

**Selected State Policies
Governing the Operation of
Community ICF/MR
Facilities**

SELECTED STATE POLICIES GOVERNING THE OPERATION OF
COMMUNITY ICF/MR FACILITIES

A TECHNICAL ASSISTANCE REPORT

Prepared for Submittal to
The Division of Retardation Services
Minnesota Department of Public Welfare

by

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I. Background

In November, 1983, the National Association of State Mental Retardation Program Directors entered into a technical assistance contract with the Minnesota Governor's Planning Council on Developmental Disabilities. The primary aims of the project supported under this contract were to assist officials of the Minnesota Department of Public Welfare to: (a) prepare revised standards and procedures governing admission to and discharge from community ICF/MR facilities; and (b) develop regulatory criteria and procedures for decertifying community ICF/MR facilities which are either serving clients who do not require the level of care furnished by an ICF/MR provider or not rendering the minimum range, types or quality of services mandated under DPW rules.

The above changes in DPW rules were required under legislation enacted by the Minnesota Legislature during its 1983 session (Article 9, M.S. 1983, Chapter 312). This legislation was designed to resolve several problems associated with the operation of the State's system of services for developmentally disabled citizens. Among the major provisions of the 1983 amendments were:

- the imposition of a cap on the number of ICF/MR-certified beds in the State (7,500 as of July 1, 1983 and 7,000 as of July 1, 1986);
- the imposition of a moratorium on approval of certificates of need for new or expanded ICF/MR facilities;

- authorization to prepare and submit a Medicaid home and community care waiver request aimed, in part, at qualifying vendors of non-ICF/MR-certified facilities and Developmental Achievement Centers for Title XIX reimbursement on behalf of eligible mentally retarded and other developmentally disabled persons;
- authorization to include Medicaid reimbursement for day training and habilitation services received by community ICF/MR residences as part of a facility's reimbursable costs.

The general intent of the above amendments was to reduce existing fiscal disincentives to placing ICF/MR-eligible retarded clients into less restrictive, community-based living alternatives, while, at the same time, exercising greater control over the future growth in ICF/MR-certified bed capacity, statewide. The new legislation also directed the Commissioner of Public Welfare to: (a) establish standard admission criteria for state hospitals and county-specific targets for the utilization of ICF/MR beds in state hospitals and community-based facilities; (b) provide technical assistance to counties in furnishing case management services, establishing screening committees, developing service programs, training staff and claiming Medical Assistance payments; (c) promulgate criteria for the decertification of beds in ICF/MR facilities; (d) create a statewide client tracking and evaluation system; and (e) develop and submit to the Legislature a biennial plan for financing and delivering residential, day and support services to mentally retarded individuals.

DPW and the counties also are obligated to institute improved case management services under the recently enacted legislation, including the establishment of screening teams to prepare and ratify placement plans for all clients and determine their eligibility for home and community-based services under the forthcoming Medicaid waiver program. Finally, the new bill requires the Commissioner of Public Welfare to establish procedures and rules for determining Medicaid payment rates applicable to various types of community-based services for eligible mentally retarded persons.

The present contract obligates NASMRPD to provide assistance to DPW officials on two, specified areas of ICF/MR policy development: (a) the preparation of admission and discharge policies applicable to community-based ICF/MR facilities; and (b) policies governing the certification/decertification of community ICF/MR facilities. More particularly, the Association agreed to:

1. Collect and analyze ICF/MR admission and discharge policies, as well as policies governing the certification/decertification of ICF/MR beds, from other states to determine whether the experiences of these states would be helpful in evolving revised Minnesota regulations;
2. Study existing Minnesota policies and practices in relationship to the certification/decertification of community-based ICF/MR facilities and recommend modifications in applicable rules and procedures in order to achieve the objectives of the 1983 legislation; and

3. Recommend specific changes in existing policies governing voluntary and/or mandatory decertification of ICF/MR beds, including procedures and criteria the Department of Public Welfare should use in making such determinations.

The purpose of this report is to analyze the contents of relevant materials gathered from other states which are operating community-based ICF/MR facilities. The remainder of the report is divided into three major sections. The first section briefly describes the methods which the Association staff used in gathering materials from other states. Sections III and IV of the report, in turn, summarize the contents of materials regarding ICF/MR admission/discharge criteria and certification/decertification rules received from other states. Where it seemed appropriate, we have included commentary regarding the applicability of such information to the situation currently facing the Minnesota Department of Public Welfare.

Because of the volume of material reviewed, it did not seem appropriate to include all of the referenced documents in the appendices to this report. Therefore, we have elected to incorporate only selected excerpts from such materials in the appendices. However, the contents of each administrative rule, regulations, guidelines, etc. are described in the text of the report and will be furnished to DPW officials upon request.

II. Methodology

Beginning in December, 1983, the NASMRPD staff contacted officials in selected states by telephone in order to determine which states had rules, regulations, administrative guidelines or other descriptive materials that might be helpful to Minnesota officials. Generally, this initial telephone call was placed to the state MR/DD director or a relevant member of his/her staff. Since the purpose of the contract was to locate policies applicable to community-based ICP/MR residences only, the Association's search for appropriate models was focused exclusively on those states which had extensive experience in regulating community-based ICF/MR facilities. During this process, a total of 21 states were contacted. Relevant materials were received from 14 of the 21 states. The contents of the materials received, along with comments on their possible applicability to the situation facing Minnesota, are summarized in the succeeding sections of this report.

In instances where there were questions concerning the meaning and intent of certain policies, as well as the state's experience in attempting to implement them, follow-up calls were made to the contact person in the particular state. The information obtained also is reflected in Sections III and IV of this report.

III. Admission and Discharge Policies Applicable to Community ICF/MR Facilities

In this section of the report we will summarize the relevant materials received from other states regarding the criteria and procedures used to admit, release and transfer clients to and from community-based intermediate care facilities for the mentally retarded. General background information will be provided concerning the particular state's community ICF/MR program. Next we will summarize the general contents of the informational materials received from each state. Then, particular provisions of applicable regulations and guidelines governing community ICF/MR admission and discharge policies will be reviewed. And, finally, the name, address and telephone number of the individual most conversant with such policies in the subject state will be provided.

A. California

1. General Background. In 1980, the California Legislature created a special licensing category for small, community-based intermediate care facilities for the mentally retarded. In the statute establishing this special licensing category (Chapter 569, California Health and Safety Code) a "small intermediate care facility/developmentally disabled habilitative" (ICF/DD-H) is defined as a "facility which provides 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer developmentally disabled persons who have intermittent

recurring needs for nursing services, but have been certified by a physician as not requiring availability of continuous skilled nursing care." Under the terms of the legislation an ICF/DD-H facility is required to meet the same fire safety standards as apply to a licensed Community Care Facility of similar size, with residents of like age and ambulatory status (i.e., they are exempted from institutional provisions of the code applicable to other ICF/DD-certified facilities). In addition, a facility licensed as an ICF/DD-H is treated as a Community Care Facility for purposes of seismic safety requirements and non-discriminatory zoning (applicable to facilities with six or fewer beds).

For rate setting purposes ICF/DD-H facilities are divided into two categories. Range A facilities must maintain an overall client ratio of 1:2 and provide 24-hour care and supervision. Range B facilities must meet the same requirements but, in addition, must be staffed for at least 16 hours a day by licensed nursing personnel or qualified mental retardation professionals. Smaller facilities (four to six beds) qualify for a slightly higher per diem reimbursement rate than larger facilities (seven to fifteen beds). Current rates vary from \$45.12 in a larger, Range A facility to \$58.14 in a smaller Range B facility.

At the present time, there are approximately 400 certified beds in 85 to 90 ICF/DD-H facilities. Thus far, the program

has expanded more slowly than officials of the Department of Developmental Services had anticipated. The main barriers to expansion, according to DDS officials, have been:

- Unrealistically low reimbursement rates have discouraged existing Community Care Facilities from seeking ICF/DD-H certification; and
- Bureaucratic delays have hindered the issuance of final operating regulations, thus contributing to an atmosphere of uncertainty about the program's future.

Final regulation, however, are now undergoing review, with the expectation that they will be issued in the Fall. New, higher reimbursement rates also are being negotiated. Once these problems are resolved DDS officials anticipate further program expansion.

2. Informational Materials Received. The contact person in the California Department of Developmental Services forwarded a complete packet of materials on the ICF/DD-H program, including copies of the original authorizing legislation, federal ICF/MR regulations and interpretive guidelines, state regulations governing the ICF/DD-H program, Medi-Cal ICF/DD-H eligibility rules, the ICF/DD-H application/facility program plan outline, step-by-step process for achieving licensure certification as an ICF/DD-H facility,

and an outline for developing a medication administration program for non-licensed personnel.

3. Policies Governing Admission and Discharge. Medi-Cal ICF/DD-H eligibility regulations (Title 22, California Administrative Code, Section 51343) spell out criteria governing admission to an ICF/DD-H facility (see Appendix A). Basically, the regulations specify that a client must be developmentally disabled, as defined in state regulations, and in need of the services provided in such a facility. The decision to authorize services on behalf of any given client is to be made by medical consultants (employed by the California Department of Health Services), based on their best professional judgement, using the following criteria:
 - a. the complexity of the patient's medical problems (i.e., are the patient's medical problems sufficiently complex to require skilled nursing care or observation on an ongoing, intermittent basis, plus 24-hour supervision, in order to meet the patient's health care needs).
 - b. the patient's need for medication. Medications may be primarily supportive or stabilizing but still require professional nurse observation, on an intermittent basis, to determine the effectiveness of the drug and the individual's response.

- c. the extent of the patient's psycho-social and developmental service needs.
- d. the patient's need for specialized developmental training and habilitative program services that are not available through other levels of care.

In addition, the Medi-Cal regulations attempt to distinguish between the needs of clients who require an ICF/DD-certified facility, as opposed to an ICF/DD-H facility. Unlike a larger ICF/DD setting, in the case of clients certified as eligible for admission to an ICF/DD-H facility, a physician must find that the client does not require continuous skilled nursing care. In addition, the client may not have any of the following developmental deficits in socio-emotional areas:

- aggression--i.e, have violent episodes which have caused serious physical injury in the past year;
- self injurious behavior--i.e., behaviors causing severe injury which require a physician's attention at least once per year;
- smearing--i.e., smears at every opportunity;
- having decubitus ulcers; and
- requiring restraints except as otherwise provided in the California Administrative Code.

The remainder of the materials forwarded by the California Department of Developmental Services outline the standards and operating procedures which govern the ICF/DD-H program and deal only tangentially with the question of admission and discharge to such facilities. For this reason they have not been reproduced and included with the present report. However, some of the materials may be useful once Minnesota begins to consider provisions in its existing rules governing intermediate care facilities for the mentally retarded (Rule 34). In particular, California's regulations governing the ICF/DD-H program (Title 22, California Administrative Code, Sections 76800-76962) may be relevant. The NASMRPD staff will send a copy of this or any of the other materials upon request.

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B. Colorado

1. General Background. Until last fall community residences serving more disabled clients in Colorado were certified as ICF/MR providers. However, in implementing its Medicaid home and community care waiver program last year, the State Division of Developmental Disabilities elected to decertify

all existing community-based ICF/MR facilities and, instead, qualify eligible residents for funding under the waiver program. The decision to take this step was influenced by two primary considerations: (a) a desire on the part of provider agencies and state MR/DD officials to circumvent limitations inherent in meeting federal ICF/MR regulatory requirements—especially the difficulty in qualifying mobile, non-ambulatory and non-self-preserving residents for care in community-based facilities which did not meet the institutional provisions of the national Life Safety Code; and (b) the capability of reducing the state's net share of the cost of operating such facilities, by excluding room and board costs as a reimbursable expense under the State's waiver program, and instead qualifying SSI eligible residents for full federal benefits. The net effect of this change was to shift a higher proportion of room and board costs in such facilities to the federal government.

In order to implement this change the Colorado Department of Health (the State licensing agency) had to issue revised regulations governing residential care facilities for the developmentally disabled. These new regulations (Chapter VIII, Part 5, 6 C.C.R. 1011-1) define a "residential care facility for the developmentally disabled" as one which approximates a typical family dwelling, housing eight or **fewer** persons. Apartments, family foster homes, and "host homes" (**i.e., a private family home providing personalized**

living and care for no more than two unrelated individuals) are excluded from the definition.

Although Colorado no longer licenses community residences as ICF/MR facilities, there may be useful lessons which Minnesota officials can draw from attempts in that State to convert former community ICF/MR residences into facilities that are eligible for waiver financing.

2. Informational Materials Received. The staff of the Colorado Division of Developmental Disabilities forwarded a copy of the Department of Health's new licensing regulations applicable to residential care facilities for the developmentally disabled (Chapter VIII, Part 5, 6 C.C.R. 1011-1).

3. Policies Governing Admission and Discharge. Under the new DOH regulations, standards governing admission and discharge to residential facilities for the developmentally disabled are quite general and largely process oriented. The operator of a residence is required to have written admission and discharge policies, spelling out criteria and procedures for admitting a new resident, including the age, types and degree of handicapping conditions of admissible clients. No other regulatory constraints are placed on who can or cannot be admitted to a facility, except that a person with a communicable disease is not considered admissible (see Appendix B).

The regulations, however, do spell out three permissible facility models—minimum supervision; moderate supervision; and specialized programs. A minimum supervision facility provides "...limited supervision, training and assistance to foster independent living." Services provided to residents include: supportive supervision, recreation, transportation, periodic specialized services, counseling and case management. Overnight staff coverage generally is not required and no specific client-to-staff ratios are established.

A moderate supervision home provides "...training in independent living skills to individuals who have not yet acquired such skills." Among the services provided are: 24-hour supervision, developmental and/or independent living training, transportation, recreation, periodic specialized services, counseling, case management and education. Such facilities must maintain a minimum staffing ratio of 1:8; additional staff may be required to meet fire safety requirements.

There are three designated types of specialized programs: (a) a behavior developmental program; (b) a social/emotional development program; and (c) an intensive developmental program. The distinction between these types of homes are spelled out in the enclosed extract from DOH regulations (see Appendix C). Generally a specialized home must main-

tain a 1:4 staff-to-client ratio during the clients¹ waking hours and a 1:8 ratio during sleeping periods, unless the residents require additional staff for safety purposes .

One unique feature of the new regulations is that Colorado is probably the first state to adopt, by state rule, the Fire Safety Evaluation System for Board and Care Homes recently developed by the National Bureau of Standards. While there is discussion in Washington at the current time about permitting the use of the NBS/FSES for community-based ICF/MR facilities, it may be several years before such a regulation is adopted in final form. Meanwhile, Colorado has incorporated FSES as part of its own state rules, thus permitting vendors of residential habilitation services under Colorado's DD waiver program to admit mobile non-ambulatory residents to community homes. This approach may be applicable in Minnesota as well, especially for those ICF/MR community homes which ultimately may be converted to Medicaid waiver financing (see Appendix D).

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C. Florida

1. General Background. The State of Florida maintains ICF/MR-certified beds both in state-operated developmental centers as well as community-based facilities. The privately operated community ICF/MR facilities include both small community residences and a number of larger nursing homes which are specializing in care of developmentally disabled clients.

In addition, over the past 18 months, the State Department of Health and Rehabilitative Services (DHRS) has certified as ICF/MR vendors a number of so-called "cluster" facilities. A cluster consists of three, eight-bed homes, co-located on the same site, serving profoundly retarded, medically fragile residents who are being transferred from two state-operated facilities. These cluster facilities were constructed by the state as part of a multi-year plan to close Orlando and Tallahassee Sunland Centers, the only State facilities specializing in services to profoundly retarded and medically fragile residents. A majority of the cluster facilities are being operated by private, non-profit and proprietary organizations, under contract with DHRS; but a few are being operated directly by state employees.

2. Information Materials Received. Officials of the Developmental Services Program Office in the Department of Health and Rehabilitative Services sent the NASMRPD staff copies of

HRS regulations governing intermediate care facilities for mentally retarded, accompanying state interpretive guidelines, and a Departmental manual on quality of care management in community-based intermediate care facilities for the mentally retarded. A copy of the basic statutory authority for state services to developmentally disabled persons also was received (Chapter 393, Florida Statute, as amended).

3. Policies Governing Admission and Discharge. The ICF/MR regulations of DHRS apply to all facilities falling in this certification category. However, there are four specified categories of facilities licensable under the regulations. They are referred to in the regulations as: developmental/residential; developmental/institutional; developmental/non-ambulatory; and developmental/medical.

An ICF/MR-certified, developmental/residential facility is defined in the regulations as a living unit or facility serving clients who are "fully ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions." Living units (but not necessarily the overall facility) must have 15 or fewer beds.

Developmental/institutional facilities, by contrast, may serve either clients who are fully ambulatory but not capable of following directions in an emergency, or clients who are mobile non-ambulatory, regardless of whether they

are capable of self-preservation. An ICF/MR-certified developmental/non-ambulatory unit is designed to care for clients who require "horizontal transport" and/or who are capable of mobility only with human assistance. Living units in such facilities must not exceed 16 beds.

Finally, a developmental/medical facility serves clients in need of continuous medical/nursing supervision due to chronic health care needs. Here again, living units in such facilities may not exceed 16 beds.

The DHRS regulations include certain exceptions applicable to ICF/MR facilities licensed in the developmental/residential category. Table I in Appendix E summarizes the differences in physical and fire safety standards applicable to the four ICF/MR licensing categories.

With the exception of the ambulation and self-preservation characteristics of the resident, the Department's regulations include no other significant differentiations between the types of residents who are eligible for placement in the various categories of facilities. Appendix F contains the provisions of the regulations applicable to facility admission policies.

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D. Illinois

1. General Background. Compared to the population of the state, Illinois has certified relatively few community-based ICF/DD facilities. Currently, the total bed capacity of ICF/DD facilities with 15 or fewer beds is 191 (approximately 175 occupied beds). Certificates of need also have been approved on an additional ten facilities (total bed capacity: 118) and another 180 beds are at various stages of the CON review process.

The Illinois Department of Public Health, the agency responsible for licensing health care facilities, maintains a single set of standards governing intermediate care facilities for the developmentally disabled. However, the existing standards include special provisions applicable to small, community-based ICF/MR facilities serving 15 or fewer residents.

One of the primary barriers in Illinois to the certification of small community-based facilities as ICF/DD providers,

according to officials of the Department of Mental Health and Developmental Disabilities, has been a requirement that residents of such facilities be capable of self-medication within 30 days of admission. Other, related problems include: (a) the complex, time-consuming process of obtaining approval of a certificate of need; and (b) the unavailability of capital dollars to construct new facilities (especially after interest rates soared to record heights during the late 1970's and early 1980's).

It now appears that a less restrictive self-medication policy may be issued in the near future. This should facilitate the certification of community residences for more severely impaired individuals. Nonetheless, DMHDD officials do not anticipate a sizeable expansion in the number of small, community ICF/DD facilities, primarily because emphasis is now being given to financing Community Residential Alternatives (a relatively new licensing category) and other options through the State's Medicaid home and community care waiver program. For example, during the current fiscal year, DMHDD officials plan to qualify 296 CRA residents for residential habilitation services under the waiver program.

2. Informational Materials Received. A copy of the Department of Public Health's Minimum Standards, Rules and Regulations for Classification and Licensure of Intermediate Care Facilities for the Developmentally Disabled, plus change sheets to the basic standards, were received from state officials.

3. Policies Governing Admission and Discharge. Standards applicable to admission and discharge from an ICF/DD facility in Illinois are rather general and do not differentiate between types of facilities (see Appendix G). The one exception relates to the ambulation status of residents of small community-based ICF/DD facilities. No resident can be admitted to the latter type of facility unless he or she is ambulatory and capable of taking actions for self-preservation under emergency situations. Another requirement is that residents of a ICF/DD with 15 or fewer beds must be either employed or enrolled in an external day program, off the grounds of the facility, at least 200 days per year, for five hours per day or more. Finally, residents of community ICF/DD facilities with 15 or fewer beds must be capable of self-administration of medications within 30 days of admission. These and other exceptions to general ICF/MR policies which apply to small community residences are detailed in Section 56 of the Department of Public Health's regulations (see Appendix H).

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E. Maine

1. General Background. Regulations governing the operation of intermediate care facilities for the mentally retarded in Maine establish two categories of such facilities: nursing ICF/MRs and group ICF/MRs. A group intermediate care facility for the mentally retarded provides services to residents who do not need nursing care, while a nursing ICF/MR serves those who do require such services.

Between 1979 and 1983, the State of Maine certified some 370 beds in small community-based residential facilities, as eligible for ICF/MR reimbursement. This action was part of the Department of Mental Health and Mental Retardation's effort to implement the Pineland Consent Decree.

In 1983, however, the State agreed to forego further, planned expansion in the number of community-based ICF/MR beds, as part of its approved Medicaid home and community care waiver program. Residential support services in community facilities that otherwise might have been certified **as ICF/MRs will be financed instead through the state's Medicaid waiver program.**

2. Informational Materials Received. A copy of the Department of Human Services (DHS) regulations governing the licensing and functioning of intermediate care facilities for the mentally retarded was obtained from officials in the Maine Department of Mental Health and Mental Retardation.
3. Policies Governing Admission and Discharge. Section 7 of the DHS regulations contain standards governing admission and release from ICF/MR facilities (see Appendix I). With the exception of the previously mentioned nursing care criteria, this section of Maine regulations makes no distinction between the criteria for admitting or releasing residents from nursing ICF/MRs and group ICF/MRs.
4. Contact Person

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F. Massachusetts

1. General Background. Although Massachusetts has had special regulations governing community intermediate care facilities for the mentally retarded since 1979, for a variety of reasons the State has certified relatively few such facilities compared to the total population of the state. Currently,

there are 16 certified facilities in this category (four Type A; and 12 Type B).

Development of new community ICF/MR facilities has been slow, according to state DMH officials, because:

- a. Four separate state agencies are involved in regulating the establishment of such homes and coordinating the actions of these agencies has been a time-consuming undertaking; and
- b. Up until recently state funding has been readily available to community residential providers interested in opening new homes; as a result, most potential vendors of ICF/MR services have been reluctant to pursue the more arduous task of opening Medicaid-certified residences.

The situation is changing, however. The Department's Division of Mental Retardation is now actively promoting the establishment of ICF/MR homes and monies are not as readily available through other, state-funded programs. Also, during its 1983 session, the Legislature appropriated roughly \$37 million in capital dollars for the construction of community facilities. DMR projections indicate that as many as 54 new community residences for non-self-preserving clients (Type A facilities) might be constructed with these monies.

If the state's pending MR waiver request is approved, further development of Type B facilities (i.e., for ambulatory, self-preserving residents) probably will be curtailed.

Existing regulations, issued by the Massachusetts Department of Public Welfare, limit the number of residents who can live in a community ICF/MR facility to between four and 15 persons. Two types of ICF/MR facilities are recognized for reimbursement purposes. Type A facilities provide active treatment to residents who may be incapable of self-preservation under emergency circumstances; therefore, such facilities must meet the institutional fire safety code, as specified in federal regulations. Type B facilities offer active treatment to recipients who are capable of self-preservation and, thus, are required to meet only lodging and rooming home sections of the Life Safety Code.

2. Informational Materials Received. Officials of the Massachusetts Department of Mental Health sent the NASMRPD staff a copy of the Department of Public Welfare's regulations governing community intermediate care facilities for the mentally retarded, as well as a copy of the Massachusetts Rate Setting Commission's rules governing prospective rate determinations applicable to ICF/MR facilities.
3. Policies Governing Admission and Discharge. Section 408.404(c) of the Department **of Public Welfare's community**

ICF/MR rules specifies that "the Department will pay only for recipients who have a potential through active treatment to move out of the ICF/MR into a setting that is less restrictive." In order to police this requirement, the Department's IPR teams are required to develop "more extensive criteria to determine whether the recipient [who has a length of stay of two years or more] can benefit from active treatment and continues to have the potential to move into a setting that is less restrictive" (Section 408.412(B)(2)(a)). In addition the Department "will not reimburse a Type A ICF/MR for any recipient whose length of stay extends beyond three years except under the circumstances where the individual's plan of care clearly demonstrates that the IPR concludes that movement by the recipient to a less restrictive setting is a demonstrably achievable goal and that it would be impossible for the recipient to achieve this goal without receiving services uniquely available to him through the ICF/MR" (Section 408.412(B)(2)(c)). Appendix J contains relevant extracts from the aforementioned Massachusetts DPW rules.

Although the question of rate setting policy is beyond the scope of the present project, Minnesota DPW officials may wish to examine the methodology used in Massachusetts to determine prospective rates for community ICF/MR facilities. The NASMRPD staff will be happy to mail a copy of these Massachusetts rules upon request.

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G. Michigan

1. General Background. The Michigan Department of Mental Health initiated its version of a community ICF/MR program in 1977, as part of a multi-year plan to reduce the number of residents in state-operated residential centers. Called Alternative Intermediate Services for the Mentally Retarded (AIS/MR), the program involved the construction of six to eight bed homes for severely and profoundly retarded persons, most of whom were transferred from state centers.

As of September, 1983, 170 AIS/MR homes had been opened across the State. By the end of the State's current fiscal year (September 30, 1984), DMH officials estimate that there will be approximately 220 such homes in operation.

2. Informational Materials Received. Guidelines governing the operation of the Alternative Intermediate Services for the Mentally Retarded Program were obtained from the Department of Mental Health (see Appendix K).
3. Policies Governing Admission and Discharge. In developing the AIS/MR program, Michigan officials attempted to draw a

distinction between clients eligible for state developmental centers and those eligible for community-based AIS/MR homes. As originally envisioned by DMH staff, the AIS/MR homes would be used to serve clients who needed intermediate care services in the community and also exhibited one or more of the following complicating factors: (a) disruptive behavior requiring special intervention; (b) physical handicaps necessitating wheelchairs, walkers and/or continued staff assistance; (c) legally blind, deaf, epileptic or other debilitating medical complications; or (d) a severe lack of adaptive skills, particularly self-help skills.

By contrast the state developmental centers were to serve: (a) the severely multiply handicapped; (b) aggressive/assaultive mentally retarded persons who are a danger to themselves or others when living in less restrictive settings; (c) persons requiring specialized diagnostic and evaluation services not ordinarily available in local communities; and (d) the severely impaired who are without adaptive skills, especially self-help skills.

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H. New York

1. General Background. The New York Office of Mental Retardation and Developmental Disabilities (OMRDD) began to certify community residences as ICF/DD vendors in the Spring of 1979, as part of a statewide effort to meet the State's obligations under the Willowbrook Consent Decree. Today the State has some 600 ICF/DD-certified community residences with a total capacity of almost 6,000 beds. Approximately 400 of these facilities are operated by non-profit, voluntary organizations and the remainder are run by the State.

The State of New York licenses an ICF/DD facility as a "community residence" under Part 681 of OMRDD rules. These rules generally parallel the requirements of federal regulations and guidelines applicable to ICF/MR facilities. A general description of New York's ICF/DD program is contained in Appendix L.

2. Informational Materials Received. Copies of final federal interpretive guidelines, as well as special interpretive guidelines applicable to small, community-based ICF/MR facilities, were received from the New York Office of Mental Retardation and Developmental Disabilities.
3. Policies Governing Admission and Discharge. In order to qualify for admission to a community ICF/DD facility in **New York**, an individual must be diagnosed as developmentally

disabled and have at least one of the following needs: health care, habilitative or rehabilitative needs as evidenced by a severe or moderate deficit in adaptive behavior or a severe behavior problem (other than one which is . diagnosed as mental illness). In addition, most residents will have at least one of the following characteristics: (a) multiple handicaps; (b) inability to ambulate; (c) behavior problems; or (d) secondary disabilities.

Criteria governing admission to state developmental centers and ICF/DD-certified community residences are largely identical. Decisions regarding the most appropriate placement for any given client usually takes into account the service and environmental needs of the client and the availability of a program vacancy that meets his/her needs profile.

Besides ICF/DD-certified residences, the Office of Mental Retardation and Developmental Disabilities also maintains non-certified community residences. The latter facilities generally serve more able clients who are capable of outside earnings (in a sheltered workshop, etc.). The decision not to certify such a facility as a Medicaid vendor usually is based on the infeasibility of meeting the physical plant requirements applicable to a certified facility and/or the fact that the additional cost of operating an ICF/DD residence is not considered justified in terms of the clientele's developmental level.

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I. North Carolina

1. General Background. Although the State Division of Mental Health, Mental Retardation and Substance Abuse Services has been promoting the development of ICF/MR group homes in North Carolina for several years, a relatively small number of facilities have been certified to date. Nonetheless, a recent surge of ICF/MR certificate-of-need requests led to the enactment last year of two bills aimed at curbing the uncontrolled expansion of the State's ICF/MR bed capacity. The first bill (H.B. 583) places a temporary moratorium (through June 30, 1984) on the issuance of certificates-of-need for new ICF or ICF/MR facilities, expansion in the certified bed capacity of existing facilities serving the mentally retarded or the conversion of any existing beds to ICF/MR or ICF status for this same purpose. The conversion of domiciliary beds, where the CON request was submitted prior to June 1, 1983, may be approved, provided that no more than 10 beds are granted to any one applicant.

The primary aim of this bill is to allow a special Department of Human Sources task force to study issues surrounding the need for expanded ICF/MR bed capacity in the state. More specifically, the task force is charged with analyzing:

- the current availability of services for mentally retarded persons in both state institutions and community-based programs;
- the criteria for establishing different levels of services, particularly ICF/MR services, appropriate to the needs of mentally retarded individuals;
- a mechanism for developing a client profile for determining appropriate placements for mentally retarded clients.
- the number of people in need of ICF/MR level of services;
- the appropriate role of state mental institutions and psychiatric hospitals, as well as other public and private residential settings, in meeting the needs of retarded clients, including the relationship between state and non-state programs; and
- the need for additional ICF/MR beds.

The second bill (H. 1395) authorizes the Department of Human Services to grant certificates of need when bed capacity can be transferred from state-operated ICF/MR facilities to community ICF/MR facilities. However, such community facilities must meet the following criteria:

- the maximum bed capacity may not exceed 15;
- the per capita costs of such facilities must be no more than the cost of care in state facilities; and
- all beds in such community facilities must be utilized for a period of at least twelve months for clients transferred from state facilities, after which 50 percent of vacant beds may be used for non-institutional clients.

Obviously, there are significant parallels between the situations currently facing Minnesota and North Carolina. Thus, communication between responsible officials in the two states may prove profitable. Copies of both H.B. 583 and H.B. 1395 can be found in Appendix M.

2. Informational Materials Received. In addition to the two aforementioned bills, the staff of the North Carolina Division of Mental Health, Mental Retardation and Substance Abuse Services sent us a copy of the Division's guidelines for establishing ICF/MR group homes.

3. Policies Governing Admission and Discharge. The Division's guidelines governing development of ICF/MR group homes provide rather general guidance regarding admission and discharge standards (see Appendix N). They do suggest, however, five models of ICF/MR group homes that might be developed, ranging from: (a) a facility serving persons who have poorly developed self-help skills (Model I); (b) a facility for persons with behavioral deficits (Model II); (c) a facility serving residents with severe to profound physical and/or sensory handicaps (Model III); (d) a facility for residents with destructive behaviors (Model IV); and (e) a facility serving clients with emotional disturbance or other psychiatric needs (Model V). These models, however, are not tied to specific staffing requirements. Instead, the staffing requirements which appear in the guidelines are adapted from existing federal ICF/MR standards.

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J. Oregon

1. General Background. Oregon has a total of eight privately operated ICF/MR facilities, two of which have 15 or fewer

beds (total bed capacity: 22). Originally, there was some discussion of converting the funding of these two facilities to the state's Medicaid home and community care waiver program. But, when the vendors objected, state officials decided to let them retain their present certification status.

The Oregon Division of Mental Health has no current plans to expand the number of community ICF/MR facilities. Instead, primary attention is being given to qualifying eligible MR/DD clients in non-medical community residences for Medicaid reimbursement under the State's waiver program.

Two levels of intensity are authorized under the waiver program—"residential training" for clients who need a more structured program and "residential care" for those who require only basic supervision and care. Generally, however, clients served in waiver-financed residences are less disabled and require less intensive programming than residents in the two, small community ICF/MR facilities.

2. Informational Materials Received. A copy of the Mental Health Division's Administrative Rules governing intermediate facilities for the mentally retarded and other developmentally disabled persons was received from the Division's staff.

3. Policies Governing Admission and Discharge. The Division's ICF/MR rules contain only general, process-oriented criteria for determining an individual client's eligibility for admission to a community-based ICF/MR facility (See Appendix 0). However, four classifications of ICF/MR residences have been established, based on the Division's resident classification instrument. These classes are:

- Class A facilities include those serving: (a) children under six years of age; (b) severely and profoundly retarded residents; (c) severely physically handicapped residents; and/or (d) residents who are aggressive, assaultive, security risks or manifest severely hyperactive or psychotic-like behavior.
- Class A-1-3 facilities serve Class A residents who, due to their serious aggressive or maladaptive behavior, present a threat to themselves and/or others to the degree that their personal liberties must be restrained and treatment can only be provided in a physically secure environment.
- Class B facilities serve moderately mentally retarded residents requiring rehabilitative training.
- Class C facilities serve residents needing vocational education programs or shelter employment.

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K. Pennsylvania

1. General Background. The Commonwealth of Pennsylvania began certifying small community residences (8 beds or less) as ICF/MR facilities in 1981. At the present time, a total of 51 small community facilities, with a total bed capacity of 351, have been certified as ICF/MR vendors.

The State also has submitted a total of six Medicaid home and community care waiver requests on behalf of the mentally retarded (two have been approved to date). Rather than submit a single, statewide waiver request, OMR officials elected to prepare county-specific proposals in the two, largest metropolitan areas of the State (Philadelphia and Pittsburgh). This decision was primarily driven by intrastate politics surrounding the Pennhurst litigation. Particularly in Southeastern Pennsylvania, where the effects of the litigation are most pronounced, State officials decided it would be advantageous to link implementation of a waiver program with the Pennhurst placement goals of Philadelphia and the four suburban counties.

In general, emphasis has shifted away from the certification of community ICF/MR facilities and toward financing expanded community bed capacity through Medicaid waiver programs. In fact, since March, 1982 OMR has actively discouraged the certification of new ICF/MR beds, except under certain limited circumstances. The principal reason for this shift was that State officials encountered numerous problems in attempting to certify community residences as ICF/MR vendors, due to regional office and intrastate interpretations of federal regulations. The waiver program allows the State, counties and vendor agencies to circumvent many of these problems, since there are no federal standards governing the operation of waiver-financed programs.

3. Policies Governing Admission and Discharge. Generally, all ICF/MR-certified facilities are required to establish their own admission and discharge policies. The State Office of Mental Retardation has indirectly impacted on admission standards by specifying the types of clients that may be admitted to such facilities. For example, during the period of major development of community ICF/MRs, OMR policies focused on the establishment of small homes to serve clients capable of self-preservation who were moving out of large state-operated institutions. No uniform admission and discharge policies governing ICF/MR facilities, however, have **been issued to date.** .

The following types of individuals are considered eligible for admission to an ICF/MR facility (see Appendix P):

- Those who require assistance with meals, dressing, getting in and out of bed, assistance with medication or other activities of daily living;
- Those who are homebound but not roombound;
- Those who are blind, ambulatory, and capable of self-care;
- Those with mild symptoms of forgetfulness, confusion, irritability, and ability to lead an independent life;
- And, those with mild emotional disturbances.

Individuals who are not eligible for admission to an ICF/MR

c.

include:

- Those who require skilled nursing care;
- Those with active communicable diseases;
- Those who are bedfast;
- Those who are completely helpless;
- Those whose behaviors indicate that they may constitute a threat to themselves or to the safety of others.

Proposed, new ICF/MR level of care criteria are currently under discussion within the Department of Public Welfare (see Appendix Q). The new criteria would limit eligibility to clients who exhibit: (a) significantly subaverage general intellectual functioning, as evidenced by performance on a standardized intelligence test defined as more than two standard deviations below the mean (I.Q. 69 or lower); and (b) a chronic deficit in adaptive behavior, documented by a licensed psychologist through empirically reliable and valid testing instruments, a series of observations, or data obtained in interviews. In addition, (a) the onset of mental retardation, as well as accompanying behavioral deficits, must have been diagnosed or documented during the client's developmental period (birth through 22); and (b) a licensed physician must identify a need for habilitation and/or specialized health services, using reliable diagnostic and prognostic tests.

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L. South Carolina

1. General Background. The State of South Carolina has had small, community-based ICF/MR vendors for a number of years.

2. Informational Materials Received. The Department of Mental Retardation supplied the NASMRPD staff with a copy of the South Carolina Department of Health and Environmental Control's minimum standards for licensing intermediate care facilities for the mentally retarded serving 15 or fewer residents.

3. Policies Governing Admission and Discharge. DHEC's standards governing admission, transfer and discharge (see Appendix R) are quite general in nature and, apparently, adapted largely from federal requirements. No resident-specific characteristics are explicitly cited in the regulations to distinguish between admissible and non-admissible clients.

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M. Texas

1. General Background. For a number of years, the Texas Department of Human Resources has certified community-based ICP/MR facilities. As of January, 1984, there were a total

of 3,952 privately operated ICF/MR-certified beds in the State. Of this number 1,071 beds were in 95 facilities with 15 or fewer beds.

In 1981, the Texas Legislature passed a measure which gave the State Department of Mental Health and Mental Retardation an expanded role in operating the ICF/MR program and placed increased emphasis on the certification of small, community-based vendors of ICF/MR services. The following year, the Texas Department of Human Resources, in cooperation with the Texas Department of Mental Health and Mental Retardation, issued revised ICF/MR regulations limiting the capacity of a certified community ICF/MR facility to six beds (see Appendix S). This so-called "six bed or less rule" applies to potential applicants for newly certified facilities, as well as current facility providers requesting an increase in their existing certified contracted bed capacity. Providers with larger bed capacities that entered the program prior to 1982, however, may retain their certification status.

In addition to limiting a facility's bed capacity, the 1982 regulations (Section 326.35.03, Texas Administrative Code) also mandate that the proposed facility:

- be located in an incorporated city which is subject to special use permits, local zoning, and/or occupancy code requirements;

- be situated in a residential neighborhood, noncontiguous to an existing facility and no closer than three miles in radius from any other ICF/MR residential facility;
and
- have access to community resources appropriate to the client's needs.

In order to qualify for approval of new or expanded bed capacity, an applicant must complete the following steps:

- (a) identify the number of developmentally disabled persons residing in the community and the surrounding geographic area that might benefit from services the facility will provide;
- (b) determine the location of other ICF/MR residential facilities, if any, in the same community and/or geographic area, as well as the number and level of clients served by such facilities;
- (c) submit a letter of support from the superintendent of the state school and the executive director of the local MH/MR center (if applicable) in whose catchment area the proposed facility will be located;
- (d) obtain, from appropriate referral sources, letters or other documentation outlining the service needs of the

clientele to be served, if the facility plans to serve other than mentally retarded individuals;

- (e) a written description of the client group to be served including the admission criteria which will be used;
- (f) a description of the educational, medical, vocational and other programmatic services that the clients require, as well as documented evidence that such services will be made available by the facility;
- (g) a written description of semi-independent and independent living alternatives that will be available for clients who successfully complete the ICF/MR facility's active treatment program, if the facility plans to serve mildly and moderately retarded clients. If no independent or semi-independent living arrangements are available, the facility must present evidence that it has initiated plans to develop such alternatives.

2. Informational Materials Received. The Texas Department of Mental Health and Mental Retardation shared with the NASMRPD staff a copy of the 1982 rules governing facility participation in the ICF/MR program, as well as DMHMR procedures for fulfilling these new requirements. In addition, copies of draft level of care criteria, applicable to community ICF/MR facilities, were forwarded to the NASMRPD staff.

3. Policies Governing Admission and Discharge. For the past five years, Texas has recognized three distinctive levels of ICF/MR facilities. Prior to that time a complicated procedure was used by the Department of Health for determining an applicant's level of care requirements. The complexity of the system, many officials felt, led to an unacceptably high number of inappropriate placements and, therefore, classes of facilities were identified to simplify the LOC process.

Currently, a further attempt is being made to clarify and streamline LOC determination criteria in the case of ICF/MR applicants. In order to be eligible for an ICF/MR level of care determination under the new, draft level of care rules, an individual would have to have an IQ of: (a) 69 or below, if he or she were mentally retarded; or (b) 75 or below with deficits in adaptive behavior, if he or she suffered from another developmental disability. In addition, the individual would have to need, and be capable of benefitting from, active treatment in a 24-hour supervised residential setting.

Eligible clients are assigned to one of three facility levels: ICF/MR I, ICF/MR V, and ICF/MR VI. Level of care determinations are based on four variables related to an individual's developmental needs, including:

- * intellectual functioning;

- adaptive behavior;
- health status; and
- ambulation status.

LOC determinations are completed by teams from the State Department of Health, using criteria jointly developed by DOH and DMRDD. The Department of Mental Health and Mental Retardation also is responsible for monitoring the performance of DOH level of care teams to assure that such determinations are consistent with applicable state policies.

To qualify for service in an ICF/MR Level I, an individual must have the potential to participate in a training program that will prepare him for eventual placement in a less structured living environment. He or she must function within the mild to moderate range of mental retardation (IQ levels 35 to 69) or, if diagnosed as cerebral palsy, epileptic or "another pervasive developmental disorder", the individual may have an IQ of up to 75. In addition the client must: (a) exhibit mild to moderate deficits in adaptive behavior; (b) his or her health status must not interfere with participation in an active treatment program; and (d) he or she must be fully ambulatory or mobile non-ambulatory. (N.B., If the individual is mobile non-ambulatory, the ICF/MR I facility must meet institutional Life Safety Code.)

Individuals served in ICF/MR V facilities must require assistance and supervision in learning and refining self-help skills. Their intellectual functioning may range between mild to severe mental retardation (IQ scores 20 to 69) or may be as high as 75 in the case of persons with developmental disabilities other than mental retardation. The individual should exhibit moderate to severe deficits in adaptive behavior and a health status which does not interfere with participation in an active treatment program. Finally the client may be ambulatory, mobile ambulatory or non-mobile.

A copy of the Texas Department of Human Resources draft ICF/MR level of care regulations can be found in Appendix T. According to DMHMR officials, these regulations have been published in proposed form for public comment and are expected to be issued as final rules by the end of the Summer.

The primary reasons for issuing new LOC criteria were to:

- establish more explicit criteria governing the eligibility of persons with disabilities other than mental retardation (cerebral palsy, epilepsy, etc.). A somewhat higher IQ cutoff is permitted for such clients, as noted above;

- draw a clearer distinction between facility certification standards and level of care criteria;
- permit a degree of overlap between care levels in order to allow somewhat more flexibility in placing residents; and
- streamline certain health and ambulation requirements.

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N. Wisconsin

1. General Background. The Wisconsin Department of Health and Social Services has been working for some time on the preparation of a set of regulations governing intermediate care facilities for the developmentally disabled. The rules, as drafted, encompass ICF/DD facilities of all sizes; however, several special exceptions are made for "small facilities for individuals with developmental disabilities", defined in draft rules as "...a facility which is licensed to serve 15 or fewer persons...". For example, one such exception is that small facilities may meet the lodging or rooming house provisions of the Life Safety Code, provided the residents

of the facility are ambulatory, receiving active treatment and capable of taking appropriate actions for self-preservation under emergency conditions.

DHSS officials have no plans to certify additional community ICF/MR facilities. Instead, emphasis is being given to financing residential services for eligible developmentally disabled clients under the state's new Medicaid home and community care waiver program.

Although specific discussions of implementation of Minnesota's planned waiver program is beyond the scope of the present study, it seems appropriate to point out that communication with Wisconsin officials may prove fruitful, since the Wisconsin program (referred to as the Community Integration Program) predates the federal waiver authority and therefore is procedurally somewhat better established and organized than similar programs in other states. A brief description of the Community Integration Program can be found in Appendix U.

Informational Materials Received. In addition to DHSS draft regulations governing intermediate care facilities for the developmentally disabled, the NASMRPD staff received copies of the guidelines and procedures for establishing Community Integration programs and a draft of a client services reporting manual for CIP.

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- 3. Policies Governing Admission and Discharge. DHSS's draft ICF/MR rules contain only general criteria governing admissions, retentions and removals from community ICF/MR facilities. No attempt is made in the draft rules to distinguish between the types of clients who are admitted to such facilities and those who are admitted to state developmental centers. The draft rules do indicate that "residents who are known to be destructive of property, self-destructive, disturbing or abusive to other residents, or suicidal..." may not be admitted to a community ICF/MR facility, "...unless the facility has and uses sufficient resources to appropriately manage and care for them". In addition, developmentally disabled individuals under 18 years of age may not be admitted to such facilities after the effective date of the regulation, unless certified for admission by the Department (see Appendix W).

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Summary

Perhaps the most striking feature of the responses we received from the fourteen states who submitted materials is the way in which the Medicaid home and community care waiver program has impacted on the states' plans to certify additional community ICF/MR facilities. Officials in six states (Colorado, Illinois, Maine, North Carolina, Oregon and Pennsylvania) told the NASMRPD staff that efforts to establish additional ICF/MR-certified community facilities have been halted or severely curtailed since Congress authorized Medicaid home and community care waivers.

With the exception of Colorado, which has converted all of its former community ICF/MR facilities to waiver financing, most of these states intend to retain currently certified facilities but have no present plans for further expansion in the number of ICF/MR-certified community beds. Although no structured attempt was made during the course of our interviews to ascertain the factors motivating this shift in policy, it became clear that most states believe the waiver program offers a less intrusive, more flexible vehicle for qualifying eligible community residents for Medicaid reimbursement. Not only is a state able to circumvent many of the rigidities associated with applying institutionally-oriented federal standards to community homes, but the waiver program also allows a state somewhat more latitude in claiming, for Medicaid reimbursement, essential daytime **and support costs on** behalf of eligible residents.

Of the states which reported ICF/MR-certified community residences, there appeared to be three basic approaches to regulating the program: (a) adhere solely to federal ICF/MR regulations and guidelines [N.B., these states were not included in our interview sample because it seemed unlikely that they would have written policies of potential value to Minnesota officials]; (b) promulgate a single set of state regulations applicable to all types of ICF/MR facilities and incorporate provisions granting certain exceptions to small facilities with fifteen or fewer beds (Florida, Illinois, Maine, Oregon and Wisconsin); and (c) issue state ICF/MR regulations and policies applicable specifically to small (15-bed-or-less) facilities (California, Massachusetts, Michigan (guidelines only), North Carolina (guidelines only), South Carolina and Texas).

Several of the states contacted during the course of this study do not specify regulatory or other written administrative criteria governing the types of clients admissible to small community-based ICF/MR facilities. Generally, these states tend to control the types of clients admitted through the vendor contracting process. Even in these cases, however, admissibility may be premised on the existence (or absence) of certain client skills/capabilities (e.g., ambulation; capability to self-medicate; absence of severe behavioral disorders; and/or capability of self preservation in an emergency). Examples of states that use this approach include: Florida, Illinois, Maine, North Carolina, Pennsylvania and South Carolina.

States which have written policies governing the admission of MR/DD clients to small ICF/MR residences, in accordance with their developmental characteristics and needs, generally have relied on the following two approaches: (a) establishing explicit level of care criteria; and/or (b) classifying facilities according to the types of clients they are capable of serving.

California regulations, for example, recognize two ranges of ICF/DD-H facilities, the latter of which (Range B) must be staffed 16 hours a day by licensed nursing personnel or qualified MR professionals. In addition, Medi-Cal ICF/DD-H eligibility rules spell out the characteristics which an individual must display in order to qualify for admission, and also specify certain socio-emotional deficits which make an applicant inadmissible (e.g., aggression, self-injurious behavior, etc.).

Maine, Massachusetts and Texas also have divided community ICF/MR facilities into classes according to the types of residents served. As pointed out earlier, Texas plans to issue explicit level of care criteria, for use in determining the appropriate type of community ICF/MR facility for any given applicant.

We did not identify a state which relies solely (or even primarily) on standardized client assessment data in assigning clients to particular types of residential facilities—although practically all states use such assessment instruments as part of the placement process. Perhaps, this lack of reliance on

standardized assessment tools is a reflection of the current state-of-the-art in measuring and classifying MR/DD clients. Typically, states use assessment data as a guide to appropriate program placement and temper such information with the professional judgments of the staff involved in making the placement decision.

Officials in one state (Colorado) reported that they had experimented with using a standardized assessment instrument (called the "Institutional Profile") for determining eligibility under the state's DD Medicaid waiver program. However, major problems were encountered, primarily because the state has not been able to set a threshold level that both includes all (or most) residents of community facilities formerly certified as ICF/MRs and also limits eligibility for day services to the number specified in the state's approved Section 2176 request.

Developmental disabilities officials in Illinois said that some thought was being given to employing the state's ICIS data system to assign clients to the most appropriate day and residential programs. While this activity is still in the early planning stages, Minnesota officials may wish to interact with the staff of the Illinois Division of Developmental Disabilities as they design the new tracking and monitoring system mandated under the 1983 legislation.

Decertification of Community ICF/MR Facilities

A second project task was to identify procedures used by other states to decertify ICF/MR beds. The aim of this task was to assist Minnesota DPW officials in drafting criteria for voluntary and mandatory decertification of beds in ICF/MR facilities, as required under Section 2 of the 1983 legislation (Article 9, M.S. 1983, Chapter 312).

Here again, we will review, on a state-by-state basis, the provisions of applicable rules, regulations, and procedures received from the contacted states. A total of seven states shared with us information and materials relevant to decertification of existing ICF/MR facilities (Florida, Illinois, Maine, Massachusetts, New York, Ohio and Texas).

A. Florida

1. Decertification Procedures. Section 400.18 of Florida Statutes spell out the basic procedures to be followed in closing a nursing home, including an iCF/MR-certified facility (see Appendix AA). Under this provision of law, a facility which voluntarily discontinues operation is obligated to give the State Department of Health and Rehabilitative Services 90 days notice in the advance of closure. The Department has a responsibility for arranging to transfer nursing home patients to other facilities and may place a representative in the facility **30 days prior to**

voluntary discontinuation of operation, or immediately upon determination by the Department that existing conditions or practices represent an immediate danger to the health, safety or security of the facility's residents.

In addition, due to past difficulties in closing substandard ICF/MR facilities, the 1983 session of the Florida Legislature added statutory provisions governing programs for developmentally disabled persons which give DHRS authority to seek an injunction to enforce the agency's standards, rules and regulations and/or terminate the operation of an intermediate care facility for the mentally retarded when any of the following conditions exist:

- a. Failure by the facility to take preventive or corrective measures in accordance with any order of the Department;
- b. Failure by the facility to abide by any final order of the Department once it has become effective and binding;
- c. Any violation by the facility constituting an emergency requiring immediate action, as provided for in the statute.

The Department also may petition a court of competent jurisdiction for the appointment of a receiver to operate an intermediate care facility for the mentally retarded when **any** of **a** number of specified circumstances related to the **availability and quality of** services rendered to residents

exists. The statute specifies the procedures and criteria courts should use in determining whether to institute receivership proceedings and the powers and duties of the receiver.

A copy of the developmental disabilities receivership statute is enclosed at Appendix BB. Thus far, according to Florida officials, the statute has been utilized on only one occasion and the facility is still in operation under the management of a new private, non-profit corporation.

2. Informational Materials Received. Copies of the following documents were received from Florida officials: Chapter 400, Florida Statutes of 1981, entitled "Nursing Homes and Related Health Care Facilities"; 1983 amendments Chapter 393, Florida Statutes (Developmental Disabilities) governing the institution of receivership proceedings.

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B. Illinois

1. Decertification Procedures. The Illinois Department of Public Health's rules governing intermediate care facilities for the developmentally disabled state that DPH officials may place "an employee or agent to serve as a monitor in a facility or may petition the circuit court for appointment of a receiver...or both...".

Under the Department's regulations violations of existing regulatory provisions are classified as Type A (most serious) through Type C (least serious). Specific procedures for dealing with violations and imposing penalties are spelled out in Section 18 of the Department's regulations (see Appendix CO.

2. Informational Materials Received. A copy of the Department of Public Health's Minimum Standards, Rules and Regulations for Classification and Licensure of Intermediate Care Facilities for the Developmentally Disabled were obtained from DMHDD officials.
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C. Maine

1. Decertification Procedures. Section 4 of the Maine Department of Human Services regulations governing the licensing and functioning of intermediate care facilities for the mentally retarded specify procedures which must be followed when the Department suspends or revokes an ICF/MR facility's license (see Appendix DD). In the case of a non-emergency suspension or revocation, the Department, in consultation with the Maine Bureau of Mental Retardation, may file a statement or complaint with the administrative court specifying alleged violations of existing statutes or regulations. If the Department finds conditions which, in the opinion of the Commissioner, "immediately endanger the health and safety of the patients", the Department, in consultation with the Bureau of Mental Retardation, may suspend the facility's license for up to 30 days or until the Department determines that an emergency no longer exists.

If the facility is involuntarily closed, DHS officials, in cooperation with the staff of the Bureau of Mental Retardation, must "make appropriate arrangements for the orderly transfer of all residents." A facility which elects to close voluntarily, is obligated to give the Department 30 days prior notice and provide assistance to residents in arranging suitable transfers prior to discontinuation of operation.

2. Informational Materials Received. A copy of the Department of Human Services' Regulations Governing the Licensing and Functioning of Intermediate Care Facilities for the Mentally Retarded was received from the staff of the Department of Mental Health and Mental Retardation.

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D. Massachusetts

1. Decertification Procedures. An ICF/MR facility in Massachusetts which voluntarily elects to withdraw from the program must provide care for recipients remaining in the facility until all transfers have been completed (see Section 408.422, DPW regulation, Appendix J). Transfers are to be accomplished in accordance with the state's general regulations governing long term care facilities, except that in the case of ICF/MR facilities the Department of Mental Health's area office are to assist the ICF/MR in placing recipients in other settings. Attention is to be given to maintaining clients in the least restrictive living environments possible.

2. Informational Materials Received. A copy of DPW's regulations governing intermediate care facilities for the mentally retarded were obtained through the staff of the Department of Mental Health.
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E. New York

1. Decertification Procedures. Part 681 of OMRDD Rules spell out procedures for withdrawing an ICF/DD facility's operating license and Medicaid certification status. Generally, if the operator elects to contest the decertification action, Medicaid reimbursement is terminated long before the facility's operating license is withdrawn, because of the State's lengthy appeals process.

The Department of Mental Hygiene also has its own receivership statute, which allows the State to seek court approval for appointment of a third party (or the State) to run a facility which fails to meet State standards until a new operator can be found or the residents relocated. The statutory conditions under which OMRDD can petition the court for appointment of a receiver, however, are vague and,

therefore, this procedure has not been used frequently in New York State.

2. Information Materials Received. None.
3. Contact Person

Tony Di Nuzzio
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F. Ohio

1. Decertification Procedures. Generally the Ohio Department of Public Welfare, in cooperation with the Ohio Department of Health, uses federal regulatory criteria for determining the conditions under which facilities may be certified or decertified (42 CFR 442.105 and 442.111). However, rules have been issued by the Department of Public Welfare governing appeals procedures when the license of a Medicaid-certified long term care facility (including an ICF/MR) is denied, terminated or not renewed. Essentially, these regulations establish the procedures for setting up and conducting appeal hearings in such cases (see Appendix EE).
2. Informational Materials Received. The Ohio Department of Mental Retardation shared with the NASMRPD staff a copy of the procedures used in appeals actions involving long term care facilities.

3. Contact Person.

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G. Texas

1. Decertification Procedures. The Texas Department of Human Resources recently issued new regulations governing the change in status of intermediate care facilities for the mentally retarded (Chapter 27, Subchapter Z, Texas Administrative Code). The new regulations establish gradations of severity of facility deficiencies and consonant penalties for each level of deficiency.

Essentially, the severity of deficiencies can be divided into two classes: those which effect the immediate health and safety of ICF/MR residents and those which do not effect the immediate safety of residents but are a health or safety hazard that have direct or immediate adverse effects on the residents health, safety, security and/or training. If the Texas Department of Health (the state Medicaid licensing agency) finds that a facility has deficiencies that effect the immediate health and safety of residents, it may initiate action to secure the appointment of a special trustee to operate the facility. If a special trustee is not

sought, then TDH officials will notify the facility administrator that it does not meet the standards necessary for continued certification, immediately withhold further Medicaid payments and cancel the facility's contract.

If the deficiencies do not effect the immediate health and safety of the residents, but are hazards that have a direct or immediate adverse impact on the residents' health, safety or security and/or training, TDH will notify the facility that it does not meet standards and initiate contract cancellation proceedings. If decertification proceedings are not initiated in such cases, TDH officials must notify the facility that they have a specific period of time (up to 60 days) to correct outstanding deficiencies. During the correction period, payments will be withheld from the facility. If the cited deficiencies are not corrected within the authorized period, TDH officials will cancel the facility's contract.

If payments are withheld from a facility for deficiencies related to resident care twice during any 12 month period, the facility's contract will be cancelled by TDH. In cases where the deficiencies do not warrant the initiation of a "vendor hold" action, TDH will notify the facility that it does not meet required standards, afterwhich cancellations proceedings may be initiated. If, however, Health

Department officials do not initiate decertification proceedings, the Department will notify the facility that it has 30 days to correct such deficiencies. If all cited deficiencies are not corrected within the compliance period, DHR will impose a "vendor hold" on payments to the facility. Afterward, if the deficiencies are not corrected within the first 60 days of the vendor hold, DHR will cancel the facility's contract. Appendix FF includes a copy of the new Texas decertification procedures related to ICF/MR-certified facilities.

The staff of the Texas Department of Human Resources, in cooperation with the Texas Department of Mental Retardation, also has developed a set of examples of ICF/MR deficiencies which may result in the imposition of sanctions against a facility. The purpose of these draft guidelines are to assist facility administrators to avoid misapplying existing State rules and policies (see Appendix GG).

H. Summary

The regulations and administrative policies which the NASMRPD staff gathered from the above states deal almost exclusively with procedures for closing Medicaid certified facilities which either elect to discontinue operations or are forced to do so because of serious or continuous violations of federal and state operating standards. By and large, the aim of such rules is to

minimize the potentially harmful effects of such closures on the facility's residents by laying out an orderly process for terminating operations.

In the case of voluntary terminations, states generally require the facility operator to take steps to relocate residents before closing its doors. State agency staff also may be responsible for effectuating inter-facility transfers in some states (e.g., Florida).

When a Title XIX facility is involuntarily decertified, most of the reporting staff either have authority to send in state agency staff (e.g., Florida and Illinois) or are authorized to seek the appointment of a trustee or receiver to operate the facility until the residents can be appropriately relocated (Florida, Illinois, New York and Texas).

None of the officials in the states we contacted reported any experience in de-certifying community ICF/MR beds in order to remain under a legislatively established ceiling. Perhaps, the closest parallel we encountered was in Colorado, where state officials elected to decertify all community ICF/MR facilities in order to convert these homes to Medicaid waiver financing. Since Minnesota's pending waiver program is premised, in part, on the conversion of selected community ICF/MR facilities to waiver financing, it might be advisable to examine Colorado's **experience** carefully, **in** an attempt **to** identify potential

problems and solutions before developing the decertification rules called for under M.S. 252.58, as amended by Section 2 of the 1983 legislation.