J. Agosta, "Waiver Transition Report," 2018 (Prepared for Minnesota Department of Human Services Disability Services Division).

Appendix A: Benefits and challenges to two-waiver configuration

Description of option	Benefits	Challenges
Consolidating four current disability waivers (BI, CAC, CADI, DD) into two 1915(c) waivers – Individual Support Waiver and Residential Support Waiver	The two-waiver option offers a way to differentiate by living setting – serving people in paid residences via the comprehensive waiver and serving people living on their own or with family through the supports waiver. This creates the ability to target resources and supports to best serve people where they live. Both waivers will combine all disability populations currently served under the four existing waivers.	Operating two waivers reduces the administrative burden from the current four waivers to two, but it does require designing and maintaining two separate waivers. This option will require a solid communication strategy and engagement with stakeholders, particularly families and other advocates who likely will be served on the Individual Support Waiver. The service offerings and any potential limits imposed on the Individual Support Waiver and access to the Residential Support Waiver will require careful consideration.

Evaluation criteria	Benefits	Challenges
Equity and access: **Responsiveness to the person's needs, preferences and circumstances regardless of diagnostic classification or waiver enrollment.**	People currently served under the four disability waivers will have access to either the Individual or Residential Support waiver based on living setting. The waivers will not differentiate by diagnostic classification.	The service array offered on both waivers must be robust enough to meet the needs of people with a variety of disabilities and support needs. Under the two-waiver option serving a cross-disability population, the real or perceived advantage of specialization by diagnostic classifications may be dissolved.
Changes and predictability: **Recognition of life changes and increased emphasis on technology, environmental modifications and adaptive aids**	• The service arrays offered on each of the waivers can be tailored to meet the specific needs of people served based on living arrangement • Both waivers can include services that promote the use of technology, environmental modifications and adaptive aids.	If person requests to move from the Individual Support Waiver into a paid residential setting under the Residential Support Waiver, the nature of the two-waiver structure creates a level of control to that access. Movement between waivers may be restricted due to capacity or other policy decisions.
Benefit alignment: **Common service menus, uniform standards and**	While residential services will only be available on the Residential Support Waiver, each waiver likely will contain a similar base set of services. However, each waiver may offer specific services that are of benefit to people based on living setting.	Providing similarity across the two waivers presents a challenge. For people who reside in the family home served on the Individual Support Waiver, it is important to acknowledge the contribution of family members providing some amount of uncompensated support.

consistent limits across waiver programs		
Administrative simplification: **Making waivers easier to understand for** people who use services **and to implement by local lead agency staff, including clear roles of the state and delegated agents in the administration of the waiver programs**	Reduces the administrative burden by reducing the number of waivers, thereby simplifying the experience for local lead agency staff and end-users	This requires a strong communication strategy including possibly framing the overall effort as operating one program with two mechanisms to receive support. Lead agencies will need to have a clear understanding of how to enroll people to the waiver most appropriate to meet their needs.
Program management streamlining: **Allows changes/amendments to be requested and approved at the same time across waiver programs, allows a single implementation of the changes and aligns waiver years for disability waivers**	Changes/amendments would be reduced to two waivers	This requires maintenance of two separate waivers. Therefore, if changes/amendments are needed related to common elements across the two waivers (i.e., change to a service definition for a service offered in both waivers) they would need to be replicated across both.
Ease of transition and impacts on people who receive services: **Ensuring minimal disruption for** people who **current**ly use **waiver**s **and informed choice on potential service changes**	Transition to two waivers can take two courses: 1. One of the existing 1915(c) waivers could serve as the receiving waiver for the Residential Support Waiver and the other three waivers could be sunsetted. A new waiver would need to be created for the Individual Support Waiver 2. Two new waivers could replace all four existing waivers	1. Path 1: The receiving waiver would need to be amended to reflect the resulting Residential Support waiver. This transition may be administratively burdensome. Plans of care would need to be changed incrementally for those on the receiving waiver 2. Path 2: Both new waivers created after 2022 must be in full compliance with the HCBS Settings Final Rule. This may impact the overall timeline to creating new waivers. Moving a person from one waiver to another does not technically require a continuation of the previous authorization if done at the end of a plan year. However, it would be necessary to assess the degree of parity between what was authorized previously and what he/she will have

		access to under the new waiver in which he/she is enrolled.
Consumer direction	In this configuration, the consumer-direction option would exist on the Individual Support Waiver only. This is an option currently not available to people living in a provider-operated residence. This allows DHS to enhance the supports waiver by including this option.	Maintaining consistency in benefit packages across those who are directing their own services and those who are not will present a challenge. The nature of consumer-directed services is distinctly different in operation and particularly related to rate determinations. Policy decisions made related to the consumer-direction option likely will affect the popularity of this option.
System impacts	Creates a streamlined approach to administration and operations	While difficult to assess overall fiscal impacts due to inability to predict changes in service patterns or latent demand, provides an ability to control access to residential options, thereby providing avenues to adhere to budget constraints
Communication considerations	Communicating the overall intent to operate one disability program with two ways to access the services a person needs	People living with family members or on their own would need reassurance the Individual Support Waiver option will meet their needs.

Appendix B: Support range descriptions

Support range 1

Below is the preliminary support range 1 description.

MnCHOICES	In general, I need no support or minimal reminding for most activities of daily living like eating, bathing, dressing and toileting. I sometimes need assistance or supervision for instrumental activities of daily living like housework, shopping or managing finances. I have no or few health support needs. I have no or few support needs for challenging behaviors. I may need some support for managing emotional needs.
Meaningful day and employment	To engage in meaningful employment, I may need initial support to explore employment or education options and find a job, including filling out applications and securing transportation. On the job, I may need intermittent help to troubleshoot any problems I experience, to manage my relationship with co-workers or tools to manage my anxiety.
Community living	To live in and access the community, I may need help to explore living options and housing or to apply for housing benefits. I may need intermittent help to pay bills, to manage my money, to find transportation or maintain my car and to keep up with housekeeping and maintenance. I may need technology support to live independently.
Safety and security	To stay safe and secure, I may need a risk assessment and plans to mitigate vulnerabilities. I may need help setting up emergency contacts and identifying additional supports to keep me safe. I usually know what to do to stay safe and can advocate for myself and manage emergencies, and I may benefit from technology.
Health living	I might manage my healthcare needs on my own but might need a healthcare plan to keep up with my medical needs. To manage and access healthcare and stay well, I may need help setting up and attending medical appointments, finding and communicating with healthcare practitioners or recognizing mental health care needs.
Social and spirituality	To build relationships and engage in leisure activities, I may need initial support to coordinate and attend activities that I am interested in. I may need minimal or intermittent support connecting with others or maintaining existing relationships. Education about healthy relationships, boundaries and dealing with aggression might also help me to maintain my relationships.
Citizenship and advocacy	To drive how my life is lived, I may need support in the form of supported decision-making. I might need temporary support to prioritize or implement my goals and may need guidance to make major decisions.

Support range 2

Below is the preliminary support range 2 description.

MnCHOICES	In general, I need minimal supervision or reminding for most activities of daily living like eating, bathing, dressing and toileting. I often need assistance for instrumental activities of daily living like housework, shopping or managing finances. I may have health support needs, but they are minimal and require prompting or oversight. I may need some support for challenging behaviors like verbal aggression, socially unacceptable behavior, susceptibility to victimization or impulsivity. I may need some support for managing emotional needs.
Meaningful day and employment	To engage in meaningful employment, I may need help to determine my interests and to develop employment skills. I could use help getting and keeping employment, education or volunteer opportunities. I may also need on-the-job support. I might need education and/or supervision and cueing to use public transportation.
Community living	To live in and access the community, I may need help to identify housing needs and/or to pay for my home. I may need direct family or staff support to complete homemaking activities such as planning and cooking meals, shopping and paying bills, and access to 24-hour support. I might need technology, home modifications, and/or specialized transportation.
Safety and security	To stay safe and secure, I may need education about emergencies, being home alone, identifying unsafe scenarios (e.g., strangers entering my home), or understanding the consequences of my actions. I may need access to 24-hour supports, or direct support to remain safe in my home or community. I may also need help to manage my emotions or behavior.
Health living	To manage and access healthcare and stay well, I may need help to schedule and attend medical appointments, to take medication, including medication for mental health needs. I may need help shopping for and preparing healthy food and reminders to exercise. I may benefit from therapies, but I don't experience frequent hospitalization.
Social and spirituality	To build relationships and engage in leisure activities, I may need help to attend events. I may need help getting connected with a social group. Education about healthy relationships, boundaries and dealing with aggression might also help me to maintain my relationships.
Citizenship and advocacy	To drive how my life is lived, I may need access to education about advocacy and advocacy opportunities, as well as support to set goals that I can achieve. I may identify people I trust to assist me in processing situations and making decisions about my life. I might need assistance setting up routines, and I may become more independent over time.

Support range L

Below is the preliminary support range L description.

MnCHOICES	In general, I need no or little support, reminding and/or supervision for most activities of daily living like eating, bathing, dressing and toileting. I sometimes or often need assistance or supervision for instrumental activities of daily living like housework, shopping or managing finances. I may have high health support needs and/or high psychosocial needs that require some daily support. I may have support needs for challenging behaviors such as injury to self, physical aggression, verbal aggression or socially unacceptable behavior. I may need support for emotional needs such as difficulties regulating emotion, withdrawal, agitation and anxiety, and may need some support for managing manic or psychotic behaviors.
Meaningful day and employment	To engage in meaningful employment, I might need help to find and keep a job. I may work independently or need support to work in the community, including prompts. I may need education to use transportation, and tools to help me manage challenging behaviors or emotional needs at my job. I may need specialized support such as nursing, behavioral or communication help.
Community living	To live in and access the community, I may need help to figure out the right living setting for me, including my own home or with family. I may need education about transportation and means to pay for it. I may need support such as assistive technology, personal emergency response systems (PERS) and/or direct assistance to fill out forms, secure housing or other benefits, pay bills, maintain my home and create emergency backup plans.
Safety and security	To stay safe and secure, I may need supportive people around me, or other forms of representation to help make decisions and manage benefits. I may need education about how to respond in emergency situations. I may need emergency supports and protocols available, a risk assessment to mitigate any vulnerabilities, assistive technology and/or periodic check-ins.
Health living	To manage and access healthcare and stay well, I may need support to schedule and attend medical appointments, follow medical routines, and recognize and understand medical/mental health needs. I may benefit from period check-ins and/or assistive technology. I may attend therapies, receive treatments or need help to comply with medication schedules.
Social and spirituality	To build relationships and engage in leisure activities, I may need help to be active in my community, including education about healthy relationships. I may also need support to express frustration in a positive way or manage other mental health or challenging behaviors so that I can maintain my relationships. I may need long-term supports to access my community, including transportation and means to pay for transportation.
Citizenship and advocacy	To drive how my life is lived, I may need supports to express my dreams and to manage my meetings. I can usually advocate for myself and make my own decisions, but I may need formal plans to make sure that I can be independent and make as many choices as possible, including expert help to maintain my employment or living situation. I may need tools to help me manage my relationships with others.

Support range 3

Below is the preliminary support range 3 description.

MnCHOICES	In general, I need some physical assistance for most activities of daily living like eating, bathing, dressing and toileting. I always or nearly always need assistance for instrumental activities of daily living like housework, shopping or managing finances. I may have a few health support needs that do not require extraordinary support. I may need minimal support for challenging behaviors like physical aggression, verbal aggression, socially unacceptable behavior, susceptibility to victimization or impulsivity. I may need minimal support for managing emotional needs.
Meaningful day and employment	To engage in meaningful employment, I may need thoughtful planning, formal supports to find and keep a job, long-term transportation support and help to complete activities that I am interested in. I may benefit from the assistance of a job coach or day programming. On-the-job, I may need prompting, direct support, constant monitoring or physical assistance.
Community living	To live in and access the community, I may need daily support for physical or emotional needs. I frequently need help to maintain my home. I may need home modifications, adaptive equipment and/or assistive technology. I likely need support to access transportation. I may need frequent physical support, including people to lift and transfer me.
Safety and security	To stay safe and secure, I may need the support of a representative or other people I identify to help me make decisions, including financial. I may need access to 24-hour supports. I may need help to abstain from eloping or hurting myself. I need to have emergency plans ready to be sure that I can remain safe in emergencies.
Health living	To manage and access healthcare and stay well, I may need a special diet, tube feeding and/or interventions to prevent choking. I may need skilled nursing visits and/or long-term supports. I may rely on others to set up appointments and to determine when I need medical care. I likely need assistance preparing healthy meals.
Social and spirituality	To build relationships and engage in leisure activities, I may need family or staff support to access the things that I want to do. I may need people to facilitate activities and to help me engage in my interests. I might need support available in social situations.
Citizenship and advocacy	To drive how my life is lived, I may need the help of a supportive person that I can depend on to help me make decisions. An advocate might help to ensure that my choices aren't limited because of my needs. Just because I need help doesn't mean that I am not able to make decisions in my life.

Support range 4

Below is the preliminary support range 4 description.

MnCHOICES	In general, I need full physical assistance for most activities of daily living like eating, bathing, dressing and toileting. I always need assistance for instrumental activities of daily living like housework, shopping or managing finances. I may have a few health support needs that do not require extraordinary support. I may need minimal support for challenging behaviors like injury to self, physical aggression, verbal aggression or susceptibility to victimization. I may need minimal support for managing emotional needs and may need some support for managing manic or psychotic behaviors.
Meaningful day and employment	To engage in meaningful employment, I may need long-term support to find a job and physical support or hand-over-hand assistance to complete work tasks. I may need help to understand work tasks or to manage mental health/behavioral needs. I may require support from more than one person and may need assistive technology or communication devices.
Community living	To live in and access the community, my living setting may need to be modified to meet my mobility needs. I may need assistive technology or a communication device. I likely need considerable support with transportation and to access the community. I may need a 24-hour plan of care.
Safety and security	To stay safe and secure, I may need help to make decisions. I likely need 24-hour access to care in case of emergencies. I may need a risk assessment and plan to mitigate risks. People who support me might need specialized training to keep me safe and secure.
Health living	To manage and access healthcare and stay well, I may need extensive emergency planning, advocacy with medical practitioners, preventative care with a social worker or RN and transition planning after hospital stays. I may need significant support for taking medication, participating in therapy and promoting my overall wellness.
Social and spirituality	To build relationships and engage in leisure activities, I may need help to find and maintain social groups, assistance communicating, hands-on assistance to participate in activities of interest, planning to attend activities due to my health/mobility needs and/or help with personal care when I am engaged in activities that I enjoy.
Citizenship and advocacy	To drive how my life is lived, I may need help to make decisions and support to maximize my ability to make decisions. I may need encouragement and communication support to make decisions, as well as people to help advocate for the things that I want.

Support range H

Below is the preliminary support range H description.

MnCHOICES	In general, I need partial to full physical assistance for most activities of daily living like eating, bathing, dressing and toileting. I always or nearly always need assistance for instrumental activities of daily living like housework, shopping or managing finances. I may have high health support needs and/or high psychosocial needs that require daily support. I may have support needs for challenging behaviors such as injury to self, physical aggression, verbal aggression, socially unacceptable behavior or property destruction. I may need support for emotional needs such as difficulties regulating emotion, withdrawal, agitation and anxiety, and I may need some support for managing manic or psychotic behaviors.
Meaningful day and employment	To engage in meaningful employment, I likely need a substantial amount of staff support. If I am not employed, I may need support to participate in other preferred activities. I often need extensive support for day-to-day activities from skilled individuals and backup plans when support is unavailable. I likely need support to attend school or to engage in other daily activities.
Community living	To live in and access the community, I need formal support to help secure appropriate housing, maintain housing and pay bills. Home modification and assistive technology can help increase my independence. I may need in-home support and other services to live in and access my community including transportation.
Safety and security	To stay safe and secure, I may need a risk assessment and planning to mitigate vulnerabilities. I might need supervision in my home and my community and 24-hour access to specialized supports, including nursing and behavioral. I may need support to deal with legal proceedings such as criminal charges, civil commitments and emergencies.
Health living	To manage and access healthcare and stay well, I may need help to schedule and attend medical appointments, and to coordinate health support. I may need monitoring for health conditions such as seizures. I may need help communicating with my providers, as well as support to secure reliable health and mental health supports. I experience health or mental health issues that require me to have an emergency plan.
Social and spirituality	To build relationships and engage in leisure activities, I may need full support to find and participate in activities with others. I may need support to ensure that my physical, emotional and medical needs are met, including when I am doing things with my friends and family. I may need long-term support to ensure that I can maintain relationships and manage behavioral or health needs.
Citizenship and advocacy	To drive how my life is lived, I may need support to engage in opportunities to make decisions and advocate for myself. I may need formal planning to help me realize my goals and ongoing support to advocate for my needs. I may need help to ensure that even when I experience health or mental health issues, I am still able to make choices for myself.

Support range E

Below is the preliminary support range E description.

MnCHOICES	In general, my support needs for daily activities are varied. I may need no support for most activities like eating, bathing, dressing and toileting, or I may need extensive support for them. I often or nearly always need assistance for instrumental activities of daily living like housework, shopping or managing finances. I have extraordinary need for health needs and/or psychosocial needs. I usually have a serious health condition such as frequent seizures, swallowing disorders, respiratory needs or other conditions that require constant support, or I may have support needs for serious challenging behaviors that may result in hurting myself or others if not supported.
Meaningful day and employment	To engage in meaningful employment, I may need fully customized employment or significant accommodations to work from home. I need at least 1:1 support the entire time that I am working. To access work or day programs, I need constant support and supervision, often from individuals with highly specialized skills. I may be at risk of hospitalization or institutionalization and need flexible options to fulfill a meaningful day.
Community living	To live in and access the community, I may need significant home modifications including ceiling track lifts, a ventilator, 24-hour 'eyes on' support or specialized staff. I may require 2:1 support to help me manage my medical/mental health needs and/or to keep others around me safe. I may be frequently hospitalized due to health or mental health needs. My housing options may be limited due to my needs, and/or I may have restrictions on my freedom related to legal involvement. I may also have trouble accessing the community.
Safety and security	To stay safe and secure, I may need specialized family or staff support (e.g., people trained to operate medical equipment and recognize health emergencies, people trained in crisis-prevention who are able to physically intervene if I am in danger or hurting myself or others). I may require 2:1 support to keep me from hurting myself or others. I likely need a guardian or other forms of representation to help me make decisions. I need emergency plans to deal with recurrent emergencies.
Health living	To manage and access healthcare and stay well, I may need specialized daily physical assistance for nutrition needs, positioning, mobility, ventilation and/or other extraordinary support needs. I may experience frequent hospitalization. I need help to schedule and attend appointments and may need specialized transportation to get there. I may need in-home medical and behavioral consultation. I may require a specialized living setting to meet my unique needs and help to advocate and communicate my health needs to others.
Social and spirituality	To build relationships and engage in leisure activities, I may need significant long-term support to help with communication and physical support to maintain my personal care or to secure my safety and the safety of others around me when I engage in community activities that I enjoy. I may have limits on my freedoms due to past criminal activity, and/or I may need planning and help to access my community in a way that suits my extensive support needs.
Citizenship and advocacy	To drive how my life is lived, I need significant support to determine my interests and goals, make decisions and/or to advocate for myself, including assistive technology. I may benefit from a strong advocate who knows me and my interests well. Though I have

	considerable support needs, a strong and well-coordinated team can help me have the stability required to make important decisions in my life.

Appendix C: Model service mixes

Corporate foster care service mix and budget ranges							
Supports level	**1**	**2**	**L**	**3**	**4**	**H**	**E**
Residential	$83,950	$83,950	$91,250	$91,250	$98,550	$104,025	$109,500
Day support services (hours/week)	10	12	12	12	18	18	20
Employment support (hours/week)	10	10	10	10	10	10	10
Day and employment subtotal	$22,000	$24,600	$25,800	$25,800	$36,600	$36,600	$45,000
Total:	$105,950	$108,550	$117,050	$117,050	$135,150	$140,625	$154,500
5 percent	$5,298	$5,428	$5,853	$5,853	$6,758	$7,031	$7,725
Budget range	$81,248 to $111,248	$83,978 to $113,978	$92,903 to $122,903	$92,903 to $122,903	$111,908 to $141,908	$117,656 to $147,656	$132,225 to $162,225

Family foster care service mix and budget ranges							
Supports level	**1**	**2**	**L**	**3**	**4**	**H**	**E**
Residential	$49,275	$58,400	$65,700	$65,700	$76,650	$76,650	$76,650
Day support services (hours/week)	10	12	12	12	18	18	20
Employment support (hours/week)	10	10	10	10	10	10	10
Day and employment subtotal	$22,000	$24,600	$25,800	$25,800	$36,600	$36,600	$45,000
Total	$71,275	$83,000	$91,500	$91,500	$113,250	$113,250	$121,650

5 percent	$3,564	$4,150	$4,575	$4,575	$5,663	$5,663	$6,083
Budget range	$44,839 to $74,839	$57,150 to $87,150	$66,075 to $96,075	$66,075 to $96,075	$88,913 to $118,913	$88,913 to $118,913	$97,733 to $127,733

Other residential service mix and budget ranges							
Supports level	**1**	**2**	**L**	**3**	**4**	**H**	**E**
Residential	$36,500	$36,500	$43,800	$52,925	$65,700	$65,700	$65,700
Day support services (hours/week)	10	12	12	12	18	18	20
Employment support (hours/week)	10	10	10	10	10	10	10
Day and employment subtotal	$22,000	$24,600	$25,800	$25,800	$36,600	$36,600	$45,000
Total	$58,500	$61,100	$69,600	$78,725	$102,300	$102,300	$110,700
5 percent	$2,925	$3,055	$3,480	$3,936	$5,115	$5,115	$5,535
Budget range	$31,425 to $61,425	$34,155 to $64,155	$43,080 to $73,080	$52,661 to $82,661	$77,415 to $107,415	$77,415 to $107,415	$86,235 to $116,235

Living with family service mix and budget ranges							
Supports level	**1**	**2**	**L**	**3**	**4**	**H**	**E**
Ind. home supports (hours/week)	N/A	N/A	3	3	7	7	7
Ind. home supports w/training (hours/week)	7	7	7	7	7	7	7
Homemaker (hours/week)	0	0	0	0	2	2	2
Personal support subtotal	$11,900	$11,900	$16,720	$16,720	$23,124	$24,524	$25,924
Extended personal care (ECP) (hours/week):	0	0	7	7	7	7	7
EPC subtotal	$0	$0	$6,090	$6,090	$6,090	$6,090	$6,090
Respite (hours/year)	168	168	240	240	336	336	336
Respite subtotal	$3,024	$3,024	$4,560	$4,560	$6,384	$6,720	$6,720
Day support services (hours/week)	5	5	7	7	12	12	12
Employment support (hours/week)	5	5	7	7	7	10	10
Day and employment subtotal	$11,000	$11,500	$16,800	$16,800	$24,900	$29,400	$33,000
Total	$25,924	$26,424	$44,170	$44,170	$60,498	$66,734	$71,734
5 percent	$1,296	$1,321	$2,209	$2,209	$3,025	$3,337	$3,587
Budget range	$0 to $27,220	$0 to $27,745	$16,379 to $46,379	$16,379 to $46,379	$33,523 to $63,523	$40,071 to $70,071	$45,321 to $75,321

Living independently mix and budget ranges							
Supports level	**1**	**2**	**L**	**3**	**4**	**H**	**E**
Ind. home supports (hours/week)	7	7	10	10	14	14	14
Ind. home supports w/training (hours/week)	7	7	7	7	7	7	7
Homemaker (hours/week)	3	3	3	3	4	4	4
Personal support subtotal	$22,646	$22,646	$27,466	$27,466	$32,948	$34,348	$35,748
Extended personal care (EPC) (hours/week)	0	0	7	7	7	7	7
EPC subtotal	$0	$0	$6,090	$6,090	$6,090	$6,090	$6,090
Day support services (hours/week)	5	5	7	7	12	12	12
Employment support (hours/week)	5	5	7	7	7	10	10
Day and employment subtotal	$11,000	$11,500	$16,800	$16,800	$24,900	$29,400	$33,000
Total	$33,646	$34,146	$50,356	$50,356	$63,938	$69,838	$74,838
5 percent	$1,682	$1,707	$2,518	$2,518	$3,197	$3,492	$3,742
Budget range	$5,328 to $35,328	$5,853 to $35,853	$22,874 to $52,874	$22,874 to $52,874	$37,135 to $67,135	$43,330 to $73,330	$48,580 to $78,580