A FISCAL IMPACT STATEMENT FOR MINNESOTA'S MENTAL RETARDATION/ DEVELOPMENTAL DISABILITIES CONTINUUM OF CARE

The Costs and Benefits of Doing Nothing Versus Changing Program and Fiscal Policies

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CAPSULE SUMMARY

We have evaluated the costs and revenues for the Minnesota MR-DD continuum of care for the 1983-1987 period. The results are clear. Doing nothing to change the current functioning of the system is the most expensive choice the State can make — by far.

There is, however, a much less expensive way, which is also programmatically more desirable. By changing programming to reduce the number of "medical residence" beds (i.e., state institution, ICFMR, and nursing home beds) in the State, and a corresponding increase in home and community-based program; and, at the same time, moving to a home and community-based waiver of Medicaid services, the state can save itself and its counties about $46 million per year in 1987. That is a saving of more than 20 percent of the State and local costs of running the MR-DD system. By following this course, the Federal government would, at the same time, save up to $23 million per year by 1987.

To achieve these changes, the current Legislature needs to:

. Order a speed-up in the pace of movement of persons into the community from State institutions (while using part of the savings from this policy to provide economic substitutes where institutions must decline or close).

. Provide incentives or sanctions for controlling the growth of ICFMR slots (e.g., through loan programs assisting in conversion from ICFMR to other activities, through

development of alternative licensure classifications which more nearly meet the needs of the clients, at less cost — partly because MA ICF-MR requirements need no longer be met).

- Require the development of new community and home-based programs, such as developmental training centers for children not needing the full level of ICF-MR services; supervised living arrangements for adults now in state institutions and community ICF-MRs — and new adults "aging in" -- who do not need the full ICF-MR panoply of services; in-home programs to support the decision of those families keeping persons at home who would be institutionalizable without such support services as respite care, homemaker, home health, chore, parent training, and other services; foster care programs for children and adults with developmental disabilities which are provided by foster caregivers with special training, and supervised by nurses with expertise in behavioral management and teaching.

- Expand existing community programs such as SILs and day programs.

- Authorize the Department of Public Welfare to either expand the regular Medicaid program (a less desirable alternative) or to develop a waiver proposal for home and community-based services (Section 1915 c of the Social Security Act).

- Provide for a restructuring of appropriations to implement a program and fiscal change. This will involve the transfer of about 5 percent of the total CSSA spending to Medicaid matching.

- Provide for a restructuring of the relationship between Medicaid and CSSA payment and administration at the County level, so that those many programs which are part-CSSA-funded and part-Medicaid-funded can be planned and administered on an integrated basis, rather than the completely fragmented basis which now exists.

SUMMARY

Introduction

The mental retardation/developmental disabilities (MR-DD) treatment system in Minnesota includes State institutions, nursing homes, intermediate care facilities in the community (ICF-MRs), supervised living facilities, family subsidy program, sheltered workshops, and day activities programs.

Through most of the '70's, Minnesota was thought of as a pioneer in MR-DD matters. Today, opinions are somewhat different. Other states have moved ahead of us in the rate at which "large, isolated, and segregated" institutions are being replaced by community and home-based programs. Our state was a pioneer in producing the small, community ICF-MR. Now, we are widely regarded as a state which has overbuilt medical facilities (we will have almost 5300 ICF-MR slots in the community in FY '84, at present rates of construction and approval), at the expense of home-based programs and non-medical residential programs. Indeed, some of these opinions come from operators of ICF-MRs, who would be happier with a full continuum of services in the State.

As the MR-DD system has grown, willy-nilly, during a period of budget shortage, the new community programs that many believe are needed have suffered strongly under the lack of new-program resources.

As is usual in budgeting, old programs have tended to grow — at least in cost -- while new programs, which provide more efficient fiscal tradeoffs, are not established.

In order to provide a wider and a longer-term view of the costs and cost burdens of the system, three groups, the Minnesota Developmental Achievement Centers Association, the Minnesota Association of Rehabilitation Facilities, and the Association of Residences for the Retarded in Minnesota, through a grant from the McKnight Foundation of Minneapolis, have contracted with Copeland Associates of Minneapolis to evaluate the current and potential fiscal impacts of operating the MR-DD system as it now functions, versus the fiscal impacts of changing program policies or fiscal policies, or both.

Conducting the Fiscal Impact Analysis

The fiscal impact analysis proceeded by

- Defining the full Minnesota continuum of care.
- Costing out that continuum for the current distribution of persons over the whole continuum (9260 in residential programs, 9614 in day programs).
- Evaluating the costs to each payor (Federal, State, Counties, and private), at present (FY 1983).
- Estimating where, programmatically, the system will go in the next four years, if nothing is done, legislatively. This involves estimating inflation in costs, increases in clients and provider slots, and increases to each payor for the years FY 1984 through FY 1987.
- Estimating, programmatically, where the system will go, if changes are made in its current movement (e.g., speeding up phasedown of institutional beds, bringing persons out of nursing homes into the community, controlling the ICF-MR supply by reducing the number of certified beds, and developing new home and community-based programs).

- Given a programmatic change, or no change, estimating the effect of changing fiscal policy (e.g., no change at all, versus increasing the use of the regular Medicaid program, versus a third alternative of using the Social Security Act's Home and Community-Based waiver approach to provide more Medicaid services in the community).

Results of the Fiscal Impact Analysis

The analysis makes very clear that

- Continuing with no program or fiscal change (Option 1) is the most expensive strategy to the "nonfederal economy" of Minnesota, moving us from a total net cost to State and Counties in 1983 of $149 million per year, in State and county tax levies, to a total cost to the two payors of $197 million in 1987. This would be especially hard on Counties, moving county costs from today's $35 million to $56 million in 1987.

- Continuing with no program change -- Option la — (i.e., institutions decrease beds at the rate of the Welsch-Noot agreement and ICF-MR growth continues unchecked from today's 4920 beds to 6040 in 1987), but expanding the regular MA program to include the non-room-and-board portion of SILS and MR Cost of Care programs and all developmental achievement centers, will have the following fiscal effects –

  a.) At $368 million in total costs in 1987, it would be the most expensive option to the public fisc ($47 million greater than Option

  b.) Because Medicaid would increase about 75 percent over the four-year period with this option, it would be the most expensive option for Medical Assistance payments ($169 million in 1987, in the Federal portion of the Medicaid payment).

  c.) State costs, under this option, would rise almost 50 percent, from $105 million in 1983 to $155 million in 1987.

- The option now being developed by the Minnesota Department of Public Welfare is called "Option 2" in our tables. This option, which would reduce State institutions to an average daily census of 1320 in 1987 and ICF-MRs to 4440 in that year, competes with Option 3 as the least expensive to the State and the counties (at $151 million to both, it is $46 million less expensive to all of Minnesota than the do-nothing-at-all option. Option 1.

- Although development of a separate option, Option 3, as separate from that being developed by the Department of Public Welfare, the option turned out to be similar to the DPW "Option 2". The differences are not great (Option 3 foresees 120 fewer beds in institutions, 150 fewer beds in nursing homes, and 160 more beds in ICF-MRs, than does Option 2); at the same time, the distribution of new community and home-based programs differs somewhat, with more in some categories, fewer in others -- e.g., Option 3 provides for about 300 more day slots than does Option 2). Fiscally, since both unite in a waiver approach, with a similar program approach, there are few differences here: Option 3 provides about 300 more day center slots for a total cost of about $3 million less in 1987 than does Option 2. Given the uncertainties of forward estimation, these are small differences indeed.

The details of the fiscal comparison are given in Table 1, below.

1983 and 1987 Option	MA	SSI	State	County	Private	Total
1983	97.29	4.04	104.75	34.74	11.43	252.25
1	138.28	5.59	141.33	56.23	17.48	358.79
la	168.86	5.59	155.10	24.79	13.89	368.23
2	149.74	11.52	135.74	15.54	11.07	324.01
3	145.95	9.60	136.54	16.37	13.33	321.89

Table 1: Comparison of Fiscal Impacts of 1987 Options and 1983 Expenditures

The CSSA-Medicaid Interaction

As we have calculated costs for each group, we have assumed that there are "automatic" transfers among accounts. This is not the case, of course. At this point, we have not gone to the fine detail of transfers needed, given that a certain option is chosen. However, we prefer to wait until later in the budget process for this question.

There is, however, one important set of accounts that should be discussed. In general, the State accounts where there is the most effect, in choosing among the options is CSSA. If Option la, 2 or 3 were to be chosen, then the problem of County-State shares must be dealt with.

In most of the options, about $17.4 million of the proposed $123 of State CSSA appropriations would need to be transferred from CSSA to Medicaid, to "even things up", leaving them as they are in our calculations. This, however, is not the only alternative that could be chosen. There are many others (County payment of part or of the nonfederal share, over and above the current 10 percent of the nonfederal share, for newly-Medicaided community services; simply increasing the Medicaid account by $17.4 million State, in effect reducing the County shares even farther than the alternative options (la, 2, and 3} do now).

As an example of the appropriation alternatives open to the State, consider Table la, below. This table compares the 1985 State and county shares, if $9.23 million of CSSA were transferred to Medicaid versus leaving that amount in the CSSA account, with the State absorbing the extra MA cost under the "no transfer" alternative.

Option	Transfer CSSA into MA		No transfer of CSSA into MA	
	State	County	State	County
Option 1	124.26	43.15		
Option 1a	128.91	22.55	138.24	13.32
Option 2	121.15	14.39	130.38	4.16
Option 3	124.62	15.61	133.85	6.78

Table 1a: Effects of Transfer/No Transfer of State CSSA Appropriations for DACs into the MA Account.

THE OPTIONS

A. Introduction

To structure any individual option for the MR-DD continuum of care, three questions must be answered simultaneously:

1. What is the program mix to be?
2. What is the financial policy?
3. What is the organizational approach?

Because the answers to each of these three questions interact with each other, they can only rarely be answered individually.

The first question, *program mix*, asks the question about the future pattern of MR-DD programs, across the whole continuum of care. In Minnesota, this means anything from an increased emphasis on the dominant medical-residence approach which now characterizes the State to a moderate -- but significant – movement into non-medical residences and home support programs. The program mix decision has important fiscal implications. One feasible target program mix for 1987 can cost almost 15 percent less, overall, than the one where current trends are leading us.

The second question, *financial policy*, asks the question about how the State should finance the future program mix. This question breaks into some important lesser questions:

. Should the State emphasize Medicaid in non-Medical residences

and home-based services in the community (as it does now in the medical residence area?

. If Medicaid is emphasized in the community, should it be administered through the regular Medicaid program, or through community-based services waiver authority (Section 1915(c) of the Social Security Act)?

. Regardless of the approach taken toward Medicaid, how should the State partition fiscal burdens between itself and the counties? This question interacts strongly with any decision to be made on both the first and third questions. For example, if an appropriation to increase Medicaid is to be made out of the CSSA account, the counties may want a stronger degree of control over Medicaid, so that they can administer the entire continuum, rather than just those diminishing parts having to do with CSSA.

The above illustrates how the fiscal questions interact with questions of *organizational policy*. Here, the questions are concerned with:

. Degree of integration of administration of MA-aided and CSSA-aided services;

. Amount and scope of control of county case management (ranging from coordination to client allocation, and from DACs alone to all portions of the continuum).

. Type of organizational control of MA and CSSA fund flows (is the county the vendor and the service provider the subcontractor to the county; or is each provider the vendor, with a direct relationship to the centralized single state agency, with no county control?).

B. Description of the Options

We have examined three program options for the next two biennia in Minnesota, for the mental retardation developmental disabilities system. They include the following:

Option 1: This option assumes that

. State institutions will decline from 2330 beds 1n 1983 to the consent degree level of 1861 in 1987.

- Nothing will be changed for MR persons under 65 1n nursing homes.
- There will be no controls on ICF-MRs 1n the community, and they will move from the current 4900 beds to 6040 in 1987.
- No new services would be introduced (i.e., DTCs, SLAs, In-home care, and Foster care).
- MR cost of care beds would decline from 600 to 500 slots.
- SILs programs would be moderately increased — from 870 to 1030.
- Day program slots and sheltered work slots would be increased only for the amount needed for growth in community ICF-MR beds.

The above option might be described as the "no-action" one, since it will result in a simple extension of where we are now, in the State. It is also the most expensive one, in total, to the Federal government, and to the State and county governments.

Option 2: This is an interpretation of the Department of Public Welfare's plan for MR facilities and programs. There are some differences from that plan here: The Department looks only as far out as 1985, we extend to 1987; DPW uses MA totals and does not include the non-MA recipients of services in some levels of care, we include all recipients of care and estimate for Medicaid as a part of the level of care; DPW does not include some levels of care in their figures (e.g., Nursing homes, MR Cost of care, (foster care), while we include all of these levels of care. As a result, our estimates tend to be extensions of Departmental estimates (at the same rates they assume) into 1986 and 1987.

Option 2 assumes

- State institutions will decline to an average daily census of 1320 by 1987.
- No changes in numbers of MR/DD nursing home clients.

. Controls on ICF-MR in the community, resulting in a decline front 5040 beds in 1984 to 4440 in 1987, through some decertification of beds.

. The development of a number of developmental training homes for children (quasi-intensive) -- 300 by 1987.

. MR cost of care would decline from 600 to 500 slots, mostly through the passage of slots into the ICF-MR or DTC services levels of care.

. SILS would grow from 870 to 1200.

. An in-home care program, growing to 400 slots by 1987, would be instituted in 1984.

. A foster care program is not yet planned; however, to "balance" the DPW program with other programs, for comparative purposes, we added a foster care program, to grow to 500 slots by 1987.

. A supervised living arrangements program, mainly for persons leaving ICF-MRs in the community, would grow from 100 slots in 1984 to 830 in 1987.

. Day Activities: About 30 percent greater than Option 1. Option 2, while starting slowly, ends up with a distribution not greatly different from Option 3.

Option 3 assumes the following:

. State institutions will decline to an average daily census of 1200 by 1987 (about 1040 beds by year-end).

. Nursing home slots for MR/DD persons will be reduced to an average of 200 by 1987.

. ICFMR beds will decline to 4600 beds, on average, by 1987.

. Developmental training homes will increase to 300 by 1987.

. Supervised living arrangements will reach 640 by midyear 1987.

. MR cost of care will decline to 300 slots.

. SILS, as in Option 2, will increase to 1200.

. In-Home care, in a large difference from Option 2, will increase to 700 slots.

. Family subsidy will not change.

- Foster care will increase to 700 slots (rather than the 500 in Option 2).
- Sheltered Work and DAC increase by 50 percent over the increase in Option 1.

Some idea of a programmatic change can be grasped by making a comparison among differing patterns of provision over the whole continuum of care. Table 1b, below, exhibits three different programs for MR-DD, by defining differing target numbers for the same number of people in the residential continuum in 1987 (but for differing numbers of persons in the day program portion, since day program slots are assigned to persons outside state institutions), with a comparison to a current reference point — the pattern for 1983.

Here, in one table, the differing target patterns for the three options can be examined for the year 1987.

		1987		
Type of Service	1983	Option 1	Option 2	Option 3
State Institutions	2,320	1.920	1,320	1,200
Nursing Homes (NH)	350	350	350	200
ICFMR's	4,920	6,040	4,440	4,600
Developmental Training Centers (DTC)	0	0	300	300
Supervised Living Arrangements (SLA)	0	0	830	640
MR Cost of Care	600	500	500	300
Supervised Independent Living (SILS)	870	1,030	1,200	1,200
In-Home Care	0	0	400	700
Family Subsidy	200	200	200	200
Foster Care	0	0	500	700
Total Residential	9,260	10,040	10,040	10,040
Sheltered Work/Work Activity	4,354	5,534	5,394	5,500
Developmental Achievement Centers (Adult)	3,860	4,460	4,780	4,844
Developmental Achievement Centers (Child)	1,400	1,400	1,400	1,500
Total Day Programs	9,614	11,194	11,574	11,844

Table 1b: A Comparison of Program Targets - The Distribution of Slots in the Continuum of Care, 1983 and in 1987 for Options 1, 2, and 3.

Those patterns and their differences can be better understood when we aggregate them into three classes of residential provision: medical facilities (state institutions, nursing homes, and ICF-MRs), non-medical group facilities (Developmental training homes, supervised living programs), and home-based programs (in-home care, family subsidy, and foster care).

The differences between today's medical-facility-oriented pattern and its future "twin", Option 1, and Options 2 and 3, which are more non-medical and home-based in their orientation, can be easily seen in Table 1c, below.

Type of Residence	1983	1987		
		Option 1	Option 2	Option 3
Medical Facilities	7,640	8,310	6,110	6,000
Non-Medical Facilities	1,440	1,530	2,830	2,440
Home-Based Program	200	200	1,100	1,600
	9,260	10,040	10,050	10,040

Table lc: Residential Patterns, 1983 and 1987.

As we have designed them, the four options can be laid out as they are below in Figure 1.

Option	Program Change	Fiscal Change
Option 1	None. Let Current Trends Continue.	None. Let Current Trends Continue.
Option 1a	None. Let Current Trends Continue.	Provide Medicaid in SILs, MR Cost of Care, and DACs, all under regular MA programs.
Option 2	Speed-up Medical Facility phasedown, and end current buildup; develop non-medical facilities and home-based programs.	Provide Medicaid in all non-medical and home-based programs, and in DACs, under waiver.
Option 3	Same general approach as Option 2, with somewhat more emphasis on home-based and DACs than Option 2.	Same general approach as Option 2.

Figure 1: The Interaction of Program and Fiscal Changes in Producing Four Options for the MR-DD Continuum of Care in Minnesota, 1983-1987.

Impact of the Options on Where People Live

At present, about 71 percent of the people in residential programs for MR in Minnesota live in state institutions, nursing homes, and community ICF-MRs, i.e., medical institutions.

Under the three options examined:

. The trend to medical institution living would continue, under Option 1, with 83 percent of all persons living in such facilities by 1987. 94 percent of all residential dollars would be spent there.

. Under the DPW Option (Option 2), the percentage of those living within medical institutions would decline to 64 percent; the percentage of residential dollars would decline to 83 percent.

. Under Option 3, the percentages would decline to 60 and 64.

Impact of the Options on the Importance of State Institutions and Nursing Homes

At present, 39 percent of all MR funding goes for State institutions and nursing homes. Under Option 1, that percentage declines to about 32 percent of the funding in 1987. Under Options 2 and 3, that percentage declines to 25 percent.

Impact on County Spending

In 1983, the Minnesota counties are spending $34,74 million dollars on MR services. If nothing is done — that is, Option 1 is selected — that will increase county costs to $56.23 million to meet the expected needs of that year (a 13 percent annual compounded increase in tax levy costs). All other options, la (using the program targets in 1, with Medicaiding of SILS, MR Cost of Care, and

DACs), 2, and 3 are less expensive to the counties than today's expenditures.

Year/Option	Cost ($ Millions)
1983	34.74
1987-1	56.23
1987-1a	24.79
1987-2	15.54
1987-3	16.37

Table 2: Cost to the Counties of Minnesota of MR Services, 1983 and 1987.

Impact on State Spending

With current spending by the State (in state general funds) at $104.75 million, the options considered would increase spending, in current dollars, by 18 to 27 percent — all of which would be below the rate of inflation (assumed to be 36 percent over the four-year period). Here Option 2 performs best.

Year/Option	Cost ($ Millions)
1983	104.75
1987-1	141.33
1987-1a	155.10
1987-2	135.74
1987-3	136.54

Table 3: Cost to the State of Minnesota of MR Services, 1983 and 1987.

Type of Service	Clients	Total	HA	SSI	State	County	Private
State Institutions	2,320	92.73	44.28	-	40.54	4.01	3.90
NH	350	5.10	2.81	-	2.06	.23	-
ICFMR	4,920	97.91	50.20	-	40.90	4.55	2.26
DTC	0	-	-	-	-	-	-
SLA	0	-	-	-	-	-	-
MR Cost of Care	600	4.69	-	2.16	.63	1.90	-
SILS	870	6.30	-	1.88	4.29	.13	-
In-Home Care	0	-	-	-	-	-	-
Family Subsidy	200	-		-	-	-	-
Foster Care	0	-	-	-	-	-	-
Total	9,260	206.73	97.29	4.04	88.42	10.82	6.16
SW/WAC	4,354	15.97	_		8.94	1.76	5.27
DAC (Adult)	3,860	21.11	-	-	5.28	15.83	-
DAC (Child)	1,400	8.44	-	-	2.11	6.33	-
Total	9,614	45.52	—	—	16.33	23.92	5.27
Grand Total		252.25	97.29	4.04	104.75	34.74	11.43

Table 4: Current Operating Costs for the MR-DD Continuum of Care in Minnesota, 1983.

Type of Service	1983	1984	1985	1986	1987
SI	2,320	2,220	2,120	2,020	1,920
NH	350	350	350	350	350
ICF-MR	4,920	5,200	5,480	5,760	6,040
DTC	0	0	0	0	0
SLAs	0	0	0	0	0
MR Cost of Care	600	500	500	500	500
SILS	870	950	1,030	1,030	1,030
In-Home Care	0	0	0	0	0
Fam. Sub.	200	200	200	200	200
Foster Care	0	0	0	0	0
	9,260	9,420	9,680	9,860	10,040
DAC (AD) ICF-MR	2,604	2,750	2,900	3,050	3,200
DAC (AD) Non-ICF-MR	1,256	1,200	1,220	1,240	1,260
DAC (Ch)	1,400	1,400	1,400	1,400	1,400
SW/WAC	4,354	4,624	4,914	5,124	5,334
	9,614	9,974	10,934	10,814	11,194

Table 5: Option 1 -- Annual Program Targets

Type of Service	Clients	Total	MA	SSI	State	Co.	Private
SI	2,220	95.82	46.22		41.24	4.48	3.98
NH	350	5.53	2.81	-	2.45	.27	-
ICF/MR	5,200	111.76	55.45	-	48.37	5.37	2.57
DTC	0	-	-	-	-	-	-
SLA	0	-	-	-	-	-	-
MR Cost of Care	500	4.22	-	1.00	.87	2.35	-
SILS	950	7.43	-	2.22	4.08	1.13	-
In-Home Care	0	-	-	-	-	-	-
Family Subsidy	200	.57	-	-	.57	-	-
Foster Care	0	-	-	-	-	-	-
Total	9,420	225.33	104.48	3.22	97.58	13.60	6.55
Sheltered Work	4,354	16.42	_		10.60*	2.10	3.72
DAC (Ad)	3,950	23.62	-	-	5.91	18.52	-
DAC (Child)	1,400	9.11	-	-	2.28	6.83	-
Total	9,614	50.15			18.79 -	27.45	3.72
Grand Total		275.48	104.48	3.22	116.37	41.05	10.27

Table 6: Option 1 - 1984. Dollars (Millions)

* Includes $2.76 million of Federal VR funds

Type of Service	Clients	Total	MA	SSI	State	County	Private
State Institutions	2,120	98.83	48.90		41.32	4.50	4.11
NH	350	5.98	3.11	-	2.58	.29	-
ICFMR	5,480	127.20	64.72	-	53.59	5.96	2.93
DTC	0	-	-	-	-	-	-
SLA	0	-	-	-	-	-	-
MR Cost of Care	500	4.56	-	2.10	.62	1.84	-
SILS	1,030	8.70	-	2.59	5.94	.17	-
In-Home Care	0	-	-	-	-	-	-
Family Subsidy	200	.61	-	-	.61	-	-
Foster Care	0	-	-	-	-	-	-
Total	9.680	245.88	116.73	4.69	104.66	12.76	7.04
SW/WAC	4,914	19.52	_	_	10.57*	2.29	6.66
DAC (Adult)	4,120	26.29	-	-	6.57	19.72	-
DAC (Child)	1,400	9.84	-	-	2.46	7.38	-
Total	10,434	55.65	-	-	19.60	30.39	6.66
Grand Total		301.53	116.73	4.69	124.26	43.15	13.70

Table 7: Option 1 - 1985. Dollars (Millions)

* Includes $2.68 million Federal VR funds.

Type of Service	Clients	Total	HA	SSI	State	Co.	Private
SI	1,920	104.40	51.57		43.73	4.76	4.34
NH	350	6.97	3.63	-	3.01	.33	-
ICF-MR	6,040	163.63	83.08	-	69.01	7.67	3.97
DTC	0	-	-	-	-	-	-
SLA	0	-	-	-	-	-	-
MR Cost of Care	500	5.31	-	2.50	.70	2.11	-
SILS	1,030	10.15	-	3.09	1.77	5.29	-
In-Home Care	0	-	-	-	-	-	-
Family Subsidy	200	.71	-	-	.71	-	-
Foster Care	0	-	-	-	-	-	-
	10,040	291.17	138.28	5.59	118.93	20.16	8.31
SW/WAC	5,534	22.95	_		11.23	2.57	9.15
DAC (Adult)	4,460	33.19	-	-	8.30	24.89	-
DAC (ch)	1,400	11.48	-	-	2.87	8.61	-
	11,194	67.62	-	-	22.40	36.07	9.15
Grand Total		358.79	138.28	5.59	141.33	56.23	17.48

Table 8 : Option 1 - 1987. Dollars (Millions)

Type of Service	Clients	Total	MA	SSI	State	County	Private
State Institutions	2,220	95.82	46.22		41.24	4.48	3.98
NH	350	5.53	2.81	-	2.45	.27	-
ICFMR	5,200	111.76	55.45	-	48.37	5.37	2.57
DTC	0	-	-	-	-	-	-
SLA	0	-	-	-	-	-	-
MR Cost of Care	500	4.22	1.15	1,00	1.87	.20	-
SILS	950	7.43	1.92	2.19	2.98	.34	-
In-Home Care	0	-	-	-	-	-	-
Family Subsidy	200	.57	-	-	.57	-	-
Foster Care	0	-	-	-	-	-	-
Total	9,420	225.33	107.55	3.19	97.47	10.46	6.55
SW/WAC	4,624	18.43	2.81	_	9.41	1.82	4.39
DAC (Adult)	3.950	28.01	14.22	-	12.41	1.38	-
DAC (Child)	1,400	10.93	1.67	-	3.46	5.80	-
Total	9,974	57.37	18.70	-	25.28	9.00	4.39
Grand Total		282.70	126.23	3.19	122.76	19.46	10.94

Table 9: Option la - 1984. Dollars (Millions)

Type of Service	Clients	Total	MA	SSI	State	County	Private
State Institutions	2,120	98.83	48.90		41.32	4.50	4.11
NH	350	5.98	3.11	-	2.58	.29	-
ICFMR	5,480	127.20	64.72	-	53.59	5.96	2.93
DTC	0	-	-	-	-	-	
SLA	0	-	-	-	-	-	-
MR Cost of Care	500	4.56	1.28	2.10	1.06	.12	-
SILS	1,030	8.70	2.28	2.59	2.06	1.77	-
In-Home Care	0	-	-	-	-	-	-
Family Subsidy	200	.61	-	-	.61	-	
Foster Care	0	-	-	-	-	-	-
Total	9,680	245.88	120.29	4.69	101.22	12.64	7.04
SW/WAC	4,914	20.69	3.23	_	10.48	2.04	4.94
DAC (Adult)	4,120	31.55	16.43	-	13.61	1.51	_
DAC (Child)	1,400	11.80	1.84	-	3.50	9.81	_
Total	10,434	64.04	21.50	-	27.69	9.91	4.94
Grand Total		309.92	141.79	4.69	128.91	22.55	11.98

Table 10: Option la - 1985. Dollars (Millions)

Type of Service	Clients	Total	MA	SSI	State	County	Private
State Institutions	1,920	104.40	51.57	_	43.63	4.76	4.34
NH	350	6.97	3.63	-	3.01	.33	-
ICFMR	6,040	163.63	83.08	-	69.01	7.67	3.97
DTC	0	-	-	-	-	-	-
SLA	0	-	-	-	-	-	-
MR Cost of Care	500	5.31	1.46	2.50	1.21	.14	-
SILS	1,030	10.15	2.60	3.09	4.22	.24	-
In-Home Care	0	-	-	-	-	-	-
Family Subsidy	200	.71	-	-	.71	-	-
Foster Care	0	-	-	-	-	-	-
Total	10,040	291.17	142.34	5.59	121.79	13.14	8.31
SW/WAC	5,334	23.46	3.67	_	11.90	2.31	5.58
DAC (Adult)	4,460	39.83	20.71	-	17.21	1.91	-
DAC (Child)	1,400	13.77	2.14	-	4.20	7.43	-
Total	11,194	77.06	26.52	-	33.31	11.65	5.58
Grand Total		368.23	168.86	5.59	155.10	24.79	13.89

Table 11: Option la - 1987. Dollars (Millions)

Type of Service	Year 1983	1984	1985	1986	1987
State Institutions	2,320	2,096	1,856	1,600	1,320
Nursing Homes	350	350	350	350	350
ICFMR	4,920	5,040	4,840	4,640	4,440
DTC	0	88	168	200	300
SLA	0	100	390	600	830
MR Cost of Care	600	500	500	500	500
SILS	870	950	1,030	1,120	1,200
In-Home Care	0	62	185	300	400
Family Subsidy	200	200	200	200	200
Foster Care	0	34	161	350	500
Total	9,260	9,420	9,680	9,860	10,040
SW/WAC	4,354	4,650	4,834	5,134	5,394
DAC (Adult)	3,860	4,030	4,280	4,530	4,780
DAC (Child)	1,400	1,400	1,400	1,400	1,400
Total	9,614	10,080	10,514	11,064	11,574

Table 12: Option 2 - Annual Program Targets

Type of Service	Clients	Total	MA	SSI	State	County	Private
State Institutions	2,096	94.84	45.75		40.89	4.44	3.76
NH	350	5.53	2.81	-	2.45	.27	-
ICFMR	5,040	108.32	53.74	-	46.88	5.21	2.49
DTC	88	1.28	.48	.34	.41	.05	-
SLA	100	1.77	.70	.39	.61	.07	-
MR Cost of Care	500	4.22	1.16	1.00	1.86	.20	-
SILS	950	7.43	1.90	2.22	3.54	.15	-
In-Home Care	62	.34	.17	-	.15	.02	-
Family Subsidy	200	.57	-	-	.57	-	-
Foster Care	34	.34	.17	-	.15	.02	-
Total	9,420	224.64	106.88	3.95	97.51	11.43	6.25
SW/WAC	4,650	17.49	-	-	9.44	2.10	5.95
DAC (Adult)	4,030	23.81	12.09	-	10.55	1.17	-
DAC (Child)	1,400	9.11	4.63	-	4.43	.45	-
Total	10,080	50.41	16.72	-	24.42	3.72	5.95
Grand Total	-	275.05	123.60		120.93	14.15	12.20

Table 13: Option 2 - 1984. Dollars (Millions)

Type of Service	Clients	Total	MA	SSI	State	County	Private
State Institutions	1,856	90.70	44.88	-	38.09	4.13	3.60
NH	350	5.98	3.11	-	2.58	.29	-
ICFMR	4,840	112.34	57.16	-	47.34	5.26	2.58
DTC	168	2.65	1.01	.71	.84	.09	-
SLA	390	7.47	3.04	1.64	2.51	.28	-
MR Cost of Care	500	4.56	1.28	2.10	1.06	.12	-
SILS	1,030	8.70	2.28	2.59	2.45	.38	-
In-Home Care	185	1.09	.57	-	.47	.05	-
Family Subsidy	200	.61	.32	-	.26	.03	-
Foster Care	161	1.74	.91	-	.75	.08	-
Total	9,680	235.84	114.56	7.04	95.35	10.71	6.18
SW/WAC	4,834	19.21	3.00		9.74	1.89	4.58
DAC (Adult)	4,280	27.31	14.22	-	11.78	1.31	-
DAC (Child)	1,400	9.84	5.12	-	4.28	.48	-
Total	10,514	56.36	22.34	-	25.80	3.68	4.58
Grand Total		292.20	136.90	7.04	121.15	14.39	10.76

Table 14: Option 2 - 1985. Dollars (Millions)

Type of Service	Clients	Total	MA	SSI	State	County	Private
State Institutions	1,320	75.24	37.17		31.66	3.43	2.98
NH	350	6.97	3.63	-	3.01	.33	-
ICFMR	4,440	120.21	61.07	-	50.74	5.64	2.76
DTC	300	6.70	2.72	1.47	2.26	.25	-
SLA	830	18.55	7.53	4.07	6.25	.70	-
MR Cost of Care	500	5.31	1.49	2.45	1.23	.14	-
SILS	1,200	11.83	3.09	3.53	4.68	.53	-
In-Home Care	400	2.76	1.43	-	1.20	.13	-
Family Subsidy	200	.71	.37	-	.31	.03	-
Foster Care	500	6.30	3.28	-	2.72	.30	-
Total	10,040	254.58	121.78	11.52	104.06	11.08	5.74
SW/WAC	5,394	22.38	3.49	_	11.36	2.20	5.33
DAC (Adult)	4,780	35.57	18.50	-	15.36	1.71	-
DAC (Child)	1,400	11.48	5.97	-	4.96	.55	-
Total	11,574	69.43	27.96	-	31.68	4.46	5.33
Grand Total		324.01	149.74	11.52	135.74	15.54	11.07

Table 15: Option 2 - 1987. Dollars (Millions)

Type of Service	Year				
	1983	1984	1985	1986	1987
State Institutions	2,320	2,100	1,840	1,520	1,200
NH	350	310	265	220	200
ICFMR	4,920	4,900	4,800	4,700	4,600
DTC	0	100	200	300	300
SLA	0	200	350	510	640
MR Cost of Care	600	500	400	300	300
SILS	870	950	1,030	1,110	1,200
In-Home Care	0	80	295	500	700
Family Subsidy	200	200	200	200	200
Foster Care	0	80	300	500	700
Total	9,260	9,420	9,680	9,860	10,040
SW/WAC	4,354	4,559	4,909	5,215	5,500
DAC (Adult)	3,860	4,100	4,340	4,580	4,844
DAC (Child)	1,400	1,425	1,450	1,475	1,500
Total	9,614	10,084	10,699	11,274	11,844

Table 16: Option 3 –
Annual Program Targets

Type of Service	Clients	Total	MA	SSI	State	County	Private
State Institutions	2,100	99.94	48.21		43.30	4.67	3.76
NH	310	4.90	2.49	-	2.17	.24	-
ICFMR	4,900	105.31	52.25	-	45.58	5.06	2.42
DTC	100	1.46	.54	.39	.48	.05	-
SLA	200	3.55	1.41	.78	1.22	.14	-
MR Cost of Care	500	4.22	1.16	1.00	1.25	.81	-
SILS	950	7.43	1.52	2.22	3.54	.15	-
In-Home Care	80	.44	.22	-	.20	.02	-
Family Subsidy	200	.57	.29	-	.25	.03	-
Foster Care	80	.80	.41	-	.35	.04	-
Total	9,420	228.62	108.50	4.39	98.34	11.21	6.18
SW/WAC	4,559	17.15	_		9.26	2.06	6.83
DAC (Adult)	4,100	24.22	12.30	-	10.73	1.19	-
DAC (Child)	1,400	9.11	4.75	-	3.92	.44	-
Total	9,614	50.48	17.05	-	23.42	3.32	4.08
Grand Total		279.10	125.55	4.39	121.76	14.53	10.26

Table 17: Option 3 - 1984. Dollars (Millions)

Type of Service	Clients	Total	MA	SSI	State	County	Private
State Institutions	1,840	94.57	46.79		39.91	4.31	3.56
NH	265	4.53	2.36	-	1.95	.22	-
ICFMR	4,800	111.41	56.69	-	46.94	5.22	2.56
DTC	200	3.15	1.20	.84	1.00	.11	-
SLA	350	6.71	2.73	1.47	2.26	.25	-
MR Cost of Care	400	3.64	1.02	1.68	.85	.09	-
SILS	1,030	8.70	2.28	2.59	2.45	.38	-
In-Home Care	295	1.74	.91	-	.75	.08	-
Family Subsidy	200	.61	.32	-	.26	.03	-
Foster Care	300	3.24	1.69	-	1.39	.16	-
Total	9,680	238.30	115.99	6.58	97.76	10.85	6.12
SW/WAC	4,909	19.50		_	10.53	2.34	6.63
DAC (Adult)	4,340	27.69	14.42	-	11.94	1.33	-
DAC (Child)	1,450	10.19	5.31	-	4.39	.49	-
Total	10,699	57.38	19.73	-	26.86	4.16	6.63
Grand Total		295.68	135.72	6.58	124.62	15.01	12.75

Table 18: Option 3 - 1985. Dollars (Millions)

Type of Service	Clients	Total	MA	SSI	State	County	Private
State Institutions	1,200	71.94	35.53	_	30.42	3.28	2.71
NH	200	3.98	2.07	-	1.73	.19	-
ICFMR	4,600	124.54	63.27	-	52.57	5.84	2.86
DTC	300	5.52	2.11	1.47	1.75	.19	-
SLA	640	14.30	5.81	3.13	4.82	.54	-
MR Cost of Care	300	3.11	.85	1.47	.67	.08	-
SILS	1,200	12.98	3.69	3.53	5.18	.58	-
In-Home Care	700	4.83	2.51	-	2.09	.23	-
Family Subsidy	200	.71	.37	-	.31	.03	-
Foster Care	700	8.82	4.59	-	3.81	.42	-
Total	10,040	250.73	120.80	9.60	103.35	11.28	5.57
SW/WAC	5,500	22.82	_	_	12.32	2.74	7.76
DAC (Adult)	4,844	36.04	18.75	-	15.56	1.73	-
DAC (Child)	1,500	12.30	6.40	-	5.31	.59	-
Total	11,844	71.16	25.15		33.19	5.09	7.76
Grand Total		321.89	145.95	9.60	136.54	16.37	13.33

Table 19: Option 3 - 1987. Dollars (Millions)

Appendix I: TECHNICAL NOTES

I. Reimbursement and Client Support Costs.

Reimbursement in the mental retardation systems tends to be, in the main, from several limited sources. They include: State appropriations for institutions, State match for Medicaid reimbursement, county match to Medicaid, State and county spending under the Minnesota Community Social Services Act, Federal Supplemental Security Income, State County supplements to Federal Supplemental Security Income, Social Security Disability payments, State and county appropriations for vocational rehabilitation purposes, Federal vocational rehabilitation funds (Section 110 of the VR Act), Federal Community Block Grant {formerly Title XX) funds, State-County general assistance, and private funding from parent and patient earnings sources.

We have accounted for most of these sources for the 9260 persons estimated to be in publicly-supported residential programs for MR/DD persons in State Fiscal Year 1983, well as for 9,614 persons receiving sheltered work and day activity services 1n the State.

However, the total amount, $252.25 million in FY 1983, does not include the full amount spent on care, treatment, social services, transportation, and income maintenance from public funds for MR-DD persons. There are also large amounts of funding not included 1n those estimates. They are funds from Federal, state, and local sources for special education

purposes; Medicare payments to hospitals and physicians for medical care; Medicaid payments to other than ICF-MRs, ICFs, and SNFs for medical care; SSI and SSDI payments to persons not in publicly-supported residential facilities and programs; Food Stamps payments; loans, interest subsidies, and rent subsidies from Federal (HUD) and State sources. Any future analyses of the continuum of care for MR-DO should be designed to estimate these costs.

II. Estimating the Expenditures for MR-DD Continuum of Care.

Expenditure data are, for the most part, from the records of the Minnesota Department of Public Welfare (DPW). Estimates are made for each level of care. Annual unit prices for 1983 and subsequent years are recorded below, in Table 20. With two kinds of exceptions, future expenditures are estimated by assuming an 8 percent annual rate of inflation in service costs. The two exceptions are:

- State institution prices are inflated further, for Options 2 and 3, in order to account for the fact that the savings for each person leaving are in marginal costs, which are lower than average costs, and that the level of average intensity of client handicap – and thus service costs – is increasing. Thus, the $54,375 per year cost for State institution patient care under Option 1, in 1987, becomes $57,000 for Option 2 and $59,950 for Option 3.

- DAC prices, for Option la (a clinic services approach to Medicaid under the regular program), are inflated an extra 20 percent for each year from 1984 through 1987. This is based upon the experience of the New York program.

In the case of services not existing in 1983, no estimate was made for the service's cost for that year.

Type of Service	Year				
	1983	1984	1985	1986	1987
State Institutions					
Option 1	$39,968	$43,164	$46,618	$50,347	$54,375
Option 2	39,968	45,247	48,869	52,777	57,000
Option 3	39,968	47,590	51,398	55,509	59,950
Nursing Homes	14,641	15,812	17,077	18.443	19,918
ICFMRs in Community	19,900	21,942	23,211	25,068	27,074
Dev. Training Homes	--	14,600	15,768	17,029	18,392
Supervised Living Arrgmt.	--	17,740	19,160	20,690	22,346
MR Cost of Care	7,810	8,434	9,110	9,838	10,625
Supervised Indep. Living	7,344	7,824	8,449	9,125	9,855
In-Home Care	--	5,475	5,913	6,386	6,897
Family Subsidy	2,619	2,829	3,055	3,299	3,563
Foster Care	--	10,000	10,800	11,664	12,597
Sheltered Work					
DAC (Adult)					
Non-Regular MA	5,470	5,908	6,380	6,890	7,442
Regular MA	6,564	7,090	7,656	8,268	8,930
DAC (Child)					
Non-Regular MA	6,027	6,508	7,029	7,592	8,200
Regular MA	7,232	7,810	8,434	9,109	9,838

Table 20: Annual Unit Prices for Each Level of the Minnesota MR-DD Continuum of Care, 1983-87.

III. Estimating the Revenues for the MR-DD Continuum of Care

Revenue for 1983 are based on expectations for the current year. Revenues for the future years under each target are dependent upon State program policy, fiscal policy and administration. Thus, the amount of Medicaid reimbursement secured will depend upon whether the State uses a waiver or not, whether it puts some new community services under Medicaid or not, and what the configuration of services in the continuum will be.

In making the technical estimates, we must know what level of government (from what account) pays what proportion of cost at each level of the continuum. The notes on estimating revenues are given below:

A. State Institutions

1. 1983. Private payments of $3.9 million come off the top of $109.50 per diem times average daily census times 365. The residual is multiplied by the .9157 Medicaid-eligible proportion of the patient population. The nonfederal amounts are apportioned to county costs at a 90:10 ratio. See Federal: State: County ratios for each year below.

2. 1984-7. Private payments are inflated at 8 percent per year (to $4.21, $4.55, $4.91, and $5.31 millions) Medicaid-eligibles move to .95 of the patient population. All else remains the same.

B. Nursing homes. 100 percent of the population are eligible for MA. The cost burdens are allocated according to MA matching for each year, between Federal and Nonfederal. Nonfederal is allocated 90:10 between State and counties.

C. Community ICF-MRs. For all years, we assume that 97.7 of the population is MA-el1g1ble. The remaining 2.3 is paid from private sources.

D. MR Cost of Care. This 1s treated in two different ways in the analysis.

1. Under Option 1, it 1s treated as a combined SSI-State

program. After SSI revenues, for 100 percent of the persons in the category, the remainder is treated as a 25:25::State:County match.

2. Under Option la, 2, and 3, it is treated as an SSI-MA program, with SSI being deducted from total cost and the remainder treated according to regular MA matching.

E. Developmental Training Homes. DTCs are treated as an SSI-MA program, with 100 percent of all clients both SSI and MA eligible.

F. Supervised Living Arrangements. SLAs are treated in the same way as DTCs.

G. Supervised Independent Living. SILS are treated as a combined SSI-MA program, with 60 percent SSI-eligible and 100 percent as MA-eligible. The 40 percent of the non-SSI-eligibles are treated as paid for, for the same amount as the SSI/Food Stamps amounts given below for each year, by the State.

H. In-Home Care. IHC 1s treated as a program in which all are eligible, under the waiver, for MA — which is allocated in the usual way.

I. Family Subsidy. This program 1s treated in two ways:

1. Under Option 1 and la, it is treated as it is currently, as a 100 percent State-paid program.

2. Under Options 2 and 3, it is treated as an MA program, in which all are eligible.

J. Foster Care. This program is treated as a combined SSI-MA program, in which all clients are eligible for both SSI and MA.

K. Sheltered Work. This program is treated in two ways:

1. Under Options 1 and la, it is supported by a combination
of Federal vocational rehabilitation dollars, State appropriations and county appropriations. Private contributions are not included.

2. Under Options 2 and 3, it is treated as a waivered service in which all persons and 30 percent of costs are MA-elig1ble.

L. DAC-Adults. This program is treated 1n three ways:

1. Under Option 1, it is funded 25 percent State, 75 percent county for all clients.

2. Under Option la, it is funded as an MA activity, in which all persons are eligible, under the regular program.

3. Under Options 2 and 3, it is funded as an HA activity (under the waiver), in which all persons are eligible.

M. DAC-Children. This program is treated in three ways:

1. Under Option 1, there is no Federal MA; total costs are divided 25:75:: State:County.

2. Under Option la, 30 percent of the clients are treated as eligible for MA; the rest is divided 25:75:: State; County.

3. Under Options 2 and 3, all costs and persons are treated as MA-eligible, with the costs being divided on the Medicaid-formula proportions relevant to each year.

In order to calculate SSI and Medicaid reimbursements, we must know two further things — the SSI/Food Stamps annual payment, during each year of the analysis, and the Medicaid matching percentages for each year of the analysis.

A. SSI/Food Stamps Amounts. Starting with $3600 per year per client, these amounts are inflated 8 percent per year ($3600, $3888, $4199, $4355, $4898). These are combined Food Stamps and SSI (or SSDI) benefits.

B. Medicaid Matching. Federal/State/County matching differs by year, because of Congressional action on matching in 1981, as well as recalculation of the Federal formula, as an ongoing part of the law. The matching rates for Minnesota are:

Year	Level of Government		
	Federal	State	County
1983	52.48	42.77	4.75
1984	50.78	44.30	4.92
1985	52.08	43.13	4.79
1986	52.00	43.20	4.80
1987	52.00	43.20	4.80

In calculating reimbursement 1n State institutions, there are a number of accounts paying for patients, other than Medicaid and State institution appropriations. Most of these are negligible, and can be ignored in assessing relative fiscal impacts of major options. Patient payments, however, cannot be ignored, since it amounted in 1983 to better than 4 percent of State institutional costs -- $3.90 million.

In estimating future amounts for each option, we have converted the total amount into an average, taken over all average daily census — $1661 per patient in 1983. We then indexed it by an 8 percent inflation factor, and then multiplied the resultant amount by the number of average daily census for the year. The results are given in the table below:

	Year				
	1983	1984	1985	1986	1987
Unit Return ($)	1661	1794	1937	2092	2260
Total ($ Millions)	3.90	3.98	4.11	4.23	4.34
Options 1 and la	3.90	3.98	4.11	4.23	4.34
Option 2	3.90	3.76	3.60	3.35	2.98
Option 3	3.90	3.76	3.56	3.18	2.71

Table 21: Estimated Annual Average Payment Per Patient in Patient Payments, by Year, and Expected Total Returns From This Source, By Year and Option — 1983-1987.

Appendix II: Notes On a Waiver

What Gets Included Under the Waiver

In the last year's session of the Legislature, the proposed legislation for MR/DD dealt mainly or only with DAC funding under a 1915(c) waiver. This is fiscally important (we estimated the effect at that time as worth about $12.6 million in increased Federal Medicaid reimbursement to the State). However, it is extremely limited 1n that it provides only about 33 to 40 percent of the total average savings to the State and its counties that are available under a waiver.

Consider the major options:

1. We can include only institutional and community ICF-MRs and adult DACs in our calculations and policy changes on a waiver approach to Title XIX in the community; or,

2. We can consider

   a. Institutional ICF-MR

   b. Community ICF-MR

   c. Workshops and DACs (adults and children; "welfare money" and "VR money").

   d. SILs

      i) "intensive"
      ii) "standard"
      iii) "specialized foster care"

   e. Cost of Care facilities for children (those not under ICF-MR)

   f. Respite Care Services

g. Home Services

i) Family Subsidies

ii) Home-based Support Services (homemaker, home wealth, personal care)

h. Case Management

i. Program Management (i.e., State and local MR-DD program management activities)

j. Training in behavior management; or, 3. Some set of services which is more than 1. and less than 2.

There are important tradeoffs here:

1. The more we move toward 2., the more we must phase down, and the faster we must phase down, institutions; and, the more we must limit the growth and the more we must decertify into the SILs category the community ICF-MR category — so long as all of this is done under the waiver.

2. The more we proceed toward 2., the more we must put into State and county administration and planning, and the design of new administrative approaches to Medicaid; and, the more we must seek ways of integrating programmatically the CSSA and Medicaid "sectors" of the MR-DD continuum.

3. The more we move toward 2., the more funding will be available.

Looking at MR-DD Financing and Organizational Options

There is a bewildering variety of individual options available. Given the number of them, there is an even more complex variety of combinations of options into major ones.

Consider some individual options:

1. Children. Use the Katie Beckett option or not? That is, shall we make all the children living with their parents and receiving some form of state and county supported service eligible for MA reimbursement?

2. State institutions. How fast shall we transfer patients into the community? Where shall we target them for the community, and how will that affect design of community facilities and services?

3. Community ICF-MR numbers and mix. Should we limit the growth of community ICF-MRs? Should we cut back (i.e., decertify) the number of community ICF-MRs and convert them to SILS? If so, what kind, where, and what are the criteria for doing this? (This may not be an option, but rather a covert "mandate", since the Feds want some control here, in exchange for the waiver).

4. DACs. Decide on both administration and program concepts:

   a. Program. The options here are a "clinic services" conversion, outside the waiver, for all DACs, a la New York (tends to be very expensive); a "Title XX" approach, with the DACs very much like they are now; or, a dual system, with some DACs providing clinic services to ICF-MR patients and some providing waivered services to persons under the waiver (very cumbersome).

   b. Administration. There are two options here:

      i) Let each DAC and/or ICF-MR have their own provider number.

      ii) Have each DAC and/or ICF-MR be a sub-contractor to a county agency, a la New York and Michigan, with the county agency becoming its own ICF-MR. This second option would be politically desirable to the counties and the DACs, probably undesirable to the ICF-MRs.

5. Case Management. Does this become an I and R and monitoring function, or does it also have patient assignment powers? If the second, is this pre-admission only, or pre and post?

6. Family subsidies and home support services. Should the family subsidy concept be expanded, or should we use home support and respite care services as substitutes?

7. SILS. Up to now, almost no one in the Department of Public Welfare seems to have been considering the Medicaiding of SILS; yet, SILS will be the keystone of future community facilities, if a waiver approach 1s taken.

8. Training. Training of employees 1s viewed as a "frill". It may well be, when there is no substantive technology available. There are such approaches in MR-DD. They appear to be cost-effective. Yet, there is no systematic way available to assure that they are employed. If put into the waiver as a separate line, we would have a chance to teach personnel in the system behavioral management and related techniques.

9. Cost of Care. After a Medicaiding of child ICF-MR residents, the Cost of Care for MR has declined some. Nevertheless, it is still large, and should be considered for Medicaiding of outpatient services and inclusion within the continuum budget.

What to do "When the Waiver Passes"

1. Develop a method for deciding that someone is in need of institutionalization or not, for possible inclusion in the waiver group. (The MDPS data system, if operating here, should — with the development of criterion rules — be an adequate approach).

2. Assure that an Individual Program Plan — with scheduled update provisions — exists for each person in the waiver group. (Again, the long form of the MDPS may be adequate).

3. Develop a method for assuring free choice of ICF-MR vs. community provision.

4. Develop a more precise and integrated statistical system for dealing with the economic calculations necessary under the waiver. (This is proceeding under the McKnight Foundation grant). Integrate these requirements with current necessary statistical requirements and the ongoing data base work of the Department.

5. For each new level of the continuum, define and publish as a rule: payment methods and rates-setting procedure, any administrative interpretations of single State agency tasks which are not the same as those now followed by MA, and program standards (in some cases, existing rules may be usable, e.g., the SILS Rule 18 to also cover adult specialized foster care for the MR-DD group).

6. Methods for deciding on stopping rules (i.e., limiting the numbers under MA to what was estimated — using the anti-woodwork provisions of the waiver).

7. Eligibility methods for children under the "Katie Beckett" rule (i.e., children at home considered 1n their own right, rather than as part of the family, in which parental income is deemed).

8. Patient liability method for those with earnings under the waiver. (HCFA has issued an instruction to its regions on this).

9. Develop cost report concepts, forms, and instructions, as part of the rate-setting process, which allow for the separation of room and board from services costs; and, within the services area, to separate "strict" education and vocational rehabilitation costs from habilitation costs.

Providing Enough "Boom" for Waivers in 1984,

In the out-years of any option which 1s waiver-oriented, there 1s much "room" in the waiver arithmetic (which requires that the cost in Medicaid dollars with the waiver is less than the cost in such dollars to the same people without the waiver) for adding MA-financed community and home-based services.

However, in the short-term, there is much less room. Indeed, this has been one of the constraints on how to develop a waiver strategy. At one point, they were considering only:

1. Medicaiding the ICF-MR clients for DACs.
2. Providing waivers for a very small number of community-based residential services

in 1984. They would extend the waiver's coverage to "other DAC persons" and other services in 1985 and beyond.

We have investigated the problem and have a tentative solution. It consists of two parts:

1. Legislatively providing for medicaiding, under the regular program for:
    a. All ICFMR clients 1n DACs
    b. All other DAC clients who are MA-el1g1ble. (This implies brining all DACs under a New York Clinic services type of regular Medicaid program, with a 20 percent added cost, because of the structure of the program),
    c. Medicaiding the service component of MR-Cost of Care and SILS under the Outpatient Services paragraph.
    d. Medicaiding Case Management and Program Management on a cost allocation basis.
2. Providing for a waiver approach, if less expensive than 1., which

a. Puts all ICFMR clients in DACs under the regular MS programs.

b. Waivers all DTCs, SLAs, MR-Cost of Care, SILs, Family subsidies, Foster/Personal Care, all eligible Sheltered work and DACs, All Case Management and Program Management.

If we do this, we will have enough room in 1984 — and even more later for waivered services. It should be noted that Option 3 provides for the Maximum Medicaid reimbursement. We will not make those amounts because some persons will not be institutionalizable, under the program criteria. It is thus a conservative estimate.