AN ANALYSIS OF THE FISCAL POLICY OPTIONS TO ELIMINATE THE FISCAL INCENTIVES FOR COUNTIES TO PLACE MENTALLY RETARDED PERSONS IN STATE HOSPITALS

Developed by:

Mental Retardation Program

Division Department of Public Welfare February, 1981

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I. BACKGROUND

Since 1975, MCAR 2.185 has designated the county social service agency to be responsible for providing case management services to persons who are mentally retarded. Case management services include diagnosis of a client's disability, assessment of a client's needs, development of an individual service plan, and the evaluation of and payment for services. The client's individual service plan must be designed to meet the assessed needs of the client in the least restrictive manner and setting. The primary criteria in Rule 185 for determining what services a client receives and which settings those services should be delivered are: (1) the assessed needs of the client; (2) the client's personal goals; and (3) the provision of services in the least restrictive setting.

II. STATEMENT OF THE PROBLEM

Because the need for and cost of human services is increasing and, federal and state financial participation is limited, the fiscal impact of providing services has become a major criterion for local government in determining what services a client receives and where those services are delivered. Federal and state financial participation has frequently encouraged local government to place clients into more restrictive service settings than is needed. As a client becomes more independent and is placed into less restrictive service settings, local governments find themselves paying more to provide the appropriate services even though the total coat of the services has decreased. For example, a county agency must pay more for community-based services than state hospital services. As a result, mentally retarded persons who need and can benefit from less restrictive (and frequently less expensive) service environments are often not provided those appropriate community-based services.

As part of the Welsch v. Noot Consent Decree, the Department of Public Welfare has agreed to develop proposals to eliminate the financial incentives that currently encourage counties to place mentally retarded persons in state hospitals. These proposals are required by the Consent Decree to be submitted to the governor for legislative consideration during the 1981 session.

Table I displays the present status of funding patterns for the three service areas. The three service areas are residential-medical assistance (MA), residential-nonmusical assistance (NON-MA), and developmental day programs (DAC). Residential-medical assistance (MA) refers to those residential services for mentally retarded persons paid by the medical assistance (Title XIX) in state hospital and community-based facilities certified as an intermediate care facility for mentally retarded (ICF/MR). Residential-nonmusical assistance (NON-MA) refers to those residential services provided to mentally retarded children (not eligible for medical assistance) and paid by sources other than medical assistance in state hospitals and community-based facilities. The cost of care program for mentally retarded children (Rule 30) is considered the source for residential-non-MA services in the community. In state hospitals, the state assumes the remaining service costs after third party payments for residential-NON-MA services. DAC refers to the developmental day programs for mentally retarded persons provided in state hospitals and community-based developmental achievement centers. In state hospitals, the day program costs are paid entirely by the medical assistance program.

In the community, development achievement center services are paid by community social service's funds.

The differences between state hospital and community cost sharing patterns point up the need for a more equitable pattern of payments, if fiscal incentives to place persons in state hospitals are to be removed*

Table I

Federal, State and County Shares for State Hospital and Community Services in F.Y. 80

	State Hospital Setting				Community Setting			
	FEDERAL	STATE	COUNTY	OTHER	FEDERAL	STATE	COUNTY	OTHER
Res MA	55.64%	44.36%	0%	0%	55.64%	39.92%	4.44%	0%
Res N-MA	O%	100%	0%	?	0%	53.7%	30.39%	16%
DAC	55.64%	44.36%	0%	0%	26.76%	22.77%	46.02%	4.45%

Several proposals are offered in this paper, each of which addresses the removal of fiscal incentives for counties to place mentally retarded persons in state hospital settings.

III. PURPOSE

The purpose of this analysis is to propose alternative fiscal policies that eliminate the fiscal incentives which encourage counties to place mentally retarded persons in state hospitals. For the purpose of this study, incentives are considered eliminated when the county agency pays for a day or residential service at the same rate (percentage) regardless of where those services are provided (i.e. in a state hospital or community-based setting).

IV. POLICY OPTIONS

This study identified twelve different fiscal policy options in three service areas which would result in equalizing county share of state hospital costs and community costs for mentally retarded persons. Listed below are three Developmental Achievement Center (DAC) options, four Residential Non-Medical Assistance (NON-MA) options, and two Residential Medical Assistance (MA) options. Table II on page 5 summarizes each of the options.

DAC Option #1

Reduce the county share of DAC costs in the community (now 46%) to the county share of DAC costs in the state hospitals (0%). The equalization would be realized by decreasing the county costs for adult DAC services in the community to nothing *(OX).* This option would require total assumption of DAC costs in the community by the state or approximately $5,982,600 additional state dollars.

DAC #1 would require adult DAC services in the community to be funded under a separate mechanism other than CSSA, such as a grant-in-aid or reimbursement mechanism.

DAC Option #2

Increase the county share of DAC costs in state hospital (now 0%) to the county share of DAC costs in the community (46%). This equalization effort would be realized by increasing county share for DAC services in state hospital by $4,613,800, increasing the state share by 966,900, and reducing the federal share by $5,580,690.

DAC #2 would require adult DAC services in the state hospitals to be paid through Community Social Services and removed from the Medical Assistance Program.

DAC Option #3

Increase the county share of DAC costs in state hospitals from the present 0% to 4.4% and decrease the county share of DAC costs in _the community from the present 46% to 4.4% for MA eligible clients only. This equalization effort would require a combination of state and federal sharing of costs. This would amount to approximately $5,956,700 additional federal dollars (Title XIX), $644,300 additional state dollars, and it would save the county approximately $3,122,200. In addition, it would free up $2,296,000 Title XX dollars.

DAC #3 would require community-based DAC services for MA eligible adults to be paid through Medical Assistance and not by Community Social Services Program. However, Community Social Service Program would continue to fund DAC services for adults, who are not MA eligible, and children in the community. The Department has proposed Co the 1981 Legislature the necessary statutory changes, M.S. 245.0313, which would require the county to pay a share (4.44%) of the Medical Assistance costs for state hospital services.

Residential Non-MA (Cost of Care) Option #1

Reduce the county share of cost of care In the community (now 30%) to the county share in state hospitals (0%). This equalization would decrease county dollars by approximately $2,393,700 and increase state dollars by the same amount.

Cost of Care #1 would require statutory changes In M.S. 252.27 to authorize the Commissioner to pay 1002 of the cost of community-based residential care for children after third party payments.

Residential Non-MA (Cost of Care) Option #2

Increase the county share of non-MA eligible state hospital costs (now 0%) to the equivalent of the county share In the community (30%). The equalization effort would increase county costs by approximately $786,900 and save the state the same amount-Cost of Care #2 would require changing existing statutes (M.S. 246.54) governing the county's share of cost of care in the state hospitals.

Residential Non-MA (Cost of Care) Option #3

Increase the county share of non-MA eligible state hospital costs (now O%) to 23% and decrease the county share of cost of care in the community from 303 to 23%. This equalization effort would increase county dollars by approximately $26,000 and save the state the same amount.

Cost of Care #3 would require changing existing statutes governing the county's share of cost of care In the state hospitals (M.S. 246.54). In order to assure that ongoing equalization efforts are maintained, it necessitates that there be one funding program for paying for residential non~MA costs in state hospitals and In the community.

Residential Non-MA (Cost of Care) Option #4

Increase the county share of state hospital residential costs for non-MA eligibles from the present 0% to 50%; increase the county share for cost of care in the community from the present 30% to 50%.

This option would require changing existing cost of care statutes governing the county share for state hospital services (M.S. 246,54) in order to allow counties to pay for state hospital care for non-MA eligibles under CSSA (M.S. 256E.06, Subd. 3).

Residential MA Option #1

Reduce the county share of MA eligible community costs (now 4.4%) to county share in the state hospitals (0%). This equalization effort would decrease county costs by approximately $1,765,600 and increase state costs by the same amount.

Residential MA Option #2

Increase the county share of state hospital residential service for MA eligibles costs (now 0%) to the county share of community residential service costs for MA eligibles (4.4%). This equalization effort would increase county dollars by approximately $2,471,300 and save the state the same amount.

MA #2 would require changing existing statutes (M.S. 245.03l3) governing the county's share of MA eligible clients In state hospitals. This option has been proposed by the Department to the 1981 Legislature.

TABLE II

POLICY OPTIONS GOVERNING COUNTY SHARE OF THE SERVICE COSTS IK STATE HOSPITAL AND COMMUNITY SETTINGS FOR MENTALLY RETARDED PERSONS

OPTIONS	STATE HOSPITAL	COMMUNITY
DAC		
#1	Maintain 0%	Decrease 46% to 0%
#2	Increase to 46%	Maintain at 46%
#3	Increase to 4.4%	Decrease from 46% to 4.4% for MA only
Residential Non-MA (Cost of Care)		
#1	Maintain 0%	Decrease from 30% to 0%
#2	Increase to 30%	Maintain at 30%
#3	Increase to 23%	Decrease from 30% to 23%
#4	Increase to 50%	Increase to 50%
Residential MA		
#1	Maintain at 0%	Decrease from 4.4% to 0%
#2	Increase to 4.4%	Maintain at 4.4%

V. WEIGHTING AND PRIORITIZING THE POLICY OPTIONS

A. Weighting

The acceptability of each proposal is measured using the following criteria.

1. Maximization of federal participation — proposals which result in an increase in federal financial participation will be favored over proposals resulting in maintenance of federal financial participation. Proposals which result in maintenance of federal financial participation will be favored over proposals resulting in a decrease of federal financial participation.

2. Minimization of additional state costs — proposals which result in a reduction in state costs will be favored over those proposals which maintain state costs. Proposals which result in a maintenance of state costs will be favored over proposals resulting in increased state costs.

3. Minimization of additional county costs — proposals which result in a reduction In county costs will be favored over those proposals which maintain or increase county costs. Proposals which maintain county costs will be favored over proposals resulting in increased county costs.

B. Weighting Methodology

A two—phased weighting process was used. Phase I consisted of weighting and ranking each option in the three service areas based on fiscal implications summarized in Table III. For example, each of the three options for day program coat equalization were weighted and ranked using the three criteria. Each option is prioritized in Table IV.

Phase II consisted of creating proposals out of combined options, and weighting and ranking each proposal using the three criteria. Each proposal consists of three options, one option from each service area (i.e. day programs, residential-medical assistance, residential nonmedical assistance).

For the purpose of the initial weighting of the options and proposals, each criterion is considered of equal importance. The second criterion, minimization of additional state costs was considered the most important when ranking certain options/proposals that equaled out. The detailed results of this process appear in Section VI, Fiscal Impacts of Nine Policy Proposals, listed with their ranking.

TABLE III

FISCAL IMPLICATIONS OF POLICY OPTIONS

IMPLICATIONS	FEDERAL SHARE	STATE SHARE	COUNTY SHARE	OTHER
DAC				
#1 Com.	3,478.8 (same)	8,942.7 (inc. of 5,982.6)	0 (dec. of 5,982.6)	578.5 (same)
#2 SH	0	5,416.2	4,613.8	0
#3 SH	5,580.69 (same)	4,004.0 (dec. of 445.33)	445.3 (inc. of 445.3)	0 (same)
Com.	5,956.7 (inc. of 2,477.9)	4,049.7 (inc. of 1,089.6)	2,4l5.1 (dec. of 3,567.5)	578.5 (same)
Residential Non-MA (Cost of Care)				
#1 Com.	0 (same)	7,536.0 (inc. of 2,393.7)	0 (dec. of 2,393.7)	1,264.0 (same)
#2 SH	0 (same)	1,836.1 (dec. of 786.9)	786.9 (inc. of 786.9)	? .
#3 SH	0 (same)	2,019.7 (dec. of 603.3)	603.3 (inc. of 603.3)	? .
Com.	0 (same)	4,819.0 (inc. of 576.7)	1,817.0 (dec. of 576.7)	1,264.0 (same)
#4 SH	0 (same)	1,311.5 (dec. of 1,311.5)	1,311.5 (inc. of 1,311,5)	? .
Com.	0 (same)	3,318 (inc. of 924.3)	3,3lS (inc. of 924.3)	1,264.0 (same)
Residential MA				
#1 Com.	22,125.8 (same)	17,640.2 (inc. of 1,765.6)	0 (dec. of 1,765.6)	0 (same)
#2 SH	30,969.78 (same)	22,219.9 (dec. of 2,471.3)	2,471.3 (Inc. of 2,471.3)	0 (same)

TABLE IV

WEIGHTING AND PRIORITIZING OF POLICY OPTIONS

OPTIONS	MAXIMUM FEDERAL SHARE	MIN. ADD. STATE SHARE	KIN. ADD. COUNTY SHARE	BANK
DAC				
#1	same	no (+5,982.6)	yes (-,982.6)	2
#2	no (-5,580.69)	no (+966.9)	no (+4,613.8)	3
#3	yes (+2,477.9)	no (+644.3)	yes (-3,122.2)	1
Residential Non-MA (Cost of Care)				
#1	same	no (+2,393.7)	yes (-2,393.7)	4
#2	same	yes (-786.9)	no (+786.9)	2
#3	same	yes (-26.6)	no (+26.6)	1
#4	same	yes (-2,235.8)	no (+2,235.8)	3
Residential MA				
#1	same	no (+1,765.6)	yes (-1,765.5)	2
#2	same	yes (-2,471.3)	no (+2,471.3)	1

VI. FISCAL IMPACTS OF TWELVE POLICY PROPOSALS

There are twelve alternative proposals identified in this analysis. Residential HA option #l has been eliminated since the Department is presently pro~posing the implementation of Residential MA option #2. Proposals A through L have been ranked according to the criteria specified in Section V.

A. Fiscal Impacts

	OPTIONS	FEDERAL	STATE	COUNTY
Proposal A.	DAC #3	5,956.7 Title XIX (increase)	644.3 (cost)	3,122.2 (savings)
Rank: #1 of 12		2,296.0 Title XX (displaced)		
	NON-MA #3	-	26.6 (savings)	26.6 (cost)
	MA #2	-	2,471.3 (savings)	2,471.3 (cost)
	Net Total.	5,956.7 (increase)	1,853.6 (savings)	624.3 (savings)
Proposal B	DAC #3	5,956.7 Title XIX (increase)	644.3 (cost)	3,122.2 (savings)
Rank: #2 of 12		2,296.0 Title XX (displaced)		
	NON-MA #2.	-	786.9 (savings)	786.9 (cost)
	MA #2.	-	2,471.3 (savings)	2,47l.3 (cost)
	Net Total	5,956.7 (increase)	2,613.9 (savings)	136.0 . (cost)
Proposal C	DAC #1	-	5,982.6 (cost)	5,982.6 (savings)
Rank: #6 of 12	NON-MA #2	-	786.9 (savings)	786.9 (cost)
	MA #2.	-	2,471.3 (savings)	2,471.3 (cost)
	Net Total	-	2,724.4 (cost)	2,724.4 . (savings)

	OPTIONS	FEDERAL	STATE	COUNTY
Proposal D	DAC #1		5,982.6 (cost)	5,982.6 (savings)
Rank: #7 of 12	NON-MA #3	-	26.6 (savings)	26.6 (cost)
	MA #2	-	2,471.3 (savings)	2,471.3 (cost)
	Net Total	—	3,484.7 (cost)	3,484.7 (savings)
Proposal E	DAC #1	-	5,982.6 (cost)	5,982.6 (savings)
Rank: #8 of 12	NON-MA #1	-	2,393.7 (cost)	2,393.7 (savings)
	MA #2	-	2,471.3 (savings)	2,471.3 (cost)
	Net Total	—	5,905.0 (cost)	5,905.0 (savings)
Proposal F	DAC *2	5,580.69 (savings)	966.9 (cost)	4,613.8 (cost)
Rank: #11 of 12	NON-MA #1	-	2,393.7 (cost)	2,393.7 (savings)
	MA #2	-	2,471.3 (savings)	2,471.3 (cost)
	Net Total	5,580.69 (savings)	889.3 (cost)	4,691.4 (cost)

	OPTIONS	FEDERAL	STATE	COUNTY
Proposal G.	DAC #2	5,580.69 (savings)	966.9 (cost)	4,613.8 (cost)
Rank: #10 of 12.	NON-MA #1	-	26.6 (savings)	26.6 (cost)
	MA #2.	-	2,471.3 (savings)	2,471.3 (cost)
	Net Total.	5,580.69 (savings)	1,531.0 (savings)	7,111.7 (cost)
Proposal H.	DAC #3	5,956.7 (cost)	644.3 (cost)	3,122.2 (savings)
Rank: #4 of 12.	NON-MA #1	-	2,393.7 (cost)	2,393.7 (savings)
	MA #2.	-	2,471.3 (savings)	2,471.3 (cost)
	Net Total.	5,956.7 (cost)	566.7 (cost)	3,044.6 (savings)
Proposal I DAC #2.		5,580.69 (savings)	966.9 (cost)	4,613.8 (cost)
Rank: #10 of 12.	NON-MA #1	~	26.6 (savings)	26.6 (cost)
	MA *92*.	-	2,471.3 (savings)	2,471.3 (cost)
	Net Total.	5,580.69 (savings)	1,531.0 (savings)	7,111.7 (cost)

	OPTIONS	FEDERAL	STATE	COUNTY
Proposal J. Rank.: #5 of 12.	DAC #1	-	5,982.6 (cost)	5,982.6 (savings)
	NON-MA #4	-	2,235.8 (savings)	2,235.8 (cost)
	MA #2	-	2,471.3 (savings)	2,471.3 (cost)
	Net Total	-	1,275.5 (cost)	1,275.5 (savings)
Proposal K Rank: #9 of 12	DAC #2	5,580.69 (savings)	966.9 (cost)	4,613.8 (cost)
	NON-MA #4	-	2,235.8 (savings)	2,235.8 (cost)
	MA #2	-	2,471.3 (savings)	2,471.3 (cost)
	Net Total	5,580.69 (savings)	3,740.2 (savings)	9,320.9 (cost)
Proposal L Rank: #3 of 12	DAC #3	5,956.7 (cost) 2,296.0 Title XX (displaced)	644.3 (cost)	3,122.2 (savings)
	NON-MA #4	-	2,235.8 (savings)	2,235.8 (cost)
	MA #2	-	2,471.3 (savings)	2,471.3 (cost)
	Net Total	5,956.7 (cost)	4,062.8 (savings)	1,584.9 (cost)

VIII. SUMMARY

The goal of this study was to identify all of the alternative fiscal policies which would eliminate the current financial incentive for counties to place mentally retarded persons in state hospitals. Twelve policy proposals were identified and ranked in accordance with the following criteria: (1) maximization of federal participation; (2) minimization of additional state costs; and (3) minimization of additional county costs.

The results of the fiscal impact analysis indicated that the most acceptable policy proposals utilize medical assistance (Title XIX) for community-based developmental achievement center services and require counties to pay for a share of the medical assistance costs for residential care in state hospitals.

The three most favorable proposals were as follows:

Proposal		Federal	State	County
A	Net Total	5,956.7 (cost)	1,853.6 (savings)	624. 3 (savings)
B	Net Total	5,956.7 (increase)	2,613.9 (savings)	136.0 (cost)
L	Net Total	5,956.7 (cost)	4,062.8 (savings)	1,584.9 (cost)

The proposed utilization of Title XIX for community-based DAC services would result in not only a significant decrease in county coats (3,122.2), but also a significant decrease in the amount of Title XX dollars (2,296.0) necessary to maintain community-based DAC programs. The counties could use these "freed up" Title XX dollars to offset the county costs incurred by paying their share of residential services in state hospitals, or to fund other Title XX eligible services. If counties use the "freed up" Title XX dollars to offset costs incurred in other service areas, the counties net costs indicated in Proposal L could be more than offset, (i.e. -1,584.9 (net county coats of Proposal L) + 2296.0 ("freed up" Title XX dollars) +711.1 (county savings)).

The Mental Retardation Program Division recommends that Proposal L be implemented as the fiscal policy alternative to eliminate the present financial incentive for counties to place mentally retarded people into the state hospitals. Proposal L is to:

> increase the county share of DAC costs In state hospitals from the present 0% to 4.4%, and decrease the county share of DAC costs in the community from 46% to 4.4% for MA eligible clients only; and
>
> increase the county share of state hospital residential costs for non-MA eligibles from the present 0% to 50%, and increase the county share from cost of care in the community from the present 30% to 50%; and

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increase the county share of state hospital residential services for HA eligibles cost (now OX) to the county share of community residential service costs for HA eligibles (4.4%).

This proposal not only meets the fiscal criteria used in the study, but also integrates effectively into current funding systems and into the Department's 1981 legislative proposals.

GMR/ME

APPENDIX I

F.Y. 80 COST SHARING DISTRIBUTIONS BY FEDERAL, STATE, COUNTY AND OTHER SOURCES.

F.Y. 80 COST SHARK DISTRIBUTIONS
AMONG, FEDERAL, STATE, AND COUNTY SERVICES

	STATE HOSPITAL SETTING						COMMUNI TY					
	No. Served	Total Exp.	Federal Share	State Share	County Share	Other Share	No. Served	Total Exp.	Federal Share	State Share	County Share	Other Share
MA Residential	2,570 (95.5%)	55,661.0	30,969.78 (55.64%)	24,691.22 (44.36%)	----- (0%)	----- (0%)	3,700	39,766	22,125.8 (55.64%)	15,874.59 (39.92%)	1.765.61 (4.44%)	---- (0%)
Non-MA Residential (Cost of Care)	122 (4.5%) children	2,623.0	---- (0%)	2,623.0 (100%)	----- (0%)	?	650 children	7,900*	---- (0%)	4,242.3 (53.7%)	2,393.7 (30.3%)	1,264.0 (16%)
DAC	1,790 adults	10,030.0	5,580.69 (55.64%)	4, 449.31 (44.36%)	----- (0%)	----- (0%)	3,600 adults	13,000.0**	3,478.8 (26.76%)	2,960.1 (22.77%)	5,982.6 (46.02%)	578.5 (4.45%)
TOTAL	2,692	68,314.0	36,550.47	31,763.53								

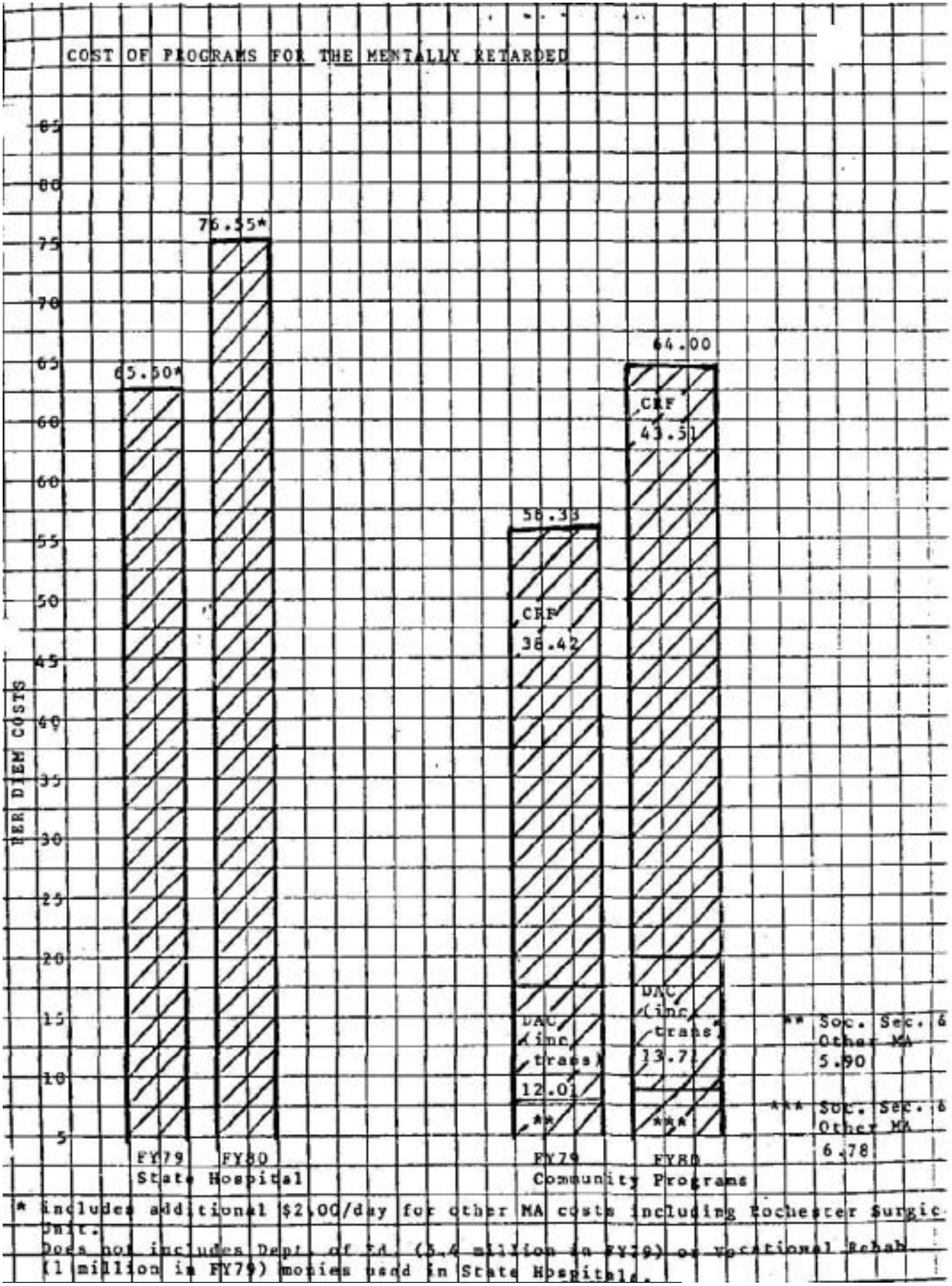
* Reflects the state, county, and third party payments of gross eligible costs for the Cost of Care program in Rule 34 facilities the shares for net eligible costs were — state 63.5%, and county 36.5%.

**This figure does not reflect DAC costs for preschool and homebound programs for F.Y. 80. These costs were estimated at 5,135.0 in F.Y. 80 resulting in a total F.Y. 80 DAC budget on 18,135.0.

APPENDIX II

COST COMPARISON BETWEEN COMMUNITY-BASED AND STATE HOSPITAL SERVICES

COST OF PROGRAMS FOR THE MENTALLY RETARDED



* Includes additional $2.00/day for other MA costs including Rochester Surgic Unit.

Does not includes Dept. of Ed. (3.4 million in FY79) or Vocational Rehab. (1 million in FY79) monies used in State Hospitals.

A. Cost of Programs for the Mentally Retarded in State Hospitals

1. Per Diem At Hospitals.

State Hospitals	Total MR Costs	Total MR Patient Days			
Brainerd	$10,912,010	$166,173	141,637		85.2
Cambridge	12,617,690	200,121	176,292	$65.67	74.9
Faribault	17,251,415	297,656	285,420	63.05	66.8
Fergus Falls	6,453,032	99,327	96,935	57.96	74.0
Moose Lake	3,435,996	49,479	46,368	64.97	82.0
Rochester	3,389,539	50,153	54,614	69.44	68.2
St. Peter	4,705,931	67,335	66,143	67.58	78.7
Willmar	3,938,594	57,271	55,445	69.69	78.6
TOTALS	62,704,207	987,515	932,514	68.77	74.3
				63.50	

2. Other MA Cost Per Diem Average — ≈1.00 — ≈1.0

3. Rochester Surgical Unit - Per Diem (Estimated: Assumes Average 70 percent utilization of services by the MR at Rochester Surgical) — 1.00 — 1.0

TOTAL Average Per Diem — 65.50 — 76.5

Note: In addition to the state hospitals per diem cost computed above, the school districts spent approximately $5.4 million in fiscal year 1979, Also, the Division of Vocational Rehabilitation spent close to $1 trillion for the Cooperative Vocational Rehabilitation Program and other guidance and screening services. These costs would also be present in the community and they should be the same for similar population groups. However, there is not readily available information on those costs for community-placed residents. Therefore these costs have been excluded from the computation.

B. Cost of Programs for the Mentally Retarded in Community-Based Facilities.

Since the purpose of this project is to compare the cost of state hospitals and community placements, it is necessary to adjust the community cost in order to account for differences in population. Therefore, the residential per diem average listed below includes only facilities with roughly equivalent populations to those of the state hospitals, that is, facilities serving the physically handicapped, the profoundly and severely retarded, and persons with behavior problems. Not necessarily the community facilities had to have all of their residents in those categories. That would have been unfair since the state hospitals also have "easy" residents. However, the facilities selected had enough difficult cases to establish them as serving populations equivalent to the populations served by the state hospitals.

		FY 1979	FY 1980 Projected
1.	Residential Per Diem (DPW Rule 52 Records)	38.42	43.51
2.	DAC Per Diem ($18.04/day of service) (DAC Cost Reports)	9.89 (Adjusted 200 days of service/year)	11.27
3.	Social Services Per Diem*	1.05	1.20
4.	Transportation Per Diem* (3.86/day of service)	2.12 (adjusted 200 days of service/year)	2.44
5.	Other Medical Assistance Per Diem*	4.85	5.58
	Total	56.33	64.00

*Based on a three-county record examination conducted in 1978 and updated for inflation.

C. Incentives for Placement

The mentally retarded average daily population in state hospitals has declined from 5,532 residents in FY 1962, to 2,780 residents in FY 1979. During the first five years of this period the decline was very slow, but starting in 1967 the population has declined steadily at a rate of 5 to 8 percent a year. The acceleration of the downward trend that started after fiscal year 1967, followed the introduction of Medicare and Medicaid by about two years. However, other initiatives such as the enactment of DPW Rules 34 and 52, federal funding for ICF/MR, Minnesota Housing Finance Agency assistance with mortgages, and the assumption by the state of all the non-federal share for the cost of care in state hospitals were not accompanied by any noticeable change in the rate of population decline.

C. (Continued)

Therefore, even if there is a definite incentive for counties to send mentally retarded residents eligible for Medicaid to state hospitals since there is no county share in the cost, historical data do not show that the counties have taken advantage of the incentive. It may be that incentives for placement in the community are stronger than incentives for placement in the state hospitals.

When so many incentives with different objectives are at work, it is very difficult to isolate the effect of just one of them analytically. Therefore, it is difficult to say how much faster the mentally retarded population of state hospitals would have declined if the reimbursement incentive to place MR persons in state hospitals had not existed.

SCHEDULE OF MR COSTS - PATIENT DATS AND PER DIEM RATES

For F.Y. 1979

STATE HOSPITAL	MR COSTS	MR PATIENT DAYS		PER DIEM RATE
BRAINERD	10,912,010	166,173		65.67
CAMBRIDGE	12,617,690	200,121		63.05
FARIBAULT	17,251,415	297,656		57.96
FERGUS FALLS	6,453,032	99,327		64.97
MOOSE LAKE	3,435,996	49,479		69.44
ROCHESTER	3,389,539	50,153		67.58
ST. PETER	4,705,931	67,335		69.89
WILLMAR	3,938,594	57,271		68.77
TOTALS	62,704,207	987,515	AV	63.50

SCHEDULE OF ESTIMATED MR COSTS AND PATIENT DAYS

For F.Y. 1980

	MR COST 1979 Cost + 10.66 %	MR PATIENT DAYS 10 Month actual 2 Month Est.	Estimated 1981 Per Diem Cost
BRAINERD	12,075,230	141,637	55.25
CAMBRIDGE	13,962,736	186,392	74.91
FARIBAULT	19,090,416	285,480	66.87
FERGUS FALLS	7,140,925	96,435	74.05
MOOSE LAKE	3,802,273	46,368	82.00
ROCHESTER	3,750,864	54,614	68.65
ST. PETER	5,207,583	66,143	78.73
WILLMAR.	4,358,448	55,445	78.61
	69,388,475	932,514	$74.41

SCHEDULE OF SHARE OF MA (TITLE XIX)

RECEIPTS MENTALLY RETARDED

	F.Y. 79	Fed. Share	State Share	County Share
		55.64%	44.36%	
Total MR Receipts	45,201,871.84	25,150,321.49	20,051,550.35	
		55.64%	39.924%	4.436%
If County Participated	45,201,871.64	25,150,321.49	18,046,395.31	2,005,155.04
	F.Y. 80 ESTIMATE			
Total MR Receipts	70,654,921.16	39,312,198.13	31,342,523.03	
		55.64%	39.924%	4.436%
If County Participated	70,654,921.16	39,312,398.13	28,208,270.72	3,134,252.29

Estimation of DAC costs in State Hospitals

A. Issues.
Determination of actual DAC costs within state hospitals is difficult to obtain for the following reasons.

1. Presently, there ere no cost codes which breakout DAC costs from residential costs in the state hospitals.

2. It is difficult to separate personnel and copital expenses (buildings, equipment, furniture, food, etc.) of DAC programs from the residential program because personnel, buildings, equipment, etc is shared.

B. DAC Formula.
Given that all state hospital DAC programs operate on state hospital grounds, share personnel, buildings, equipment and other support services) it was determined that the most accurate estimation of DAC costs in fiscal year 1980 would be a formula which incorporates *a* proportion of each state hospital's average time in DAC program and incorporates the percent of program distribution costs.

The following steps outlines the formula used in estimating the annual DAC costs for mentally retarded persons in state hospital for F.Y. 1980 as shown in Table 1.

Step #1: Average per day cost for mentally retarded residents in state hospitals during F.Y. SO.

Step #2: Program distribution factor of 80S reflects cost estimate proportion of three shifts in the state hospitals, e.g. #1 Shift = 40%, #2 Shift = 40%, #3 Shift = 20% assuming changes in personnel working.

Step #3: Average time in DAC is a factor determined by all state hospital DAC programs operating 6 hours per day and the majority of the resource allocation occurring for 16 hours out of the day.

$$\frac{6 \text{ hrs}}{16 \text{ hrs}} = .375$$

Step #4: Estimated per day DAC cost is determined by multiplying each state hospital's average per day cost by the program distribution factor and by the average time in DACs.

Brainerd: Est. per day DAC cost = $75.11 X 80% X .375 = $22.53

Step #5: Estimated total DAC costs is determined by multiplying each state hospital's average per day DAC cost by DAC days by the number of DAC clients.

Brainerd: Est. annual DAC cost = $22.53 x 260 days X 244 clients - $1,429,493.5

Total annual costs for mentally retarded residents in state hospital during F.Y. 80 includes building depreciation, central office costs, collection costs, support costs, bonding interest rates, furnishings and maintenance expenses. Source was Dave Lofgred, Reimb. Division, (6-2700).

APPENDIX III

ESTIMATION OF DAY PROGRAM COSTS IN THE STATE HOSPITALS

ESTIMATED ANNUAL DAC COSTS FOR MENTALLY RETARDED PERSONS IN STATE HOSPITALS FOR F.Y. 1980

State Hospital	Aver. Per day Cost	Prog. Dist. factor	Avg. time in DACS factor	Avg. per day DAC cost	TMR Clients	DAC Clients	Est. Annual DAC Costs	Total Annual Costs	% DAC Costs
Brainerd	75.11	80%	.375	22.53	128	244	1,429,493.5	11,752,458	12%
Cambridge	75.05			22.52	176	338	1,979,057.6	14,352,093	14%
Faribault	64.58			19.37	205	565	2,846,040.6	18,838,947	15%
Fergus Falls	71.18			21.35	70	200	1,110,200.0	6,819,236	16%
Moose Lake	77.88			23.36	20	112	680,243.2	3,471,383	20%
Rochester	81.26			24.38	48	71	450,054.8	4,028,805	11%
St. Peter	75.19			22.56	40	141	827,049.6	4,885,964	17%
Willmar	76.25			22.88	39	119	707,907.2	4,165,293	17%
					726	1,790	10,030,046.5	$68,314,179	

APPENDIX IV

PROJECTED EXPENDITURES FOR COMMUNITY SOCIAL SERVICES IN CALENDAR YEAR 1980

APPENDIX V

MENTALLY RETARDED UNDER 18 YEARS OF AGE IN STATE HOSPITALS ON FEBRUARY 4, 1981

PROJECTED EXPENDITURES FOR COMMUNITY SOCIAL SERVICE IK CALENDAR YEAR 1980

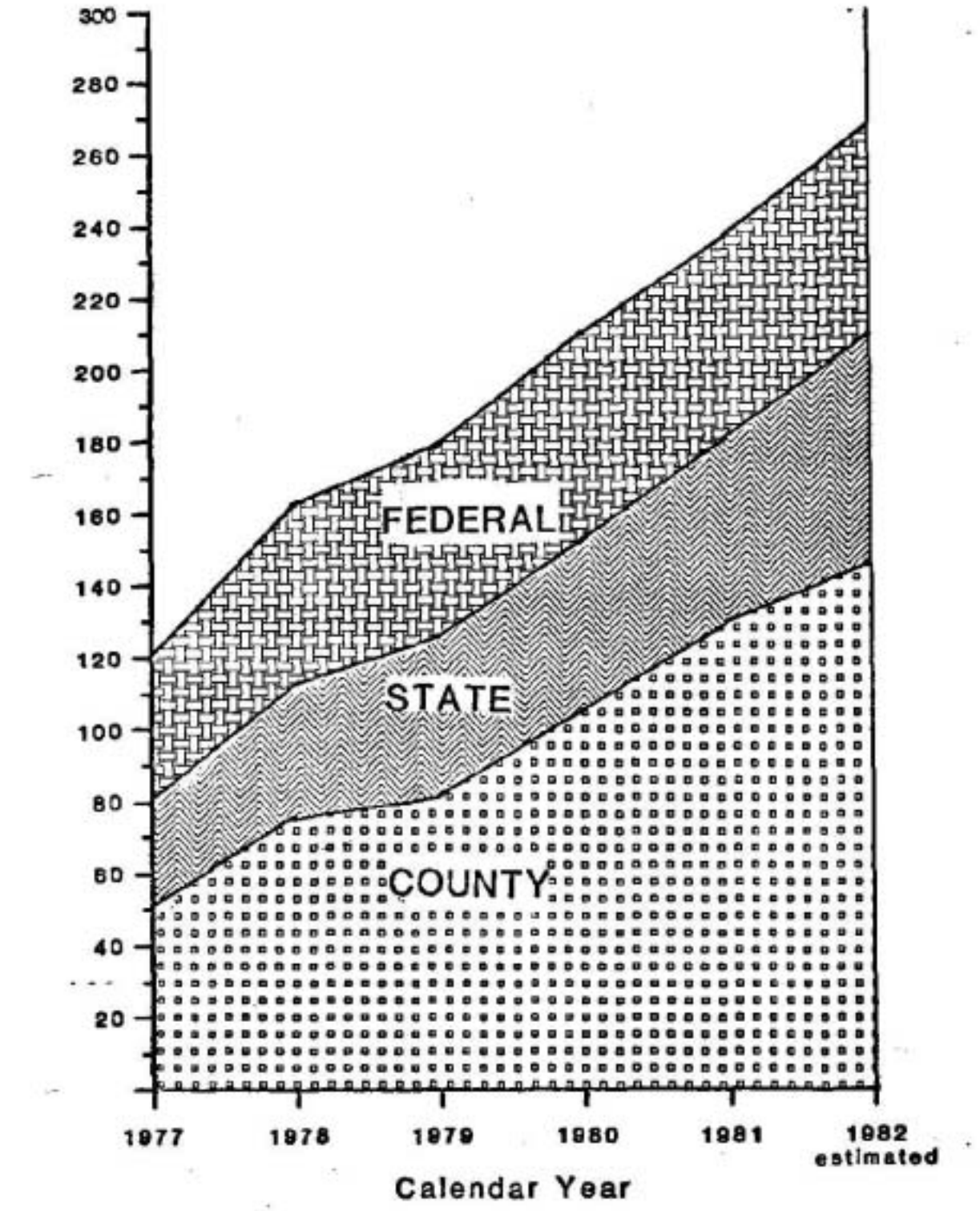
ESTIMATED TOTAL EXPENDITURES[1]	=	211,085,428	
FEDERAL SHARE[2]	=	56,491,378	(26.76%)
STATE SHARE[3]	=	48,060,650	(22.77%)
COUNTY SHARE	=	97,143,424	(46.02%)
OTHER	=	9,389,976	(4.45%)

1. Based on county budgeted expenditures for calendar 1980 by federal, state, county and other fiscal sources.

2. Includes Title XX, Title IV-B, and other Federal sources.

3. Includes state appropriations for the following program/services: Community Social services, Cost of Care (MR and Ell), State Wards, Deinstitutionalization (MR, MI), Family Subsidy, Rule 14 (MI), Daycare sliding fee, and Indigent Indian acct.

FUNDING SOCIAL SERVICES



MENTALLY RETARDED UNDER 18 YEARS OF AGE IN STATE HOSPITALS ON FEBRUARY 4,1981

STATE HOSPITAL	MA ELIGIBLE	NON-MA ELIGIBLE	TOTAL
Brainerd	40	47	87
Cambridge	18	31	49
Faribault	20	14	34
Fergus Falls	16	10	26
Moose Lake	0	0	0
Rochester	7	5	12
St. Peter	5	2	7
Willmar	8	2	10
Total	114	111	225

The total number of mentally retarded persons in state hospitals is 2,516, of which 225 (8.9%) were children under 18 years of age. Of the children, 114 (50.7%) were HA eligible and 111 (49.3%) were non-MA eligible.

APPENDIX VI

The Bases in Federal Regulation for the Utilization of Title XIX for Community—Based DAC Services

of Public Welfare

Art Noot
Commissioner

February 6, 1981

Ardo Vrobel
Director, Mental Retardation Division

6-2160

Medicaid Funding for DAC Services

I would like to add to your memo to Darcy Miner, dated January 22, 1981, concerning the question whether federal regulations allow payment for DAC services.

ICF/MR. Regulations Allow Payment for DAC Services

The statement in the DAC portion of the memo, states that DAC services could possibly be funded "only if the focus of the centers was changed quite drastically from an educational model to a medical one.*

Changing from an education to a medical focus is one of two ways that day developmental (not educational; rather habilitation and training) services can be paid under Title XIX. In addition to the medical focus, another route that is permissible 1B that of a contract/agreement with an outside qualified resource in order to furnish the required services (lCF/MR 442.417). Professional and Special Program services must be provided to residents based on their need (442,455), which includes training and habilitation services (ICF/MR 442.463).

Section 442.455 further provides that program and services provided by or to the ICF/MR facility must meet the standards, and that contracts for these services must state that these standards will be met. Section 442.417 states that the agreement must "Identify responsibilities, functions, objectives and other terms agreed to."

Final Draft of Proposed Interpretive Guidelines for ICF/MR as they apply to facilities serving 15 or fewer persons (see attached), make numerous references to a "coordinated program of services conducted outside the facility", involving both "day services" and "training activities which occur in the facility."

Interpretive Guidelines for s442.455 speaks to "written agreements" with outside resources which provide required institutional services, and programs and services In order to "achieve the residents" treatment, training and habilitation objectives." Section 442.417 deals with the agreement and method of payment for outside resource as applicable to the overall plan of care.

Conclusion: There is significant evidence in the ICF/MR regulations and their interpretational guidelines, that the facility must provide all required services and that the regulations allow delivery within the facility, and outside the facility in order to achieve compliance with all
required services.

Day Programs in Other States

Robert Gettings, Executive Director, Rational Association of State Mental Retardation Program Directors, Inc., Washington, D.C. states that four or five states pay for day progress under Title XIX (NY, Michigan, New Jersey, California), and approximately ten are exploring/ planning to do so. Most states provide day programs outside the residential facility under one or both options (i.e., certified medical vendor, facility contract/agreement). Minnesota is probably the only state using Title XX for day programs for persons in ICF/MR facilities.

Vermont provides day treatment under the heading of "clinic services" through community mental health centers (700-500 mentally retarded)) from two to eight hours per day. Such services need not be "certified" but rather need to be "approved" community mental health services.

Michigan pays for day programs, including case management, through the contract/agreement route. Each facility has an agreement by resident name for day services, and the department pays the day program provider directly. Their program has three cost centers; 1) residential, 2) day programs, and 3) case management. Costs range from $65 to $100 per diem with an average of about $85.

Illinois is looking at the possibility of funding day services under Title XIX. They currently have five "pilot" programs funded under Title XX, which are expected to contract with the ICF/MR facilities. Their plan is a "take off" from the New York program.

Maine provides its day program through the contract/agreement route. The ICF/MR facility contracts with an outside day program for all residents. These are full time programs providing the full range of services needed on an individual plan basis (except vocational and educational services). Rate for day programs is set by the Bureau of Mental Retardation and the state Title XIX agency, The current rate is 4,575 per year per client. The facility pays the day program. The per diem for both residential and day programs is approximately $75.

EF/bcc
Attachment

cc: Robert Baird
Ron Young, M.D.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Thomas D. Morford

Memorandum

Date

From Thomas G. Morford, Director
Office of Standards and Certification
Health Standards and Quality Bureau, HCFA

Subject Request for Comments on Final Draft of Proposed Interpretive Guidelines for the Standards for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) as They Apply to Facilities Serving 15 or Fewer Persons

To Interested Colleagues

The comments received on the first draft of the proposed guidelines which were widely circulated centered on the following major points:

a. The basic support of the guidelines as a needed improvement was nearly unanimous. What was significant was that providers, advocates, and government agencies shared a basic support of the document.

b. The only major disagreement with the basic document was the argument that the regulations were not meant to serve the small facility and there was a basic questioning of two separate guidelines.

   Our response again is that while there is only one program and one regulation, it can be applied to facilities "serving four or more persons, in single or multiple units" and surveyors are faced with the task of applying the regulations in widely disparate settings. We received wide support for guidelines which will aid surveyors in applying the regulations in these different settings.

c. The most consistent suggestions included the view that the introduction could be improved, especially in terms of the relationship of the facility with outside services vis a vis the requirement for active treatment. Hopefully, the second draft is an improvement. There was common agreement that the section on work (442.404(h)) needed further clarification in terns of shared work in the facility. This change was also made.

Host of the remaining comments were isolated or shared by only a few commenters. In some instances, comments were evenly split on an item (e.g., some wanted to retain monthly heights and weights, while others supported our new language).

Hopefully, the changes we made, all based upon suggestions, will be agreeable to those who either did not comment on the item or expressed an alternate view to the one chosen.

It is our intention that this draft of the guidelines will be the final draft submitted for clearance. If you have serious problems with the document you may call Dr. Wayne Smith of my staff at (301) 594-7651 rather than submit them in writing (which you are welcome to do for the record, of course). All

comments must be received by January _31 to be considered. Written comments can be sent to Dr. Smith at the following address:

Dr. Wayne Smith
Dogwood East Building, Soon
2F3 1849 Gwynn Oak Avenue
Baltimore, Maryland 21207

Thank you for your interest and assistance.

PLEASE NOTE: In order to reduce the time in preparation, we did not run column headings for the second draft of these guidelines, and we have deleted the "Rationale for Change" column. As a result of numerous comments, many of the "Rationale for Change" statements have been incorporated in the proposed guideline. Below is a sample column heading:

EXISTING REGULATION	EXISTING GUIDELINE	PROPOSED GUIDELINE
435.1009	435.1009	435.1009

You will find consistent left-to-right correspondence for each regulation, so on the tap of each page you can tell which regulation you are dealing with We should also mention that the third column is the most important one. It combines those parts of the existing guidelines which are being retained with the new language being added. Any problems in understanding the format, please call Wayne Smith, Ph.D. at (301) 594-7651, or FTS 934-7651. Thank you.

P.S. When the final guidelines are promulgated, the columns will include the existing regulation, the revised guideline and survey procedures, as is done at present.

INTERPRETIVE GUIDELINES AND SURVEY PROCEDURES FOR THE APPLICATION OF THE STANDARDS FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICFs/MR) AS THEY APPLY TO FACILITIES SERVING 15 OR FEWER PERSONS

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INTERPRETIVE GUIDELINES AND SURVEY PROCEDURES FOR THE APPLICATION OF THE STANDARDS FOR INTERMEDIATE CAKE FACILITIES FOR THE MENTALLY RETARDED (ICFs/MR) AS THEY APPLY TO FACILITIES SERVING 15 OR FEWER PERSONS

In recent years there has been a sharp increase in the number and types of residential alternatives to large institutions for mentally retarded persons. Most of these alternatives consist of residential environments which serve 15 or fewer people. There has also been a marked increase in the number of these facilities seeking and gaining certification, as ICFs/MR. While the current standards for ICFs/MR (42 CFR Section 442, Subpart G, and other relevant parts) permit the certification of facilities serving 15 or fewer persons as ICFs/MR, there has been wide variation in the interpretations of the existing standards and guidelines in terms of compliance requirements for small facilities which are emerging and the differences which exist between operating small and large facilities.

This material has been developed to provide Regional Offices, State survey agencies, surveyors, consultants, supervisors and providers with assistance in their efforts to make appropriate survey and operational decisions in facilities serving 15 or fewer mentally retarded persons by providing a basis for the consistent and equitable interpretation of the standards nationally. It should be stressed that in no way does this guideline revision replace the standards, nor does it replace the interpretive guidelines and survey procedures for facilities serving more than 15 persons. This revision attempts to recognise the legitimate differences between the operation of small and large facilities and seeks to allow for them without altering the basic programmatic intent of the standards, namely the provision of active treatment services.

An effort has been made to interpret the standards for ICFs/MR for 15 or fewer persons within the framework of the principles of normalization, least restrictive environment, and the developmental model of program services delivery, including the interdisciplinary (and to a large extent, transdisciplinary) approach to interventions- While these terms may be misused or overused in some service delivery contexts, many experts in the area of developmental disabilities believe that if a developmentally disabled person requires out-of-the-home care, the small, home-like facility has a greater possibility of providing the quality of cars envisioned in the intended sense of these concepts titan does the large, congregate facility. While the department supports the development of service delivery mechanisms which most effectively facilitate the positive development of mentally retarded persons, it is important to review the scope and intent of the ICF/MR program in order to avoid confusion about what services must be provided and what constitutes active treatment in a small ICF/MR. The applicable definitions in 42 CFR 435.1009 stress that each ICF/MR must provide "in a protected residential setting, on-going evaluation, planning, 34-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his optimal ability." The facility exists "primarily for the diagnosis, treatment, or rehabilitation of the mentally retarded or persons with related condition's." Additionally, the facility must provide "active treatment" which means an aggressive and organized effort to fulfill each resident's fullest functional capacity. It

requires *a* program of behaviorally stated goals and objectives which are based upon an appropriate assessment of needs and strengths which are integrated into the resident's full experience in the facility. Active treatment has as its goal the fullest development of which the resident is capable, in the least time necessary, within the most reasonable cost possible. Persons not in need of active treatment services must not be classified for ICF/MR level of care. Thus, boarding homes or other settings which provide nominal supervision and 'no active treatment services themselves cannot be certified.

A major difficulty in surveying a small ICF/MR seeking certification is found in deciding if the facility is capable of providing active treatment services. Many providers of care seeking certification as small ICRs/MR contend that if the facility provides active treatment through a coordinated program of services conducted outside the facility than it can be said to be providing active treatment services. Active treatment, though, as required by statute and defined in the regulations is a continuous, unified process which may involve both day service a and the training activities which occur in the facility, both "reinforcing" each other so that the resident receives a comprehensive and consistent program of intervention. This requirement is founded in the well-demonstrated knowledge that retarded persons require extensive training in the skills they need in all of the environments in which those skills will be utilized. This is called "generalization training." Thus, their need for training is not confined to five or six hour blocks of time.

The question arises, then, as to how the small facility provides active treatment within the facility itself as well as through a coordinated program of outside services. Providers ask if they must duplicate the professional services obtained through the outside programs. Others contend that in order to provide truly normalizing care, it is inappropriate for the residents to come home from their day programs and be able to enjoy their free time following their own interests and pursuits. Neither view represents a completely accurate understanding of the active treatment process in a small ICF/MR. In the first instance, it is required by the standards that certain professional services be provided, though they may be acquired through outside sources. The requirement for active treatment in these instances in terms of what the facility itself must do is found in the way the facility provides for the continuity of training by integrating its own program with that of an outside source, and vice-versa. For example, if a facility serves physically handicapped, mentally retarded persons who attend a day program at a local center and one of them receives training from an occupational therapist (OT)in adaptive feeding methods, then the facility has the responsibility to reinforce the formal training at breakfast and dinner for the resident. If the facility is able to use the *same* OT from the center to train and supervise the facility's staff in the use of the training techniques necessary for them to be effective "generalization trainers," then the facility does not need to hire its own OT consultant for the resident. On the other hand, if the facility has developed and implemented a structured program to reduce a stereotypical behavior (e.g., excessive hand movements), the outside resources working with the resident must likewise assume responsibility for carrying through with the facility's program carefully and consistently.

Secondly, no one will disagree that the retarded person, like everyone else, has a right to leisure time activities and private time. However, if one accepts the notion that active treatment does not simply mean the application of formal therapy interventions, but rather that it is a process which, like excellent parenting, unfolds continuously, then ore accepts the need for responding appropriately to the developmental needs of individuals as they present themselves, no: as they are "prescribed." If a retarded person is Classified as being in need of active treatment services (thereby meeting the definition of an "inpatient" in 435.1009), then this means that the resident is deficient in skills across the spectrum of development to one degree or another. Thus, socially, emotionally, cognitively, physically, and communicatively, the resident can benefit from staff who can interact with him or her both formally and informally in *a* way which supports the goals and objectives of the individual plan of care. This implies that the staff is adequately trained to carry out programs designed by the interdisciplinary team. One can readily envision for example, staff implementing a behavior shaping program designed to teach a resident how to use leisure time productively rather than allowing the resident to come home and stare at a television set, or the staff members may carry through with a specific portion of a language program in the facility by the way in which they structure their communications with the resident and the way they structure his language production as well. Certainly, the staff would be expected to keep accurate performance data as a part of an effective intervention program.

From this brief analysis of what constitutes active treatment in a small ICF/MR, it should be clear that the requirement is explicit that the facility must provide active treatment within the facility itself and is responsible for coordinating its active treatment programs with whatever outside services which may be secured. Thus, the concept of active treatment in the small facility is a shared responsibility between the facility and outside resources. While the content and quality of programs provided by outside resources is not usually under the direct control of the facility, the facility must secure outside programs and services that adequately meet the developmental needs of the residents. Surveyors should be reminded that they have the responsibility of assuring the quality of all the services the residents receive, regardless of how they are acquired. If the surveyor finds that the facility and/or outside sources are not providing active treatment in the sense explained in this introduction, then the surveyor must question seriously the appropriateness of the certification the facility either possesses or for which it is applying. Thus, the surveyor is responsible for determining that the facility is, in fact, providing active treatment to a population of clients classified as needing those services. While the Department recognises that many retarded persons have completed the habilitation process and are using all their skills productively and independently in various work settings in the community while continuing to live in facilities serving 15 or fewer persons, it has never been the intent Of the ICF/MR program as it exists now to provide financial support to facilities serving these individuals.

While the role of the surveyor is to assess the performance of facilities using the standards and guidelines, the judgments the surveyor makes about the facility are highly dependent upon the nature of the residents being served. Thus, there must be a close working relationship with those agencies which

resources.

If the ICF/MR does not employ a qualified professional to furnish a required institutional service, it must have in effect a written agreement with a qualified professional outside the ICF/MR to furnish the required service.

(b) The agreement must--

(1) Contain the responsibilities, functions, objectives, and other terms agreed to by the ICF/MR and the qualified professional; and

(2) Be signed by the administrator or his representative and by the qualified professional.

Interpretive Guideline

The facility has a written agreement with an outside resource which provides direct services to residents. The minimum terms of agreement specify the responsibilities of both the facility and the outside resource, the qualifications of resource staff, a description of the type of service to be provided, the method of payment, and the duration of the agreement.

Required institutional services are those professional services that the facility has direct responsibility for providing, e.g., physical therapy, occupational therapy, speech therapy, and audiology.

The facility has a written agreement for those services provided to residents by outside sources. Agreements should specify the qualifications of the resource staff, a description of the service to be provided, method of payment, and the duration of the service. All services provided by outside resources must be incorporated in the overall plan of care in the form of measurable goals and objectives. Timely and detailed performance-based reports should be submitted to the facility to enable facility staff to respond to outside training objectives and changes.

Required institutional services are those professional services that the facility has direct responsibility for providing, e.g., physical therapy, occupational therapy, speech therapy, and audiology. See also "Quality Standards for Outside Resources," Section 442.335.

the IGF/HR conducts research, it must comply with the statement of assurance on research involving human subject required by 45 CFR 46.105 through 46.108.	Written, legal effective, informed consent of the resident or his guardian is obtained before involving any resident in a research project. Written assurances, acceptable to DHHS, that researcher will comply with DHHS.	Written, legally effective, informed consent of the resident or his guardian is obtained before involving any resident in a research project.

outside resources.

(a) Programs and services provided by the ICF/MR or to the ICF/MR by outside agencies or individuals must meet the standards for quality of services required in this subpart.

(b) All contracts for these services must state that these standards will be met.

The facility has written agreement with an outside resource which provides the direct services to residents. The minimum terms of agreement specify the responsibilities of both the facility and the outside resource, the qualifications of resource staff, a description of the type of service to be provided, the method of payment, and the duration of the agreement.

Required institutional services are those professional services that the facility has direct responsibility for providing, e.g., physical therapy, occupational therapy, speech therapy, and audiology.

Professional services should be provided in the community to the extent possible.

Programs and services are focused upon the individual needs of residents and ~~are designed to~~ achieve the resident's treatment, training, ~~,~~ and habilitation objectives.

The parent facility has a written agreement with an outside source which ensures that said outside source will provide written, documented, periodical reports on the adjustment of the resident. The reports should include but are not limited to the following:

(1) progress reports
(2) treatment plans
(3) short-term goals for treatment

The quality of services from outside resources must meet the full requirements of active treatment services as defined in 435.1009.

Goals and objectives from programs provided by outside sources should be reflected in the plan of care to enable facility staff to provide continuity and generalization training, and outside services should reflect the goals and objectives established by the facility.

In no case may facilities in which residents receive services from outside resources provide only room, board, and minimal supervision. Assurances must be available that quality care is provided both within and outside the facility and that all services are integrated and meet individual needs.

Reports to and from outside resources should be as timely and frequent as necessary to ensure a flow of information sufficient to operate a comprehensive, consistent and continuous program of training, reinforcement, and generalization. See also 442.417.

Programs and services are focused upon the individual needs of residents and are designed to achieve the resident's treatment,

442.456 Needed services.

In addition to the resident living services detailed in 442.432 through 442.451, the ICF/MR must provide professional and special programs and services to residents based upon their needs for these programs and services.

442.456

The provision of professional and special programs and services is contingent upon a thorough evaluation of the strengths and weaknesses of each resident. Such evaluations must be adequate to determine the resident's needs and to make appropriate recommendation and plans for services to meet those needs. Such evaluations must also be updated as needed to modify services to meet the resident's changing needs.

442.456

The provision of professional and special programs and services is contingent upon a thorough evaluation of the strengths and weaknesses of each resident. Such evaluations must be adequate to determine the resident's needs and to make appropriate recommendation and plans for services to meet those needs. Such evaluations must also be updated as needed to modify services to meet the resident's changing needs.

See especially the Introduction to these guidelines for a discussion of the facility's requirement to provide active treatment services which extend beyond whatever outside programming may occur. See the guideline for 442.455 also.

certify the residents for Medicaid participation and the Inspection of Care Review Teams to ensure that appropriateness of placement and classification has occurred. The surveyor can easily familiarize him/herself with each resident's record and can be alert to residents who do not appear to be in need of the services the facility is certified to provide. Since most residents of small facilities go to programs outside the facility each day, the surveyor could arrange either to visit *the* facility late in the afternoon or ask that the residents return to the facility somewhat earlier than usual in order for the surveyor to have personal knowledge of the residents the facility serves. Any concerns about the appropriateness of the resident's placement should be reported to the Inspection of Care Review learns.

These interpretive guidelines and survey procedures are multi-purpose in design. First, they are to serve as a surveyor's tool, since they include standards for certification, interpretation of the standards, and suggestions as to how to survey. Secondly, these interpretative guidelines will also be available to other professional personnel in the State agency such as consultants and supervisors, to assure Chat they have an understanding of the requirements and goals necessary for participation in the Medicaid Program by facilities for the mentally retarded persons. Finally, many providers will secure copies for their own guidance.

The standards, interpretive guidelines and survey procedures should be viewed and used simultaneously. Often, elements in the standards are not repeated in the interpretive guidelines because these elements are self evident; only those elements where clarification seemed appropriate are included. Also, in evaluating compliance with specific standards, the surveyor must utilise the definitions of qualifications of personnel and terns used in the standards and Section 405.1101, "Definitions". For example, to determine if the physical therapist meets the requirements of the standard, the surveyor should refer to 405.1101(q) for a definition of the qualifications of the position.

The surveyor is to evaluate situations as they exist and exercise his/her judgment in determining if a standards is in compliance. Often, the interpretive guidelines specify a particular number of conditions not found in the standards themselves. Such specificities are accompanied by such terms as "it is recommended" or "at least" to convey that these are recommendations; and are not the final consideration in determining compliance. Examples should not be viewed as the only possible way to meet a standard.

As discussed earlier, the frequency and duration of consultation are not specified in the standards requiring the use of qualified consultants. Requiring a specific number of hours or visits does not assure effective or quality consultation. In some cases, interpretaive guidelines may recommend a minimal number of hours considered desirable for consultation. However, the surveyor must decide if the time spent in the facility by the consultant is sufficient. A well controlled behavior management system may require many hours of consultation a month, depending upon such factors as staff capabilities, training, and the cooperation of the administrator of the facility in implementing a consultant's recommendations. Conversely, if a poorly run behavior management service is observed, although consultation is frequent, the problem may be due to the administrator's refusal to implement the consultant's recommendation, etc. Thus, the end product, the quality of

the service in question particularly in terms of the effect of the service on the resident, must be the determining factor, not just the number of hours « consultant spends in the facility. A number of the standards state that the facility should have established procedures to implement the requirements in the standard. This it rot to be confused with the policy of a facility. The distinction between policy and procedures is that a policy is the authoritative decisionmaking as to how a particular activity *is to* be accomplished or situation is to be dealt with. The procedure is the method by which that policy is carried out. For example, a facility *may* develop a policy chat states that only the individual prescription system shall be used in the facility. The procedure for accomplishing that policy would explain how the physician's prescription order is transmitted to the pharmacy, what is expected of the pharmacist in dispensing the drug, how the dispensed drug is delivered to the facility, etc.

Frequently, in the survey procedures, the surveyor is directed to interview facility personnel to obtain sufficient information to make his final recommendations. While interviews with the administrator, or the qualified mental retardation professional must necessarily be in depth, the surveyor need not disrupt the facility by protracted interviews of all the staff. A few well-phrased questions to many of the staff will elicit the desired information. At all times, the surveyor must strive to be an effective interviewer. Questions should be put in plain language; for example, Co determine if a staff member is aware of disaster procedures and his role in such events, a surveyor may simply ask, "If you smelled smoke, what would you do?" This will result in effective communication.

Questions should also be directed to the appropriate personnel. If the facility has established procedures, with designated staff responsible for particular functions, for example, administration of medications is restricted Co specific staff members, questions should be directed to the personnel charged with this responsibility.

Every effort should be made to talk informally with various residents, preferably apart from the staff, from which you can gain a more comprehensive new of the total facility and its effect upon the residents.

For a thorough discussion of the issues inherent in the ICF/MR program, see: Gardner et al. Program Issues _in Developmental Disabilities: A Resource Manual for Surveyors and Reviewers. Baltimore: Paul H. Brookes, 1980.