FISCAL DISINCENTIVES IN THE SERVICE SYSTEM FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

by

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The Metropolitan Council coordinates the planning and development of the Seven-County Metropolitan Area. The Council is authorized by state and federal laws to plan for highways and transit, sewers, parks and open space, airports, land use, air and water quality, solid waste management, health, housing, aging and the arts. Together, the Council and its Metropolitan Health Planning Board serve as the health systems agency for the Metropolitan Area.

ABOUT THIS REPORT

This report examines a set of funding and cost-sharing mechanisms that result in placement of developmentally disabled people in the most expensive residential settings even when they could be served more appropriately by less expensive services.

The report describes how adjusting cost-sharing formulas and program funding changes incentives to county governments that, in Minnesota, are responsible for placement decisions.

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SUMMARY

The number of mentally retarded people in Minnesota state hospitals has declined dramatically since the 1960s, and an array of services has been developed to house and support these people in the community. In addition, community services for other developmentally disabled people have been established. However, a disproportionate percentage of the funds available for residential services are going to support people in the most restrictive, most expensive settings.

Fiscal disincentives are one barrier to more appropriate placements. Three levels of government--federal, state, and county--may share costs of services, but funding sources and cost-sharing formulas differ among programs. As a result, in some cases, one level of government may elect a more costly service because its share of the cost is less than for another more appropriate service, or because funds are more plentiful for one program than for a less expensive alternative. In Minnesota, the problem particularly affects county governments, which are responsible for placement decisions.

Fiscal disincentives are generated in three ways:

1. When programs have different cost sharing formulas:

   For example, the state and federal governments pay almost 95 cents of every Medicaid dollar expended on behalf of a county's eligible clients. However, when alternative services are funded through CSSA, the county pays at least 50 cents of every dollar. Given the choice of a 5-cent payment under Medicaid or a 50-cent payment under CSSA, the county fiscal incentive is clear: place as many people as possible in Medicaid funded services.

2. When both allocation programs and entitlement programs are available to finance related services:

   The funds expended on behalf of an eligible client are not restricted in an entitlement program such as Medicaid, which pays for state hospital and community group home care. But other services -- day programs, foster care, and other institutional alternatives -- are usually funded from the Community Social Services Act (CSSA), a limited state grant to counties. When that grant is exhausted, the county must expend its own revenue. The resulting incentive: to conserve limited CSSA money by funding as many clients as possible through unlimited Medicaid.

3. When clients receive benefits from several programs simultaneously:

   Often eligibility for a program is linked to a client's eligibility for other programs. Consequently, when personal income exceeds the limit for a key program, clients may find that they lose all program benefits. In the end, the client may lose money by making more income.

These types of disincentives affect each part of the residential service system. Counties pay less, for example, to keep someone in a state hospital than a community group home. This is because counties pay half of the cost of day programs for group home residents, but only 5 percent of these costs for residents of state hospitals. Similarly, although semi-independent living

services (SILS) cost $40 per day and group homes cost $67 per day,* the county pays more for SILS, the less expensive service.

Benefit "notches" affect most disabled people striving for independence. When people earn too much they understandably lose eligiblity for income maintenance programs. However, loss of medical/food/shelter benefits tied to the income maintenance program leaves the person poorer for working more. Similarly, since many programs only reimburse services provided in institutions, families must often place a disabled child out of the home to get public assistance with medical costs.

To illustrate the effects of strategies for reducing fiscal disincentives, this report examines the cost impacts of three strategies on a hypothetical county with a caseload of 1,000 people. The strategies included:

1. Increasing the appropriation for less restrictive settings.

2. Providing grants to counties to support less restrictive settings and equalizing the amount counties pay in each setting.

3. Extending Medicaid financing to include less restrictive settings. Counties would pay the same percentage of the cost of each setting.

All three deinstitutionalization strategies save money. However, not all strategies increase the incentive to use more appropriate placements. When appropriations are increased without adjusting cost sharing formulas, county costs increase with deinstitutionalization. Both state alternative care grants and expanded Medicaid financing contain strong incentives for counties to place people in less restrictive settings. While alternative care grants decrease county costs, the state must assume the additional cost burdens. Medicaid financing, on the other hand, shifts state and county cost decreases to the federal government.

To implement an effective program to reduce fiscal disincentives, government must: provide adequate case management to ensure appropriate placement, allow counties to keep some of the savings, and ensure that extending Medicaid financing does not lead to rapid escalation in the daily cost of services.

Recent state legislation (Minnesota Laws 1983, Chap. 312) contains several provisions that alter the way services are funded and provided to developmentally disabled people. One of the goals of the legislation is to contain costs by reducing fiscal disincentives. The appendix examines the provisions of the legislation and its cost impact on the hypothetical county caseload.

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*These are average costs and include the daily cost of a day program in a developmental achievement center (DAC).

BACKGROUND

In the last two decades a significant decline in the population of state institutions for mentally retarded people and a concommitant growth in community based services has occurred. In Minnesota, the mentally retarded population of state hospitals declined to 2,371 at the end of 1982 from a high of 6,100 in 1963 (Office of Legislative Auditor, 1983). The number of Medicaid certified facilities (ICF/MR) has grown from 105 in 1974 to 311 at the end of 1982 with a capacity of 4,900 licensed beds (Metropolitan Health Board, 1980). Prompted by the Welsch Consent Decree (1980), the state has committed itself to reduce further the number of state hospital residents to 1,850 by 1987.[1]

This rapid change in service delivery strategy reflects an evolution in philosophy and attitudes about disabled people and their potential for development. To accommodate the sometimes dramatic improvements in skill level that have resulted from appropriate programming, a range of services has evolved. These services are often arrayed along dimensions such as: most intensive to least intensive, most costly to least costly, dependent consumer to independent consumer/producer. In Minnesota, the array of services includes residential, day programming and support services as listed in Table 1.

TABLE 1. THE ARRAY OF SERVICES IN MINNESOTA

Residential	Day Programming	Support
• state hospitals	• public schools	• diagnosis
• community group homes	• developmental achievement centers	• referral
• foster homes	• work activity	• therapy
• semi-independent living	• sheltered work	• medical treatment
• independent living with support		• case management
		• respite care
		• in-home services

[1] A major impetus for deinstitutionalization in Minnesota was a court case known initially as Welsch v. Likins (373 F. Supp. 487, D. Minn.,1974) -- a class action suit brought in 1973 by six mentally retarded residents of Minnesota state hospitals. In December, 1977 the state and the plaintiffs reached an agreement, known as a consent decree, regarding staffing and program requirements at Cambridge State Hospital. In September, 1980, a consent decree covering all Minnesota state hospitals serving mentally retarded persons was reached. (Welsch v. Noot Consent Decree; No. 4-72-Civ. 451. U.S. District Court, District of Minnesota, U.S. District Judge Earl Larson. September 15, 1980.)

This paper examines why most people in the residential services system are concentrated in the most restrictive and most expensive services. It focuses on one type of barrier to appropriate placement -- fiscal disincentives. Disincentives, in this context, are policies and funding mechanisms--or the interaction of policies and mechanisms -- that discourage use of specific service settings. In the case of fiscal disincentives, the obstacle is the cost experienced by the governments that finance services. Because funding formulas vary, some levels of government -- in particular, local governments -- pay more for services that are less expensive overall.

Disincentives can be fiscal and/or administrative. For example, the tangle of public programs required to support clients in some community settings creates administrative disincentives apart from the question of costs. Similarly, disincentives can influence individual choices as well as the choices made by agencies responsible for placement. For instance, disabled people who are competitively employed may reduce working hours if their earned income threatens their eligibility for key medical benefits or income maintenance programs.

Political and fiscal disincentives assumed new prominence in 1981 when Congress relaxed restrictions on use of federal Medicaid funds for noninstitutional services.[2] The Home and Community-Based Waiver authority allows states to eliminate some fiscal and administrative disincentives by consolidating the funding and equalizing for all residential services the share of the cost that state and local governments pay.[3]

Copeland and Iversen (1981) examined the implications of a shift to Medicaid funding of noninstitutional services. They examined three plans that differed with respect to the extent the state pursued Medicaid financing of community services and the extent to which it reduced its institutionalized developmentally disabled population. The report concluded, in part, that accelerated deinstitutionalization (to 1,200 people by the end of FY 1985) with maximum use of Medicaid would save the state $73.2 million and the counties $103 million over six years, when compared with the plan of the Minnesota Department of Public Welfare (1981b).

A recent study of community residential facilities for mentally retarded people in Minnesota (Office of Legislative Auditor, 1983) found that while the

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[2] The Omnibus Reconciliation Act of 1981 (P.L. 97-35) added a new provision to Title XIX (Medical Assistance) of the Social Security Act - Section 1915(c) - granting to the Secretary of Health and Human Services the authority to approve waivers of Medicaid restrictions in order to permit Medicaid funding of home and community-based care for certain elderly and disabled persons who otherwise would require care in a Title XIX certified facility (i.e. a state hospital or group home).

[3] The federal government pays 52.2 percent of Medicaid funded services, while the state pays 43 percent and local government pays 4.8 percent. (State Health Planning and Development Agency, 1982).

population of state hospitals continues to decline, the total number of mentally retarded people in long term care settings -- state hospitals and community group homes -- has increased steadily. The report recommended that the Department of Public Welfare increase the availability of residential alternatives, encourage facilities to serve more dependent clients, and limit development of new group homes.

Recent state legislation (Minn. Laws 1983, Chap. 312) empowers the Department of Public Welfare to seek Medicaid waivers to fund day programs for group home residents, and to apply for home and community-based services waivers to provide an array of alternative services under the Medical Assistance program.

To understand how fiscal disincentives operate in the residential system, a brief review of the major programs that fund services for developmentally disabled people is necessary. The major sources of public financing for services include:

Medicaid (Medical Assistance, Title XIX of the Social Security Act). A state-federal program that finances medical services and long-term care for poor and disabled people. Medicaid pays for state hospital care and funds the system of community group homes in Minnesota. The federal government pays roughly half the cost. The state and the counties share the nonfederal expenses (90 percent state, 10 percent county). (42,45 CFR; Minn. Stat. 256B (393).

Community Social Services Act (CSSA). A state block grant to counties for social services that the counties match with at least equal amounts of their own revenue. Because it is a block grant, different counties plan and use the money to finance different services. Generally, some CSSA money is used to finance DACs, foster care, the county portion of SILS expenses, in-home support projects and respite care. While the state, theoretically, pays half the cost of CSSA services, the demand for these services is so high that counties often overmatch the state grant by a ratio of 2:1. (Minn. Stat. 256E).

Title XX. A federal grant to states to help finance social service costs. The funds are allocated according to a formula. Local governments supply one dollar for every three dollars of the federal grant. Title XX defined a group of mandatory and optional services, but many of these restrictions have been lifted and Title XX money is generally combined with the CSSA grant to counties. (Title XX Social Security Act, DPW Rule 160).

Supplemental Security Income (SSI). A federal program to provide minimum levels of income to aged, blind, or disabled people. Developmentally disabled people who are eligible for SSI receive a monthly grant of up to $284.30 (December, 1982) depending upon their income and resources. Recipients who have moved beyond state hospitals and group homes to less restrictive settings use SSI funds to pay for room, board, and personal needs. SSI is a consolidation of three federal categorical programs for aged, blind, and disabled people. (Title XVI, Social Security Act, 20 CFR).

Minnesota Supplemental Assistance. A state-county program to supplement SSI benefits or to help aged, blind, or disabled people who are ineligible for SSI because of excess income or resources. The monthly MSA benefit is calculated by subtracting the individual's net income from a county determined "need standard" for rent and basic necessities. Net income includes wages and benefits from other government programs. (Minn. Statutes 256D.393; DPW Rule 57).

Semi-Independent Living Services (SILS). A state-county program to provide counseling and related community support services to maintain and improve a client's ability to function in a noninstitutional setting. The program assists people who no longer need a 24-hour supervised residential placement, but are not yet able to live independently. SILS recipients live in apartments, rooming houses, foster homes, and their own homes. They are provided with several hours per week of training and counseling. The county applies to the state for SILS money and contracts with private vendors or provides the services itself. The state pays 81 percent of the cost for SILS clients who are coming from institutional settings or are at risk of institutional placement, and 50 percent of the cost for all other SILS recipients. (Minn. Stat. 252.28; DPW Rule 18).

Table 2
HOW LEVELS OF GOVERNMENT SHARE THE COSTS
OF MAJOR PUBLIC PROGRAMS

Program	Federal Share	State Share	Local Share
Medicaid	52.2%	43.0%	4.8%
CSSA	----	50.0	50.0[a]
Title XX	75.0	----	25.0
SSI	100.0	----	----
MSA	----	85.0	15.0
SILS	----	81.0	19.0[b]
Family Subsidy	----	100.0	----

Sources: Office of Legislative Auditor (1983).
State Health Planning and Development Agency (1982).

[a] Many counties are overmatching their state CSSA grant and contributing roughly 60 percent of their social services budget.

[b] Assumes the person is transferring to SILS from an ICF-MR or is at risk of institutionalization. For all others, the state pays 50 percent of cost.

HOW FISCAL DISCENTIVES OCCUR

Fiscal disincentives usually result from one or more of the following factors:

1. When allocation programs and entitlement programs are both available to finance related services

   The amount of funds expended on behalf of an eligible client is not restricted in an entitlement program such as Medicaid. But other services -- day programs, foster care, and other alternatives -- are usually funded out of CSSA, a limited state grant to counties. When that grant is exhausted, the county must expend its own revenue. The incentive: to conserve limited CSSA money by funding as many clients as possible through unlimited Medicaid.

2. When programs require different matching rates

   For example (see Table 2), the state and federal governments pay almost 95 cents of every Medicaid dollar expended on behalf of a county's eligible clients. However, if other services are funded through CSSA, the county pays at least 50 cents of every dollar. Given the choice of a 5 cent payment under Medicaid or a 50 cent payment under CSSA, the county fiscal incentive is clear: place as many people as possible in Medicaid funded services.

3. When clients receive benefits from several programs simultaneously
   Often eligibility for a program is linked to a client's eligibility for other programs. Consequently, when personal income exceeds the limit for a key program, clients may find that they lose all program benefits. In the end, the client may lose money by taking a job.

The incentive to local governments to maximize their use of entitlement programs like Medicaid is not in itself perverse. But the three factors discussed interact to encourage the use of services regardless of their overall cost and the needs of the client. This paper examines the links between the different components of the system and the specific disincentives operating at each point. The impact on public expenditures of different placement strategies is explored. Finally, this report addresses appropriate safeguards for ensuring movement to less restrictive settings while avoiding potential pitfalls which may result from expansion of new services.

DISINCENTIVES TO MOVE FROM STATE HOSPITALS TO COMMUNITY GROUP HOMES

1. Unequal County Share of State Hospital vs. Community Group Home Costs

This classic fiscal disincentive is illustrated in Table 3. Although Medicaid funds both state hospital and community group home (ICF-MR) placements, the per diems do not include the same services. State hospital daily rates include

the cost of day programs and other support services provided on site.

Community group home rates represent only the cost of residential services. Day and support services for group home residents are financed through CSSA or county revenue alone. Because of different funding formulas, the county pays at least half the cost of these services.

Table 3
DAILY COST OF STATE HOSPITAL VS.
COMMUNITY GROUP HOME SERVICE[a]

	Per Diem	County Costs $	County Costs %
State Hospital[b]			
Total	109.50	5.23	4.8%
Community Group Home			
Residential	51.71	2.48	4.8%
Day Program	14.88[c]	7.44	50.0%
Total	66.59	9.92	14.9%

Sources: Office of Legislative Auditor (1983)
Developmental Disabilities Program (1983)
Copeland and Iversen (1981)

[a] Community group home costs include only residential and day program costs. State hospital per diem costs are all inclusive. Assumes governments share costs as per Table 1.

[b] State hospital per diems are not divided into residential and day program portions. DPW estimates that 15% of the per diem is used for developmental day programs.

[c] Annualized day program costs. Cost per service day is $25.75 (211 service days per year).

Note several points in Table 3. First, the average cost of a community placement is less expensive than state hospital care even when the cost of day programs is included. Second, when only the cost of residential services is considered, the county pays less for group homes than for state hospitals. But when the cost of day programs is added, the county pays less in state hospitals because it can avoid the high CSSA matching rate for community day programs and additional medical, administrative, and support services.

Strained budgets have led some counties to reduce day programming services for all recipients in order to stretch the budget to meet a portion of everyone's need.[4] Other counties have refused to provide day programming for additional clients. These cuts inhibit movement from state hospitals because:

a. Group homes are reluctant to accept new residents who lack full time day programming. Federal regulations (42 CFR 442.463) require that ICFs-MR provide active training and habilitation services to all residents regardless of age, degree of retardation, or accompanying disabilities or handicaps. In Minnesota this requirement has most frequently been met by providing developmental achievement center (DAC) services on a regular basis (DPW Rule 34). As reductions in DAC programs for developmentally disabled people continue, compliance with the active treatment provision is jeopardized. Because providers have been limited since July 1981 to a 10 percent annual increase in rates (see below), few group homes can assume the additional staff costs of providing day programs for residents who must stay home several days per week because their DAC services have been reduced.

b. State hospitals are reluctant to discharge residents without the assurance of full time day programs. The Welsch Consent Decree (1980) and other court decisions (Judge Earl Larson, 1982a, 1982b) require discharge plans to avoid "dumping" state hospital residents on unprepared communities.

3. Lack of Facilities and Staff.

While the community has made great strides in serving people at all levels of functioning, current reimbursement and licensing rules discourage providers from making the changes needed to serve more dependent clients. The recent caps imposed on annual per diem rate increases[5] do not allow providers to cover the costs of added staff, enriched programs, or improved physical facilities. A recent study (Developmental Disabilities Program, 1982) found that almost one-half of state hospital admissions were for behavior or behavior-related problems. Of the admissions of individuals coming from a community group home, 85 percent resulted from behavior problems that the facility could not handle. Clearly, some flexibility is needed in the reimbursement system to enable existing providers to effectively serve residents with special needs.

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[4] A January, 1983 decision by the Minnesota Supreme Court (Swenson v. State of Minnesota, #C9-82-34 (Minn. S. Ct. January 21, 1983) prohibits counties from arbitrarily reducing DAC services below the level recommended by the client's individual service plan.

[5] For 1982 and 1983, the Legislature limited rate increases for residential facilities to 10 percent (1981 Minn. Laws, First Special Session, Chap. 2, Section 3). The rate limit is effective until January 30,1983; however, the Governor's budget message proposed a reduction in the limit from 10 percent to 8 percent to take effect July 1, 1983. In the budget balancing bills enacted during the Third Special Session of 1982, the Legislature also reduced payments to ICF-MR and other Medicaid vendors by 4 percent. This reduction affects services provided between January 1 and June 30, 1983 and is based on the per diem rate in effect for that period. (Minn. Laws 1982, 3rd Spec., Chap. 1, Art II, Sec. 1, Subd. 4(a)).

In addition, efforts need to be undertaken to recruit new providers and to establish innovative ways to serve the most dependent clients in community settings.

DISINCENTIVES TO MOVE FROM COMMUNITY GROUP HOMES TO LESS INTENSIVE SETTNGS

1. Unequal County Share of Costs of Group Homes vs. Alternatives.

Although the county assumes additional costs when a person moves from a state hospital to a group home, the fiscal disincentives to movement are even stronger for less restrictive settings. Alternatives such as adult foster care, supervised apartments, or independent living face complex, unstable, and inadequate funding. Figure 1 illustrates that as the setting becomes less restrictive:

1. the cost to government decreases,
2. the number of necessary funding sources increases, and
3. the cost to the county increases because these alternatives are heavily dependent on county revenue and do not receive federal funds.

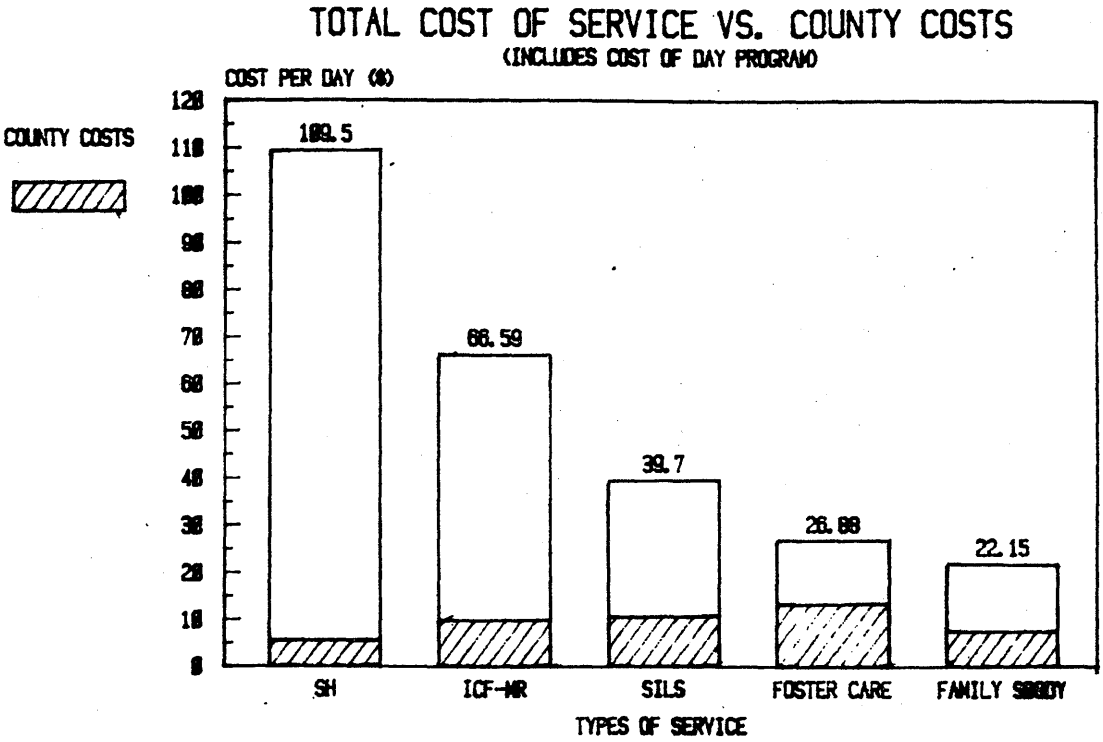
2. Bad Economic Conditions Increase the Risk of Failure in the Community.

Lack of competitive employment or sheltered work leaves the developmentally disabled person with only public resources to provide for daily needs. Until the person is economically self-sufficient, meeting these needs requires a complicated package of public programs--rent subsidy, SSI/MSA, food stamps, and Medicaid for example. Should the person become ineligible for a key program, the entire community placement may be jeopardized. Interlocking eligibility for programs (see below) may terminate the client automatically from other programs, or loss of one program's benefits may leave the person with insufficient resources to continue in the community. Rather than risk failure of these community placements, both the group home and the case manager may prefer to leave the client in a Medicaid funded residence.

3. Interlocking Program Eligibility Causes Benefit "Notches".

As clients progress to independent living, they risk potential interruptions in service as their income fluctuates. When the client receives benefits from only one program the problem rarely occurs. Most programs, in order to retain a work incentive, permit clients to keep a portion of the income they earn. However, when eligibility for several programs is linked and the client's income terminates eligibility for a key program, the cumulative loss of benefits may exceed the additional income earned. This net loss is called a "notch". Disabled SSI recipients, for example, are automatically eligible for Medicaid, and depend upon this program to pay their medical costs. At a certain income level the person loses SSI eligibility and, automatically, Medicaid eligibility. Though the person's earned income may be higher than the previous SSI grant, the cost of assuming medical expenses generates a net loss. The person was better off financially by not working. (See Figure 2).

Figure 1



Funding comes from :

State Hospital	ICF-MR	SILS	Foster Care	Family Subsidy
MA	MA	SILS	CSSA	CSSA
	CSSA	CSSA	MSA/SSI	Family Subsidy
		MSA/SSI	County Revenue	
		Sect. 8		

Sources: Office of Legislative Auditor (1983), p. 22
Copeland and Iversen (1981)

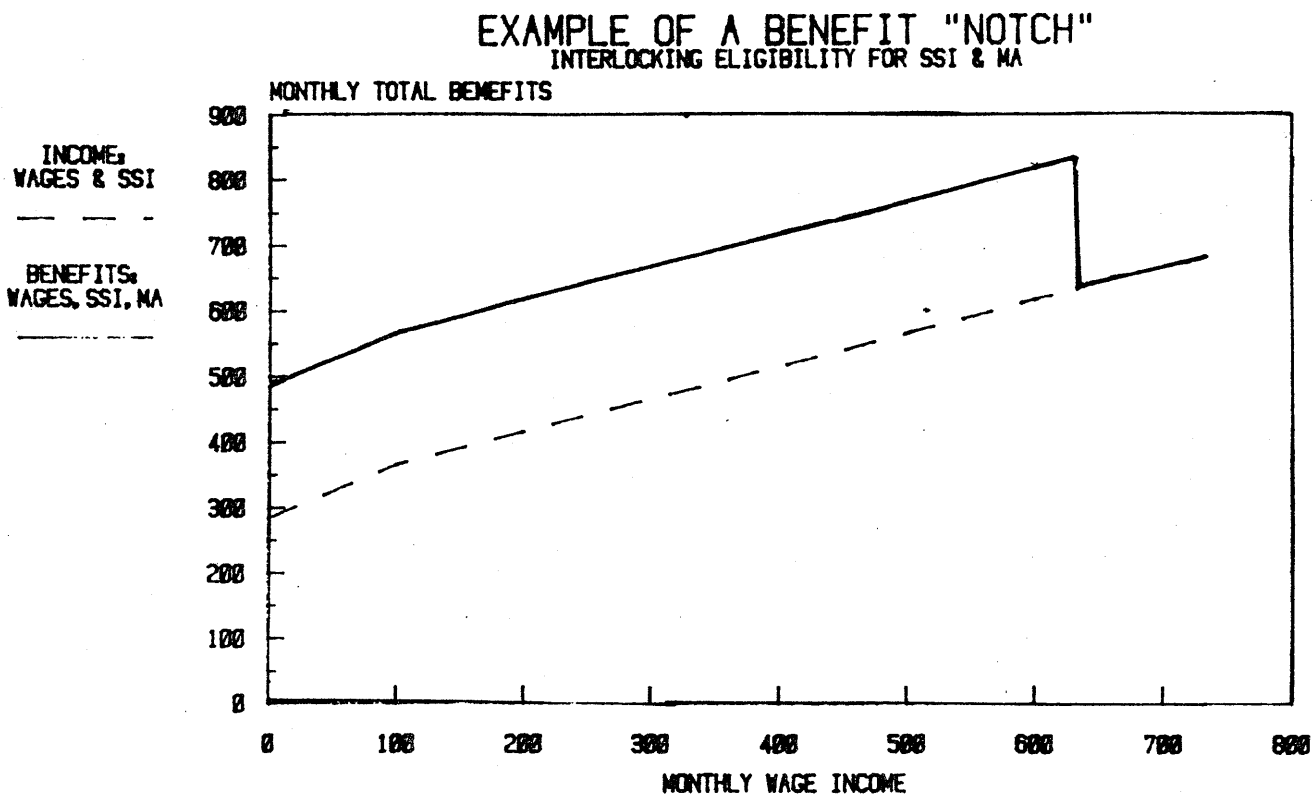
Assumes governments share costs as per Table 2.

Daily cost for all community settings include annualized day program cost of $14.88 per day.

SILS and foster care per diems include cost of room and board.

See pages 5ff. for explanation of acronyms and programs.

Figure 2



Client Earnings	Monthly SSI Grant	Total Monthly Income	Medical Benefits	Total Monthly Income & Benefits
-0-	$284	$284	$200	$484
100	266	366	200	566
200	217	417	200	617
500	67	567	200	767
700	-0-	700	-0-	700

SSI regulations permit the recipient to keep a portion of monthly earned income. The first $65 and 50% of remaining earned income are "disregarded" in calculating the amount of the monthly grant.

Figure 2 assumes the person incurs average monthly medical expenses of $200.

At $700 of earned income, the "notch" is apparent. Even after SSI income disregards, the person earns too much to receive an SSI grant. When termination of SSI eligibility results in loss of Medicaid benefits, the person receives $66.50 less in total monthly income and benefits than the person earning $500 per month.

A three-year federal experiment (DPW, 1981a) addresses this problem. Previously, anyone earning more than $300 per month for ten months or more was judged capable of "substantial gainful activity" and, therefore, no longer disabled. Often this meant that the person lost Medicaid benefits as well. Amendments to the Social Security Act (P.L.96-265, 1980), permit disabled people to retain disability status and Medicaid eligibility if they meet all SSI disability criteria except for the earnings limit.

In Minnesota, state statutes contain a similar provision (M.S.256D, 12MCAR 1.057). Disabled people retain categorical eligibility for Medicaid even if their income exceeds SSI limits so long as the income does not exceed eligibility guidelines for the Medicaid program. In addition, when the federal government rules that a Minnesota resident is no longer disabled, the person can appeal the ruling to a state medical review team. The review team cannot restore SSI benefits but can continue the person's Medicaid eligibility.[6]

DISINCENTIVES TO STAY IN THE FAMILY HOME

1. Inadequate Funding for In-Home Supports.

Successful deinstitutionalization requires two simultaneous processes: (1) demission of those who are inappropriately placed in restrictive settings, and (2) corrective action to prevent new admissions from the community. Yet the least adequate, most fragmented funding is used to finance in-home supports, a generic term for any effort to help families -- through cash payments or support services -- to maintain a developmentally disabled person in the family home. In Minnesota, two types of programs provide these supports:

1. The Family Subsidy Program (M.S.252.27(4), 12MCAR 1.019) provides families of retarded children with monthly state grants of up to $250. Families apply to county social service agencies. The Department of Public Welfare selects participants based on severity of handicap, need, and potential for development. The program costs the state less per client than the state share of any other service. Since the program is funded entirely by the state, the county conserves CSSA funds; however, the state allocation does not meet the demand for these grants. In 1982, the program supported 150 families and had a waiting list of 80 families. The Department of Public Welfare expects the waiting list to double during fiscal year 1983 (Office of Legislative Auditor, 1983).

2. Respite Care, until 1981 was funded in many counties from "Cost of Care" funds (M.S.252.27, 12MCAR 1.030) -- a state/county program to

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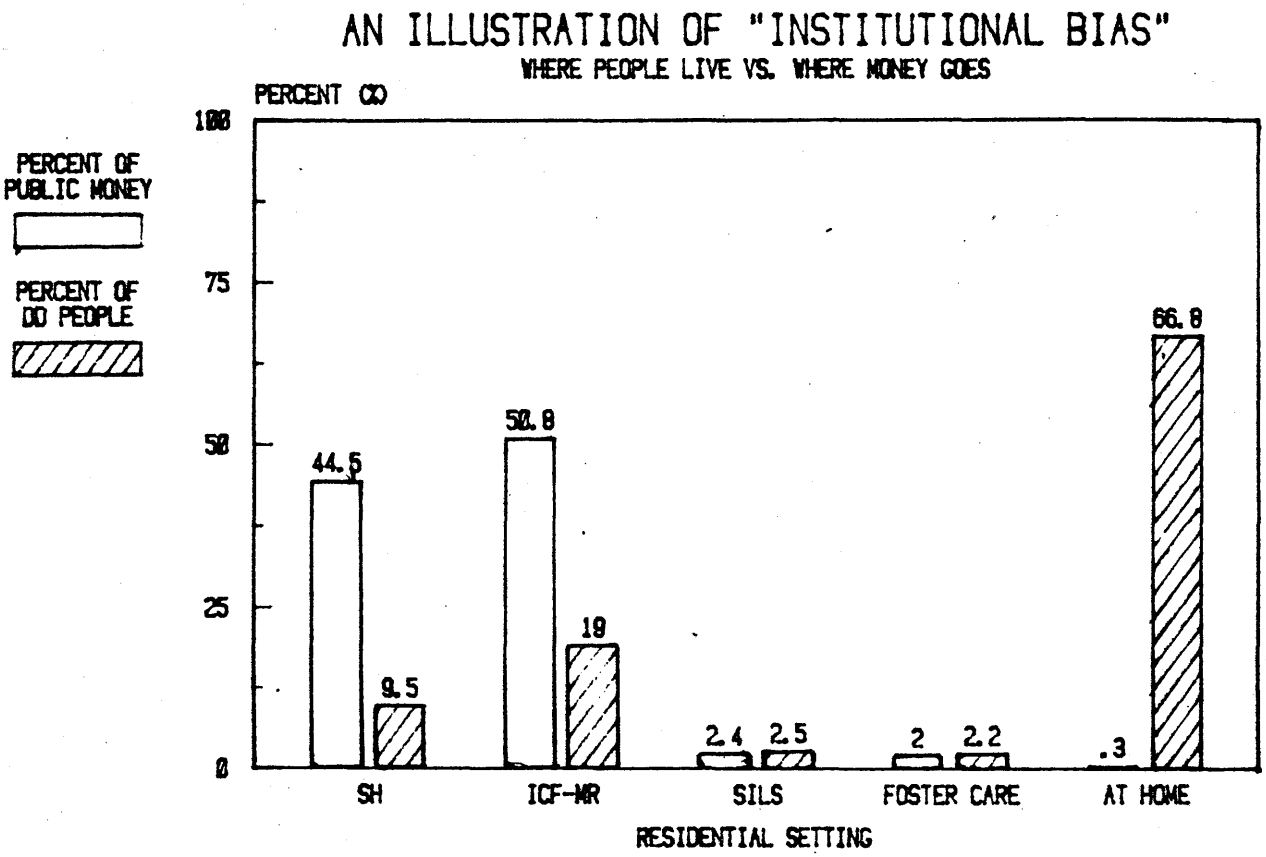
[6] Federal District Court Judge Earl Larson has recently issued a ruling (Mental Health Association of Minnesota v. Schweiker, 554 F. Supp. 157) that significantly limits the Social Security Administration's termination or denial of benefits to disabled mentally ill SSI recipients. See Minnesota D.D. Law Reporter, Vol. II, No. 5, January, 1983, pg. 3-5, for a summary and analysis of this decision.

Figure 3



Sources: Office of Legislative Auditor (1983), p. 22
Developmental Disabilities Program (1983)

Cost of day programming has been excluded. Room and board costs have been included.

Does not include county expenditures for respite care or in-home support programs.

support group home placements for children whose families were ineligible for Medicaid. When a change in interpretation of Medicaid regulations made these families eligible, the cost of care appropriation was folded into the CSSA allocation to counties. Once counties exhaust their CSSA funds, respite care must be supported with county revenues alone. Consequently, though timely respite care may prevent or forestall placing a child in an expensive institution, there is little cost incentive to the county to fund the service.

3. Eligibility Notches.

One important disincentive was recently addressed by the federal government in the much publicized case of Katie Beckett, a young girl from Iowa who was placed in an institution because her family could not afford her medical expenses (U.S. Department of Health and Human Services, 1982). SSI eligibility for children is based on parental income unless the child is in an out-of-home placement. Since Medicaid eligibility is tied to SSI, families are driven to institutionalize the child in order to obtain public assistance with their medical bills, even though the child could be served more cheaply at home.

In Minnesota, a similar disincentive operates, although its effect is much less severe. For foster care, respite care and similar non-institutional services, parent contributions are determined according to a fee schedule. While a statewide schedule existed until recently, current practice allows each county to develop its own schedule and to use different schedules for each service. Consequently, charges vary widely from county to county. Moreover, the fee schedules constitute still another incentive to place the child in a group home or state hospital where standardized fee schedules -- which are often less costly to the parents -- apply.[7]

4. Fear of Increasing Caseloads Inhibits Innovation.

Many families who would never place their child in a state institution would welcome the opportunity to use respite care or in-home support programs. However, it is hard to estimate how many families would use these services if the funding were available. Without appropriate controls on eligibility, the cost of in-home supports to serve new clients might soon exceed the savings realized from preventing institutional placements. Case management and pre-admission screening are both effective ways to ensure that in-home supports are targeted to those at risk of institutionalization and that availability of new services doesn't replace informal care.

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[7] The proposed revisions to DPW Rule 47, which governs provision of Medicaid services, include a standard statewide fee schedule for all Medicaid services -including ICF-MR care. County fee schedules will still determine parent contributions for non-Medicaid funded residential services.

SOLVING THE PROBLEM OF FISCAL DISINCENTIVES

Eliminating fiscal disincentives requires a fundamental shift in the way we finance services, share costs among levels of government, and reward providers for good performance. Three first steps might be taken to alleviate the disincentives discussed:

1. Reorganize the way that costs are shared so that services which are least expensive overall are also least costly for the level of government responsible for placement decisions.

2. Reduce the complexity and instability of funding for less restrictive alternatives. Consolidate the numerous programs which fund alternatives and stabilize their funding.

3. Recruit providers who will serve more dependent clients and create incentives for existing providers to move higher functioning residents to less restrictive settings -- and replace them with more dependent clients. These incentives might include bonuses to providers who move clients. Coupled with selective relaxation of the 10 percent cap on annual cost increases, these incentives would increase the capability of the existing system to serve more difficult clients.

OPTIONS

Several strategies might incorporate these three initial steps. Two that are often discussed include:

1. Alternative care grants: These grants would combine state funds with a county contribution and would increase the available dollars for non-institutional services. If the local share of costs was appropriately adjusted so that it did not exceed the county share of group home or state hospital care, alternative care grants would provide a strong incentive for counties to move clients to less restrictive settings.

   Unless the grants also funded the cost of day programs, this option would not eliminate the substantial difference in local share of group home vs. state hospital care. Moreover, in order to equalize the county's share of costs, the state must shoulder a larger portion of the costs. In some cases the state's share would exceed its contribution to state hospital costs.

Table 4
DAILY COST PER CLIENT:[a]
Current Financing Methods

Level of Government	State Hospital	Group Home and DAC	SILS and DAC	Foster Care and DAC	Family Subsidy and DAC
Federal	57.16	26.99	9.48	----	----
State	47.09	29.68	20.02	13.44	14.71
Local	5.25	9.92	10.80	13.44	7.44
Total	109.50	66.59	39.70	26.88	22.15

Source: Office of Legislative Auditor (1983).

Community settings include costs of residential and day programs only. State hospital per diem costs are all inclusive. DAC costs are annualized ($14.88/day).

[a] Assumes costs are shared by governments as per Table 2.
[b] Assumes person is coming from an ICF-MR and receives SSI/MSA.

Table 5
DAILY COST PER CLIENT:
Alternative Care Grants with Equalized
County Cost for All Services

Level of Government	State Hospital	Group Home and DAC	SILS and DAC	Foster Care and DAC	Family Subsidy and DAC
Federal	57.16	26.99	9.48	----	----
State	47.09	34.35	24.97	21.63	16.90
Local	5.25	5.25	5.25	5.25	5.25
Total	109.50	66.59	39.70	26.88	22.15

Source: Office of Legislative Auditor (1983).

Community settings include costs of residential and day programs only. State hospital per diem costs are all inclusive. DAC costs are annualized ($14.88/day). Here, county pays same amount regardless of setting, and the state assumes the reduction in county share.

2. Medicaid funding of non-institutional services. Recent federal legislation (P.L. 97-35) permits states to expand the scope of Medicaid reimbursable services so long as the new services are intended to reduce the use of institutions or Medicaid certified group homes. A full range of services would be financed, but governments would share the costs in the same manner they share other Medicaid costs. The advantages of this strategy are several:

Table 6
DAILY COST PER CLIENT:
Medicaid Financing of All Services[a]

Level of Government	State Hospital	Group Home and DAC	SILS and DAC	Foster Care and DAC	Family Subsidy and DAC
Federal	57.16	34.76	23.24	14.03	11.56
State	47.09	28.63	14.61	11.56	9.53
Local	5.25	3.20	1.85	1.29	1.06
Total	109.50	66.59	39.70	26.88	22.15

Source: Office of Legislative Auditor (1983).

Community settings include costs of residential and day programs only. State hospital per diem costs are all inclusive. DAC costs are annualized ($14.88/day). Here, all day and residential services are Medicaid funded. For SILS, service cost and day program cost are funded by Medicaid; room and board are funded through SSI/MSA grant.

1. Local governments would pay the same share of costs for all services, thus removing the incentive to institutionalize.

2. The administrative complexity of the residential funding would be reduced since one program -- Medicaid -- would fund all services in the continuum.

3. The federal government would share in the cost of alternative services that currently are funded solely from state and local revenue.

This strategy assumes that most clients are eligible for Medicaid and that services are limited primarily to those in institutions or at risk of being placed in an institution. Because of the restrictions of the legislation, only limited expansion in caseload would be permitted. In addition, the cost per day of alternative services may increase if new federal regulations were written for alternative services. Finally, the Medicaid definition of "training and habilitative services"[8] may restrict Medicaid reimbursement to DACs or similar programs thus generating a new set of potential disincentives to placement in competitive employment or in vocational programs with less stable funding.

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[8] "...(those) intended to aid the intellectual, sensorimotor, and emotional development of a resident." (42 CFR 442.401).

HOW STRATEGIES AFFECT COSTS: AN ILLUSTRATION

Because the strategies are funded differently, the effects on federal, state, and local share of costs vary. Assume a hypothetical county with a caseload of 1,000 mentally retarded people.

Assume that the county's clients are distributed among services in a manner resembling the state average (Developmental Disabilities Program, 1983):

Service	% of Clients
state hospital	27.0
group homes	57.0
SILS	6.8
foster care	6.8
family subsidy	2.4 [a]
	100.0

How would a moderate program of deinstitutionalization affect costs? Assume the county shifts 20 percent of its clients from state hospitals to group homes, and also moves 20 percent of its group home residents in equal numbers to three alternative care settings.[9]

Services	#Clients Currently	#Clients After Deinstitutionalization
state hospital	270	216
group homes	570	510
SILS	68	106
foster homes	68	106
family subsidy	24	62
Total	1000	1000

Tables 7 through 11 examine the costs to each level of government under the current situation and under three options:

OPTION A: Increase funding for non-institutional services, but retain the current method of sharing costs.

[a] Does not include those in county supported respite care or in-home support programs.

[9] The Welsch Consent Decree provided for a reduction in mentally retarded residents of state hospitals from 2700 to 1850. This represents a 31 percent reduction. The recent report by the Legislative Auditor (1983) cites estimates which conclude that 10-20 percent of those currently in ICF-MR care could move to less restrictive alternatives.

OPTION B: Increase funding through alternative care grants which equalize the county share of costs for all services.

OPTION C: Increase funding by using Medicaid to fund all services in the continuum.

Table 7
DAILY COST FOR 1,000 CLIENTS:
Current Financing Methods[a]

Level of Government	State Hospital	Group Home and DAC	SILS and DAC	Foster Care and DAC	Family Subsidy and DAC	Total
Federal	15433	15384	645	----	----	31462
State	12714	16918	1361	914	353	32260
Local	1418	5654	694	914	179	8859
Total	29565	37956	2700	1828	532	72581
Clients	270	570	68	68	24	1000

a. Costs per client per day as per Table 4.

Table 8
DAILY COST FOR 1,000 CLIENTS AFTER 20% DEINSTITUTIONALIZATION:
Increased Allocations but No Adjustments
To Local Share of Costs[a]

Level of Government	State Hospital	Group Home and DAC	SILS and DAC	Foster Care and DAC	Family Subsidy and DAC	Total
Federal	12347	13765	1005	----	----	27117
State	10171	15136	2122	1425	912	29766
Local	1134	5059	1081	1425	461	9160
Total	23652	33960	4208	2850	1373	66043
Clients	216	510	106	106	62	1000

a. Costs per client per day as per Table 4.

Table 9
DAILY COST FOR 1,000 CLIENTS AFTER 20% DEINSTITUTIONALIZATION:
Alternative Care Grants with Equal County
Costs for All Services[a]

Level of Government	State Hospital	Group Home and DAC	SILS and DAC	Foster Care and DAC	Family Subsidy and DAC	Total
Federal	12347	13765	1005	----	----	27117
State	10171	17519	2647	2293	1048	33678
Local	1134	2677	556	556	325	5248
Total	23652	33961	4208	2849	1373	66043
Clients	216	510	106	106	62	1000

a. Costs per day per client as per Table 5.

Table 10
DAILY COST FOR 1,000 CLIENTS AFTER 20% DEINSTITUTIONALIZATION:
Medicaid Financing of All Services[a]

Level of Government	State Hospital	Group Home and DAC	SILS and DAC	Foster Care and DAC	Family Subsidy and DAC	Total
Federal	12347	17728	2463	1487	717	34742
State	10171	14601	1549	1225	590	28136
Local	1134	1632	196	137	66	3165
Total	23652	33961	4208	2849	1373	66043
Clients	216	510	106	106	62	1000

a. Costs per day per client as per Table 6.

Table 11.
SUMMARY: DAILY COSTS TO EACH LEVEL OF GOVERNMENT UNDER FOUR OPTIONS

	Current Situation	20% Deinstitutionalization A	B	C
Federal	31,462	27,117	27,117	34,742
State	32,260	29,766	33,678	28,136
Local	8,859	9,160	5,248	3,165
Total	72,581	66,043	66,043	66,043

All three deinstitutionalization strategies save money. Regardless of the option, the overall cost of serving these 1,000 clients declines by about $6,500/day after a modest shift of residents to less restrictive settings.

The impact on each level of government differs with the option. In Option A, the county pays more when it moves clients to less restrictive settings because the county share of these costs is higher. In Option B the county share is equal for all services which generates a strong incentive to move clients to less restrictive settings. Because this reduction in county costs must be shouldered by the state, state costs under Option B increase $1418 per day. In Option C, the federal government shares in the costs of services. State and county costs decrease substantially, although federal costs increase by $3280 per day.

CAVEATS

Whenever services are expanded or funding systems are changed, there is a calculated risk. A worthwhile plan can be undermined by mistakes in implementation or by ignoring important factors. Here are a few concerns that must be addressed by any strategy to reduce fiscal disincentives.

1. Since 1980, Minnesota has consolidated community social services funding under the Community Social Services Act (CSSA). Counties have used these limited forumula grants to fund a broad array of services to mentally retarded people and to several other target groups.

   Most plans to reduce fiscal disincentives help counties by lowering the local share of costs or by replacing CSSA funding with another source of funds. However, if all county CSSA savings simply revertto the state, the incentive for county participation is reduced. Furthermore, counties may fear that as new funding sources replace CSSA, reduction in their CSSA grants will not take into account actual current county expenditures for these services.

2. Similarly, while the cost of alternatives is demonstrably cheaper than state hospital care, the manner in which state hospital per diems are calculated may undermine incentives to demit state hospital residents.

Because of the high fixed cost of state hospitals, as the number of clients declines, the cost per client increases. Consequently, county savings by moving clients from the state hospital are eaten up by the increased cost per day to serve those residents who remain.

3. The cost of Medicaid funded services has tended to increase faster than services for which the county contracts directly with vendors (State Health Planning and Development Agency, 1982). Counties fear a loss of local control over caseloads and per diems if a federal/state program like Medicaid is introduced. Proposals to fund non-institutional services should include methods of restraining Medicaid cost increases. Retaining local negotiation of vendor contracts has been suggested. However, county interest in cost containment may be diminished since local governments would pay less than 5 percent of the cost if these services are funded through Medicaid. An alternative might be to distribute Medicaid money as a grant to counties, thus increasing the incentive to maximize the number of people served.

4. Pre-admission screening and case management are necessary to ensure that expansion of the continuum is targeted to those at risk or currently in institutions. If non-institutional services are to effectively contain costs, then expanded services cannot attract unlimited numbers of people not currently in the system. In short, new services cannot supplant informal care.

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APPENDIX: IMPACT ON FISCAL DISINCENTIVES OF RECENT STATE LEGISLATION

Recent state legislation significantly changes the method of funding and providing services to mentally retarded people. The changes contained in Article 9 of S.F. 1234 (Minn. Laws 1983, Chap. 312)* affect both residential and day program services in Minnesota.

This appendix summarizes the major provisions of the legislation and traces its effect on the hypothetical county caseload presented earlier. In particular, the costs experienced by federal, state, and county government before and after the legislative changes are compared.

The major provisions of S.F. 1234 which affect the county caseload include:

1. A moratorium on new ICF-MR beds and a ceiling on the number of beds of 7500 by July 1, 1983 and 7000 by July 1, 1986. Assuming our hypothetical county has approximately the same number of beds per capita as the rest of the state, the legislation prevents the county from increasing the number of ICF-MR beds unless existing beds are decertified.

2. DAC funding is shifted from CSSA to Medicaid for those in ICFs-MR. This equalizes the scope of services covered by Medicaid for those in state hospitals and in community ICFs-MR, thus eliminating the incentives to place someone in a state hospital to shelter the county from CSSA costs of day programs in the community. Besides those in ICFs-MR, Medicaid will also fund day programs for those diverted from ICFs-MR to four waivered services (see below). DAC funding for those who do not reside in group homes will still be funded through CSSA.

3. The state is empowered to apply for federal "home and community based waivers". These waivers permit the state to extend Medicaid funding to services which can be used as alternatives to state hospital or community ICF-MR care. Eligibility is restricted to those currently in state hospitals or group homes or who are certified by a county screening team as needing that level of care in the near future.

   Because the federal government intended the waivers as a cost containment measure, growth in alternative services is restricted. The state must ensure that Medicaid expenditures with the waivered services do not exceed Medicaid expenditures in a system without the waivered services.

4. The county CSSA allocation will be reduced to help pay for increased state Medicaid costs for DAC services.

For counties, the waiver means that many people in group homes and state hospitals can be moved to lower cost alternatives without creating excessive new demands on county or state/county CSSA funds. For those eligible for the

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* Because it empowers the state to seek a variety of federal waivers, the legislation is popularly known as the "waiver bill", and is referred to as such throughout the discussion in the appendix.

new waivered services, fiscal disincentives to place in more restrictive settings are virtually eliminated, but those currently living at home can access alternative services only if they are certified as in imminent risk of institutionalization or group home placement.

The proposed alternative home and community-based services to be funded under the waiver include:

1. In-Home Family Services (IFS): Services to maintain a child in the family home. Includes homemaking and in-home training for parents and siblings, respite services, and specialized services and therapy.

2. Developmental Training Homes (DTH): Habilitative services to special needs children and adolescents in settings of up to three clients. Targeted to children and adolescents who would otherwise require ICF-MR or state hospital placement.

3. Supervised Living Arrangements (SLA): Habilitative services to special needs adults in settings of up to six clients. Targeted to adults who would otherwise require ICF-MR or state hospital placement. Several types of SLAs will be developed.

4. Semi-Independent Living Services (SILS): Habilitative, homemaker, and home health services to enable individuals to be placed or remain in a variety of independent community settings. As a Medicaid funded service, this program will be targeted to those currently placed in ICFs-MR or state hospitals or at risk of such placement, although others will continue to receive SILS services funded by the current state/county program.

DAILY COSTS FOR HYPOTHETICAL COUNTY CASELOAD

It is difficult to determine the full cost impact of the new legislation. Many of the alternative services are new and so their per diems can only be estimated. In addition, the manner in which ICF-MR beds will be decertified and reallocated has not been established. When services such as DACs become eligible for MA, their per diems may increase if they are required to meet more stringent federal regulations.

The provisions of the legislation follow closely an earlier analysis by the Department of Public Welfare (DPW, 1983). The assumptions used for cost and caseload projections in that document have been applied here. Although the DPW analysis spans four fiscal years, this appendix looks only at the cumulative effect of waivered services at the end of four years and is intended only to illustrate the intent of the waiver program, and its effects on costs and caseloads.

Briefly, the net effect of the waiver legislation is to reduce the total cost of serving the hypothetical county's caseload by roughly $11,000 per day. Table 12 lists costs by level of government in FY 1983 and in FY 1987 with and without the waiver legislation. Note that with the waiver legislation, federal costs increase slighlty but are offset by significant decreases in state and county expenditures.

Table 12
SUMMARY: DAILY COST BY LEVEL OF GOVERNMENT
FOR HYPOTHETICAL COUNTY CASELOAD

	FY 1983	FY 1987	
		No Waiver	With Waiver
Federal	31056	45592	46007
State	33409	48721	43428
County	10065	14376	8646
Total	74530	108689	98081

Table 13 shows the sources of the increases and decreases. Medical Assistance costs decrease because former ICF-MR and state hospital clients are diverted to less expensive alternative services. Both CSSA and SILS costs decrease because clients who would ordinarily be funded by these programs have become eligible for Medicaid funding. Transferring DAC funding to MA for community group home clients is a major source of CSSA savings.

Table 13
HOW DAILY GOVERNMENT COSTS
CHANGE WITH USE OF WAIVER

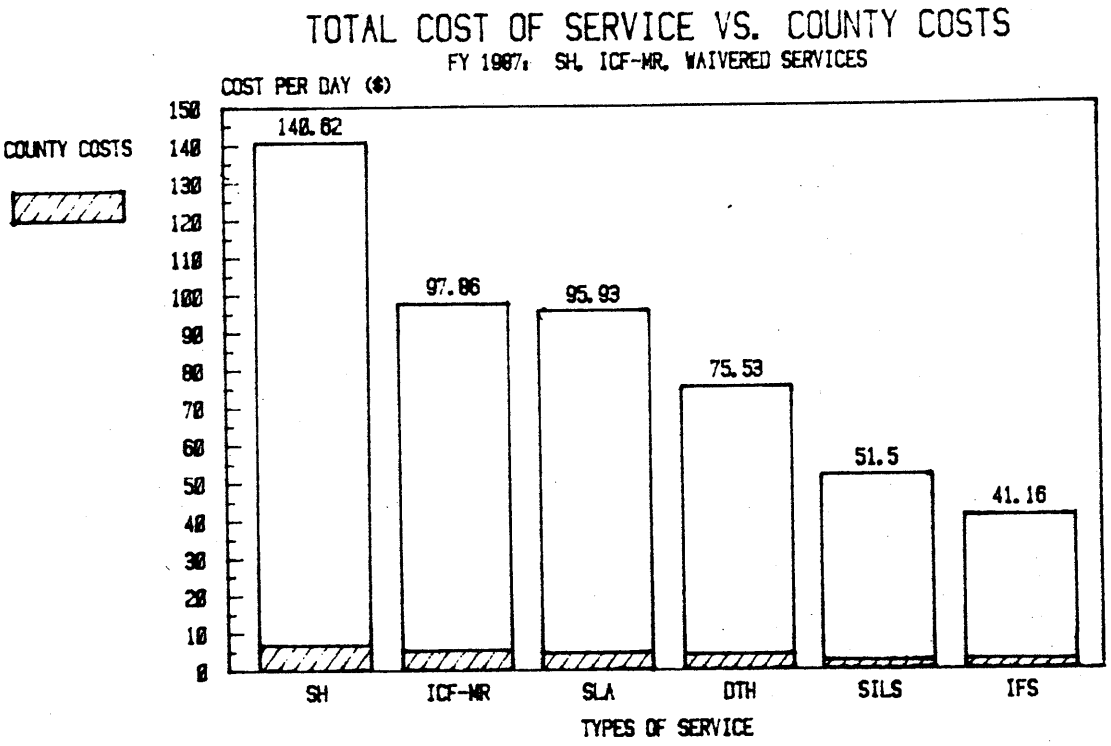
	Federal	State	County	Total
MA	-897	-740	-83	-1720-
CSSA	-	-5869	-5869	-11738
SILS	-	-169	-40	-209
Family Subsidy	-	0	-	0
SSI	+1312	-	-	+1312
MSA		+1485	+262	+1747
Total	+415	-5293	-5730	-10608

Only SSI and MSA increase because clients who move to waivered services require SSI/MSA subsidies for daily room and board. Only for the federal government are other savings offset by SSI/MSA increases, and even here the increase is small.

EFFECTS ON COUNTY SHARE OF COSTS

As was discussed earlier, although alternatives to community ICFs-MR and state hospitals are often cheaper, the manner of funding these services often results in county costs that are higher for services which are least expensive overall. Figure 4 shows how the legislation affects county costs.

Figure 4



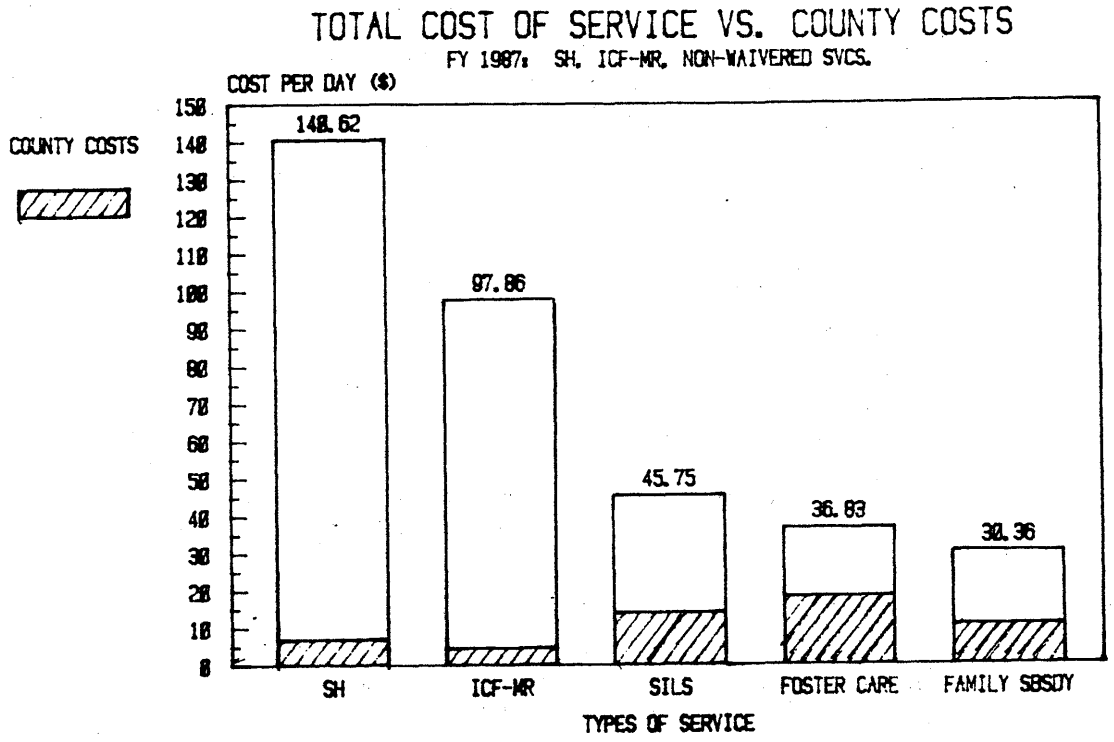
Per diems include cost of day program.

Because the legislation creates four new alternatives to state hospital or community group home care, and all four alternatives are funded through Medicaid, the county pays the same percentage (4.8 percent) of costs regardless of the setting. Furthermore, because day programs are also Medicaid funded regardless of the setting, the county incentive to place in more restrictive settings to conserve the CSSA budget is eradicated. The county share of costs now declines with the total cost of services.

Although fiscal disincentives have been eliminated for those in ICFs-MR or waivered services, a portion of the county's caseload will still be served by state/county funded services such as foster care, SILS (state grant or CSSA) and family subsidy. These are people who are not certified as needing ICF-MR level care and, therefore, can not access waivered services.

Figure 5 demonstrates that for these clients, county costs do not decline as the overall cost of the service declines. Services for these clients will continue to depend heavily on county funds. In particular, when these clients require day programs as well as residential services, the cost to the county is higher for these clients than for those in more restrictive services.

Figure 5



Per diems include cost of day program.

Whether these disincentives will actually affect placement decisions for those ineligible for waivered services is a function of several assumptions:

1. Most people needing services will be certifiable as ICF-MR eligible and can be served in waivered services or group homes. Hence, few clients will require non-waivered services.

2. County screening committees will prevent restrictive placements for those not needing higher levels of care.

3. County savings under the waiver are substantial and can be shifted to adequately serve clients not eligible for waivered services.

Table 15
ASSUMPTIONS: HYPOTHETICAL COUNTY CASELOAD FOR RESIDENTIAL SERVICES

	FY 1983	FY 1987	
		No Waiver	With Waiver
Current Services			
SH	270	225	158
ICF-MR	570	710	519
SILS	68	99	99
Foster Care	68	71	71
Family Subsidy	24	24	24
Subtotal	1000	1129	871
Waivered Services			
DTH	-	-	39
SLA	-	-	103
IFS	-	-	39
SILS			77
Subtotal	0	0	258
Total	1000	1129	1129

Without the waiver, ICF-MR spaces grow dramatically because few alternatives exist for those ready to leave these settings or for those coming into the system for the first time. The effect of the waiver is to reduce the number of state hospital and ICF-MR beds by 258 and to divert those people and new clients coming from home to one of four waivered services.

Tables 16 and 17 show how the legislation changes the way services are funded with and without the waiver and the way costs are shared. Two complex, important changes should be noted.

1. DAC Services: Those DAC clients who live in ICFs-MR (roughly 60 percent of the current DAC population) are funded through Medicaid, as are DAC clients who are placed in waivered services. The remaining clients are funded from CSSA as at present.

2. SILS: New SILS clients coming from ICFs-MR or state hospitals, or at risk of these placements, are funded through the Medicaid waiver. State SILS funding continues for current SILS clients who came from or were at risk of ICF-MR placement. SILS clients not at risk of ICF-MR placement are shifted to CSSA funding beginning January 1, 1984.

As these tables indicate, four Medicaid funded services are created to accommodate those who can leave ICFs-MR or state hospitals or who might otherwise be placed in those settings.

Table 16
HOW SERVICES ARE FUNDED:
Waiver vs. Current System

Funding Sources

	Current	Waiver	Change
SH	MA	MA	
ICF	MA	MA	
SILS: Grp.1[a]	SILS	MA	X
Sils: Grp.2	SILS	SILS	
SILS: Grp.3	CSSA	CSSA	
Foster Care	CSSA	CSSA	
Family Subsidy	Family Subsidy	Family Subsidy	
DTH	none	MA	X
SLA	none	MA	X
IFS	none	MA	X
DAC:ICF/SH	CSSA	MA	X
DAC at risk	CSSA	MA	X
DAC:other	CSSA	CSSA	
Case Mgmt: for waiver services	none	CSSA	X
Cast Mgmt: others	CSSA	CSSA	

Sources: Developmental Disabilities Program, 1983.
DPW, 1983

[a] Group 1 SILS are those coming from ICF-MR or at risk of such placement. Group 2 are those currently on state SILS grant program. Group 3 are those not at risk of ICF-MR placement.

Table 17
HOW GOVERNMENTS SHARE COSTS OF SELECTED SERVICES:
Waiver vs. Current System

	Current System			Waiver System		
	Fed.	State	County	Fed.	State	County
Residential						
SH	52%	45%	4.8%	no change from current		
ICF-MR	52	45	4.8	no change from current		
SILS Grp.1[a]	24	63	13.0	48%	46%	6.0%
Grp.2[a]	24	63	13.0	no change from current		
Grp.3	-	50	50.0	no change from current		
Foster Care	-	50	50.0	no change from current		
Family Subsidy	-	100	-	no change from current		
DTH[a]	not applicable			50	44	6.0
SLA[a]	not applicable			50	44	6.0
IFS	not applicable			52	43	4.8
Day/Support						
DAC:ICF	-	50	50	52	45	4.8
DAC: at risk	-	50	50	52	43	4.8
Case Mgmt. for waivered services	-	50	50	62	43	4.8
Case Mgmt: others	-	50	50	no change from current		

[a] Includes cost of room and board through SSI (100% federal) and MSA (85% state, 15% county) in addition to funding for programming.

Tables 18 and 19 outline the assumptions used in projecting the cost impact for the hypothetical county with and without the waiver. Note in Table 18 that the development of waivered services does not increase the total number of people served under Medicaid. But the range of Medicaid reimbursable services for those who would end up in the MA funded system anyway is expanded. In FY 1987 fully 28 percent of the MA funded clients are in lower-cost alternatives to state hospitals or ICFs-MR.

Table 18
ASSUMPTIONS: CLIENTS SERVED AND DAILY COST/CLIENT:
Medicaid Funded Services

	FY 1983		FY 1987		
	Per Diem[c]	# Clients	Per Diem[c]	Number of Clients	
				No Waiver	With Waiver
Residential:					
SH[a]	93.08	270	119.87	225	158
ICF-MR[a]	51.71	570	77.11	710	519
DTH[b]	-	-	54.78	-	39
SLA	-	-	75.18	-	103
IFS	-	-	20.41	-	39
SILS	-		30.75		77
Subtotal	-	840		935	935
Day/Support					
DAC:SH	16.42	270	21.16	225	158
DAC:ICF	-	-	20.39	-	311
DAC:at risk	-	-	21.47	-	129
Case Mgmt:	-	-	2.74	-	258

Sources: Developmental Disabilities Program, 1983.
DPW, 1983.

a State hospital per diems include residential services only. State hospital day program costs are cited in day/support section.

b Per diems for DTH, SLA, and SILS include room and board costs funded from SSI/MSA.

c All per diems are average costs of service. DAC per diems are costs per day for 365 days, not for service days alone. FY 1987 per diems reflect 6-8 percent inflation per year and a small premium for increased severity of clientele.

Table 19
ASSUMPTIONS: CLIENTS SERVED AND DAILY COST/CLIENT:
Non-Medicaid Funded Services

	FY 1983		FY 1987		
	Per Diem	# Clients	Per Diem	# Clients	
				No Waiver	With Waiver
SILS:					
State Grant[a]	25.06	48	28.05	75	75
Other	9.07	20	11.28	24	24
Foster Care[a]	12.00	68	16.33	71	71
Family Sub.[b]	8.22	24	9.86	24	24
DAC:					
Non-MA					
Adults	15.78	547	19.92	666	96
Preschool	16.51	164	20.84	164	164
Case Mgmt.					
Non-MA	1.36	1058	1.36	1138	947

Source: DPW, 1983.

[a] Per diems include cost of room and board funded through SSI/MSA. SILS "other" clients are assumed to be too high functioning for SSI eligibility.

[b] Assumes $250/mo. grant for FY'83 and increase to $300/mo. grant for FY 87.

In Table 19 the number of clients receiving non-Medicaid funded DAC and case management services is significantly lower with the waiver than without because many of these clients are shifted to Medicaid funding. One key assumption is that the existing foster care, SILS, and family subsidy programs will not grow once waivered services are in place, but will be maintained at current levels to accomodate new clients who do not have access to waivered services because they are not certified as needing ICF-MR level care.

DAILY COSTS

The impact of the new legislation can best be demonstrated by examining the cost impact on federal, state and county government for the hypothetical caseload.

Table 20 summarizes the effect of the waiver on Medical Assistance costs. The legislation increases Medical Assistance costs in two ways: 1) by funding DAC services for ICF-MR residents, and 2) by funding four new waivered services and case management for those receiving waivered services.

Table 20
ANNUAL MEDICAL ASSISTANCE EXPENDITURES
(in thousands of dollars)

	FY83	FY87	
		No Waiver	Waiver
Residential/Support			
SH	$9173	$9844	$6913
ICF	10758	19983	14607
DTH	-	-	581
SLA	-	-	2301
CFS	-	-	291
SILS	-	-	472
Subtotal	19931	29827	25164
Day/Support Services			
Case Mgmt.	-	-	258
DAC: SH	1618	1738	1220
DAC:ICF	-	-	2314
DAC "at risk"	-	-	1011
Subtotal	1618	1738	4803
Total	21549	31565	29967

Note however that the increases are offset by dramatic savings in MA expenditures for state hospitals and community ICFs-MR. In fact, even with the extension of MA funding, the waiver saves nearly $1.6 million annually in FY 1987 MA costs.

The waiver legislation affects other budgets besides Medical Assistance. Because federal regulations prohibit Medicaid funding of room and board for those in waivered services, most clients diverted from ICFs-MR will receive federal SSI and state/county MSA to pay for their daily needs. Similarly, since the legislation does not cover everyone on the county caseload, a full accounting of the public expenditure for these clients is necessary to completely evaluate the waiver's impact.

Tables 21 through 23 examine the daily total cost of serving the hypothetical county caseload and break down the the share of costs assumed by each level of government. These totals for each level of government are the source of the entries in Tables 12 and 13.

Table 21
DAILY COST* BY LEVEL OF GOVERNMENT:
Hypothetical County Caseload: FY 1983

Service	# Clients	Per Diem	Costs Total	Fed.	State	County
Residential						
SH[a]	270	93.08	25132	13119	10807	1206
ICF-MR[a]	570	51.71	29475	15386	12674	1415
SILS:						
at risk[b,c]	48	25.06	1155	237	756	162
others[d]	20	9.07	182	-	91	91
Foster Care[b]	68	12.00	816	-	408	408
Family Subsidy	24	8.22	197	-	197	-
Waiver						
DTH	-	-	-	-	-	-
SLA	-	-	-	-	-	-
IFS	-	-	-	-	-	-
SILS	-	-	-	-	-	-
Day & Support						
DAC: MA[e]	270	16.42	4433	2314	1906	213
DAC: CSSA[f]	734	15.94	11702	-	5851	5851
Case Mgmt: MA	-	-				
Case Mgmt:CSSA[g]	1058	1.36	1438		719	719
Total			74530	31056	33409	10065

Sources: Developmental Disabilities Program (1983).
DPW (1983).

a Residential per diem cost only. Day program costs are listed under day programs and support.

b Includes room and board funded from SSI/MSA.

c At risk includes those from SH or ICF-MR or at risk of these placements. Counties receive 81 percent state reimbursement for these clients and 50 percent for all others.

d Assumes that "other" clients are too high functioning to qualify for SSI/MSA funding. Room and board must be funded from client resources.

e Assumes only SH residents receive MA reimbursement for DAC services.

f Includes 60 percent of those from ICF-MR, 10 percent of those from SILS, and 50 percent of foster care placements, 187 adult clients not receiving residential services and 164 preschoolers. Per diem is weighted average of adult and preschool per diems.

g Assume case ratio of 1:50.

* Assumes costs shared as per Table 14.

Table 22
DAILY COST* BY LEVEL OF GOVERNMENT:
Hypothetical County Caseload: FY 1987
Without Waiver

Service	# Clients	Per Diem	Costs Total	Fed.	State	County
Residential						
SH[a]	225	119.87	26971	14079	11597	1295
ICF-MR[a]	710	77.11	54749	28579	23542	2628
SILS:						
at risk:[b,c]	75	28.05	2103	449	1364	290
others[d]	24	11.28	270	-	135	135
Foster Care[b]	71	16.33	1160	-	580	580
Family Subsidy	24	9.86	237	-	237	-
Waiver						
DTH[b]	-					
SLA[b]	-					
IFS	-					
SILS[b]	-					
Day & Support						
DAC: MA[e]	225	21.16	4761	2485	2047	239
DAC: CSSA[f]	830	20.35	16890	-	8445	8445
Case Mgmt:MA[g]	1138	1.36	1548		774	774
Total			108689	45592	48721	14376

a Residential per diem costs only. Day program costs are listed under day programs and support.

b Includes room and board funded from SSI/MSA.

c At risk includes those from SH or ICF-MR or at risk of these placements. Counties receive 81 percent state reimbursement for these clients and 50 percent for all others.

d Assumes that "other" clients are too high functioning to qualify for SSI/MSA. Room and board are funded from client resources.

e Assumes only SH residents receive MA reimbursement for DAC services.

f Includes 60 percent of those from ICF-MR, 10 percent of those from SILS, and 50 percent of foster care placements, 179 adult clients not receiving residential services and 164 preschoolers. Per diem is weighted average of adult and preschool per diems.

g Assumes case ratio of 1:50.

* Assumes costs shared as per Table 14.

Table 23
DAILY COST* BY LEVEL OF GOVERNMENT:
for Hypothetical County Caseload: FY 1987
With Waiver

Service	Clients	Per Diem	Costs			
			Total	Fed.	State	County
Residential						
SH[a]	158	119.87	18939	9886	8144	909
ICF-MR[a]	519	77.11	40021	20891	17209	1921
SILS:						
at risk[b,c]	75	25.25	1895	450	1194	251
others[d]	24	11-28	270	-	135	135
Foster Care[b]	71	16.33	1160	-	580	580
Family Subsidy	24	9.86	237	-	237	-
Waiver						
DTH[b]	39	54.78	2139	1066	950	123
SLA[b]	103	75.18	7744	3908	3410	426
IFS	39	20.41	796	416	342	38
SILS[b]	77	30.75	2368	1136	1078	154
Day & Support						
DAC:MA[e]	728	20.75	15105	7885	6495	725
DAC:CSSA[f]	264	20.50	5412	-	2706	2706
Case Mgmt: MA	258	2.74	707	369	304	34
Case Mgmt: CSSA[g]	947	1.36	1288	-	644	6441
Total			98081	46007	43428	8646

a Residential per diem costs only. Day program costs are listed under day programs and support.

b Includes room and board funded from SSI/MSA.

c At risk includes those currently on the state grant program who come from SH or ICF-MR or are at risk of these placements. Once waivered services are in place, new at risk clients will receive SILS under the MA waiver.

d Assumes that "other" clients are too high functioning to qualify for SSI/MSA. Room and board are funded from client resources.

e Assumes SH and community ICF-MR residents receive MA reimbursement for DAC. Also includes all SLA and one-third of waivered SILS placements.

f Includes 10 percent of non-waivered SILS and 50 percent of foster care clients, 57 adults not receiving residential services and 164 preschoolers.

g Case management for those in waivered services is MA funded. Assumes case ratios of 1:25. For CSSA, case ratios of 1:50 are assumed.

* Assumes costs shared as per Table 14.