ASSESSMENT OF THE IMPACT OF THE ICF/MR MORATORIUM

DEPARTMENT OF HUMAN SERVICES
JANUARY 1988

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
Human Services Building
444 Lafayette Road
St. Paul,
Minnesota 55155-38 15
January 28, 1988

The Honorable Jerome Hughes
President of the Senate
328 Capitol
St. Paul, Minnesota 551S5

The Honorable Robert E. Vanasek Speaker
of the House of Representatives 463 State
Office Building St. Paul, Minnesota 55155

Dear Senator Hughes and Representative Vanasek:

I am pleased to submit this report on the Assessment of the Impact of the ICF/MR Moratorium required in Minnesota Statutes, Section 252.291, subdivision 4.

The Department is particularly pleased with the success of the Home and Community-Based Waiver Program for persons with mental retardation or related conditions in significantly reducing Minnesota's reliance on ICF/MR care.

I trust that you will find this report informative.

Sincerely,

SANDRA S. GARDEBRING
Commissioner

cc: Representative Paul Ogren, Chairperson
Health and Human Services Committee

Senator Linda Berglin, Chairperson
Health and Human Services Committee

Representative Lee Greenfield, Chairperson
Health and Human Services Division of
Appropriations

Senator Don Samuelson, Chairperson
Health and Human Services Division of
Finance

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I. SUMMARY

- The legislative moratorium on the building of additional ICF/MR beds has provided that impetus needed for reducing the State's reliance on residential services provided by ICFs/HR and encourage the continued development of individualized service options such as home and community-based services alternatives for persons with mental retardation and related services.

- The total number of certified ICF/MR beds In the state has been reduced from 7,559 in 1983 to 6,618 in 1987 surpassing the moratorium reduction target of 7,000 certified beds and continued reductions are expected in C.Y. 1988.

- The historical increase in State Medical Assistance payments for persons with mental retardation and related conditions slowed considerably after full implementation of the moratorium in addition to rate rule policies, from an average rate of 30 percent a year (from 1981-1964) to less than 1 percent a year (from 1984-1987).

- The moratorium did not affect the ability of the State to meet ita bed reduction targets for regional treatment centers as required under the Welsch v. Gardebring consent decree. However continued deinstitutionalization may require limited and targeted small ICF/MR development.

- While the state has continued to use the mechanisms available to alter existing community based capacity to serve clients with greater service needs, additional funding may be needed for further development of alternative home and community-based services to continue the progress of deinstitutionalization of the regional treatment centers clients. Table 9 shows the distribution of community ICFs/MR by licensure category, size, and region. As can be seen, there are a disproportionate number of large (17 beds or more) "B" facilities throughout the state. Of the 1,535 Class B facilities, 1,133 or 74 percent have 17 beds or greater.

- While the use of Medicaid home and community-based waivers has resulted in serving more persons within their home counties, there exists a disparity in the geographic distribution of ICF/MR beds, particularly small ICFs/MR designed to serve persons with severe handicaps.

- While the number of new waiver diversions has been based on Minnesota's historical ICF/MR growth and has been successful in diverting individuals from ICF/MR placement, the demands for residential services exceed the number of waiver diversions

available, especially as more persons with mental retardation or related conditions are screened and assessed to be placed out of nursing homes.

II. BACKGROUND

Federal-state coat sharing provisions for ICF/MR certified facilities for persons with mental retardation first became available as an optional service under the Medicaid Program in 1971. Minnesota led the nation in the development and use of ICF/MR certified facilities and has consistently maintained approximately 20 percent of the total ICF/MR beds in the United States.

In 1977 Minnesota had 154 ICF/MR facilities and by 1986 the number of facilities had more than doubled to 354 facilities providing services to approximately 6,850 persons with mental retardation and related conditions. Only one other state in the country had a greater number of ICFs/MR. (In 1986 New York's 686 ICF/MR facilities provided services to 17,000 persons.)[1]

Minnesota was also one of the first states to develop and use small ICF/MR facilities (group homes and facilities with fewer than 16 beds) which was added as an optional service under Medicaid in 1977. Prior to the passage of federal legislation authorizing the Medicaid Home and Community-Based Waivers, the use of smaller ICFs/MR had been the only way for states to use favorable federal-state cost sharing provisions under Medicaid to support community-based residential programs. In 1977 when the option was first made available, Minnesota had 77 percent of all small private ICF/MR group homes nationwide and 78 percent of all small private ICF/MR residents in the United State. By 1986 more states were using this option and while Minnesota had over a third of its residents in the smaller community-based facilities it represented only 13 percent of the nation's total capacity.[2]

States have used different methods of service delivery and financing for meeting the needs of their citizens with mental retardation and related conditions. Minnesota has in the past relied on federal-state financing through the Medicaid Program which has in the past strictly limited federal matching payments to services provided in certified ICFs/MR. Other states have relied more heavily on state/county financed and administered service systems and less on the federal cost sharing provided through the Medicaid ICF/MR option. This reliance on federal financing provision is represented by the large number of ICFs/MR in Minnesota compared to other states. While Minnesota had a total of 354 ICFs/MR in June 1986, over half of the states (36) had less than 50 certified ICFs/MR and 41 states had less than 100.[3]

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1. *Lakin, Charlie K. et al, Medicaid's Intermediate Care Facility for the Mentally Retarded Program: An Update. University of Minnesota, Center for Residential and Community Services, November 7987. pp 17-21.*
2. *Lakin, et at, p.20*
3. *Lakin, et at, P.21*

Not surprisingly, Minnesota has consistently had the highest rate of utilization of ICF/MR services in the United States. In 1986 Minnesota's utilization rate was over two and one-half times the national average - 163.5 ICF/MR residents per 100,000 of the State's population compared to national average of 60.2 per 100,000 of the United States population. Medical Assistance costs have also been high. Between 1978 and 1986 total expenditures for ICF/MR services in Minnesota increased from $16 million to $107 million.

In 1983 the Office of the Legislative Auditor in a report evaluating community residential programs for persons with mental retardation and related conditions found that Minnesota relied too heavily on ICFs/MR and residential care for persons with mental retardation and related conditions while less restrictive and less expensive alternatives had largely been neglected. The Legislative Auditor recommended that more emphasis be placed on less-restrictive alternative services and made the following specific recommendations:

- The Department of Human Services and the Legislature should limit the development of new ICF/MR facilities.

- The Legislature should increase the availability and use of alternatives to ICF/MR care.

- The Legislature and Department of Human Service should encourage existing facilities to serve more dependent clients.

A legislative moratorium on development of ICFs/MR beds was mandated in the Laws of 1983, Chapter 312, Article 9. The moratorium was effective June 10, 1983, and required a reduction of ICF/MR certified beds, as well as a restriction on new development. In 1983 thirty-five percent of ICF/MR certified beds were located in the State's seven regional treatment centers (the state hospital system) and the moratorium applied to the regional treatment centers, as well as to the community ICFs/MR.

The moratorium mandated that "in no event" could the number of certified ICFs/MR, both in the community and in the regional treatment centers combined, exceed 7,500 on July 1, 1983, or 7,000 on July 1, 1986. By reducing the number of persons served in ICFs/MR, it was the intent of the Legislature to make additional funds available for less restrictive and possibly less expensive home and community-based service alternatives to ICFs/MR.

The development of alternative home and community-based services is consistent with the goals of the Department as stated in the 1987 State Plan for Services to Persons with Mental Retardation and Related Conditions. The mission of the Department is to help those whose personal and family resources are not adequate to meet their

basic human needs to "attain their maximum degree of self-sufficiency consistent with their individual capabilities. . . and to achieve these goals while promoting the dignity, safety, and rights of individuals . .through responsible use of public resources." The Department believes that the service system should be based on the individual needs and should make available to individuals the same patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society (referred to as normalization) and that these services should enable persons with mental retardation to be visible and active participants in their communities.

III. IMPLEMENTATION OP THE MORATORIUM

The Commissioner of Human Services determined in March 1983 that the need for ICF/MR beds in the State had been met and no additional beds would be added beyond those already approved for development. This administrative moratorium preceded the legislative moratorium by three months and all proposals for additional ICF/MR beds submitted after March 31, 1983, were denied. Table 1 shows the number of need determination denials made in F.Y. 1983 by the Governor's geographic regions. There were 272 denials with the largest number of denials occurring in the metropolitan region (region 11). Need determination applications were not accepted after June 1983 and thus there were no denials after this date,

TABLE 1

Need Determination Denials for New ICF/MR Beds by Region {Post-Moratorium, March-June 1963)

Region	Number Requested and Denied
1	0
2	6
3	28
4	15
5	0
6	16
7	0
8	0
9	0
10	73
11	132
State Total	272

The length of time needed to complete the process for proposal submission, approval, and actual bed addition averages about 18 months and the building and actual certification of a bed may take longer. Thus there was a net of 269 beds approved prior to March 31, 1983, which were added to the numbers of certified beds up through the end of calendar year 1986. Table 2 shows the number of certified ICF/MR beds in Minnesota by year. The 269 bed additions occurring after 1983 represents beds authorized under need determination approvals made prior to the implementation of the moratorium.

Table 2

Certified ICF/MR Beds in Minnesota by Year

C.Y.	Regional Treatment Center ICFs/MR	Community ICFs/MR	Total ICF/MR Beds
1980	3079	4117	7196
1981	2849 (-230)*	4507 (+390)	7356 (+160)
1982	2679 (-170)	4659 (+152)	7338 (-18)
1983	2617 (-62)	4942 (+283)	7559 (+221)
1984	2395 (-222)	5121 (+179)	7516 (-43)
1985	2315 (-80)	5203 (+82)	7518 (+2)
1966	2315 (-0)	5211 (+8)	7526 (+8)
1987	1950 (-365)	4868 (-343)	6818 (-708)

**Represents the change in the number of certified beds from previous year.*

Source: Minnesota Department of Health Certified Facilities File, December 1987.

In order to facilitate the decertification of beds to comply with the moratorium limits, the Commissioner requested that the Department of Health decertify surplus regional treatment center beds, as well as those beds made available by the movement of individuals with mental retardation to community-based programs. Between 1983 to 1987 a total of 729 ICF/MR beds in regional treatment centers had been decertified. In addition, a total of 343 community ICF/MR beds were decertified in 1987. These decertifications were a result of decertifying facilities that did not meet existing state and federal licensing standards, as well as those which have participated in the voluntary decertification of beds. Table 3 shows the distribution of decertified beds by region. Bed decertifications in the community have been targeted to larger facilities and in areas where beds are more readily available.

As of December 1987 Minnesota was in compliance with the 7,000 moratorium bed limit with a total of 6,818 certified ICF/MR beds in the state.

Table 3

Number of Current ICF/MR Beds (C.Y. 1987)
and Distribution of Decertified Beds
by Region (C.Y. 1985-1987)

Region	Regional Treatment Center ICFs/MR: No. of Current Beds	Regional Treatment Center ICFs/MR: Number Reduced	Community ICFs/MR: No. of Current Beds	Community ICFs/MR: Number Reduced	Current Community ICF/MR Beds per 16,000 Population
1	0	-	141	0	14.86
2	0	-	96	0	14.18
3	101	-42	334	-51	10.41
4	201	-69	200	-35	9.59
5	256	-107	102	0	7.60
6	0	-	157	-40	11,14
7	544	-138	436	-66	11.54
8	0	-	325	-8	24.52
9	170	-17	250	0	11.32
10	678	-12	603	-44	14.60
11	0	-	2224	-99	10.58
State	1950	-445	4868	-343	11.55

IV. IMPACT OF THE MORATORIUM

A. Increased Use of Medicaid Home and Community-Based Service Waivers and Other Alternative Services

As the Legislature intended, one of the main impacts of the ICF/MR moratorium has been the increased development and use of home and community-based service alternatives to ICF/MR residential care. The primary vehicle for providing alternative services is through the Medicaid Home and Community-Based Service Waiver.

The federal Medicaid Home and Community-Based Service Waiver legislation was included in Section 2176 of the Omnibus Reconciliation Act of 1981 (Public Law Ho. 97-35). The program provided for the first use of Medicaid funds to pay for noninstitutional home and community-based services to certain populations including persons with mental retardation and related conditions. The services provided under the waiver were to be targeted to those persons who, in the absence of alternative services, would remain in an ICF/MR (referred to as

a conversion) or would be placed in a Medicaid certified ICF/MR from the community within one year (referred to as a diversion). States electing to use the waiver option are required to demonstrate that the total amount of state Medicaid expenditures will not exceed total expenditures in the absence of the waiver.

Included in the Minnesota Laws of 1983 (Chapter 312, Article 9) was the legislative authorization for the Department to apply for a waiver from federal Medicaid regulations to provide home and community-based services for persons with mental retardation and related conditions. This provision was passed in conjunction with the moratorium and was intended to strengthen the funding and availability of home and community-based services as alternatives to ICF/MR residential-based care. The 1983 laws required that if a waiver was not approved and implemented by June 30, 1984, the ICF/MR moratorium would be repealed. The Department submitted its application in January 1984 and was approved in April for a three-year period (July 1, 1984 to July 1, 1987). The waiver was recently renewed for a five-year period beginning July 1, 1987, to June 30, 1992.

The amount of Medicaid funds available for the provision of home and community-based care is related to the implementation of the ICF/MR moratorium. The Department uses the limitation on building new beds to demonstrate the cost effectiveness of use of the Medicaid waiver in its federal waiver application and thus provides that estimated "savings" used to fund waiver services. These "savings" are projected in two ways (1) based on reducing the current numbers of persons in ICFs/MR and subsequent costs through the process of moving persons out of ICFs/MR to home and community-based services (conversions), and (2) based on limiting the growth of ICF/MR case loads by "diverting" newly eligible recipients from ICF/MR placement through the provision of home and community-based waiver services. Thus the moratorium has provided the impetus to develop alternatives to ICF/MR placement through the use of the waiver.

As of November 1987 there were over 1,100 persons receiving services under the waiver and it is projected that an additional 2,000 persons will be served by 1992. Table 4 shows the number of persons receiving waivered services up through June 30, 1987, and the projected number of persons to receive waivered services for F. Y. 1988 through F.Y. 1992.

Table 4

Number of Clients Projected
to Receive Waivered Services
F.Y. 1988 to F.Y. 1992

	F.Y. 88	F.Y. 89	F.Y. 90	F.Y. 91	F.Y. 92
Persons receiving waivered services on June 30, 1987	1000	1000	1000	1000	1000
Additional persons receiving services - Total	565	565	405	385	365
Diversions	165	165	165	165*	165*
Regional Center Bed Reductions	200	200	140	120	100
Community ICF/MR Bed Reduction	200	200	100	100	100
Total Slots Available	1,565	2,130	2,535	2,920	3,285
Estimated Unduplicated Persons**	1665	2287	2748	3174	3577

**The federal government did not approve the diversion request for these years.*

***Unduplicated persons were estimated by multiplying the previous year end caseload by 1.10*

The waiver program has also provided opportunities to work with providers and counties to convert existing ICF/MR capacity to smaller, less restrictive living arrangements for current residents. The waiver allows for decertification of beds through the conversion of existing bed capacity into community placements. Currently the Department has approved or is under negotiation with counties and facilities to discuss service conversion involving 400 certified beds and has agreement for most of the contracts.

Other service alternatives to ICF/MR care include supported living facilities, supported living arrangements, family subsidy, and foster care. Table 5 shows the distribution of alternative home and community services alternatives along with the distribution of ICF/MR certified beds.

TABLE 5

DISTRIBUTION OF COMMUNITY-BASED ICF'S/MR BEDS AND SERVICE ALTERNATIVES BY REGION IN MINNESOTA (1987)

	COMMUNITY ICF'S/MR BEDS (BY FACILITY SIZE) < 17 BEDS	17+ BEDS	TOTAL (A)	WAIVER ALLOCATIONS (B)	SILS RECIPIENTS (C)	ADULT FOSTER CARE (D)	FAMILY SUBSIDY RECIPIENTS (E)	TOTAL COMMUNITY-BASED RESOURCES (SUM A THRU E)
REGION 1	108	33	141	50	20	36	4	251
REGION 2	96	0	96	30	27	20	1	174
REGION 3	265	69	334	62	112	63	21	612
REGION 4	200	0	200	92	64	73	17	446
REGION 5	102	0	102	48	45	56	9	260
REGION 6	127	30	157	76	69	81	6	361
REGION 7	293	143	436	166	109	97	23	831
REGION 8	65	240	325	70	48	26	3	472
REGION 9	206	44	250	65	86	S9	9	491
REGION 10	412	191	603	137	217	58	27	1,042
REGION 11	925	1,299	2,224	585	249	361	223	3,642
STATE TOTAL	2,819	2,049	4.868	1,423	1,040	900	343	9,582

***Note: Four hundred and ten mentally retarded persons in adult foster care (49.6%) were eligible for the Home and Community Based Waiver in 1987. The TOTAL RESOURCES column, therefore, represents some duplication.

Also, the count of waiver allocations does not include allocations for Community ICF's/MR beds not yet decertified.

•••Data Sources:

a. ICF'S/MR data.. .Minnesota Department of Health.
b. Adult Foster Care data. . .Minnesota Department of Human Services, Social Services Division.
c. Title XIX Waiver data, SILS data and Family Subsidy data. . .Minnesota Department of Human Services, Division for Persons with Developmental Disabilities.

B. Containment of State Medical Assistance Costs

The implementation of the moratorium has brought the historical growth of ICF/MR beds to a halt which, along with Rule 53 rate changes, has resulted in a significant reduction in the growth of Medical Assistance expenditures for ICF/MR services. Prior to 1983 ICF/MR beds were certified at a rate or 236 new beds a year.

While the state share of Medical Assistance expenditures more than doubled between 1981 and 1987 (from $20 million to $45 million) the rate of increase slowed to less than 1 percent per year between 1985 and 1987. A significant decrease from the increases of 30 percent or more per year between 1981 and 1984. Table 6 shows the historical rate of growth of Medical Assistance payments from 1981 to 1987. Table 7 shows the rate of increase in Medical Assistance payments for the same years.

Table 6

Summary of Minnesota
Medical Assistance expenditures
for Community ICFs/MR
(F.Y. 1981 to F.Y. 1987)

Fiscal Year	Total Payments	Federal Share	State Share	County Share
1981	$ 50,747,684	$28,236,011	$20,260,505	$2,251,167
1982	68,744,859	37,043,167	28,531,523	3,170,169
1983	83,776,384	43,967,941	35,827,599	3,980,844
1984	105,709,992	53,676,891	46,829,791	5,203,310
1985	104,431,099	54,387,716	45,039,044	5,004,338
1986	107,332,085	57,122,136	45,188,954	5,020,995
1987	108,106,739	57,739,809	45,330,237	5,036,693

Source: Department of Human Services Projections for the F.Y. 1986-1989 Biennium, November 5, 1987.

Table 7

Percentage Increase in

State/County Payments to ICFs/MR
(F.Y. 1981 "to 1987)

Fiscal Year	State Share		County Share	
	Dollars	Percent	Dollars	Percent
1981-1982	$ 8,2710,018	411	$ 919,002	412
1982-1983	7,296,076	26	810,675	26
1963-1984	11,002,192	31	1,222,466	31
1984-1985	-1,790,747	-4	-198,972	-4
1985-1986	149,910	.3	16,657	.3
1986-1987	141,283	.3	15,698	.3

Source: Department of Human Services Projections for the F.Y. 1988-1989 Biennium, November 5, 1987.

C. Impact on the Ability of the State to Meet its Consent Decree Bed Reduction Taraeta in Regional Treatment Centers

The Welsch v. Gardebring consent decree required that on July 1, 1987, that no more than 1,850 persons with mental retardation would reside in the State's regional treatment centers. Since the community ICFs/MR were seen as one of the major placement potentials for persons coming out of the regional treatment center there was some concern that the moratorium might have a negative impact on meeting the consent decree reduction targets.

The legislative moratorium had virtually no impact on the State's ability to meet the consent decree reduction targets. In fact, the reduction target of 1,850 persons was met in April 1986 over one year ahead of time. In addition, the Legislative Auditor in his Report on the Deinstitutionalization of Mental Retarded Persons (February 1986) found no evidence that the moratorium had adversely affected compliance with the population reduction requirements of the decree.

Table 8 shows the growth in the number of new ICF/MR beds from 1982 to 1986 and the reduction of clients with mental retardation residing in regional treatment centers. Even though not all clients were transferred to community ICFs/MR, the capacity has been available to meet the needs. (The increase in the number of new beds was due to need determination authorizations prior to the implementation of the moratorium.)

TABLE 8

Change in Community ICF/MR Beds and Reduction in Clients with Mental Retardation Residing in Regional Treatment Centers

C. Y.	Change in Community ICF/MR Beds	Reduction in Regional Center Average Daily Population
1982	+152	-114
1983	+283	-116
1984	+179	-113
1985	+ 82	-175
1986	+ 8	-184
1987	-343	-148

Regional treatment center population reductions have been achieved despite the moratorium primarily because (1) new and existing ICF/MR beds have been used to admit more persons (proportionately) from regional treatment centers than ICF/MR programs which opened prior to 1984 and because more people from regional treatment centers are being discharged to community settings other than ICFs/MR (e.g., to family of foster homes using waivered services).

While progress has been made in the placement of children from regional treatment center into appropriate community settings continues to be an issue. Currently there are 10 to 12 children in state hospitals who need community placement from four counties. These children have conditions which require intensive medical supervision and treatment or require intensive behavior management supervision. Community services have not been readily available for these children due to the long wait to be admitted to existing specialized programs or the lack of development of an appropriate community-based program. While the home and community based waiver is allowing the state to better develop individualized community programs to serve these people, the number of available services is limited. In F.Y 1986 twenty children with severe disabilities were placed in community programs through the use of the home and community-based service waiver.

D. Equity in the Dispersion of Services to Parsons with Mental Retardation

Another goal of the Department has been to develop greater equity in the dispersion of services to community-based persons with mental retardation throughout the State. While over half

of the ICF/MR beds in the state are located in the metropolitan area, the proportion of beds per 10,000 population in Region 11 is just slightly above the State average. As can be seen in Table 9, the number of community ICF/MR beds per 10,000 population varies by region, from 7.6 beds per 10,000 population in Region 5 to 24.5 beds per 10,000 population in Regional 8.

Historically the types and location of ICF/MR beds are frequently maldistributed in relation to the needs of the population. Because some areas of the state have more ICF/MR beds than others there has been a history of persons residing in ICFs/MR outside their home county. Approximately 30 percent of the people served in the community ICF/MR programs are the financial responsibility of a county other than the county in which the facility is located. In addition, the maldistribution of the existing ICF/MR capacity results in "unuseable" beds in relation to the needs of the county or region. The following are example of "unuseable" beds:

We have Class "A" beds where we need Class "B" beds. This is particularly a problem given our lack of success in changing the program of existing A facilities to serve more dependent clients.

° We have large facilities which that are licensed for children when the demand for placement of children in such facilities is down especially in rural areas.

° The State has "B" facilities where this capacity is not needed. Only one-third of the 1300-1400 beds in "B" facilities are occupied by persons who actually require the accessible housing provided by "B" facilities. Table 9 shows the distribution of community ICFs/MR by licensure category, size, and region. As can be seen, there are a disproportionate number of large (17 beds or more) "B" facilities throughout the state. Of the 1,535 Class "B" facilities, 1,133 or 74 percent have 17 beds or greater.

° We have several counties which have no ICF/MR capacity to serve persons with severe handicaps, particularly small ICFs/MR.

The use of waivered services has provided some opportunity to serve persons closer to home. Counties are provided the flexibility needed to develop services targeted to individual needs and keep those persons closer to home. Yet again these services are limited and there may be existing needs for small ICFs/MR to serve those clients with severe handicaps. Table 9 also shows the distribution of waivered services by region. The allocation of waivered services by 10,000 population is more evenly distributed from 2.56 per 10,000 population in Region 3 to 5.28 in Region 8.

TABLE 9

COMMUNITY-BASED ICF'S/MR BEDS AND TITLE XIX WAIVERED SERVICES ALLOCATIONS PER 10,000 POPULATION IN MINNESOTA BY REGION (1987)

REGION	1986 REGIONAL POPULATION	# OF ICF'S/MR BEDS	ICT'S/MR BEDS PER 10,000 POP	# OF WAIVER ALLOCATIONS	WAIVER ALLOC. PER 10,000 POP	ICF'S/MR BEDS & WAIVER ALLOC PER 10,000 POP
REGION 1	94,909	141	14.86	50	5.27	20.12
REGION 2	67,723	96	14.18	30	4.43	18.61
REGION 3	320,875	334	10.41	82	2.56	12.96
REGION 4	208,563	200	9.99	92	4.41	14.00
REGION 5	134,240	102	7.60	48	3.58	11.17
REGION 6	140,946	157	11.14	78	5.53	16.67
REGION 7	377,894	436	11.54	166	4.39	15.93
REGION 8	132,556	325	24.52	70	5.2B	29.80
REGION 9	220.914	250	11.32	85	3.85	15.16
REGION 10	412,952	603	14.60	137	3.32	17.92
REGION 11	2,102,441	2,224	10.58	585	2,78	13.36
	4,214,013	4,868	11.55	1,423	3,38	14.93

••••Data Sources:

a. ICF'S/MR data....Minnesota Department of Health.
b. Title XIX Waivered Services data. . .Minnesota Department of Human Services, Division for Persons with Developmental Disabilities.
c. This data does NOT include ICF's/MR beds in Regional Treatment Centers.

E. Increase In the Use of Existing ICF/MR Beds to Serve More Dependent Clients

Minnesota has provided services to a broad array of individuals including those with mild levels of retardation. According to one national survey, in 1982 Minnesota had the highest proportion of persons with mild to moderate levels of retardation residing in ICFs/MR in the nation. An analysis of data collected in the 1984 Quality Assurance and Utilization Review by Lewin and Associates, showed that about one-third of ICF/HR residents were totally oriented and had no behavior problems.[4] The Legislative Auditor's Report of 1983 included in its recommendations a limit on adding new beds to the system and recommended that existing ICF/HR capacity be used to serve clients with greater service needs.

A great effort has been made to place persons in the community who currently reside in regional treatment centers and who have traditionally been persons with the more demanding service needs. In F.Y. 1986 regional treatment center persons with mental retardation and related conditions was reduced by 209 persons which included 20 children with severe disabilities who were placed in community programs.

While the State has reduced its reliance on the ICF/MR service system including regional treatment centers primarily through the services provided under the Medicaid Home and Community-Based Waiver, the resources available under the waiver are limited especially in serving large numbers of persons with high needs, yet, some parts of the state have not been used waivered services to its full capacity.

The State has also encouraged community ICFs/MR to serve persons with greater service needs through temporary special need rate funding and rate adjustments. There are currently 15 facilities which have either completed or are in the process of completing modifications to their physical plant to serve more dependent persons. Moreover, currently 33 ICFs/MR are receiving additional funds for 92 persons with special needs. Recent revisions in the federal Life Safety Codes governing small ICFs/MR allow greater flexibility to modify their physical plant and enable these facilities to serve persons with greater needs. The Department has modified its funding rules to encourage such modifications and allow these facilities to modify their staffing and programs to serve persons with greater needs. Table 10 shows the number of community based ICFs/MR beds by size of facility, licensure class, and region of location.

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4. Presentation by Lewin and Associates to the 1986 Advisory Committee on Alternative Reimbursement Methods for Providers of Mental Retardation Services, July 16, 1986.

TABLE 10

NUMBER OF COMMUNITY-BASED ICF'S/MR BEDS BY SIZE OF FACILITY AND LICENSURE CLASS, BY REGION IN MINNESOTA (1987)

REGION	*CLASS "A" FACILITIES* < 17 BEDS	17+ BEDS	TOTAL CLASS "A" BEDS	*CLASS "B" FACILITIES* < 17 BEDS	17+ BEDS	TOTAL CLASS "B" BEDS	**COMMUNITY ICF'S/MR BEDS** (BY FACILITY SIZE) < 17 BEDS	17+ BEDS	TOTAL
REGION 1	92	0	92	16	33	49	108	33	141
REGION 2	82	0	82	14	0	14	96	0	96
REGION 3	189	40	229	76	29	108	266	69	334
REGION 4	191	0	191	9	0	9	200	0	200
REGION 5	65	0	60	97	0	37	102	0	102
REGION 6	118	30	145	12	0	12	127	30	187
REGION 7	278	87	365	15	56	71	293	143	436
REGION 8	70	145	215	15	98	110	85	240	325
REGION 9	168	0	168	38	44	82	206	44	250
REGION 10	310	0	310	102	191	293	412	191	603
REGION 11	857	614	1,471	68	688	783	925	1,299	2,224
STATE TOTAL	2,417	916	3,333	402	1,139	1,596	2,819	2,049	4,868

*** Data Source: Minnesota Department of Health. Class "A" and Class "B" are facility

licensure classifications reflecting different Health Department standards. Typically, a facility classified as Class "A" serves persons who can self-pressure and a facility classified as a Class "B" serves persons who cannot self-preserve and are more dependent.

There la a continued need for the state to work with counties and existing small ICFs/MR to change their capacity to serve persons with greater service needs. With the funding mechanisms available (i.e., special need rate funding and rate adjustments), the Department will be more aggressively encouraging counties and small ICFs/MR to systematically change their program to serve persons with greater service needs.

V. RECOMMENDATIOHS

Recommendation 1

That program changes in small community-based ICFs/MR be accelerated to serve the increasing number of persons with severe handicaps needing community-based services, including those persons coming from regional treatment centers. The program changes include rate adjustment increases for more intensive programs and life safety code modifications, changes from a class A to class B facility, and adapting children facilities to serve adults, when feasible. The Department will be more aggressively working with counties and providers to accelerate the number of facilities changing their programs or physical plants.

Recommendation 2

That the additional demands for residential support services for persons with developmental disabilities be met primarily by implementing TEFRA 134 for children, expanding semi-independent living services for adults, providing personal care attendant services, and utilizing foster care arrangements.

The implementation of TEFRA 134 would provide statewide support to families caring for their developmentally disabled child at home without the child having to be in a home and community-based waiver program. Implementing this program would significantly reduce the need for ICF/MR placement or waivered service allocation for children, thereby freeing up existing and additional resources for adults.

Approximately 240 persons in the community are in need of semi-independent living services, but there are not sufficient state funds to reimburse counties for those services, this individuals may lose independent living skill abilities gained through their public education experience if such support services are not made available. The Department will be considering this need as part of their 1989 budget process with input from the Commissioner's Task Force for Persons with Developmental Disabilities.

Moreover, recent federal legislation has made it more feasible for states to secure home and community-based waivers for persons with mental retardation or related conditions requiring placement from nursing homes.

Recommendation 3

That community resources be made available to persons living in ICFs/MR and no longer need that level of care. Currently there are 130 persons in community ICFs/MR or waivered service programs who could be moved to semi-independent living services arrangements if funding were available. This movement has become increasingly important as federal criteria for ICF/MR eligibility has been clarified in August 1987. ICF/MR beds made available because of this movement could then be used for persons inappropriately placed in nursing homes or persons in the community eligible for and needing ICF/MR care.

Recommendation 4

That limited and targeted ICF/MR development be considered to meet the needs of persons with severe handicaps when it has been determined that no other community resources are available. The total number of ICF/MR beds is being reduced significantly. A tightly structured exemption to the ICF/MR moratorium would allow the state and counties to meet the needs of those persons with severe handicaps more consistently throughout the state. This development would be considered only after a county fully utilized their waiver allocations changed their existing ICF/MR capacities to the extent possible and fully utilized semi-independent living services, family subsidies, personal care, and other generic social and medical services.

KESrm