Community Residential Programs for Mentally Retarded Persons

Program Evaluation Division
Office of the Legislative Auditor
State of Minnesota

Program Evaluation Division

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Office of the Legislative Auditor
State of Minnesota

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PREFACE

In June 1982, the Legislative Audit Commission directed the Program Evaluation Division to study community programs for mentally retarded persons. Legislators and others were concerned that the state was not providing an appropriate mix of services. They were also concerned by the growing cost of programs the state has developed.

Our study focused on residential services provided to mentally retarded persons. In this report, we document problems in how state agencies plan and regulate the financing of residential services. However, this report's most important conclusion is that Minnesota has continued to place too much emphasis on long-term residential care. To reduce the population of state hospitals, the state has encouraged development of community residential facilities that are too restrictive and expensive. At the same time, Minnesota has not adequately developed alternative services that could enable retarded persons to live more independently.

We hope that this report will help legislators understand important issues relating to community residential services for the retarded. We also hope that our conclusions and recommendations will help guide policy makers in the legislature and state agencies as they debate these issues.

We were assisted in our study by the full cooperation of the staff in the Department of Public Welfare, Department of Health, and the Department of Energy, Planning, and Development. This study was conducted by Allan Baumgarten (project manager), Jack Benjamin, and Marie Scheer.

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PROGRAM EVALUATION DIVISION

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EXECUTIVE SUMMARY

In recent years, Minnesota has made major efforts to provide residential care to mentally retarded persons in community settings. Nearly 5,000 mentally retarded children and adults now live in more than 300 community residential facilities in all parts of the state.

We evaluated how the state plans, regulates, and finances residential services for retarded persons. Our study examined these questions:

- Has the Department of Public Welfare (DPW) effectively planned and encouraged a mix of residential services for the retarded? Do recently opened facilities meet identified needs?

- Are the mechanisms used to set reimbursement rates for community residential facilities effective in containing costs?

A. MENTALLY RETARDED PERSONS IN MINNESOTA

Various estimates place the number of mentally retarded persons in Minnesota between 35,000 and 125,000. Most are mildly retarded, live independently or with their families, and have little contact with the services that are described and analyzed in this report.

During the 1960s, more than 6,000 retarded persons lived in Minnesota's state hospitals. As in other states, the number of state hospital residents has dropped sharply since then. At the end of 1982, state hospital population was under 2,400. A judicial decree requires further reductions during the next five years.

The locus of residential care for the retarded has shifted from state hospitals to community homes, known as Intermediate Care Facilities for the Mentally Retarded, or ICFs-MR. National surveys have identified Minnesota as the highest state user of community ICF-MR services. In 1977, there were 170 community facilities in Minnesota. By the end of 1982, there were 311 facilities, serving 4,900 children and adults. Although the population of state hospitals continues to decline:

- The total number of mentally retarded persons in long-term care settings--state hospital and community--has increased steadily in recent years.

In 1978, the average population in hospitals and community facilities was about 6,300. By 1982, it had increased to more than 7,100.

Most community facilities, especially newer ones, are small, serving six to twelve residents. A few of the older facilities are quite large; six have more than 100 beds each. The ownership of these facilities is almost evenly divided between non-profit organizations and for-profit providers.

Retarded persons are also served by three other types of residential programs. During 1981, about 1,650 children and adults lived in county-supervised foster care homes. A second program provides semi-independent living services (SILS) to about 600 retarded persons living in their own homes and apartments. Through that program, licensed vendors assist retarded persons with money management, transportation, food preparation, and other needs. Finally, the state provides a monthly subsidy to about 180 families to assist them in caring for their mentally retarded children at home.

About 25,000 mentally retarded persons participate in publicly supported educational and training programs through developmental achievement centers and sheltered workshops and in special education classes. These programs provide mentally retarded persons with training in daily living and employment skills. Education and training programs are briefly described in this report but are not the focus of analysis.

B. PLANNING AND REGULATING COMMUNITY RESIDENTIAL SERVICES

For the past ten years, in a case now known as Welsch v. Noot, the state has been involved in litigation over the services provided to mentally retarded persons in state hospitals. A consent decree in the case requires a major reduction during the next five years in the number of mentally retarded persons living in state hospitals. To meet this mandate, DPW has stressed transferring state hospital residents to community ICFs-MR, and has encouraged development of new ICFs-MR.

At the same time, we found that:

- DPW has not effectively limited new admissions to state hospitals.

The department has paid little attention to screening new admittees and developing alternative community services that would help to avoid institutionalization. As a result, the rate of population reduction in state hospitals has slowed, as the number of discharges declines and new admissions continue.

DPW's efforts to plan residential services for the mentally retarded are inadequate in several areas. For example, in its 1981 Six-Year Plan, DPW calls for development of additional ICF-MR capacity and expansion of other programs. But the plan does not identify needs or service priorities in different areas of the state. Thus, DPW and county boards cannot critically review proposals for new facilities.

In the absence of comprehensive planning, distribution of ICF-MR capacity is uneven. While there are .868 ICF-MR beds per 1,000 population in counties in the Brainerd State Hospital service area, there are more than twice as many beds per 1,000 population in the Willmar State Hospital area.

We also found that alternatives to ICF-MR care are inadequately developed and not widely available in Minnesota. Services such as SILS (Semi-Independent Living Services), professional foster care, and home assistance are less restrictive and less expensive than ICF-MR programs, but they are not widely used. These programs are funded through a combination of state categorical grants and county social service budgets. Because of different funding formulas, it usually costs counties more to use these programs than to place a mentally retarded person in Medicaid-funded community facilities or state hospitals.

Development of new ICF-MR capacity has already exceeded DPW's 1987 goal. But, we found that new facilities are not adequately meeting identified state needs, such as reducing the population of state hospitals. In a survey of recently opened facilities, we found that only 22 percent of the residents come from state hospitals. Most come from family homes or from other community residential facilities.

New facilities are serving only a small number of persons who are very dependent because of mobility or behavior problems. Residents of new facilities are generally no more dependent than residents living in ICFs-MR in 1979.

We therefore conclude that:

- The process by which state agencies plan and regulate new facilities is not effective in meeting state needs.

Development of a new community ICF-MR requires a series of applications and approvals. Several divisions within the Department of Public Welfare and the Department of Health conduct separate reviews of a proposal, as do county boards and regional health planning agencies. Some of the reviews are not well coordinated, resulting in overlapping and sometimes inconsistent decisions. Also, some key issues, such as cost containment, are neglected during these reviews.

During each review, state and local agencies analyze a proposed reimbursement rate that has been approved by DPW. However, the provider may request a higher "interim rate" after the reviews are completed and before the facility begins operation. In the past, DPW has routinely granted such requests. Furthermore, a provider may seek a retroactive "settle-up rate" after the first year of operation, in order to recover higher actual costs. In our analysis of recently opened facilities, we found that:

- The settle-up per diem rate was on average 38 percent higher than the rate seen during the review process.

- The settle-up rate was on average 22.4 percent higher than the interim rate used during the first year of operation.

The Department of Public Welfare, as manager of the state Medicaid budget, must work more aggressively to contain the rates of new facilities.

C. FINANCING COMMUNITY RESIDENTIAL SERVICES

Medicaid pays the costs of residential care for almost all mentally retarded persons living in ICFs-MR. The availability of Medicaid funding has been a major factor in the rapid growth and high utilization of community facilities.

During fiscal year 1982, more than $68 million was spent in Medicaid funds on residential care for the retarded in community facilities. This cost is shared by federal, state, and county governments as follows: 55.6 percent federal, 40 percent state, and 4.4 percent county. Community ICF-MR services are a growing part of the state's Medicaid budget, and now account for nine percent of Medicaid expenditures. State hospitals and community ICFs-MR together account for nearly 20 percent of Minnesota's Medicaid budget.

The Department of Public Welfare sets a reimbursement rate for each ICF-MR through DPW Rule 52. The department establishes prospective per diem rates by examining the historical costs and predictable cost changes reported each year by providers. Although the rule requires consideration of licensing and program requirements in setting rates, Rule 52 does not link rates to resident characteristics or program quality. Instead, reimbursement rates are set on a cost-plus-profit basis.

The average per diem rate in 1982 was $51.71, nearly double the 1978 average. By comparison, the average per diem rate in skilled nursing facilities was $50.32. ICF-MR rates range from a low of $22.87 to a high of $117.00. The per diem rate covers the cost of operating the facility plus an earnings allowance. It does not cover the cost of day activities, such as attending a developmental achievement center. That cost is paid out of the county social service budget. Nor does the per diem rate cover costs of resident medical care, which are paid for elsewhere in the Medicaid budget.

Certain provisions of Rule 52 make it relatively easy for providers to develop new facilities. For example, the rule does not require a minimum capital investment, does not limit reimbursable interest rates on debt, and does not limit the initial per diem rate which can be paid.

D. EFFECTIVENESS OF RULE 52

We analyzed the effectiveness of Rule 52 in achieving state objectives and examined how community facilities might be affected by changes in the rule or in Medicaid reimbursement. Our analysis covered certain categories of costs as well as specific provisions designed to limit rate increases or to reduce Medicaid expenditures. Data reported in this section are based on our analysis of the 1981 cost reports of 238 ICFs-MR.

1. INTEREST AND EARNINGS

Recently opened ICFs-MR have per diem rates that are significantly higher than the rates paid to older facilities. For example, the average per diem rate for facilities opened in the past three years is $55.85, while the average rate for older facilities is $48.23.

Much of this increase is because of increased costs in two categories--earnings and property--and not because of increases in the costs of direct resident care. The rule's earnings allowance attempts to provide a reasonable return on the provider's investment. Property costs include interest payments on debt and depreciation allowance. Property costs have increased because of inflation in construction costs, the extensive use of debt financing, and high interest rates in recent years.

We conclude that:

- Rule 52 does not effectively limit interest expense.

The rule places no limits on interest expense for non-profit providers. While the rule imposes a nominal limit on interest expense for proprietary providers, we found the rule also enables a provider to easily avoid the effect of that limit through an alternative method of calculating the earnings allowance.

To calculate a for-profit facility's rate, the rule presumes that the provider has capital invested equal to 35 percent of the value of the facility's fixed assets, and has debt equal to the remaining 65 percent. Interest expense is allowed only on the presumed amount of debt. An earnings allowance is calculated to provide a ten percent, after tax, return on the presumed capital investment.

However, most facilities are heavily debt-financed, and few providers actually have 35 percent capital investment. In fact, some facilities are indebted in excess of the value of their fixed assets. As a result, many providers are better served by an alternative method of calculating the earnings allowance. Under that method, known as the minimum cost of capital, a provider receives an allowance for each resident day, plus all disallowed interest expense.

Our analysis showed that many providers incurred large amounts of disallowed interest, but were able to recover their expense through the minimum cost of capital allowance.

We found two important problems in this area:

- Because there are no effective limits on interest expense, a provider has no incentive to negotiate a lower interest rate, to delay development in a time of high interest rates, or to invest personal capital and reduce debt.

- Because the state pays an earnings allowance based on presumed equity or based on disallowed interest, the allowance bears no relationship to a fair return on actual capital invested. The rule discourages provider investment.

We therefore recommend that:

- DPW should revise Rule 52 to establish effective limits on reimbursable interest expense.

This might include setting limits on interest rates or limiting the amount of debt on which interest expense can be recovered.

We also recommend that:

- DPW should revise Rule 52 to pay an earnings allowance that is based on actual capital investment, and that encourages and rewards investment.

2. EQUITY AND LONG-TERM FISCAL SOLVENCY

Because Rule 52 does not require any capital investment by a provider, most new facilities are largely debt-financed. Of facilities opened in 1981, none had the presumed equity of 35 percent, and only two had 25 percent equity. Several facilities were indebted above the value of their fixed assets.

The Department of Health and other state agencies are concerned that low equity increases property costs and per diem rates, burdens a provider with high fixed costs, and limits flexibility to deal with possible reductions in occupancy or Medicaid reimbursement. The Department of Health has raised these questions in its review of recent applications for Certificates of Need to develop new ICFs-MR.

We analyzed these issues through a series of simulations and concluded that:

- Large amounts of debt financing do increase ICF-MR per diem rates, and increased equity reduces them.

But the reduction is not large, averaging about $.50 for each $10,000 of added equity. Also, increased equity does not usually provide a better return to the provider.

We also found that:

- Highly debt-financed facilities are particularly vulnerable to reductions in Medicaid reimbursement.

Under the current system, most facilities can anticipate positive cash flows for the next twenty years. However, cash flows become low in the sixth to eighth years of operations, and remain positive only if the provider incurs debt to finance the purchase of new furnishings and equipment.

If the state reduced reimbursement, as it did for the first half of 1983, a heavily indebted facilty would soon face negative cash flows. In order to continue to make debt payments, the provider would have to invest additional capital. Or, the provider may seek to sell or refinance the facility. In our analysis, we noted that facilities with less debt are in a much better position to handle temporary or sustained reductions in reimbursement.

3. CAPS AND PAYMENT REDUCTIONS

The state has limited ICF-MR reimbursement in two important ways. First, the state imposed caps on annual rate increases in per diem rates. Until June 30, 1983, such increases are limited to ten percent. Second, the state imposed a temporary four percent reduction in reimbursement to Medicaid providers, which is due to expire at the same time.

We found that:

- The ten percent cap has been effective in limiting rate increases.

In our analysis, average rates for 1982 increased 9.5 percent over 1981, to $50.44. Our analysis showed that if there had not been a ten percent cap, the average rate would have increased 14 percent, to $52.56. If the state continues to impose a cap of ten percent or less, then savings will accumulate, since a lower rate in one year becomes the base for the next year.

We also found that:

- Reductions in reimbursement could have a more significant effect than caps.

The current four percent reduction cuts directly into a provider's cash flow. If the reduction were continued for more than six months, it would affect the solvency of many providers, particularly those who already face financial problems.

Both caps and payment reductions are effective ways of limiting the state's Medicaid budget. But because they affect facility revenues across-the-board, they may hurt an efficient provider more than an inefficient one. Furthermore, the limits do not distinguish

between costs of direct resident care and other costs, such as property or administration. Caps discourage providers from modifying their programs or facilities to meet state needs. Finally, they may also encourage the development of new facilities, whose initial rates would not be limited by the caps.

Nevertheless, Rule 52, by itself, is ineffective in containing ICF-MR rates. We therefore recommend that effective July 1, 1983:

- The Legislature and DPW should impose a cap on rate increases of no more than ten percent, based on anticipated inflation rates.

We also recommend that:

- The Legislature and DPW consider the use of caps on reimbursement for specific cost categories, such as administration.

4. INCENTIVES

Rule 52 rewards providers who maintain high occupancy rates. If occupancy exceeds 93 percent, the provider benefits from an increased per diem rate. In 1982, this incentive added $0.77 to the average per diem rate. In some cases, though, the provider did not benefit from the incentive because the rate increase was limited by the ten percent cap.

Occupancy in ICFs-MR has traditionally been high and currently averages 97 percent. We question whether DPW needs to pay a premium to reward high occupancy and recommend that at least the premium be reduced.

5. LEASES

A growing number of residential facilities are operated through lease arrangements. We found that the language of Rule 52 is not consistent with Generally Accepted Accounting Principles and does not protect the state's interests. For example, the state may be asked to pay twice for certain property costs when a provider purchases a facility that he or she previously leased. In Chapter III we recommend changes in Rule 52 that would better protect the state's interests in lease arrangements.

E. ADMINISTRATION OF RULE 52

Department of Public Welfare auditors are responsible for reviewing a facility's annual cost report and setting rates for the following year. We found two problems in this area. First, Rule 52 limits reimbursement to "reasonable costs," but this term is poorly

defined in the rule and is somewhat arbitrarily enforced by DPW. Second, DPW adjusts cost reports and a provider's proposed rate without adequately documenting the justification for the change.

The absence of documentation hampers the department's efforts to resolve rate appeals prompted by such adjustments. DPW faces a growing backlog of rate appeals, but has inadequate information about the issues to be resolved and about the state's potential liability in each case. In Chapter III we offer a series of recommendations designed to make rate-setting more predictable and to resolve the appeals backlog.

F. POLICY OPTIONS

In our view, the state relies too heavily on ICFs-MR for residential care for retarded persons. Alternatives that are less expensive and less restrictive have been largely neglected. We recommend that the Legislature consider a series of policy changes that would provide opportunities for mentally retarded persons to develop and live more independently.

The Legislature should:

- Increase the availability and use of alternatives to ICF-MR care, including SILS, professional foster care, and family assistance programs.

We present our views in Chapter IV on how these programs can be strengthened and provided with more stable funding. Various estimates suggest that ten to twenty percent of current ICF-MR residents could benefit from SILS or other programs.

We also recommend that:

- The Legislature and DPW should encourage existing facilities to serve more dependent clients.

If alternatives to long-term residential care were available, then existing capacity could be used to serve more dependent persons. State licensing and reimbursement systems should be modified so that providers are encouraged to change their facilities as needed to serve persons now in state hospitals or who may be at risk of entering a hospital.

Finally, we recommend that:

- DPW and the Legislature should limit development of new facilities.

New development should be allowed only to meet very specific, targeted priorities, and where those needs cannot be served within existing facilities or through alternative services.

INTRODUCTION

During the last 20 years, the number of mentally retarded people in Minnesota's state hospitals has fallen from 6,100 to 2,400. At the same time, the state has made major efforts to provide residential care to mentally retarded persons in community settings. Legislators and others have asked if the state is developing an appropriate array of community residential services. They have also expressed concerns over the growing costs of some of those services.

The Program Evaluation Division has conducted an evaluation of community residential programs for the mentally retarded. We studied the activities of state agencies who are responsible for planning, regulating, and financing these programs.

This report presents the results of our study. Chapter I provides descriptive information on mentally retarded persons in Minnesota and the programs that serve them. Chapter II presents our analysis of how state agencies plan and regulate community residential programs. Chapter III examines DPW Rule 52, the mechanism used to set reimbursement rates for providers of residential services. Finally, Chapter IV analyzes policy questions about the state's role in providing residential services, and presents a series of recommendations. A glossary of terms and a table presenting statistics about services available in Minnesota's counties are appended to this report.

I. MENTALLY RETARDED PEOPLE IN MINNESOTA: CHARACTERISTICS, SERVICES, AND FUNDING

This chapter describes mentally retarded people in Minnesota--where they live, learn, and work. The chapter reviews the major residential and developmental services for mentally retarded people and funding for these services. We present evaluation findings, conclusions, and recommendations in later chapters.

Attitudes about and programs for mentally retarded persons have changed dramatically in recent years. The number of persons in institutions (state hospitals) has declined as more retarded persons remain with their families or reside in residential facilities in community settings. Opportunities in the community for education and development have increased, and a significant number of mentally retarded persons learn basic living and employment skills close to where they live. The cost of residential and developmental services, not including special education classes, was more than $175 million in 1982.

A. WHO ARE MINNESOTA'S MENTALLY RETARDED PEOPLE?

1. DEFINITION OF MENTAL RETARDATION

According to the American Association on Mental Deficiency, mental retardation is "subaverage general intellectual functioning which originates during the developmental period and is associated with impairment of adaptive behavior."[1] This definition is widely accepted in the field of developmental disabilities.[2] It contrasts with common opinions of the nineteenth century, which viewed mentally retarded persons as subhuman, a menace to society, objects of pity, or diseased people.[3]

Intelligence tests determine different levels of retardation. Table 1 depicts ranges in measured intelligence and associated levels of mental retardation, based on a test commonly used in Minnesota and elsewhere.

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[1]President's Committee on Mental Retardation, Mental Retardation: The Known and the Unknown, February 1975, p.2.

[2]Department of Public Welfare Rule 34, which provides licensing standards for residential facilities for mentally retarded people, incorporates this definition of mental retardation.

[3]Phillip Roos, Trends in Residential Institutions for the Mentally Retarded, the University Council for Educational Administration, pp. 2-4.

TABLE 1

LEVELS OF MENTAL RETARDATION

Level of Mental Retardation	Stanford-Binet Score
Borderline	69 - 84
Mild	52 - 68
Moderate	36 - 51
Severe	20 - 35
Profound	19 and below

Source: President's Committee on Mental Retardation, Mental Retardation: The Known and The Unknown, February 1975, p.5.

2. PREVALENCE OF MENTAL RETARDATION

The prevalence of mental retardation is a measure of the number of mentally retarded people in a given population, and is important in estimating the need for services. Nevertheless, expert estimates of the prevalence of mental retardation in Minnesota vary widely, depending on which definition is used. In Figure 1 three frequently used estimates of prevalence are applied to 1980 census data for Minnesota.[4] They yield estimates that range from 36,700 to 122,300.

The highest estimates include a large number of people who are mildly retarded and who live independently. The only firm data are on those mentally retarded people aided by public services. Approximately 25,000 mentally retarded people in Minnesota receive some form of residential or developmental service through a public agency.

[4]Census data for 1980 show Minnesota's total population to be 4,077,148, and the state's school age population to be 1,029,860.

FIGURE 1

PREVALENCE AND POPULATION
OF MENTALLY RETARDED PERSONS IN MINNESOTA

	Estimated Prevalence of Mental Retardation		Estimated Number of Mentally Retarded People in Minnesota
1.	Conley: Three percent of the total population are retarded, with variations related to socio-economic factors.*	1.	122,300, including 30,900 of school age.
2.	Bock: Three percent of school age children and 1.2 percent of adults may need some attention from public service agencies.**	2.	63,800, including 30,900 of school age.
3.	Baroff: 0.5 percent of the total population are mildly retarded, and 0.4 percent are moderately to profoundly retarded.***	3.	20,400 mildly retarded and 16,300 moderately to profoundly retarded, of all ages.

*Conley in President's Committee on Mental Retardation, Mental Retardation: The Known and the Unknown, February 1975, p.12.

**Mental Retardation Program Division, Department of Public Welfare.

***George S. Baroff, "Predicting the Prevalence of Mental Retardation in Individual Catchment Areas," Mental Retardation, vol. 20, no.3, June 1982, p.134.

B. WHERE DO MENTALLY RETARDED PEOPLE LIVE?

The majority of mentally retarded persons in Minnesota live either in their own homes or with their families. Approximately 7,100 mentally retarded people live in community settings which are licensed and supported by public agencies. The state administers a variety of programs to help mentally retarded persons maintain independent, non-institutional living, and to pay families for certain costs of home care for their mentally retarded children. Mentally retarded persons still in state hospitals are generally more dependent and disabled than those living in the community.

1. STATE HOSPITALS FOR MENTALLY RETARDED PERSONS

The first residential facility for mentally retarded people in the United States was established in Massachusetts in 1848.[5] Within thirty years similar institutions, now called state hospitals, were built in most other states. According to one authority, this earliest phase in the development of state hospitals was one of optimism and habilitative efforts, in which these institutions tried to prepare mentally retarded persons for a return to society.[6] By the 1880s, this philosophy had changed to one of protecting mentally retarded people from society. From 1880 until 1925, the focus was reversed, and state hospitals were viewed as custodial warehouses necessary to protect society from mentally retarded persons. The role of these public institutions has changed since 1925, as attitudes about dependent populations have changed. For example, during the last two decades there has been increased concern about the quality of state hospital care, and about the types of mentally retarded persons who should be served in state hospitals.

The number of mentally retarded persons in state hospitals in this country increased from 2,429 in 1880 to a peak of nearly 195,000 in 1967.[7] Figure 2 illustrates national population trends in institutions since 1880, and shows that the number of mentally retarded persons in state hospitals fell to approximately 140,000 by 1980.

The population of mentally retarded persons in Minnesota's state hospitals has followed a similar pattern. Figure 3 shows that this population reached a peak of nearly 6,100 in 1963, and decreased to 2,371 by 1982. Note that the decline in Minnesota's institutionalized populations has been much more dramatic for mentally ill than for mentally retarded persons.[8]

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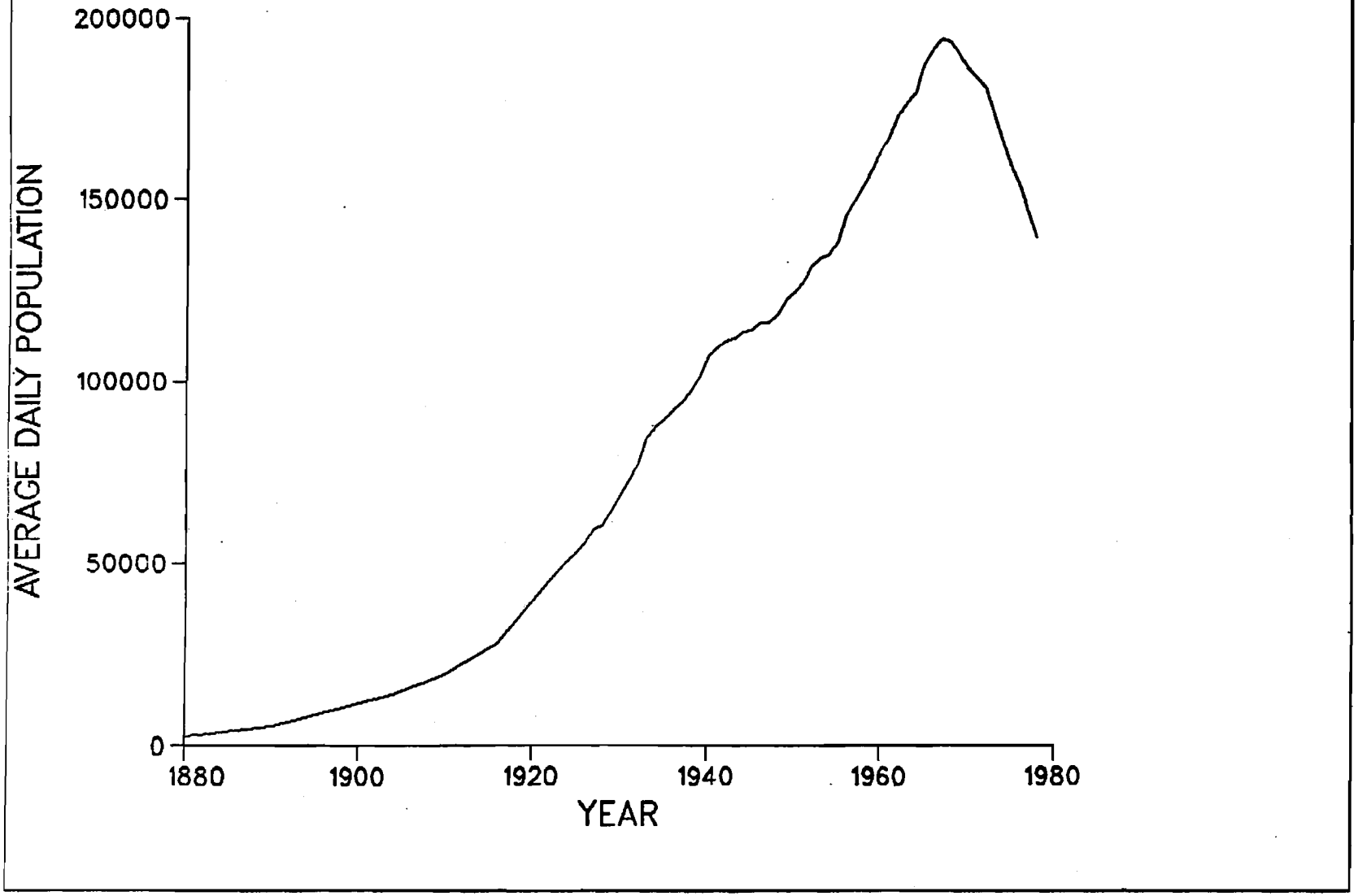
[5] K. Charlie Lakin, Demographic Studies of Residential Facilities for the Mentally Retarded, University of Minnesota, p. 1.

[6] Roos, Trends in Residential Institutions, pp. 2-3.

[7] Lakin, Demographic Studies, p.70.

[8] Research and Statistics Division, Department of Public Welfare.

FIGURE 2
U.S. STATE HOSPITALS:
MENTALLY RETARDED RESIDENTS
1880–1980



Source: Lakin, p. 70.

In 1980, Minnesota had 66 mentally retarded persons in state hospitals for every 100,000 general population.[9] This rate was slightly above the national average. North Dakota had the highest rate, more than double that of Minnesota.

2. DEINSTITUTIONALIZATION

The decline in institutional populations is consistent with the development known as deinstitutionalization, whereby fewer persons enter state hospitals, those entering stay for shorter periods, and many long-term residents are discharged. Normalization is a companion philosophy, which holds that mentally retarded persons should be provided the most normal, least restrictive settings for their daily living, learning, and working routines.

A major impetus for deinstitutionalization in Minnesota was the court case known as Welsch v. Likins.[10] (The name of the case was changed to Welsch v. Dirkswager in 1977 and to Welsch v. Noot in 1979 to reflect changes in the administration of DPW). This was a class action suit brought in 1973 by six mentally retarded residents of Minnesota's state hospitals. On February 15, 1974, the U.S. District Court held that mentally retarded persons committed to Minnesota state hospitals have a constitutional right to minimally adequate care, in the least restrictive setting. The court also held that certain conditions at Cambridge State Hospital violated constitutional rights under the cruel and unusual punishment clause and the due process clause.[11] An order issued on October 1, 1974, imposed 27 standards affecting operations at Cambridge, including these six requirements:

(1) use of services in the community before admitting persons to Cambridge;

(2) achievement of specified staff-resident ratios;

(3) development of individual treatment plans;

(4) changes to the physical plant;

(5) limits on the use of seclusion and restraints; and

(6) a written plan for the orderly placement in the community of all appropriate Cambridge residents.

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[9] Gordon C. Krantz, Robert H. Bruininks, and Jane L. Clumpner, Mentally Retarded People In State-Operated Residential Facilities: Year Ending June 30, 1980, December 1980, p. 43.

[10] Welsch v. Likins, 373 F. Supp. 487 (D. Minn., 1974).

[11] Welsch v. Likins, United States District Court, District of Minnesota, No. 4-72-Civ. 451, October 1, 1974.

In December 1977, the state and the plaintiffs in the case reached an agreement, known as a consent decree, which further clarified staffing and program requirements at Cambridge.[12] A September 1980 consent decree covered all state hospitals serving Minnesota's mentally retarded people.[13] This agreement imposed on DPW more than one hundred requirements, including the following:

(1) a scheduled reduction in the number of mentally retarded persons in state hospitals from 2,650 to 1,850 by July 1, 1987;

(2) limits on new admissions;

(3) specified staffing ratios;

(4) changes in resident treatment;

(5) a request by DPW for state funding for the expansion of various services in the community; and

(6) funding of a court monitor.

From 1977 to 1982 Minnesota had programs for mentally retarded people at eight state hospitals. Table 2 shows that the number of mentally retarded persons in these institutions decreased by nearly 20 percent between 1978 and 1982. Faribault has the largest program, serving nearly one-third of the mentally retarded people in Minnesota state hospitals. State hospitals provide room and board, daytime activities, training in basic living skills, and medical care.

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[12] Welsch v. Dirkswager, United States District Court, District of Minnesota, No. 4-72-Civ. 451, December 28, 1977, p. 2.

[13] Welsch v. Noot, United States District Court, District of Minnesota, No. 4-72-Civ.451, September 1980.

TABLE 2

MENTALLY RETARDED PEOPLE
IN MINNESOTA STATE HOSPITALS
(Average Daily Populations)

	1978	1979	1980	1981	1982
Brainerd*	511	470	440	396	366
Cambridge	576	553	527	510	514
Faribault	856	833	807	774	764
Fergus Falls	288	282	278	268	259
Moose Lake	143	141	133	129	119
Rochester**	151	149	153	129	--
St. Peter	208	191	192	184	186
Willmar	162	161	158	158	163
Total	2,895	2,780	2,688	2,548	2,371

Source: Residential Facilities Division, Department of Public Welfare.

*Includes Minnesota Learning Center.

**Closed July 1, 1982.

3. COMMUNITY RESIDENTIAL FACILITIES

As state hospital populations have declined, the number of mentally retarded people living in community-based intermediate care facilities for the mentally retarded (ICFs-MR) has increased.[14] These are residential facilities licensed by DPW and the Department of Health, and certified as Medicaid providers.[15] They provide room and board,

[14]In this report, we use the terms community residential facility and ICF-MR interchangeably. It should be noted that Minnesota's state hospitals are also certified as Medicaid-eligible ICFs-MR, and that two community facilities licensed by DPW are not certified as ICFs-MR.

[15]Medicaid originated in 1965 amendments to the Social Security Act, and pays for specific medical and ancillary services to needy recipients. Counties implement the program through requirements in federal and state laws and regulations. Medicaid is also known as Medical Assistance or Title 19.

and arrange for other services such as medical or dental care, and speech or physical therapy. They do not provide day programs for their residents. DPW licensing rules require such activities to be provided outside the facility.

The number of certified community residences in Minnesota grew dramatically in the mid-1970s. Before 1970 there were six licensed residences; in January 1983, there were 311, with capacity for 4,900 residents. Figure 4 shows that DPW licensed 46 new facilities in 1976 alone. There are certified community residences in all regions of Minnesota with more than 40 percent located in the Minneapolis-Saint Paul region.[16]

Approximately 55 percent of Minnesota's ICFs-MR are for-profit operations. Some providers, both for-profit and non-profit, operate systems of facilities. Twenty providers, out of a total of 151, own facilities with capacity for 2,300 persons, nearly one-half of statewide capacity.[17] The largest provider operates 27 facilities with capacity of 520.

Figure 5 shows that even as state hospital population has declined, the total number of mentally retarded persons in long-term care settings--state hospital and community--has increased steadily in recent years. In 1978, the average population in hospitals and community facilities was about 6,300. By 1982, it had increased to more than 7,100. There are now nearly 4,800 persons in community residences, 116 per 100,000 general population. On a per capita basis, Minnesota relies on certified community facilities more than any other state.

Certified community residences serve an average of 16 persons each and 75 percent of facilities have 16 or fewer residents. These facilities are licensed as either Class A or Class B residences, depending on the self-preservation skills of their occupants--Class B facilities serve more dependent populations. Minnesota's certified community residences serve mentally retarded people of all ages, and all degrees of impairment. There are approximately 500 children and nearly 4,300 adults in community residences.

4. CHARACTERISTICS OF RESIDENTS

Mentally retarded persons still in state hospitals are much more dependent and disabled than those now in community facilities. Nearly 90 percent of mentally retarded persons still in state hospitals are severely or profoundly retarded, compared to 40 percent of those now in community facilities.

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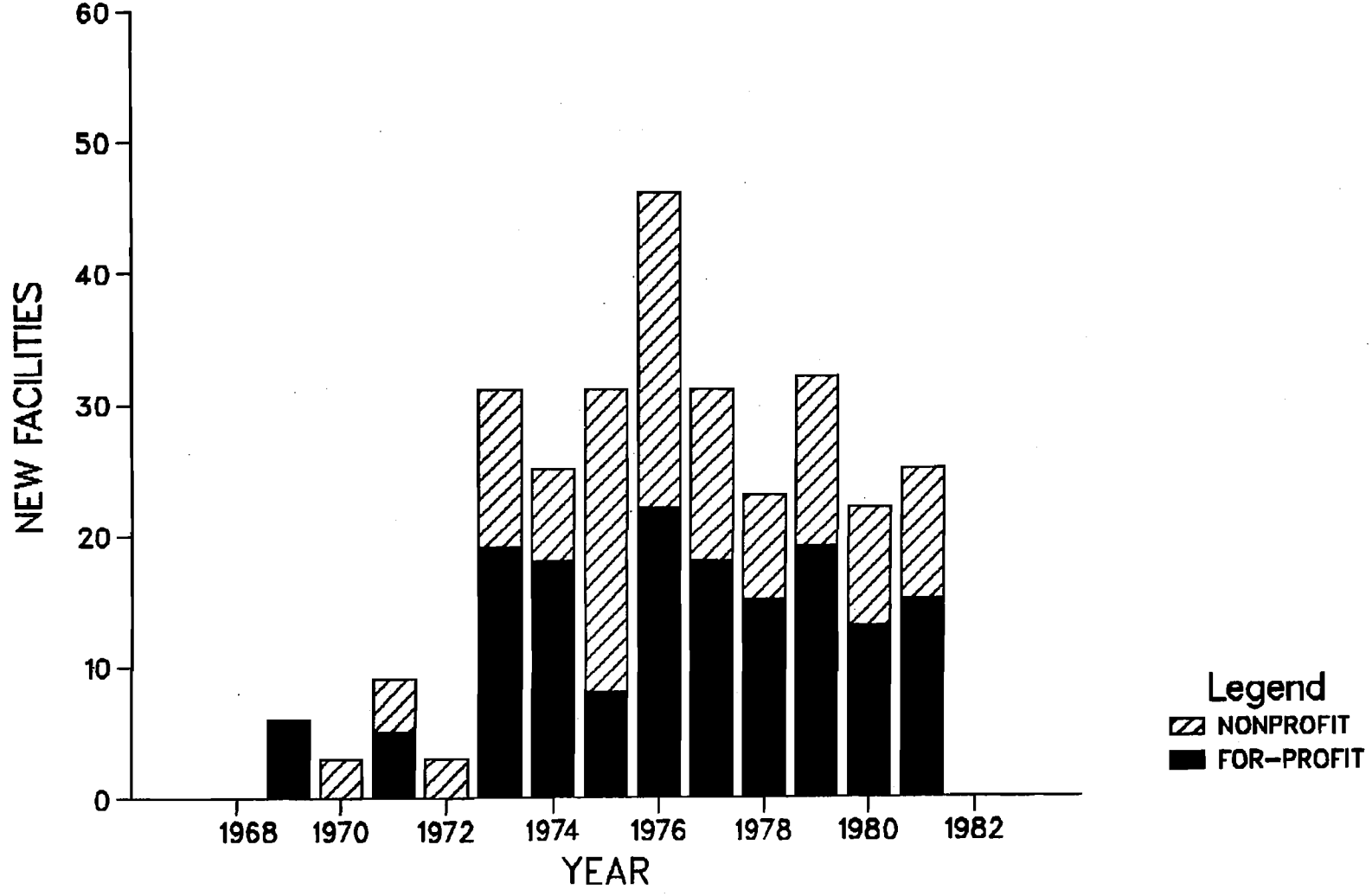
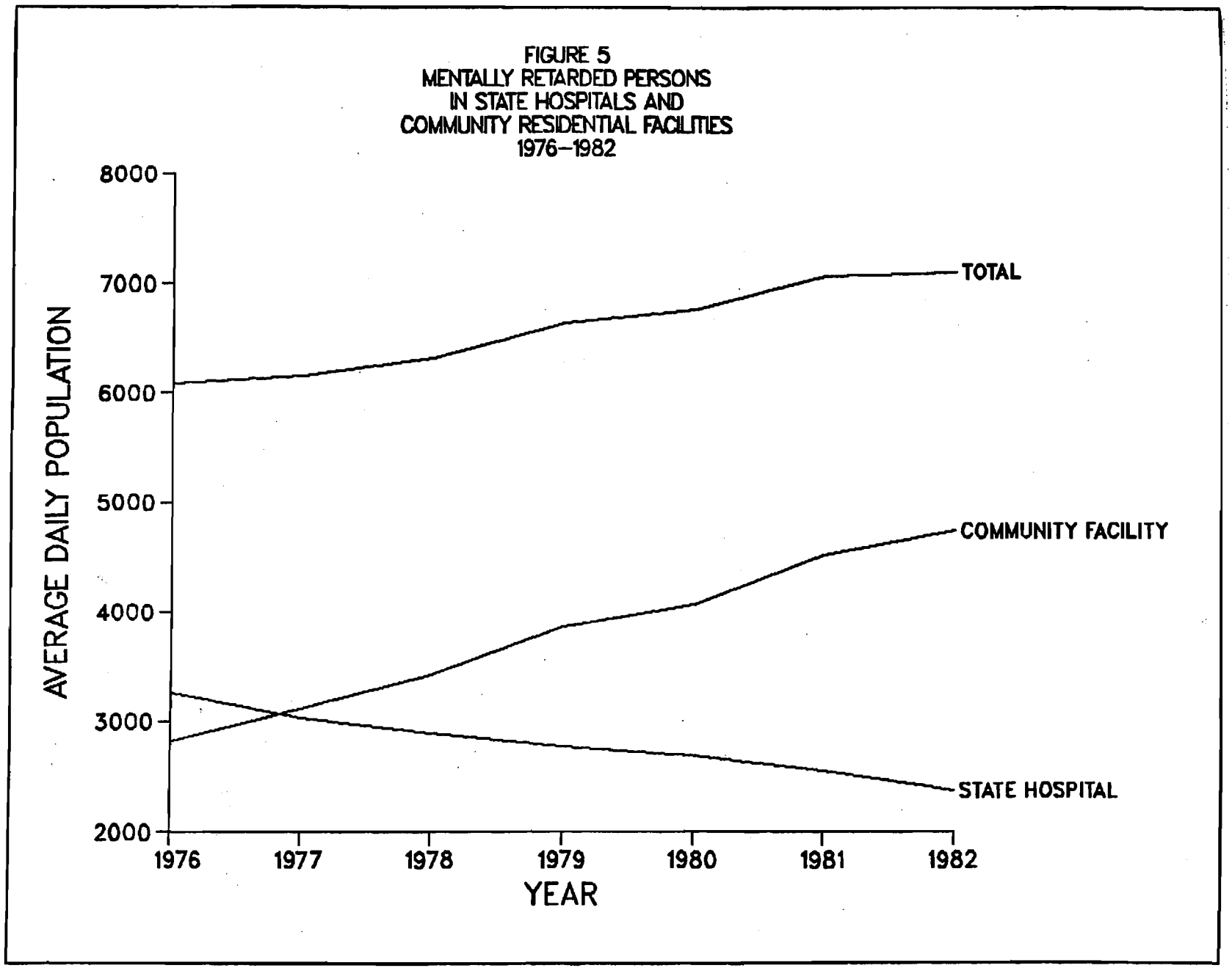
[16]We discuss geographical distribution of services in Chapter 2.

[17]Mental Retardation Program Division, Department of Public Welfare.

FIGURE 4
DEVELOPMENT OF COMMUNITY RESIDENTIAL FACILITIES
FOR MENTALLY RETARDED PERSONS
1969–1981



Source: Licensing Division, Department of Public Welfare.



Source: Social Services Division, Department of Public Welfare.

Figure 6 and Table 3 are profiles of mentally retarded persons in state hospitals and community facilities.

5. OTHER RESIDENTIAL PROGRAMS

The discussion so far has concentrated on two residential settings--state hospitals and certified community facilities. However, three residential programs serve about 2,300 mentally retarded persons who live independently, with their families, or in foster care arrangements.

a. Semi-Independent Living Services

Semi-independent living services (SILS) are provided by licensed vendors or county social service agencies to mentally retarded persons living in their own homes or apartments, often shared with other retarded people. The SILS provider helps with money management, transportation, food preparation, or other activities, depending on each participant's need. The goal is to support the SILS client in whatever manner is necessary to maintain independent functioning and to reduce the need for institutional placement. The state and participating counties fund and administer SILS. The legislature first appropriated funds in 1981, although several counties had previously developed their own programs. In fiscal year 1982, 30 licensed vendors served 652 clients. DPW estimates that nearly 500 more persons could have benefited from SILS during that year. Total SILS expenditures were $1.2 million in 1982, with 48 percent state and 52 percent county funding.[18]

b. Family Subsidy

A subsidy is available to a small number of families who care for their mentally retarded children at home. DPW pays families up to $250 per month for certain costs of home care for mentally retarded children who are at risk of placement in a state hospital or certified community facility. Reimbursable expenses include medical equipment, child sitting, respite care, transportation, and special diets. Families apply to county social service agencies, and DPW selects participants based on severity of handicap, need, and potential for development. Eligibility is not related to family income or county of residence. Approximately 60 counties participate.

The program is entirely state-funded, except for county administrative costs. The family subsidy program began in 1976, with an appropriation of $150,000 for 50 participating families. In 1982, an appropriation of $398,200 supported 150 families. There is a waiting list of 80 families, which DPW expects will more than double in fiscal year 1983.

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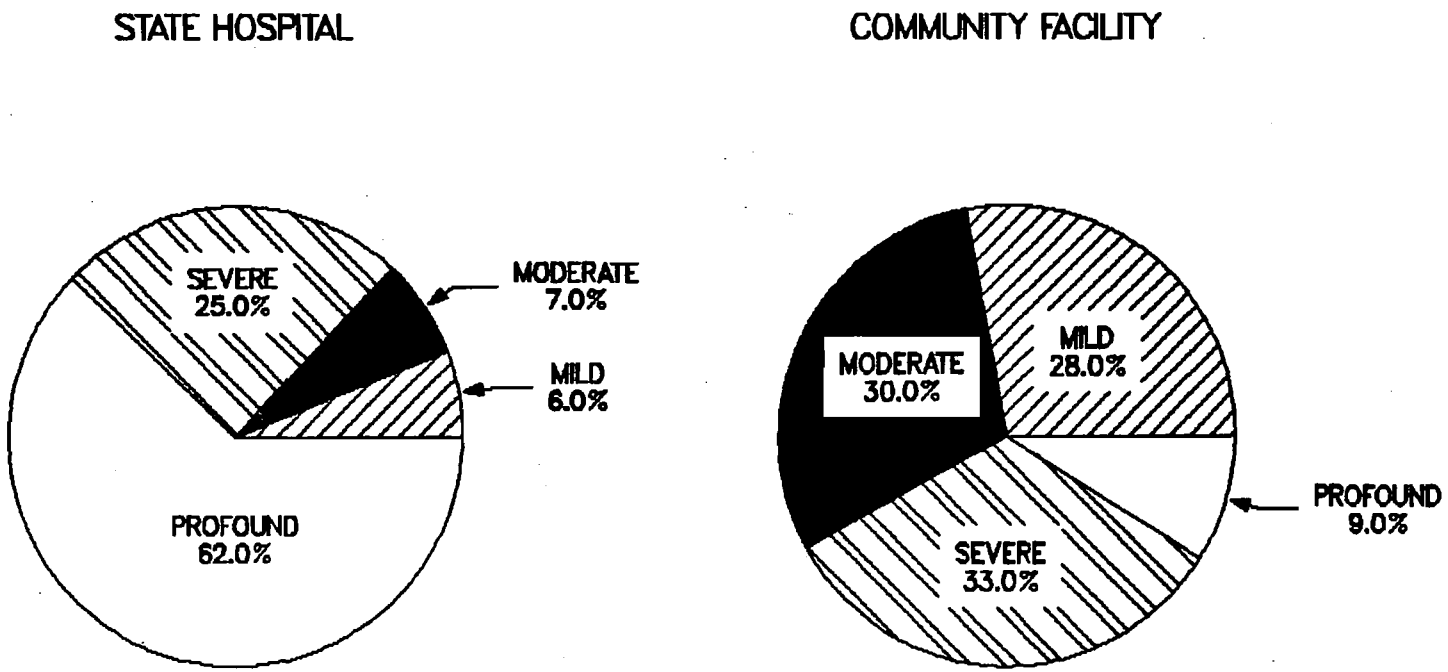
[18] These figures do not include housing and food costs for SILS clients, which are generally paid by Supplemental Security Income (SSI), Minnesota Supplemental Aid (MSA), Social Security Disability, or earnings. See Table 5 on page 22.

FIGURE 6
FUNCTIONING LEVELS OF MENTALLY RETARDED PERSONS 1979



Source: Quality Assurance and Review, Department of Health, 1979.

TABLE 3

DAILY LIVING SKILLS OF MENTALLY RETARDED PERSONS
1979

	State Hospital	Community Facility
Grooming		
Normal	9%	41%
Some Impairment	42	53
Total Impairment	49	6
Eating		
Normal	31	79
Some Impairment	53	20
Total Impairment	16	1
Behavior		
Normal	17	48
Some Impairment	35	39
Total Impairment	48	13
Toilet Training		
Normal	43	84
Some Impairment	29	11
Total Impairment	28	5

Source: Quality Assurance and Review, Department of Health, 1979.

c. Foster Care

Foster care homes provide children or adults with alternatives to their own homes, or to other living arrangements. Providers offer household services in a family-living situation, to a maximum of four adults or seven children. The Department of Public Welfare licenses foster care homes for children under DPW Rule 1, and some counties certify foster care homes for adults under DPW Rule 51.[19] For calendar year 1981, 50 counties reported providing foster care services to 1,653 mentally retarded persons--761 adults and 892 children.[20] State support for foster care is included in social services block grants to counties. Many foster home residents pay for room and board through Supplemental Security Income or Minnesota Supplemental Aid.

C. WHERE DO MENTALLY RETARDED PEOPLE LEARN?

Residential care is only one of many services which mentally retarded persons may need. Others include training in daily living skills, special education programs, work activities, transportation, and health care. Table 4 shows that more than 25,000 mentally retarded people received developmental services in 1982.[21]

1. SPECIAL EDUCATION

Since 1971, Minnesota law has required every school district to ensure that "all handicapped children are provided with the special instruction and services which are appropriate to their needs."[22] State law requires school districts to provide special instruction for all handicapped students between ages 4 and 21; and authorizes districts to provide special education for pre-school handicapped children, or trainable mentally retarded students through age 25.[23]

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[19]12 MCAR §2.001, and 12 MCAR §2.051.

[20]Social Services Bureau, CSSA Effectiveness Report, Department of Public Welfare, 1981.

[21]The figures may double-count recipients of more than one service.

[22]Minn. Stat. §120.17, Subd. 3a.(a).

[23]Minn. Stat. §120.17, Subd. 1 and 1a. Subd. 1a, authorizing classes for trainable mentally retarded persons from ages 21 through 25, expires June 30, 1983.

TABLE 4

DEVELOPMENTAL SERVICES FOR MENTALLY RETARDED PERSONS
FISCAL YEAR 1982

	Number of Programs	Enrollment
Special Education -- School Districts	a	15,135
Day Programs -- State Hospitals	135	1,900
Developmental Achievement Centers -- Community	144	4,300 adults 1,475 children
Work Activity Centers	28[b]	1,300
Sheltered Workshops	28[b]	1,600

Sources: Department of Education, 1981-83 Proposed Biennial Budget. Developmental Disabilities Planning, Policy Analysis Series, 1981 and 1982.
Department of Public Welfare, Six Year Plan of Action.
Licensing Division, Department of Public Welfare.
Division of Vocational Rehabilitation, Background Information on Minnesota's Long-Term Sheltered Employment/Work Activity Program, Department of Economic Security, May 1982.

[a]Each of the state's 437 school districts must ensure that all handicapped children receive special education.

[b]Plus affiliated satellites.

Rules of the State Board of Education require that school districts provide:

(1) access to a free appropriate public education;

(2) use of the least restrictive classroom setting;

(3) individual educational plans;

(4) procedural safeguards;

(5) parental involvement; and

(6) appropriate physical facilities.[24]

Federal laws and regulations from the mid-1970s contain similar requirements.[25]

The State Department of Education reported that on December 1, 1981, there were 10,357 persons in classes for the educable mentally retarded and 3,729 persons in classes for the trainable mentally retarded.[26] Many consider special education to be a significant development for mentally retarded children, which has ensured appropriate education, raised expectations, and provided more normal daily routines.

2. DEVELOPMENTAL ACHIEVEMENT CENTERS

Prior to legislation requiring schools to provide special education, many retarded children attended day activity centers, now known as developmental achievement centers (DACs).[27] These centers now provide developmental training to many pre-school and adult mentally retarded persons who live in the community.[28] DACs teach basic living skills, such as eating and grooming; offer training for independent functioning, such as job readiness and the use of public

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[24] 5 MCAR §§1.0120-1.0129.

[25] P.L. 94-142, 20 U.S.C. §§1401, 45 C.F.R. §121 a.1, and 45 C.F.R. §84.33.

[26] State Department of Education, Special Education Unduplicated Child Count, December 1, 1981. These figures do not include 391 mentally retarded persons at state hospitals who are the responsibility of local education agencies, and do not include trainable mentally retarded students ages 21 through 25.

[27] State law first authorized DACs in 1961.

[28] DAC participants live in certified community facilities (41 percent), foster homes (5 percent), nursing homes (5 percent), or with their families (46 percent).

transportation; and provide enrichment opportunities. Each participant's program follows an individual plan. Most DACs operate during normal school hours--six hours a day, five days a week. The Department of Public Welfare licenses the centers under DPW Rule 3, and county boards have primary responsibility for their funding. There were 144 licensed DACs in 1982, with a capacity of 5,800. All DACs are owned by non-profit organizations.

3. DAY PROGRAMS AT STATE HOSPITALS

State hospitals provide day programs for their residents similar to developmental activities offered by community DACs. Residents leave their immediate living areas and go to their day activities locations on each state hospital campus. Programs run five days a week, six hours a day--a pattern corresponding to that of community DACs and schools.

4. WORK ACTIVITIES

Sheltered workshops and work activity centers provide employment and training to handicapped workers, including mentally retarded persons. Federal regulations authorize these workshops and centers to employ persons whose handicaps prevent competitive employment and to pay these workers less than the minimum wage.[29] Under state law sheltered workshops are to provide employment for rehabilitation purposes or when opportunities do not exist in competitive employment.[30] Work activity centers emphasize the development of basic vocational skills, while providing limited wages. In 1982, there were 28 private non-profit workshops and activity centers, employing approximately 2,900 mentally retarded persons. State appropriations subsidize these operations, and the Commissioner of Economic Security monitors their compliance with various standards. Utilization of these centers stays near 100 percent.

D. FUNDING PROGRAMS FOR MENTALLY RETARDED PEOPLE

Approximately 10,000 mentally retarded persons received publicly-supported residential or developmental services in 1982, not including special education. Total costs which can be attributed directly to care for mentally retarded people were more than $175 million in 1982, and residential care required 75 percent of this total. Table 5 lists major categories of residential and developmental services, with levels of participation and expenditure.

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[29] 29 U.S.C. §201, 29 U.S.C. §214 (a), 29 C.F.R. §525.

[30] Minn. Stat. §129A.01.

TABLE 5

SERVICES FOR MENTALLY RETARDED PERSONS
FISCAL YEAR 1982

	Average Number of Recipients	Annual Budget (in millions)	Average Daily Cost
Residential Services			
State Hospital	2,371	$ 60.2	$74.76[a]
Certified Community Facility	4,744	68.7	51.71[b]
SILS--Residential Costs	552[c]	1.2	11.51
Family Subsidy	150	0.4	7.27
Total	7,817	$130.5	
Developmental Services			
State Hospital DAC	1,900	$ 10.6	$13.19[a]
Community DAC, Adults	3,893	19.1	25.75
Community DAC, Children	1,254	7.8	38.26
SILS-- Service Costs	552	1.2	8.49
Work Activity	2,900	6.5[d]	5.61
Total	10,499	$ 45.2	
		$175.7	

Sources: Mental Retardation Program Division, Department of Public Welfare.
Department of Public Welfare, Minnesota Income Maintenance, 1982, pp. 14, 16, 47.
Department of Public Welfare, Cost Containment Proposal, October 28, 1982, p. 2.
State of Minnesota, Detailed Biennial Budget Proposal, 1981-83 for Health, Welfare, Corrections, p. D-0538.

[a]DPW staff estimate that 85 percent of the state hospital per diem payment is for residential services, and that 15 percent is for developmental services.

[b]Average as of August, 1982.

[c]A total of 652 persons participated.

[d]Total estimated 1982 budget of the Division of Vocational Rehabilitation, Department of Economic Security, for work activity and sheltered workshops. Approximately 65 percent of the clients are retarded persons.

Table 5 shows that 1982 per diem rates were $87.95 in state hospitals, and averaged $51.71 in certified community facilities.[31] Per diem rates for community residences ranged from $22.87 to $117.00. In general, newer facilities, those serving more dependent people, and those located in the Minneapolis-St. Paul region have the highest per diem rates.

State hospitals and certified community facilities offer the most intensive--and most costly--residential services. However, daily costs are difficult to compare. For example, in addition to room and board, state hospital per diem rates cover developmental, medical, and transportation costs, which are not included in per diem rates for certified community residences.

Since 1971, Medicaid has paid for care provided by certified vendors to mentally retarded persons in state hospital programs, community residential facilities, and nursing homes. In Minnesota, 1982 Medicaid costs were shared as follows: 55.64 percent federal,[32] 39.92 percent state, and 4.44 percent county.

SILS, the family subsidy program, and DACs have not kept pace with demand, because these programs rely on state or county funding sources which have become less predictable in recent years. The state pays all family subsidy program costs and approximately 50 percent of SILS costs, through categorical appropriations. The state pays part of the costs of DACs through social services block grants to counties.

The availability of federal funds for facilities certified under the Medicaid program has encouraged the development or use of certified community facilities, nursing homes, and state hospitals as residences for mentally retarded people. Table 6 shows that the costs of state hospitals and community facilities for mentally retarded persons are nearly 20 percent of all Medicaid expenditures in Minnesota.

Table 6 shows:

- Medicaid expenditures in Minnesota increased nearly 85 percent between 1978 and 1982, when they reached three-fourths of a billion dollars.
- Long-term care expenditures are now 66 percent of all Medicaid costs.

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[31] Prior to fiscal year 1983, state hospitals set one per diem rate for all residents regardless of diagnosis. For fiscal year 1983, the per diem rate for mentally retarded people was set at $109.50, the rate for the mentally ill was $83.65 and that for the chemically dependent was $65.55.

[32] The Department of Public Welfare reported that the basic federal matching rate will drop to 52.67 percent on October 1, 1983.

TABLE 6

MEDICAID EXPENDITURES FOR LONG-TERM CARE IN MINNESOTA
(Expenditures in $ millions)[1]

	1978		1980		1982	
	Expenditure	Average Per Diem Rate	Expenditure	Average Per Diem Rate	Expenditure	Average Per Diem Rate
State Hospital, ICF-MR[2]	$ 47.3	$52.50	$ 69.0	$65.20	$ 70.8	$87.95
Community ICF-MR	24.2	27.33	39.8	38.38	68.8	51.71
Skilled Nursing Facility	104.1	29.13	161.7	38.39	232.2	50.32
Nursing Home, ICF-1	72.5	23.61	91.2	30.92	114.8	40.21
Nursing Home, ICF-2	8.6	15.92	9.1	21.00	11.0	27.05
Total Long-Term Care Expenditures	$256.7		$370.8		$497.6	
Total Medicaid Expenditures	$407.5		$566.4		$749.6	

Sources: Department of Public Welfare, Minnesota Income Maintenance, September 30, 1982.
Department of Public Welfare, Nursing Home Cost Summary, 1977-1980.
Long-Term Care Rates Division, Department of Public Welfare.

[1]Figures represent total Medicaid expenditures. For 1982, shares were 55.6 percent federal, 39.9 percent state, 4.4 percent county, in Minnesota.

[2]Figures include costs of day activities, medical care, and other services paid through the state hospital budget.

- Expenditures for community ICF-MR facilities nearly tripled between 1978 and 1982.

- Per diem rates for community ICF-MR facilities nearly doubled between 1978 and 1982.

These trends have important implications for the Medicaid program, and for the development of the mix of services needed by Minnesota's mentally retarded persons.

II. REGULATING AND PLANNING COMMUNITY PROGRAMS FOR THE MENTALLY RETARDED

The Department of Public Welfare is responsible for planning and regulating residential and developmental services for mentally retarded persons as required by state legislation, federal Medicaid regulations, and the Welsch v. Noot consent decree.[1] This chapter examines the planning and regulation of community residential services.

We asked:

- Has the Department of Public Welfare effectively planned and encouraged community services for mentally retarded persons that are cost effective, properly distributed throughout the state, and of acceptable quality?
- Do recently opened residential facilities meet needs identified in state laws, administrative rules, and the Welsch v. Noot consent decree?

A. PLANNING RESPONSIBILITIES

Past legislative actions and the consent decree have shaped state planning for mental retardation services. Each has implications for planning and policy. The consent decree establishes objectives to be met within a specific time period, and legislation mandates programs and provides authority for their implementation. This section looks at the effectiveness of planning to meet these mandates and objectives.

1. ROLE OF THE DEPARTMENT OF PUBLIC WELFARE

The Commissioner of Public Welfare exercises planning authority through three administrative functions:

(1) licensing residential programs as required by DPW Rule 34;[2]

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[1] Minn. Stat. Chapter 252. Under Minn. Stat. §252.28, "the Commissioner of Public Welfare may determine the need, location, and program of public and private residential and day care facilities and services for mentally retarded children and adults."

[2] 12 MCAR §2.034.

(2) approving proposed facilities and programs as required by DPW Rule 185;[3] and

(3) complying with state responsibilities in the Welsch v. Noot consent decree.[4]

The primary purpose of Rule 34 is to establish minimum standards for community residential programs for mentally retarded persons. It also provides broad authority for coordinating other planning activities. Rule 34 requires facility developers to comply with Rule 185 to obtain a letter of recommendation from the county, and with Department of Health Rule 391 to obtain licensure as a supervised living facility. Therefore, Rule 34 provides a viable mechanism for the Department of Public Welfare to coordinate, plan, and shape the development of new community residential services.

2. RESPONSIBILITIES DELEGATED TO THE COUNTIES

The Commissioner of Public Welfare delegates certain planning responsibilities to counties through DPW Rule 185. That rule:

- establishes minimum standards for case management and the planning, coordination, and development of services for all individuals who are mentally retarded;
- defines responsibilities of county officials in reviewing facility proposals including determining need for a proposed facility or service, obtaining citizen participation, and employing qualified personnel to ensure that informed decisions are made;
- requires the service developer to describe characteristics of potential residents, show where they currently reside, and to identify daytime program or work activities available to them; and
- authorizes the county board to forward an approved proposal with a letter of recommendation to the Commissioner of Public Welfare.

Through Rule 185, the counties provide critical input at the initial planning and proposal step. This would be an appropriate time to conduct a comprehensive assessment of the proposal, including cost effectiveness, alternative service needs, and the appropriateness of each residential placement. This information could be useful for statewide planning, cost containment, and equitable distribution of services.

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[3] 12 MCAR §2.185.

[4] Welsch v. Noot, United States District Court, District of Minnesota, No. 4-72-Civ. 451, September, 1980.

3. REQUIREMENTS OF THE CONSENT DECREE

Under the Welsch v. Noot consent decree, the Commissioner of Public Welfare is responsible for reducing the number of mentally retarded residents in state hospitals, increasing staff-resident ratios, and providing community-based services as an alternative to institutional care. The consent decree requires that:

- persons discharged from state institutions be placed in community programs which appropriately meet their individual needs;
- mentally retarded persons be admitted to state institutions only when no appropriate community placement is available; and
- reductions in state hospital population and planning for new services be based on annual assessments of mentally retarded residents conducted by interdisciplinary teams.

4. SIX-YEAR PLAN

The Department of Public Welfare developed a six-year plan in response to the Welsch v. Noot consent decree. The six-year plan states that "Minnesota has a basically sound system of services to the mentally retarded population, which requires no major change of direction from what has been in place for two decades." Nevertheless, we found the following problems with the department's six-year plan for services to mentally retarded persons.

- The plan identifies many of the problems in the service system and sets goals for resolving them, but falls short of providing statewide guidelines for development of services.

Little attention is given to the importance of planning for statewide distribution of facilities and services. The objectives and principles of the plan focus on increasing certain services, providing additional technical assistance to counties and developers of services, and establishing an information system for planning purposes. However, there is no attempt to set priorities for service development or to determine appropriate geographic distribution of services. The lack of such specific and substantive direction encourages uneven development of services.

- The plan calls for developing 400 additional ICF-MR beds by 1987, but does not address geographic distribution of these facilities.

Thus, the determination of need process is necessarily limited by county boundaries, and does not view proposals in a regional or statewide context. In the absence of a comprehensive analysis of local service needs, county and state officials cannot critically review proposals for new facilities and services.

- The plan focuses on planning for the needs of persons coming out of state hospitals, but does not give equal weight to the service needs of mentally retarded persons in the community who may be candidates for institutional or residential care.

The lack of uniform screening criteria and the limited availability of alternative services may result in inappropriate placement in long-term residential facilities. Placement criteria are not uniform across the state and may even vary among caseworkers in a given county.

- The plan does not address the future role of state hospitals.

State hospitals consume a significant portion of the Medicaid budget and have resources and expertise in providing care and services to mentally retarded individuals. Under the plan, the population of state hospitals is to be reduced by 800 residents, but no attention is given to the future role of state hospitals, alternative uses of staff, or how money could be shifted to other services.

The absence of a statewide plan for geographic distribution of residential and developmental services reduces the department's effectiveness in planning because:

- There are no statewide planning guidelines for approving or disapproving proposals.
- Planning roles and accountability are unclear.
- Priorities for future development of services have not been established.

5. DPW'S POLICY FOR REDUCING STATE HOSPITAL POPULATION

The Welsch v. Noot consent decree mandates reduction in the state hospital population to 2,375 residents in July 1983, 2,100 residents in July 1985, and 1,850 residents in July 1987. As of October 1982, state hospital reports showed the current population to be 2,343, which is somewhat ahead of schedule.

State hospital population reductions have been accomplished primarily through discharges rather than limiting new hospital admissions. The department's policy has been to encourage transferring residents out of state hospitals as the primary approach in reducing population. For example, DPW informational Bulletin 82-12 summarizes state hospital population reductions in 1981, and rates counties' performance on "ability to move their clients out of the state hospitals."

We found the following problems with this policy:

- The Department of Public Welfare has not effectively limited new admissions to state hospitals.

Figure 7 shows that during a two year period ending October 1982, the number of discharges decreased and is now close to the number of new admissions. If this problem is not solved, the rate of reduction in total state hospital populations may decrease.

- There is no standard procedure for screening persons applying for admission to the state hospitals and determining their service needs.

By emphasizing the service needs of persons transferred from state hospitals DPW has encouraged the development of residential facilities. It has paid little attention to identifying the service needs of persons seeking admission to state hospitals and to developing alternative services that would meet those needs in a community setting.

- The remaining institutional population may need intensive levels of care.

Persons recently discharged from state hospitals have typically been less dependent residents, while more dependent persons stay behind. If the future role of state hospitals is to care for the most dependent individuals, DPW should plan for the special needs of these persons.

B. DEVELOPMENT OF RESIDENTIAL SERVICES

An acceptable system of services for mentally retarded persons in Minnesota must comply with criteria in the consent decree, state statute, and administrative rule. The system of services should include a continuum of residential and developmental services that are geographically accessible and provide an array of programs that are alternatives to institutional placement. In order to implement this system, funding should be designed so county priorities and individual placement decisions are made on the basis of what service is needed and most appropriate, and not on variation in funding formulas. We looked at distribution of services, types of available services, and program funding formulas to determine what efforts had been made to increase the availability of services.

1. GEOGRAPHIC DISTRIBUTION OF SERVICES

Table 7 shows the distribution of services for the mentally retarded by state hospital catchment (service) areas. (See Appendix A for a map of state hospital catchment areas.) For ICF-MR facilities and developmental achievement centers, the table shows the number of facilities or centers, the licensed capacity, and the ratio of placements to 1,000 general population. The capacity of work activity centers, sheltered workshops, and semi-independent living service programs is summarized for each catchment area.[5] Table 7 shows the following:

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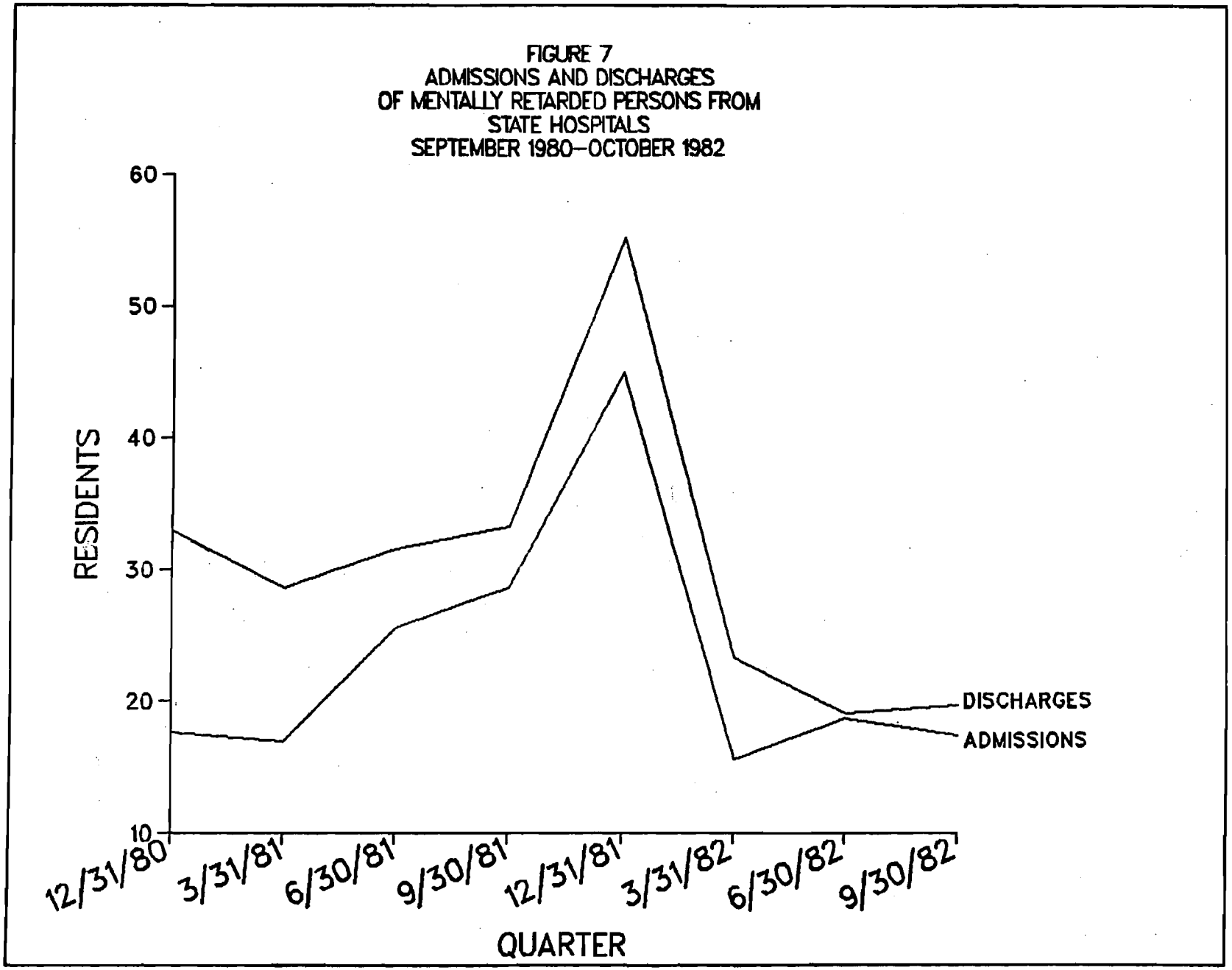
[5]This information is presented in the Appendices for each county.



Sources: Welsch Consent Decree, Report of the Monitor, June 1982.
Residential Facilities Division, Department of Public Welfare.

TABLE 7

DISTRIBUTION OF RESIDENTIAL AND DEVELOPMENTAL SERVICES
BY STATE HOSPITAL CATCHMENT AREA

		Intermediate Care Facilities for the Mentally Retarded			Developmental Achievement Centers			Semi-independent Living Services	Work Activity Centers/ Sheltered Workshops
Catchment Area	Population	Facilities	Beds	Beds/ 1,000	Centers	Capacity	Capacity/ 1,000	Capacity	Capacity
Fergus Falls (15 counties)	282,364	32	356	1.260	16	455	1.611	33	In 13 counties
Brainerd (14 counties)	396,283	27	344	.868	17	737	1.859	89	In 7 counties
Moose Lake (4 counties)	269,300	27	296	1.099	6	466	1.730	80	In 3 counties
Cambridge (9 counties)	899,035	50	876	.974	25	1049	1.166	212	In 7 counties
Willmar (21 counties)	383,386	37	740	1.930	23	818	2.133	55	In 18 counties
St. Peter (11 counties)	302,810	23	408	1.347	11	439	1.449	111	In 10 counties
Faribault (13 counties)	1,535,255	113	1,859	1.210	44	1,850	1.205	328	In 13 counties
STATE TOTALS	4,068,433	309	4,879	1.199	142	5,814	1.429	908	71 counties

Sources: Minnesota Population and Housing Characteristics - 1980 Complete Count Census Data, Minnesota Analysis and Planning System, Agricultural Extension Service, University of Minnesota.
Rule 34 Facilities Sorted by County, Department of Public Welfare. December 10, 1982.
Licensing Division, Department of Public Welfare.
Division of Vocational Rehabilitation, Department of Economic Security.

- Distribution of ICF-MR beds is very uneven.

The ratio of ICF-MR capacity to population ranges from .868 beds per 1,000 population for the Brainerd catchment area to 1.930 beds per 1,000 population for the Willmar catchment area.[6] These figures indicate that there is twice the ratio of beds to population in some areas compared to others. The statewide average is 1.199 beds per thousand population.

- Distribution of developmental achievement centers (DACs) also varies widely.

The ratio of developmental achievement center capacity to population ranges from 1.166 per thousand in the Cambridge catchment area to 2.133 per thousand in the Willmar catchment area. The statewide average is 1.429 per thousand population. Rule 34 requires that developmental achievement center or other day programs be available to ICF-MR residents. About 40 percent of DAC clients reside in community residential facilities.

- Work activity centers and sheltered workshops are well distributed throughout the state.

According to the Division of Vocational Rehabilitation (DVR), all but a dozen counties have work activity or sheltered workshop programs. DVR staff estimates that fifty to sixty percent of the clients in those programs are mentally retarded.

As we have noted, semi-independent living services (SILS), foster care, and family assistance programs are less costly and less restrictive alternatives to community residential placement. But,

- Alternative programs are under-developed and poorly distributed throughout the state.

The availability of SILS programs in Minnesota is uneven. There are 40 licensed SILS programs serving 27 counties. The number of available slots varies widely among catchment areas from 33 in Fergus Falls to 328 in Faribault.

SILS program expenditures and results have also been uneven. For example, the average per client cost in fiscal year 1982 ranges from less than $1,000 to more than $7,000. Most vendors are paid according to hours of client contact; those costs ranged from under $5.00 per hour to more than $20.00 per hour. While DPW reports that one-fourth of the 107 SILS clients who left programs in 1982 graduated to independent living, nearly 20 percent moved back to an ICF-MR or other residential placement.

There is only one statewide program that helps mentally retarded persons to remain in their family homes--the family subsidy program. In 1982, fifty percent of the 162 family subsidy grants

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[6]The Willmar catchment area shows a high ratio of beds per thousand because it includes Redwood county, with one 132 bed facility.

were made to families in the Minneapolis-Saint Paul area, and 82 percent of those were in Hennepin and Ramsey Counties.[7] The family subsidy program is administered by the Department of Public Welfare, with referrals made by county caseworkers. Only a few counties offer other home-based programs such as homemaker assistance, respite care, or training for families of mentally retarded persons.

While 50 counties provide some form of foster care,

- Professional foster care programs exist in only a few counties and lack uniform standards.

Professional foster care is an enriched program that uses experienced providers, pays a higher per diem rate, and provides on-going support. This program is especially effective for children, because it provides nurturing care in a family setting. It is often useful for adults who need a family setting. Wider use of this program may be inhibited by the lack of statewide standards and relatively high cost paid by counties.

The uneven statewide distribution of residential and developmental services is in part the result of inadequate planning and suggests the need for comprehensive planning by the Department of Public Welfare to direct future development.

2. THE MENTAL RETARDATION SERVICE SYSTEM HAS AN INSTITUTIONAL BIAS

The state's mental retardation service system is highly dependent on state hospital and other residential care. A national survey reported that in 1979 Minnesota had more small ICFs-MR than any other state.[8] More recently, the Department of Public Welfare reported that the state already has exceeded the number of ICF-MR beds that was projected for 1987.[9] The rate of expansion continues: 22 new facilities opened in 1981; 21 new facilities opened in 1982; and 27 new facilities have been approved by DPW and are expected to open in 1983.

Past emphasis on custodial care for the mentally retarded has resulted in a statewide service system with the following problems:

- substantial investment in buildings and real estate, heavy reliance on Medicaid reimbursement, and high administrative costs;

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[7] Data from Assistant Director, Family and Guardianship Section, Department of Public Welfare. Information is for fiscal year 1981-1982.

[8] Intergovernmental Health Policy Project. Current and Future Development of Intermediate Care Facilities for the Mentally Retarded: Survey of State Officials, 1979, p. 14.

[9] Mental Retardation Program Division, Department of Public Welfare.

- limited funding available for services and programs that stress skills for independent living and competitive employment; and

- little incentive for county case workers or facility operators to transfer people to more independent settings, restricting the opportunities for mobility within the service system.

The least expensive and least restrictive services are also the least available. Thoughtful planning and development of incentives are needed so that alternative services are more widely available and evenly distributed in the state.

3. REIMBURSEMENT FORMULAS CONTRIBUTE TO LOW AVAILABILITY OF SOME SERVICES

The existing service system was shaped by funding policies that favor institutional residential care. Community ICFs-MR became eligible for federal Medicaid reimbursement in 1974. Under Medicaid, the federal government pays more than one-half of the costs. In Minnesota, the state and counties divide the non-federal portion in a 90 percent state, 10 percent county split. Virtually all Rule 34 facilities are certified Medicaid vendors, and most serve only Medicaid recipients.

State policy encourages counties to develop services as alternatives to residential placement but there is little incentive to do so. Since these services are not reimbursed by Medicaid, they are more costly to the counties. Some examples of this disparity are:

- Some funding for developmental achievement centers, adult foster care, and respite care are is provided in the Community Social Services Act block grant to counties. Though the statute requires counties only to match the state grant, most counties actually provide 60 percent or more of their social service budgets.[10]

- For semi-independent living services, counties pay 20 percent of program costs for persons transferring to the program from a state hospital or an ICF-MR, and 50 percent of costs for others.

- Family subsidy is a state administered program requiring no county contribution. The few counties offering other home-based support services fund those programs out of the social services budget.

Table 8 presents average costs of these services in St. Louis, Blue Earth and Dakota counties.

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[10] Minn. Stat. §256E.06, Subd. 5.

TABLE 8

AVERAGE SERVICE COSTS

Service	St. Louis County	Blue Earth County	Dakota County
ICF-MR (daily)	$ 44.40	$ 47.00	$57.42
DAC (daily)	$ 28.77	$ 22.00	$27.00
SILS (hourly)	$ 23.00	$ 20.00	$17.29
Foster Care (monthly)	$244.00	$319.00	$600.00

Sources: Estimates from mental retardation specialists, social service departments of St. Louis, Blue Earth, and Dakota counties, December 1982.
Program Evaluation Division analysis, December 1982.

County officials set priorities for programs that are paid for through the Community Social Services Act block grants, and county caseworkers are responsible for individual placements. The result is that utilization of services is determined at the local level, yet counties are the least affected by the resulting cost. There is a financial incentive for counties to place individuals in an intermediate care facility, which is the most expensive and most restrictive setting. This is inconsistent with state policy encouraging placement in the least restrictive setting and runs counter to state cost-containment efforts.

RECOMMENDATIONS

We recommend that:

- DPW should develop a statewide plan for distribution of residential services to be used as a guide in review of future program proposals.

The plan should provide a framework for approving or disapproving proposals, clarify planning roles and accountability, and set priorities for future service development.

- DPW should set priorities that encourage the development of less restrictive and less costly alternative services.

The statewide plan should include guidelines for county services planning, and a process for setting priorities. This could be required as part of the mental retardation portion of the Community Social Services Act plan.

- DPW should establish screening criteria for more appropriate placement within the mental retardation service system.

The state should offer guidelines for placing people within the system so that counties could follow a consistent procedure in identifying needs and providing services.

C. REGULATING NEW COMMUNITY FACILITIES

1. DESCRIPTION OF THE REGULATORY PROCESS

Development of a new community residential facility requires a series of applications and approvals governed by state statutes, administrative rules, and federal regulations. The process is lengthy--typically 12 to 18 months will pass before a proposed facility begins operation. It begins with the provider's request for a county letter of recommendation to the Commissioner of Public Welfare, and ends with federal certification of the provider as a Medicaid vendor. Figure 8 is a graphic presentation of the process.

a. Developer Presents Proposal to the County Board

A proposal for a new facility is usually initiated in one of two ways: (1) a community group may identify a need for a facility and contact a specific developer, or (2) a developer may independently determine potential demand. The developer presents a proposal for the county board's review under Rule 185. After its review, the county board sends a letter of recommendation to the Commissioner of Public Welfare. In this first and very critical phase, the county board's review is usually limited to characteristics of the residents, program standards, and zoning questions.

b. Commissioner of Public Welfare Approves Proposal.

The second half of the Rule 185 need determination includes a joint review by three DPW divisions: Mental Retardation, Licensing, and Long-Term Care Rates. The divisions examine whether the proposal is complete, will cause undue concentration of facilities in a specific geographic area, and whether the proposed rate is acceptable.

c. Developer Applies for Rule 34 Licensure

Approval of the facility proposal by the Commissioner of Public Welfare enables the developer to proceed with four license requirements concurrently:

(1) Department of Public Welfare Rule 34 establishes minimum standards for the residential program: developmental and remedial services, admission and discharge procedures, and administrative policies and practices.

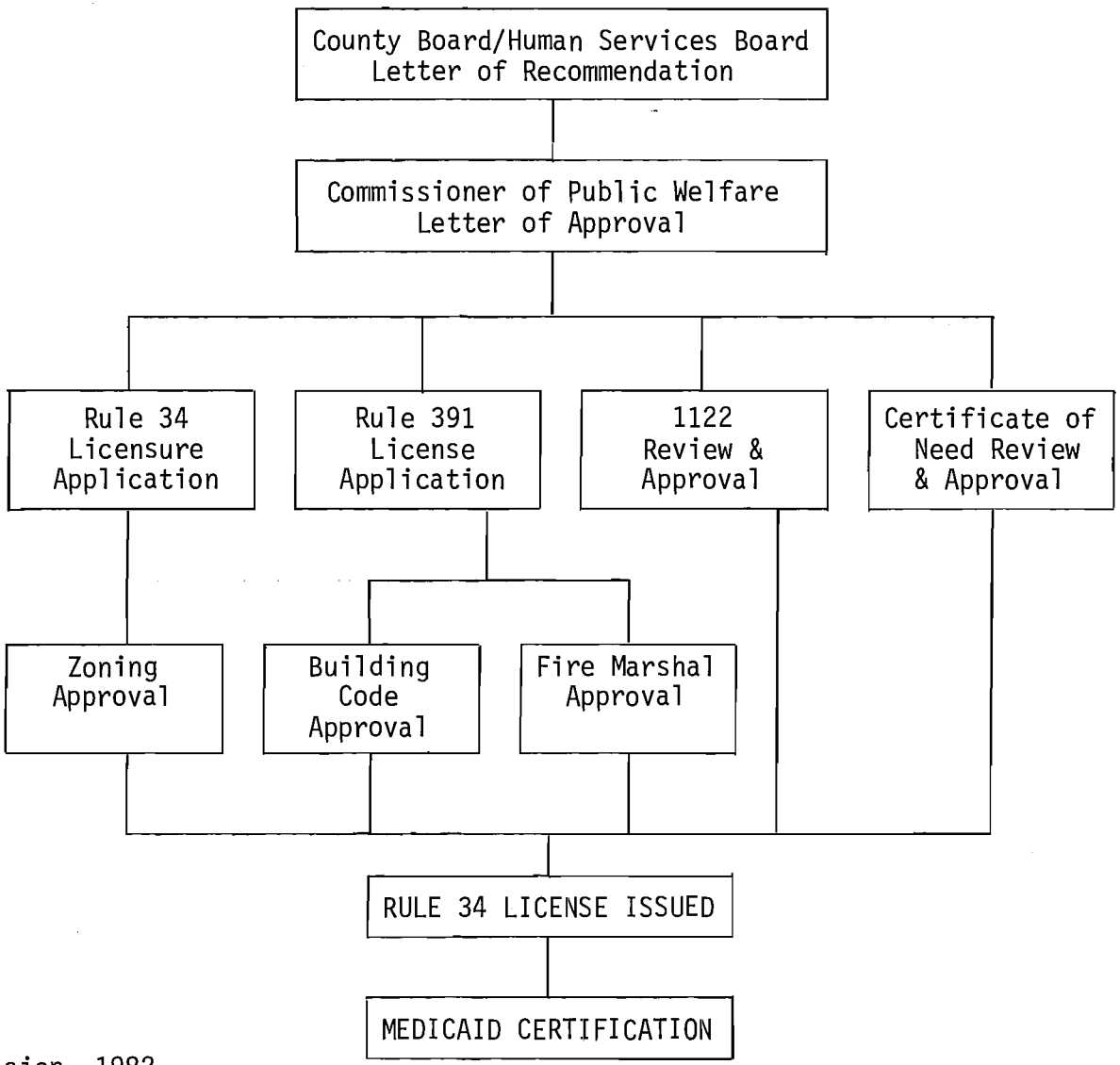
FIGURE 8

RULE 34 LICENSURE AND MEDICAID CERTIFICATION

REGULATIONS

- County Need Determination
  12 MCAR §2.185.D.4(a)
- Commissioner of Public Welfare Need Determination
  12 MCAR §2.185.D.4(c)
- License for Group Homes for Mentally Retarded
  12 MCAR §2.034
- License for Supervised Living Facility
  7 MCAR §1.391
- Section 1122 Review
  42 USC §1320a
  (P.L. 92-603)
- Certificate of Need
  Minn. Stat. §§145.832-45
  & 7 MCAR 1.661
- Medicaid Certification
  42 USC §1396d(d)

PROCESS



Source: Program Evaluation Division, 1982.

(2) Department of Health Rule 391 establishes minimum standards for the facility: construction, equipment, maintenance, and operation as they relate to sanitation and safety of the buildings, and to the health, treatment, and well-being of the residents. Licensure is contingent on satisfactory review by the State Fire Marshal, Department of Public Safety; the Building Code Standards Division, Department of Administration; and Survey and Compliance Division, Department of Health.

(3) New facilities must also apply for a Certificate of Need and for federal capital expenditure review (§1122). Federal regulations require new health care facilities to be reviewed for compliance with planning and cost containment criteria. A certificate of need is granted by the Commissioner of Health based on the health systems agency's report and recommendations of the commissioner's staff. Capital expenditure certification is the responsibility of the health planning section of the Department of Energy, Planning, and Development.

d. Developer Applies for Federal Medicaid Certification

Certification as an intermediate care facility for the mentally retarded permits the facility to be reimbursed through the Medicaid program for care provided to eligible residents. Federal requirements for participation in the program are similar to requirements for supervised living facilities, and further ensure the quality of residential care and programs.

2. THE REGULATORY PROCESS COULD BE STRENGTHENED AND BETTER COORDINATED

The regulatory process requires ten separate approvals prior to licensure as a Rule 34 facility and certification as a Medicaid vendor. We found the following problems with the regulatory process:

- Initial review of a proposal is too limited.

The initial county review is critical, yet receives only limited attention. The Rule 185 review does not give adequate consideration to cost-effectiveness of the proposal, evaluation of alternative services available in the county, and determination of how well the proposal fits the priorities of a statewide plan.

- There is no coordinated review procedure for simultaneous proposals.

Even when several facility proposals are pending in one county, each proposal is considered independently. It is possible that facilities may be approved or denied based on order of application rather than established criteria. This practice suggests the need for priorities and criteria in the facility review process.

- Some reviews are not well-coordinated. DPW and the Department of Health conduct their reviews independently, with only informal communication, and maintain six separate filing systems.

The concurrent reviews for Rule 34 licensure and for Rule 391 licensure could be better coordinated, either through a joint decision making process, or, at a minimum through a master filing system.

- There is duplication in the collection of information.

Much of the same information is compiled for the state and federal cost containment and planning reviews. As a result, information in the files is duplicated, some agency staff may be repeating the work of others, and developers must monitor separate reviews.

3. THE REGULATORY PROCESS IS NOT EFFECTIVE IN CONTAINING COSTS

Despite numerous reviews, the cost containment issue is neglected. Several rate setting and adjustment steps are built into the regulatory process in order to accommodate changes or unanticipated costs experienced by the developer. The developer must submit a proposed per diem rate for review by the county board and approval by DPW. This rate is compared with average regional rates, allowing for inflation and projected construction costs. The approved rate is also used during Certificate of Need approval, and capital expenditure review. This rate is not final or binding on the provider. In many cases, the provider will request that DPW approve a new interim rate prior to opening the facility. In the past, such requests have been routinely granted.

Rule 52 allows a provider to request a settle-up and a new per diem rate after the first year of operation, based on actual costs. This is the base rate for future adjustments. Table 9 presents proposed, interim, and settle-up rates for facilities opened in 1981.

We found that settle-ups have been quite large.

- The settle-up rate was an average of 38 percent higher than the rate seen during the planning reviews; and

- The settle-up rate was an average of 22.4 percent higher than the interim rate used during the first year of operation.

These increases are only partly explained by the time lapse between the initial proposal and the opening of the facility.

We concluded that:

- The availability of large settle-ups makes the earlier review procedures ineffective for containing the costs of new facilities.

TABLE 9

COMPARISON OF PROPOSED, INTERIM, AND SETTLE-UP RATES
FOR FACILITIES OPENED IN 1981

Facility	(1) Proposed Per Diem Rate (CON/§1122)	(2) Interim Per Diem rate (Rule 52)	(3) Settle-up Per Diem Rate (Rule 52)	Percent Increase (3)-(1)	Percent Increase (3)-(2)
Caromin--Two Harbors	$33.66	$41.92	$56.05	66.5%	33.7%
Oak Ridge--Aitkin	33.54	37.58	48.18	43.6	28.2
Charis House--Brainerd	47.37	46.53	58.70	23.9	26.1
Swift County Group Home	33.23	40.76	47.91	44.2	18.3
Opportunity Manor--St. Cloud	41.17	46.10	46.41	12.7	0.7
REM--St. Cloud	NA	63.78	*	NA	NA
Residential Alternatives VI	43.05	42.01	60.69	41.0	44.5
Elm Residence	46.78	51.86	61.26	31.0	18.1
Hiawatha Adult Home	45.50	77.31	*	NA	NA
ACR Cummins	58.71	60.51	68.50	16.6	13.2
Good Neighbor--Edmund	51.01	57.05	62.63	22.7	9.8
Logan	74.32	74.32	81.57	9.7	9.7
Minnesota Jewish Group II	49.44	49.44	*	NA	NA
Nekton--Hodgson	58.57	58.57	*	NA	NA
NE Respite Care	35.38	57.95	70.94	100.5	22.4
Oakwood Residence	66.31	60.93	*	NA	NA
REM--Bloomington	NA	64.19	*	NA	NA
REM--Minnetonka	35.61	69.89	*	NA	NA
Residential Alternatives VIII	48.64	48.36	*	NA	NA
The Woodlands--Orono	72.02	72.02	103.75	44.0	44.0
				Average Increase = 38.0%	Average Increase = 22.4%

Sources: Rule 52 Cost Reports--Department of Public Welfare.
§1122 and Certificate of Need Files--Department of Energy, Planning and Development, Minnesota Department of Health.

Notes: *Final rate not yet established as of December 27, 1982.
NA = Not Available.

The settle-up process weakens the previous review process because the developer can submit an acceptable estimate, and later present first year costs that are substantially higher. The developer bears little financial risk in making these estimates and securing a final rate. In fact, the Medicaid budget absorbs this risk when final rates are substantially above interim and proposed rates.

- DPW does not work aggressively to limit the costs of new facilities.

The department takes the view that it cannot use Rule 52 as a cost-containment mechanism. In the last year, the Department of Health has attempted to use the Certificate of Need review as a tool to limit the costs of new facilities. It is encouraging that a state agency is trying to deal with this problem. However, the Department of Health may not be the proper agency to do it, particularly since the Certificate of Need review is scheduled to be discontinued on March 15, 1984. Furthermore, the Department of Health has little expertise in programs serving the mentally retarded. Finally, the Commissioner of Public Welfare is ultimately responsible for the solvency of the state Medicaid budget.

- Statewide data on costs are inadequate.

In attempting to analyze the cost-effectiveness of proposals, reviewing bodies and agencies have little information to enable comparison. There is no authoritative, statewide data base which would enable reviewers to compare proposed facilities on the basis of cost, location, program, and client characteristics. Frequently, the developer is asked to provide the data for these comparisons.

4. THE REGULATORY PROCESS DOES NOT MEET THE CHALLENGE OF REDUCING STATE HOSPITAL POPULATIONS

The regulatory process can be used to direct development of new facilities and placement of state hospital residents. The department's six-year plan calls for new ICF-MR development to serve hospital residents and "more seriously handicapped people." Development has exceeded the projections for 1987, but persons leaving state hospitals have filled only a small portion of the new beds.

We examined files for 22 facilities which were opened during 1981 for information on the sources and characteristics of residents. We compared information in the initial determination of need proposal with characteristics of the actual residents. Our survey showed that new facilities generally served the clients that they proposed to serve. We also found, as shown in Table 10, that:

- Twice as many residents were admitted to the new facilities from family homes as from state hospitals.

- More residents were transfers from other ICFs-MR facilities than from state hospitals.

- Most residents were mildly or moderately retarded.

TABLE 10

RESIDENTS OF ICFs-MR OPENED IN 1981

	Proposed Residents (percent)	Actual Residents (percent)
1. Source of Residents (N=202)		
Family	32.0%	40.0%
State Hospital	18.0	21.5
Other ICFs-MR	25.5	28.5
Foster Home	14.0	6.5
Other*	10.5	3.5
	100.0%	100.0%
2. Degree of Retardation (N=202)		
Profound	12.0	11.5
Severe	24.5	32.0
Moderate	37.5	32.0
Mild	26.0	24.5
	100.0%	100.0%

Sources: Mental Retardation Program Division, Department of Public Welfare; Program Evaluation Division Survey, 1982.

*Typically nursing home or board and care facility.

The new facilities are serving only a few individuals who are very dependent because of problems with behavior or mobility. The Department of Public Welfare has recently made some progress in this area. Our review of facilities which the department has approved during the last twelve months indicates these facilities will serve a somewhat higher proportion of very dependent persons and more state hospital residents.

RECOMMENDATIONS

We recommend that:

- DPW should strengthen Rule 185 so the initial review is more comprehensive.

The Rule 185 review should include a closer examination of issues of cost, alternative services, and statewide needs. Furthermore, the department should develop a statewide data base of service costs,

client and program characteristics, and geographic distribution. This would improve review capability and provide information to the counties so that they could critically analyze proposals.

- DPW should use its authority in Rule 34 to improve coordination of license reviews and combine application documents.

The department should convene a review panel of staff from the various licensing and program divisions to study and bring about shared decision making.

- DPW should take a more agressive role in controlling the costs of new facilities.

DPW should limit the size of settle-ups for new facilities to ten percent over the interim rate. The department should grant increases in interim and settle-up rates only in strictly limited situations, where the provider could not have foreseen the change. In general, DPW should hold providers accountable for their initial proposals and for costs in the first year of operation.

III. ANALYSIS OF REIMBURSEMENT FOR RESIDENTIAL CARE

The availability of Medicaid funding for residential care in community facilities has been a major factor in their rapid growth and high utilization. The Department of Public Welfare (DPW) is responsible for the Medicaid program and for setting rates for reimbursing providers of residential care. DPW Rule 52 establishes a mechanism for setting reimbursement rates. In this chapter, we examine DPW Rule 52 and reimbursement for residential care.

We wanted to know:

- Is the rate-setting mechanism effective in achieving state objectives of containing costs while encouraging the availability of quality residential services for the mentally retarded?
- How would changes in Rule 52 or the Medicaid program affect the state and providers?
- Does DPW administer the rate-setting process effectively?

Our analysis focused on specific cost areas as well as issues of reimbursement policy.

A. INTRODUCTION TO RATE-SETTING

Governmental jurisdictions use a variety of formulas to set rates for human services, but there are three basic methods.[1] Price related rate-setting requires a competitive market to ensure that prices set by providers are appropriate. Cost related rate-setting is generally considered necessary when there is no competitive market. Flat rates can be set without regard to prices or costs.

Minnesota uses cost related rate-setting, which is the most common approach for reimbursing residential facilities. This method requires ascertaining the provider's costs, determining their reasonableness, and reimbursing only reasonable costs. Many states use price indices, such as the consumer price index, to adjust rates.

Cost related rate-setting may be retrospective or prospective--Minnesota sets prospective rates, with retrospective adjustments. In retrospective approaches, the payment is calculated after the provider delivers the service. Actual costs of the service are determined and reimbursed, with or without cost limits established in

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[1]David A. Richardson, Rate Setting in the Human Services: A Guide for Administrators, Project Share, Department of Health and Human Services, September 1981, p. 57.

advance. With this approach the funding source has no opportunity for controlling costs, once services are authorized. Sixteen states, including Michigan, use retrospective reimbursement.

Prospective approaches set rates before the provider delivers the service. Prospective rates result either from the negotiation of budgets which providers submit, or from the application of mathematical formulas. Theoretically this approach provides the funding source with more opportunity for cost control. Twenty-six states use prospective reimbursement methods, including Iowa, South Dakota, and Wisconsin. Six states, including Illinois and North Dakota, use a combination of rate-setting approaches.[2]

ICF-MR per diem rates cover the cost of different ancillary services in each state--a fact which may complicate comparisons. Examples of different services which may be included in per diem rates are physical therapy, occupational therapy, drugs, medical supplies, and medical equipment. Minnesota's ICF-MR per diem rate covers drugs, medical supplies, and medical equipment, as well as room and board.

B. RATE-SETTING IN MINNESOTA

The Medicaid program pays virtually all of the cost of licensed residential care for Minnesota's mentally retarded people. Federal regulations and Minnesota Statutes (Chapter 256B) govern the program. DPW Rule 52 defines the process and formula for setting per diem payment rates for Medicaid recipients in certified facilities for the mentally retarded.[3]

Rule 52 first took effect on August 14, 1973 and has been revised three times.[4] Its objectives are to:

(1) define a system for determining Medicaid per diem rates for community residential facilities serving more than four mentally retarded persons;

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[2]Health Care Financing Administration, Medicaid Program Characteristics Summary Tables, Department of Health and Human Services, April 1982.

[3]12 MCAR §2.052. Federal regulations and Chapter 256B have little direct effect on this rate-setting process, particularly in comparison to the detailed requirements of Rule 52.

[4]On November 8, 1982, DPW filed a notice of intent to revise Rule 52 a fourth time. DPW had not developed specific revisions when this report was written, but was expected to consider incentives to improve resident care, to discourage appeals, and to control costs.

(2) promote efficiency, economy, and uniform treatment of providers;

(3) satisfy federal requirements for rate-setting methods which are cost related or which incorporate reasonable charges;

(4) recognize licensing and certification requirements; and

(5) establish effective accountability.[5]

Rule 52 is "intended to compensate the provider for the reasonable costs incurred by prudent management."[6] Although the rule acknowledges required licensing and certification standards, it does not explicitly tie reimbursement to provider performance, needs of residents, or quality of care measures. Certain aspects of Rule 52 make it relatively easy for new providers to get established. For example, the rule does not require a minimum investment, and does not limit reimbursable interest rates or the initial per diem rate which can be paid.

Under Rule 52 each provider's per diem rate for the upcoming year is based on a determination of allowable actual costs from the previous year, plus projections for known or anticipated changes. Cost changes are subject to specific limits. Some cost changes are tied to economic indices, such as the consumer price index. If the final rate over-compensates the provider, then a year end adjustment is made to reimburse DPW. However, the provider must absorb any operating costs which exceed per diem payments. DPW calculates new rates at the end of each facility's fiscal year, using information which providers submit on prescribed forms.

Reduced to an equation, Rule 52 calculates the per diem rate as follows:

$$\text{Per Diem Rate} = \text{Historical Rate} + \text{Incentive Factor} \pm \text{Known Cost Changes} - \text{Government Grants}$$

The per diem rate resulting from this equation is subject to certain limits, which we discuss in Section F of this Chapter.

The historical rate is a determination of the allowable costs which occurred in the most recent fiscal year, divided by resident days. Variable costs, such as salaries and food, are divided by actual resident days. Fixed costs, such as property costs, are divided by 93 percent of total capacity days, for all facilities of more than ten beds and most smaller facilities. This rewards providers

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[5]Rule 52 is similar to DPW Rule 49 (12 MCAR §2.049), which establishes rate-setting procedures for Medicaid recipients in nursing homes.

[6]12 MCAR §2.052.A.2.

who maintain occupancy greater than 93 percent of capacity. According to DPW, occupancy in these facilities averages 97 percent.[7]

Known cost changes are future cost increases or decreases known at the time the provider files the cost report. Specified categories of known cost changes include salaries and wages, equipment, interest, depreciation, and food. For DPW approval, proposed known cost changes must be reasonable. The rule defines reasonable costs to be necessary and ordinary costs related to patient care, which prudent and cost-conscious management would pay.

Under current circumstances, the other two items in the equation are insignificant. The incentive factor allows the provider to retain one-half of any savings which result whenever the historical rate is less than the historical rate for the previous year. That is, if allowable costs decrease from one year to the next, then the provider keeps one-half of the difference for that one year. In practice this provision offers little incentive for cost control, since the rule otherwise reimburses actual costs up to fairly generous limits. In the past, government grants of state or county funds helped facilities begin operations. Such grants have become very rare.

For 1982 the average per diem rate for ICFs-MR in Minnesota was $51.71. The lowest rate was $22.87, and the highest was $117.00. Per diem rates have nearly doubled since 1978, when the average rate was $27.33.

We analyzed cost reports of 238 of Minnesota's ICFs-MR. The average per diem rate for 1982 for these 238 facilities was $50.44--very similar to the statewide average of $51.71 noted above. Rates for 1982 increased an average of 9.5 percent over 1981.

The average per diem rate of $50.44 is based on six categories of cost. Figure 9 shows that earnings, property, and administrative costs accounted for more than one-third of the average per diem rate.

In general, facilities with higher per diem rates are located in the Minneapolis-Saint Paul region; are new; have fewer than seven or more than sixteen residents; are licensed by the Department of Health as Class B facilities; are proprietary operations; and are members of systems of facilities.

Ninety-six facilities in our sample are located in the Minneapolis-Saint Paul region, and had an average per diem rate of $56.74 in 1982. The other 142 facilities had an average rate of $46.41--about 20 percent lower.

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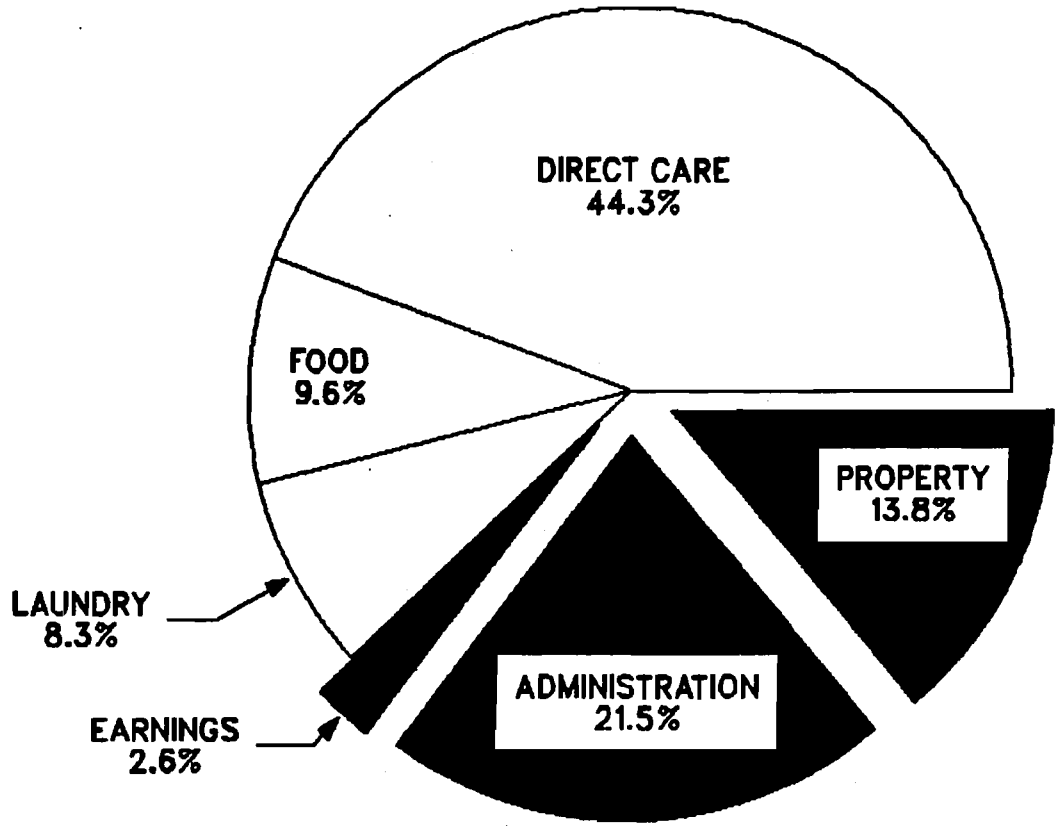
[7]Social Services Bureau, Department of Public Welfare, 1983.

FIGURE 9
AVERAGE COST ITEMS



Source: Program Evaluation Division Analysis, 1982.

As shown in Table 11, new facilities had the highest per diem rates for 1982.

TABLE 11

YEARS OF FACILITY OPERATION

Years of Operation	Number of Facilities (%)	Average Per Diem Rates
0 to 2	9 (4.6%)	$59.03
2 to 4	44 (22.6)	54.05
4 to 6	67 (34.3)	50.40
6 to 8	41 (21.0)	45.63
8 to 10	26 (13.3)	38.77
10 to 12	4 (2.1)	54.49
12 or more	4 (2.1)	42.23

Source: Program Evaluation Division Analysis, 1982.

Table 12 shows that the smallest and the largest facilities had higher average per diem rates.

TABLE 12

LICENSED CAPACITY

Licensed Capacity	Number of Facilities (%)	Average Per Diem Rates
0 to 6	84 (35.5%)	$54.69
7 to 10	51 (21.5)	46.35
11 to 16	63 (26.6)	46.52
17 to 32	11 (4.6)	56.58
33 to 48	14 (5.9)	55.10
49 or more	14 (5.9)	50.56

Source: Program Evaluation Division Analysis, 1982.

Facilities which are licensed as Class B (to serve residents who are not capable of self-preservation) have higher average per diem rates. For 1982, 28 Class B facilities had average rates of $65.52, while 211 Class A facilities had rates averaging $48.59.

Proprietary facilities had slightly higher 1982 per diem rates than the non-profit providers in our sample. There were 113 proprietary facilities, with an average per diem rate of $52.07. Rates for 124 non-profit facilities averaged $50.16. Our sample included 165 facilities which were members of systems. Per diem rates for system members averaged $52.20, while the 72 facilities which were not members of a system had average rates of $46.91.

C. MODELING THE RULE 52 RATE-SETTING PROCESS

In order to answer questions about Rule 52 rate-setting, we developed a computerized model of the Rule 52 reimbursement formula. The model uses data collected from actual cost reports and a financial planning and analysis software package.[8] The model enables us to:

- calculate the per diem rate of a given facility, whether actual or devised by us for our analysis;
- simulate the per diem rate for facilities given increases in actual costs due to inflation, and the limitations in the rule;
- analyze the fiscal health of facilities over a period of years, by comparing annual balance sheets and cash flows; and
- pose "what if" questions to determine what effect changes in the rule would have on different facilities or groups of facilities.

We collected data from the annual cost reports of 238 facilities for which final rates had been set for fiscal years ending in 1982.[9] We also used data from a file developed by the Developmental Disabilities Planning Section of the Department of Energy, Planning, and Development. That office has produced a series of useful studies about costs of services for the retarded, and other subjects. The base data were also used to provide descriptive information about the facilities in our files and to analyze significant relationships between types of facilities and certain expenses.

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[8]The package is known as IFPS--Interactive Financial Planning System. It is a proprietary system, developed by Execucom, Inc. and used by arrangement with Control Data Cybernet Services.

[9]Our file does not include data for about two dozen new facilities still operating under interim rates. Because DPW had not set final rates, our files do not include another two dozen facilities operated by the largest ICF-MR provider in the state. Except where otherwise noted, these omissions should not affect the usefulness of our analysis.

Our mathematical description of the rule was reviewed for technical accuracy by DPW staff and by a certified public accountant who works with many ICF-MR providers. We did not attempt to simulate all aspects of the rule. Where we wanted to analyze aspects of the formula in detail, we used a series of equations. In other areas, we inserted bottom-line figures from the cost reports.

We made certain assumptions about the rule and the operation of facilities:

- Occupancy and licensed capacity of facilities do not change from the 1981 cost report.
- Certain costs are adjusted annually according to indices published by an economic forecasting firm.[10]
- The costs allowed under Rule 52 are the total costs for the facility. There are two exceptions: principal payments on long-term debt, and income tax are calculated by the model and included in our analysis of cash flow.

In fact, a facility is likely to incur costs that are categorically disallowed by Rule 52, or which are found to be in excess of the rule's reasonable cost principles.[11] Furthermore, many facilities generate tax losses which can be used to shield income from other sources, thus increasing the provider's return.

Subsequent sections of this chapter provide additional detail about our use of the model and report the results of our analysis of significant aspects of rate-setting for ICFs-MR. In this chapter we report data from our base data files and the results of our simulations and other analysis.

D. INTEREST EXPENSE AND EARNINGS

Per diem rates are closely related to the number of years an ICF-MR has been operated--the newer the facility, the higher the rate. Much of the increase is found in two closely related cost categories: property, including interest and depreciation, and earnings. The rule contains an earnings allowance which is intended to provide a return on capital.

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[10] "The Long-Term Outlook," Data Resources U.S. Review, July 1982, p. 1.141.

[11] On the other hand, the provider will deduct these costs, as well as others, from taxable income. Provisions of federal tax law, particularly the Economic Recovery Tax Act of 1981, offer benefits to providers not considered in the rule.

We found:

- An average facility opened in the last three years had daily property and earnings costs of $11.19, and a total per diem rate of $55.85.

- For an average older facility, property and earnings costs were only $6.35 of a $48.23 per diem rate.

Property costs have increased because of inflation in construction costs, the extensive use of debt financing, and high interest rates in recent years. The earnings allowance for proprietary providers has increased because it is often based on interest expense.

We analyzed this aspect of the reimbursement formula and concluded:

- Rule 52 does not effectively control interest expense.

- The earnings allowance paid to providers bears little relationship to a return on capital investment.

1. INTEREST EXPENSE

There is no limit on interest expense for non-profit providers, and they typically incur large interest expense.[12] Of the 30 facilities reporting the highest interest expense in 1981, 21 were owned by non-profit operators.

The rule imposes a nominal restriction on interest expense for proprietary providers. They are allowed interest expense on only 65 percent of their fixed assets, based on the average interest rate on their capital debt. However, most providers need not worry about this limitation, since they can usually recover all disallowed interest through the earnings allowance.

The Rule 52 earnings allowance for proprietary providers is calculated in two ways. The allowance is intended to provide a ten percent return, after taxes, on the first 35 percent of equity. A six percent return is allowed on equity exceeding 35 percent. The rule presumes that the provider has invested capital equal to 35 percent of the facility's fixed assets. In fact, most facilities are largely debt financed, and few providers have 35 percent equity. Of 90 facilities which we modeled:

- Fewer than one-fourth had 35 percent equity.

- More than one-fourth had capital debt in excess of the book value of their fixed assets.

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[12]The only restriction is that the interest rate may not be more than what a borrower would have to pay in an arms-length transaction in the money market, at that time.

Many of these facilities have large amounts of disallowed interest and are better served by the second earnings calculation, called the minimum cost of capital. In that calculation, a provider receives an allowance for each resident day--currently $.73--plus all disallowed interest. Under Rule 52, a non-profit provider also receives the resident day allowance.

The result is that a provider who has large amounts of disallowed interest will recover that expense through the earnings allowance. For two-thirds of the proprietary homes in our model, the provider was reimbursed for all disallowed interest through the minimum cost of capital allowance.

Because Rule 52 does not effectively limit interest expense, providers have little incentive to try to negotiate more favorable rates, to delay development until interest rates decline, or to invest additional capital to reduce borrowing. Even though interest rates were very high during the past three years, development of new facilities continued. Several new facilities entered into long-term mortgages with high interest rates.

DPW Rule 49, which governs Medicaid reimbursement for nursing homes, places two important controls on interest expense. Like Rule 52, it allows interest expense for non-profit providers. But after the third year of operation, Rule 49 disallows interest on debt which exceeds the net value of the facility's fixed assets. Furthermore, Rule 49 does not allow interest expense for proprietary homes when the interest rate exceeds twelve percent.

2. EARNINGS ALLOWANCE

A second problem is that the earnings allowance usually bears little resemblance to a return on investment. Rule 52 states that proprietary providers are allowed "a reasonable return on capital provided." To calculate the allowance, the rule presumes that the provider has invested capital equal to 35 percent of the fixed assets of the facility. In the few instances where a provider has at least 35 percent equity, the earnings allowance serves the purpose described by the rule. But in the case of debt-financed facilities, the earnings allowance provides a return on investment far in excess of that described in the rule. In the next section, we show that Rule 52 encourages debt financing and discourages personal investment by providers.

E. EQUITY REQUIREMENTS

Most new ICFs-MR are largely debt-financed; the provider invests very little personal cash. Rule 52 does not require any cash investment and permits facilities to be completely debt-financed. Of facilities opened in 1981, for which information was available none had equity of 35 percent, the proportion presumed by Rule 52. Only two facilities had 25 percent equity, while most of the facilities had capital debt exceeding 90 percent of their fixed assets.

Some facilities are indebted above the value of their fixed assets. This is often true for homes financed by the Minnesota Housing Finance Agency (MHFA), under its program of providing mortgages for group residences for developmentally disabled persons. For non-profit providers, MHFA will finance the entire cost of site acquisition, construction, and closing costs, as well as certain development costs. MHFA then adds a two percent financing fee and a ten percent development cost escrow to the principal.[13]

The Minnesota Department of Health (MDH) and other state agencies are concerned that low equity:

- increases property costs and thus per diem rates;
- burdens a provider with high fixed costs, while limiting flexibility to deal with possible decreases in occupancy or Medicaid reimbursement; and
- indicates that the provider is less committed to the facility and its program.

The Commissioner of Health has raised these issues in considering recent applications for Certificates of Need for new ICFs-MR. In five cases, the commissioner remanded the application to the regional Health Systems Agency (HSA) for additional consideration of issues of equity and cost. In other cases, the Department of Health has negotiated with the provider to limit the per diem rate or the amount of debt incurred.

We analyzed the Department of Health's concerns using our computerized simulation of the Rule 52 reimbursement formula. We modeled the effects of reducing debt and increasing owner equity for a group of recently opened, largely debt-financed facilities. Table 13 shows the results for three facilities.

We found:

- Large amounts of debt increase per diem rates, and increased equity reduces it.

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[13]The escrow is held by MHFA and may be used "to pay current and delinquent operating expenses and principle and interest payment on the mortgages, to maintain a reserve for replacement, and under certain circumstances, to provide for additional amenities for building modifications." Minnesota Housing Finance Agency, Final Private Placement Memorandum Relating to $4,935,000 Minnesota Housing Finance Agency Housing Development Bond, 1981 Series A, 1981, p. 22. The provider receives some of the interest income generated by the escrow account, but is not reimbursed by DPW for the interest expense.

TABLE 13

HOW WOULD INCREASED EQUITY AFFECT RECENTLY OPENED ICFs-MR?

CASE 1: Proprietary--12 Class A Beds--Aitkin County. Per Diem Rate: $51.45
Fixed Assets: $173,642. Capital Debt: $177,104. Average Interest Rate: 12.49%

ADD:	EQUITY	%	ANNUAL INTEREST EXPENSE	ANNUAL EARNINGS ALLOWANCE	PER DIEM COST OF INTEREST AND EARNINGS	PER DIEM RATE
$ 0	-$ 3,462	-2.0%	$22,130	$10,962	$6.15	$51.45
10,000	6,538	3.8	20,780	9,680	5.82	51.12
30,000	26,538	15.3	18,080	8,854	5.57	50.87
50,000	46,538	26.8	15,380	8,854	5.52	50.82
75,000	71,538	41.2	12,252	9,500	5.34	50.64

CASE 2: Non-profit--12 Class A Beds--Polk County. Per Diem Rate: $39.49
Fixed Assets: $119,476. Capital Debt: $140,195. Average Interest Rate: 12.6%

ADD:						
$ 0	-$20,179	-17.3%	$17,665	$ 2,516	$5.94	$39.49
10,000	- 10,719	- 8.9	16,405	2,516	5.57	39.12
30,000	9,281	7.7	13,885	2,516	4.83	38.38
50,000	29,281	24.5	11,365	2,516	4.09	37.64
75,000	54,281	45.4	8,215	2,516	3.16	36.71

CASE 3: Proprietary--10 Class A Beds--Rock County. Per Diem Rate: $62.63
Fixed Assets: $114,181. Capital Debt: $140,999. Average Interest Rate: 18.5%

ADD:						
$ 0	-$26,818	-23.5%	$26,085	$14,702	$8.37	$62.63
10,000	- 16,818	-14.7	24,235	12,852	7.83	62.09
30,000	3,182	2.8	20,535	9,152	6.74	61.00
50,000	23,182	20.3	16,835	5,822	5.76	60.02
75,000	48,182	42.2	12,210	6,315	5.45	59.71

Source: Program Evaluation Division Simulation, 1982.

But the reduction is not large. The amount of reduction varies, depending on the interest rates charged on the loans. Facility 3's per diem rate decreased by $.50 for each $10,000 of added investment, until about 20 percent equity was reached. The decrease in Facility 1's rate is smaller, partly because its loans were at lower interest rates.

Furthermore,

- Increases in equity do not provide a better return on investment for the provider.

As we noted above, most proprietary providers have large amounts of disallowed interest and benefit from the minimum cost of capital allowance--$.73 per resident day plus all disallowed interest. Facility 1 benefits from the minimum cost of capital allowance until it reaches about 15 percent equity. After that point, its added equity will not increase the provider's return until equity exceeds 35 percent.[14] However, the provider loses the earnings that could be realized by putting available cash into other investments.

- Non-profit providers have even less incentive to increase equity.

As illustrated by Facility 2, a non-profit provider's earnings allowance is completely independent of equity and investment. The provider will receive the same allowance whether the facility is debt-free or entirely debt-financed.

We agree with the Commissioner of Health's position that the state should be concerned about the long-term solvency of facilities that are heavily debt-financed. We found that:

- Highly debt-financed facilities are particularly vulnerable to reductions in Medicaid reimbursement.

We modeled a group of recently opened facilities, and simulated expenses, reimbursement, and cash flow over a twenty-year period. In addition to the assumptions described in section C of this chapter, we also assumed that the facility would incur additional debt twice during the twenty years in order to finance new investment in furnishings and equipment. We also assumed that the owners withdraw all positive cash flows from the facility, since the operations are labor intensive, and a provider has few opportunities to reinvest cash.

We first simulated the effects of the current reimbursement system. We found that facilities experience positive cash flows throughout the simulation's twenty years. In several cases, however,

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[14]This example illustrates the point made in our discussion of earnings: the earnings allowance bears little resemblance to a return on capital investment.

the cash flows became quite low in the sixth to eighth years of operation, and remain positive only because of the effect of new investment and debt on per diem rates.

A typical ICF-MR is financed by a level-payment, long-term loan. During the first years of operation, most of the loan payment is interest expense, reimbursable under Rule 52. Payments of principal, which are not reimbursed, are very small. But in later years, the principal portion of the payment increases, leaving the provider with a big, unreimbursed cash expense. Providers could prepare for this by establishing a reserve for the depreciation allowance and not using it for cash flow. This reserve could also be used to meet a provider's working capital needs. Rule 52 reimburses a provider for interest on working capital loans.

We then simulated the effect of changes in Medicaid reimbursement and in the facility's balance sheet. We asked:

- What if Medicaid reimbursement was reduced by four percent?[15]
- What if an eight percent cap was imposed on annual rate increases?[16]
- What if the facility's capital debt was reduced by $40,000?

1. REIMBURSEMENT REDUCTION

When a facility's reimbursement revenue is cut by four percent, cash flow immediately suffers. In the cases we simulated, the facilities experienced negative cash flows as early as the third year. The negative cash flows continued throughout the twenty-year simulation.[17] One significant exception was a facility with relatively high equity--about 31 percent--which was able to maintain a positive cash flow until the twelfth year of the simulation, at which time cash flow dipped below zero. Figure 10 shows the effect of a four percent reduction in reimbursement on a typical facility.

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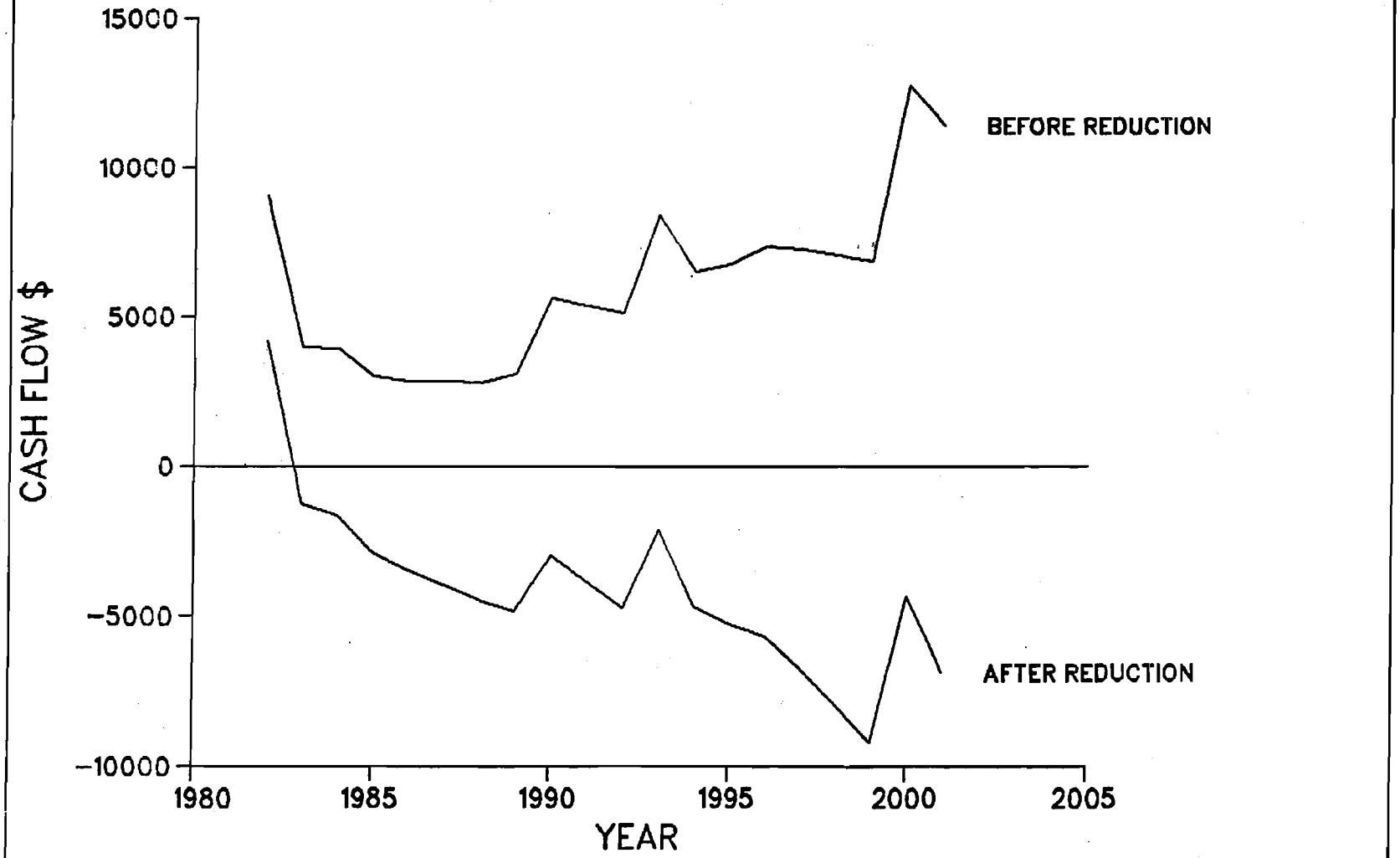
[15]This strategy was adopted for a six-month period, in the budget balancing bill enacted in the Third Special Session of 1982. Payment to ICFs-MR and other Medicaid vendors will be reduced by four percent.

[16]We discuss the issues of caps on annual rate increases in more detail in Section F of this chapter.

[17]The facilities also experience a net loss for income tax purposes, which may be a benefit to proprietary operators with other sources of income.

FIGURE 10
HOW A FOUR PERCENT REDUCTION IN REIMBURSEMENT AFFECTS CASH FLOW



Source: Program Evaluation Division Simulation, 1982.

A provider cannot continue to make loan payments if cash flows are insufficient. The choices typically available to the provider at that time are:

- increase personal capital investment;
- refinance the facility, in order to benefit from increased interest expense reimbursement and the appreciated value of the facility; or
- sell the facility.

The usefulness of refinancing or selling may be limited by caps on annual rate increases. However, the state should be concerned that a sustained period of reduced reimbursement will increase turnovers in ownership of ICFs-MR.

2. MORE RESTRICTIVE CAP

Most of the new facilities that we analyzed would not be seriously hurt by an eight percent cap on rate increases.[18] In some cases, cash flow would be reduced, particularly where increases in per diem rates lagged behind increased expenses. Generally, the per diem rate catches up after one or two years. Cumulative cash flows would be reduced, which would make the facility less attractive to prospective buyers.

3. REDUCTION OF DEBT

The reduction of debt and the investment of additional capital in the facility generally improves the cash flow of a facility throughout the twenty-year simulation. Reduced debt also reduces the fixed costs of a facility, making it slightly less vulnerable to reductions in reimbursement. However, these improvements may not be significant, especially if the facility was not highly indebted.

RECOMMENDATIONS

We recommend changing Rule 52 in two ways:

- The rule should effectively limit interest expense.

This can be done by setting maximum interest rates beyond which the state will not reimburse. The maximum rates should be tied to measures of market interest rates, up to a fixed ceiling. Or, the state should decline to pay interest expense on debt which exceeds the value of a facility's fixed assets, adjusted for depreciation. This limit should be applied immediately to all new facilities and to any new debt incurred by existing facilities.

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[18] The forecasts of annual inflation used in our model rarely exceed eight percent.

- The rule should pay an earnings allowance which is based on capital investment.

The allowance should be based on actual investment. A provider should receive a return that rewards and encourages capital investment.

F. LIMITATIONS AND PAYMENT REDUCTIONS

Average per diem rates and Medicaid expenditures for facilities for the mentally retarded have increased dramatically in recent years. Rule 52 and the Legislature have imposed caps on the amount by which a per diem rate can increase from one year to the next; and across-the-board reductions in the amounts paid to providers.

1. CAPS ON RATE INCREASES

For 1982 and 1983, the Legislature limited rate increases for residential facilities to ten percent.[19] This law applied to payments for rate years beginning during the biennium ending June 30, 1983, and is effective until that date. The cap applied to all nursing homes and ICFs-MR.

We found:

- The 10 percent cap has been effective, in the short run, in limiting rate increases.

Our three-year simulation of per diem rates for 90 facilities showed that 1982 rates for virtually all of these facilities were reduced because of the ten percent cap. The average per diem rate for our sample increased by 9.5 percent, to $50.44. The average rate would have increased by 14 percent, to $52.56, without the ten percent cap.

Long-term effects of this cap are uncertain. Providers probably adjust their spending patterns to take advantage of the cap. Providers have an incentive to increase spending at a rate close to, but not exceeding, the limit. A higher rate helps pay for more services, salaries, or profit, and ensures a high base for future rates. However, expenditures beyond the cap are not reimbursed.

Providers may react differently to temporary or permanent caps. Facing a temporary cap, providers may postpone expenditures or make other decisions which lead to higher costs at a later time. A permanent cap may ensure that spending patterns and costs stay within desired boundaries.

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[19] 1981 Minn. Laws, First Special Session, Chapter 2, Section 13.

From the state's perspective, savings accumulate, as the capped rate for one year becomes a lower base for the following year. A cap controls both the rate paid and the base for the next year.

The present statutory cap expires June 30, 1983. If the Legislature does not enact a similar cap by then, the existing limit in Rule 52 will take effect. Rule 52 limits Medicaid per diem rates to a 15 percent increase over the previous rate for each facility.[20] This limit does not apply to:

- costs incurred to meet minimum and immediate requirements imposed by any governmental agency;
- reasonable salary changes in excess of 15 percent of historical salaries; and
- providers whose requested per diem rate is less than 80 percent of the statewide weighted average.

We simulated the effects of maintaining a ten percent cap and of establishing an eight percent cap. Table 14 shows effects of these caps on one facility's approved rates, rate increases, and cash flow, over time. These are indications of savings for the state, and management flexibility for the facilities.

TABLE 14

EFFECTS OF DIFFERENT CAPS ON A TYPICAL FACILITY

	10 PERCENT CAP				8 PERCENT CAP			
Year	Approved Rate	Rate Increase	Effect of Cap	Cash Flow	Approved Rate	Rate Increase	Effect of Cap	Cash Flow
1983	$ 87.88	7.7%	$0	$4,000	$ 87.88	7.7%	$0	$4,000
1985	99.23	5.8	0	3,031	99.23	5.8	0	3,031
1987	114.30	7.4	0	2,857	114.30	7.4	0	2,857
1989	134.10	9.8	0	3,124	131.90	8.0	2.20	- 145
1991	155.20	6.7	0	5,415	153.80	8.0	1.33	3,435

Source: Program Evaluation Division Simulation, 1982.

Table 14 shows that rates for this facility will increase to $155.20 by 1991, under a ten percent cap. However, rate increases did not reach ten percent in any of these years--the ten percent cap had no effect. On the other hand, an eight percent cap reduced per diem rates in two of the years depicted in Table 14. Also, an eight percent cap caused more significant reductions in facility cash flow, compared to a ten percent cap. This pattern holds for other cases which we analyzed.

[20] MCAR §2.052.B.4.b.

2. PAYMENT REDUCTIONS

During the third special session of 1982, the Legislature reduced payments to all Medicaid vendors by four percent.[21] This reduction affected services provided between January 1 and June 30, 1983; and was based on the rate in effect for that period.

We simulated the effects of continuing the payment reduction beyond its scheduled expiration on June 30, 1983. We were interested in possible savings, and the fiscal solvency of facilities. Table 15 compares the four percent payment reduction and the 10 percent cap, for one facility.

TABLE 15

EFFECTS OF CAP VS. PAYMENT REDUCTIONS
ON A TYPICAL FACILITY

	10 PERCENT CAP			4 PERCENT REDUCTION		
Year	Annual Reimbursement	Cash Flow	Taxable Income	Annual Reimbursement	Cash Flow	Taxable Income
1983	$192,461	$4,000	$5,786	$184,763	-$1,235	-$1,912
1985	217,311	3,031	6,325	208,618	- 2,880	- 2,367
1987	250,246	2,857	6,948	240,237	- 3,949	- 3,062
1989	293,659	3,124	8,216	281,913	- 4,863	- 3,530
1991	339,827	5,415	9,240	326,234	- 3,828	- 4,353

Source: Program Evaluation Division Simulation, 1982.

In this simulation results are dramatic and consistent. Cash flows change from positive to negative under the payment reduction, which could signal operating problems for the facility. Even more dramatic is the change in taxable income which becomes increasingly negative under the payment reduction provision. Other simulations produced similar results.

3. CAPS VS. PAYMENT REDUCTIONS

Based on our simulation, we found:

- Payment reductions offer greater, more dependable savings compared to caps.
- Payment reductions reduce cash flows and taxable income more dramatically than caps.

[21] Minn. Laws 1982, 3rd Spec., Chap. 1, Art II, Sec. 1, Subd 4(a).

These comments reflect the size of the caps and reductions we analyzed. The results might be different for caps and reductions of different sizes.

We have three concerns about caps and payment reductions:

(1) Caps and reductions may limit needed management flexibility and create undesirable incentives for providers.

Caps allow more operating flexibility than payment reductions, which decrease facility revenues regardless of the efficiency or effectiveness of the operation. Caps encourage spending up to, but not beyond, specified limits. Payment reductions probably encourage reporting more costs which are allowable but not out-of-pocket. Caps and reductions may encourage more spending for fixed costs and less for direct resident care costs, to maintain the provider's return and to take advantage of an occupancy incentive which we discuss in Section G of this chapter.

(2) Caps and reductions affect all providers.

Rule 52 reimburses allowable costs within limits, whether services are good or poor. Caps and limits exaggerate this problem. To improve services, facilities generally incur increased costs. If caps or reductions limit reimbursement, then improved services may not be possible.

(3) Caps and reductions affect costs and revenues indiscriminately--those for direct services to residents, as well as those for facility profits.

It may be possible to target caps and reductions to shield direct services to residents. Limits could apply specifically to daily administrative costs rather than to resident services.

We analyzed administrative costs and their relationship to per diem rates, and found:

- Daily administrative costs ranged from $2.51 to $20.75 and from 8.5 percent to 34.9 percent of total per diem rates.

- 25 percent of facilities outside the Minneapolis-Saint Paul region had daily administrative costs above $11.50, and 10 percent had costs above $13.10.

- 25 percent of facilities in the Minneapolis-Saint Paul region had daily administrative costs above $13.00, and 10 percent had costs above $15.64.

Rule 52, by itself, is ineffective in controlling the growth of per diem rates. Therefore, we recommend that:

- To control spending for long-term care, the Legislature should continue to impose overall caps which are tied to anticipated inflation rates.

Furthermore:

- If additional caps or reductions are needed, they should be tied to limits on reimbursement for administrative costs.

For example, payment could be limited to the 80th percentile of daily administrative costs in the Minneapolis-Saint Paul region and in the rest of the state for the previous rate year. DPW could set different maximum payments for administrative costs for facilities of different sizes. Administrative costs would need to be defined more clearly, if used in this way. This approach should limit costs without affecting direct care and should give providers more flexibility in administering their facilities. By giving providers more flexibility, this change would also reduce DPW's laborious work in reviewing costs such as top management compensation, consulting fees, and retirement benefits. DPW may wish to consider the use of categorical caps as an alternative means of limiting reimbursement for property and earnings costs.

G. OCCUPANCY INCENTIVE

Rule 52 contains an incentive encouraging high occupancy rates.[22] Under the rule, a historical per diem rate is determined by dividing reported costs by resident days. Variable costs are divided by actual resident days, and fixed costs are divided by 93 percent of capacity resident days.

Facilities with occupancy rates above 93 percent benefit, because a lower denominator is substituted in the calculation of the per diem rate--the lower the denominator, the higher the resulting rate. Consider a hypothetical facility of 11 beds, with actual occupancy of 99 percent and $100,000 in fixed costs. Case 2 applies the incentive factor, unlike Case 1:

- Case 1: $100,000 ÷ [(11 beds X 365 days) X (.99)]
  = $100,000 ÷ 3,975
  = $25.16 reimbursement for fixed costs.

- Case 2: $100,000 ÷ [(11 beds X 365 days) X (.93)]
  = $100,000 ÷ 3,734
  = $26.78 reimbursement for fixed costs

In this hypothetical example the occupancy incentive increases reimbursement for fixed costs by $1.62, or 6.5 percent.

The occupancy incentive penalizes facilities whose occupancy rate falls below 93 percent. Consider the hypothetical case above, substituting an actual occupancy rate of 88 percent. Case 3 shows reimbursement for fixed costs when the occupancy incentive is not applied:

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[22] MCAR §2.052.B.1.a.

- Case 3: $100,000 ÷ [(11 beds X 365 days) X (.88)]
  = $100,000 ÷ 3,533
  = $28.30 reimbursement for fixed costs.

In Case 3 the 93 percent occupancy factor reduces daily reimbursement by $1.52.

The rule's occupancy incentive treats large and small facilities differently. A facility smaller than eleven beds may use actual resident days or the 93 percent factor, whichever is more favorable to it, when calculating the fixed cost portion of its per diem rate. This means that small facilities benefit from the incentive if occupancy is high, but are not penalized if occupancy is below 93 percent. Facilities of eleven or more beds do not have this option, but must apply the 93 percent factor regardless of actual occupancy rates.

Table 16 summarizes the results of our analysis. As per diem rates increase, so do the per diem costs of the occupancy incentive; in Case A the occupancy incentive adds $5.18 to the per diem rate projected for the year 2001. The occupancy incentive adds $0.77, or 1.5 percent, to the average per diem rate of $50.44.

TABLE 16

OCCUPANCY INCENTIVE FOR THREE TYPICAL FACILITIES

Year	Per Diem Rate	Per Diem Cost of Occupancy Incentive	Occupancy Incentive as Percent of Per Diem Rate
Case A:	Proprietary--6 Class A Beds--Hennepin--100% Occupancy		
1982	$ 81.61	$1.82	2.2%
1986	106.40	2.04	1.9
1991	155.20	2.88	1.9
2001	307.80	5.18	1.7
Case B:	Non-Profit--12 Class B Beds--Dakota--99.9% Occupancy		
1982	$ 94.21	$0.90	1.0%
1986	124.30	2.07	1.7
1991	177.50	2.69	1.9
2001	344.30	4.28	1.2
Case C:	Proprietary--32 Class B Beds--Stearns--85% Occupancy		
1982	$ 32.33	-$0.77	-2.4%
1986	37.62	- 0.85	-2.3
1991	55.41	- 1.27	-2.3
2001	111.80	- 2.55	-2.3

Source: Program Evaluation Division Simulation, 1982.

According to the state's Developmental Disabilities Office, nearly 90 percent of ICFs-MR in Minnesota have occupancy rates of 93 percent or above.[23] The statewide average occupancy rate has been consistently high since 1976, and is now 97 percent. High occupancy probably reflects the significant demand for residential care, and has little to do with the occupancy incentive in the rule. If so, then the objective of the incentive could be met without paying this premium.

We recommend that:

- DPW should revise Rule 52 to reduce the incentive premium by replacing the 93 percent occupancy factor with a 96 percent occupancy factor.

Since we see no reason why small facilities should experience lower long-term occupancy rates than large facilities, we also recommend that:

- DPW should apply a minimum occupancy factor of 85 to 90 percent for facilities of fewer than eleven beds.

These changes would recognize recent experience, would produce some savings, and remove a provision which unduly benefits small facilities.

H. TREATMENT OF LEASES UNDER RULE 52

A small but growing number of residential facilities are operated through lease arrangements. In our file of 238 facilities, 20 facilities, many of them recently opened, were leased. Leasing may be an attractive option when a provider is unable to secure traditional financing or chooses not to do so.

We found that treatment of leases under Rule 52 poses three potential problems for the state:

(1) The language of Rule 52 is not consistent with Generally Accepted Accounting Principles (GAAP) and is not clear enough to protect the state's interests in these arrangements.

(2) The state's control over investment in ICFs-MR is reduced.

(3) The use of lease arrangements allows a provider to escape some of the scrutiny of the Certificate of Need and §1122 capital expenditure reviews discussed in Chapter II.

Under Rule 52, rental charges under bona fide leases are allowable costs unless:

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[23]Developmental Disabilities Planning, Policy Analysis Series, No. 4, p. 9.

- rental charges result from a sale, lease-back arrangement, or lease with option to buy at a price less than anticipated value; or

- rental charges are paid to a related or controlled organization.[24]

If the rental charges are disallowed, then Rule 52 allows a provider the actual costs of capital interest, depreciation, property tax and so on, associated with the facility. These expenses are subject to the other limitations built into the rule.

However, the language of Rule 52 is inconsistent with GAAP. Under GAAP, leases are divided into capital leases and operating leases. No matter what labels the parties put on a lease, it is treated as a capital lease if any of these four conditions are met:

(1) The lease transfers ownership at the end of the lease period.

(2) The lease contains a bargain purchase option.

(3) The term of the lease is greater than or equal to 75 percent of the asset's economic life.

(4) The present value of the minimum lease payment is greater than or equal to the fair value of the asset.[25]

If none of these conditions is met, the lease is treated as an operating lease, and the lessee's costs are the rental charges only.

In many cases, a lease is used as a means of financing the construction and later purchase of an ICF-MR. The lease typically includes an option to buy. Sometimes the lease specifies a sale price, based on the cost of construction. In other cases, no purchase price is set by the lease.

In either case, the language of the rule is not explicit enough. "A price less than anticipated value" is less clear than GAAP, and is not definite enough to protect the state's interests in this area. The state should be concerned for several reasons. First, if no purchase price is set, then the parties can set a high price, which would not be subject to state review. On the other hand, if a price is not tied to the market value of the property, then the purchase price may be unreasonably low, and the state has, in effect, financed the down payment of the provider through per diem payments made while the facility was leased.

A lease, by itself, does not increase reimbursement during the life of the lease. We found the property and earnings portion of

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[24] 12 MCAR §2.052.D.4.

[25] Financial Accounting Standards Board Statement No. 13, as amended.

the per diem rate is not significantly different for leased or owner-operated facilities. The average per diem rate for leased facilities is significantly higher because of higher costs in other areas.

The problem for the state may occur if the provider exercises an option to purchase the facility. That transaction probably would be viewed as an arms-length sale, and would not be subject to state review under Certificate of Need or §1122 capital expenditure review. In this case, the provider would begin to depreciate the facility, beginning from its purchase price basis. Because of the age of the facility, the provider could choose to depreciate over less than the traditional 35 year building life. Also, interest expense would be based on the new mortgages on the facility.

The state, therefore, would be asked to pay a second time for depreciation expense. In one case, DPW now reimburses a provider $121,310 each year for the annual lease payment on a 32-bed facility. These payments, which presumably cover interest and depreciation costs and a return to the owner, will exceed $600,000 in a five-year lease period. If the provider purchases the facility after five years and pays the original construction price, the state will be asked to pay again for property expenses that it has already paid for five years. If the sale price is higher, then the state will pay higher depreciation expenses over the facility's life. This is similar to the costs arising from a sale of a facility between two providers, except in this case there would be no opportunity for the state to recover the depreciation expense that it has paid out.

We recommend that:

- DPW should change Rule 52 to incorporate Generally Accepted Accounting Principles.

- Where the operator purchases a leased facility, DPW should reduce allowable depreciation by the amount the state paid out during the lease period.

Thus the basis for depreciation and for debt allowance would be limited to the purchase price less an amount calculated by DPW, based on the original value of the facility and the time elapsed during the lease period.

I. ADMINISTRATION OF RULE 52

Rule 52 establishes reporting requirements, authorizes DPW audits, and provides appeal rights. Each provider submits statistical data, financial statements, and reports of historical costs and known changes. Upon request, providers must make available their federal and state income tax returns. Cost reports are due within three calendar months after the close of each provider's fiscal year. Upon written request, DPW grants a routine extension of 60 days. DPW may reduce the per diem rate by 20 percent, if a provider fails to comply with these requirements.

All cost reports are subject to a desk audit, and may receive a field audit. A desk audit is a review of the accuracy and appropriateness of the cost report itself, which results in a per diem rate being set. A field audit is a more thorough review of records which support the cost report and the rate set in the desk audit. Changes in approved rates result from both types of audit. Providers have 30 days to appeal new rates. Informal and formal procedures are available for handling appeals.

DPW staff in the Department's Bureau of Support Services enforce Rule 52. Two desk auditors in this bureau's Long Term Care Rates Division set per diem rates. Sixteen auditors in the Fiscal Audits Division perform field audits of selected Rule 52 and all nursing home rates. An attorney in the Bureau of Support Services handles appeals of these cases.

1. DESK AUDITS

A provider submits a cost report with a proposed rate, which the desk auditor adjusts to produce an approved rate. When a cost report is unclear or incomplete, the desk auditor requests additional information from the provider. Justification for changes to the proposed rate, and all communication with a provider, are significant items for the record for each facility. This information may help in setting subsequent rates or processing appeals.

We reviewed 238 files of Rule 52 facilities, and found inadequate records of contacts with providers and little evidence to show why changes were made to requested rates. Many of the rate changes we observed were related to interpretations of "reasonable costs". This is an important concept which could help in controlling rates and costs but one which is poorly defined in Rule 52.

The desk auditor sends written notice of approved rates to each provider. This letter shows the new rate and its effective date, with brief reference to the reasons for any changes. DPW sends letters concerning final rates and temporary rates -- the latter follow a cursory review of cost reports.

We recorded the number of days which elapsed between the date DPW received each cost report and the date it issued the final rate letter. The elapsed time is an indication of how long DPW took to set final rates. For 226 facilities we found:

- On the average, 95 days elapsed between DPW receiving a cost report and sending a notice of the final rate. The median elapsed time was 76 days and the range was from 6 to 303 days.

This record probably reflects delays in getting adequate information from some providers, when the cost report is insufficient. Providers submit cost reports about three months after the close of their fiscal year, and DPW takes an average of three months to set a final rate. Thus one-half of the year, or more, may pass before a provider knows its per diem rate for that year.

2. APPEALS

Rule 52 authorizes a provider or county to appeal a new per diem rate within 30 days of DPW's notification of the new rate. The rule provides that any amount in dispute will not be adjusted until a final determination is made under specified appeal procedures. Resulting adjustments are retroactive to the effective date of the appealed rate. DPW must pay any adjustment within 45 days, and providers must pay within 120 days.

DPW uses three approaches to settling appeals:

(1) The staff attorney responsible for appeals processing seeks informal resolution through direct contact with the appealing party.

(2) DPW and the appealing party can choose a process in which both parties present evidence to a hearing examiner, after agreeing to accept the findings of the hearing examiner with no further right of appeal.

(3) Formal contested cases involve a hearing before a hearing examiner, with the presentation of evidence and cross-examination of witnesses. The hearing examiner makes recommendations to the Commissioner of Public Welfare, who makes a final decision. The commissioner's decision may be appealed to district court.

In October 1982, DPW faced a backlog of 150 Rule 52 appeals and over 500 Rule 49 (nursing home) appeals. According to the department this backlog began in 1979. In January 1982, the department hired an attorney on a two-year basis to resolve these appeals. Between January 1982 and November 1982, this attorney resolved approximately 40 appeals, tried to identify appeals which could be consolidated and expedited, and worked to automate the processing of appeals data.

Providers and DPW have different incentives for filing or settling appeals. Providers have an incentive to appeal when they owe DPW a refund--either because the previous year's allowable costs fell below that year's approved rate, or because DPW set a temporary rate which proved to be higher than the final rate. DPW has an incentive not to settle an appeal whenever the rate being paid is less than the rate which the provider requested.

Further delays in resolving rate appeals may jeopardize the state's ability to capture matching federal funds to pay the cost of appeals settlements. The U.S. Department of Health and Human Services (HHS) has used new regulations to suspend payment of state claims for reimbursement of payments made to Medicaid vendors in settlement of rate appeals.[26] HHS staff has told us that their enforcement of this rule will change, so that payments to vendors in settlement of old rate appeals will be viewed as current expenditures,

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[26] 45 CFR §§95.1-95.34 (1982).

eligible for federal financial participation. However, the U.S. Congress recently has used appropriations acts to limit federal reimbursement to state institutions for prior years, notwithstanding statutes or regulations to the contrary. Congress may take similar action with regard to reimbursement for privately operated long-term care facilities.

We found:

- DPW has virtually no information regarding the characteristics of pending appeals, such as the issues being appealed or the amount of money involved.
- DPW has no clear set of priorities among pending appeals or criteria by which to set priorities.
- New appeals are added to the backlog with no obvious effort to give priority to cases which could be settled quickly, or resolved through informal means.

RECOMMENDATIONS

1. DESK AUDITS

We recommend:

- Each Rule 52 file should contain explanations of rate changes, identifying specific provisions of the rule which authorize the change, with an interpretation of its application to the case at hand.
- All communication with providers should be documented through summaries of telephone conversations and copies of letters.
- DPW should propose revisions to Rule 52 which clarify the meaning of "reasonable costs." This should include specific, objective standards by which "reasonableness" will be determined.
- DPW should consider automating rate-setting to expedite the process and to improve its information about expenditures and rates.
- DPW should continue to limit the use of temporary rates, because of the extra time necessary to calculate both temporary and final rates, and because they may encourage appeals.

2. APPEALS PROCESS

We recommend:

- DPW should compile basic data regarding the current backlog of appeals, including the basis for each appeal, estimated fiscal effect, precedential value, and the number of appeals filed by each provider.

- DPW should give priority to appeals in the backlog which can be resolved quickly, can be consolidated, or involve large amounts of money.

- DPW should emphasize informal means of resolving disputes even before appeals are filed, so that the least cumbersome and least costly means are used to resolve the greatest number of disputes.

- DPW should consider using part-time or contract employees to resolve old appeals, and use permanent employees to resolve incoming appeals in a more timely manner.

IV. POLICY ALTERNATIVES

In previous chapters we concluded:

- Providers may be overbuilding community residential facilities for the retarded.

Development of new ICFs-MR continues at a rapid pace, even though goals established by the Department of Public Welfare have already been passed. But,

- These new facilities are not meeting needs identified in the Welsch v. Noot consent decree and in DPW plans.

Most residents of the new facilities do not come from state hospitals. Furthermore, most are not highly dependent.

We also concluded that:

- Per diem rates for new facilities are high and continue to rise.

In part, this is because the state is making an expensive, long-term investment in property and buildings. Numerous reviews and regulations for new facilities have not effectively controlled their costs. In fact,

- DPW Rule 52 is generally ineffective in controlling the costs of ICF-MR care.

The availability of Medicaid funding for ICFs-MR has been a key factor in their rapid growth and high utilization. We think that the state relies too heavily on community residential facilities, much as it relied too heavily in the past on state institutions. At the same time:

- Alternatives to ICF-MR care, such as semi-independent living services (SILS) and foster care, lack stable funding and are not well developed.

We have offered recommendations to correct problems with reimbursement and with statewide planning and regulation of residential services. However, we believe that policy makers in the Legislature and DPW should take a broader view of residential services for mentally retarded persons. They should establish priorities among service needs, and should adapt funding mechanisms to meet those goals. This chapter presents approaches for consideration by policy makers.

Our proposals are in three areas:

(1) increasing the availability and use of alternative forms of residential care;

(2) encouraging existing facilities to serve more dependent individuals; and

(3) limiting development of new ICFs-MR.

These recommendations stress state objectives of deinstitutionalization and normalization, the need for mentally retarded persons to have opportunities to develop and grow within their communities, and the importance of making effective use of existing resources.

A. STRENGTHEN ALTERNATIVES TO RESIDENTIAL CARE

Alternative residential services, such as semi-independent living services (SILS), professional foster care, or family assistance, are not widely available in Minnesota. These programs are not well developed and lack stable funding. The absence of alternative services slows a mentally retarded person's development toward independence. It may result in inappropriate placement in a long-term care facility, or remaining in a facility long past the time that the person is ready for a more independent setting.

Staff of the Department of Public Welfare and the Department of Health, and ICF-MR providers estimate that 10 to 20 percent (500-1,000) of community ICF-MR residents are ready for SILS or other independent settings. Furthermore, many children and some adults might be better served by professional foster care than in an ICF-MR.

We propose that the state take measures which encourage counties to develop and use alternative forms of residential care for mentally retarded persons. As we discussed in Chapter II, the state should strengthen alternative services by developing statewide standards and certification measures. The state should also identify existing county programs which are effective and which could provide models for use by other counties.

Funding of these programs presents a bigger challenge. In general, the state's goal should be to enable a county case worker to choose from an array of services, and to reach a placement decision free from fiscal incentives which presently encourage using the most restrictive and expensive programs. The state should consider three changes in funding residential services.

(1) Use of Medicaid to pay the cost of SILS, foster care, and home assistance for the mentally retarded.

This would require the state to apply for a waiver under Section 2176 of the 1981 Omnibus Budget Reconciliation Act. It would also require the state to establish a program to screen admissions to state hospitals and ICFs-MR.

(2) Change reimbursement formulas so that the daily cost to the county for alternative programs is no more than what it pays for ICF-MR care.

For example, if a county's average daily cost for ICF-MR care is $2.28 (4.44 percent of $51.50), the state could increase its own SILS contribution so that a county's share would be about $2.28 per day.

(3) Provide state seed money to encourage counties to develop professional foster care and home assistance programs. If these programs are successful, then they could be duplicated in other counties.

B. EXISTING FACILITIES SHOULD SERVE MORE DEPENDENT CLIENTS

Continued reduction of the population of state hospitals depends partly on the availability of community ICF-MR services which can serve more dependent people. In general, state hospital residents and mentally retarded persons who are likely to enter state hospitals will be more dependent than most current ICF-MR residents, and may need additional support.

Current reimbursement and licensing rules discourage providers from making the changes needed to serve more dependent clients. The caps imposed on annual per diem rate increases do not allow a provider to cover the costs of added staff, enriched program, or improved physical facilities. Though we concluded that such caps are needed to restrain the growth of per diem rates, nonetheless we feel that some flexibility is needed in the reimbursement system to enable existing facilities to serve more dependent persons.

We propose that DPW reimburse providers for certain added costs associated with serving individuals identified by county case managers.[1] Such a program should focus on serving state hospital residents and adults likely to enter state hospitals who need an ICF-MR program. Furthermore, the program should be restricted to small, existing facilities, in order to provide a home-like atmosphere and to avoid the need for new facilities.

In broad outline, such a program could look like this. After county officials identified eligible persons, they would ask providers in the area to propose ways of serving them. The proposals would specify changes in staff, program, and facility needed to serve the individuals; the costs of those changes; and the increase in per diem rate needed. For example:

- A rural county identifies four retarded individuals with serious behavior problems. A provider with an eight-bed facility proposes to serve two of them by adding a half-time counselor at an annual cost of $9,000, which would increase the facility's per diem rate by about $3.10.

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[1]The Mental Retardation Program Division of DPW has offered its own proposal in this area. The two proposals share many of the same ideas, but differ on significant points. We have benefitted from reviewing DPW's ideas.

In another example, a provider may propose a combination of added staff and physical improvements in order to meet the certification requirements for serving two persons with ambulation problems in a specific area of the facility. This would require the approval of the Department of Health and the State Fire Marshal.

The proposals would be reviewed jointly by the county staff, DPW Licensing, Long-Term Care Rates, and Mental Retardation Divisions, and other agencies, if necessary. They would compare the merits of different proposals and could negotiate the terms of the accepted proposal. Competition among providers would be encouraged.

When a proposal is accepted, DPW would increase the provider's per diem rate as soon as the provider began to implement the proposal. During the first year, the provider would be subject to a program audit to determine if the proposal was implemented correctly; and to a fiscal audit, to verify the additional expenses. If the audit findings were satisfactory, the program and increased reimbursement would continue. If not, DPW would require payback of the money and would reduce the per diem rate. The rate increase would not be limited by any cap on annual increases and would become part of the rate base for determining increases in later years.

Successful implementation of this proposal requires three things: the availability of alternative services so that ICF-MR residents can move, opening facilities to more dependent persons; strong county case management to match individuals with appropriate services on the basis of need; and the willingness of the state to pay providers for serving more dependent clients. We feel that improved utilization of existing facilities is far preferable to continued investment in new facilities.

C. DEVELOPMENT OF NEW ICFs-MR SHOULD BE LIMITED

Development of new community ICF-MR beds has already passed the 1987 goals outlined in DPW's Six-Year Plan. Furthermore, the Commissioner of Public Welfare has already approved development of new facilities providing more than 300 slots, most of which will open during 1983.

- By January 1984, there will be more than 5,200 community ICF-MR beds in Minnesota.

No one, including DPW, has tried to establish the "right" number of community ICF-MR beds for Minnesota. But even as the population of state hospitals declines, the total number of mentally retarded people in long-term care settings--community ICFs-MR and state hospitals--continues to increase.

If Medicaid funding for ICF-MR care is available, demand for new facilities will increase as fast as supply increases. But ICF-MR care is expensive, second only to state hospitals in cost. Community ICF-MR services consume an ever-increasing share of the

state's troubled Medicaid budget. Furthermore, continued expansion of ICF-MR beds is occurring at the same time that more cost-effective and less restrictive alternatives are neglected. Waiting lists of mentally retarded persons requesting ICF-MR placement would shrink if alternative services were available.

We propose that the state impose strict limits on development of new ICFs-MR. New development should be targeted to specific needs identified in statewide plans. These plans should establish the number of ICF-MR beds needed in the state as well as capacity required for alternative services. New development should be allowed only where existing facilities or alternative programs will not meet the needs of the area.

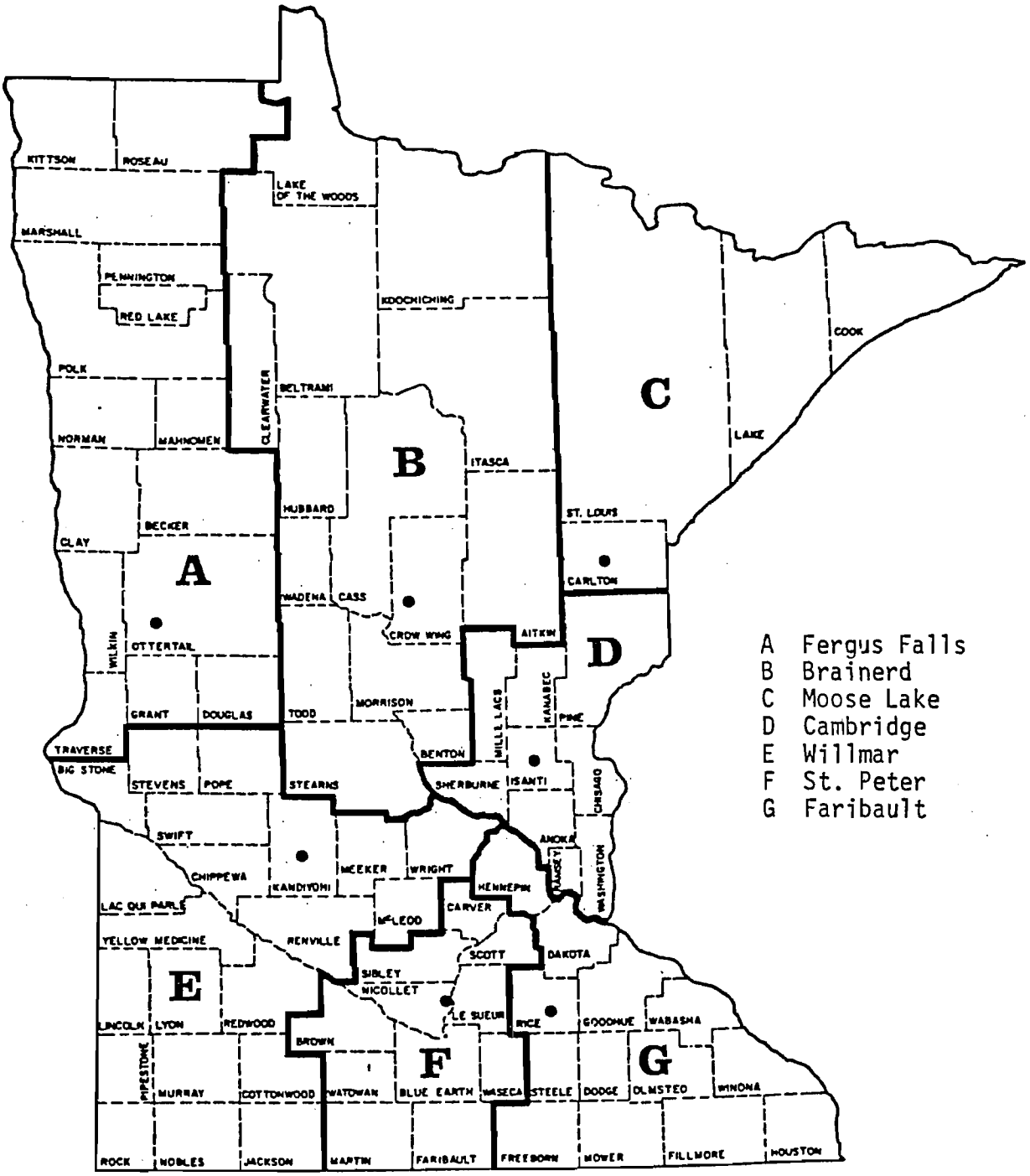
Construction of new facilities should be viewed as a third choice, coming after use of alternative programs and improved use of existing ICFs-MR. Limits on new development would reduce the growth of the state's Medicaid budget, and are a necessary part of a state strategy to contain Medicaid costs.

Thus, we are proposing that the Department of Public Welfare and the counties apply more stringent criteria in reviewing new proposals for facilities. Furthermore, DPW and the counties should take a closer look at projects already under development to see if these projects meet needs that could be met through less costly programs.

The commissioner's authority for licensing facilities, caring for the needs of retarded persons, and managing the state Medicaid program is broad enough to take these steps. However, it may be useful for the legislature to make a specific delegation of authority through language in appropriations laws or amendments to the licensing laws.

APPENDIX A

MENTAL RETARDATION
STATE HOSPITAL CATCHMENT AREAS



Source: Developmental Disabilities Planning, Policy Analysis Series, No. 4, p. 18.

APPENDIX B

COUNTY SERVICES FOR MENTALLY RETARDED PERSONS

	1980 Population	Utilization of State Hospitals: Residents	Utilization of State Hospitals: Rate per 1,000	ICF/MR Capacity (Not Including State Hospital Beds): Number of Facilities	ICF/MR Capacity (Not Including State Hospital Beds): Capacity	ICF/MR Capacity (Not Including State Hospital Beds): Capacity per 1,000	DAC Capacity: Number of Centers	DAC Capacity: Capacity	DAC Capacity: Capacity per 1,000	SILS Capacity	Work Activity Center/ Sheltered Workshop
Aitkin	13,404	15	1.119	1	12	.895	1	44	3.282	--	Yes
Anoka	195,998	46	.234	2	59	.301	2	65	.331	8	No
Becker	29,336	19	.647	3	25	.852	1	75	2.556	5	Yes
Beltrami	30,982	19	.613	4	47	1.517	1	45	.145	15	Yes
Benton	25,187	13	.561	1	23	.913	--	--	--	--	No
Big Stone	5,166	3	.580	--	--	--	1	20	3.871	--	Yes
Blue Earth	52,314	50	.956	5	96	1.835	2	70	1.338	55	Yes
Brown	28,645	28	.977	4	28	.977	1	40	1.396	25	Yes
Carlton	29,936	20	.668	3	25	.835	1	85	2.839	Shared	Yes
Carver	37,0[illegible]3	17	.459	2	116	3.131	1	63	--	--	No
Cass	21,050	21	.997	2	16	.760	1	30	1.425	11	Yes
Chippewa	14,941	11	.736	1	15	1.003	1	40	2.667	15	Yes
Chisago	25,717	7	.272	2	27	1.049	1	108	4.199	--	Yes
Clay	49,327	29	.588	3	24	.486	2	42	.851	10	Yes
Clearwater	8,761	3	.342	1	15	1.712	1	56	6.391	6	No
Cook	4,092	4	.977	--	--	--	--	--	--	Shared	Yes
Cottonwood	14,854	12	.808	2	57	3.837	2	39	2.625	--	No
Crow Wing	41,722	36	1.863	1	12	.287	2	88	2.109	--	Yes
Dakota	194,279	51	.263	12	207	1.065	10	227	1.116	25	Yes
Dodge	14,773	11	.774	2	22	1.489	1	45	3.046	--	Yes
Douglas	29,839	24	.804	4	52	1.867	1	30	1.005	--	Yes
Faribault	19,714	See Martin County		2	19	.963	1	35	1.775	30	Yes
Fillmore	21,930	17	.775	1	12	.547	1	35	1.595	--	Yes
Freeborn	36,329	17	.468	2	47	1.293	1	56	1.541	25	Yes
Goodhue	38,749	17	.438	4	96	2.477	3	90	2.332	30	Yes
Grant	7,171	6	.837	1	6	.836	1	24	3.346	--	Yes
Hennepin	941,411	541	.574	62	1,021	1.084	19	920	1.044	58	Yes
Houston	18,382	6	.326	1	13	.707	1	36	1.958	--	Yes
Hubbard	14,098	10	.709	1	8	.567	1	30	2.127	4	No
Isanti	23,600	6	.254	1	8	.338	--	--	--	--	No
Itasca	43,069	26	.603	2	35	.812	1	60	1.393	14	Yes
Jackson	13,690	6	.438	--	--	--	1	18	1.314	--	No
Kanabec	12,161	6	.493	1	8	.657	1	48	3.947	32	Yes
Kandiyohi	36,763	12	.326	6	139	3.780	2	84	2.284	30	Yes
Kittson	6,672	13	1.948	1	10	1.498	1	20	2.997	--	Yes
Koochiching	17,571	13	.739	1	16	.910	2	63	3.585	--	Yes
Lac Qui Parle	10,592	4	.377	--	--	--	1	15	1.416	--	Yes
Lake	13,043	12	.920	1	6	.460	1	18	1.380	--	Yes
Lake of The Woods	3,764	3	.797	--	--	--	--	--	--	--	No
LeSueur	23,434	20	.853	1	14	.597	1	40	1.706	--	Yes
Lincoln	8,207	See Lyon County		1	15	.182	--	--	--	--	No
Lyon	25,207	23	.509	3	45	1.785	1	70	2.777	--	No
McLeod	29,657	13	.438	3	70	2.360	1	115	3.877	--	Yes
Mahnomen	5,535	7	1.264	--	--	--	1	14	2.529	--	Yes
Marshall	13,027	12	.921	1	10	.767	1	22	1.688	--	Yes
Martin	24,687	58	1.022	4	50	2.025	1	45	1.822	Shared	Yes

	1980 Population	Utilization of State Hospitals: Residents	Utilization of State Hospitals: Rate per 1,000	ICF/MR Capacity (Not Including State Hospital Beds): Number of Facilities	ICF/MR Capacity (Not Including State Hospital Beds): Capacity	ICF/MR Capacity (Not Including State Hospital Beds): Capacity per 1,000	DAC Capacity: Number of Centers	DAC Capacity: Capacity	DAC Capacity: Capacity per 1,000	SILS Capacity	Work Activity Center/ Sheltered Workshop
Meeker	20,594	15	.728	1	15	.728	1	40	1.942	--	Yes
Mille Lacs	18,430	8	.430	--	--	--	1	30	1.627	--	Yes
Morrison	29,311	30	1.023	1	12	.409	1	40	1.364	--	No
Mower	40,390	33	.817	6	89	2.203	2	76	1.881	50	Yes
Murray	11,507	See Lyon County		1	14	1.216	1	33	2.867	--	Yes
Nicollet	26,929	14	.519	--	--	--	--	--	--	--	Yes
Nobles	21,840	8	.366	3	31	1.419	1	40	1.862	--	Yes
Norman	9,379	9	.959	2	12	1.279	1	28	2.985	--	Yes
Olmsted	92,006	38	.413	8	120	1.340	1	75	.815	30	Yes
Ottertail	51,937	53	1.020	9	106	2.040	3	77	1.482	18	Yes
Pennington	15,258	8	.528	2	30	1.966	1	34	2.228	--	Yes
Pine	19,871	16	.805	1	8	.402	1	45	2.264	--	Yes
Pipestone	11,690	5	.428	1	10	.855	1	38	3.250	--	No
Polk	34,844	35	1.004	4	40	1.149	2	80	2.295	--	Yes
Pope	11,657	10	.858	1	6	.514	--	--	--	--	No
Ramsey	459,784	290	.631	39	762	1.657	12	617	1.341	142	Yes
Red Lake	5,471	12	2.193	--	--	--	--	--	--	--	No
Redwood	19,341	11	.568	1	132	6.824	1	89	4.601	10	Yes
Renville	20,401	10	.490	1	15	.735	1	39	1.911	--	Yes
Rice	46,087	32	.694	7	138	2.994	2	106	2.299	50	Yes
Rock	10,703	5	.467	1	10	.934	1	24	2.242	--	Yes
Rosseau	12,574	16	1.272	1	33	2.624	--	--	--	--	No
St. Louis	222,229	125	.562	23	265	1.192	4	363	1.633	90	Yes
Scott	43,784	20	.458	2	58	1.324	1	55	1.256	--	Yes
Sherburne	29,908	12	.401	1	12	.401	1	32	1.069	30	Yes
Sibley	15,448	14	.906	1	15	.970	1	32	2.071	Shared	Yes
Stearns	108,161	55	.508	10	132	1.220	4	213	1.969	40	Yes
Steele	30,328	9	.296	2	31	1.002	1	44	1.450	35	Yes
Stevens	11,322	5	.442	1	8	.706	1	30	2.649	--	Yes
Swift	12,920	7	.542	1	10	.773	1	31	2.399	--	Yes
Todd	24,991	25	1.000	1	10	.400	1	38	1.520	--	No
Traverse	5,540	5	.902	--	--	--	--	--	--	--	No
Wabasha	19,335	14	.724	2	16	.827	1	40	2.068	10	Yes
Wadena	14,192	17	1.197	1	8	.563	1	30	2.113	--	No
Waseca	18,448	11	.596	2	16	.867	1	24	1.300	--	Yes
Washington	113,571	26	.228	3	18	.158	6	104	.915	Shared	Yes
Watonwan	12,361	See Martin County		--	--	--	1	30	2.426	Shared	Yes
Wilkin	8,454	15	1.774	1	6	.709	1	9	1.064	--	Yes
Winona	46,256	26	.562	2	22	.475	2	37	.799	25	Yes
Wright	58,681	12	.204	9	118	2.010	3	31	.528	--	Yes
Yellow Medicine	13,653	12	.879	2	30	2.197	1	40	2.929	--	No

Sources: Minnesota Population and Housing Characteristics - 1980 Complete Count Census Data, Minnesota Analysis and Planning System, Agricultural Extension Service, University of Minnesota.
Current Utilization of State Hospitals for Mentally Retarded People by Counties as of 12-31-82, Department of Public Welfare, January 27, 1983.
Rule 34 Residential Facilities Sorted by County, Department of Public Welfare, December 10, 1982.
Licensed Developmental Achievement Centers (DACs) for Persons Who are Mentally Retarded, Division of Licensing, Department of Public Welfare, 8-82.
Licensed Rule 18 Semi-Independent Living Services, Mental Retardation Division, Department of Public Welfare, 10-29-82.
Directory of Rehabilitation Facilities, Workshops and Work Activity Centers, Division of Vocational Rehabilitation, Department of Economic Security, March 1982.

APPENDIX C

GLOSSARY OF TERMS AND ACRONYMS

I. TERMS

Alternative care services: An array of community based support services that enable mentally retarded persons to develop and maintain an independent life style.

Deinstitutionalization: A policy limiting new admissions to state hospitals, reducing the length of stay, and increasing the rate of discharge.

Developmental services: Programs which enable mentally retarded persons to learn job and decision making skills to increase their capacity for competitive employment and independent living.

Fixed costs: Costs which do not vary with incremental changes in the population served; e.g., property costs.

Institutional care: Total care in a setting that is isolated from society.

Normalization: A goal of enabling mentally retarded persons to achieve a lifestyle with norms and patterns typical of persons in the mainstream of society.

Residential care: Programs which provide mentally retarded persons with twenty-four hour supervision, including rehabilitation services, and daily activities in a setting away from the residential facility.

Variable costs: Costs subject to change because of incremental changes in the population served; e.g., salaries, food.

II. ACRONYMS

CSSA	Community Social Services Act
DAC	Developmental Achievement Center
DPW	Department of Public Welfare
GAAP	Generally Accepted Accounting Principles
ICF-MR	Intermediate Care Facility for the Mentally Retarded
SILS	Semi-Independent Living Services
SLF	Supervised Living Facility

APPENDIX D

STATE STATUTES, ADMINISTRATIVE RULES, AND FEDERAL REGULATIONS

I. STATE STATUTES

Minnesota Statutes §§ 145.832-845. Minnesota Certificate of Need Act. The purpose of this act is to promote comprehensive health planning in Minnesota which includes cost containment, avoids duplication, and provides a method of review and approval of new development. This law will terminate March 15, 1984 unless the Legislature acts to continue it.

Minnesota Statutes §§ 245.781-812. Public Welfare Licensing Act. This act authorizes the Commissioner of Public Welfare to license providers of day care and residential services for facilities with five or more physically or mentally handicapped adults.

Minnesota Statutes § 252.28. Mentally Retarded and Epileptic; State Hospitals. Provides authority for the Commissioner of Public Welfare to determine the need, location and programs of public and private residential and day care facilities for mentally retarded children and adults.

Minnesota Statutes Chapter 252A. Mental Retardation Protection Act. Authorizes the Commissioner of Public Welfare to supervise those mentally retarded citizens who are unable to provide fully for their own needs, and to protect their human and civil rights by assuring the full range of needed social, financial, residential and habilitative services to which they are lawfully entitled.

Minnesota Statutes Chapter 256E. Community Social Services Act. This law establishes a system of planning for and providing community social services administered by each county or human services board.

II. ADMINISTRATIVE RULES

12 MCAR § 2.001 (DPW Rule 1). Family foster care, group family foster care. These standards apply to foster care homes for persons under the age of eighteen years.

12 MCAR § 2.003 (DPW Rule 3). Standards for group day care of school and pre-school children. These standards are currently used to license developmental achievement centers (DACs). Rule 38 is being developed to provide standards for DACs and will be promulgated in 1983.

12 MCAR § 2.018 (DPW Rule 18). Standards for the provision of semi-independent living services (SILS) to people who are mentally retarded. These standards apply to programs for mentally retarded persons whose dependency requires services above the level of food and lodging, but do not need 24-hour per day care or supervision.

12 MCAR § 2.034 (DPW Rule 34). Standards for the operation of residential programs and services for persons who are mentally retarded. This rule sets licensure requirements for any residential program which provides residential or domiciliary service for mentally retarded individuals.

12 MCAR § 2.051 (DPW Rule 51). Standards for foster homes for adults. Delegates to county welfare departments authority to approve adult foster homes. This rule was promulgated prior to the Community Social Services Act and therefore may not be enforceable through state or county authority.

12 MCAR § 2.052 (DPW Rule 52). Regulations for determining welfare per diem rates for providers of residential services to the mentally retarded. Establishes the criteria by which welfare rates for facilities serving mentally retarded residents are to be determined.

12 MCAR § 2.185 (DPW Rule 185). County board or human service board responsibilities to individuals who are or may be mentally retarded. This rule delegates to county boards or human service boards responsibility and authority for planning and provision of services to mentally retarded persons.

7 MCAR §§ 1.391-401 (MDH Rule 391). Regulations for construction, equipment, maintenance, operation and licensure of supervised living facilities. Governs facility licensure requirements for community residential facilities for mentally retarded persons licensed under DPW Rule 34.

7 MCAR § 1.661 (MDH Rule 661). Rules implementing, enforcing and administering the certificate of need act. Sets forth an approval procedure to promote comprehensive health planning.

III. FEDERAL REGULATIONS

42 C.F.R. 442. Public Health. Chapter IV, Health Care Financing Administration. Standards for Payment for Skilled Nursing and Intermediate Care Facility Services.

42 C.F.R. 122/123. Public Health. Chapter I, Public Health Service. Health Systems Agency and State Health Planning and Development Agency Reviews; Certificate of Need Programs.

42 C.F.R. Chapter I, Public Health Service. (Subchapter 1). Medical Care Quality and Cost Containment. (SSA §1122).

STUDIES OF THE PROGRAM EVALUATION DIVISION

Final reports and staff papers from the following studies can be obtained from the Program Evaluation Division, 122 Veterans Service Building, Saint Paul, Minnesota 55155, 612/296-8315.

1977

1. Regulation and Control of Human Service Facilities
2. Minnesota Housing Finance Agency
3. Federal Aids Coordination

1978

4. Unemployment Compensation
5. State Board of Investment: Investment Performance
6. Department of Revenue: Assessment/Sales Ratio Studies
7. Department of Personnel

1979

8. State-sponsored Chemical Dependency Programs
9. Minnesota's Agricultural Commodities Promotion Councils
10. Liquor Control
11. Department of Public Service
12. Department of Economic Security, Preliminary Report
13. Nursing Home Rates
14. Department of Personnel, Follow-up Study

1980

15. Board of Electricity
16. Twin Cities Metropolitan Transit Commission
17. Information Services Bureau
18. Department of Economic Security
19. Statewide Bicycle Registration Program
20. State Arts Board: Individual Artists Grants Program

1981

21. Department of Human Rights
22. Hospital Regulation
23. Department of Public Welfare's Regulation of Residential Facilities for the Mentally Ill
24. State Designer Selection Board
25. Corporate Income Tax Processing
26. Computer Support for Tax Processing

27. State-sponsored Chemical Dependency Programs, Follow-up Study
28. Construction Cost Overrun at the Minnesota Correctional Facility - Oak Park Heights
29. Individual Income Tax Processing and Auditing
30. State Office Space Management and Leasing

1982

31. Procurement Set-Asides
32. State Timber Sales
33. Department of Education Information System
34. State Purchasing
35. Fire Safety in Residential Facilities for Disabled Persons
36. State Mineral Leasing

1983

37. Direct Property Tax Relief Programs
38. Post-Secondary Vocational Education at Minnesota's Area Vocational-Technical Institutes
39. Community Residential Programs for Mentally Retarded Persons

In Progress

40. State Land Acquisition and Disposal