EXECUTIVE SUMMARY

Currently, Iowa's MH/DD System is plagued with funding inequities stemming from the use of base year county funding strategies as a foundation of funding the system. This is further exacerbated by the inability of the state to fund current system growth.

A statewide management plan for MH/DD adult services will be developed under this proposal to provide direction to a county or region to implement. Eligible individuals will be assessed by one of two assessment tools based upon disability. Based on the individual assessed need, an individual budget allocation will be granted and supports may be purchased using dollars in this allocation. Counties or regions will submit needs based budgets and dollars based on these budgets will be allocated. If funding will not cover all the needs, budgets will be reduced and a statewide waiting list established.

This proposal will have counties levy 100% of their current fund 10 levy authority. These dollars will be encumbered before additional state or federal dollars are allocated to the county or region. (Note: A standard levy rate, or rebasing are components that may need to be addressed in the future.) All other funds currently going to counties such as, property tax relief dollars, growth dollars, risk pool dollars, community services dollars, etc. will be pooled in a State Mental Health fund. After the county levy has been fully encumbered, dollars from the State Mental Health fund will be distributed to counties from the State to supply individual county needs as reported through the Community Services Network data system.

This proposal has the capacity to eliminate legal settlement, county funding silos, system inequities, waiting lists based on an individual county, county waiver slot issues and provides for individualization and flexibility at the consumer level. In addition this proposal addresses both short term and long term funding of the MH/DD System as well as long term management strategies.

Any questions regarding this proposal should be submitted to Brad Leckrone, Wright County Community Services Director.

Transforming Iowa's MH/DD System

PART I Management Strategy

The Counties, the State MHDS division of the Iowa Department of Human Services in conjunction with the MH/DD/MR/BI Commission and the Governor's DD Council will develop a state wide management plan to be implemented by individual counties or, if counties choose, regions as developed by Iowa Code 28E. The statewide management plan will not develop a list of core services to fund as services will be determined by the needs of the individual who receives financial support. The statewide management plan will define eligibility criteria or "clinical criteria", assessment tools, and management practices in authorizing funding (i.e. reviewing requests to purchase supports against need, planning and progress), receiving remittances and paying of remittances as well as the development and submission of budgets.

A Fiscal Board will be created to oversee the budgetary and financial aspects of this model. The functions of the Board would include: County budget review/approval, special circumstances funding, and, if necessary, assessment review and validity. A suggested membership of the Board would include County Boards of Supervisors, Personnel from the Department of Human Services, County CPCs, and members from the MH/MR/DD/BI Commission. This Board will enhance continued partnership and stability in oversight and policy making.

Each county or region will be responsible for the development and submission of a fiscal year budget to the Fiscal Board at an appointed time (suggested January 1st prior to the fiscal year). The budget will consist of historical expenditures for services that cannot be anticipated, such as involuntary civil commitments and anticipated growth and services that are prone to fluctuation such as outpatient mental health services and medications. The budget will also consist of documented and authorized needs budgeted at an individual consumer level. Finally the budget will contain an amount for administrative costs to manage and implement MH/DD financial supports.

Each person determined to be eligible in accordance with the state plan for MH/DD financial aid will be assessed by one of two assessment tools. Persons with a developmental disability or a Brain Injury will be assessed using the Supports Intensity Scale or SIS while persons with a persistent mental illness will be assessed using the Level of Care Utilization System or LOCUS. Case managers and county social workers will receive regular training on how to implement the assessment tool and will complete the tool annually or upon any life event that may cause an individual's needs to change. Upon completion of the tool, the individual will receive a score. Based upon this score the individual will be provided with a monthly individual budget. The individual can then access the monthly budget to purchase necessary supports based upon their documented or assessed needs. Supports will be requested in advance and the request must show how the support will meet a documented or assessed need based on the applied assessment tool and score.

Individual budgets will be established based upon the defined score within the assessment tool and not based upon a range of levels of need. For example, a person may be assessed by the SIS as having a score of 59 which falls within level III of need. Level III may have a range of funding from $3,382 to $6,381 a month but the score of 59 equates to $4,715 a month. Thus the individual's budget based upon their assessed or documented need is $4,715 a month. The individual may choose not to access all of those

dollars and they cannot access more than those dollars. This figure is placed in an individual budget. (See the attached SIS budget spread sheet to see a disbursement of dollars to score.)

The SIS has a 7.98% difference between each level. The scores are then distributed from the ICF/MR cap at the upper most level and score of 103 down to the lowest level and score of 6. Thus each individual score is reflective of the statistical norm that the SIS has identified as 7.98% from level to level. As a result individual budgets can be reliably attained and assigned. This same principle can be assigned to the LOCUS with the cap being an average of the daily ICF/PMI rate. For more details on the SIS assessment and the development of an individual budget see the attached documents.

Once individuals who are eligible for financial support have been assessed and given an individual budget allocation, the bulk of the county or regional budget can be developed based upon the encumbrances of the individual budget allocations. Once the county or regional budget is developed and submitted to the Fiscal Board, state and federal dollars can be allocated to where the assessed need is and in the amount of needs greater than the county levy authority. This can be done reliably based on the use of the assessment tools and the established individual budgets. In addition, each individual, with assistance if necessary, can develop their own support plans and purchase the supports they desire based on the flexibility of the individual budget or they may use their allocation to continue to purchase supports as they have historically done. The state will not have to develop a core set of services that administrative entities should fund. Instead, the individuals themselves will define what their individual set of services will be based upon their needs, goals and desires. The case manager and the team will assist them in the development of the necessary supports required to meet the outcomes they have identified in the individual comprehensive or support plan.

Individual budgets can be adjusted as individual needs change. For example, if a person has a life change of moving from the parental home to their own living arrangement, then the needs will change and thus funding must change to meet the new needs. At this point a new assessment would be completed and the individual budget changed. Counties and regions using the Community Service Network can submit real-time data. This can then be used to ascertain the changing needs within the system at any point in time.

Should Mental Health funding fall below the statewide assessed need, the Fiscal Board can determine the percentage of the shortage and individual budgets can be adjusted down by this percentage (From top levels and scores down so that the greatest needs are fully funded i.e. ICF/MR). At this point a state wide waiting list would be implemented instead of regional or county waiting lists. Individuals, with the assistance of their team, will determine how to handle the cuts in their individual budget. This allows for maximum flexibility and the management of risk so that the statewide budget will always balance. Once funds are available, budgets will be restored if necessary, and waiting lists reduced or eliminated. As a caveat, children can be assessed three years before entering the adult MH/DD System, creating the ability to predict future system costs and to plan accordingly for predictable system growth.

PART II Funding Strategy

Currently, Iowa's MH/DD System is plagued with funding inequities stemming from the use of base year county funding strategies as a foundation of funding the system. This is further exacerbated by the inability of the state to fund current system growth.

Plans have been discussed that altogether remove county property taxes as a part of the funding strategy for Iowa's MH/DD System. While the removal of county property tax dollars from the MH/DD System may reduce the systems funding complexities, such plans do not address how the state or Medicaid would be able to replace this critical source of MH/DD funding in Iowa. As a result little headway has been made in the transformation of Iowa's MH/DD System.

County property tax dollars can continue to be a foundational part of Iowa's MH/DD System without the current funding complexities that are involved. (Note: Re-basing is necessary for this to be fully effective, which will require some counties to levy more and some less than they currently are. It may be helpful to address a standard levy rate in the future; however this issue can be addressed after other parts of this proposal have been accomplished.) This proposal has Iowa counties expending dollars in the amount of 100% of their base year as their portion of the County/State MH/DD Partnership.

Each county will encumber 100% of its county MH/DD Levy. All other funds currently going to counties such as, property tax relief dollars, growth dollars, risk pool dollars, community services dollars, etc. will be pooled in a State Mental Health fund. These funds would then be distributed by the State to counties to supply individual county needs as reported through the Community Services Network data system, should a county need those dollars after the county levy has been fully encumbered. Approximately 90 of 99 counties are levying 100% of their base year, thus this proposal would have a minimal impact on <u>overall</u> county funding and allow funding for the system through a pool of dollars that are currently in a funding formula silo.

By pooling the dollars, Iowa's MH/DD system does not lose its foundational funding, is able to eliminate the practice of "legal settlement" because funding follows the individual, eliminates county waiting lists and in place creates a state wide waiting list if necessary, eliminates county by county MR Waiver slots and instead is able to create a statewide MR Waiver waiting list if necessary, and is able to eliminate county management plans and in their place create a statewide management plan.

Example: *

Each County will levy the maximum amount currently allowed for in Fund 10.

a. Every county will encumber this amount, (note this is the maximum levy) and then additional Fund 10 (State Mental Health Fund) dollars will be allocated to the counties from the State as additional service dollars are needed. These dollars include property tax relief, growth, community services and etc..
    i. For example: If a county has a maximum levy of $500,000 then that county will levy $500,000 and the State MH Fund, will provide the balance. If a county budgets $750,000 to fund services, the county will fund $500,000 and 250,000 would be allocated from the State MH Fund. If a county budgets $1.25 million then the county will fund $500,000 and the State MH Fund will fund (by whatever means at its disposal) $750,000. The county will pay its maximum levy, period. This year the county paid $500,000, next year the county would pay $500,000 even though new consumers moved into that county. The improvement in this proposal is that all non county levied dollars can be allocated where they are needed. This moves us towards a needs based funding system instead of a variegated funding system.
    ii. This proposal changes the need for a county risk pool. The State is encouraged to continue to set aside some dollars as a risk pool. These funds could then be

used to cover the costs of any spikes in historical expenditures such as commitments, or outpatient services. The Fiscal Board will oversee and develop the fund guidelines for this risk pool. For example, should a county's budgetary needs change significantly based on large swings in unanticipated expenditures the county would request a budget amendment to the Fiscal Board. The Fiscal Board would review individual requests and allocate needs based on the State MH Fund Risk Pool guidelines established by the Fiscal Board.

Note: Re-basing may be necessary for this to be fully effective, which will require some counties to levy more and some less than they currently are. (It may be helpful to address a standard levy rate in the future; however this issue can be addressed after other parts of this proposal have been accomplished.)

PART III Outcomes

The above restructuring would provide the greatest amount of individualization and flexibility at the consumer level and allow the system to overcome some of its greatest obstacles.

The main criticisms of the MH/DD system over the last 10 years has been legal settlement, system funding inequities and a lack of consistency between counties. This proposal would eliminate the need for legal settlement and move the state to a residency based system. It would de-categorize dollars and allow the Fiscal Board to move dollars to where the greatest documented need is without the use of complicated and disparate funding formulas. It would also eliminate policy inequities across the state as all counties and regions would operate using the same state management plan. In addition the system would be allowed to use existing resources to develop and enhance community capacity that flexibly meets documented individual needs in a cost effective way which has already been proven across the nation to produce greater results and a higher quality of life.

This proposal also maintains the strength of the system by maintaining county funding and administration of the system at the local level closest to the individuals in need. It addresses the issues of a state wide waiting list and how the list will be established and handled. It addresses the HCBS/MR Waiver slot necessity of being issued on a statewide not a county or regional based system.

Finally, consumer advocates have historically approved of systems of funding that establish the flexibility of individual budget allocations that allow the consumer to create and fund their own personal support systems. As a goal, we in the State of Iowa should choose to develop a system that supports individuals with disabilities which enhance their ability to live as independently as possible in the least restrictive environment and should recognize that individual dignity comes in part from being able to direct and control where your life is and is going. Public funding must move to a nobler goal of assisting individuals to achieve lives of high purpose, deeply embedded in their communities, engaged in meaningful relationships, and pursuing both economic and spiritual goals.

10 Major Policy Questions/Issues to Consider

(Note: Much of the information below has been taken from the Supports Intensity Scale manual and additional information from Supports Intensity Scale studies and statistics)

1. What goals are important to establish before embarking on Individual Budget Allocations (IBAs) development?

Meet the critical needs of individuals by tying funding to the individual's needs, maintaining the ability to respond to changing needs and circumstances, and enhancing the person-centered planning process with choice among services and providers;

Distribute resources equitably, using the same standards and process for all people, such that the resource decisions differ according to individual differences in needs;

Enhance the capacity and flexibility of Wright County's provider network by supporting diversity and giving providers the opportunity to retool and refocus;

Enhance credibility and understanding by making the decisions about each individual's supports and funding consistent and explainable;

Control costs within total funds available by improving the system's capacity for planning and budget projection and by spending resources more logically, wisely, and predictably

2. What factors influence the choice of a tool to measure support needs?

When deciding on a tool, counties are faced with several factors and ensuing policy decisions. Such factors often include: (a) the overall cost associated with using a tool, (b) whether or not a county wants to use a home-grown legacy tool or use a new tool, (c) the overall reliability and validity the tool can offer, and (d) the ability for the tool to work within the county's current cultural framework.

3. For budget development, is full population data or a random sample better to achieve the established goals?

To start, a representative random sample may be drawn to work from. If this approach is taken, means for assessing the impacts of changed practices and rates must be tested against the larger population. Field-tests may be used to probe at such impacts. Where there is already a strong relationship between assessed needs and service costs, systematic field-tests may be very useful. At the least, field-tests would help identify and smooth out logistical difficulties. Of course, larger samples would increase the certainty of the results.

4. What cost/expenditure data are counties using to build budgets?

Wright County has used historical waiver expenditure data, this has helped us to grow increasingly individualized over the past three years, from the county's MHIS payment system. In addition, County's

can also triangulate their historical cost information with a survey of types of services and supports, a survey of the direct service hours provided in each type, and a comprehensive survey of organizational costs and income related to providing services in its service provider organizations. These surveys of costs and income should include all revenue streams. This information could be obtained from CRIS Cost reports and Waiver Cost Reports. Using these three sources of information will allow counties to resolve conflicts in the incoming informational streams.

5. What can be done to improve the relationship between assessed individual support needs and resulting allocations/ expenditures?

A central issue in using the SIS for resource allocation decisions is the relationship between an assessment of need (using SIS scores and perhaps other complementing variables) and historical expenditures (or planned budget allocations or service hours). When developing a resource allocation algorithm, the goal is to establish the highest correlation between SIS scores and expenditures. In essence, the greater the correlation, the greater the variance explained, and thus the greater the confidence in using a measure of support need like the SIS scores to establish individual budget allocations.

6. How are counties developing budget models when they have more than one funding source?

A pattern of "supports services" has emerged across the counties wherein currently, 99 counties operate separate "management plans". Traditional "County Funded Services" operate side-by-side with the waivers that may provide more extensive services at times. Use of historical expenditures of the total service costs for an individual in relation to SIS scores can be used to develop IBAs.

7. How do budget models accommodate individuals with exceptional care needs and related costs?

Counties may address the issue in several ways.

Develop ways to identify and separate individuals whose needs and associated costs are extraordinarily different (often higher) from others.

Develop rules and procedures, and designate staff to handle the process for adjusting or making exceptions to the IBA based on participant health and welfare needs or other factors specified by the county. Any criteria that are applied to adjust the budget are clear and explicit.

Develop safeguards that come into play when the amount of the limit is insufficient to meet a participant's needs.

Convene a committee to review exceptional care and cost. It is not uncommon for counties to call the committee to consider individual circumstances one at a time to develop new budget amounts.

Notify participants of the amount of the limit to which their IBA is subject and to which services the limit applies.

Counties may choose to:

Adjust individual budget allocations to raise or lower the allocation as warranted. Few would complain about their budget allocation being raised, but lowering an allocation may well prompt complaint.

Counties should be well prepared to defend any adjustment and to assure that the individual's needs are addressed.

Decide to leave high allocations unchanged, even if the allocation is not warranted. Some individuals may have been previously awarded a high allocation, and policy makers may elect to maintain its level without adjustment.

Remove any individual deemed to have extraordinary needs and associated costs from the budget model. Doing so would make it clear that these individuals are exceptions whose needs must be carefully documented and addressed. These individuals may represent a long term and perfectly valid exception to an otherwise useful and reliable resource allocation system.

8. How often should counties reassess support needs?

The decision about how often to reassess a decision is influenced by the cost of reassessment, but also by judgment over how much individual support needs change over time. Where resources are a concern, policy makers may decide to reassess less often than they might otherwise. Yet, the complete cost of assessment using the SIS and building a resource allocation model is often less than a fraction of one percent of the total waiver service. Likewise, where support needs are thought to be stable there may be little call for frequent reassessment.

9. How should counties roll out their assessment-informed resource allocation models?

Generally, counties may implement the new model all at once or phase it in over time. Phasing in a new model can itself take many forms. Counties may phase in the model with certain cohorts first, say new enrollees, or in certain parts of the county and expand application to other areas over several months. Counties may also implement a portion of a person's new allocation at first so that it is a mix of the new amount and what the person received previously. With time, the new budget takes hold completely. Regardless of the strategy chosen, policy makers are seeking a solution whereby individuals and providers can reasonably endure and adjust to near-term fiscal impacts.

10. What should counties do when new people are added, county budgets are reduced, and there is a need to keep rates current and reconcilable?

It is critical that great care be exercised in the development and review of the reimbursement system, to ensure that the revised rates do not result in major disruptions of the services and supports, or exceed funding constraints.

Six Trends That Created the Need for Change

Changes in Expectations for People with Disabilities

The expectations for people with intellectual disabilities have changed dramatically over the past 50 years. Prior to the 1950s it was accepted as inevitable that adults with intellectual disabilities and closely related developmental disabilities who lacked the adaptive skills needed to live independently and maintain employment on a competitive job would live on the margins of society. Many life experiences (e.g., living in own home, holding a paid job, having a long-term romantic relationship) were perceived to be unrealistic and therefore unattainable for the majority of these people.

Times have changed. Today people with intellectual disabilities receive supports that enable them to live in the same communities as their loved ones, in homes similar to those in which others. Because it has been demonstrated that all people, including people with very significant functional limitations, can do meaningful work in community settings, it is expected that people with intellectual disabilities should work at paid jobs for community-based employers. It is not only realistic to expect people with intellectual disabilities to live as full-fledged members of a community; many consider it a systemic failure when this does not occur.

Functional Descriptions of Disabilities

Functional descriptions of disabilities do not focus solely on biological characteristics, but rather on a person's performance on tasks that are required for successful functioning in contemporary society. An adaptive behavior assessment revealing an individual's relative strengths and limitations across a variety of adaptive skill areas is an example of a functional description. Although medical and functional descriptions can each provide useful information, functional descriptions have proven to be extremely useful to those seeking answers to questions such as: What support does this person need? What skills does this individual need to learn? How can the environment be modified to better accommodate this person's abilities and needs?

Because functional descriptions provide information regarding ways in which a person's current level of skills is matched (or mismatched) with the demands of the environment, functional descriptions are useful when identifying and creating supports that assist an individual in participating in a variety of settings and activities. For example, if a person's competence limits his or her ability to do something that he or she wants to do, such as riding the bus to work, functional descriptions may lead to identifying: (a) the specific skills a person needs to acquire and the strategies needed to teach the individual these skills, (b) tools (i.e., assistive technologies) that an individual might use to enhance his or her performance in particular settings or activities, (c) strategies for modifying the design or the demands of settings and activities so that individuals of differing abilities can be accommodated, or (d) a combination of these supports. The focus on functional descriptions of disabling conditions has led to a focus on identifying supports that enhance a person's participation and successful functioning in community life.

Chronological-Age-Appropriate Activities

Previously many assumed that people with intellectual abilities had "minds" similar to those of children. The developmental-age-appropriate assumption resulted in tailoring life activities and experiences to people’s "mental ages:' For example, adults might be encouraged to engage in childlike activities (e.g., playing with toys de-signed for young children) as opposed to adult activities. Because they were considered to be "eternal children;' an overriding value of the service delivery system was to provide protection from life's unpleasantries; therefore adults with intellectual disabilities were not encouraged to take risks.

In contrast, the chronological-age-appropriate perspective holds that people, regardless of intellectual abilities or limitations, should have the opportunity to have life experiences and engage in activities consistent with their chronological ages. Interacting with people consistent with one's chronological age reduced stigmatization and affords individuals greater personal dignity and respect. Individuals with intellectual disabilities are capable of successfully fulfilling adult roles in society when provided with

proper support. The importance that has been placed on meeting chronological-age-appropriate needs has focused attention on developing and delivering supports in age-appropriate settings.

Consumer-Driven Services and Supports

As services to people with intellectual disabilities expanded during the past 50 years, national, state, and local systems of service delivery emerged. Although these systems provided new opportunities to people with disabilities and their families, in order to receive assistance "consumers" often had to fit in with the "programs" that were offered. For example, if a person with a disability wanted assistance in finding and keeping a job, he or she was compelled to participate in a service organization's vocational "program".

In the best cases, people had some options regarding various facets of a program (e.g., options about types of work, where to work, with whom to work). However, in far too many situations there were no such options, and people with disabilities had to participate in the predetermined program or forfeit eligibility with the sponsoring organization.

In contrast, the consumer-driven approach requires support providers to tailor supports to the needs and preferences of the person and his or her family. In this approach each person determines the types of settings and activities in which he or she wants to participate, and the onus is on the support provider to collaborate with people with disabilities and their families to identify and arrange needed supports.

The strength of the consumer-driven approach is also evident in the movement toward providing funding directly to people with disabilities and their families rather than to "programs" administered by service provider organizations. Some argue that direct funding of organizations invariably forces people to fit into existing programs offered by the organizations.

It is difficult to address effectively an individual's support needs unless these needs are clearly identified and communicated. The movement toward consumer-driven services and supports is directly related to the need for tools such as the SIS that reliably and validly measure individual support needs.

Support Networks That Provide Individualized Supports

A change in thinking has occurred with respect to the people who provide supports to individuals with intellectual disabilities and how to best provide supports. The traditional care-giver approach assumed that due to limitations in adaptive skills, people with intellectual disabilities needed paid caregivers to help with dressing, grooming, cooking, and so on. Although some people require personal care, the role of caregiver is now perceived as too narrow to meet the full needs of individuals. That is, there are many other critical support needs across a broad range of settings and activities that should not be ignored.

It has become clear that people with intellectual disabilities need support networks composed of many individuals who provide many different types of support. Although natural supports (i.e., supports that are inherent in the environment such as coworkers, neighbors, classmates, bus drivers, and police officers) may not be sufficient to provide the full range of supports that many people with intellectual disabilities require, true community integration and inclusion will be unattainable as long as providing support remains the sole purview of paid staff.

The new "supports paradigm" shifts the focus from care giving to investing time in creating and nurturing support networks; thus this paradigm shift redefines, but does not eliminate, the role of paid staff. Paid staff should place emphasis on identifying and developing the capacities of "natural supports" (i.e., people who can provide assistance on a daily basis that is not particularly intrusive or time consuming, and who provide similar support to others in the environment). Support networks offer several advantages over a care-giver model, including: (a) enhanced opportunities for individuals to experience a sense of "social belonging" due to increased opportunities to establish meaningful relationships with others, (b) increased number of people who become committed to an individual's success, and (c) increased capacity among the general population for including people with disabilities.

The "supports paradigm" holds that supports should follow a person to whatever settings the person wants and needs to be. Supports should not only be mobile, but should also be individualized (i.e., tailored to the unique characteristics of the individual and the settings). A key premise of the supports paradigm is that assistance to people with intellectual disabilities should be provided in settings where the individual needs and wants to be. Two key implications of the supports paradigm are the need to (a) identify, describe, and understand people in regard to their pattern and intensity of support needs, and (b) focus on planning and service delivery on providing supports that reduce the gap between an individual's level of personal competence and the demands of the settings in which the person participates.

A Focus on Community

Based on the trends of the past several decades, today's field of human services focuses on enhancing the community participation of people with disabilities. This focus can be summarized as follows:

Because of the mismatch between an individual's list of skills and the demands of the environment, individuals with intellectual disabilities and closely related developmental disabilities need support in establishing networks that include a wide variety of family members, friends, acquaintances, and paid support staff. People in a person's network need to provide support that enables that person to engage in chronological-age-appropriate activities in community settings that are consistent with his or her personal goals and preferences.

The five key trends center around the concept of supports. Therefore there is a need for assessment and planning processes that (a) allow for the reliable and valid assessment of individual support needs, (b) promote thoughtful identification of and planning for support provision, (c) encourage conscientious monitoring and revision of support plans, and (d) advance public policy and organizational structures that enable individual support needs to be addressed in an efficient and equitable manner.

Translating all this into practice is challenging. For example, what if a person wants to be supported in settings and activities that are not chronological-age appropriate? In such cases the chronological-age approach clashes with the consumer-driven approach, and complex issues must be weighed against one another to determine which approach takes precedence. What if resources are not sufficient to support a person in settings and activities consistent with his or her personal preferences? Can a consumer ever be told "no, it's not in the budget" in a consumer-driven planning process? In a world of finite resources, how does a planning team decide which activities and settings are priorities and how does a team monitor itself to assure that certain settings and activities are not dismissed simply because they are relatively expensive

or inconvenient? How can existing service delivery systems and structures be transformed to one providing consumer-driven, individualized supports?

The SIS and the planning procedures do not provide definitive answers to these questions, but they can help planning teams and organizations better align resources and strategies that enhance personal independence and productivity. The SIS and the related planning processes are intended to promote greater participation in a complex society by people with intellectual disabilities and ultimately improve their quality of life.

A Support Needs Assessment, Planning, and Monitoring Process

Component 1: Identify Desired Life Experiences and Goals

Component 1 involves identifying priority areas to be addressed when developing a individualized support plan.. Using a consumer driven approach to identify desirable life experiences and goals ensures: (a) respect for the individual to assure that he or she remains in control of the process, (b) participation of a team of friends and supporters that recognizes the dreams and goals of the individual, (c) a role for people in addition to professionals and a primary emphasis on community resources, and (d) the creation of and strategies for achieving life experiences desired by the person being supported.

It is essential that a person's current daily activities and environments be compared with what the person prefers or considers desirable, everyday experiences and situations. Informally interviewing the person and his or her family and advocates can help identify (a) priority areas in which the person desires lifestyle changes and (b) current activities the person would like to maintain. In addition, interviews can identify supports needed to maintain or change priority activities as desired.

Component 2: Determine the Pattern and Intensity of Support Needs

Component 2 of the planning process involves assessing person's support needs using a sound support needs scale. Information from the SIS can be used in conjunction with consumer driven planning to guide a team to develop an individualized plan to achieve the person's desired goals. The Support Needs Profile is particularly useful to inform and guide a planning team to identify supports that should be introduced, maintained, or discontinued for an individual to achieve a culturally valued lifestyle. Informal assessments, such as direct observation and anecdotal narrative, can be used in conjunction with the SIS and consumer driven planning to identify support needs.

Component 3: Develop the Individualized Plan

A planning team needs to combine information from Component 1 (prioritize preferences in terms of life experiences and goals) and Component 2 (determine the pattern and intensity of support needs) to develop an individualized plan. An individualized plan is completed when the team has identified: (a) the individual's interests and preferences, (b) the needed support areas and activities, (c) the settings the person is most likely to be in as well as the activities in which the individual will participate, (d) the specific support functions that will address the identified support needs, (e) natural supports available to the person, (f) valued personal outcomes, and (g) a mechanism to monitor the provision and effectiveness of the support provided. The result should be an unambiguous, individualized plan that specifies (a) the

settings for and activities in which a person is likely to engage during a typical week, and (b) the types and intensities of support that will be provided (and by whom).

Component 4: Monitor Progress

For the planning team, Component 4 involves comparing the actual outcomes of the support planning process to the desired outcomes identified by the individual and his or her team. Further, expected supports received/not received are evaluated. Planning teams can then identify barriers to implementation and achievement of anticipated outcomes and introduce strategies to promote desired lifestyle changes. A responsive process is characterized by regular communication among planning-team members regarding potential changes to a plan based upon the changing needs and circumstances of the individual.

(The above information in this paper was taken from the Supports Intensity Manual and articles on the Supports Intensity website)

The Individual Budget Allocation (IBA)

The SIS is classifies individuals into one of four intensity levels. These levels are as follows:

Level I = 1 - 60

Level II = 61 - 84

Level III = 85 - 116

Level IV= more than 116

To increase an individual's support intensity classification level based on specific criteria one can use any of the medical or behavioral indicators in Section 3 of the SIS to increase the Supports Intensity Classification by one level. For example, if and individual has a score of "2" on any of the medical or behavioral needs scales their SIS classification would be increased. Thus the assessment is flexible enough to take special needs into account.

The SIS uses Raw Scores from the assessment and translates these scores into a supports needs index and percentile ranking. Costs for supports generally increase as SIS scores rise. Wright County's individual budget allocations takes the ICF/MR daily cap (currently $315.47) times 30.44 days times a percentage range captured and validated through SIS field test sampling. The percentage is determined as follows ($F(\text{frequency of distribution})=7.98$, $p<.0001$) This distributes one hundred individual allocations of funding across four levels of intensity. The allocations can be adjusted by manipulating the percentage of the ICF/MR daily cap that is allowed for the distributed score. Thus an individual with a SIS score of 6 falls into level one and will be allocated 3% of the ICF/MR daily cap or a monthly budget of $288.00. An adjustment of the percentage of the cap will raise or lower all individually distributed allocations. Wright County has found that the percentage across allocations needed to be reduced to a negative 12% to be in line with historical expenditure levels. This will vary by geographical area as cost and types of services vary across these areas. The percentage increase across each distributed allocation begins at the lowest score and level and increases as the scores increase. Thus individuals scoring in level IV at the high end of the distributed allocations experience minimal adjustments in allocations when the percentage of cap is adjusted. The highest score and individual allocation will always result in an allocation at the ICF/MR

daily cap. In this way the allocations can be adjusted to meet financial resource requirements with the least amount of impact to those with the highest assessed needs. This also allows for any adjusted decreases to be handled at an individual allocation level with maximum flexibility by the individual and the team.

Wright County's Individual Budget Allocation is an Excel spreadsheet broken out across 5 separate pages (Schedule, DD Budget, CMI Budget, Time Sheet and SIS Funds) The SIS Funds sheet calculates the percentages of distribution across SIS scores and the individual allocations related to the score as explained above. This is the sheet where one would adjust the parentage of cap and distributions.

The DD Budget is the sheet where the SIS raw scores for each area are entered and the individual budget calculated. Row 11 is where the raw scores are entered. The raw scores are then automatically translated into standard scores and percentile ranking. Cell L19 provides the suggested monthly individual budget. Cell L20 is where the funder will enter in the approved allotment of the individual budget. Remember that Section 3 will provide more information as to any special needs the client may have. This will assist the funder in approving more funds than the calculations suggest and how much. Should the scores indicate in section three that the individual should be moved to the next level based on special needs the funder can review the levels and individual allocations on the SIS Funds sheet to determine an appropriate monthly allocation. The allocation is a total services and supports allocation, not just county funds. Proposed expenditures can then be listed by Chart of Accounts Activity and Sub Activity in Rows 23 through 91. Columns D & E in rows 23 through 91 is where an agency or person that will provide the service or support is to be listed. Column F is where the cost per unit will be listed. Column G is where the number of units per month is listed. Column H, if checked (x), indicates if the service is a Medicaid funded service or not. Column I calculates the total monthly cost for a Medicaid service. Column J calculates the county cost of the service for either full county funding or the Non Federal Share of the Medicaid Cost in Column I. Column K is where private funding or other funding sources can be listed. Column L calculates the total service cost. (Note: Cell L16 determines the county share of any Medicaid costs in Column I) Rows 92 through 95 provide subtotals for the total budget, indicating costs allocated toward Medicaid and toward the county or other sources. Cells highlighted in yellow indicate cells that can be edited or where data should be entered.

The CMI Budget sheet is much the same as the DD Budget Sheet with the exception that the score is derived from the LOCUS instead of the SIS. To see how the scoring and allocations are distributed for the CMI Budget review Rows 11 through 142 in Columns F through L.

The Schedule Sheet looks much like the DD and CMI Budget Sheets in that it provides a section to break out budgeted services by Chart of Account Activity and Sub Activity. The purpose of this sheet is for planning. Wright County feels it is best to plan for services and supports using the Schedule Sheet without focusing on allocations, as the allocations may not always be indicative of the need. Thus service and support planning based upon assessed needs can be listed on the Schedule Sheet and then translated to the budget sheet. This process allows the county to test budget allocations on new individuals entering the system on whom there is no historical expenditure data to examine. It also allows for a comparison of current services and supports being utilized in comparison to assessed budget allocations. Once the county feels they have the percentage of cap adjusted accurately based upon historical data and experience they may no longer need to use the Schedule sheet but can go directly to the Budget Sheets.

The Time Sheet is used by Wright County for individualized support providers the consumer chooses to hire using the allocated budget. This time sheet functions very much like the Consumer Choice Option Time Sheets do.

Wright County has chosen to have the case managers complete the SIS assessment on their own and then review this with providers of supports and services. Should there be a discrepancy between the case manager's assessment and the provider's assessment further clarification will be gathered to determine actual needs.

SIS Individual Budget Allocations

Level	Standard Score TOTAL	Support Needs Index	Percentile Ranking	Annual County Share	Annual Federal Share	Annual Budget	Monthly Budget	% of Cap
Level IV	103	150	100	$33,752.30	$81,482.58	$115,234.88	$ 9,602.91	100%
	102	148	100	$33,415.47	$80,669.44	$114,084.91	$ 9,507.08	99%
	101	147	100	$33,078.64	$79,856.29	$112,934.94	$ 9,411.24	98%
	100	146	100	$32,741.82	$79,043.15	$111,784.96	$ 9,315.41	97%
	99	145	100	$32,404.99	$78,230.00	$110,634.99	$ 9,219.58	96%
	98	144	100	$32,068.16	$77,416.86	$109,485.02	$ 9,123.75	95%
	97	143	100	$31,731.33	$76,603.71	$108,335.04	$ 9,027.92	94%
	96	141	100	$31,394.51	$75,790.56	$107,185.07	$ 8,932.09	93%
	95	140	100	$31,057.68	$74,977.42	$106,035.10	$ 8,836.26	92%
	94	139	100	$30,720.85	$74,164.27	$104,885.13	$ 8,740.43	91%
	93	138	100	$30,384.03	$73,351.13	$103,735.15	$ 8,644.60	90%
	92	137	100	$30,047.20	$72,537.98	$102,585.18	$ 8,548.77	89%
	91	136	100	$29,710.37	$71,724.84	$101,435.21	$ 8,452.93	88%
	90	135	99	$29,373.55	$70,911.69	$100,285.23	$ 8,357.10	87%
	89	133	99	$29,036.72	$70,098.54	$ 99,135.26	$ 8,261.27	86%
	88	132	99	$28,699.89	$69,285.40	$ 97,985.29	$ 8,165.44	85%
	87	131	98	$28,363.06	$68,472.25	$ 96,835.32	$ 8,069.61	84%
	86	130	98	$28,026.24	$67,659.11	$ 95,685.34	$ 7,973.78	83%
	85	129	97	$27,689.41	$66,845.96	$ 94,535.37	$ 7,877.95	82%
	84	128	97	$27,352.58	$66,032.81	$ 93,385.40	$ 7,782.12	81%
	83	126	96	$27,015.76	$65,219.67	$ 92,235.42	$ 7,686.29	80%
	82	125	95	$26,678.93	$64,406.52	$ 91,085.45	$ 7,590.45	79%
	81	124	95	$26,342.10	$63,593.38	$ 89,935.48	$ 7,494.62	78%
	80	123	94	$26,005.27	$62,780.23	$ 88,785.51	$ 7,398.79	77%
	79	122	93	$25,668.45	$61,967.09	$ 87,635.53	$ 7,302.96	76%
	78	121	92	$25,331.62	$61,153.94	$ 86,485.56	$ 7,207.13	75%
	77	120	91	$24,994.79	$60,340.79	$ 85,335.59	$ 7,111.30	74%
	76	118	89	$24,657.97	$59,527.65	$ 84,185.61	$ 7,015.47	73%
	75	117	87	**$24,321.14**	**$58,714.50**	**$ 83,035.64**	**$ 6,919.64**	**72%**
Level III	74	116	86	$23,984.31	$57,901.36	$ 81,885.67	$ 6,823.81	71%
	73	115	84	$23,647.49	$57,088.21	$ 80,735.70	$ 6,727.97	70%

	72	114	82	$23,310.66	$56,275.07	$ 79,585.72	$ 6,632.14	69%
	71	113	81	$22,973.83	$55,461.92	$ 78,435.75	$ 6,536.31	68%
	70	111	77	$22,637.00	$54,648.77	$ 77,285.78	$ 6,440.48	67%
	69	110	75	$22,300.18	$53,835.63	$ 76,135.81	$ 6,344.65	66%
	68	109	73	$21,963.35	$53,022.48	$ 74,985.83	$ 6,248.82	65%
	67	108	70	$21,626.52	$52,209.34	$ 73,835.86	$ 6,152.99	64%
	66	107	68	$21,289.70	$51,396.19	$ 72,685.89	$ 6,057.16	63%
	65	106	65	$20,952.87	$50,583.04	$ 71,535.91	$ 5,961.33	62%
	64	105	63	$20,616.04	$49,769.90	$ 70,385.94	$ 5,865.50	61%
	63	103	58	$20,279.22	$48,956.75	$ 69,235.97	$ 5,769.66	60%
	62	102	55	$19,942.39	$48,143.61	$ 68,086.00	$ 5,673.83	59%
	61	101	53	$19,605.56	$47,330.46	$ 66,936.02	$ 5,578.00	58%
	60	100	50	$19,268.73	$46,517.32	$ 65,786.05	$ 5,482.17	57%
	59	99	47	$18,931.91	$45,704.17	$ 64,636.08	$ 5,386.34	56%
	58	98	45	$18,595.08	$44,891.02	$ 63,486.10	$ 5,290.51	55%
	57	96	39	$18,258.25	$44,077.88	$ 62,336.13	$ 5,194.68	54%
	56	95	37	$17,921.43	$43,264.73	$ 61,186.16	$ 5,098.85	53%
	55	94	35	$17,584.60	$42,451.59	$ 60,036.19	$ 5,003.02	52%
	54	93	32	$17,247.77	$41,638.44	$ 58,886.21	$ 4,907.18	51%
	53	92	30	$16,910.94	$40,825.30	$ 57,736.24	$ 4,811.35	50%
	52	91	27	$16,574.12	$40,012.15	$ 56,586.27	$ 4,715.52	49%
	51	90	25	$16,237.29	$39,199.00	$ 55,436.29	$ 4,619.69	48%
	50	89	23	$15,900.46	$38,385.86	$ 54,286.32	$ 4,523.86	47%
	49	87	19	$15,563.64	$37,572.71	$ 53,136.35	$ 4,428.03	46%
	48	86	18	$15,226.81	$36,759.57	$ 51,986.38	$ 4,332.20	45%
	47	85	16	**$14,889.98**	**$35,946.42**	**$ 50,836.40**	**$ 4,236.37**	**44%**
Level II	46	84	14	$14,553.16	$35,133.27	$ 49,686.43	$ 4,140.54	43%
	45	82	13	$14,216.33	$34,320.13	$ 48,536.46	$ 4,044.70	42%
	44	82	13	$13,879.50	$33,506.98	$ 47,386.48	$ 3,948.87	41%
	43	80	9	$13,542.67	$32,693.84	$ 46,236.51	$ 3,853.04	40%
	42	79	8	$13,205.85	$31,880.69	$ 45,086.54	$ 3,757.21	39%
	41	78	7	$12,869.02	$31,067.55	$ 43,936.57	$ 3,661.38	38%
	40	77	6	$12,532.19	$30,254.40	$ 42,786.59	$ 3,565.55	37%
	39	76	5	$12,195.37	$29,441.25	$ 41,636.62	$ 3,469.72	36%
	38	75	5	$11,858.54	$28,628.11	$ 40,486.65	$ 3,373.89	35%
	37	74	4	$11,521.71	$27,814.96	$ 39,336.67	$ 3,278.06	34%
	36	72	3	$11,184.88	$27,001.82	$ 38,186.70	$ 3,182.23	33%
	35	71	3	$10,848.06	$26,188.67	$ 37,036.73	$ 3,086.39	32%
	34	70	2	$10,511.23	$25,375.52	$ 35,886.76	$ 2,990.56	31%
	33	69	2	**$10,174.40**	**$24,562.38**	**$ 34,736.78**	**$ 2,894.73**	**30%**
Level I	32	68	1	$ 9,837.58	$23,749.23	$ 33,586.81	$ 2,798.90	29%
	31	67	1	$ 9,500.75	$22,936.09	$ 32,436.84	$ 2,703.07	28%
	30	65	1	$ 9,163.92	$22,122.94	$ 31,286.86	$ 2,607.24	27%
	29	64	1	$ 8,827.10	$21,309.80	$ 30,136.89	$ 2,511.41	26%
	28	63	1	$ 8,490.27	$20,496.65	$ 28,986.92	$ 2,415.58	25%
	27	62	1	$ 8,153.44	$19,683.50	$ 27,836.95	$ 2,319.75	24%
	26	61	1	$ 7,816.61	$18,870.36	$ 26,686.97	$ 2,223.91	23%
	25	60	1	$ 7,479.79	$18,057.21	$ 25,537.00	$ 2,128.08	22%

	24	59	1	$ 7,142.96	$17,244.07	$ 24,387.03	$ 2,032.25	21%
	23	57	1	$ 6,806.13	$16,430.92	$ 23,237.05	$ 1,936.42	20%
	22	56	1	$ 6,469.31	$15,617.78	$ 22,087.08	$ 1,840.59	19%
	21	55	1	$ 6,132.48	$14,804.63	$ 20,937.11	$ 1,744.76	18%
	20	54	1	$ 5,795.65	$13,991.48	$ 19,787.14	$ 1,648.93	17%
	19	53	1	$ 5,458.83	$13,178.34	$ 18,637.16	$ 1,553.10	16%
	18	52	1	$ 5,122.00	$12,365.19	$ 17,487.19	$ 1,457.27	15%
	17	50	1	$ 4,785.17	$11,552.05	$ 16,337.22	$ 1,361.43	14%
	16	49	1	$ 4,448.34	$10,738.90	$ 15,187.24	$ 1,265.60	13%
	15	48	1	$ 4,111.52	$ 9,925.75	$ 14,037.27	$ 1,169.77	12%
	14	47	1	$ 3,774.69	$ 9,112.61	$ 12,887.30	$ 1,073.94	11%
	13	46	1	$ 3,437.86	$ 8,299.46	$ 11,737.33	$ 978.11	10%
	12	45	1	$ 3,101.04	$ 7,486.32	$ 10,587.35	$ 882.28	9%
	11	44	1	$ 2,764.21	$ 6,673.17	$ 9,437.38	$ 786.45	8%
	10	42	1	$ 2,427.38	$ 5,860.03	$ 8,287.41	$ 690.62	7%
	9	41	1	$ 2,090.55	$ 5,046.88	$ 7,137.43	$ 594.79	6%
	8	40	1	$ 1,753.73	$ 4,233.73	$ 5,987.46	$ 498.96	5%
	7	39	1	$ 1,416.90	$ 3,420.59	$ 4,837.49	$ 403.12	4%
	6	38	1	$ 1,080.07	$ 2,607.44	$ 3,687.52	$ 307.29	**3%**