STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of Rules of the Department of Human Services Governing the Funding and Administration of Home and Community-Based Services for Persons with Mental Retardation

STATEMENT OF NEED AND REASONABLENESS

INTRODUCTION

Proposed rule parts 9525.1800 to 9525.1930 establish procedures that govern the funding and administration of home and community-based services provided to persons with mental retardation. The rule parts are proposed as permanent rule parts to replace parts 9525.1800 to 9525.1930 [Emergency]. Authority for the establishment of the proposed rule parts is given to the commissioner in Minnesota Statutes, sections 256B.092, subdivision 6, 256B.501, subdivision 2, 256B.502 and 256B.503. The provisions of rule parts 9525.1800 to 9525.1930 establish training and licensing standards for the delivery of home and community-based services paid for under medical assistance, identify who is eligible to receive home and community-based services, and establish procedures for funding and administering these services.

HOME AND COMMUNITY-BASED SERVICES AS AN ALTERNATIVE TO PLACEMENT IN INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

During the 1970s the state of Minnesota led the nation in the development of community-based intermediate care facilities for the mentally retarded (ICFs/MR).

These facilities provided a community alternative to placement in a state hospital (state-operated ICF/MR), thereby enabling the state to reduce the state hospital population of persons with mental retardation from more than 6,000 in the 1960s to just under 2,400 by 1982. While the creation of ICFs/MR decreased the state hospital population, the total number of persons with mental retardation in long-term care settings increased steadily. By the end of 1982, there were 311 community facilities serving 4,900 children and adults. Minnesota had become the highest state user of community ICFs/MR. (LAC Report February, 1983 "Evaluation of Programs for Mentally Retarded Persons")

In June of 1982, concern about the growing cost of these facilities and the lack of alternative services prompted the Legislative Audit Commission to direct the Program Evaluation Division to study community programs for persons with mental retardation. The results of the study were published in February, 1983 in a report entitled "Evaluation of Programs for Mentally Retarded Persons." During this same period of time the Governor's Planning Council on Developmental Disabilities also took a look at policy alternatives for serving persons with developmental disabilities during the 1980s and published their findings in Developmental Disabilities and Public

Policy, a review for policymakers (January, 1983). Both documents stressed the need to develop alternatives to ICF/MR care but recognized that the development of service alternatives is directly linked to the availability of state and federal funding. As a means of addressing this problem both documents mentioned the Title XIX waiver process. The LAC report recommended that the state apply for a waiver under section 2176 of the federal Omnibus Budget Reconciliation Act of 1981. The waiver would enable Minnesota to receive the same rate of federal financial participation for providing an array of less costly home and community-based services as the rate for ICF/MR services, as long as the persons served would otherwise require placement in an ICF/MR.

The LAC recommendations were debated by the 1983 Legislature which then passed Chapter 312 of Laws of Minnesota, 1983. Chapter 312 authorized the commissioner of the Department of Human Services to apply for a Title XIX waiver to provide home and community-based services to persons with mental retardation and to promulgate emergency and permanent rules to implement the waiver. With the passage of this legislation a new era in the provision of services to persons with mental retardation began.

WAIVER DEVELOPMENT

Development of the waiver application began in August of 1983 when the staff of the Department of Human Services, Mental Retardation Division, conducted regional workshops throughout the state to gather public input on how the waiver should be written. To encourage continued public participation in the development process a mental retardation Title XIX Waiver Steering Committee funded by the McKnight Foundation was established. As part of the McKnight project reactor panels were then established to give input to the Steering Committee on specific areas of concern such as residential services, in-home family services and case management.

Twenty-six people served on the Steering Committee and another 100 people participated in the reactor panels. After the initial waiver proposal was written the draft was circulated to over 200 people who are involved in the delivery of services to persons with mental retardation (see Exhibit A). The attached document (Exhibit B) is the result of all of that human effort. This document was used as a base in the development of these rule parts. Please note that the letters to Robert Wren and attachments are included as part of the waiver document. The letters and attachments are part of the waiver as approved by the United States Department of Health and Human Services. Any further mention of the waiver includes these additional documents.

RULEMAKING HISTORY

The Department's waiver application was approved by the United States Department of Health and Human Services in April of 1984. With the assistance of an advisory committee composed of county representatives, providers, and advocates for persons with mental retardation the department

soon developed parts 9525.1800 to 9525.1930 [Emergency] to implement the approved waiver. The emergency rule parts were published in August 1984.

Following a 25-day public comment period, the emergency rule parts were revised based on public comments. The revised emergency rule parts took effect on October 22, 1984. During the revision process the need for provider qualifications and licensing standards was identified. Because these issues required substantial changes in the emergency rule parts they were addressed later through the temporary amendment process. The temporary amendments were published in February of 1985 and took effect on April 23, 1985.

The proposed permanent rule parts were developed concurrently with the temporary amendments and will replace both the emergency rule parts and the temporary amendments. The department was assisted in both processes by an advisory committee composed of county representatives, providers and advocates for persons with mental retardation (see exhibit C).

NEED FOR AND REASONABLENESS OF RULE PROVISIONS

Many of the provisions in these rule parts are necessary to comply with the requirements of the waiver approved by the United States Department of Health and Human Services and to meet the requirements in Title 42 of the Code of Federal Regulations. Other provisions are needed so that the commissioner and the counties can effectively administer home and community-based services. In the following narrative the need for and reasonableness of each provision is affirmatively presented by the department as required by Minnesota Statutes, section 256B.092, subdivision 6, 256B.501, subdivision 2, 256B.502 and 256B.503 and in accordance with the provisions of the Minnesota Administrative Procedure Act, Minnesota Statutes, Chapter 14 and the rules of the Office of Administrative Hearings.

9525.1800 DEFINITIONS.

This rule part defines words and phrases that have a meaning specific to parts 9525.1800 to 9525.1930, that may have several possible interpretations, or that need exact definitions to be consistent with the authorizing legislation. Terms used in a manner consistent with common use in the mental health or human services field are not defined unless a definition is necessary to clarify the rule.

Subpart 1. Scope. This provision is needed to clarify that the definitions apply to the entire sequence of parts 9525.1800 to 9525.1930.

Subpart 2. Billing rate. This definition is necessary to notify providers of the units of time that are acceptable as a basis for billing the medical assistance program for home and community-based services. It is necessary to standardize the definition to establish a basis of fiscal accountability as required under the provisions of the waiver. It is

reasonable to define the term in this way because it is consistent with the billing system set up by the department for the medical assistance program which has been implemented successfully under parts 9525.1800 to 9525.1930 [Emergency]. It is reasonable to continue this process to avoid unnecessary disruption of the billing system due to promulgation of the permanent rule parts. This use of the term also conforms with standard practices in private industry, for example, consultants often have hourly and daily billing rates.

Subpart 3. Case manager. This definition is necessary to clarify who is responsible when a duty is assigned to the case manager. It is reasonable to use this term because it is consistent with the way the term is used in other department rules. The duties assigned are those duties assigned to the case manager under parts 9525.0015 to 9525.0145 [Emergency]. It is reasonable to specify that the case manager is "the person designated by the county" because counties are responsible for providing case management services under Minnesota Statutes, sections 256B.092 and 256E.08 and therefore, have both the responsibility and the authority to designate the appropriate staff to provide these services.

Subpart 4. Client. This definition is necessary to identify the person receiving home and community-based services. It is necessary to have its meaning clearly established to clarify for whom services are provided and billed for under the medical assistance program. It is reasonable to use the term client because it is a generally accepted term used in both the public and private human services field to designate the person to whom a service is provided. The definition given the term is reasonable because it is consistent with the definition of client found in Webster's Third New International Dictionary, G. & C. Merriam Co., Springfield, Massachusetts, 1981. The definition also provides a reasonable way to delete unnecessary words in a reference frequently repeated in the rule parts.

Subpart 5. Commissioner. This definition is necessary to clarify the meaning of "commissioner" as used in the rule parts. The term "commissioner" is used throughout the rule parts as an abbreviation for the commissioner of the Minnesota Department of Human Services or the commissioner's designated representative. It is reasonable to use an abbreviation to shorten the length of the rule parts. It is reasonable to limit use of the term to the commissioner of human services, because he or she has the statutory authority and responsibility to promulgate and administer these rule parts.

It is necessary and reasonable to include within the definition persons to whom the commissioner has the authority to delegate the functions described in the rule parts because it would be physically impossible for the commissioner to perform all of the tasks assigned to the commissioner in the rule parts. It is reasonable to allow this delegation of authority to enable the commissioner to delegate his or her responsibilities to qualified staff who can effectively manage and control the implementation of the rule parts. Including this delegation of responsibility in the definition also notifies interested parties of this delegation.

Subpart 6. County board. This definition is necessary to provide an abbreviated method of identifying the persons responsible for carrying out many of the duties outlined in the rule parts. It is reasonable to define the term as "the board of commissioners for the county of financial responsibility" to distinguish this county board from the county board of the host county. This distinction is necessary to avoid confusion about which duties are assigned to which county board in the rule parts. It is reasonable to assign the majority of the duties to the county of financial responsibility because the duties affect the finances of that county. This assignment of duties is also consistent with the duties assigned to the county of financial responsibility in Minnesota Statutes, section 256B.092, subdivision 1, and 256E.08, subdivision 1.

Subpart 7. County of financial responsibility. The definition of county of financial responsibility is necessary to clarify the meaning of subpart 6 and to clearly differentiate between the county where the home and community-based services are provided (the host county) and the county that is responsible for arranging and billing for the services (the county of financial responsibility). It is reasonable to define county of financial responsibility by referencing the statutes so that the rule parts will be in conformance with the statutes.

This is also a reasonable way of shortening the definition and avoiding unnecessary duplication of statutory language because the statutory definition is quite detailed. This definition is also used in other department rules including the rule governing medical assistance payments for day training and habilitation services (parts 9525.1200 to 9525.1330) and the emergency rule governing county case management services for persons with mental retardation (parts 9525.0015 to 9525.0145 [Emergency]). It is reasonable to use the same definition to promote consistency between department rules.

Subpart 8. Daily intervention. Daily intervention is used as a criterion for determining eligibility for home and community-based services in part 9525.1820. To assure that eligibility is determined fairly and consistently throughout the state it is necessary to define the term. The definition is reasonable because it conforms with the requirements of the Health Care Financing Administration (HCFA) as reflected in the waiver (see exhibit B). To secure approval of the waiver the department had to assure HCFA that persons receiving home and community-based services required daily intervention to manage their daily affairs. It is reasonable to define intervention as "supervision, assistance or training" because all of these affect the management of the client's daily affairs. It is necessary to include provision of these services by a "provider, family member or foster family member" because some clients will receive services while living with their families and others will be placed out of the home. The phrase "each day for more than 90 consecutive days" is necessary to clarify that the intervention must be required on a long-term basis because home and community-based services are meant to provide an alternative to long-term care provided in an intermediate care facility for the mentally retarded.

Subpart 9. Department. This definition is necessary to clarify that the specific department referred to in the rule parts is the Minnesota

Department of Human Services. Substituting "department" for the full name of the department is a reasonable way of shortening the rule parts.

Subpart 10. Diversion. This definition is necessary to distinguish between the two categories of persons who are eligible for home and community-based services under title 42 of the Code of Federal Regulations, Section 441.301. Section 441.301 requires that services be furnished only to (1) persons currently receiving and continuing to need the level of care provided in an ICF/MR, for whom home and community-based services are determined to be an appropriate alternative; and (2) persons who would be placed into an ICF/MR in the absence of home and community-based services. "Diversion" is a reasonable term to describe the provision of services to the second group because they are "diverted" from placement in an ICF/MR by provision of home and community-based services. The phrase "within one year" is necessary to comply with title 42 of the Code of Federal Regulations, section 441.302(d) which requires "a reasonable indication that they [eligible persons] might need such services in the near future." Because "in the near future" is a vague standard, for the purpose of parts 9525.1800 to 9525.1930 it is necessary to define "in the near future." "Within one year" is a reasonable definition of "in the near future" because it is consistent with the "at risk" standard used in 12 MCAR § 2.02003 [Temporary]. It also parallels the time period covered by a county proposal under part 9525.1880 which aids the county in preparing a proposal.

Subpart 11. Family. The term "family" is used in the rule parts as a component of eligibility for certain services and as a disqualifier for reimbursement. It is necessary to define the term to clearly designate who is considered "family" and therefore eligible for certain services and disqualified from receiving reimbursement for providing services. It is reasonable to include in the definition of family persons related by blood, marriage, or adoption because these persons are typically considered part of a person's family. It is reasonable to limit the definition to the persons listed because these are the people most closely associated with the client and most likely to live in the same household. Listing the persons is also necessary to clarify who is included in the definition.

Subpart 12. Fiscal year. It is necessary to define fiscal year because the term is used to describe the period for which allocations are made under part 9525.1890. This time period is consistent with the time intervals in the waiver. It is reasonable to use the state's fiscal year in the waiver and these rule parts to simplify accounting procedures for the state. This time period also enables the department to base the allocations on the latest legislative appropriations.

Subpart 13. Geographic region. This term is used in part 9525.1890 with regard to reallocation of money. The definition is necessary to clarify which counties are eligible to receive the reallocated money. It is reasonable to use the economic development regions established by the governor under Minnesota Statutes, section 462.385, because the counties are already familiar with these regions. It is necessary to include the phrase "in effect on July 1, 1984" to ensure that for the purposes of this rule the regions remain the same. July 1, 1984 is a reasonable date to use because

it is the beginning of the first fiscal year during which money was allocated under the emergency rule parts which preceded these rule parts.

Subpart 14. Home and community-based services. This definition is necessary to identify the services which are funded under these rule parts. It is reasonable to limit the defined services to services "authorized under United States Code, title 42, section 1396 et seq. and authorized in the waiver granted by the United States Department of Health and Human Services" because only services authorized by the United States Department of Health and Human Services can be reimbursed using medical assistance money. Because the purpose of these rule parts is to govern "home and community-based services" funded under medical assistance, it is reasonable to limit the definition to the services which have been approved for funding by the United States Department of Health and Human Services. It is reasonable to reference the rule part in which the specific services are defined to avoid duplicating the definitions here while providing a quick reference for anyone who wants to know more about a specific service.

Subpart 15. Host county. This definition is necessary to distinguish between the county which is financially responsible for provision of home and community-based services to a client and the county in which the services are provided (see subpart 7). It is reasonable to use the term "host county" to designate the county in which the services are provided because this is consistent with the common usage of the term "host."

Subpart 16. Individual habilitation plan. This term is used in the service limitations and contract provisions of the rule parts. It is necessary to define this term to clarify what is meant in these instances. It is reasonable to define the term by referencing parts 9525.0015 to 9525.0145 [Emergency] because those rule parts govern all services to persons with mental retardation. Referencing the rule parts improves consistency between the department's rules and makes it easier for the counties to comply with the rule requirements.

Subpart 17. Individual service plan. This term is used throughout the rule parts and is necessary to identify the document in which the client's service needs are identified. It is reasonable to define the term by referencing parts 9525.0015 to 9525.0145 [Emergency] for the same reasons given in support of definition of individual habilitation plan in subpart 16.

Subpart 18. Intermediate care facility for the mentally retarded or (ICF/MR). This term is used throughout the rule parts and has a central role in describing conditions governing client eligibility. It is necessary to define the term to clarify for all affected parties what type of facilities are included in the definition. It is reasonable to define the type of facility on the basis of licensing and certification because licensing and certification are required to operate an ICF/MR in Minnesota and it is easy to ascertain if a facility meets these criteria.

It is reasonable to define the term by referencing the statutes so that the rule parts will be in conformance with the statutes. This is also a

reasonable way of shortening the length of the definition and avoiding unnecessary duplication of statutory language.

The term "intermediate care facility for the mentally retarded" is a generally accepted term used by federal and state governments and providers to define a level of care funded under the medical assistance program. (For example, the term is used in United States Code, title 42, sections 1396, et seq., Code of Federal Regulations, title 42, section 442.400 et seq., Minnesota Statutes, section 256B.501 and other department rules including parts 9525.1210 to 9525.1330 and 12 MCAR § 2.05301 to 2.05315 [Temporary]). Use of the acronym "ICF/MR" is a reasonable way to shorten the length of the rule parts.

Subpart 19. Placement. This definition is necessary to distinguish between the two groups of persons who are eligible for home and community-based services under title 42 of the Code of Federal Regulations, section 441.301. The two groups are specified in the statement of need and reasonableness for the definition of diversion in subpart 10. The term "placement" is used to refer to the provision of services to clients in the first category - persons who are discharged from an ICF/MR placement and provided home and community-based services. The term is necessary to provide a short way of referring to persons who were in an ICF/MR before receiving home and community-based services. The use of the term is reasonable because it is easily distinguished from its companion term diversion.

Subpart 20. Primary caregiver. This definition is necessary to provide a short way of referring to a person other than a member of the client's family who provides services to the client in the client's home. It is necessary to identify these persons because in some cases they are eligible for respite services. It is reasonable to call this person a caregiver because it is consistent with the way the term is used in other social services including the department's caregiver program through volunteer services. Because the person regularly "gives care" to the client, the term is also reasonably descriptive. It is necessary to limit the definition to the person who has primary responsibility for the services to avoid confusing this person with others who occasionally provide services to the client, because only the primary caregiver would need the relief provided by provision of respite care services to the client.

Subpart 21. Provider. This definition is necessary to clarify that these rule parts apply to providers of home and community-based services under these rule parts and not to providers of other services. It is reasonable to limit the definition to these providers because they are the providers whose funding and licensing is governed by these rule parts.

Subpart 22. Room and board costs. Under these rule parts and the waiver, room and board costs are not reimbursable except for respite care provided out of the client's residence. It is necessary to define "room and board costs" to inform the providers and the county boards which costs are considered unallowable so that they can accurately estimate and measure their costs and won't knowingly bill for costs that are unallowable. The definition is reasonable because it is consistent with the provisions

defining room and board found in 12 MCAR § 2.02001 to 2.02011 [Temporary], and part 9535.2400.

Subpart 23. Screening team. This definition is necessary to clarify who is considered part of the screening team. The screening team is responsible for evaluating service needs and this evaluation affects the person's eligibility for services under these rule parts. It is reasonable to define the term by referencing Minnesota Statutes, section 256B.092 because the members of the screening team are clearly defined in the statutes and by referencing the statutes there is no possibility of inconsistency between the rule parts and the statutes.

Subpart 24. Service site. This definition is necessary because under these rule parts size limitations and licensing standards are applied to service sites, and in order to facilitate application of these limits and standards, all interested parties must know what is considered a service site. The county board must know what a service site is to determine whether a provider should be licensed and to enforce the size limitations. The providers must know what a service site is to determine if they need a license or if the size of their facility meets the requirements in the rule parts. It is reasonable to define the service site as the "location at which home and community-based services are provided" because this use of the term "site" is consistent with the common definition of the term and because the focus in the rule parts is on the provision of home and community-based services. This definition is also consistent with the definition of service site used in other department rules such as 12 MCAR 2.02001 to 2.02011 [Temporary].

Subpart 25. Short-term. This term is used to differentiate between respite care (a temporary service) and other services which are provided for longer periods of time. It is necessary to define the term because it is subject to many different interpretations. It is reasonable to define short-term as less than 90 24 hour days in a fiscal year because this is consistent with the time period for temporary care as used in Minnesota Statutes, section 252A.11, subdivision 3.

Subpart 26. Statewide average reimbursement rate. This definition is necessary to clarify how money will be distributed to the county boards under part 9525.1910, subpart 2. Clearly defining this part of the distribution process also helps county boards to determine if the home and community-based services they plan to provide can be provided within the fiscal limitations of the waiver. It is reasonable to use the formula described in this definition to arrive at the statewide daily reimbursement rate because this is the formula which was used in the waiver and approved by the United States Department of Health and Human Services.

Subpart 27. Waiver. This definition is necessary to differentiate between the waiver which authorizes the services governed by this rule and other waivers which the department has applied for. It is reasonable to limit the definition of waiver to the waiver of Title XIX requirements for home and community-based services to persons with mental retardation because only that application affects these rule parts. It is necessary to include

all amendments made to the application because the state must comply with the amendments in funding services under these rule parts.

9525.1810 APPLICABILITY AND EFFECT.

Subpart 1. Applicability. This subpart is necessary to inform counties, providers, and other interested parties of the rule parts which govern the provision of home and community-based services, and to whom the rule parts apply. This statement of applicability is reasonable because it accurately states who is governed by the rule parts. The statement is also consistent with the authorizing legislation (Minnesota Statutes, sections 256B.092, subdivision 6, 256B.501, subdivision 2, 256B.502 and 256B.503). Inclusion of an applicability section is part of standard rulemaking procedure.

Subpart 2. Effect. This subpart is necessary to inform all interested parties that these rule parts shall only continue in effect as long as the waiver is in effect. Because the major source of funding for the services governed by these rule parts is dependent on the approval of the waiver, it is reasonable to limit the effect of the rule parts to the duration of the waiver. It is reasonable to inform interested persons of that limitation in this rule part so that they will be able to plan accordingly.

9525.1820 ELIGIBILITY.

Subpart 1. Eligibility criteria. This subpart is necessary to clarify who is eligible to receive the services funded and administered under these rule parts. It is reasonable to list the eligibility criteria in a specific rule part to aid interested persons in determining if a person qualifies for services reimbursable under these rule parts. It is reasonable to establish clear client eligibility criteria so that the screening teams can make fair and consistent determinations. These criteria also improve fiscal accountability by limiting the provision of services to those persons determined to be eligible.

Item A is necessary because home and community-based services are funded under the medical assistance program and federal financial participation for these services is not available for persons who aren't eligible for medical assistance. It is reasonable to limit the provision of these services to persons eligible for medical assistance to receive maximum federal financial participation and target state funds to the persons that the medical assistance program was designed to assist. It is reasonable to refer to Minnesota Statutes, Chapter 256B to determine if the person is eligible for services because this chapter governs the provision of medical assistance to needy persons and contains specific criteria for eligibility. Referencing the statute eliminates unnecessary duplication of statutory language and ensures that the same eligibility standards are applied for home and community-based services as are applied for other medical assistance funded services.

Referencing subpart 2 is reasonable because subpart 2 clarifies how medical assistance eligibility is determined for children residing with their parents. It is necessary to clarify this issue because these rule parts specifically allow the provision of services to children residing with their parents. Normally the medical assistance eligibility of these children would be determined considering the parents' income and resources, however the department has provided for suspension of the deeming requirements in the Code of Federal Regulations, as part of the waiver (under the circumstances set forth in subpart 2) to encourage families to maintain their children at home.

Item B is necessary because the services to be provided under these rule parts are designed to meet the needs of persons with mental retardation. Moreover, the waiver which provides the funding for these rule parts was approved for persons with mental retardation. Other programs and other waivers are available for other persons. It is reasonable to include this criterion to ensure that services are provided only to the persons these rule parts were designed to serve. It is reasonable to require that the determination be made in accordance with parts 9525.0015 to 9525.0145 [Emergency] because those rule parts govern all services to all persons with mental retardation and contain specific criteria for a diagnosis of mental retardation. Referencing the rule parts eliminates unnecessary duplication of rule language and increases consistency between department rules.

Item C is necessary to clarify that these services may be funded under the waiver only for persons who need the level of care provided in an ICF/MR. This provision is necessary to comply with Minnesota Statutes, section 256B.092, subdivision 4. The requirement is reasonable because it is consistent with the provisions in the waiver and with the requirements in title 42 of the Code of Federal Regulations section 441.301.

Item D is necessary to clarify that only persons who need daily intervention are eligible to receive home and community-based services. This requirement is reasonable because it is consistent with the requirements under the waiver as explained in the letter to Robert E. Wren (see Exhibit B). Assessing the client's need for daily intervention is a reasonable way of determining if the client is in need of the level of care provided by an ICF/MR because an ICF/MR is designed to meet client needs by providing care on a daily basis.

Subpart 2. Medical assistance eligibility for children residing with their parents. This subpart is necessary to inform interested persons that eligibility for medical assistance for a person under 21 who resides with his or her parent or parents shall be determined without considering parental income and resources under certain circumstances. This provision is reasonable because it facilitates the department's goal of serving children in their natural homes, aids the county in meeting their state hospital utilization targets as required in the Welsch v. Levine No. 4-72 Civil 451 (D. Minn., Sept. 15, 1980) (Welsch Consent Decree) (see Exhibit D) and is consistent with the requirements in United States Code, title 42, section 1396 a(10)(A)(ii)(IV).

9525.1830 PROVISION OF HOME AND COMMUNITY-BASED SERVICES.

Subpart 1. Conditions. This subpart is necessary to inform interested persons of the conditions that must be met before home and community-based services are provided. It is reasonable to list these conditions to ensure that they are consistently applied throughout the state.

Item A is necessary to inform interested persons that home and community-based services need only be provided if the county board can provide the services within its total allocation of home and community-based services money. This provision is reasonable because a limited amount of money is available to provide these services and the county board must not exceed its total allocation. The waiver as currently approved does not entitle every client eligible for medical assistance to receive home and community-based services but does provide an alternative means of funding certain services for some clients.

Item B is necessary to inform interested persons that to receive home and community-based services the person must have been recommended for these services by the screening team. This provision is necessary to comply with title 42 of the Code of Federal Regulations, section 441.302(c) which requires "an evaluation of the need for home and community-based services" and with Minnesota Statutes, section 256B.092, subdivision 4, which provides for payments to county boards for the "costs of providing alternative home and community-based services to medical assistance eligible mentally retarded persons screened under subdivision 7 [screening teams established]." This provision is reasonable because it encourages appropriate placement of persons with mental retardation. This provision is also consistent with the provision in parts 9525.0015 to 9525.0145 [Emergency] and with the duties assigned to the screening team in Minnesota Statutes, section 256B.092, subdivision 7 and 8.

Item C is necessary to inform all interested persons that the commissioner must authorize payment for home and community-based services before these services can be provided under parts 9525.1800 to 9525.1930. It is reasonable to require authorization by the commissioner because the commissioner is responsible to the federal government for the money spent for these services and required by Minnesota Statutes, section 256B.092, subdivision 2 "to authorize payments for medical assistance services" (home and community-based services are medical assistance services).

Item D is necessary to comply with federal regulations protecting the person's right to choice. This provision is reasonable because it is consistent with the consumer choice requirement in parts 9525.0015 to 9525.0145 [Emergency] and complies with the requirements regarding free choice of providers found in the Code of Federal Regulations, title 42, section 431.51 and the requirements regarding the client's choice of alternatives under the waiver found in the Code of Federal Regulations, Title 42, section 441.302(d).

Item E is necessary to ensure appropriate placement of the person. This provision is reasonable because it is consistent with the requirements in

parts 9525.0015 to 9525.0145 [Emergency] which require the assessment of client needs and the development of an individual service plan, and limit services that may be authorized to those provided in accordance with the individual service plan. It is reasonable to base the provision of home and community-based services on the goals and objectives specified in the person's individual service plan to facilitate achievement of the identified goals and objectives and to ensure that only necessary services are provided as required in Minnesota Statutes, section 256B.092, subdivision 3.

Item F is necessary to inform the county board that it must have a signed agreement with the state before services can be provided. A signed agreement is necessary to provide programmatic and fiscal accountability. This provision is a reasonable way to provide accountability and ensure that the county board is aware of its legal responsibilities when providing home and community-based services. The requirement is consistent with general medical assistance program requirements in part 9500.0960 which mandate state/provider agreements. (The county board is considered the provider for the purposes of the agreement under these rule parts.)

Subpart 2. Written procedures and criteria. This subpart is necessary to promote consistency in the way that the county board determines whether home and community-based services can be provided to the person within the county allocation. It is reasonable to allow the county board to establish the procedures so that the procedures will be consistent with the service needs identified in the county and resources of the county. It is reasonable to require written procedures and criteria so that the determinations made by the county are all made in the same manner. Establishing a written procedure helps to prevent discriminatory or arbitrary decisions and gives interested persons notice of the conditions applicable in that county. It is reasonable to require consistency with the rule parts, the waiver, and the federal regulations because all of these regulate how funds governed by these rule parts may be spent. If the county board developed written procedures and criteria which were not consistent with the rule parts, the waiver and the federal regulations, the cost of the services might not be reimbursable. It is reasonable to require consistency with the goals established by the commissioner for making determinations to link the county board's determination with the statewide goals for these services.

9525.1840 PARENTAL CONTRIBUTION FEE.

Subpart 1. Out-of-home placements. This subpart is necessary to notify parents of clients under age 18 that Minnesota Statutes, section 256B.14 requires parental contribution fees. It is reasonable to include this provision to make certain that families placing a child outside their home are aware of their financial responsibilities under the medical assistance program. It is reasonable to reference the statute to inform parents of the actions that may be taken to obtain payment without unnecessarily duplicating statutory language.

Subpart 2. In-home services. This subpart is necessary to notify parents of clients under age 18 receiving services while residing with the

parent that they may also be liable for a parental contribution fee if the client's eligibility was determined without considering parental income or resources. It is reasonable to include this provision to make certain that parents with children receiving services in their home are aware that they may have to contribute toward the cost of the services received under the medical assistance program. It is reasonable to reference the statute for the reasons given in the statement of need and reasonableness for subpart 1.

9525.1850 PROVIDER REIMBURSEMENT.

This part is necessary to inform providers of the criteria they must meet to receive medical assistance reimbursement for providing home and community-based services. It is necessary to establish criteria in this part to promote consistent treatment of providers throughout the state and to establish minimum standards for the quality of the services provided. It is necessary to establish minimum standards to protect the health, safety and rights of the persons with mental retardation who receive these services. It is particularly important to have standards for home and community-based services because these services are designed to be provided in small settings at scattered sites and supervision of those providing the services will be more difficult than in ICFs/MR. Establishing standards is a reasonable way for the commissioner to fulfill his responsibilities under the Mental Retardation Protection Act, Minnesota Statutes, section 252A.01 to 252A.21, under the Public Welfare Licensing Act, Minnesota Statutes, section 245.781 to 245.812 and 252.28, subdivision 2, and under Minnesota Statutes, section 256.01, subdivision 2 (2) and (3). It is also a reasonable way to comply with the assurances required in the waiver. Compliance with these standards assists the county in protecting the safety, health, or well-being of the clients as required in Minnesota Statutes, section 256E.08, subdivision 1.

It is reasonable to apply items B to E only to persons who provide services that can be billed under part 9525.1860 subpart 3, item A because these are the persons who provide services directly to the person with mental retardation. It is reasonable not to require this training for persons who are not in direct contact with the client because the training is related to training, supervising and caring for persons with mental retardation and would not be applicable for clerical, custodial or other staff who are not directly involved in providing services to clients. This statement of applicability was added to the temporary amendments in response to comments received during the 25-day comment period (see Exhibit E finding #1). Providers were concerned that without this statement they would be unable to hire anyone, even a custodian or bookkeeper, who did not meet the training and experience requirements.

Item A is necessary to inform interested persons that the licensing requirements in Minnesota Statutes or rules apply to the services funded under these rule parts. This provision is necessary to comply with title 42 of the Code of Federal Regulations, section 441.302. It is reasonable to require that home and community-based services meet the applicable licensing standards to protect the persons with mental retardation served under these rule parts. It is reasonable to use existing rules to avoid unnecessary

duplication of rule language and to prevent the development of conflicting standards. By using existing rules for the licensing of home and community-based services this provision makes it possible for the county board to use existing mental retardation services providers or generic providers to provide home and community-based services. Promoting the use of existing community resources especially generic services (when those services or resources are adequate to meet the client's needs) is also consistent with the requirements for an individual service plan in parts 9525.0015 to 9525.0145 [Emergency] and limits the costly proliferation of specialized services that are not actually needed.

Item B is necessary to inform interested persons that the persons providing services under these rule parts must meet established professional standards and to inform them of the training required if there are no established standards. This provision is necessary to ensure the health and welfare of the clients are required in the Code of Federal Regulations, title 42, section 441.302.

It is reasonable to require that only providers who meet established standards receive reimbursement under these rule parts to ensure that persons receiving home and community-based services receive at least the same quality of services as persons receiving similar services through another funding source. It is necessary to establish training requirements if no professional standards have been established to protect the health, safety, and well-being of the persons with mental retardation receiving services from these persons. By requiring that the provider complete training in areas related to the care, supervision, and training of persons with mental retardation the provision ensures that the persons providing home and community-based services are aware of the needs of persons with mental retardation and at least minimally trained to meet those needs.

It is reasonable to require that the training be completed within two years because new methods of training, supervising and caring for persons with mental retardation are constantly being developed. Using the new methods of training, supervising and caring for persons with mental retardation is often more effective for home and community-based service clients because the new methods are designed for the new service settings which are being developed and provided under these rule parts. For instance, in the last few years here has been increasing emphasis on involvement with nonhandicapped persons, provision of services in the least restrictive environment and providing services appropriate to the person's chronological age. It is reasonable to require that providers be aware of recent developments in the field so that they can use the most effective methods.

It is reasonable to require that the case manager approve the training because the case manager is required to be familiar with the needs of the clients and the training offered in the county and surrounding area, and can determine if the training received is appropriate.

The amount of training required was reviewed by the advisory committee and considered reasonable. Few comments were received on this requirement when the temporary amendments were published, which indicates that in general the

county boards and providers felt the requirement could be met. Twenty-four hours of training is the amount required for homemakers under part 9565.1200. This amount of time is roughly equivalent to the amount of time spent in a three-credit course at a college under the quarter system. This is a fairly minimal amount of time in which to become familiar with a given topic but is enough to ensure that generic service providers acquire at least some knowledge of the needs of persons with mental retardation.

The training topics were chosen because they relate to the needs of persons with mental retardation as identified by department staff and the advisory committee. It is reasonable to specify these topics to clarify what type of training is required.

It is reasonable to allow the county boards to grant a variance of this provision for respite care providers who provide the care in their residence or the client's residence to encourage the provision of respite care by the family's natural support system (friends, neighbors, and relatives). These people are likely to know the client and his or her needs and to be instructed by the client's family on the care to be provided.

It is reasonable to allow the county to grant a variance to this provision for providers who ensure that the training will be completed within six months to enable the county board to develop and provide new home and community-based services when no qualified providers are available. It is reasonable to require that the training be completed within six months to ensure that all providers are brought up to the minimum standards required in a reasonably short period of time thereby minimizing the risks associated with having persons without the required training providing services to clients. The six-month variance gives the provider time to set up and complete the necessary training without unduly delaying meeting the requirement and unnecessarily prolonging the provision of services by unqualified individuals.

It is reasonable not to apply these requirements to providers of minor physical adaptations because they are not directly involved in the care, training, and supervision of persons with mental retardation.

Item C is necessary to inform interested persons that providers of home and community-based services must have experience in the care, training, and supervision of persons with mental retardation or related conditions. It is reasonable to require that providers have experience working with persons with mental retardation due to the special service needs of this population. Requiring the experience within the last five years is reasonable because the methods used in providing these services change rapidly and a person with experience from more than five years ago might not be aware of the most recent developments in the care, training, and supervision of persons with mental retardation. It is reasonable to include experience with related conditions because similar methods are used for the care, treatment, and supervision of these person and persons with mental retardation.

It is reasonable to allow the county to grant a variance to the requirements of this item for a respite care provider for the reasons given in the

rationale for item B. Allowing a variance for an employee working under the direct, on-site supervision of a qualified mental retardation specialist is a reasonable way to allow the provider to train new employees who do not have the required experience while still protecting the health, safety, and well-being of the clients.

It is reasonable not to apply this provision to providers of minor physical adaptation for the reasons given in the rationale for item B. It is reasonable to exclude homemakers from the requirement in this item because the type of services provided by homemakers do not change much based on the client's condition (for example, homemaker services for the elderly and for persons with mental retardation would both include providing assistance with food planning and preparation, personal care and general household duties). Also homemaking methods do not change as rapidly as treatment or training techniques.

Item D is necessary to comply with the assurances made in the department's waiver application. This requirement is reasonable because it is consistent with the requirement for ICFs/MR found in the Code of Federal Regulations, title 42, section 442.411.

Item E is necessary to develop, enhance, and maintain the skills of persons providing home and community-based services. It is reasonable to require that these persons complete the ongoing training required in any applicable rules to ensure that persons receiving home and community-based services receive the same quality of services as persons receiving similar services through another funding source. It is reasonable to use applicable rules to avoid duplication of training requirements or conflicting requirements. It is reasonable to establish ongoing training requirements if ongoing training is required to keep all persons providing home and community-based services up-to-date on new developments in the field of mental retardation. It is reasonable to require that the persons providing home and community-based services remain up-to-date on new developments in the field of mental retardation so that they will be better able to provide their clients appropriate and effective services which are developed based on knowledge of current practices. It is reasonable to exclude a provider of minor physical adaptations from this requirement for the reasons given in item B.

It is reasonable to require 18 hours of training each year because it is comparable to the amount of training required of many other professionals in the state. The department researched the continuing education requirements in Minnesota for other professionals (including dentists, pharmacists, attorneys, real estate brokers, chiropractors and nursing home administrators) and found that most professions require an average of 15 to 20 hours per year of continuing education. Eighteen hours is also the amount of training required for special services or group family foster homes under part 9545.0150. This requirement is a compromise position worked out in the December 20, 1984 advisory committee meeting. (The rule draft at that time required 12 hours of training. An experienced county mental retardation services supervisor suggested 24 hours.)

It is reasonable to require that the ongoing training be approved by the case manager so that he or she can check to see that the training is pertinent to the needs of the clients served by the provider. This language was added after the temporary amendments were published in response to a comment made by John W. Barker of Focus Homes, Inc. (See Exhibit E, Finding #6.)

It is reasonable to allow the county board to grant a variance to this requirement for providers of respite care for the reasons given in the rationale for item B.

Item F is necessary to protect the health, safety and well-being of the person with mental retardation served in home and community-based services by eliminating as potential providers persons who have been abusive to children or vulnerable adults. It is reasonable to reference the statutes to avoid unnecessary duplication of statutory language and ensure consistency with the statutory requirements. It is appropriate to inform potential providers of the applicability of this statute because some services are provided to children and others are provided to persons with mental retardation who are within the statutory definition of vulnerable adults.

Item G is necessary to protect the provider and the county board by ensuring that the services are covered by a legally enforceable contract. Requiring a contract with the host county is consistent with the requirements in other department rules including parts 9525.0015 to 9525.0145 [Emergency] and 9550.0010 to 9550.0092. Requiring a contract with the host county eliminates unnecessary duplication of efforts when more than one county board uses a single provider and standardizes the rates charged for a service by the provider.

Item H is necessary to comply with Minnesota statutes, section 256B.092, subdivision 1, which requires that the county of financial responsibility authorize placement for services. This requirement also helps to ensure that the county of financial responsibility has determined which services are needed by the persons for whom the county is financially responsible and that only necessary services are provided as required in Minnesota Statutes, section 256B.092, subdivision 3. This requirement is consistent with the requirements in parts 9525.0015 to 9525.0145 [Emergency] and is a reasonable way of protecting the county of financial responsibility from liability for unauthorized and unnecessary expenses.

Item I is necessary to inform providers of the major department rules that apply to home and community-based services and to ensure that the provider is willing to comply with those rules. It is reasonable to reference these rules to avoid unnecessary duplication of statutory language. The rules referenced are the rules governing the administration of the Medical Assistance program (9500.0775 to 9500.1080) the rules governing the Surveillance and Utilization Review Program (9505.1750 to 9505.2150) and these rule parts which govern the provision of home and community-based services. It is reasonable to reference the rule parts mentioned because home and community-based services are funded through the medical assistance program and as such are subject to the administrative requirements governing

the medical assistance program and the reviews required under the surveillance and utilization review program.

Item J is necessary to clarify that the client's parent or guardian cannot be reimbursed for providing services to the client. It is reasonable to exclude the parent or guardian from reimbursement because the parent or guardian is responsible for caring for the client, just as he or she would care for a child who did not have mental retardation. It is reasonable to limit reimbursement in this way to make the limited resources available go as far as possible. This requirement is consistent with federal medicare policy as stated in title 42 of the Code of Federal Regulations, section 405.315.

9525.1860 REIMBURSABLE SERVICES.

This subpart is necessary to inform interested persons of the services that can be reimbursed under these rule parts. It is reasonable to list the services and limits in the same part for the convenience of persons using these rule parts.

Subpart 1. General limits. This subpart is necessary to inform interested persons that subparts 2, 3, 4 and 5 must be read in conjunction to determine if a particular service is reimbursable. It is reasonable to state this immediately to minimize confusion. It is necessary to state that these services are only reimbursable for as long as the waiver is in effect to clarify that these services are only reimbursable under the medical assistance program under the waiver. It is reasonable to give notice that these services are only reimbursable while the waiver is in effect so that providers will not expect reimbursement from the state if the waiver is no longer in effect. It is reasonable for the state not to reimburse for these services if the waiver is no longer in effect because the state allocation for such services covers only approximately 42 percent of the total costs of the services and would be insufficient to cover the total cost if no federal financial participation money was received.

Subpart 2. Definitions. This subpart is necessary to eliminate confusion by ensuring that all interested persons are using the same service definitions. These terms could be defined in a number of different ways. However, to obtain federal financial participation and ensure compliance with the federal waiver regulations (Code of Federal Regulations, title 42 sections 441.300, 441.310 and 441.180) it is necessary to define them in a manner consistent with the definitions used in the waiver. The initial definitions and the list of services were developed by the department staff with input from consultants, providers, advocates, and county representatives. (See Exhibit A). Changes were made in the list and definitions to comply with the requirements of the United States Department of Health and Human Services. (See Exhibit B.)

Item A is necessary to clarify what services are to be classified as case management for the purposes of the waiver and these rule parts. This definition is reasonable because it is consistent with the definition used

in parts 9525.0015 to 9525.0145 [Emergency] which govern the provision of case management services to all persons with mental retardation. It is reasonable to use the same definition in these rule parts because case management services for persons receiving home and community-based services should be similar to case management services for persons receiving other mental retardation services, regardless of the funding source. This definition is also reasonable because it is consistent with the definition of case management included in the waiver application.

Item B is necessary to clarify what services are classified as day habilitation for the purposes of the waiver and these rule parts. This definition is reasonable because when read in conjunction with the definition of habilitation services it is consistent with the definition of day habilitation in the waiver.

Item C defines the type of services included in day habilitation and residential-based habilitation. This definition is necessary to clarify what type of services are classified as habilitation services for the purposes of the waiver and these rule parts. It is reasonable to define habilitation services as a separate definition to eliminate repetitious language in the other two definitions. The definition is reasonable because it is consistent with the way habilitation services are defined in the waiver and stresses development of the same skills as in the definition of day training and habilitation services under parts 9525.1200 to 9525.1300. The definition is consistent with the definition is consistent with the definition in title 42 of the Code of Federal Regulations, section 442.401 but gives more detail to provide guidance to county boards and providers in determining what services are included.

Item D is necessary to clarify what services are classified as homemaker services for the purpose of the waiver and these rule parts. The definition is reasonable because it is consistent with the provisions in the waiver. It is reasonable to require that homemaker services be provided by a homemaker who meets the qualifications in rule part 9565.1200 so that homemakers providing services to persons receiving home and community-based services are governed by the same rule parts as homemakers providing services to other persons. The waiver also specifies that these services will be provided by a trained homemaker. It is reasonable to reference part 9565.1200 because it specifies the type of training to be provided for qualified homemakers.

Item E is necessary to clarify what services are classified as in-home family support services for the purposes of the waiver and these rule parts. In-home family support services were included in the waiver to provide an alternative for a family which has placed or is considering placing a child with mental retardation outside the family home. These services provide assistance to the family so that the child can be maintained at home. It is reasonable to provide such services because they are cost effective and are consistent with the directive given by the court in the Welsch Consent Decree. This definition is reasonable because it focuses on maintenance of the child in the family home and is consistent with the way the services are described in the waiver.

Item F is necessary to clarify the term applied to days when a client is temporarily away from services. This definition is necessary because these days are only reimbursable under specific conditions (see subpart 4, item C). It is reasonable to define leave days as days when the client is "temporarily absent from services" to clarify that leave days are meant only to cover temporary absences. Temporary is not specifically defined to give the county board flexibility in determining when to authorize leave days.

Item G is necessary to clarify what adaptations are classified as minor physical adaptations for the purposes of the waiver and these rule parts. The reference to subpart 3, item E in the definition is necessary because the United States Department of Health and Human Services requested that the commissioner specifically identify the adaptations to be provided under the waiver.

It is reasonable to limit the adaptations paid for under these rule parts to those adaptations which enable the client to avoid placement in an ICF/MR because one of the major purposes of the waiver and these rule parts is to provide services "to support people to remain in or return to their own home" (Exhibit B, page 1). It is reasonable to focus on adaptations which increase the client's mobility or protect the client and others against injury because these adaptations are necessary to protect the client as required in the Mental Retardation Act and to increase the client's independent functioning as required in Minnesota Statutes, section 256E.08, subdivision 1. It is reasonable to only provide minor physical adaptations for clients with mobility problems, sensory deficits or behavior problems because these persons were identified by the department and others involved in the development of the waiver and subsequent rule parts as the persons for whom minor physical adaptations are most needed. It is reasonable to target these services to the persons most in need to most effectively use the limited resources available. Also, to provide services in the least restrictive environment as required in parts 9525.0015 to 9525.0145 [Emergency], it is important not to change the client's environment unless the changes are necessary. This definition is consistent with the way this service is described in the waiver.

Item H is necessary to clarify what services are considered residential-based services for the purpose of these rule parts. It is necessary to identify these services because day habilitation services can only be provided to clients receiving a residential-based service (see subpart 4, item A). It is reasonable to limit the definition to in-home family support services and supported living arrangements because of the services reimbursable under these rules and eligible for federal financial participation, these are the ones based in the client's residence. This definition is consistent with the way residential habilitation services are described in the waiver.

Item I is necessary to clarify what services are considered respite care for the purposes of the waiver and these rule parts. The definition is consistent with the way these services are described in the waiver. The definition is reasonable because it is consistent with the way the term is used in the human services field. The definition is also consistent with

the meaning of the term "respite" given in Webster's Third New International Dictionary, 1981, G & C Merriam Company.

Items J and K are necessary to clarify what services are considered supported living arrangements for the purposes of the waiver and the rule parts. These definitions are consistent with the way the services are described in the waiver application.

It is reasonable to limit the provision of services to adults to service sites of six or less to provide a more homelike environment consistent with the purposes of the waiver and the requirements for an individual service plan in parts 9525.0015 to 9525.0145 [Emergency]. The number six was chosen because to create a more homelike environment it is necessary to locate services in a residential area and Minnesota Statutes, section 245.812, subdivision 3, states that a licensed residential facility serving six or fewer persons shall be considered a permitted single family residential use of property for the purposes of zoning. Limiting the size to six also encourages the provision of services in existing housing.

It is reasonable to limit the size of service sites for children to three to create a family-like setting. According to the state demographer the number of children in a Minnesota family is around two; therefore, limiting the size of SLAs for children to three will result in settings reasonably similar to the average family home.

Size limits are consistent with past department policy. The department has been working to decrease the size of facilities serving persons with mental retardation since the 1970s. The case management rule (12 MCAR § 2.185) which took effect in February, 1981, included a provision restricting the size of new facilities to no more than eight.

Similar limits to those in this item have been successfully implemented in Michigan according to Shirley Schue, M.S., Case Management Supervisor, Mental Retardation Division. Ms. Schue was previously employed by Northeast Michigan Community Mental Health (see attached resume, Exhibit F). The limits proposed also have been implemented in Minnesota already under rule parts 9525.1800 to 9525.1930 [Emergency].

Item L is necessary to allow the timely implementation of new services as they are approved by the United States Department of Health and Human Services (DHHS). It is reasonable to reimburse for the provision of any services approved by DHHS to encourage the development of new, less restrictive services that provide an alternative to traditional ICF/MR services. Increasing the services available makes it easier to meet the client's individual needs as required in rule parts 9525.0015 to 9525.0145 [Emergency].

Subpart 3. Billing for services. This subpart is necessary to clarify how time may be billed for under these rule parts. It is necessary to identify what time may be billed for to comply with the requirements in Minnesota Statutes, section 256B.501, subdivision 2, which states that "the commissioner shall establish procedures" ...[that] specify the costs that are allowable for payment through medical assistance." Specifying the time

which may be billed for ensures: (1) statewide consistency in the method by which the amount of billable service is determined; and (2) statewide uniformity in the service reporting system that provides data needed to evaluate program impact and effectiveness. The method developed to meet the need for statewide standardization is reasonable because is follows the common practice of measuring units of service by the hours expended in providing the service.

The limits in this subpart are reasonable because they allow the provider to bill for time spent providing services of direct benefit to clients and restrict payment for time spent on activities that don't directly benefit the client, thereby focusing limited dollars on services that directly benefit the client. These limits are similar to the limits established for the provision of semi-independent living services (SILS) in 12 MCAR § 2.02001 to 2.02011 (Temporary). The SILS program has been operating sucessfully with the limits since June 1984.

It is reasonable to exempt providers of minor physical adaptations from the limits in this subpart because the services they provide do not typically require client contact.

Subpart 4. Service limitations. This provision is necessary to clearly identify the limits that apply to the home and community-based services covered under the waiver. It is reasonable to list these limits in this rule part to make it easy for providers to find the limits which apply to the services they are providing.

Item A is necessary to inform interested persons of the limitations that apply to the provision of day habilitation services. It is necessary to state these limits and require compliance with them to comply with the provisions of the waiver and Minnesota Statutes, section 256B.501, subdivision 1(d). The need for and reasonableness of the subitems is given below.

Subitem (1) is necessary to comply with the waiver which states that day habilitation services "will only be offered as a waivered service to those individuals who receive at least one residential habilitation service." It is reasonable to limit the provision of day habilitation services under the waiver to persons who receive residential-based services because provision of day habilitation services alone is not sufficient to prevent institutionalization. Day habilitation services are seen as a vital part of an array of services provided under the waiver but must be provided with other services. This position is supported by the position taken by the Health Care Financing Administration in the March 13, 1985 issue of the Federal Register, Volume 50, No. 49, section V, A. page 10020 (see exhibit G).

Subitem (2) is necessary to comply with the waiver which states that "reimbursement for day habilitation services will not include vocational rehabilitation services as defined in the Vocational Rehabilitation Act." The provision was included in the waiver because the Code of Federal Regulations, section 441.13(b) prohibits reimbursement of vocational and

educational services under the medical assistance program. It is reasonable not to reimburse these costs under the waiver because they are funded under the Vocational Rehabilitation Act.

Subitems (3) and (4) are necessary to comply with Minnesota Statutes, section 256B.501, subdivision 1(d). It is reasonable to require that day habilitation services be provided at a different site than the client's place of residence because parts 9525.0015 to 9525.0145 [Emergency] require that the daily schedule of the person receiving services approximate that of the general public and most members of the general public spend part of their day away from their place of residence. It is reasonable to require that day habilitation services be provided by an organization that does not have a direct or indirect financial interest in the organization that provides the residential services to prevent possible conflicts of interest. Requiring separation of day habilitation and residential services also ensures that a single provider does not have 24-hour control over the life of a person with mental retardation. Involving more providers establishes a natural system of checks and balances in the service system for the protection of the client.

Item B is necessary to comply with the waiver. It is necessary to limit the provision of homemaker services to the situations stated because in other situations these services would not be necessary and the client would not be at risk of placement in an ICF/MR if they were not provided. Because federal financial participation is contingent upon the person being at risk of ICF/MR placement it is necessary to limit the provision of homemaker services in this way. The description of services provided is reasonable because it includes the duties commonly performed by a homemaker.

The limits in Item C are necessary to control costs incurred for services when the client is not present at the service. It is reasonable to limit the payment of leave days to supported living arrangements because other services can more easily adapt to the temporary absence of a client and adjust their costs accordingly. Allowing leave days for residential but not day services is also consistent with the reimbursement policy established by the department in rules 12 MCAR § 2.05301 to 2.05315 [Temporary] and parts 9525.1200 to 9525.1330.

Because a residential service such as the SLA has only a small number of clients and staff, cost adjustments are difficult to make. To encourage these providers to hold an opening for the client it is necessary to reimburse them for costs incurred while the client is temporarily absent. Ensuring that the client can return to the same SLA after a temporary absence is an important part of creating a more home-like environment and aids the client in achieving the goals and objectives in his or her individual service plan by minimizing unnecessary disruptions of daily routines.

It is reasonable to reimburse only for leave days if the client intends to return to the service because if the client does not intend to return the provider does not need to hold an opening for the client. It is reasonable to limit leave days to the situations mentioned in subitems (1) to (4) because these are times when the client is planning to return to the service.

It is reasonable to link the leave days to the individual service plan so that the county case manager can determine if leave days are necessary and appropriate and are therefore eligible for reimbursement. It is reasonable to require county authorization if the leave days are not included in the individual service plan to ensure that the county board is aware that the leave days have been taken and can determine if it is appropriate to reimburse the provider for these days. It is reasonable to require documentation of the leave days including the reasons the leave days were authorized to enable the commissioner to determine whether the costs incurred were necessary and therefore may be funded in accordance with Minnesota Statutes, section 256B.092, subdivision 3.

Item D is necessary to comply with the cost projections in the waiver which are based on an average cost of $3,000 per eligible individual. This figure was based on an informal survey conducted by Anne Bruggemeyer, Long-Term Care Division and a review of other waiver applications. Ms. Bruggemeyer contacted county and hospital staff who had experience with contractors who had modified homes for persons with physical handicaps and asked for their recommendations. In addition, the Mental Retardation Division staff reviewed waiver applications submitted by other states and determined that this amount was reasonable. Under the emergency rules minor physical adaptations have been made for three clients (up to June 1985). The cost of these adaptations has been less than $3,000 in all three cases. An average instead of a maximum amount was chosen to allow maximum flexibility in meeting client needs. This approach was suggested by reviewers involved in the development of the waiver.

It is necessary to adjust the limit each fiscal year to comply with the waiver. The adjustment process is a reasonable way to keep pace with inflation. It is reasonable to use the all urban consumer price index as a basis for the adjustment because it is also used to adjust costs for ICF/MR services under 12MCAR § 2.05301 to 2.05315 [Temporary]. The effects of inflation should be similar for both programs.

It is necessary and reasonable to limit minor physical adaptations to the purchase and installation of the items listed in subitems (1) to (13) to comply with the waiver. These items were reviewed by the advisory committee which agreed that the list, with a few amendments, would cover most of the minor physical adaptations they could think of. The advisory committee would have preferred a more open ended list but the United States Department of Health and Human Services required the department to list specific items. A few additional items were recommended; however, the department will have to amend the waiver to include these items. Subitem 13 was added to enable the department to include the additional items if the amendment is approved. It is reasonable to require that minor physical adaptations be constructed in accordance with applicable state and local building codes to protect the health and safety of the clients and their families.

Item E is necessary to prevent double billing and to comply with the waiver which states that "none of the requested home and community-based services will be furnished to recipients while they are inpatients/residents of a hospital, SNF, ICF, or ICF/MR." [See also: Code of Federal Regula-

tions, title 42, section 441.301(b)(1)(ii)]. It is reasonable not to provide home and community-based services in these instances because the services would be provided in addition to institutional services rather than as an alternative to institutional services. It is reasonable to make an exception to this requirement for authorized leave days for a hospitalized client for the reasons given in the rationale for item C.

Item F is necessary to clarify for whom respite care may be provided and to inform interested persons of the size limitations applied to respite care. Respite care is necessary to provide the persons who normally care for the client time off in which to rest and recuperate. It is reasonable to limit the persons to be benefited by the provision of respite care to the client's family, foster family or primary caregiver because these persons normally provide care for the client on a daily basis with no built in days off. Giving these persons relief benefits the client by assisting the caregiver to cope with the demands of caring for the client on a daily basis.

It is reasonable to limit the size of a respite care service site to six clients for the reasons given in the rationale for subpart 2, items J and K. It is reasonable to allow a variance of this requirement under the circumstances stated to enable the county board to more easily provide respite care for clients with multiple handicaps. This variance process was added during the temporary amendment process in response to comments from county staff involved in implementing the waiver and the Governor's Planning Council on Development Disabilities (see Exhibit E, finding #7).

Item G is necessary and reasonable to comply with the waiver and title 42 of the Code of Federal Regulations, section 440.180(b). Section 440.180(b) states that federal financial participation for home and community-based services "is not available in expenditures for the cost of room and board except when provided as part of respite care..."

Item H is necessary to clarify how the cost of the services listed in subitems (1) to (9) is to be billed for and who these services must be provided by. It is reasonable to include these costs in the provider's rate to minimize the number of billings that must be submitted for each client and to eliminate any potential duplicate billings for medical assistance services for clients in home and community based services. It is reasonable to require that these services be provided by or under the supervision of a licensed or certified professional because this requirement is consistent with the requirements for medical assistance payments under rule parts 9500.0750 to 9500.1080. It is reasonable not to reimburse these costs under any other rule or rules so that the total medical assistance costs for persons in home and community-based services are reflected in the cost of the home and community-based services.

Subpart 5. Other applicable rules. This subpart is necessary to inform interested persons of the standards applicable to home and community-based services. Applying these standards is necessary to protect the health, safety, and well-being of persons with mental retardation who are receiving home and community-based services. It is reasonable to apply these standards to home and community-based services because they govern

comparable services which are provided to other persons throughout the state. It is reasonable to apply the same standards to services provided to persons with mental retardation who are served under the waiver to ensure that at a minimum the same quality services are provided for these persons as are provided for other Minnesotans. Using the same standards eliminates unnecessary promulgation of duplicate standards. The rationale for using existing rules is also given in the statement of need and reasonableness for part 9525.1850.

Item A -It is reasonable to require that homemaker services be provided in compliance with parts 9565.1000 to 9565.1300 because those rule parts contain standards for the general provision of homemaker services.

Item B - It is reasonable to require that day habilitation and training services be licensed by the department because the department is responsible for licensing such services under Minnesota Statutes, sections 245.781 to 245.812 and 252.28, subdivision 2, the Public Welfare Licensing Act.

Item C - It is reasonable to license supported living arrangements (SLAs) for children under parts 9545.0010 to 9545.0260 because these rule parts govern foster care for children and SLAs are designed to provide a family-like environment similar to a foster home.

Item D - It is reasonable to license supported living arrangements (SLAs) for more than four adults under parts 9545.0210 to 9525.0430 because these rule parts govern facilities serving more than four persons with mental retardation. It is reasonable to license SLAs for four or fewer adults under parts 9555.6100 to 9555.6400 because these rule parts govern the provision of adult foster care and SLAs serving four or fewer adults are similar to foster homes.

It is necessary to include additional standards from the child foster care rule parts (9545.0090, item A, 9545.0140; 9545.0180, and 9545.0190, subparts 3 and 5) because the adult foster care rule parts are very general and do not provide adequate protection for persons who qualify for home and community-based services - persons who need the level of care provided by an intermediate care facility. The provisions from the child foster care rule parts were added at the request of the advisory committee and are meant to be used as a temporary measure while the department completes the process of revising the adult foster care rule parts.

Item E - The licensing required for respite care is necessary to ensure that the same quality of care is provided for clients in respite services as is required for longer term home and community-based services. The standards are reasonable because they are consistent with the standards in items C and D. These standards were selected for the reasons given in the rationales for items C and D.

It is reasonable to exempt a person who provides respite care for fewer than 30 days a year from these standards to encourage the use of friends and relatives as respite care providers. Because these persons are not making a living providing respite care services it would unreasonable to require them

to meet the same standards as are required for professional respite care providers. Other reasons for treating these persons differently are given in the rationale for part 9525.1850. This exemption is also consistent with the Public Welfare Licensing Act, Minnesota Statutes, section 245.791 which excludes from the licensing requirements "day care or residential care provided for a cumulative total of less than 30 days in any 12-month period."

Item F - is reasonable to allow the county board to request a variance from compliance with the child foster care rules (parts 9545.0010 to 9545.0260) under the conditions stated in this item to facilitate the development of home and community-based services. Because home and community-based services are similar to but not exactly the same as foster care the county board may find some of the standards do not fit for home and community-based services. As long as the health, safety and development of the clients is not endangered by varying these standards it is reasonable to allow the county board and the provider some flexibility. It is necessary to request the information required in subitems (1) to (3) to enable the commissioner to determine if granting the variance will endanger the health, safety or development of the persons receiving the services. The information requested is similar to the information requested for a variance under the rule parts governing family day care licensing (parts 9545.0315 to 9545.0445). The commissioner is responsible for granting the variance request because the commissioner is responsible for granting the license under parts 9545.0010 to 9545.0260. It is reasonable to require that the variance request be granted or denied within 30 days to facilitate the timely development of services. Thirty days is necessary to enable the commissioner to adequately review the variance request. It is reasonable to allow the county to request reconsideration in case an error is made in denying the request or additional information becomes available at a later date.

Item G is necessary for essentially the same reasons as given in the rationale for item F. The variance process is a county process because the approval of adult foster care is a county function.

9525.1870 PROVIDER CONTRACTS AND SUBCONTRACTS

Subpart 1. Contracts. This subpart is necessary to inform county boards and providers that written contracts between providers and host counties are required if services are to be reimbursed under these rule parts and that these contracts must be developed in accordance with parts 9550.0010 to 9550.0092 which govern the general administration of public social services. It is necessary to establish contract requirements and require county boards and providers to comply with these requirements to promote uniformity and consistency in the contracts developed throughout the state.

The reasonableness of prescribing contracts for services is supported by past department practice. Minnesota Statutes, section 256E.08, subdivision 1, and parts 9550.0010 to 9550.0092, allow county boards to provide community social services directly or by contracting. Parts 9550.0010 to

9550.0092 require that county boards use written purchase of service contracts for purchasing services they do not provide directly. It is reasonable to require contracts because unwritten agreements are more ambiguous and more difficult to enforce. The counties or department will find it easier to enforce the terms of a contract and compel a provider to fulfill its responsibilities when the contract is written. This subpart is, therefore, necessary to enable the county board to ensure that appropriate services are provided and protect the health, rights, and safety of persons with mental retardation.

It is reasonable to require compliance with parts 9550.0010 to 9550.0092 where applicable because these rule parts govern other contracts entered into by the county boards and it is more convenient and efficient to use an existing procedure. Use of the contract requirements in parts 9550.0010 to 9550.0092 also eliminates the need to create an additional set of contract requirements which might conflict with the requirements in parts 9550.0010 to 9550.0092 and create unnecessary confusion.

Special requirements for the provision of home and community-based services make it necessary to require, in addition to the standard contract requirements of parts 9550.0010 to 9550.0092, the inclusion of the information specified in items A to F and the provision in subpart 2. The need for and reasonableness of each of these items is discussed below.

Item A - The number of clients served determines the criteria to be used, under part 9525.1860, subpart 4, to license or approve the service. It is necessary to include this information in the contract because it establishes the minimum and maximum number of clients that the provider can serve without violating the terms of the contract or the provider's license. It is reasonable to include this information in the contract because it enables the department or the county board to easily determine the appropriate criteria to apply to carry out their responsibilities under part 9525.1860, subpart 4.

Items B and C - Part 9550.0090, subpart 2, Item B, requires that individual service plans include goals and objectives. Objectives, by definition (see part 9550.0010, subpart 16) must be measurable. The inclusion of the information specified in items B and C is necessary to insure that the services provided will, in a measurable way, assist the clients in attaining their identified goals and objectives.

In both parts 9525.0015 to 9525.0145 [Emergency] and 9550.0010 to 9550.0092, the department has made a move toward greater accountability for the outcomes of the services provided. Items B and C, which link the services to be provided to the achievement of desired outcomes, are a reasonable means of ensuring that county boards and providers are aware of the need for accountability.

Item D - These rule parts, 9525.1800 to 9525.1930, govern medical assistance reimbursement for home and community-based services. County boards, providers, and subcontractors must comply with these rule parts to qualify for medical assistance reimbursement. It is necessary to include

the information in item D in all contracts, because it ensures that the county board and the provider are aware of and willing to comply with these requirements. Item D is a reasonable means of promoting compliance with these rule parts and enabling the county board to enforce these rules.

Item E - Part 9525.1850, Item E, requires the provision of ongoing training as a condition of receiving medical assistance reimbursement. (The need for and reasonableness of this requirement is discussed in the statement of need and reasonableness for that part.) To meet the requirements of part 9525.1850, item E, the ongoing training must be approved by the case manager. It is necessary to include the information under item E in the contract because it ensures that the provider is aware of this obligation and it ensures that the case manager will have an opportunity to review and approve the proposed ongoing training prior to the county board's signing of the contract. This is a reasonable means of ensuring that the ongoing training requirements are met without creating an entirely separate review and approval process.

Item F is necessary to enable the county board to meet the requirements in its agreement with the state. It is reasonable to include in the provider's contract any actions the provider must take to assist the county in complying with the agreement to ensure that the provider is aware of these responsibilities and has a legal obligation to cooperate with the county board.

Subpart 2. Required provision. The required contract provision is needed to legally enforce the concepts and principles stated in subpart 1, above. The requirement that the department be a third party beneficiary to the contract is necessary to enable the department to legally enforce the contract if the county lacks the necessary resources or ability to do so. It is reasonable for the department to be able to enforce the contract because the department is accountable to the federal government for the appropriate expenditure of medical assistance funds under the waiver. Also under the Mental Retardation Act, Minnesota Statutes, Chapter 252A, the department is accountable for the protection of persons with mental retardation. To fulfill these responsibilities the department must be able to enforce the contract. It is reasonable for this provision to be included in all contracts because it provides notice to the provider of the department's status.

Subpart 3. Subcontracts. The term "subcontractor" means one who has contracted with the original contractor (in this case, the provider) for the performance of all or a part of the work or services included in the original contract. See Black's Law Dictionary, Fifth Edition, West Publishing Company, St. Paul, 1979, at p. 294. Therefore, it is reasonable that the terms of the subcontract meet all the applicable requirements of the original contract (in subpart 1) under the law of contracts, as provided in Items B and C. The requirement in Item A that the provider have written permission from the host county to subcontract is necessary to inform the host county that not all services are being provided directly by the contractor. The host county needs to know if a subcontractor is used so that the host county can determine if the subcontractor meets the rule requirements and

therefore if the provider is meeting the requirements of the original contract.

Subpart 4. Noncompliance. This subpart is necessary to clarify that the county board (not the department) is responsible for matters of provider noncompliance, and to facilitate the orderly implementation of the rule parts. A mechanism for enforcing compliance with parts 9525.1800 to 9525.1930 is necessary to fairly and consistently apply the rule parts, and to protect the health, rights, and safety of persons with mental retardation. County responsibility for enforcing the contracts and a county's authority to delegate responsibilities in accordance with established county board policies are consistent with a county board's responsibilities in providing social services under Minnesota Statutes, section 256E.08, subdivision 1, and parts 9550.0010 to 9550.0092. See also Minnesota statutes, chapter 393 (County Welfare Board) and 402 (Human Services Act).

The 30-day requirement for notifying the commissioner is necessary to protect the health, rights, and safety of persons with mental retardation and to keep the commissioner informed of potential breaches of contract to which the department is a third party beneficiary. The 10-day notice when the provider fails to take corrective action is a reasonable way to keep the commissioner informed of the provider's and the county's actions so that the commissioner will know when to intervene as a third party beneficiary. Because the commissioner is responsible for protecting persons with mental retardation under the Mental Retardation Protection Act, Chapter 252A, it is necessary that the commissioner be informed when services are not being provided in accordance with the provider's contract.

9525.1880 COUNTY PROPOSAL AND APPROVAL OF COUNTY PROPOSAL

This part is necessary to inform the county board of the requirements for proposals to provide home and community-based services. Participation in the home and community-based services waiver is a county option. For the department to determine which counties are interested in participating in the program and to what extent, it is reasonable to have each county board that is interested in providing home and community-based services submit a proposal.

Subpart 1. Application forms and deadlines. This subpart is necessary to inform the county boards that there will be prescribed deadlines and forms for the submittal of proposals. It is reasonable for the commissioner to prescribe the forms to make it easier to compare the proposals submitted when determining how to allocate the money for home and community-based services. It is reasonable for the commissioner to set a deadline for submittal of proposals so that all proposals are received in time for the commissioner's review and can be given equal consideration.

Subpart 2. Contents of county proposal. This subpart is necessary to inform the county boards of the information that must be included in each county proposal. It is reasonable to specify what must be included to promote consistency between proposals and ensure that the commissioner receives

the information needed to determine each county's allocation of diversions and conversions. It is reasonable to base the proposal on individually identified persons to target the limited dollars to persons whose needs have been identified.

The need for and reasonableness of the individual items and subitems in this part is given below.

Item A is necessary to enable the commissioner to determine if the program goals and objectives of the county board comply with the statewide goals of the department. It is reasonable in developing a new program to review the county board program goals and objectives to determine if the program is being developed in a cohesive way in the various parts of the state and if, in general, the program will further the goals of the department.

Item B is necessary to enable the department to determine how many persons each county board expects to provide with home and community-based services so that funds can be allocated in relation to the requests. It is reasonable to request this information from the county board because the county board is responsible for identifying the service needs of the persons for whom the county board is financially responsible under Minnesota Statutes, section 256B.092, subdivision 1 and parts 9525.0015 to 9525.0145 [Emergency]. Also, the costs of providing home and community-based services will vary depending on the factors in subitems (1) to (4). Therefore, in order to determine the county and statewide costs of providing home and community-based services it is necessary to obtain this information.

The information required in subitems (1) and (2) is necessary to enable the commissioner to determine if the proposal is consistent with the goals of the department listed in subpart 3. For example, the commissioner must know how many children are to be served and their current living arrangements to determine if the proposal will reduce the number of children in state-operated ICFs/MR. It is also necessary to identify the client's current living arrangement to determine if the client is considered a diversion or a placement for the purposes of these rule parts and the waiver.

The information required in subitem (3) is necessary to determine if all of the persons included in the proposal are eligible for home and community-based services. It is reasonable to request this information in the proposal to avoid allocating money for services to ineligible persons.

The information requested in subitem (4) is necessary to enable the commissioner to evaluate the information in item F, and determine whether planning and preparation are based on identified service needs. It is reasonable to request this information because it should be readily available from the proposed clients' individual service plans.

The information requested in subitem (5) is necessary to enable the commissioner to determine when the county board proposes to begin providing home and community-based services and for how long. This information is necessary in determining the appropriate amount to allocate under part 9525.1910, subpart 2.

The information requested in subitem (6) is necessary to enable the commissioner to analyze the cost of providing specific types of home and community-based services and to study the development of home and community-based services in the state. This is a reasonable request because it only asks for information known to the county board. It is reasonable for the commissioner to collect this data so that the department can look at alternative ways of allocating home and community-based services dollars and can help to develop cost-effective services.

Items C and D are necessary to enable the commissioner to determine if the proposal complies with the goals of the department as stated in subpart 3, items A and B. It is reasonable to require that the county board consider the Welsch Consent Decree in developing the proposal because home and community-based services are an essential community resource available to the county board to assist the county board in meeting the county utilization targets (see Exhibit H). It is reasonable to encourage county boards to use this resource in order to further compliance with the Welsch Consent Decree and Minnesota Statutes, section 252.291, subdivision 3.

Item E is necessary to enable the commissioner to determine if the proposal complies with the goal of the department stated in subpart 3, item C. It is reasonable to require that the county board consider how the proposal limits the development of new community-based ICF/MR beds and reduces the county's use of existing ICF/MR beds because home and community-based services are an essential resource available to the county board to assist the county board in reducing its use of ICF/MR beds. Reduction of beds is required in Minnesota Statutes, section 252.291. It is reasonable to encourage county actions directed at reducing the use of ICF/MR beds to comply with the statute.

Item F is necessary to enable the commissioner to determine how soon the county board will be able to provide the identified services and whether the proposal complies with the department goal of integrating home and community-based services into the county board's administrative services planning system as required in subpart 3, item D. This item is also necessary to enable the commissioner to more accurately allocate funds under part 9525.1910, subpart 2. To allocate funds the commissioner must determine the total number of days services will be provided to clients. The information in item B, subitems (5) and (6) and item F will aid the commissioner in making this determination.

Subpart 3. Review and approval of proposal. This subpart is necessary to inform the county board and other interested persons of the criteria to be used in approving the county proposals. It is reasonable to list the criteria so that the county board can draft its proposal to meet the criteria , thereby decreasing the need for revisions and resubmissions. Stating the criteria in the rule part ensures that the same criteria will be applied in reviewing each proposal and therefore increases consistency in the approval process.

It is necessary to limit the commissioner's review to proposals submitted in accordance with subparts 1 and 2 to ensure that all of the infor-

mation needed for the approval process is available. It is reasonable to review only proposals submitted within the deadlines and containing the required information to encourage compliance with these requirements.

It is reasonable to approve only proposals that meet the requirements of these rule parts to encourage compliance with the rule parts and ensure that money is not allocated for ineligible persons or providers or to pay for services which are not reimbursable under these rule parts.

It is reasonable to base the approval of the proposals on compliance with department goals to facilitate the development of a cohesive service system which fits into the continuum of services being developed in the state, furthers the goals of the department, fulfills the mandates placed on the department by the legislature and results in a reduction in state-operated ICF/MR beds as required by the court.

The goals in items A, B, and C are reasonable goals to apply to home and community-based services proposals because they are consistent with the direction given to the department by Minnesota Statutes, section 252.291 and with the court imposed mandates in the Welsch Consent Decree. Minnesota Statutes, section 252.291 establishes a moratorium on the development of new ICFs/MR and sets goals for the total number of certified beds in 1983 and 1986. The statute also requires the commissioner to establish "county utilization targets to limit and reduce the number of intermediate care beds in state hospitals and community facilities" and "plans for development of the number and types of services alternative to intermediate care beds."

The Welsch Consent Decree (part III, paragraph 12-15) mandates population reduction targets for persons with mental retardation in state hospitals. These targets require that the state hospital population not exceed 2100 on July 1, 1985 and 1850 by July 1, 1987. In addition paragraph 17 of the Welsch Consent Decree requires that any child admitted to a state institution after September, 1980 not be served in a state hospital for more than one year.

Because Minnesota has a state supervised/county administered system of service delivery it is both reasonable and necessary to involve the county boards in the accomplishment of the goals listed in items A to C. It is also reasonable to specifically address these goals in the approval of county proposals for home and community-based services because home and community-based services are alternative services which provide a means to meet the goals.

Item D is a reasonable goal for any services to be administered at the county level because it promotes good management practices. It is particularly applicable for home and community-based services because home and community-based services are part of a continuum of care that includes a array of services administered by the county boards. Some of the services to be funded under these rule parts are, in fact, already available in the counties for other client populations through other funding sources. To avoid unnecessary development of duplicate services it is necessary to integrate home and community-based services into the county board's administrative services planning system.

To provide the county board with an opportunity to correct its proposal it is necessary for the commissioner to notify the county board if the proposal is not approved, and inform the county board of the reasons for not approving the proposal. This notification process is consistent with other administrative practices of the department and is a reasonable way to provide for corrective action.

It is necessary to limit the amount of time the county board has for revising the proposal to seven days because all of the proposals must be in before the allocation process can be completed. To give the county board additional time would unduly delay the allocation process. This time frame was contained in the emergency rule parts as published and no negative comments were received. In addition the advisory committee reviewed the deadline and raised no objections.

9525.1890 ALLOCATION OF HOME AND COMMUNITY-BASED SERVICE MONEY

Subpart 1. Allocation of diversions. This subpart is necessary to inform county boards of the method to be used by the commissioner to allocate diversions for the county. The method chosen is reasonable because it correlates the allocation with past patterns of ICF/MR use (historical utilization) and population trends (projected per capita utilization) so that county allocations will have an equitable effect on ICF/MR utilization in the state. This approach is consistent with the standards for proposals and criteria for approval of proposals given in part 9525.1880 and with the methods used to establish utilization targets for state hospitals (see Exhibit H).

It is reasonable to consider historical utilization because the department staff has observed that changes in county historical utilization from year to year tend to reflect the county's need for ICF/MR services. This effect is reflected in the need determination process. Per capita utilization is also an important consideration because the incidence and prevalence of mental retardation is related to general population changes. (See Exhibit I).

It is necessary and reasonable to adjust these projections to conform with the number of diversions projected in the waiver because the department will only receive federal financial participation money for the number of diversions projected in the waiver and no funds have been appropriated by the legislature to fund additional diversions. (The cost savings projected in the waiver are based on serving a limited number of diversions.)

It is reasonable to adjust the projections based on the county board's actual use of diversions the previous fiscal year to avoid allocating diversions where they cannot be used and to enable the department to meet the statewide projections in the waiver.

It is reasonable to base the county board's allocation of money for diversions on the lesser of the number of diversions in the approved county proposal and the number of diversions projected for the county by the com-

missioner because: 1) if the county proposal is for less than the commissioner's projection, using the commissioner's projection would allocate to the county more diversions than the county board planned for; or 2) if the county board's proposal contains more than the number of diversions projected by the commissioner allocating all of the diversions requested might result in an inequitable distribution of diversions throughout the state thereby hindering some of the counties' efforts to comply with the department's goals as stated in part 9525.1800, subpart 3.

Subpart 2. Allocation of placements. This subpart is necessary to inform the county board of the method to be used in allocating placements for the county. It is reasonable to base the number of placements on the number in the approved county proposal because the department wants to encourage county boards to move clients currently in ICFs/MR into home and community-based services and the waiver does not restrict the number of placements that can be made. It is reasonable to consider the extent to which these placements result in an overall reduction in the county board's utilization of state operated and community-based ICF/MR beds because this is consistent with the goals stated in part 9525.1880, subpart 3 and is necessary to comply with the waiver. It is necessary to evaluate the overall reduction in the county board's utilization of state-operated and community-based ICF/MR beds in order to determine if home and community-based services are being used effectively to meet department goals.

Subpart 3. Notification of allocation. This subpart is necessary to inform county boards that they will be notified of their allocation. This notification is necessary so that the county board can adjust its plans to correspond with its allocation. It is reasonable to require notification in writing to provide documentation of the action.

Subpart 4. Review of allocation; reallocation. This subpart is necessary to provide a review process for the commissioner to use to review the use of home and community-based services allocations by the county boards and to adjust the allocations as necessary to maximize the use of home and community-based services. It is reasonable to provide a review and adjustment process because county boards cannot anticipate all of the circumstances that might affect the use of their home and community-based services allocations. Some county boards may find they are unable to use all of their allocated money while other county boards find they could use more than the amount they were allocated. If no adjustments are made, some money may be unused that could be used if reallocated.

It is reasonable to review the projected and actual use of home and community-based services on a quarterly basis and report the findings to the county boards to enable the county boards to adjust the use of their allocation to maximize the benefits to the clients in their county. This information also enables a county board to determine if it will need all of its initial allocation. Based on this information the county board may want to update its proposal.

It is necessary to identify any allocations that will not be used as soon as possible so that if a reallocation is needed it can be made in time for the county board receiving the allocation to adjust its plans to maximize use of the reallocation. It is reasonable for the commissioner to consult with the county board before reducing the initial allocation to

determine if the county board plans to use the initial allocation later in the fiscal year.

It is reasonable to reallocate the unused portion of the county board's initial allocation to another county board in the same geographic area (if possible) to encourage the development of home and community-based services throughout the state rather than concentrating services in one geographic area. In the development of ICF/MR services the geographic location of services was not adequately considered and consequently there is a great deal of variation in the concentration of community ICF/MR services among the geographic areas (see Exhibit I).

It is reasonable to reallocate the use of the unused portion of the allocation to a county board or county boards in the region that plans to start or expand services because these county boards will obviously need the allocation. It is reasonable to reallocate in another geographic region, if the projected service needs in the geographic region are not sufficient to use the unused allocation, for that region, to ensure that the allocation is used to the greatest extent possible.

Subpart 5. Preference given. This subpart is necessary to inform interested persons that preference may be given to certain proposals or parts of proposals. It is reasonable to allow the commissioner to give preference to county proposals from counties which had not previously provided home and community-based services to facilitate the development of services statewide. It is reasonable to encourage the development of services statewide to enable clients to have access to services in or near their family home. Encouraging provision of services in the home community is consistent with past department policy and encourages family involvement as required in rule parts 9510.1020 to 9510.1140 [Emergency] and 9525.0015 to 9525.0145 [Emergency]. It is reasonable to give preference to funding of services for clients previously served in home and community-based services to prevent these clients from being sent back to ICFs/MR due to lack of funding. If funding for clients served in home and community-based services during the previous year is not given preference, county boards will be reluctant to move clients into home and community-based services, providers will be reluctant to provide these services, and clients will suffer from the instability of the program.

Subpart 6. Special projects. This subpart is necessary to enable the commissioner to fund special projects to serve very dependent persons with special needs. It is necessary to establish special projects for this population group because it is difficult for county boards to serve this population group within the statewide average reimbursement rate. It is difficult for county boards to serve this population in a cost effective manner because of the low incidence of the conditions covered under this subpart. Therefore it is reasonable to allow the commissioner the option of establishing statewide programs if necessary to meet the specialized needs of this population.

The authority for this provision is found in Minnesota Statutes, section 256B.501, subdivision 8. The need for this provision was identified by

the department Welsch Compliance Unit and county staff in charge of developing waivered services.

This subpart is limited to special projects designed to serve very dependent persons with special needs who meet the criteria in parts 9525.1820 and 9510.1050, subpart 2, items C and D. The reference to part 9525.1820 is necessary to clarify that the eligibility criteria for home and community-based services also apply to services for persons served under this subpart. The reference to part 9510.1050, subpart 2, items C and D is reasonable because this rule part establishes the client eligibility for a special needs rate exception for an ICF/MR or day training and habilitation service. It is reasonable to use the same client eligibility in these parts to improve consistency between department rules and avoid unnecessary duplication of rule language.

It is reasonable to use the reallocated or reserved funds to provide additional money only to county boards that are unable to fund home and community-based services for this population within the statewide reimbursement rate to prevent unnecessary reallocations. This provision is not meant to substitute for county cost averaging but rather is meant to provide assistance with costs or needs that cannot be handled by the county board.

9525.1900 AGREEMENT BETWEEN STATE AND COUNTY.

Subpart 1. Contents of agreement. This subpart is necessary to notify the county board that it must have a legally binding written agreement with the state in order to receive home and community-based services money and to clarify what must be included in the agreement. It is reasonable to require a written agreement because these services are funded by the medical assistance program. To receive funding from the medical assistance program for other types of medical assistance services, providers must have a written agreement with the state. It is reasonable to apply the same requirements to home and community-based services to promote consistency between department rules.

The county board as the recipient of the funds and the service broker is for the purposes of these rule parts considered the provider. Even if the county board contracts for the provision of the services the county board is responisble for billing the state for the home and community-based services. It is reasonable to have the county board handle billings for home and community-based services to cut down on the number of separate billings submitted (thereby simplifying accounting procedures for the department) and to make it easier for individual providers by enabling them to work with one governmental body instead of two. The need for and reasonableness of the specific provisions follows.

In Items A to I reference is made to other rule parts. It is reasonable to reference the rule parts to avoid unnecessary duplication of language in this rule part and the agreement.

Item A is necessary to clearly establish that the county board agrees to provide services funded under these rule parts only to persons who meet

the criteria in rule parts 9525.1820 and 9525.1830. It is reasonable to limit the use of home and community-based services money to funding services for persons who meet the eligibility criteria to comply with the requirements in the statutes and federal regulations (see statement of need and reasonableness for rule parts 9525.1820 and 9525.1830).

Item B is necessary to clearly establish that the county board agrees to use home and community-based services money only for the reimbursable services described and limited in rule part 9525.1860. It is reasonable to limit the use of home and community-based services money to the services in 9525.1860 because these are the services allowed in the waiver.

Item C is necessary to clearly establish that the county board agrees to use home and community-based service money only to reimburse providers that meet the requirements in rule parts stated. This requirement is necessary to enforce the standards established in rule parts 9525.1850 and 9525.1870. It is reasonable to include this language in the agreement to inform the county board of its responsibilities.

Item D is necessary to clearly establish that the county board agrees to provide services within the limits established in these rule parts. This provision is necessary to maintain the costs of providing home and community-based services within the state budget allocations and the projections in the waiver. It is reasonable to require the county board to agree to this because the county board administers the program and is therefore in the best position to control costs.

Item E is necessary to clearly establish that the county board agrees to keep the records required. This provision is necessary to ensure that all documentation needed to receive federal financial participation is maintained. It is reasonable to include this in the agreement to inform the county board of its responsibilities.

Item F is necessary to clarify that the provision of home and community-based services is governed by parts 9525.0015 to 9525.0145 [Emergency] and to clearly establish that the county board agrees to comply with parts 9525.0015 to 9525.0145 [Emergency]. Parts 9525.0015 to 9525.0145 [Emergency] govern the provision of case management and other services to all persons with mental retardation. Because parts 9525.1800 to 9525.1930 are also designed to serve persons with mental retardation, it is reasonable to require that the county board provide the services governed by these rule parts in accordance with parts 9525.0015 to 9525.0145 [Emergency]. Referencing the rule parts eliminates unnecessary duplication of language.

Item G is necessary to clearly establish that the county board agrees to comply with these rule parts. This provision is necessary to inform the county board of its responsibilities. This provision is necessary to enable the commissioner to enforce the provisions of 9525.1800 to 9525.1930.

Item H is necessary to inform the county board of the Chapter in the statutes that applies to the provision of home and community-based services and to clearly establish that the county board is aware of and agrees to

comply with the statute. This provision is reasonable because the statutes supersede the department rules and the county board should be informed of the statutes affecting these services.

Item I is necessary to inform the county board of the United States Code sections that apply to the provision of home and community-based services and to clearly establish that the county board is aware of and agrees to comply with the code and all regulations promulgated thereunder. It is reasonable to require compliance with the United States Code cited because only services provided in accordance with the code are eligible for federal financial participation. If services are not provided in accordance with the Code, they cannot be funded under the waiver and these rule parts.

Subpart 2. Additional Requirements. This subpart is necessary to specify the other provisions that must be included in the agreement. If the county board provides home and community-based services in addition to case management, it is reasonable to include in the agreement the services to be provided so that the department is informed that the county board is providing these services directly. It is necessary to inform the department of the services provided directly so that the commissioner can determine if the administration of the case management services is separate from the administration of any other service as required in 9525.0035 [Emergency] subpart 4. Separate administration of case management and other services is necessary to prevent potential conflicts of interest.

It is reasonable to include a provision specifying what actions the commissioner may take if the county board fails to comply with these rule parts and the agreement to ensure that the county board is aware of and agrees to these actions. Inclusion of this provision is consistent with standard practices for written contracts and with the contract requirements in part 9525.1870. The commissioner must be able to take the specified actions to curtail unallowable expenses and provide an incentive to comply with the rule parts. The actions listed are consistent with the remedies specified in part 9525.1930. Further justification for these actions is given in the statement of need and reasonableness for part 9525.1930, subpart 1.

9525.1910 COUNTY BOARD FUNDING OF HOME AND COMMUNITY-BASED SERVICES.

This part is necessary to inform the county board of the general standards and limits it must comply with in authorizing and billing for home and community-based services.

Subpart 1. County board responsibility is necessary as an introduction, linking all of the subparts.

Subpart 2. Distribution of money. This subpart is necessary to inform the county board that its allocation of home and community-based services is limited in accordance with the statewide reimbursement rate. It is necessary to limit the county board allocation to enable the department to meet the projections in the waiver. This method of establishing limits was

chosen in order to give the county board flexibility in determining the cost and amount of services to be provided to each client. The department considered establishing per client or per service limits. Per client limits were rejected because client needs vary greatly. Using an average instead of a limit gives the county board the flexibility to fund a higher cost client by offsetting the cost of services to the higher cost client with the cost of services to a lower cost client. Setting per service limits was rejected because many home and community-based services are just getting established and it would be difficult to establish a fair price.

Subpart 3. Rate setting. This subpart is necessary to inform the county board of the host county that the rate setting process and data used to determine the rate must be documented. It is necessary to retain documentation so that the commissioner can determine if the costs meet the criteria in subpart 4, item C. It is necessary for the commissioner to review rates to ensure compliance with Minnesota Statutes, section 256B.501, subdivision 2, which states that "Approved rates shall be established on the basis of methods and standards that the commissioner finds adequate to provide for the costs that must be incurred for the quality care of residents in efficiently and economically operated facilities and services."

Subpart 4. Cost limitations. This subpart is necessary to comply with Minnesota Statutes, section 256B.501, subdivision 2, which states that "the commissioner shall establish procedures and rules for determining rates...[t]he procedures shall specify the costs that are allowable for payment through medical assistance."

No dollar limitation in the amount of home and community-based services money that may be used per client needs to be established for the reasons given in the statement of need and reasonableness for subpart 2. Because no individual limits are established it is necessary to limit total expenditures in accordance with items A and B. It is reasonable to use the total costs for county boards that apply jointly and to use an average based on all clients included in the proposal to give the county boards maximum flexibility and encourage cooperative efforts. The cost criteria in item C are necessary to comply with the requirements in Minnesota Statutes, section 256B.501, subdivision 2. The criteria in subitems (1), (3) and (4) are also used in determining rates for ICFs/MR under 12 MCAR §§ 2.05301-2.05315 [Temporary] and nursing homes under parts 9549.0010 to 9549.0080. Subitem (2) is consistent with the requirement for nursing homes in part 9549.0035 and was added to provide a safeguard against the use of home and community-based services money for services which have not been proven to be effective.

Subpart 5. Assessment for costs which exceed allocation. This subpart is necessary to inform the county board of the possible consequences of not complying with subpart 4, items A and B. It is reasonable to only assess the county board if federal financial participation is denied, disallowed or required to be returned in order to provide the greatest amount of flexibility statewide. It is necessary to assess the cost to the county boards if federal financial participation is denied, disallowed or required to be returned because these county boards are responsible for the total expen-

ditures exceeding the federal requirements. The assessment is necessary to pay for the costs of providing home and community-based services. Only the county boards which exceeded the total allocation are assessed the excess cost to provide an incentive for maintaining county costs within the county board allocation.

9525.1920 REQUIRED RECORDS AND REPORTS

Subpart 1. Provider records. This subpart is necessary to inform providers and subcontractors of the records that they are required to maintain when providing services under these rule parts. It is reasonable to require that the provider and subcontractor maintain complete program and fiscal records and supportive documentation so that the county board and the commissioner can determine if the services as provided meet the standards in parts 9525.1800 to 9525.1930. These records are also needed to determine if the services are "efficiently and economically operated" as required in Minnesota Statutes, section 256B.501. This requirement is consistent with the recording requirements in other department rules such as the rule governing special needs rate exceptions (part 9510.1130, subpart 1).

These records are subject to the maintenance schedule, audit availability requirements, and other provision of parts 9505.1750 to 9505.2150 because home and community-based services are funded under the medical assistance program and parts 9505.1750 to 9505.2150 establish procedures used by the Surveillance and Utilization Review Section of the Department of Human Services for the identification of suspected fraud or abuse in the medical assistance program which apply to all services funded under medical assistance.

Subpart 2. County board records. This subpart is necessary to inform county boards of the records they must maintain when providing services under these rule parts. Requiring complete fiscal records and supporting documentation is necessary to enable the commissioner to determine if the county board is in compliance with these rule parts and the state/county provider agreement. It is necessary to identify the clients served so that the commissioner can determine if the clients meet the eligibility standards in part 9525.1820. The requirements in this subpart are consistent with the requirements in other department rules such as the rule governing funding for semi-independent living services (12 MCAR §§ 2.02001 to 2.02011 [Temporary]). It is reasonable for these records to be subject to parts 9505.1750 to 9505.2150 for the reasons given in the statement of need and reasonableness for subpart 2.

Subpart 3. Availability of records. This subpart is necessary to inform county boards and providers that their records must be available, on request, to the commissioner and the federal Department of Health and Human Services (DHHS). This requirement is necessary to enable the department and DHHS to fulfill their supervisory responsibilities. The rule parts cited are rule parts which apply to all medical assistance funded services.

Subpart 4. Retention of records. It is necessary to inform county boards and providers of the period of time they must retain the records

required in subparts 1 and 2. It is necessary to retain the records to give the department or DHHS sufficient time to audit the records. The retention period stated was chosen to comply with the requirements in parts 9505.1750 to 9505.2150 which governs all services funded by medical assistance.

9525.1930 PENALTIES AND APPEALS.

Subpart 1. Noncompliance. Minnesota Statutes, section 256B.092, subdivision 6, 256B.501, subdivision 2, 256B.502 and 256B.503 provide the commissioner with the authority to establish procedures and rules for administering medical assistance funds for home and community-based services. It is necessary to specify within these rule parts the remedies available to the commissioner for failure to comply with the rule parts to inform county boards, providers, and other affected parties of the possible consequence of noncompliance and provide an incentive to comply with the rule parts.

The consequences selected by the department, and specified in this subpart, are fiscal sanctions, consistent with the contractual remedies specified in part 9525.1870, subparts 2 and 3, and common law remedies available for breach of contract. It is reasonable to impose financial sanctions because the department is ultimately responsible for the funds spent under this program and would be subject to similar sanctions from the United States Department of Health and Human Services if the department violates the Federal Regulations governing the provision of home and community-based services.

In addition, withholding, withdrawing, or requiring repayment of funds are reasonable sanctions to impose for noncompliance because these sanctions provide for retaining or retrieving funds which can be reallocated to support programs that are in compliance. Fiscal sancations are also a reasonable way to ensure that those who do not meet compliance responsibilities do not continue to receive the same advantage (i.e., state and federal reimbursement) as those who meet the compliance responsibilities. Fiscal penalties for noncompliance provide an incentive to county boards and providers to comply with the requirements of these rule parts.

It is reasonable to require the county board to pursue the same contract remedies because the county board is responsible for administering home and community-based services for the commissioner. Because the county board contracts directly with the providers, the county board is also in the best position to enforce the contract. The commissioner, as a third party beneficiary, should only be involved in contract enforcement when the county does not enforce the contract.

It is reasonable to hold the provider liable if a subcontractor violates the contract by failing to comply with these rule parts because the contractor under part 9525.1870, subpart 3, ensures that the subcontractor will meet the initial contract provisions (including compliance with parts 9525.1800 to 9525.1930).

Subpart 2. Exception. This subpart is necessary to clarify that providers who contracted prior to May 1, 1985 shall not be subject to the sanctions under subpart 1 until January 1, 1986. This provision is reasonable because prior to April 23, 1985 (the effective date of the temporary amendments) providers were not subject to the requirements of the rule parts specified under subpart 2.

May 1, 1985 was chosen as the date for implementing the requirements in the temporary amendments in all contracts to allow the county boards time to complete any negotiations that were in process when the temporary amendments took effect. It is reasonable to retain the same time line in the permanent rule parts to promote consistency between the emergency and permanent rule parts and provide a smooth transition for providers who entered into contracts before May 1, 1985.

It is necessary to specify the date on which providers must comply to notify the affected providers so that they can prepare to meet the requirements. January 1, 1986 is a reasonable date on which to require compliance because it coincides with the county fiscal year which is frequently when contracts are renegotiated. The date chosen gives counties and providers eights months to make the transition which should allow them to train staff and obtain the appropriate licenses.

Subpart 3. Appeals by county boards. This subpart is necessary to inform county boards of their right to appeal the commissioner's decision. Inclusion of an appeals process is consistent with the provisions of Minnesota Statutes, section 256B.064. Section 256B.64 governs appeals by medical assistance providers which the county boards are for the purposes of these rule parts. The appeals provision is also consistent with due process rights. Inclusion of an appeals process is reasonable because withholding, recouping, or withdrawing the allocation negatively affects the county board's current finances.

The provisions under this subpart are reasonable because they are consistent with the statutory provisions of Minnesota Statutes, sections 14.57 to 14.63. It is reasonable to use provisions consistent with 14.57 to 14.62 because the county boards are familiar with these provisions and using this procedure is a reasonable way to standardize treatment of appeals.

Thirty days notice by the commissioner is necessary to enable the county board to evaluate the commissioner's decision and determine whether to appeal. It is reasonable to use 30 days notice because this is a standard notice period used in other department rules such as 12 MCAR § 2.02001 to 2.02011 [Temporary] and parts 9525.0015 to 9525.0145 [Emergency]. This time period was also used in the emergency rule parts which these rule parts replace. It is reasonable to retain the same time period to avoid unnecessary confusion about when appeals must be filed.

It is necessary to require the county board to appeal in writing, stating the reasons for the appeal, to facilitate the appeal process and provide evidence of the appeal. This requirement is reasonable because it helps both parties focus on the issues contested, thereby facilitating the resolution of the appeal.

It is reasonable for the commissioner not to take the proposed action before the hearing so that if the appeal is resolved in favor of the county board, the county board will not have been unnecessarily deprived of funding for home and community-based services. It is reasonable to provide an exception to protect the public welfare and the interests of the home and community-based services program because approval of the waiver was based on certain assurances the department made to the United States Department of Health and Human Services. The department could lose federal financial participation and possibly the right to provide home and community-based services under the medical assistance program if the county board does not comply with certain provisions of these rules.

Subpart 4. Appeals by individuals. Minnesota Statutes, section 256.045, subdivision 2, requires that an applicant for social services whose application has been denied, or ...a recipient whose assistance has been suspended, reduced, or terminated be given the opportunity to contest the action or decision. This subpart is necessary to inform county boards and individuals who apply for or receive home and community-based services of this statutory right. It is reasonable to include these provisions in the rule parts governing home and community-based services because the rule parts are more accessible to county boards and other affected parties than the statutes are. Also, the provisions in the rule parts clarify how the statutes apply to home and community-based services.

Item A is necessary to clarify which specific decisions or actions in the administration of home and community-based services are appealable under Minnesota Statutes, section 256.045.

Subitem (1). Part 9525.1830, subpart 2, requires the county board to establish written procedures and criteria for determining whether an eligible individual has met all the conditions required to receive home and community-based services. It is necessary to permit an individual to appeal a decision by the county board where the county board has failed to follow these written procedures because failure to follow the written procedures could result in the improper denial of services. Although the county board is provided a defense to appeal under item B this is only true if the procedures are followed. It is reasonable to require that the county board follow their written procedures so that all applicants are treated consistently. Further justification for requiring written procedures is given in the rationale for part 9525.1830, subpart 1, item E.

Subitem (2). Part 9525.1830, subpart 1, item E, provides for county board authorization of home and community-based services in accordance with goals and objectives specified in the person's individual service plan. Minnesota Statutes, section 256.045, allows for an applicant to appeal the denial of their application. The provision is subitem (2) is consistent with this statutory provision, and clarifies for county boards and affected parties that a "failure to authorize services" is appealable as a denial of service.

Subitem (3). Title 42 of the Code of Federal Regulations, section 431.51, requires states to permit individuals who are recipients of Medicaid

(or Medical Assistance) a "free choice of vendors." Failure to inform an individual of feasible service alternatives precludes the individual making a "free choice." The provisions for appeal under subitem (3), (a) and (b), are necessary to encourage compliance with the federal requirement under title 42 of the Code of Federal Regulations, section 431.51.

Item B. Under part 9525.1830, subpart 1, item A, one of the conditions for receiving home and community-based services is a determination that the county board can provide those services "within its allocation of home and community-based services money." The provision in item B is necessary to clarify that the county board has no obligation to provide home and community-based services beyond its allocation, and that the county board has an absolute defense where it can prove its denial of service was based on inadequate money. This provision is reasonable, because the home and community-based services program is not an entitlement program and only limited funds are available for services under the program.

Item C. This item is necessary to identify the notice, appeal and hearing procedures to be followed when an individual appeals. It is reasonable to reference Minnesota Statutes, section 256.045, because this statute provides detailed procedures for individual social service appeals, and referencing the statute avoids unnecessarily duplication of statutory langauge.

CONCLUSIONS

The foregoing statements address the need and reasonableness of the proposed rule parts 9525.1800 to 9525.1930. To a great extent the need for the rules are prescribed by state statute, federal requirements under the waiver and the inherent responsibility of the Minnesota Department of Human Services to exercise prudent management of public funds.

WITNESSES

The Department will not have outside witnesses testify on its behalf at the public hearing.

Date: July 3, 1985

LEONARD W. LEVINE, COMMISSIONER
DEPARTMENT OF HUMAN SERVICES

EH-01

EXHIBIT A

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

ICE OF THE
COMMISSIONER
612/296-2701

GENERAL
INFORMATION
612/296-6117

MEMORANDUM

DATE: December 8, 1983

TO: MR Title 19 Waiver Steering Committee
McKnight Project Reactor Panel
County Social Service Directors
Chief Executive Officers, State Hospitals
Interested Others

FROM: Margaret Sandberg
Assistant Commissioner
Mental Health Bureau

Phone: 612/297-4284

SUBJECT: Title XIX Waiver for Mentally Retarded Persons

Enclosed is a copy of the final draft of the Department's Title XIX Home and Community Based Waiver Request for Mentally Retarded Persons. This final draft is being distributed to over 200 people who are involved in the delivery of services to the mentally retarded and who have participated in activities related to the development of this waiver application. There are two reasons for this distribution: the first is to acquaint you with the scope of the waiver request and the second is to obtain your input prior to our submission to the Federal Government.

As you know, we are targeting July 1, 1984 as the beginning date for implementation, and we have a considerable amount of preparation work to do to assure a smooth transition into the waivered services models. In addition to our work at the state and local levels, we must have adequate time to work with the Federal Government to gain their approval of the waiver application. It is for this latter reason that we must insist on a shorter than desired turn-around time for your input. Therefore, the deadline for input is December 22, 1983.

When you review the waiver request, please keep the following in mind:

1. This is an application to the Federal Government and is required to be written in their language and format.

2. This is a request and not an implementation plan. The Federal Government has made it clear that each state must decide their

own strategies for implementation so long as they are consistent with the request.

3. The services requested are broad in nature to allow maximum flexibility for system design.

4. There will be a new waiver rate setting rule which is not included in the appendices. Also, the appended rules will be reviewed and revisions made, if necessary.

5. The estimated number of people to be served in ICF/MRs is given in total annual unduplicated figures rather than average daily census. This is a federal requirement of the waiver application and reflects the number of people who "flow through" a facility's beds as opposed to the number of certified beds.

6. The request does not include persons with related conditions. The Department is studying the feasibility of later amending the waiver to include this group. However, all persons who are currently residing in ICF/MRs will be eligible for waivered services.

7. New clients placed from an ICF/MR into a SILS program after the waiver is implemented will be eligible for waiver funding if they meet the waiver criteria and their bed is not refilled. This can be accomplished in one of two ways: conversion of a community ICF/MR to waivered services or replacement of the client by a State Hospital client and decertification of the State Hospital bed.

I have included a form for your comments which covers the major areas of the waiver request. I would appreciate it if you would use only this form as it will expedite our review. Please keep your comments concise.

The Division of Mental Retardation staff will be conducting regional workshops in late February/early March at which time there will be an opportunity for further discussion. Meanwhile, we will again be calling upon you to ask for your assistance in developing and revising rules, policies and procedures for waiver implementation to assure a smooth transition. We value your continued participation.

Finally, I want to express my appreciation to all of you who have worked on this project. We at the Department are very excited about the many opportunities for expanding the service array that this waiver can bring to our mentally retarded citizens. We look forward to working with you on this mutually worthwhile goal.

MS:gj
Enclosures

WAIVER APPLICATION INPUT

Agency: _____

Form Prepared by: Name: _____

Title: _____

I. WAIVERED SERVICES REQUESTED:

II. INDIVIDUAL PLAN OF CARE:

III. HEALTH & WELFARE SAFEGUARDS (LICENSING, ETC.):

IV. ASSESSMENT (LEVEL OF CARE):

WAIVER APPLICATION INPUT (CONTINUED)

V. FINANCIAL ACCOUNTABILITY:

VI. WAIVERED SERVICES DOLLARS (COST PER SERVICE):

VII. WAIVERED SERVICES - NUMBERS OF PEOPLE PER YEAR:

VIII. WAIVERED SERVICES - DISTRIBUTION OF PEOPLE PER SERVICE(S):

Please return to: Cindy G. Becker
Mental Retardation Division
Department of Public Welfare
4th Floor Centennial Building
St. Paul, MN 55155

Mental Retardation Title 19 Waiver Steering Committee

Harold Trende	Carver County
John B. Peterson	West Central Industries/MARF
G. A. Moudry	DLC - Dakota County
Sue Abderholden	ARCMN
Anne Henry	Legal Advocacy
Marcie Jolyn	Honor DFL Caucus
Linda Sutherland	State Planning/DD Program
Joe Zaker	DHS
Pat Senans	Stearns County Social Services
Rolf Herggevick	Fillmore County Social Services
Nancy Feldman	DHS
John Haine	Kandiyohi County
Perry Zimmem	Pipestone County
Donald Sandve	Benton County
Mary Sundy	DHS
Delores Baumhofer	AMC - Human Service Policy Comm.
David W. Stevens	Blue Earth County Commissioner
Larry Odegard	AFSCME Council 6
Robert E. Wren	HCFA
Betty Hubbard	Minn. Committee for the Handicapped
Bev L. Barker	McLeod County
L. Van Klindeworth	Goodhue County
Cal Wunsch	Morrison County
Stephen C. Burke	Wright County
Duane Swansen	Nobles County Family Service
Darryl Meyer	Todd County Social Services

EXHIBIT B

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

HOME AND COMMUNITY-BASED SERVICES

WAIVER REQUEST

PURSUANT TO SECTION 1915(c) OF THE SOCIAL SECURITY ACT

January, 1984

TABLE OF CONTENTS

INTRODUCTION

Over the past two decades, Minnesota has witnessed a major shift in the design and scope of services to the mentally retarded from a primary reliance on large, state operated institutions in the 60's to the development of smaller group home settings in the community in the 70's. This shift was facilitated by the availability of significant federal financial participation under the Title XIX ICF/MR program. The purpose of this waiver request, which was authorized by Congress in Section 2176 of the Omnibus Budget Reconciliation Act and by the 1983 Minnesota Legislature in chapter 312, is to further Minnesota's efforts in developing less restrictive, more normalized services in home and community-based settings for their mentally retarded citizens. This waiver will allow Minnesota to reduce its reliance on traditional long-term care facilities through the development of an array of individually-based services.

Currently, Minnesota has one of the highest number of out-of-home placements in ICF/MR facilities (state and private) in the nation. The provision of waivered services requested in this application will promote community living and integration in the least restrictive environment consistent with individual client needs. Services will be developed to support people to remain in or return to their own homes. For those clients for whom this is not feasible, waivered services will be provided in out-of-home community-based settings. From a fiscal stand point, the effect of the waiver will be the reduction of spiraling long-term care

expenditures and the simultaneous increase in cost-effective alternatives.

ADMINISTRATION OF THE WAIVER

The Department of Public Welfare is the single state agency responsible for the Medical Assistance Program in Minnesota. On a state level, the Bureau of Income Maintenance and Bureau of Mental Health's Division of Mental Retardation within the Department will jointly administer this waiver program. On a local level, there are 87 counties in Minnesota, each of whom is responsible for determining income and service eligibility of clients, program development and monitoring, case management, and contracting for services. The Department is responsible for rule and policy development, assisting and monitoring county programs and distributing and reporting funds available under the waiver.

WAIVERS REQUESTED:

A waiver is requested for a three-year period beginning July 1, 1984 under section 1915(c) of the Social Security Act to provide home and community-based services to mentally retarded individuals who would otherwise require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

A waiver of the statewideness requirements in section 1902(a)(1) of the Act is requested. Even though the State of Minnesota will make waivered services offered under this request available throughout the state, the nature of the population distribution

(rural vs. urban) invariably results in differences in the variety and intensity of services across the state. We, therefore, have not included a list of political subdivisions that would be targeted for the development of waivered services. Rather, we are requesting a waiver of statewideness to assure that the development of home and community-based services occurs in a systematic manner based on sound planning and the capability to develop resources in any given locale.

A waiver of the amount, duration, and scope requirements in section 1902(a)(10) of the Act is requested.

Finally, Minnesota requests the authority under section 1902(a)(10)(A)(ii)(VI) to provide Medicaid services, including home and community-based services requested in this waiver, to those mentally retarded children and adults, who would otherwise be ineligible while living at home because of the SSI deeming rules.

ELIGIBILITY:

Client Eligibility:

Home and community-based services requested in this waiver will only be provided to mentally retarded, Medicaid eligible persons who:

. are currently receiving the level of care provided in an ICF/MR and for whom home and community-based services are determined to be an appropriate alternative, or

. would otherwise require the level of care provided in an ICF/MR in the absence of home and community-based services.

County case managers will determine whether an individual is mentally retarded in accordance with the provisions of the Department of Public Welfare's Rule 185. County financial workers will determine whether an individual is eligible for the Medical Assistance Program pursuant to the existing standards and procedures of the Department of Public Welfare.

Post Eligibility Treatment of Income and Resources:

Minnesota will reduce its payment for home and community-based services provided to eligible individuals in accordance with the provisions of 42 CFR 435.726.

WAIVERED SERVICES:

The State of Minnesota requests that the home and community-based services described below be included under this waiver request. The provision of these services in terms of amount, frequency, and duration will depend on each client's needs.

None of the requested services will be furnished to recipients while they are inpatients/residents of a hospital, SNF, ICF, or ICF/MR.

Federal financial participation for services will not be available in expenditures for the cost of room and board except when provided as part of respite care in an out-of-home setting approved for such purpose.

CASE MANAGEMENT:

Case management is the service responsible for locating, coordinating, and monitoring social, habilitative, medical, and other services, both on a formal and informal basis, to meet the needs of eligible clients and their families. Specifically, case managers will be responsible for client assessment and screening, developing individual service plans, arranging services, coordinating services, monitoring and evaluating client progress/outcome, and assuring that clients' rights are protected. Case management will be the responsibility of the county level of government.

RESPITE CARE:

Respite care services are short-term care provided to an individual due to the absence or need for relief of those persons normally providing the care. The purpose of this service is to maintain the individual in the community and avoid institutionalization. This service may be provided in the individual's home or in an out-of-home setting approved by the county for such purposes. The provision of respite care in terms of amount and location will be based on the individual's needs and include day and overnight services. Respite care services provided under this waiver will include both care and room and board payments, as appropriate.

HOMEMAKER:

Homemaker services are general household activities provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him/herself or others in the home. Homemaker services will be directed toward enabling an individual to remain in his or her home and thus avoid institutionalization. Services include meal preparation, cleaning, simple household repairs, laundry, shopping for food, clothing, and supplies, and other routine household care. In addition to these services, homemakers will provide ongoing monitoring of the individual's well-being, including home safety.

HABILITATION:

Habilitation services are directed towards increasing and maintaining the physical, intellectual, emotional, and social functioning of mentally retarded individuals through the delivery of health and social services in order to avoid institutionalization. Services will be designed to provide assistance, training, supervision, and monitoring, as needed, in the following areas which include but are not limited to: self-care, sensory/ motor development, interpersonal skills, communication, reduction/ elimination of maladaptive behavior, community living and mobility, health care, leisure and recreation, money management and household chores.

Habilitation services will be provided either directly by or under the supervision of a qualified mental retardation professional as

defined in 42 CFR 442.401. In addition to services provided by direct care staff, supportive services in the areas of behavior management, medical, and therapeutic services will by provided by professionals within the scope of their practice.

Respite care and homemaker services may also be provided for clients needing habilitation services. Following is a description of the types of habilitation services to be offered.

I. Residential Habilitation Services:

These services are provided to individuals who cannot be maintained at home or who need outside support in the home.

A. In-Home Family Support Services:

These are habilitation services provided to mentally retarded children and adolescents and their families, including biological and adoptive, in the family's home to enable the child to remain in or return to the home. In-home family support services include training of the child and training of the family to increase their capabilities to care for and maintain the child in their home. Services will be provided by individuals or agencies approved by the State for such purposes.

B. Supported Living Arrangements for Children:

This program involves the provision of habilitation services to mentally retarded children and adolescents who

have severe developmental problems, medical conditions, behavior or emotional problems, and/or physical deficits which result in a family's inability to maintain them in their home. Services will be provided outside of the biological or adoptive homes in family style settings for up to three clients.

C. Supported Living Arrangements for Adults:

This program offers habilitation services to mentally retarded adults who require up to and including 24-hour supervision, assistance, or training due to their lack of adequate self-care skills, medical conditions, behavior or emotional problems, and/or physical deficits. Services will be provided in a client's place of residence, specialized adult foster homes, and group homes for up to six clients.

D. Semi-Independent Living Services:

This program provides habilitation services to adults who require, on an average, less than eight hours a week of supervision, assistance, or training. The services will be directed towards increasing or maintaining a client's skills in self-care, money management, behavior management, community living and mobility, and household management to enable them to live as independently as possible in the community. This program will only be offered as a waivered service to clients who are placed

from an ICF/MR or to those who move from a more supervised waivered setting. These services will be provided in a client's place of residence, specialized adult foster home or group home for up to six clients.

II. Day Habilitation:

This service will only be offered as a waivered service to those individuals who receive at least one residential habilitation service offered under this waiver request. Day habilitation services are directed at the development and maintenance of life skills and community integration. The services include supervision, training, and assistance in the areas of self-care, communication, socialization, use of leisure and recreation time, and behavior management. In addition, these services may include, depending upon client needs and functioning, training in community survival skills, money management, and therapeutic activities designed to increase an individual's adaptive living skills. Day habilitation services will be provided away from an individual's place of residence. The hours of service per day will be based upon client's individual needs and functioning. All day habilitation services will be coordinated with the client's residential habilitation services by the case manager.

Non-medical transportation services will also be provided by day habilitation providers to enable individuals to par-

ticipate in these services. This is particularly critical in Minnesota where people are dispersed geographically and may need to travel significant distances between their residential and day program sites.

Reimbursement for day habilitation services will not include vocational rehabilitation services as defined in the Vocational Rehabilitation Act.

In addition to the services described above, Minnesota will offer one other home and community-based service:

MINOR PHYSICAL ADAPTATIONS TO THE HOME:

Minor physical adaptations to the home will be used to enable some mentally retarded individuals with mobility problems, sensory deficits, and/or behavior problems to be maintained in their home. Under this waiver request, home includes a client's place of residence whether it be in their own home, their family's, or an out-of-home residential setting which provides habilitation services. These adaptations will enable clients with mobility and sensory deficits to access and utilize their home from the outside and inside through the addition of such things as wheelchair ramps and handrails. For clients with behavior problems such as property destruction and aggression, adaptations will afford the client and others increased protection through such additions as shatter-proof windows. An average of $3,000 (with annual inflationary increases) per eligible individual will be reimbursed for this category of service. This is clearly a cost-effective alternative when compared to the average ICF/MR cost.

INDIVIDUAL PLAN OF CARE:

An individual written plan of care will be developed by qualified individuals for each recipient covered under this waiver. This plan of care will describe the services to be furnished, their frequency, and the type of provider who will furnish them. The plan of care will be subject to the approval of the State Medicaid agency. Following is a description of the plan of care and qualifications of the individual responsible for developing it.

The development and implementation of a client's Individual Plan of Care is a two level system in Minnesota consisting of the Individual Service Plan and Individual Program Plan. The Individual Service Plan is a comprehensive document developed by the county which describes the residential, day, and support services necessary to meet a client's individual needs. The Individual Program Plan is a detailed plan developed by the service provider setting forth both short-term and long-term goals with detailed methods for achieving movement toward the Individual Service Plan.

Contents of the Individual Service Plan:

Determination of intellectual functioning and programming implications by a psychologist licensed in the State of Minnesota

Adaptive behavior assessment and programming implication

Prenatal, birth, and early development history

Family History and assessment

Medical/health assessment

School reports, as appropriate

Psychiatric evaluation, if indicated by other reports

Vocational evaluation reports, as appropriate

Observations and interviews about the family and the environment

Behavioral assessment

Identification of client's needs and strengths

Identification of services needed in intensity, frequency, and duration and priorities for service delivery.

Contents of the Individual Program Plan:

Description of services to be delivered including intensity, frequency, duration, location, and person(s) responsible for the service

Specific and time-limited objectives for the client in each service area

Time frames for review and evaluation

Identification of needed medical and support services and/or equipment

Qualifications of Persons Responsible for Developing the Individual Plan of Care:

The Individual Service Plans for clients receiving waivered services will be developed by a case manager employed by the County Board's Local Social Service Agency. The Local Social Service

Agency is the local agency designated and authorized by the County Board to be responsible for the delivery of social services. Case managers must have at least a bachelor's degree and experience in a field related to the treatment and care of persons who are mentally retarded. The Individual Service Plans are developed with the cooperation and involvement of the client, parents, relative or guardian. The case manager coordinates the acquisition of the necessary material/input for completion of the plan.

Individual Program Plans, on the other hand, include all of the above people along with relevant service provider staff. At this level, a qualified professional employed by the provider coordinates the necessary material/input.

ASSURANCES:

The Minnesota Medicaid agency provides the following assurances to HCFA:

Safeguards

Necessary safeguards will be taken to protect the health and welfare of the recipients of the services. Those safeguards include adequate standards for provider participation. All State licensure or certification requirements for services or for individuals furnishing services provided under the waiver will be met.

A description of the safeguards is as follows:

Standards governing the provision of home and community-based services requested under this waiver can be found in Appendix A.

Counties will be responsible for contracting for all waivered services. Using state standards, all waivered services will be licensed or otherwise approved on an annual basis by county or state personnel. In addition, ongoing monitoring of services will be done by county staff.

Financial Accountability

The State assures HCFA that it will maintain and require providers of waivered services to maintain financial accountability for funds expended for these services. Providers of waivered services will be required to submit the same information elements required for all other Medicaid providers for reimbursement. Furthermore, these providers of waivered services will be required to maintain records for a five-year period and will adhere to the current surveillance and utilization regulations adhered to by all other Medicaid providers of services.

Federal and state expenditures will be processed and monitored through the Minnesota Welfare Information System, an approved MMIS. Waivered services will be identified by separate and distinct procedure codes and all information on services provided will be client-specific to provide adequate documentation and an audit trail.

The State assures HCFA that it will make available to HHS, the Comptroller General, or their designees', appropriate financial records documenting the cost of services provided under the waiver.

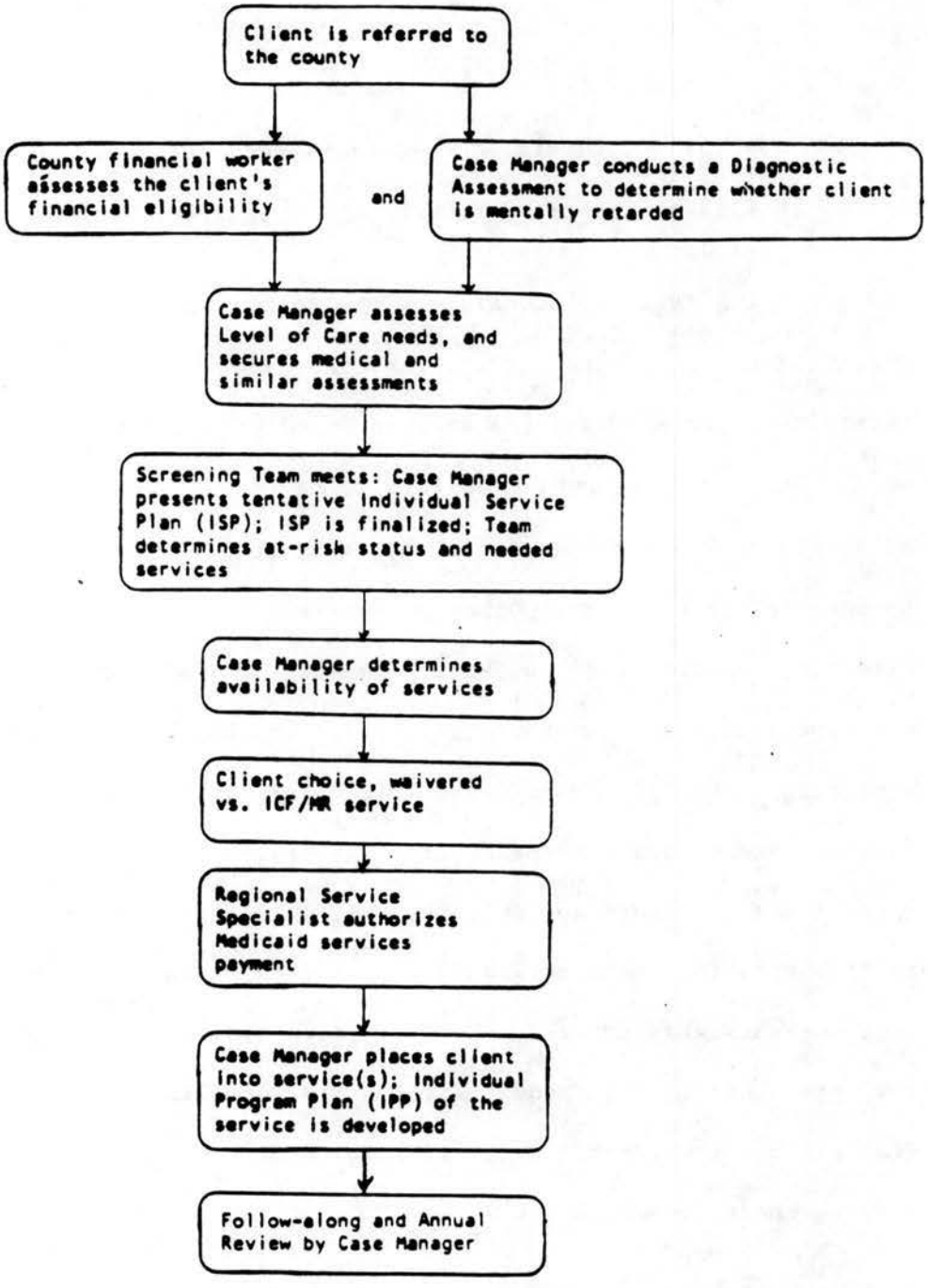
Individual Assessments

The state agency will provide for an evaluation of the need for home and community-based care for recipients who are entitled to the level of care provided in an ICF/MR, as defined by 42 CFR 440.150, and for whom there is a reasonable indication that they might need such services in the near future. Minnesota Statutes, section 256B.092, subdivision 7, directs each county agency to establish a screening team to carry out this responsibility.

The screening team will consist of the county case manager, the client, the client's parents or guardian, and a qualified mental retardation professional (as defined in 42 CFR 442.401) assigned by the Department of Public Welfare. The case manager will consult with the client's physician or other persons, as necessary, to make this evaluation. Other persons may be invited to the screening team meeting; however, no member of the team may have any direct or indirect provider interest in the client's case. The screening team will review diagnostic data; health, social, and developmental assessment data using the instrument in Appendix B and information contained in the client's Individual Service Plan as the basis for their evaluation. The flow chart on the next page outlines this process. Re-evaluation will be coordinated by the case manager on an annual basis. The screening team will re-evaluate a client when the client's level of care and associated service needs change.

Written documentation of all evaluations and re-evaluations will be maintained by the county case manager for four years.

WAIVERED SERVICES FLOWCHART



Informing Beneficiaries of Choice

If a recipient is determined to be likely to require the level of care provided in an ICF/MR, the recipient or his or her representative will be informed of the feasible alternatives, if any, available under the waiver, and permitted to choose among them. The agency will provide for a fair hearing as specified under 42 CFR Part 431, subpart E, for any recipient who is denied the service of his or her choice available under the waiver or under the plan.

Average Per Capita Expenditures

The average per capita expenditures under the waiver will not exceed the average per capita expenditures for the level of care provided in an ICF/MR that would have been made had the waiver not been granted as demonstrated below. The worksheets for waivered services and ICF/MRs can be found in Appendix C.

Explanation of Terms for Cost-Effectiveness Equation:

$$\frac{(A \times B) + (C \times D)}{F + H} \leq \frac{(F \times G) + (H \times I)}{F + H}$$

"A": Figures used represent the estimated total annual unduplicated number of ICF/MR recipients less the number of recipients of waivered services. See "F" for additional explanation.

"B": These figures are the estimated average annual cost per client in "A". See "G" for additional explanation. These costs will be closely monitored as clients are placed into waivered services. Amendments to this waiver will be submitted if these costs significantly change.

"C": These figures were based upon three factors:
(1) Projected diversions which were derived from the number of new ICF/MR beds which were formally requested and subsequently denied through the Department's need deter-

mination process which is a prerequisite to a certificate of need. Denial of these new beds was predicated on the implementation of the waiver. (See Appendix C for additional detail.)

(2) Reduction of the State Hospital population and subsequent decertification of beds. Minnesota projects that the provision of waivered services will accelerate our past experience with returning people to the community.

(3) Reduction of the number of community ICF/MR clients and subsequently beds through the placement of clients into lesser restrictive waivered services and conversion of small ICF/MRs to waivered services programs.

The distribution of clients (see Appendix C) was based on professional projections using such indicators as respite admissions, past placements, and informal and formal needs assessments.

"D": Estimated average Medicaid payment for "C". While Minnesota does not have much experience in providing alternatives to ICF/MR level of care on a statewide basis, we projected these costs based upon similar models which have been operating in various local communities.

"F": These figures represent the estimated total annual unduplicated number of ICF/MR recipients. The figures were calculated by multiplying the projected average monthly client case load for each fiscal year by 1.166. The factor of 1.166 is the factor resulting from dividing the actual unduplicated count of 7,401 in FFY 82 (HCFA 2082) by the actual average monthly client case load of 6,347 for the same period.

"G": These figures represent the projected average annual payment per each ICF/MR recipient. These cost projections were based upon compliance with federal court orders governing the deinstitutionalization of state hospitals, historical case load and costs increases for ICF/MR recipients, and providing daytime training and habilitation for ICF/MR recipients.

"H": There are no recipients who will be receiving noninstitutional long-term care services as an alternative to institutional care under the state plan.

"I": There are no costs in this area.

Cost-Effectiveness Equation

$$\frac{(A \times B) + (C \times D)}{F + H} \leq \frac{(F \times G) + (H \times I)}{F + H}$$

FY '85

$$\frac{(7{,}919 \times \$27{,}523) + (465 \times \$16{,}792)}{8{,}384} \leq \frac{(8{,}384 \times \$27{,}523) + (0)}{8{,}384}$$

$$\frac{\$217{,}954{,}637 + \$7{,}808{,}280}{8{,}384} \leq \frac{\$230{,}752{,}832}{8{,}384}$$

$$\frac{\$225{,}762{,}917}{8{,}384} \leq \frac{\$230{,}752{,}832}{8{,}384}$$

$$\$26{,}928 \leq \$27{,}523$$

FY '86

$$\frac{(7{,}583 \times \$29{,}505) + (1{,}010 \times \$18{,}708)}{8{,}593} \leq \frac{(8{,}593 \times \$29{,}505) + (0)}{8{,}593}$$

$$\frac{\$223{,}736{,}415 + \$18{,}895{,}080}{8{,}593} \leq \frac{\$253{,}536{,}465}{8{,}593}$$

$$\frac{\$242{,}631{,}495}{8{,}593} \leq \frac{\$253{,}536{,}465}{8{,}593}$$

$$\$28{,}235 \leq \$29{,}505$$

FY '87

$$\frac{(7{,}138 \times \$31{,}509) + (1{,}665 \times \$20{,}458)}{8{,}803} \leq \frac{(8{,}803 \times \$31{,}509) + (0)}{8{,}803}$$

$$\frac{\$224{,}911{,}242 + \$34{,}062{,}570}{8{,}803} \leq \frac{\$277{,}373{,}727}{8{,}803}$$

$$\frac{\$258{,}973{,}812}{8{,}803} \leq \frac{\$277{,}373{,}727}{8{,}803}$$

$$\$29{,}419 \leq \$31{,}509$$

Summary of Cost Effectiveness Equation:

	FY '85	FY '86	FY '87
A = Estimated number of ICF/MR recipients	7,919	7,583	7,138
B = Estimated average annual Medicaid payment for A	$27,523	$29,505	$31,509

C = Estimated home and community-based care recipients with the waiver	465	1,010	1,665
D = Estimated average annual Medicaid payment for C	$16,792	$18,708	$20,458
F = Estimated number of ICF/MR recipients without the waiver	8,384	8,593	8,803
G = Estimated average annual Medicaid payment for F	$27,523	$29,505	$31,509
H = Estimated number of noninstitutional service recipients without waiver	0	0	0
I = Estimated average annual Medicaid payment for H	$ 0	$ 0	$ 0

The numbers of recipients provided above are estimated total annual unduplicated totals. The dollars reflect the estimated average annual cost per recipient.

Medical Care

The quality of medical care necessary for the individual will be maintained under the arrangements contemplated.

Annual Report on Impact

The agency will provide HCFA annually with information on the impact of the waiver on the type, amount, and cost of services provided under the State plan and on the health and welfare of recipients. The information will be consistent with the data collection plan designed by HCFA.

CT-B

APPENDIX A

Safeguards

CLIENT SCREENING AND TRACKING
INITIAL INFORMATION

CASE NUMBER IN CSIS _____ REFD BY _____ MR KEY NUMBER _____

CLIENT LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

MA IDENTIFICATION NUMBER _____ SEX [M] [F] BARD OF COMMISSIONER? [Y] [N]

DATE OF CLIENT'S BIRTH 19 [Y Y] / [M M] / [D D] COUNTY OF FINANCIAL RESPONSIB _____ COUNTY OF ACTUAL RESIDENCE _____ COUNTY OF CASE MANAGEMENT RESPONSIB _____ CSIS CASE STATUS _____

NAME OF CASE MANAGER _____ WORKER NUMBER _____

PERSON AUTHORIZED TO SIGN FOR CLIENT [C] CLIENT [P] PARENT NAME OF PERSON IF OTHER THAN CLIENT OR PARENT _____

DSM III DIAGNOSTIC CODES PRIMARY _____ SECONDARY _____ TERTIARY _____

GENERAL LEVEL OF FUNCTION
CHECK ONE
- [1] NOT MENTALLY RETARDED
- [2] BORDERLINE OR ABOVE
- [3] MILDLY RETARDED
- [4] MODERATELY RETARDED
- [5] SEVERELY RETARDED
- [6] PROFOUNDLY RETARDED
- [7] MR, LEVEL NOT SPECIFIED
- [8] NOT KNOWN WHETHER RETARDED

MEDICAL NEEDS
CHECK ONE
- [1] GENERALLY HAS NO SERIOUS MEDICAL NEEDS
- [2] NEEDS REGULAR VISITS FROM NURSE OR VISITS TO DOCTOR
- [3] NEEDS TO HAVE NURSE ON SITE DAILY BUT NOT CONSTANTLY
- [4] NEEDS MEDICAL PERSONNEL ON SITE AT ALL TIMES

VISION FUNCTION WITH CORRECTION IF USED
- [1] FULL VISION
- [2] DIFFICULTY AT LEVEL OF PRINT
- [3] DIFFICULTY WITH OBSTACLES
- [4] HAS NO USEFUL VISION

PERSONAL MOBILITY STATUS
- [1] NO IMPAIRMENT IN MOBILITY
- [2] IMPAIRED BUT MOBILE
- [3] NOT INDEPENDENTLY MOBILE

COMMUNICATION
CHECK HIGHEST APPLICABLE NUMBER
- [1] SPEECH EASILY UNDERSTOOD
- [2] SPEECH DIFFICULT TO UNDERSTAND
- [3] USES SIGN LANGUAGE
- [4] USES GESTURES AND/OR SOME SIGNS
- [5] HAS NO FUNCTIONAL COMMUNICATION

TOILETING COMPETENCE
- [1] HAS FULL CONTROL BOWEL AND BLADDER
- [2] OCCASIONAL LOSS OF CONTROL IN DAY
- [3] INCONTINENT OR FREQ LOSS OF CONTROL

HEARING FUNCTION WITH AID IF ONE IS USED
- [1] FULL HEARING
- [2] DIFFICULTY AT LEVEL OF CONVERSATION
- [3] DIFFICULTY WITH ALARM SOUNDS
- [4] NO USEFUL HEARING

SEIZURE STATUS
CHECK HIGHEST APPLICABLE LEVEL
- [1] NO HISTORY OF SEIZURES
- [2] SEIZURES, CURRENTLY CONTROLLED
- [3] MINOR SEIZURES 1 TO 10 PER MONTH
- [4] MAJOR SEIZURES 1 TO 10 PER YEAR
- [5] MAJOR SEIZURES MORE THAN 10/YR

CEREBRAL PALSY STATUS
CHECK HIGHEST APPLICABLE NUMBER
- [1] NO MANIFESTATIONS OF CEREBRAL PALSY
- [2] CP WITH MINOR FUNCTIONAL IMPAIRMENT
- [3] CP FEEDS SELF SPEECH INTELLIGIBLE
- [4] CP IS FED OR SPEECH UNINTELLIGIBLE

IS THIS PERSON CAPABLE OF INDEPENDENT SELF-PRESERVATION IN THE EVENT OF AN EMERGENCY? [Y] [N]

MALADAPTIVE BEHAVIORS ... TYPE, FREQUENCY, AND INTENSITY

TYPE OF BEHAVIOR	ENTER HIGHEST APPLICABLE CODE FREQUENCY	INTENSITY
INJURIOUS TO SELF		
INJURIOUS TO OTHERS		
DESTRUCTIVE OF PROPERTY		
BREAKS RULES AND LAWS (EG RUNNING AWAY, SUBSTANCE ABUSE, FIRE SETTING, COERCIVE SEXUAL BEHAVIOR)		
EMOTIONAL DISTURBANCE (EG MOOD SWINGS, PHOBIAS, DELUSIONS, THREATENED OR ATTEMPTED SUICIDE)		
DISTURBED ORIENTATION TO PERSONS (EG EXCESSIVE TEASING, TEMPER OUTBURSTS, NON COMPLIANCE)		
DISTURBED ORIENTATION TO OBJECTS (EG TWIRLING, PICA, MOUTHING OBJECTS, RUMINATING)		

FREQUENCY CODES
- 0 LESS THAN ONCE PER YEAR
- 1 MORE THAN ONE/YEAR LESS THAN ONE/MONTH
- 2 MORE THAN ONE/MONTH LESS THAN ONE/WEEK
- 3 MORE THAN ONE/WEEK LESS THAN ONE/DAY
- 4 MORE THAN ONE/DAY LESS THAN ONE/HOUR
- 5 MORE THAN ONE EPISODE PER HOUR
- 6 MORE THAN ONE/MINUTE OR CONSTANTLY

INTENSITY CODES
- 0 DOES NOT DO THIS OR IT IS NOT A PROBLEM
- 1 NUISANCE BUT DOES NOT INTERFER WITH PROGRAMMING
- 2 INTERFERES WITH OWN PROGRAM ONLY
- 3 DISRUPTS MORE THAN ONE BUT NOT THE ENTIRE GROUP
- 4 DISRUPTS THE ENTIRE GROUP OR UNIT
- 5 DISRUPTS AN ENTIRE CENTER OR FACILITY PROGRAM
- 6 REQUIRES IMMEDIATE MEDICAL ATTENTION OR INTERVENTION TO PREVENT HARM TO SELF OR OTHERS

CLIENT SCREENING AND TRACKING
INITIAL INFORMATION

CASE NUMBER IN CSIS _____ REPD BY _____ MR KEY NUMBER _____

CLIENT LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

MA IDENTIFICATION NUMBER _____ SEX [M] [F] BARD OF COMMISSIONER? [Y] [N]

DATE OF CLIENT'S BIRTH 9 Y Y / M M / D D

COUNTY OF FINANCIAL RESPONSIB _____

COUNTY OF ACTUAL RESIDENCE _____

COUNTY OF CASE MANAGEMENT RESPONSIB _____

CSIS CASE STATUS _____

NAME OF CASE MANAGER _____ WORKER NUMBER _____

PERSON AUTHORIZED TO SIGN FOR CLIENT [C] CLIENT [P] PARENT NAME OF PERSON IF OTHER THAN CLIENT OR PARENT _____

DSM III DIAGNOSTIC CODES PRIMARY _____ SECONDARY _____ TERTIARY _____

GENERAL LEVEL OF FUNCTION
CHECK ONE

1. NOT MENTALLY RETARDED
2. BORDERLINE OR ABOVE
3. MILDLY RETARDED
4. MODERATELY RETARDED
5. SEVERELY RETARDED
6. PROFOUNDLY RETARDED
7. RR, LEVEL NOT SPECIFIED
8. NOT KNOWN WHETHER RETARDED

MEDICAL NEEDS
CHECK ONE

1. GENERALLY HAS NO SERIOUS MEDICAL NEEDS
2. NEEDS REGULAR VISITS FROM NURSE OR VISITS TO DOCTOR
3. NEEDS TO HAVE NURSE ON SITE DAILY BUT NOT CONSTANTLY
4. NEEDS MEDICAL PERSONNEL ON SITE AT ALL TIMES

VISION FUNCTION WITH CORRECTION IF USED
CHECK ONE

1. FULL VISION
2. DIFFICULTY AT LEVEL OF PRINT
3. DIFFICULTY WITH OBSTACLES
4. HAS NO USEFUL VISION

PERSONAL MOBILITY STATUS
CHECK HIGHEST APPLICABLE NUMBER

1. NO IMPAIRMENT IN MOBILITY
2. IMPAIRED BUT MOBILE
3. NOT INDEPENDENTLY MOBILE

COMMUNICATION
CHECK HIGHEST APPLICABLE NUMBER

1. SPEECH EASILY UNDERSTOOD
2. SPEECH DIFFICULT TO UNDERSTAND
3. USES SIGN LANGUAGE
4. USES GESTURES AND/OR SOME SIGNS
5. HAS NO FUNCTIONAL COMMUNICATION

TOILETING COMPETENCE
CHECK HIGHEST APPLICABLE NUMBER

1. HAS FULL CONTROL BOWEL AND BLADDER
2. OCCASIONAL LOSS OF CONTROL IN DAY
3. INCONTINENT OR FREQ LOSS OF CONTROL

HEARING FUNCTION WITH AID IF ONE IS USED
CHECK ONE

1. FULL HEARING
2. DIFFICULTY AT LEVEL OF CONVERSATION
3. DIFFICULTY WITH ALARM SOUNDS
4. NO USEFUL HEARING

SEIZURE STATUS
CHECK HIGHEST APPLICABLE LEVEL

1. NO HISTORY OF SEIZURES
2. SEIZURES, CURRENTLY CONTROLLED
3. MINOR SEIZURES 1 TO 10 PER MONTH
4. MAJOR SEIZURES 1 TO 10 PER YEAR
5. MAJOR SEIZURES MORE THAN 10/YR

CEREBRAL PALSY STATUS
CHECK HIGHEST APPLICABLE NUMBER

1. NO MANIFESTATIONS OF CEREBRAL PALSY
2. CP WITH MINOR FUNCTIONAL IMPAIRMENT
3. CP NEEDS SELF SPEECH INTELLIGIBLE
4. CP IS FED OR SPEECH UNINTELLIGIBLE

IS THIS PERSON CAPABLE OF INDEPENDENT SELF-PRESERVATION IN THE EVENT OF AN EMERGENCY? [Y] [N]

MALADAPTIVE BEHAVIORS ... TYPE, FREQUENCY, AND INTENSITY

ENTER HIGHEST APPLICABLE CODE

TYPE OF BEHAVIOR	FREQUENCY	INTENSITY
INJURIOUS TO SELF		
INJURIOUS TO OTHERS		
DESTRUCTIVE OF PROPERTY		
BREAKS RULES AND LAWS (EG RUNNING AWAY, SUBSTANCE ABUSE, FIRE SETTING, COERCIVE SEXUAL BEHAVIOR)		
EMOTIONAL DISTURBANCE (EG MOOD SWINGS, PHOBIAS, DELUSIONS, THREATENED OR ATTEMPTED SUICIDE)		
DISTURBED ORIENTATION TO PERSONS (EG EXCESSIVE TEASING, TEMPER OUTBURSTS, NON COMPLIANCE)		
DISTURBED ORIENTATION TO OBJECTS (EG TWIRLING, PICA, MOUTHING OBJECTS, RUMINATING)		

FREQUENCY CODES

0 LESS THAN ONCE PER YEAR
1 MORE THAN ONE/YEAR LESS THAN ONE/MONTH
2 MORE THAN ONE/MONTH LESS THAN ONE/WEEK
3 MORE THAN ONE/WEEK LESS THAN ONE/DAY
4 MORE THAN ONE/DAY LESS THAN ONE/HOUR
5 MORE THAN ONE EPISODE PER HOUR
6 MORE THAN ONE/MINUTE OR CONSTANTLY

INTENSITY CODES

0 DOES NOT DO THIS OR IT IS NOT A PROBLEM
1 NUISANCE BUT DOES NOT INTERFER WITH PROGRAMMING
2 INTERFERES WITH OWN PROGRAM ONLY
3 DISRUPTS MORE THAN ONE BUT NOT THE ENABLE GROUP
4 DISRUPTS THE ENABLE GROUP OR UNIT
5 DISRUPTS AN ENTIRE CENTER OR FACILITY PROGRAM
6 REQUIRES IMMEDIATE MEDICAL ATTENTION OR INTERVENTION TO PREVENT HARM TO SELF OR OTHERS

CLIENT SCREENING AND TRACKING
SCREENING RECORD

Y Y / M M / D D
DATE OF SCREENING ACTION

COUNTY WHERE SCREENED

MR KEY NUMBER

NAME OF REGIONAL SERVICES SPECIALIST

RSS NUMBER

REPORTS TO (OF SERVICES RECEIVING) AND DECISIONS AND RECOMMENDATIONS OF TEAM

WHAT IS THE LEVEL OF SUPERVISION NEEDED BY THIS PERSON?

- [ ] 1 FULLY INDEPENDENT - NEEDS ONLY PERIODIC MONITORING TO ASSURE THAT PROBLEMS WILL BE MET IF THEY ARISE, BUT OTHERWISE THE PERSON MANAGES HIS/HER OWN AFFAIRS ADEQUATELY
- [ ] 2 SEMI-INDEPENDENT - NEEDS SOME SUPERVISORY STAFF CONTACT AVERAGING LESS THAN EIGHT HOURS PER WEEK BUT DOES NOT REQUIRE LIVE-IN STAFFING
- [ ] 3 MODERATE SUPERVISION - NEEDS STAFF IN DAILY SUPERVISORY CONTACT AT PEAK HOURS AND ON WEEKENDS BUT DOES NOT REQUIRE LIVE-IN STAFFING
- [ ] 4 SUBSTANTIAL SUPERVISION - NEEDS LIVE-IN STAFF ON SITE AT ALL TIMES BUT STAFF NEED NOT BE AWAKE AT NIGHT
- [ ] 5 INTENSIVE SUPERVISION - NEEDS STAFF ON SITE FOR SUPERVISION AND STAFF AWAKE AT ALL TIMES

ASSESSMENT OF SPECIFIC SERVICES NEEDED IN RESIDENTIAL AND/OR DAY PROGRAM

AREA OF FUNCTION	CARE	TRG
SELF CARE		
PERSONAL HYGIENE		
PERSONAL MOBILITY		
COMMUNITY TRANSPORTATION		
SOCIALIZATION AND SOC FUNCTION		
COMMUNICATION		
LEISURE AND RECREATION		
MONEY MANAGEMENT AND BUDGETING		
COMMUNITY LIVING		
HOUSEHOLD MANAGEMENT		
HEALTH AND MEDICAL MANAGEMENT		
INFANT LEVEL STIMULATION		
VOCATIONAL AND PREVOCATIONAL		

IN APPROPRIATE BOXES ABOVE ENTER CODES OF THE HIGHEST LEVEL NEEDED BY THE CLIENT

CARE LEVEL	TRAINING LEVEL
P PHYSICAL ASSIST	M MANUAL GUIDANCE
S SUPERV & CONTROL	D DEMONSTRATION
M MONITORING	V VERBAL
I INDEPENDENT OR APPROPRIAT TO AGE	O DOES NOT NEED TRG IN THIS AREA

RECOMMENDED RESIDENTIAL PROGRAM SETTING
CHECK ONE

- [ ] NATURAL OR ADOPTIVE FAMILY
- [ ] 2 LONG TERM FOSTER PLACEMENT
- [ ] 3 WITH RELATIVES NOT IMMEDIATE FAMILY
- [ ] 4 OWN HOME OR APT FULLY INDEPENDENT
- [ ] 5 OWN HOME OR APT SUPV LESS THAN 24 HOURS
- [ ] 6 OUT OF HOME SUPV LESS THAN 24 HOURS
- [ ] 7 OUT OF HOME SUPERVISED 24 HOURS
- [ ] 8 SKILLED NURSING FACILITY

SUPPORT SERVICES - CHECK THOSE CLIENT IS CURRENTLY RECEIVING, AND THOSE NEEDED

AREA OF SERVICE	RCVG	IN NEEDED
ROUTINE MEDICAL SERVICES OR SPECIALIZED MEDICAL SERVICES		
SPECIALIZED DENTAL SERVICES		
PHYSICAL THERAPY BY PT OR AIDE		
OCCUP THERAPY BY OTR OR AIDE		
LANGUAGE OR SPEECH THERAPY		
MENTAL HEALTH SERVICES		
TRAINING FOR FAMILY MEMBERS		
SPECIAL TRANSPORTATION		
SPECIAL RECREATION		
LEGAL GUARDIAN STATE OR PRIVATE CONSERVATOR		
LEGAL AID SERVICE		
VOLUNTEER INSTRUMENTAL ADVOCATE		
VOLUNTEER EXPRESSIVE ADVOCATE		
TECHNICALLY SKILLED BEHAV MANAGE		
DAY RESPITE SERVICE		
OVERNIGHT RESPITE SERVICE		

RECOMMENDED DAY PROGRAM SETTING
CHECK ONE

- [ ] PRESCHOOL PROGRAM HOME BASED
- [ ] 2 PRESCHOOL PROGRAM CENTER BASED
- [ ] 3 ELEMENTARY SCHOOL PROGRAM
- [ ] 4 SECONDARY SCHOOL PROGRAM
- [ ] 5 POSTSCHOOL TRANSITION PROGRAM
- [ ] 6 DAY HABILITATIVE PROGRAM
- [ ] 7 LONG TERM WORK ACTIVITY
- [ ] 8 LONG TERM SHELTERED EMPLOYMENT IN SWS
- [ ] 9 PROTECTED WORK STATION IN INDUSTRY
- [ ] 10 COMPETITIVE EMPLOY FULL OR PART TIME
- [ ] 11 RETIREMENT PROGRAM
- [ ] 12 OTHER

IENT SCREENING AND TRACKI
MOVEMENT AND STATUS RECORD

Y Y / M M / D D
DATE OF THIS STATUS REPORT

THIS STATUS REPORT IS
[1] INITIAL
[2] SUBSEQ

STATUS MR FLOW

MR KEY NUMBER

Y Y / M M / D D
DATE CLIENT WAS REFERRED TO COUNTY

Y Y / M M / D D
DATE COUNTY DETERMINED WHETHER PERSON IS MENTALLY RETARDED

DID THE COUNTY DETERMINE THAT THIS PERSON IS MENTALLY RETARDED?
[N] END
[Y] CONTINUE

Y Y / M M / D D
DATE SCREENING TEAM MEETING

PERSONS PRESENT AT AND PARTICIPATING IN SCREENING TEAM
CHECK ALL APPLICABLE

- [ ] CLIENT
- [ ] PARENT OR GUARDIAN
- [ ] AUTH ADVOCATE _____
- [ ] OTHER _____
- [ ] OTHER _____
- [ ] COUNTY CASE MANAGER
- [ ] REGIONAL SERVICE SPECIALIST

IS THIS PERSON ELIGIBLE FOR MEDICAID? [Y] [N]

DOES THIS TEAM DETERMINE THIS PERSON TO BE AT RISK OF ICF/MR PLACEMENT? [Y] [N]

CLIENT'S RESIDENTIAL PLACEMENT AT THE TIME OF SCREENING TEAM MEETING
CHECK ONE

- [1] WITH NATURAL OR ADOPTIVE FAMILY
- [2] IN LONG TERM FOSTER CARE
- [3] WITH RELATIVES NOT IMMEDIATE FAMILY
- [4] IN OWN HOME OR APT FULLY INDEPENDENT
- [5] IN OWN HOME/APT SUPV LESS THAN 24 HOURS
- [6] OUT OF HOME SUPV LESS THAN 24 HOURS
- [7] OUT OF HOME SUPERVISED 24 HOURS
- [8] SKILLED NURSING FACILITY
- [9] STATE HOSPITAL

CLIENT'S DAY PROGRAM PLACEMENT AT THE TIME OF SCREENING TEAM MEETING
CHECK ONE

- [1] IN PRESCHOOL PROGRAM HOME BASED
- [2] IN PRESCHOOL PROGRAM CENTER BASED
- [3] IN ELEMENTARY SCHOOL PROGRAM
- [4] IN SECONDARY SCHOOL PROGRAM
- [5] IN POSTSCHOOL TRANSITIONAL PROGRAM
- [6] IN ADULT DAY HABILITATION PROGRAM
- [7] IN LONG TERM WORK ACTIVITY
- [8] IN LONG TERM SHELTERED EMPLOYMENT IS SWS
- [9] IN PROTECTED WORK STATION IN INDUSTRY
- [10] IN COMPETITIVE EMPLOY FULL OR PART TIME
- [11] IN RETIREMENT PROGRAM
- [12] IN OTHER

IDENTIFICATION OF PROVIDERS OF SERVICES, CURRENT AND PLANNED

CURRENT .....
ENTER THE PROVIDER NUMBERS FOR SERVICES BEING PROVIDED AT THE TIME OF THIS MOVEMENT AND STATUS REPORT

PLANNED .....
ENTER THE PROVIDER NUMBERS FOR SERVICES TO BE PROVIDED IN NINETY DAYS IF DIFFERENT FROM FROM CURRENT PROVIDER
USE 0000000 IF THAT TYPE IS TO BE TERMINATED
USE 9999999 IF THE SAME PROVIDER IS TO CONTINUE

_____	..... RESIDENTIAL	_____
_____	..... DAY	_____
_____	..... SILS	_____
_____	..... NAME THE TYPE OF SERVICE	_____
_____	..... NAME THE TYPE OF SERVICE	_____

CLIENT SCREENING AND TRACKING
MOVEMENT AND STATUS RECORD

Y Y / M M / D D
DATE OF THIS STATUS REPORT

THIS STATUS REPORT IS
1 INITIAL
2 SUBSEQ

STATUS MR FLOW

MR KEY NUMBER

Y Y / M M / D D
DATE CLIENT WAS REFERRED TO COUNTY

Y Y / M M / D D
DATE COUNTY DETERMINED WHETHER PERSON IS MENTALLY RETARDED

DID THE COUNTY DETERMINE THAT THIS PERSON IS MENTALLY RETARDED?
N END
Y CONTINUE

Y Y / M M / D D
DATE SCREENING TEAM MEETING

PERSONS PRESENT AT AND PARTICIPATING IN SCREENING TEAM
CHECK ALL APPLICABLE

- ☐ CLIENT
- ☐ PARENT OR GUARDIAN
- ☐ COUNTY CASE MANAGER
- ☐ REGIONAL SERVICE SPECIALIST
- ☐ AUTH ADVOCATE _____
- ☐ OTHER _____
- ☐ OTHER _____

IS THIS PERSON ELIGIBLE FOR MEDICAID? Y N

DOES THIS TEAM DETERMINE THIS PERSON TO BE AT RISK OF ICF/MR PLACEMENT? Y N

CLIENT'S RESIDENTIAL PLACEMENT AT THE TIME OF SCREENING TEAM MEETING
CHECK ONE

1 WITH NATURAL OR ADOPTIVE FAMILY
2 IN LONG TERM FOSTER CARE
3 WITH RELATIVES NOT IMMEDIATE FAMILY
4 IN OWN HOME OR APT FULLY INDEPENDENT
5 IN OWN HOME/APT SUPV LESS THAN 24 HOURS
6 OUT OF HOME SUPV LESS THAN 24 HOURS
7 OUT OF HOME SUPERVISED 24 HOURS
8 SKILLED NURSING FACILITY
9 STATE HOSPITAL

CLIENT'S DAY PROGRAM PLACEMENT AT THE TIME OF SCREENING TEAM MEETING
CHECK ONE

1 IN PRESCHOOL PROGRAM HOME BASED
2 IN PRESCHOOL PROGRAM CENTER BASED
3 IN ELEMENTARY SCHOOL PROGRAM
4 IN SECONDARY SCHOOL PROGRAM
5 IN POSTSCHOOL TRANSITIONAL PROGRAM
6 IN ADULT DAY HABILITATION PROGRAM
7 IN LONG TERM WORK ACTIVITY
8 IN LONG TERM SHELTERED EMPLOYMENT IS SRS
9 IN PROTECTED WORK STATION IN INDUSTRY
10 IN COMPETITIVE EMPLOY FULL OR PART TIME
11 IN RETIREMENT PROGRAM
12 IN OTHER

IDENTIFICATION OF PROVIDERS OF SERVICES, CURRENT AND PLANNED

CURRENT .....
ENTER THE PROVIDER NUMBERS FOR SERVICES BEING PROVIDED AT THE TIME OF THIS MOVEMENT AND STATUS REPORT

PLANNED .....
ENTER THE PROVIDER NUMBERS FOR SERVICES TO BE PROVIDED IN NINETY DAYS IF DIFFERENT FROM FROM CURRENT PROVIDER
USE 0000000 IF THAT TYPE IS TO BE TERMINATED
USE 9999999 IF THE SAME PROVIDER IS TO CONTINUE

_____ ..... RESIDENTIAL ..... _____

_____ ..... DAY ..... _____

_____ ..... SILS ..... _____

_____ ..... _____ .... _____
NAME THE TYPE OF SERVICE

_____ ..... _____ .... _____
NAME THE TYPE OF SERVICE

APPENDIX C

ICF/MR and Waivered Services Worksheets

WAIVERED SERVICES WORKSHEET

"C" NUMBER OF HOME AND COMMUNITY BASED CARE RECIPIENTS UNDER WAIVER

The number of recipients for case management is unduplicated and equals 100% of the clients projected to be served under the waiver. The numbers of recipients for residential habilitation services are also unduplicated and total the number receiving case management. The remaining services are duplicated; for example, a person receiving in-home family services may also receive respite and homemaker services.

The number of clients projected to receive waivered services ("C") was derived as follows:

	FY 85	FY 86	FY 87
Diversions	280	280	280
State Hospital Bed Reductions	135	175	225
Community ICF/MR Bed Conversion	50	90	150
	465	545 *	655 **
		+465	+1,010
		1,010	1,665

* from FY 85
** from FY 85 & 86

"D" ESTIMATED AVERAGE ANNUAL MEDICAID PAYMENT FOR "C"

These costs are based on a combination of statewide experience and individual provider experience for similar programs. Since Minnesota has limited experience in providing alternative services, close attention will be given to the costs during implementation and amendments to this waiver will be made if necessary.

	Number of Recipients		Average Annual Cost		Totals
FISCAL YEAR 1985					
Case Management	465	x	$ 938	= $	436,170
Residential Habilitation					
In-Home Family Support	140	x	7,190	=	1,006,600
Supported Living Arrangements/ Children	93	x	13,333	=	1,239,969
Supported Living Arrangements/ Adults	163	x	15,540	=	2,533,020
Semi-Independent Living Services	69	x	4,725	=	326,025
Day Habilitation	186	x	6,229	=	1,158,594
Respite	221	x	1,500	=	331,500
Homemaker	194	x	3,276	=	635,544
Minor Physical Adaptation	47	x	3,000	=	141,000
				$	7,808,422
				+	465
					16,7[illegible]

INTERMEDIATE CARE FACILITY/MENTAL RETARDATION WORKSHEET

"F" NUMBER OF ANNUAL UNDUPLICATED ICF/MR RECIPIENTS WITHOUT THE WAIVER:

Projected avg. ICF/MR Caseload x 1.166 = Projected Unduplicated ICF/MR Recipient Count

	State Hospital	+	Community ICF/MR		
FY 85	2,060	+	5,130	x 1.166 =	8,384
FY 86	1,960	+	5,410	x 1.166 =	8,593
FY 87	1,860	+	5,690	x 1,166 =	8,803

State Hospital - average caseload

The projections for FY '85, '86, and '87 were based on a decreasing average caseload of 100 clients each year. This is consistent with actual net decreases over the past few years and compliance with the Welsch vs. Levine Consent Decree.

Community ICF/MR - average caseload

The caseload projections were based upon maintaining the FY '84 average monthly caseload of 4,850 and adding 280 clients each year thereafter. The 280 beds is based on the number of additional beds requested and denied by the Department since March 1983. Based on the chart below, the Department feels that this number (280) is also consistent with the number of new community ICF/MR beds opened since July 1978.

Year	# Beds Opened
7/78 - 6/79	209
7/79 - 6/80	302
7/80 - 6/81	414
7/81 - 6/82	247
7/82 - 6/83	262

"G" ESTIMATED AVERAGE ANNUAL MEDICAID PAYMENT OF "F"

I. In State Hospital

a. Base for FY '84
State hospital Medical Assistance expenditures in FY '84 were calculated based upon the average monthly billings (number of recipients) and Medical Assistance expenditures from July 1983 through October 1983.

	Average Monthly Billings	Monthly Cost per Client	Total Costs
FY '84 Base	2,160	$3,611.96	= $93,622,000

b. Projections for FY '85, '86, '87
The projections for FY '85 through FY '87 were based upon increasing the average monthly cost per recipient by 12% per year. This projection is consistent with historical cost increases.

FISCAL YEAR 1986

	Number of Recipients		Average Annual Cost		Totals
Case Management	1,010	x	$ 984	=	$ 993,84
Residential Habiliation					
In-Home Family Support	249	x	7,550	=	1,879,950
Supported Living Arrangements/ Children	202	x	14,093	=	2,846,786
Supported Living Arrangements/ Adults	436	x	16,426	=	7,161,736
Semi-Independent Living Services	123	x	4,961	=	610,203
Day Habilitation	477	x	6,866	=	3,275,082
Respite	450	x	1,575	=	708,750
Homemaker	362	x	3,440	=	1,245,280
Minor Physical Adaptations	55	x	3,150	=	173,250
					18,894,877
				+	1,010
					18,708

FISCAL YEAR 1987

Case Management	1,665	x	1,034	=	1,721,610
Residential Habilitation					
In-Home Family Support	347	x	7,927	=	2,750,669
Supported Living Arrangements/ Children	300	x	14,882	=	4,464,60
Supported Living Arrangements/ Adults	829	x	17,346	=	14,379,834
Semi-Independent Living Services	189	x	5,209	=	984,501
Day Habilitation	891	x	7,399	=	6,539,049
Respite	689	x	1,654	=	1,139,606
Homemaker	516	x	3,612	=	1,863,792
Minor Physical Adaptations	66	x	3,308	=	218,328
					34,061,989
				+	1,665
					20,458

	x Monthly Billings	x Monthly Cost Client	= Total Costs
FY '85	2,060	$4,045.40	$100,002,0
FY '86	1,960	4,530.84	106,565,0
FY '87	1,860	5,074.54	113,264,0

II. Community ICF/MR

a. Projections for FY '85, '86, '87
Average monthly recipient costs were based upon inflating the previous year projection by 5% for the existing caseload, and inflating the previous year projection by 12% for the new caseload (+280) which is consistent with previous increases.

	Average Monthly Billings	x Average Monthly Cost per Client	= Total Residentia Costs
FY '84	4,850	$1,726.73	$100,496,00
FY '85	5,130	1,849.98	113,885,00
FY '86	5,410	1,954.71	126,900,00
FY '87	5,690	2,065.03	141,000,00

b. Day Training and Habilitation
In addition, $7,673,000 will be added to the $100,496,000 for the period January-June 1984 to pay for daytime training and habilitation for residents of community based ICF/MR programs.

The following amounts by fiscal year were added to the residential portion of the ICF/MR budgets to pay for day training and habilitation:

	Day Habilitation
FY '84 (6 mos.)	$ 7,673,000
FY '85	16,867,000
FY '86	20,074,000
FY '87	23,113,000

c. Total Community ICF/MR Costs

	Day Habilitation	plus Residential	= Total Costs
FY '84 (6 mos.)	$ 7,673,000	+ $100,496,000	= $108,169,00
FY '85	16,867,000	+ 113,885,000	= 130,752,00
FY '86	20,074,000	+ 126,900,000	= 146,974,00
FY '87	23,113,000	+ 141,000,000	= 164,113,00

III. Total ICF/MR Costs

When the projected state hospital and community ICF/MR costs (including daytime habilitation) are added, the following total costs result:

	Total ICF/MR Costs
FY '84	$201,791,000
FY '85	230,754,000
FY '86	253,539,000
FY '87	277,377,000

IV. Costs per Recipient

The costs per recipient were calculated by dividing the total projected ICF/MR costs by the projected unduplicated caseload during the same period.

$$\frac{\text{Total Projected ICF/MR Costs}}{\text{number of different recipients}} = \text{Average Annual Cost per recipient}$$

	Total ICF/MR Costs	Unduplicated number of Recipients	Average Cost per Recipient
FY '84	$201,791,000	8,174	$24,687
FY '85	230,754,000	8,384	27,523
FY '86	253,539,000	8,593	29,505
FY '87	277,377,000	8,803	31,509

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

OFFICE OF THE COMMISSIONER
612/296-2701

GENERAL INFORMATION
612/296-6117

PLEASE REPLY TO 612/296-6916

February 23, 1984

Mr. Robert Wren
Division of Provider Services
Department of Health & Welfare
6325 Security Blvd. #405E
Baltimore, Maryland 21207

Dear Mr. Wren:

Pursuant to your conversation with Cindy Becker on February 17, 1984, the following information is being submitted as an addendum to Minnesota's Home and Community-Based Services Waiver Request for Mentally Retarded Persons.

Page 2: Waiver of Statewideness

The State of Minnesota requests a waiver of the statewideness requirements in section 1902(a)(1) of the Social Security Act to enable the home and community based services to be phased in on a voluntary county basis.

Page 3: Client Eligibility

Medicaid eligible clients include persons who are determined to be categorically needy, medically needy, and optional categorically needy.

Page 4: Post Eligibility Treatment of Income and Resources

This section should be deleted since Minnesota is a 209b State.

Page 6: Habilitation

Replace second sentence of first paragraph with "Services will be designed to provide assistance, training, supervision, and monitoring, as needed, in the following areas: self-care, sensory/motor development, interpersonal skills, communication, reduction/elimination of maladaptive behavior, community living and mobility, health care, leisure and recreation, money management and household chores."

Page 7: Direct Care Staff

Direct care staff are responsible for providing assistance, training, and supervision to individual clients. They are involved in the client's daily activities directly through the implementation and monitoring of individual programs.

Page 14: Financial Accountability

Providers of waivered services will submit client-specific invoices to counties who will in turn submit invoices to the Department for processing and payment through the Medicaid Management Information System.

Page 15: Individual Assessments-Re-evaluation

Replace the next to the last sentence in the second paragraph with: "All clients will be annually re-evaluated by case managers."

Page 16: Informing Beneficiaries of Choice

Case managers will inform beneficiaries of their choice at the screening team meetings. This will be documented on the last page of the screening tool (see attachment).

Page 16: Appendix C: Denial of New ICF/MR Beds - Supporting Documentation

Attached is a table identifying those providers and county agencies whose requests for additional ICF/MR beds were denied by the Department. As stated in the waiver application, denial of these new beds was predicated on approval and implementation of the waiver pursuant to Minnesota Statute passed in 1983 (see attached pages 114 and 130).

Please feel free to call Cindy Becker (612/296-6916) if you need additional information. Once again, I look forward to your approval of this application.

Sincerely,

LEONARD W. LEVINE
Commissioner

LWL:eh

attachments

PROPOSED ICF/MR FACILITIES WHICH WERE DENIED DEVELOPMENT by the COMMISSIONER of PUBLIC WELFARE DURING 1983 in ANTICIPATION OF WAIVER IMPLEMENTATION

DATE	FACILITY	COUNTY	NUMBER of BEDS
4/15/83	Community Residential Services I	Ramsey	6
4/15/83	Community Residential Services II	Ramsey	6
4/15/83	Community Residential Services III	Ramsey	6
4/15/83	United Care Center	Ramsey	6
4/22/83	Forestview - Plymouth	Hennepin	18
4/20/83	Greenwood - North	Ramsey	36
5/12/83	Residential Alternatives XII	Hennepin	32
5/16/83	Our House of Minnesota III	Ramsey	6
9/21/83	Gilbert Group Home	St. Louis	16
9/21/83	REM-Montevideo	Chippewa	18
9/21/83	REM-Morris	Stevens	15
9/21/83	Muriel Humphrey Residence 5	Hennepin	8
9/21/83	Muriel Humphrey Residence 6	Hennepin	8
9/21/83	Pine Ridge Homes 4	Carlton	12
9/21/83	Project New Hope-Mahnomen	Mahnomen	6
9/21/83	Laura Baker School	Rice	73
	16 proposals	total beds	272

eh

concentration of community residential facilities within any town, municipality or county of the state.

(2) In determining whether a license shall be issued pursuant to this subdivision, the commissioner of public welfare shall specifically consider the population, size, land use plan, availability of community services and the number and size of existing public and private community residential facilities in the town, municipality or county in which a licensee seeks to operate a residence. Under no circumstances may the commissioner newly license any facility pursuant to this section except as provided in section 245.812. The commissioner of public welfare shall establish uniform rules and regulations to implement the provisions of this subdivision.

(3) Licenses for community facilities and services shall be issued pursuant to section 245.821.

Subd. 4. [RULES; DECERTIFICATION OF BEDS.] The commissioner shall promulgate in rule criteria for decertification of beds in intermediate care facilities for the mentally retarded, and shall encourage providers in voluntary decertification efforts. The commissioner shall not recommend to the commissioner of health the involuntary decertification of an intermediate care facility for beds for the mentally retarded prior to the availability of appropriate services for those residents affected by the decertification. The commissioner of health shall decertify those intermediate care beds determined to be not needed by the commissioner of welfare.

Sec. 3. [252.291] [LIMITATION ON DETERMINATION OF NEED.]

Subdivision 1. [MORATORIUM.] Notwithstanding section 252.28, subdivision 1, or any other law or rule to the contrary, the commissioner of public welfare shall deny any request for a determination of need and refuse to grant a license pursuant to section 245.782 for any new intermediate care facility for mentally retarded persons or for an increase in the licensed capacity of an existing facility except as provided in subdivision 2. In no event shall the total of certified intermediate care beds for mentally retarded persons in

community facilities and state hospitals exceed 7,500 beds as of July 1, 1983, and 7,000 beds as of July 1, 1986. "Certified bed" means an intermediate care bed for the mentally retarded certified by the commissioner of health for the purposes of the medical assistance program under United States Code, title 42, sections 1396 to 1396p, as amended through December 31, 1982.

Subd. 2. [EXCEPTIONS.] The commissioner of public welfare in coordination with the commissioner of health may approve a new intermediate care facility for mentally retarded persons only in the following circumstances:

(a) when the facility is developed in accordance with a request for proposal system established pursuant to subdivision 3, clause (b);

(b) when the facility is necessary to serve the needs of identifiable mentally retarded persons who are seriously behaviorally disordered or who are physically or sensorily impaired; or

(c) to license beds in new facilities where need was determined by the commissioner prior to the effective date of this section.

Subd. 3. [DUTIES OF COMMISSIONER OF PUBLIC WELFARE.] The commissioner shall:

(a) establish standard admission criteria for state hospitals and county utilization targets to limit and reduce the number of intermediate care beds in state hospitals and community facilities in accordance with approved waivers under United States Code, title 42, sections 1396 to 1396p, as amended through December 31, 1982, to assure that appropriate services are provided in the least restrictive setting;

(b) provide technical assistance so that county boards may establish a request for proposal system for meeting individual service plan objectives through home and community-based services; alternative community services; or, if no other alternative will meet the needs of identifiable individuals for whom the county is financially responsible, a new intermediate care facility for mentally retarded persons; and

approval of the governor after consulting with the legislative advisory commission as provided in section 3.30. Release of these funds shall also be contingent upon submission of a plan prepared by the commissioner. The plan shall describe the following:

(1) the organization, development, and responsibilities of requested staff;

(2) specification of all the administrative costs associated with the program;

(3) how the information system will be integrated into the community services information system, the medicaid management information system, and any other data processing operations of the department;

(4) the methods for implementing the system; and

(5) the projected costs for the maintenance and operation of the system.

The plan shall be submitted to the chairmen of the house appropriations and senate finance committees.

Sec. 11. [REPEALER.]

The provisions of sections 2, 3, 5, 7, subdivisions 1, 4, and 10 are repealed effective June 30, 1984, if a home and community based waiver under United States Code, title 42, section 1396n(c), as amended through December 31, 1982, is not approved by June 30, 1984.

Sec. 12. [EFFECTIVE DATE.]

Sections 1 to 11 are effective the day following final enactment."

Delete the title and insert:

"A bill for an act

relating to the organization and operation of state government; appropriating money for welfare, corrections, health, and other purposes with certain conditions; providing appropriations for the departments of public welfare, economic security, corrections, health, sentencing guidelines commission, corrections ombudsman, and health related boards; providing an entitlement to certain child care services; increasing marriage license and dissolution fees; providing for distribution of federal maternal and child health block grant money; requiring cost

increase limits and other cost containment measures in medical care programs; amending eligibility standards; changing general assistance to allow employment through grant diversion and work registration requirements, and federal benefit application incentives; providing for job training for certain persons; allowing for certain changes in the services for the mentally retarded; amending Minnesota Statutes 1982, sections 13.46, subdivision 2; 15.61; 129A.03; 144.653, subdivision 2; 144A.04, subdivision 5; 144A.10, subdivision 2; 145.881; 145.882; 145.921, subdivision 1; 245.62; 245.66; 245.83; 245.84, subdivisions 1, 2, and 5; 245.85; 245.86; 245.87; 246.57, by adding a subdivision; 251.011, subdivision 6; 252.24, subdivision 1; 252.28; 256.01, subdivision 2; 256.045, subdivision 3; 256.82, by adding a subdivision; 256.966, subdivision 1; 256.967; 256.968; 256B.02, subdivision 8; 256B.04, subdivision 14, and by adding a subdivision; 256B.041, subdivisions 2 and 5; 256B.06, subdivision 1; 256B.061; 256B.064, subdivision 1a; 256B.07; 256B.14, subdivision 2; 256B.17, subdivision 4, and by adding subdivisions; 256B.19, by adding a subdivision; 256B.27, subdivisions 3 and 4; 256D.01, subdivision 1; 256D.02, subdivision 4, and by adding a subdivision; 256D.03, subdivisions 3, 6, and by adding subdivisions; 256D.05, subdivision 1a; 256D.06, subdivision 5; 256D.09, subdivision 2, and by adding a subdivision; 256E.06, subdivision 2, and by adding a subdivision; 260.191, subdivision 2; 268.242, subdivision 2; 261.23; 268.12, subdivision 12; 357.021, subdivisions 2 and 2a; 401.14, by adding a subdivision; 401.15, subdivision 1; 517.08, subdivisions 1b and 1c; Laws 1982, chapter 614, section 13; proposing new law coded in Minnesota Statutes, chapters 145; 252; 256; 256B; 256D; and 268; repealing Minnesota Statutes 1982, sections 256D.02, subdivision 14; 256D.05, subdivision 1a; 256D.06, subdivision 1a; Laws 1981, chapter 323, section 4; chapter 360, article II, section 54, as amended; and the section proposed to be coded as section 471.365 contained in a bill styled as H.F. No. 1290 during the 1983 regular legislative session."

IENT SCREENING AND TRACKING
INITIAL INFORMATION

1. CSTS CASE NUMBER

2. REFD BY

3. MR KEY NUMBER

CLIENT LAST NAME | FIRST NAME | MIDDLE INITIAL

5. MA IDENTIFICATION NUMBER

6. SEX [M] [F]

7. WARD OF COMMISSIONER? [Y] [N]

8. DATE OF CLIENT'S BIRTH (M M / D D / Y Y)

9. COUNTY OF FINANCIAL RRSPONISIBILITY

10. COUNTY OF ACTUAL RESIDENCE

11. COUNTY OF CASE MANAGEMENT RESPONSIBILITY

12. CSTS CASE STATUS

13. NAME OF CASE MANAGER

14. WORKER NUMBER

15. PERSON AUTHORIZED TO SIGN FOR CLIENT [C] [P] CLIENT/PARENT/OR NAME OF PERSON IF OTHER THAN CLIENT OR PARENT

DSM III CODES

16. PRIMARY

17. SECONDARY

18. TENTIARY

19. GENERAL LEVEL OF FUNCTION
CHECK ONE

- [1] NOT MENTALLY RETARDED
- [2] BORDERLINE OR ABOVE
- [3] MILDLY RETARDED
- [4] MODERATELY RETARDED
- [5] SEVERELY RETARDED
- [6] PROFOUNDLY RETARDED
- [7] MR, LEVEL NOT SPECIFIED
- [8] NOT KNOWN WHETHER RETARDED

.DICAL NEEDS
CHECK ONE

- [1] GENERALLY HAS NO SERIOUS MEDICAL NEEDS
- [2] NEEDS REGULAR VISITS FROM NURSE OR VISITS TO DOCTOR
- [3] NEEDS TO HAVE NURSE ON SITE DAILY BUT NOT CONSTANTLY
- [4] NEEDS MEDICAL PERSONNEL ON SITE AT ALL TIMES

21. VISION FUNCTION WITH CORRECTION IF USED

- [1] FULL VISION
- [2] DIFFICULTY AT LEVEL OF PRINT
- [3] DIFFICULTY WITH OBSTACLES
- [4] HAS NO USEFUL VISION

22. PERSONAL MOBILITY STATUS

- [1] NO IMPAIRMENT IN MOBILITY
- [2] IMPAIRED BUT MOBILE
- [3] NOT INDEPENDENTLY MOBILE

23. COMMUNICATION
CHECK HIGHEST APPLICABLE NUMBER

- [1] SPEECH EASILY UNDERSTOOD
- [2] SPEECH DIFFICULT TO UNDERSTAND
- [3] USES SIGN LANGUAGE
- [4] USES GESTURES AND/OR SOME SIGNS
- [5] HAS NO FUNCTIONAL COMMUNICATION

24. TOILETING COMPETENCE

- [1] HAS FULL CONTROL BOWEL AND BLADDER
- [2] OCCASIONAL LOSS OF CONTROL IN DAY
- [3] INCONTINENT OR FREQ LOSS OF CONTROL

25. HEARING FUNCTION WITH AID IF ONE IS USED

- [1] FULL HEARING
- [2] DIFFICULTY AT LEVEL OF CONVERSATION
- [3] DIFFICULTY WITH ALARM SOUNDS
- [4] NO USEFUL HEARING

26. SEIZURE STATUS
CHECK HIGHEST APPLICABLE LEVEL

- [1] NO HISTORY OF SEIZURES
- [2] SEIZURES, CURRENTLY CONTROLLED
- [3] MINOR SEIZURES 1 TO 10 PER MONTH
- [4] MAJOR SEIZURES 1 TO 10 PER YEAR
- [5] MAJOR SEIZURES MORE THAN 10/YR

27. CEREBRAL PALSY STATUS
CHECK HIGHEST APPLICABLE NUMBER

- [1] NO MANIFESTATIONS OF CEREBRAL PALSY
- [2] CP WITH MINOR FUNCTIONAL IMPAIRMENT
- [3] CP FEEDS SELF SPEECH INTELLIGIBLE
- [4] CP IS FED OR SPEECH UNINTELLIGIBLE

28. IS THIS PERSON CAPABLE OF INDEPENDENT SELF-PRESERVATION IN THE EVENT OF AN EMERGENCY? [Y] [N]

29. MALADAPTIVE BEHAVIORS ... TYPE, FREQUENCY, AND INTENSITY.
SEE MANUAL FOR DESCRIPTIONS OF THE BEHAVIORS LISTED HERE. ENTER HIGHEST APPLICABLE CODE.

TYPE OF BEHAVIOR	FREQUENCY CODE	INTENSITY CODE
INJURIOUS TO SELF		
INJURIOUS TO OTHERS		
DESTRUCTIVE OF PROPERTY		
BREAKS RULES AND LAWS		
EMOTIONAL DISTURBANCE		
DISTURBED ORIENTATION TO PERSONS		
DISTURBED ORIENTATION TO OBJECTS		

FREQUENCY CODES

- 0 LESS THAN ONCE PER YEAR
- 1 MORE THAN 1/YEAR LESS THAN 1/MONTH
- 2 MORE THAN 1/MONTH LESS THAN 1/WEEK
- 3 MORE THAN 1/WEEK LESS THAN 1/DAY
- 4 MORE THAN 1/DAY LESS THAN 1/HOUR
- 5 MORE THAN ONE EPISODE PER HOUR
- 6 MORE THAN 1/MINUTE OR CONSTANTLY

INTENSITY CODES

- 0 DOES NOT DO THIS OR IT IS NOT A PROBLEM
- 1 NUISANCE BUT DOES NOT INTERFERE WITH PROGRAM
- 2 INTERFERES WITH OWN PROGRAM ONLY
- 3 DISRUPTS MORE THAN ONE BUT NOT THE WHOLE GROUP
- 4 DISRUPTS THE WHOLE GROUP OR UNIT
- 5 DISRUPTS AN ENTIRE CENTER OR FACILITY PROGRAM
- 6 REQUIRES IMMEDIATE MEDICAL ATTENTION OR INTERVENTION TO PREVENT HARM TO SELF OR TO OTHERS

CLIENT SCREENING AND TRACKING
MOVEMENT AND STATUS RECORD

1. ☐☐ / ☐☐ / ☐☐☐☐ DATE THIS STATUS REPORT

2. THIS STATUS REPORT IS
- 1 INITIAL
- 2 SUBSEQ

3. ☐ STATUS MR FLOW

4. ☐☐☐☐☐☐☐ MR KEY NUMBER

5. ☐☐ / ☐☐ / ☐☐☐☐ DATE CLIENT WAS REFERRED TO THE COUNTY AS PROBABLY RETARDED

6. ☐☐ / ☐☐ / ☐☐☐☐ DATE COUNTY DETERMINED WHETHER PERSON IS MENTALLY RETARDED

7. DID THE COUNTY DETERMINE THAT THIS PERSON IS MENTALLY RETARDED?
- Y CONTINUE
- N END

8. COUNTY DETERMINATION - IS THIS PERSON ELIGIBLE FOR MEDICAID? Y N

9. CLIENT RESIDENTIAL PLACEMENT AT TIME OF THIS STATUS REPORT
CHECK ONE

- 1 WITH NATURAL OR ADOPTIVE FAMILY
- 2 IN LONG TERM FOSTER CARE
- 3 WITH RELATIVES NOT IMMEDIATE FAMILY
- 4 OWN HOME OR APT FULLY INDEPENDENT
- 5 OWN HOME/APT SUPV LESS THAN 24 HRS
- 6 OUT OF HOME SUPV LESS THAN 24 HRS
- 7 OUT OF HOME SUPV 24 HRS ICF/MR
- 8 OUT OF HOME SUPV 24 HRS OTHER
- 9 SKILLED NURSING FACILITY
- 10 STATE HOSPITAL

10. CLIENT DAY PROGRAM PLACEMENT AT TIME OF THIS STATUS REPORT
CHECK ONE

- 1 IN PRESCHOOL PROGRAM HOME BASED
- 2 IN PRESCHOOL PROGRAM CENTER BASED
- 3 IN ELEMENTARY SCHOOL PROGRAM
- 4 IN SECONDARY SCHOOL PROGRAM
- 5 IN POSTSCHOOL TRANSITIONAL PROGRAM
- 6 IN ADULT DAY HABILITATION PROGRAM
- 7 IN LONG TERM WORK ACTIVITY
- 8 LONG TERM SHELT EMPLOYMENT IN WORKSHOP
- 9 IN PROTECTED WORK STATION IN INDUSTRY
- 10 COMPETITIVE EMPLOYMENT FULL OR PART TIME
- 11 IN RETIREMENT PROGRAM
- 12 IN OTHER _____

NOTE THAT THE FOLLOWING DETERMINATIONS ARE THOSE OF THE TEAM

11. WHAT IS THE LEVEL OF SUPERVISION NEEDED BY THIS PERSON AT THIS TIME?

- 1 FULLY INDEPENDENT - NEEDS ONLY PERIODIC MONITORING TO ASSURE THAT PROBLEMS WILL BE MET IF THEY ARISE BUT OTHERWISE THE PERSON MANAGES HIS/HER OWN AFFAIRS ADEQUATELY
- 2 SEMI-INDEPENDENT - NEEDS SOME SUPERVISORY STAFF CONTACT AVERAGING LESS THAN EIGHT HOURS PER WEEK BUT DOES NOT REQUIRE LIVE-IN STAFFING
- 3 MODERATE SUPERVISION - NEEDS STAFF IN DAILY SUPERVISORY CONTACT AT PEAK HOURS AND ON WEEK ENDS BUT DOES NOT REQUIRE LIVE-IN STAFFING
- 4 SUBSTANTIAL SUPERVISION - NEEDS LIVE-IN STAFF ON SITE AT ALL TIMES BUT STAFF NEED NOT BE AWAKE AT NIGHT
- 5 INTENSIVE SUPERVISION - NEEDS STAFF ON SITE FOR SUPERVISION AND STAFF AWAKE AT ALL TIMES

12. RECOMMENDED RESIDENTIAL SETTING
CHECK ONE

- 1 NATURAL OR ADOPTIVE FAMILY
- 2 LONG TERM FOSTER PLACEMENT
- 3 WITH RELATIVES NOT IMMEDIATE FAMILY
- 4 OWN HOME OR APT FULLY INDEPENDENT
- 5 OWN HOME/APT SUPV LESS THAN 24 HOURS
- 6 OUT OF HOME SUPV LESS THAN 24 HOURS
- 7 OUT OF HOME SUPV 24 HRS ICF/MR
- 8 OUT OF HOME SUPV 24 HRS OTHER
- 9 SKILLED NURSING FACILITY

13. RECOMMENDED DAY PROGRAM SETTING
CHECK ONE

- 1 PRESCHOOL PROGRAM HOME BASED
- 2 PRESCHOOL PROGRAM CENTER BASED
- 3 ELEMENTARY SCHOOL PROGRAM
- 4 SECONDARY SCHOOL PROGRAM
- 5 POSTSCHOOL TRANSITION PROGRAM
- 6 DAY HABILITATIVE PROGRAM
- 7 LONG TERM WORK ACTIVITY
- 8 LONG TERM SHELT EMPLOYMENT IN WORKSHOP
- 9 PROTECTED WORK STATION IN INDUSTRY
- 10 COMPETITIVE EMPLOYMENT FULL OR PART TIME
- 11 RETIREMENT PROGRAM
- 12 OTHER _____

CLIENT SCREENING AND TRACKING
SCREENING RECORD

1. DATE OF THIS SCREENING ACTION (M M / D D / Y Y)

2. COUNTY WHERE SCREENED

3. MR KEY NUMBER

4. NAME OF REGIONAL SERVICES SPECIALIST

5. RSS NUMBER

PERSONS PRESENT AT AND PARTICIPATING IN SCREENING TEAM
CHECK ALL APPLICABLE

6. ☐ CLIENT
7. ☐ PARENT OR GUARDIAN
8. ☐ COUNTY CASE MANAGER
9. ☐ REGIONAL SERVICES SPECIALIST
10. ☐ AUTHORIZED ADVOCATE _____
11. ☐ OTHER _____
12. ☐ OTHER _____

13. DOES THIS TEAM DETERMINE THAT THIS PERSON IS AT RISK OF ICF/MR PLACEMENT? Y | N

14. ASSESSMENT OF SPECIFIC SERVICES NEEDED IN RESIDENTIAL AND/OR DAY PROGRAM
ENTER CARE AND TRAINING CODES FROM BELOW

AREA OF FUNCTION	CARE	TRG
SELF CARE		
PERSONAL HYGIENE		
PERSONAL MOBILITY		
COMMUNITY TRANSPORTATION		
SOCIALIZATION & SOCIAL FUNCTION		
COMMUNICATION		
LEISURE AND RECREATION		
MONEY MANAGEMENT AND BUDGETING		
COMMUNITY LIVING		
HOUSEHOLD MANAGEMENT		
INFANT LEVEL STIMULATION		
VOCATIONAL AND PREVOCATIONAL		

CARE LEVEL CODES
- P PHYSICAL ASSIST
- S SUPERV & CONTROL
- M MONITORING
- O DOES NOT NEED CARE IN THIS AREA

TRAINING CODES
- M MANUAL GUIDANCE
- D DEMONSTRATION
- V VERBAL
- O DOES NOT NEED TRG IN THIS AREA

15. SUPPORT SERVICES THAT CLIENT IS CURRENTLY RECEIVING, AND THOSE NEEDED
CHECK ALL THAT APPLY

AREA OF SERVICE	RCVING	NEEDED
SPECIALIZED MEDICAL SERVICE		
SPECIALIZED DENTAL SERVICE		
PHYSICAL THERAPY BY PT OR AIDE		
OCCUP THERAPY BY OTR OR AIDE		
LANGUAGE OR SPEECH THERAPY		
MENTAL HEALTH SERVICES		
TRAINING FOR FAMILY MEMBERS		
SPECIAL TRANSPORTATION		
SPECIAL RECREATION		
LEGAL GUARDIAN STATE OR PVT		
CONSERVATOR		
LEGAL AIDE SERVICES		
VOLUNT INSTRUMENTAL ADVOCATE		
VOLUNT EXPRESSIVE ADVOCATE		
TECH SKILLED BEHAV MANAGEMENT		
DAY RESPITE SERVICE		
OVERNIGHT RESPITE SERVICE		
HOMEMAKER SERVICE		

16. SERVICES RECOMMENDED.
CHECK WHETHER A SERVICE IS RECOMMENDED AND IF SO WHETHER IT IS TO BE PROVIDED UNDER A WAIVER

SERVICE	RECOMM?	WAIVERED?	SERVICE	RECOMM?	WAIVERED?
CASE MANAGEMENT	Y N	Y N	SLA/CHILDREN	Y N	Y N
DAY RESPITE	Y N	Y N	SLA/ADULTS	Y N	Y N
OVERNIGHT RESPITE	Y N	Y N	DAY HABILITATION	Y N	Y N
HOMEMAKER SERVICE	Y N	Y N	MINOR PHYSICAL ADAPT	Y N	Y N
IN HOME FAMILY SERVICE	Y N	Y N	ICF/MR	Y N	Y N
SILS	Y N	Y N	OTHER _____	Y N	Y N

17. CLIENT CHOICE OF SERVICES
SEE MANUAL. WAS THE CHOICE PRESENTED TO THE CLIENT IN THE AUTHORIZED MANNER? Y | N

DOES THE CLIENT ASSENT TO ALL THE ABOVE RECOMMENDATION? Y | N
IF NOT WHAT WAS THE ADJUSTMENT?

18. RSS SIGNATURE _____ 19. (M M / D D / Y Y)

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

OFFICE OF THE COMMISSIONER
612/296-2701

GENERAL INFORMATION
612/296-6117

PLEASE REPLY TO 612/296-2701

March 1, 1984

Mr. Robert Wren
Division of Provider Services
Department of Health & Welfare
6325 Security Blvd. #405E
Baltimore, Maryland 21207

Dear Mr. Wren:

It was a pleasure meeting you on Monday. I want to thank you very much for taking the extra effort to come in to Washington to help facilitate the approval process of our Title XIX Waiver for Mentally Retarded Persons.

This letter responds to the issues we discussed over the telephone on February 29, 1984.

1. Financial Accountability

Consistent with the requirements for other Medicaid providers, providers of waivered services will maintain financial records for a five year period which pertain to their costs of providing services including purchase invoices, all accounting records, and contracts for supplies and services.

At the local level, counties will enter into service agreements with providers which will detail the client(s) to be served, the type of services, units of service and budget. Providers will bill the counties on a client specific voucher system. Counties will then bill the Department on client-specific invoices. These invoices will be processed through the MMIS which will edit against eligible clients, providers and rates. The Department, through MMIS, will pay the counties who will pay the providers. The Department will also send monthly remittance notices to the county which details the clients and services for which payment was made. An audit trail will be provided through MMIS, county information systems and providers records.

2. "G" Estimated Average Annual Medicaid Payment Per ICF/MR Recipient

Increase over previous years: The reason for the increase in the average Medicaid payment per ICF/MR recipient is the addition of Medicaid funding for day training and habilitation services for ICF/MR residents pursuant to 442.463.

Prior to January 1, 1984, this service had been supported by state and county funds. Last year, Minnesota discovered that this service should have been funded by Medicaid as a benefit of ICF/MR services. This additional cost is not a result of the waiver, rather it is a separate issue relating to coverage of day training and habilitation services through the ICF/MR program and could have been done years ago. However, since this funding did not begin until January 1, 1984, it will only begin to be documented on the HCFA 2082 forms when this federal fiscal year is completed. The anticipated amount of additional funds are as follows:

*	
SFY '84	$ 7,673,000
SFY '85	16,867,000
SFY '86	20,074,000
SFY '87	$ 23,113,000

*SFY = State Fiscal Year

3. Diversions

As previously stated, the Department projects 280 diversions for each year of the waiver. This number is consistent with three indices:

(a) Between July 1978 and July 1983, an average of 286 community-based ICF/MR beds were opened as follows:

	Number of Beds Opened
SFY '79	304
SFY '80	309
SFY '81	414
SFY '82	247
SFY '83	262

This is the same information contained in Appendix C of the Waiver request.

(b) The Department has denied requests for 272 additional community ICF/MR beds in anticipation of the Waiver from April to September 1983.

(c) The September 30, 1982 forecast for expenditures prepared by Minnesota's Income Maintenance Bureau projected a 280 person increase in average monthly recipients of community ICF/MR's. This projection was based on continuation of the status quo and was developed six months prior to the state's legislation authorizing the Waiver Application. (see attached)

In addition, the Deparment is under a Consent Decree (Welsch v. Levine) which mandates a reduction in state hospital beds. In order to achieve this reduction, it is also

necessary to reduce the number of admissions. This can be accomplished by one of two ways: increasing the number of community ICF/MR beds or expanding the number and types of community services through the Waiver. I'm sure you will share our opinion that the latter option is most preferable both in terms of individualized program development and cost-effectiveness.

Finally, Minnesota exceeds almost every state in the number of community ICF/MR beds (see attached charts). During the past five years, over 1400 beds have been opened which in and of itself, is more than most states have in total. As you can see by the next chart, the trend in community ICF/MR beds has been steadily increasing. This rate of increase far exceeds the rate of decline in state hospitals because approximately 65 - 75% of the clients in community ICF/MR's come directly from the community, thereby preventing their placement into a state hospital. To date very few other types of services have been available in Minnesota. We see the Waiver as the only viable option to stem and even decrease the growth in community ICF/MR's by providing cost-effective alternatives to this level of care.

Based on this and the indices cited above, we submit that without the Waiver, the number of community ICF/MR beds would increase by 280 beds per year.

I hope this letter adequately responds to the concerns you expressed. Please feel free to call me (612/296-2701) or Cindy Brown (612/[illegible]) if you need additional information. Once again, thank you for your time.

Sincerely,

Leonard E. Levine
Deputy Commissioner for

LEONARD W. LEVINE
Commissioner

LWL:eh

attachments

ATTACHMENT #1

MINNESOTA
INCOME MAINTENANCE

PROJECTIONS FOR
THE F.Y. 1984 - 1985 BIENNIUM

SEPTEMBER 30, 1982

MINNESOTA DEPARTMENT
OF PUBLIC WELFARE

Nursing Home Recipients and Cost Projections
Biennium Ending June 30, 1985
(Not Including State Institution-MR)

Fiscal Year	Monthly Average Recipients	Monthly Average	Total	Federal	State	County
BASE PERIOD						
1976	26,883	$ 438.16	$141,350,244	$ 80,343,480	$ 42,701,908	$18,304,856
1977	27,576	526.49	174,223,963	99,028,898	67,668,589	7,526,476
1978	29,141	597.31	208,873,545	116,248,573	83,366,655	9,258,320
1979	29,838	687.43	246,136,751	136,015,169	99,119,269	11,002,313
1980	30,787	816.64	301,703,048	167,591,104	120,694,519	13,417,438
1981	32,335	945.18	366,749,982	204,057,931	146,406,438	16,285,613
1982	33,309	1,067.72	426,776,510	229,895,394	177,193,004	19,688,112
PROJECTED						
1983	34,839	$1,192.72	$498,640,000	$261,701,000	$213,244,000	$23,695,000
1984	36,066	1,344.41	581,850,000	295,452,000	257,759,000	28,639,000
1985	37,246	1,523.09	680,750,000	354,521,000	293,607,000	32,622,000

Average Monthly Recipients By Type of Care

Fiscal Year	Total	ICF 1	ICF 2	ICF/MR	SNF
BASE PERIOD					
1976	26,883	12,010	2,157	2,134	10,582
1977	27,576	11,598	2,055	2,230	11,701
1978	29,141	11,661	2,046	2,649	12,785
1979	29,838	11,480	1,733	2,944	13,681
1980	30,787	11,141	1,687	3,172	14,787
1981	32,335	11,301	1,692	3,525	15,817
1982	33,309	10,936	1,643	4,064	16,666
PROJECTED					
1983	34,839	11,186	1,643	4,344 +280	17,666
1984	36,066	11,186	1,643	4,624 +280	18,613
1985	37,246	11,186	1,643	4,904 +280	19,513

ATT. 2

UTILIZATION OF INTERMEDIATE CARE FOR MENTALLY RETARDED (ICF/MR)

(Per every 100,000 Persons)

1977

	Minnesota	Region V	United States
State Operated Residential Facilities	67.9	59.5	68.6
Community Residential Facilities	79.0	40.8	28.8
Total	146.9	100.3	97.4

In 1977-78, Minnesota had a utilization rate of ICF/MR's which was

46.4% higher than Region V overall
50.8% higher than United States average overall
194% higher than Region V for community facilities
274% higher than United States for community facilities

MINNESOTA'S UTILIZATION OF INTERMEDIATE CARE FOR MENTALLY RETARDED

(Per every 100,000 Persons)

	Utilization
June 77	146.9
June 78	154
June 79	158
June 80	163
June 81	170
June 82	172
June 83	175
June 84	178

Figure 2

Mentally Retarded People in Residential Care per 100,000 State Population By Size of Facility: United States, 1982 (100% Reporting)

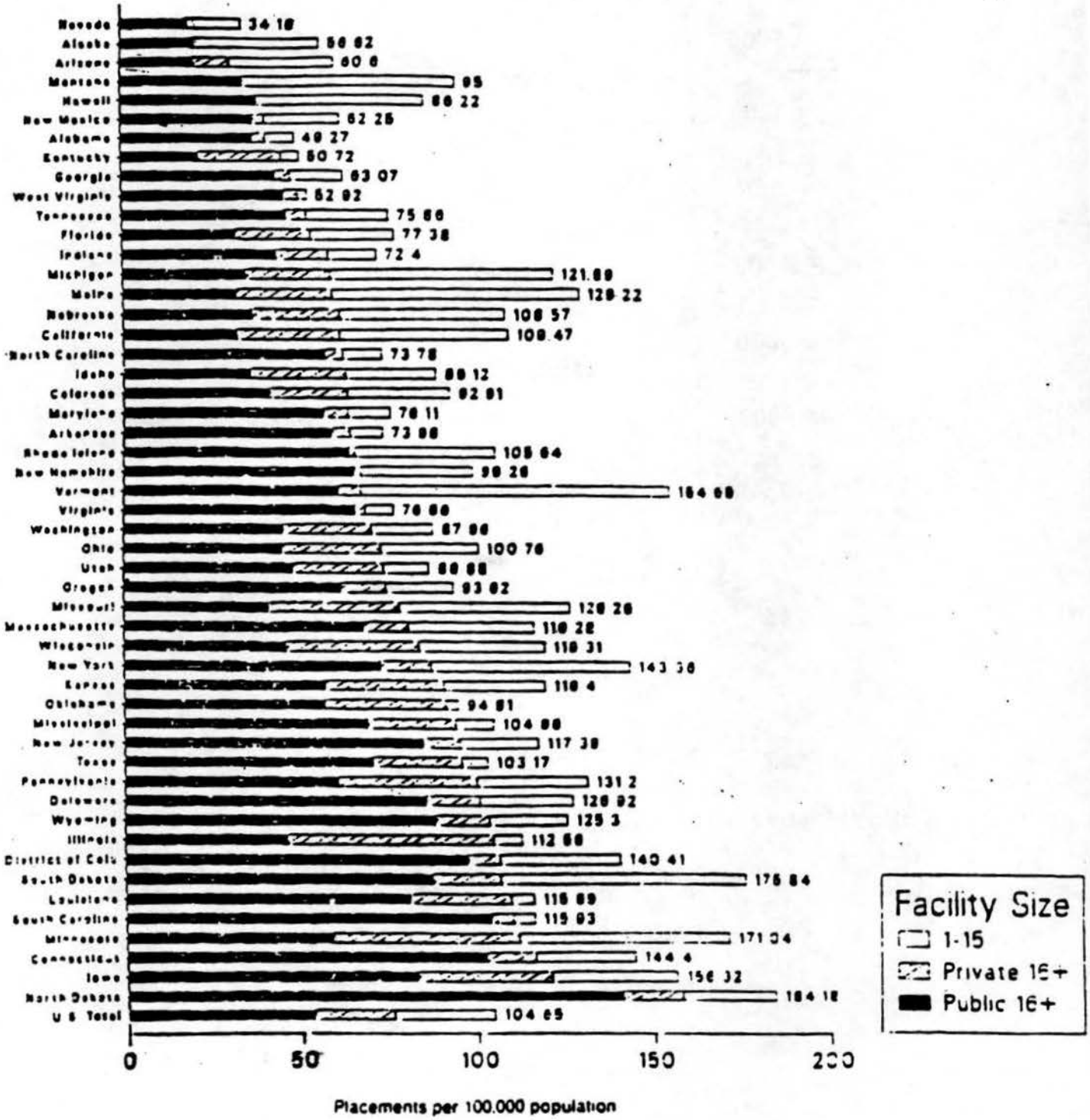
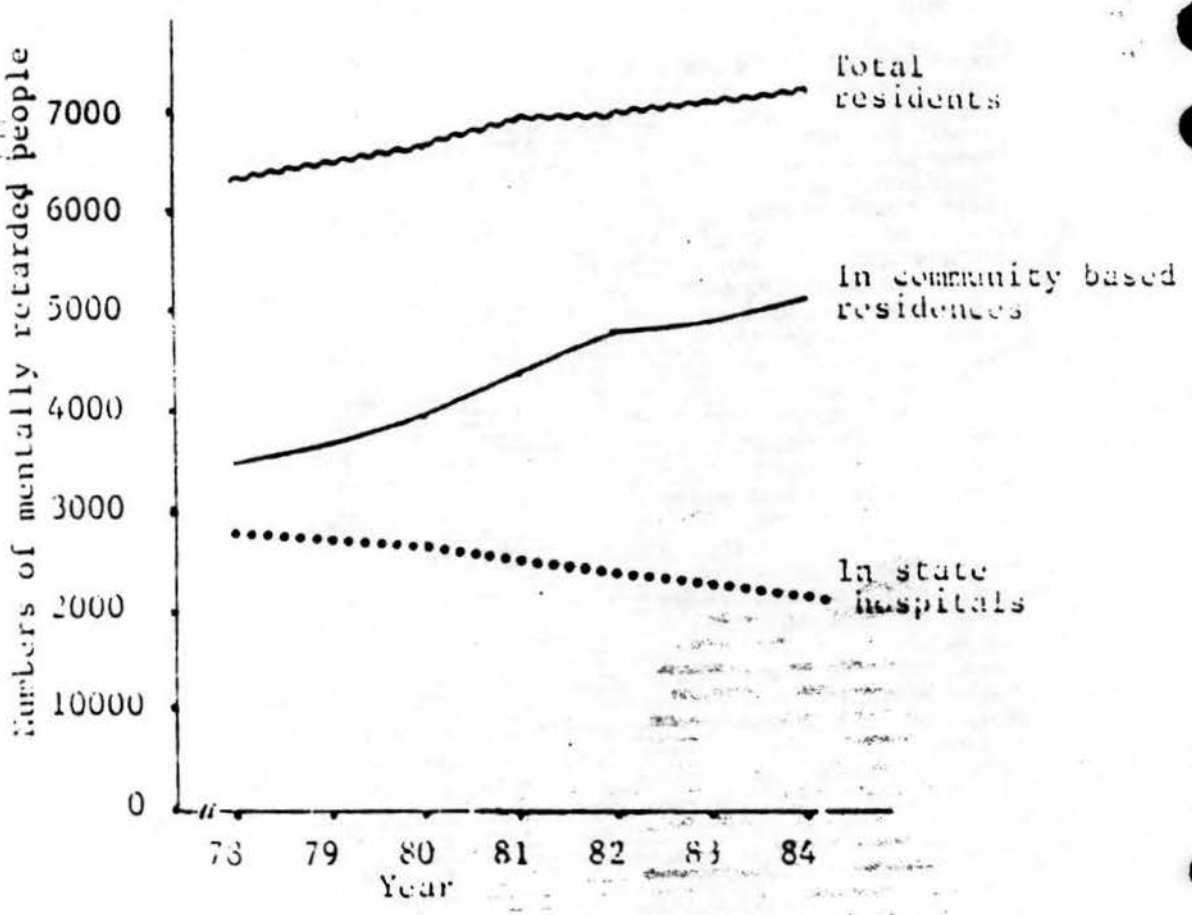


Figure 2 presents the number of mentally retarded people per 100,000 of the general population living in smaller facilities (1-15 residents) and in larger public and private facilities (16+ residents). States are rank ordered according to the per capita rate of placement in larger facilities.

- Approximately 105 of every 100,000 people in the U S were placed in residential care for the mentally retarded, with 76 of these individuals placed in larger facilities.
- State placement rates in larger publicly operated facilities ranged from 18 to 140 per 100,000 people. Most states (38) placed more people in larger public facilities than in either larger private or smaller facilities.



Numbers of mentally retarded people in state hospitals (dotted line), in community based residences (straight line), and total (wavy line); by years, 1978 to present.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

OFFICE OF THE COMMISSIONER
612/296-2701

GENERAL INFORMATION
612/296-6117

PLEASE REPLY TO 612/296-2701

March 6, 1984

Mr. Robert Wren
Division of Provider Services
Department of Health and Welfare
6325 Security Boulevard #405E
Baltimore, Maryland 21207

Dear Mr. Wren:

This letter responds to the telephone conversation between Bob Wardwell of your staff and Cindy Becker on March 6, 1984.

> Minnesota will use the same financial eligibility criteria for individuals covered under the waiver as that approved for use in our state plan.

Sincerely,

LEONARD W. LEVINE
Commissioner

LWL:eh

DPW-628
(2-80)

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

OFFICE OF THE
COMMISSIONER
612/296-4314

GENERAL
INFORMATION
612/296-6117

PLEASE REPLY TO 296-2701

March 12, 1984

Mr. Robert E. Wren, Director
Division of Provider Services
Coverage Policy (OCP)
Health Care Financing Administration
6325 Security Boulevard
Room 405 East Highrise Building
Baltimore, Maryland 21207

Dear Mr. Wren:

This letter is in response to the information requested by Bob Wardwell of your staff in a telephone conversation with Cindy Becker on March 9, 1984.

Minnesota will offer home and community-based services to eligible persons if the services cost more than the average ICF/MR as long as the aggregate medical assistance costs under the waiver are less than the aggregate medical assistance costs without the waiver.

Minor physical adaptations to the home will be offered to eligible persons to enable them to avoid institutionalization. The following adaptations will be offered:

- wheelchair ramps
- handrails and grab bars
- bathtub and toilet elevation
- doorway widening
- shatterproof windows
- alternate warning systems: blinking lights and tactile alarms
- handle replacement for doorknobs
- lowering kitchen work surfaces
- wheelchair space under cabinets and sinks
- handles and hoses for showerheads
- hinge replacement for doors
- shower and bathtub seats

As stated in the waiver, the average one-time expenditure for this service is projected to be $3,000.00 per individual.

Attached is Minnesota's licensing rule for day habilitation programs. It is used for both children and adult programs.

Please contact Cindy Becker (612/296-6916) if you need additional information.

Sincerely,

LEONARD W. LEVINE
Commissioner

LWL:eh

attachment

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

OFFICE OF THE COMMISSIONER
612/296-2701

GENERAL INFORMATION
612/296-6117

April 12, 1984

PLEASE REPLY TO 612/296-2701

Mr. Robert E. Wren, Director
Division of Provider Services
Office of Coverage Policy (OCP)
Health Care Financing Administration
6325 Security Blvd.
Room 405 East Highrise Building
Baltimore, Maryland 21207

Dear Mr. Wren:

This letter is in response to the information requested by the Associate Administrator. This request was relayed to Cindy Becker in a telephone conversation April 11, 1984.

(1) Minnesota assures that the same assessment, criteria, and process described in the waiver application to evaluate an individual's need for home and community based services will be used to evaluate an individual's need for ICF/MR services.

(2) Supported Living Arrangements for Children or Adults: This program of habilitation services will be provided to eligible clients who require daily staff intervention due to behavior problems, medical conditions, physical deficits and/or lack of adequate survival skills. Since these clients require staff intervention to manage their daily affairs, individual program planning will address both structured and unstructured activities on a 24-hour basis. Daily staff intervention means direct care or professional staff providing on-site supervision, training, or assistance to a client in the following areas: self-care, sensory/motor development, interpersonal skills, communication, reduction/elimination of maladaptive behavior, community living and mobility, health care, leisure and recreation, money management, and household chores. A variety of interventions will be utilized to provide clients with appropriate staff intervention in accordance with their needs ranging from daily supervision during waking hours to 24-hour supervision with live-in staff.

(3) Semi-Independent Living Services: Minnesota withdraws this service from the waivered services requested.

(4) Attached is the revised formula and associated back-up material. The revised formula reflects the elimination of the estimated number of clients and funds projected in the semi-independent living services category. However, rather than dropping this number of people to be served from the total projections for each year of the waiver, the Department has increased the estimated number of people to be served in supported living arrangements (SLA) and associated day habilitation services to maintain the same overall total number of clients to be served. Because of the large number of clients currently receiving ICF/MR serivces, the Department is confident that the expansion of the SLA category is justified. The Department assures HCFA that clients who require semi-independent living services as previously described in the waiver will not be funded in the SLA category; rather other non-waivered funds will be utilized for this group. In order to be eligible for SLA services under the waiver, clients must require daily staff intervention and 24-hour programming as described in (3) above.

Please contact Cindy Becker (612/296-6916) if you have additional questions.

Sincerely,

LEONARD W. LEVINE
Commissioner

LWL:eh

enc.

CC Pat Richter, Region V, HCFA

WAIVERED SERVICES WORKSHEET

"C" NUMBER OF HOME AND COMMUNITY BASED CARE RECIPIENTS UNDER WAIVER

The number of recipients for case management is unduplicated and equals 100% of the clients projected to be served under the waiver. The numbers of recipients for residential habilitation services are also unduplicated and total the number receiving case management. The remaining services are duplicated; for example, a person receiving in-home family services may also receive respite and homemaker services.

The number of clients projected to receive waivered services ("C") was derived as follows:

	FY 85	FY 86	FY 87
Diversions	280	280	280
State Hospital Bed Reductions	135	175	225
Community ICF/MR Bed Conversion	50	90	150
	465	545 *	655 **
		+465	+1,010
		1,010	1,665

* from FY 85
** from FY 85 & 86

"D" ESTIMATED AVERAGE ANNUAL MEDICAID PAYMENT FOR "C"

These costs are based on a combination of statewide experience and individual provider experience for similar programs. Since Minnesota has limited experience in providing alternative services, close attention will be given to the costs during implementation and amendments to this waiver will be made if necessary.

	Number of Recipients		Average Annual Cost		Totals
FISCAL YEAR 1985					
Case Management	465	x	$ 938	= $	436,170
Residential Habilitation					
In-Home Family Support	140	x	7,190	=	1,006,600
Supported Living Arrangements/ Children	93	x	13,333	=	1,239,969
Supported Living Arrangements/ Adults	232	x	15,540	=	3,605,280
				=	
Day Habilitation	232	x	6,229	=	1,445,128
Respite	221	x	1,500	=	331,500
Homemaker	194	x	3,276	=	635,544
Minor Physical Adaptation	47	x	3,000	=	141,000
				$	8,841,510
				+	465
					19,014

* includes an additional $319.00 to accommodate rounding calculations

FISCAL YEAR 1986

	Number of Recipients		Average Annual Cost		Totals
Case Management	1,010	x	$ 984	=	$ 993,840
Residential Habiliation					
In-Home Family Support	249	x	7,550	=	1,879,950
Supported Living Arrangements/ Children	202	x	14,093	=	2,846,786
Supported Living Arrangements/ Adults	559	x	16,426	=	9,182,134
Day Habilitation	559	x	6,866	=	3,838,094
Respite	450	x	1,575	=	708,750
Homemaker	362	x	3,440	=	1,245,280
Minor Physical Adaptations	55	x	3,150	=	173,250
					$20,868,620*
				÷	1,010
					20,662

*includes an additional $536.00 to accommodate rounding calculations

FISCAL YEAR 1987

Case Management	1,665	x	1,034	=	1,721,610
Residential Habilitation					
In-Home Family Support	347	x	7,927	=	2,750,669
Supported Living Arrangements/ Children	300	x	14,882	=	4,464,600
Supported Living Arrangements/ Adults	1,018	x	17,346	=	17,658,228
Day Habilitation	1,018	x	7,399	=	7,532,182
Respite	689	x	1,654	=	1,139,606
Homemaker	516	x	3,612	=	1,863,792
Minor Physical Adaptations	66	x	3,308	=	218,328
					$37,349,280*
				+	1,665
					22,432

*includes an additional $265.00 to accommodate rounding calculations

$$\frac{(7,919 \times \$27,523) + (465 \times \$19,014)}{8,384} \leq \frac{(8,384 \times \$27,523) + (0)}{8,384}$$

$$\frac{\$217,954,637 + \$8,841,510}{8,384} \leq \frac{\$230,752,832}{8,384}$$

$$\frac{\$226,796,147}{8,384} \leq \frac{\$230,752,832}{8,384}$$

$$\$27,251 \leq \$27,523$$

FY '86

$$\frac{(7,583 \times \$29,505) + (1,010 \times \$20,662)}{8,593} \leq \frac{(8,593 \times \$29,505) + (0)}{8,593}$$

$$\frac{\$223,736,415 + \$20,868,620}{8,593} \leq \frac{\$253,536,465}{8,593}$$

$$\frac{\$244,605,035}{8,593} \leq \frac{\$253,536,465}{8,593}$$

$$\$28,465 \leq \$29,505$$

FY '87

$$\frac{(7,138 \times \$31,509) + (1,665 \times \$22,432)}{8,803} \leq \frac{(8,803 \times \$31,509) + (0)}{8,803}$$

$$\frac{\$224,911,242 + \$37,349,280}{8,803} \leq \frac{\$277,373,727}{8,803}$$

$$\frac{\$262,260,522}{8,803} \leq \frac{\$277,373,727}{8,803}$$

$$\$29,792 \leq \$31,509$$

Summary of Cost Effectiveness Equation:

	FY '85	FY '86	FY '87
A = Estimated number of ICF/MR recipients	7,919	7,583	7,138
B = Estimated average annual Medicaid payment for A	$27,523	$29,505	$31,509

C = Estimated home and community-based care recipients with the waiver	465	1,010	1,665
D = Estimated average annual Medicaid payment for C	$19,014	$20,662	$22,432
F = Estimated number of ICF/MR recipients without the waiver	8,384	8,593	8,803
G = Estimated average annual Medicaid payment for F	$27,523	$29,505	$31,509
H = Estimated number of noninstitutional service recipients without waiver	0	0	0
I = Estimated average annual Medicaid payment for H	$ 0	$ 0	$ 0

The numbers of recipients provided above are estimated total annual unduplicated totals. The dollars reflect the estimated average annual cost per recipient.

Medical Care

The quality of medical care necessary for the individual will be maintained under the arrangements contemplated.

Annual Report on Impact

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

APR 17 1984

Leonard W. Levine
Commissioner
State of Minnesota
Department of Public Welfare
Centennial Office Building
St. Paul, Minnesota 55155

Dear Mr. Levine :

I am pleased to inform you that **your request for Medicaid waivers** to provide home and community-based services to eligible Medicaid recipients as authorized under the provisions of section 1915(c) of the Social Security Act, **has been approved.**

Specifically, you request waivers to provide case management, respite care, homemaker, habilitation and minor physical adaptations to the home to eligible mentally retarded Medicaid recipients who would otherwise require institutional care. You also asked for waivers of the "statewideness" and "amount, duration, and scope of services" requirements specified in sections 1902(a)(1) and 1902(a)(10) of the Social Security Act, respectively.

Based on the assurances you provided, I approve the revised waiver request cited above for a 3-year period effective July 1, 1984 as requested. With a satisfactory showing, the waiver may be renewed at the end of the initial 3-year period.

The waiver request, as revised, conforms fully to the requirements of the statute and Medicaid regulations. You can be proud of the fact that the effort and cooperation provided by you and your staff enabled us to expedite our approval.

Sincerely yours,

Carolyne K Davis

Carolyne K. Davis, Ph.D.

.ARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Refer to: FQA-712

6325 Security Boulevard
Baltimore, MD 21207

July 31, 1984

Mr. Leonard W. Levine
Commissioner
Department of Public Welfare
State of Minnesota
Centennial Office Building
St. Paul, Minnesota 55155

Dear Mr. Levine:

In Minnesota's original waiver request (page 3) your State indicated it would use its institutional deeming rules under the waiver program. You are now asking that the Health Care Financing Administration provide specific written authority under section 1902(a)(10)(A)(ii)(VI) of the Act to use its institutional deeming rules under the waiver.

Although no specific reference was made, the approval letter forwarded to you on April 17, 1984 authorizes Minnesota to use its institutional deeming rules under the waiver. We are in the process of developing final regulations on home and community-based services which will address the deeming issue. Until the final regulations are published, Medicaid Action Transmittal 82-8 details the actions States may take with respect to deeming of income and resources under a home and community-based waiver program.

We trust that this information will meet your needs.

Sincerely yours,

Robert E. Wren
Director
Division of Provider Services
Coverage Policy, OCP, BERC

EXHIBIT C

Rule 41 (Permanent Rule Parts 9525.1800 to 9525.1930)
Advisory Committee Members

Sue Abderholden, Associate Director
Association for Retarded Citizens
ARC-Minnesota
3225 Lyndale Avenue South
Minneapolis, MN 55408

Gerald Mueller, Executive Director
Minnesota Developmental Achievement
Center Association
S-277 Griggs-Midway Building
1821 University Avenue
St. Paul, MN 55104

Harold Tapper, Executive Director
Association of Residences for the
Retarded in Minnesota
1885 University Avenue
St. Paul, MN 55104-3486

Elaine Saline and Roseanne Faber
Development Disabilities Council
1821 University, Suite 212
St. Paul, MN 55104

Anne Henry
Legal Advocacy for Developmentally
Disabled Persons
222 Grain Exchange Building
Minneapolis, MN 55415

Delores Baumhofer, County Commissioner
Association of Minnesota Counties
Community Service Building
7th and Washington
Montevideo, MN 56265

Michael Corman
Dakota County Human Services Department
1580 W. Highway 55
Hastings, MN 55033

George Steiner
Minnesota Association of Social Service
Directors
Courthouse
Anoka, MN 55303

HRI-Exhibit

EXHIBIT D

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

FOURTH DIVISION

-oOo-

Patricia Welsch, by her father and natural guardian, Richard Welsch, et al., on behalf of herself and all other persons similarly situated,

Plaintiffs,

-vs-

Arthur Noot, et al.,

Defendants.

CONSENT DECREE

No. 4-72 Civil 451

-oOo-

TABLE OF CONTENTS

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

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Patricia Welsch, by her father and natural guardian, Richard Welsch, et al., on behalf of herself and all other persons similarly situated,

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-vs-

Arthur Noot, et al.,

Defendants.

PROPOSED CONSENT DECREE

No. 4-72 Civil 451

-o0o-

PART I

1. Unless otherwise specified, the actions required by this Decree are the joint responsibility of the defendant Commissioner of Public Welfare and the defendant Chief Executive Officers of Brainerd State Hospital, Cambridge State Hospital, Faribault State Hospital, Fergus Falls State Hospital, Moose Lake State Hospital, Rochester State Hospital, St. Peter State Hospital, and Willmar State Hospital, their successors in office, agents, employees and all persons in active concert or participation with them.

PART II

DEFINITIONS

2. The term "Commissioner" refers to the Commissioner of the Department of Public Welfare of the State of Minnesota or the Commissioner of any successor department assigned responsibility for the functions governed by this Decree.

3. The terms "state institutions" or "state hospitals" refers to those institutions listed in paragraph 1 of this Decree.

4. The term "resident population" includes, for purposes of determining the staff allocations required to meet

staff ratios and for purposes of determining compliance with provisions governing reduction of resident population, all mentally retarded persons residing at the state hospitals as well as persons assigned to the hositals who are absent due to visits, camping, medical leave, provisional discharge or who have a comparable temporary absence which would not require a formal readmission to permit the person to return to the hospital.

5. "Full time equivalent positions" are those state complement positions which are authorized and funded by the Legislature. As of July, 1980, there are 5,677 such positions available to be allocated by the Department of Public Welfare. In determining compliance with any staff requirements of this Decree, only full time equivalent positions may be considered. Although a state hospital remains free to employ individuals subsidized through programs such as Foster Grandparents, Comprehensive Employment and Training Act, Work Equity Program, etc., such staff are not to be considered in meeting staff requirements.

6. "Over-complement positions" are those over and above the authorized full time equivalent positions assigned to a state hospital. These positions are not to be considered in determining compliance with any of the staffing requirements of this Decree. The sole exception to this general principle is to the extent that full funding for an over-complement position is actually allocated to the hospital filling the position.

7. The term "direct care staff" includes those persons employed at an institution as human services technicians, human services technicians senior, human services specialists, or human services specialists senior who are responsible directly for providing a resident with care, treatment, training and the like. Persons in civil service classifications other than those mentioned in the preceding sentence may be included within the direct care staff, subject to the prohibition against double counting stated in Paragraph 58.

8. The term "supervisory staff" refers to persons in residential program services or daytime program services at an institution who have responsibility for supervision of the staff assigned to a building, unit, or other similar component of the residential living areas or daytime program services such as a DAP leader, an Assistant Group Supervisor, Unit Director, Group Supervisor, or other person having supervisory responsibility for a living unit or portion of the daytime program services at an institution.

9. The term "professional staff" refers to persons who are Qualified Mental Retardation Professionals as that term is defined in 42 C.F.R. §442.401(1979) and any other persons with a bachelor's degree who have specialized training in providing care or training for mentally retarded persons and one year of experience in providing care or training to mentally retarded persons.

10. The term "semi-professional staff" refers to persons with education and experience greater than that required of direct care staff but lesser than that required of professional staff.

11. "Major tranquilizers" refers to medications which are phenothiazines, thioxanthines, and butyrophenones and other similar medications (such as loxapine) which would customarily be classified as antipsychotic agents. The term "major tranquilizers" specifically excludes medication administered solely for the purpose of seizure control and medications customarily classified as antianxiety agents such as barbiturates, benzodiazepines, diphenylmethane derivatives, and glycerol derivatives.

PART III

PROVISIONS RELATING TO REDUCTION IN STATE INSTITUTION POPULATION

Population Reduction Requirements

12. By July 1, 1987, the population of mentally retarded

persons in the state hospitals and the Minnesota Learning Center shall not exceed 1,850.

13. No identifiable group of state hospital residents, such as physically handicapped persons or persons with severe behavior problems, shall be excluded from the community placement efforts required to meet the population reduction requirements. The defendants shall not be obligated to meet any quota of placements among such identifiable groups.

14. Overall institutional population of mentally retarded persons shall be reduced to:

a. No more than 2600 by July 1, 1981.

b. No more than 2525 by July 1, 1982.

c. No more than 2375 by July 1, 1983.

d. No more than 2225 by July 1, 1984.

e. No more than 2100 by July 1, 1985.

f. No more than 1950 by July 1, 1986.

g. No more than 1850 by July 1, 1987.

15. The population levels indicated for July 1, 1981, 1983, 1985, and 1987 are binding and obligatory upon the Department; the levels indicated for 1982, 1984, and 1986 are advisory and non-binding.

Admissions

16. Mentally retarded persons shall be admitted to state institutions only when no appropriate community placement is available. The county has responsibility for locating an appropriate community placement, or, in the event that none exists, insuring that such placement is developed. In accordance with whatever authority is granted by statute and rule the Commissioner shall assure that counties perform their duties with respect to community placements.

Special Procedures Regarding Admission of Children

17. For any child admitted to a state institution after the entry of this Decree, an appropriate community placement must be located or developed so that the child's residency at the state hospital does not exceed one year from the date of admission, except that the County shall have until January 1, 1983, to locate or develop an appropriate community placement for children admitted to a state institution during the time period from the date of this decree until January 1, 1982. If an appropriate community placement becomes available to a child prior to the deadline established by this paragraph, the child shall be placed in that community program as soon as possible.

18. If the county determines that appropriate community services cannot be developed within the one year period due to the specialized care needs of the child and unavailability of support services or staff in the community, the county may request, no later than the ninth month of institutionalization, an extension of time from the monitor. For those children covered by the exception stated in paragraph 17 the county has until September 30, 1982, to request an extension of time from the monitor. The monitor shall notify the Commissioner and counsel for the plaintiffs when an extension of time is requested. The county shall provide evidence regarding 1) the child's service needs, 2) why those needs cannot currently be met in the community, 3) the program that is being provided to the child at the institution, and 4) the efforts that have been made to locate or develop community services, including efforts to work with several counties to establish a specialized regional community service.

19. The monitor, or a hearing officer appointed by the monitor pursuant to paragraph 95 (g) of this Decree, shall consider all the evidence presented by the county, parents, and other interested persons. The monitor may appoint an advocate to represent the interests of the resident.

20. An extension of time for development of community services shall be granted only if no appropriate community alternatives exist or can be developed within the required time limit. The monitor or hearing officer shall recommend whatever additional steps are necessary to expedite the development of appropriate community services for the child. In addition, the monitor may recommend changes in the program being provided at the institution if such are found necessary to insure an appropriate program of habilitation. Recommendations of the monitor are appealable to the Court pursuant to paragraph 95 (h) of this Decree.

Assessments

21. For each resident of an institution a detailed assessment must be made yearly at the time of the annual interdisciplinary team meeting to identify the type of community placement needed by that resident and the scope of services the resident will need when discharged to a community placement. This assessment shall be made in terms of actual needs of the resident rather than in terms of services presently available. The county and the Commissioner shall use these assessments in planning for and implementing the reduction in institution population required by this Decree and in developing plans for new residential and non-residential community based services.

Discharge Plans

22. The parties acknowledge that Minnesota law places the responsibility for establishing a continuing plan of after-care services upon the counties. Accordingly, prior to a resident's discharge from an institution, the county social worker, in cooperation with the resident, the parents or guardian, community service providers, and the interdisciplinary team shall formulate a discharge plan which includes, but is not limited to, the following provisions:

a. The type of residential setting in which the resident shall be placed;

b. The type of developmental or work programs (work activity, sheltered workshop, or competitive employment) which will be provided to the resident;

c. An individual habilitation plan consistent with Department of Public Welfare Rule 185 to be implemented when the resident is placed in the community placement;

d. The scope of supportive services which shall be provided to meet the resident's needs as defined in the assessment made pursuant to paragraph 21;

e. Within 60 days after placement the county social worker shall visit the resident in the community placement (after notice to the community program) to assess whether she or he is being provided the programs and services required by the discharge plan. The defendant Chief Executive Officers shall make available, upon request of the county social worker, the appropriate member or members of the resident's interdisciplinary team for the purpose of assisting with or conducting the assessment required herein. The county social worker shall provide to the hospital and the community program a written assessment of the appropriateness of the program and services being provided. The hospital shall in turn forward this assessment to the monitor with additional comments, if any, by a member or members of the interdisciplinary team on the appropriateness of the placement.

23. If, within 75 days after placement, the county has not provided the hospital with the written assessment required by paragraph 22 (e), the hospital shall report this fact to the monitor and to the Commissioner. The Commissioner shall assure that such an assessment is conducted and submitted to the monitor within 90 days after placement.

Placement in Community Programs

24. Persons discharged from state institutions shall be placed in community programs which appropriately meet their individual needs. Placement shall be made in either a family home or a state licensed home, state licensed program, or state licensed facility except when, because of the resident's independent living skills, the most appropriate placement would be an independent community residence, such as an apartment. In addition, until July 1, 1981, placement may also be made in a certified foster home for four or less.

25. For those persons not returning to their family home, preference shall be given to placement in small residential settings in which the population of mentally retarded persons does not exceed 16, and to facilities which, although exceeding 16 in total size, have living units of no more than 6 persons. However, defendants are not obligated to assure placement of any quota of residents in settings or living units of a particular size.

26. All persons discharged from state institutions shall be provided with appropriate educational, developmental or work programs, such as public school, developmental achievement programs, work activity, sheltered work, or competitive employment.

Appeal From Community Placement Decision

27. A state hospital resident or the resident's parent or guardian may object to a proposed community placement by appealing the placement decision pursuant to Department of Public Welfare Rule 185, which provides appeal procedures under Minn. Stat. §256.045, social service appeal.

Technical Assistance

28. The Commissioner shall allocate three staff positions to be filled by persons whose functions will be to assist in all phases of the development of community-based services for mentally retarded persons in order to implement this Decree, including the provision of technical assistance to persons

developing community-based services for mentally retarded persons.

29. The persons selected by the Commissioner to fill these positions shall be capable by reason of education or work experience to fulfill the functions described in this section of this Decree. One of the positions shall be filled no later than November 1, 1980 by a person who will coordinate the technical assistance functions. The other two positions will be filled no later than January 1, 1981.

30. The Commissioner shall make every possible effort to obtain non-classified civil service positions for the three technical assistance staff. The positions shall be funded at the level necessary to obtain qualified personnel. These three positions shall be in addition to the current six positions in the mental retardation division, which shall not be reduced during the pendency of this Decree.

31. The Commissioner shall submit candidates for these positions to a screening committee of five persons, three of whom shall be chosen by counsel for the plaintiffs and two of whom shall be chosen by the Commissioner. The screening committee shall interview the candidates and submit a report to the Commissioner ranking them and stating their qualifications for the positions.

32. The Commissioner shall provide the clerical services, travel funding, and other support necessary to assure that these persons may effectively carry out the technical assistance functions described in this section.

33. Without limiting the scope of their functions described in paragraph 28, the persons selected to fill the positions referred to in that paragraph shall:

a. Inform developers and prospective developers of the applicable statutory and regulatory provisions, and of the community resources available to assist in development of community-based services;

b. Investigate the availability of funding for development of community-based services for mentally retarded persons from state sources in addition to the Department of Public Welfare, from federal agencies, from counties and local government units, and from private sources;

c. Assist developers and prospective developers in obtaining necessary information from and providing necessary information to governmental agencies at the local, regional, state, and federal levels;

d. Assist providers in planning for the development of individual habilitation plans, with special emphasis on assisting in the development of programs for persons who are physically handicapped or who present severe behavior problems;

e. Assist in the management of the development of new community-based services and utilization of existing programs;

f. Assist in the resolution of problems between community-based services and other components of the comprehensive program for mentally retarded persons;

g. Assist county boards and community mental health boards, as applicable, in (1) identifying the needs of their mentally retarded persons, (2) developing service plans based on the needs of the mentally retarded persons, (3) developing appropriate programs and services, (4) monitoring and evaluating service adequacy and effectiveness;

h. Assist state hospitals in developing plans for the deinstitutionalization process;

i. Assist in coordinating the management and development of community-based programs and services with other components of the mental retardation service system.

Licensors

34. On-going training shall be provided by experts in programming for mentally retarded persons to all Department of

Public Welfare licensors of residential and non-residential programs for mentally retarded persons in the following areas: program planning for mentally retarded persons, behavior management, communication programs, and the needs of physically handicapped persons. When conducting a licensing review to assess whether appropriate programs of habilitation are actually being provided, licensors shall directly observe program implementation, conduct interviews, review records and documents, and use appropriate checklists in their assessments.

35. For each biennium, the Commissioner shall determine the number of licensors required to fulfill his responsibility to assure that licensed programs for mentally retarded persons are meeting the standards set by law or rule and shall include in his budget request a specific request for funds sufficient to fill the needed licensing positions.

PART IV

STAFF REQUIREMENTS FOR STATE HOSPITALS

Positions Covered

General

36. As of the date of this Decree, there are 5,677 full time equivalent positions allocated to serve mentally retarded (MR), mentally ill (MI), and chemically dependent (CD) persons in state hospitals.

37. For purposes of settlement, the parties agree that 2915.93 of these positions will be deemed to be serving mentally retarded individuals. There shall be no reduction in this staff allocation until such time as each state hospital has positions sufficient to meet all of the staffing requirements of paragraphs 46 through 55 of this Decree.

38. The parties also agree that 1556.52 positions will be deemed to be serving mentally ill and chemically dependent individuals. Nothing in this Decree governs the future use of these positions.

39. The remaining 1204.55 positions will be deemed to serve the needs of all three groups. If there is a reduction or reallocation of these positions, at least 45 percent of staff removed from these positions must be allocated to serve mentally retarded persons. (For example, if 100 of these positions are eliminated, at least 45 will be reallocated to serve mentally retarded individuals and will be added to the 2915.93 positions referred to in paragraph 37.) This process of reallocating at least 45 percent of these positions shall continue until such time as each state hospital has positions sufficient to meet all of the staffing requirements of paragraphs 46 through 55.

40. The classifications in paragraphs 37 through 39 are based upon classifications used in the Fiscal Year 1981 Salary Roster, a copy of which is on file with the Court. Appendix A, attached to this Decree, provides details of the method by which the positions have been classified. If a dispute should arise in the future because of any reorganization by the Department of Public Welfare, the classifications used in Appendix A and in the 1981 Salary Roster shall be used as guidelines for determining the distribution of staff.

Specialized Facilities

Hospital Units

41. The staffing standards of paragraphs 46 through 55 do not apply to the four units licensed as hospitals at the state institutions--Unit 1A at Brainerd State Hospital, Infirmary West at Cambridge State Hospital, the acute hospital ward (Third Floor) at Faribault State Hospital, and the medical unit at Rochester State Hospital. The staffing allocation for each of these units shall not be reduced from the level existing as of July 1, 1980, unless the reduction is justified by a decline in the number of mentally retarded persons served by the specialized unit or by a determination by the Commissioner either that a lesser number of staff or that another comparable service (for example, a local

general hospital) would still maintain the level of medical care provided by those units. If the Commissioner decides to reduce the number of staff allocated to any of these units, notice of such reduction shall be provided to the monitor and to counsel for the plaintiffs at least eight weeks prior to implementation of such reductions. Counsel for the plaintiffs may request the monitor to determine whether the action proposed by the Commissioner is consistent with this paragraph in accordance with the procedures established in Part VIII of this Decree.

Rochester Surgical Unit

42. The Commissioner may reduce the present allocation of staff assigned to the surgical unit at Rochester State Hospital only if mentally retarded residents are provided the same range of surgical services of the same quality as is presently provided at Rochester State Hospital.

Minnesota Learning Center

43. The staffing allocation presently made for the Minnesota Learning Center at Brainerd State Hospital shall not be reduced from the level of July 1, 1980, unless it is justified by a decline in the number of mentally retarded persons served by that unit or the Commissioner establishes in proceedings before the monitor in accordance with Part VIII of this decree that a reduction in staff will not reduce the level of physical care or habilitation provided the residents of that unit.

44. Positions assigned to hospital units (paragraph 41), the surgical unit at Rochester State Hospital, or the Minnesota Learning Center shall not be counted in establishing compliance with the ratios of paragraphs 46 through 55 of this Decree.

Support Staff

45. The allocations of janitors, foodservice workers, and housekeepers shall be sufficient to assure that their functions (including the sorting and folding of laundry) are adequately performed without requiring routine assistance from

direct care staff during times when residents are in the residential living area.

Number of Staff Required

46. Sufficient physicians licensed to practice in the State of Minnesota shall be employed to assure consistent attainment of a ratio of 1:175 of such physicians to the total number of mentally retarded residents in each hospital.

47. Sufficient registered nurses shall be employed to allow consistent attainment of a ratio of 1:45 of such nurses assigned to the residential living areas to the total number of mentally retarded residents in each hospital.

48. Sufficient qualified personnel shall be employed to provide dental services specified in 42 C.F.R. §§457-462 (1979).

49. Sufficient physical therapists shall be employed to allow consistent attainment of a ratio of 1:50 of such therapists to the total number of non-ambulatory mentally retarded residents in each hospital. If it is not possible for a state hospital to hire enough physical therapists to fulfill this requirement, professionals such as occupational therapists shall be used to meet this ratio.

50. Sufficient persons qualified to assist the therapists required under paragraph 49 shall be employed to allow consistent attainment of a 1:30 ratio of such persons to non-ambulatory mentally retarded residents in each hospital.

51. Sufficient social workers and social worker case aides shall be employed to allow consistent attainment of 1:40 ratio of such persons to the total number of residents in each hospital. No more than 50% of the total number of such persons shall be social worker case aides.

52. Sufficient direct care staff in residential program services shall be employed to allow allocation of 10.55 full time equivalent positions to each household within a hospital. For purposes of determining compliance with this section, the number

of households in a hospital will be deemed to be equal to the total mentally retarded population of the hospital divided by 15.

53. A sufficient number of supervisory staff, professional staff, and semi-professional staff in residential living areas shall be employed to allow a consistent attainment of a ratio of 1:8 of such staff to the total number of residents at each hospital. No more than 25% of these positions may be filled by semi-professional staff persons. Persons filling these positions to meet the overall 1:8 ratio may not be considered in assessing compliance with the 10.55 full time equivalent positions required in paragraph 52 above.

54. Sufficient direct care staff in daytime program services shall be employed to allow allocation of such staff at a ratio of 1:5 of such staff to the total number of residents who do not receive such services from the public school.

a. The number of direct care staff allocated to meet this 1:5 ratio may be reduced to the extent that residential direct care staff provided by paragraph 52 are routinely assigned to follow residents and to engage in teaching and training in daytime program services.

b. The maximum number of residential direct care staff counted to meet the 1:5 ratio will be .5 positions from each household of persons served by daytime program services. The number of households will be deemed to be equal to the number derived by dividing the total number of persons in daytime program services by 15.

55. A sufficient number of supervisory, professional, and semi-professional staff in daytime program services shall be employed to allow consistent attainment of a 1:6.5 ratio of such staff to the total number of residents who do not receive such services from the public schools.

a. No more than 40% of these positions may be

filled by semi-professional staff persons.

b. A maximum of 3/8 (37.5%) of the persons required by this section may also be counted in determining compliance with the direct care ratio of paragraph 54 if these persons are routinely assigned to the teaching and training of residents.

Use of Staff

56. Although the allocation of direct care positions for residential services is to be at 10.55 per household, the actual deployment of staff for each household need not be uniform. Actual deployment of staff shall take into account the special needs of physically handicapped persons, persons with severe behavior problems, and persons with substantial communication deficiencies.

57. Of the persons required to meet the direct care staff requirements of either paragraph 52 or 54 above, there must be a sufficient number of recreation aides responsible for implementing a program of organized recreation activities under the supervision of qualified professional or semi-professional persons to allow consistent attainment of a 1:50 ratio of such recreation aides to the total number of residents at each hospital.

58. In assessing compliance with paragraph 46 to 55 above, positions allocated to meet the requirements of one paragraph may not be counted again to meet the requirements of a second paragraph. The only exceptions to this provision prohibiting double counting are 1) the provision which allows the 1:5 direct care ratio of paragraph 54 to be met by counting 37.5% of the professional and semi-professional staff of paragraph 55, 2) the provision which allows counting .5 positions per household of direct care staff from paragraph 52, and 3) the recreation aides provision of paragraph 57.

Cambridge State Hospital

59. Staffing patterns at Cambridge State Hospital for the period from July 1, 1980, through June 30, 1981, are governed by an agreement of the parties entered before the Cambridge monitor on June 16, 1980. As of July 1, 1981, standards at Cambridge shall be controlled by the terms of this decree. Positions assigned to Cambridge State Hospital may not thereafter be transferred to any other state hospital unless Cambridge State Hospital retains a staff allocation sufficient to meet all of the terms of this decree.

In-Service Training For Staff

60. In-service training programs at the state institutions shall include increased emphasis on the proper care of physically handicapped persons (with particular emphasis on their positioning needs), proper implementation of behavior management programs, effective training for severely and profoundly retarded persons in communication skills, and training with regard to the services provided mentally retarded persons by residential and non-residential community service providers. Persons with expertise in these areas not employed by the Department of Public Welfare or at one of the institutions involved in this action shall regularly be used to augment such in-service training.

Consultant Services

61. Funding for the staffing requirements of this Decree shall not be achieved by reduction in funding for consultants providing special services for mentally retarded persons as reflected in the Department's report on file with the Court.

Reporting of Recruiting Difficulties

62. In the event that a Chief Executive Officer is consistently unable to fill a position or positions required by this Decree, a report shall be made and submitted in accordance

with Part IX of this Decree detailing efforts made to recruit for such position or positions.

PART V

REQUIREMENTS WITH RESPECT TO INDIVIDUAL RESIDENTS

Individual Habilitation Plans

63. Each resident must be provided with an individualized habilitation plan and programs of training and remedial services as specified in Department of Public Welfare Rule 34. These plans shall be periodically reviewed, evaluated, and, where necessary, altered to meet the current needs of the particular resident.

Adapted Wheelchairs

64. Each resident who requires a wheelchair must be provided one adapted to his size and personal positioning needs.

Mechanical Restraint, Seclusion, Separation

65. For purposes of this section of this Decree, the following definitions apply:

a. The term "mechanical restraint" refers to all forms of restraint used to restrict the movement of an individual or the movement or normal function of a portion of the individual's body such as restraint chairs, four-point restraint to a bed, cuff and belt, camisoles, arm boards, face masks, standing boxes, posey boards, and the like, with the following exceptions:

(1) All forms of manual restraint;

(2) Standing boxes when used as part of a physical therapy program;

(3) Devices used to provide support for the achievement of functional body position or proper balance;

(4) Devices customarily used on a short-term basis for specific medical and surgical (as distinguished from behavioral) treatment;

(5) Safety devices to prevent injury from incoordination or loss of consciousness, such as ties or tying jackets, seizure helmets, seat belts, and bed rails;

(6) Seat belts in a motor vehicle.

b. The term "seclusion" refers to the placement of an individual alone in a room or other small area from which egress is prohibited except that it does not include separation when used in accordance with this section.

c. The term "separation" refers to the placement of an individual for a brief time in a room or other small area from which egress is prohibited but only when done without use of mechanical restraint and in accordance with the procedures specified in this section of this Decree.

66. Except as provided in paragraph 69, no resident shall be placed in mechanical restraint, seclusion, or separation except in accordance with a behavior management program which meets the requirements of this section of this Decree and which is authorized by a committee consisting of, at a minimum, the following persons:

a. The Chief Executive Officer or that person's representative designated from among senior administrative personnel at the institution;

b. The Medical Director or a physician licensed to practice in the State of Minnesota selected by the Medical Director;

c. A staff member with substantial experience in behavior management programs;

d. A supervisory staff member from a living unit (This member of the committee may also fill the committee position required by subparagraph (c), above, if the person has substantial experience in behavior management programs.);

e. The resident or patient advocate at the institution;

f. One person experienced in behavior management programs who is not employed by the Department of Public Welfare or by one of the institutions under the supervision of the Commissioner.

67. A behavior management program which includes the use of mechanical restraint or seclusion shall be authorized by the committee only if that program is to be used to consequate specified behavior or behaviors which cause physical injury to the resident restrained or secluded or to others and only if the program:

a. States the behavioral objectives of the program.

b. Identifies and, if necessary, defines all behaviors relevant to the program.

c. Contains procedures designed to reduce or eliminate the maladaptive behaviors which occasion the use of mechanical restraint or seclusion.

d. Contains procedures designed to replace the maladaptive behaviors which occasion the use of mechanical restraint or seclusion with behaviors which are adaptive and appropriate. A procedure of routinely reinforcing the resident on a periodic basis (such as every 30 or 60 minutes or other time period not related to the actual incidence of the targeted maladaptive behavior) for the non-occurence of the targeted maladaptive behaviors, based upon a momentary observation or time-sampling, shall not satisfy the requirements of this subparagraph.

e. Specifies that the procedures required by subparagraphs (c) and (d) shall be implemented on all shifts and in all appropriate areas of the institution, unless the program specifies that for assessment of the efficacy of the procedures

used it will initially (within the first week) be implemented only in a designated area or areas, only on certain shifts, or only for short periods of time.

f. Is submitted to the committee with documentation that other less restrictive measures of modifying or of replacing the targeted maladaptive behavior have been systematically tried and have been demonstrated to be ineffective or that the present incidence of the behavior is such that the likelihood of severe physical harm to the resident or others is so great that other less restrictive measures cannot reasonably be employed. (This documentation shall include reference to the date, time, and place of the action or actions of the resident which render the use of mechanical restraint or seclusion necessary.)

g. Specifies less restrictive measures which must be used prior to placing the individual in mechanical restraint or seclusion, unless documentation is presented to the committee which demonstrates that immediate implementation of mechanical restraint or seclusion is necessary if the program can reasonably be expected to be effective.

h. Specifies the schedule for use of the program.

i. Specifies the person or persons responsible for implementation of the program.

j. Specifies the data to be collected to assess progress toward the objectives of the program.

k. Specifies the procedures to be followed in modifying the program based on the data collected.

l. Specifies the criteria to be used in determining whether to continue with the program including:

(1) A description of the changes in behavior which must occur;

(2) The period of time allowed during which each change in behavior must occur if the program is to be continued;

(3) A specific fixed date when the program shall terminate unless, prior to that date, the committee authorizes continuation of the program. This date shall not be later than three months from the date of authorization of the program by the committee. The committee may, at the time the program is authorized or at any subsequent time, direct that the program shall be terminated at an earlier time.

m. Specifies the procedure to be followed in placing an individual in mechanical restraint or seclusion.

n. Specifies the persons authorized to place the individual in mechanical restraint or seclusion.

o. Specifies that mechanical restraint or seclusion may not be employed for a period longer than 15 minutes unless:

(1) Use of longer periods of mechanical restraint or seclusion is essential for effective implementation of the behavior management program, in which instance the use of such longer periods of use of mechanical restraint or seclusion shall be monitored by professional, semi-professional, or supervisory staff in the residential living area or daytime program area, or,

(2) Extended periods of use of mechanical restraint or seclusion (such as at meal times or at night) are necessary to prevent injury to the resident or to others, in which case:

(a) The program and all documentation submitted to the committee shall be submitted to the Assistant Commissioner of Mental Health of the Minnesota Department of Public Welfare, to the monitor, and to counsel for the plaintiffs, and,

(b) Reasonable attempts are made on a regular basis to render such extensive or continuous programs unnecessary through the use of intensive behavior management programs.

68. A behavior management program which includes the use of separation shall be authorized by the committee only if that program is used to consequate specified, 1) self-injurious behavior, 2) aggressive behavior (which must include physical harm or the serious threat of it to others), 3) behaviors demonstrated to occur on a consistent basis prior to these specified self-injurious or aggressive behaviors in situations in which other less intrusive procedures have been used in response to these antecedent behaviors and have been demonstrated to be ineffective in reducing or preventing these specified self-injurious or aggressive behaviors, or 4) serious property destruction or the imminent threat of serious property destruction on the part of the resident and only if the program:

a. Meets all the requirements of subparagraphs (a) through (n) of paragraph 66 of this Decree (substituting "separation" in those subparagraphs for "mechanical restraint or seclusion").

b. Documents that use of separation would constitute withdrawal of the individual from a situation which affords positive reinforcement.

c. Specifies that termination of the use of separation will occur upon the cessation of the targeted maladaptive behavior together with completion of a specified minimum time-out duration, upon demonstration of social responsiveness or cooperation with the observer, or after 15 minutes, whichever is the shortest period of time, unless the program may reasonably be expected to require a longer period of separation (not to exceed an hour) in order to be effective when

intitally (within the first week) implemented and then only if the program specifies that:

(1) Supervisory personnel approve the use of that procedure in excess of 15 minutes and that approval is noted in the resident's permanent record.

(2) Documentation of the resident's behavior in the separation roor is made on no less than ten minute intervals and in sufficient detail to pro .de a basis to determine what changes may be required in the separation procedure or the behavior management program to render use of such extended periods of confinement unnecessary.

(3) If appropriate, staff persons interact or attempt to interact with the resident in order to facilitate release from confinement.

d. Specifies that a staff person must observe the resident at all times while the resident is in separation.

e. Provides that any room used to confine a resident as part of a separation program shall:

(1) Be free of objects or fixtures that can be broken or cause or inflict injury and otherwise provide a safe environment for the resident.

(2) Have an observation window or other device which permits continuous monitoring of the resident during separation.

(3) Have a locking device which permits the door to be opened from the outside without a key.

(4) Be large enough to allow the resident to stand, to stretch his or her arms, and to lie down.

(5) Be well-lighted, well-ventilated, and clean.

69. Mechanical restraint or seclusion, not part of a behavior management program, may be used only on an emergency

basis to prevent the resident restrained or secluded from injuring himself or others; provided that:

a. Each use shall be reviewed by administrative personnel with sufficient authority to direct the development and implementation of a treatment program to address the behavior resulting in the use of mechanical restraint or seclusion, which program shall be developed and implemented, if appropriate, in accordance with this Decree.

b. Documentation of this review, including an assessment of the appropriateness of emergency use of mechanical restraint or seclusion, shall be entered in the resident's permanent record.

c. The review shall be discussed by supervisory personnel with staff persons who were on duty in the living unit or other area at the time of the emergency use of mechanical restraint or seclusion.

70. In each instance in which mechanical restraint, seclusion, or separation is employed, regardless of whether it occurs as part of a behavior management program, the person instituting its use shall record in the resident's record:

a. A detailed description of the precipitating behavior.

b. The expected behavioral outcome.

c. The time when the resident was restrained or secluded.

d. The time when the resident was released.

e. The actual behavioral outcome.

71. Any resident placed in mechanical restraint or seclusion shall be checked at no less than ten-minute intervals. Documentation of these checks and a brief description of the resident's condition at each check must be placed in the resident's record at least every hour.

72. A copy of all programs received by the committee pursuant to paragraphs 66 through 68 of this Decree, together with all documentation submitted in support of the request for approval of the program, and a record of the committee's action on the proposal shall be:

a. Entered into the resident's permanent records, unless the program is disapproved in which instance a notation shall be made in the record and a reference made to the place where the disapproved program is filed.

b. Maintained in a central file by the committee.

73. A report shall be provided to the monitor and counsel for the plaintiffs of each injury suffered by a resident as a result of the use of mechanical restraint, seclusion, or separation procedures.

74. Paragraphs 65 through 73 of this Decree do not apply to the Minnesota Learning Center at Brainerd State Hospital. Nothing in this Decree shall bar any action by any resident with regard to the use of mechanical restraint, seclusion, or separation at the Minnesota Learning Center.

Limitations on the Use of Major Tranquilizers

75. Major tranquilizers must not be administered to residents for punishment, for the convenience of the staff, or as a substitute for program.

76. Major tranquilizers may be used for control or modification of behavior of residents only when necessary to prevent injury to the resident or others or when the behavior involved has been found to be a substantial impediment to implementation of the plan for habilitation of the resident.

77. Major tranquilizers must not be used for the purpose of controlling or modifying behavior of residents unless a physician licensed to practice medicine in the State of Minnesota has prescribed medication for that purpose. The physician who prescribes such medication must insure that the target or

objectionable behaviors to be modified are specified in the resident's record.

78. Major tranquilizers must not be used for the purpose of controlling or modifying behavior of residents unless records based upon direct staff observation are consistently maintained. Random surveys, which shall include daily samples, may be used in preparing such records. Such records must show the number of times the target or objectionable behavior specified in accordance with paragraph 77, above, has occurred. Major tranquilizers must not be used unless the determination to prescribe or to continue the prescription of such medication and the determination of the dosage of such medication to be administered is based upon evaluation of the efficacy of the medication in controlling or modifying the specified behavior as demonstrated by the incidence of target or objectionable behaviors recorded in accordance with this paragraph.

79. Nothing in this section of this Decree shall be construed to prevent the Medical Director of the appropriate institution from prescribing the administration of major tranquilizers to a resident in a manner inconsistent with the provisions of this section so long as the basis for the clinical judgment to do so is recorded in the resident's record and copies of all portions of the resident's file which are pertinent to that decision are submitted to the monitor in accordance with Part IX of this Decree.

80. Paragraphs 75 to 79 of this Decree apply only at Moose Lake State Hospital.

81. Counsel for the plaintiffs no earlier than March 1, 1981, and no later than December 31, 1981, may request the monitor to determine in a manner consistent with part VIII of this Decree whether this section of the Decree should be applied at Cambridge State Hospital, St. Peter State Hospital, or Willmar State Hospital. This section of the Decree shall not apply to these

three institutions except upon further Order of the Court.

PART VI

PHYSICAL PLANT

82. In each institution, toileting and bathing areas used by mentally retarded residents shall be modified as necessary to insure privacy no later than July 1, 1981.

83. The Department of Public Welfare shall seek an appropriation to provide carpeting or an alternative floor covering for all areas which will be in use for mentally retarded persons in state hospitals in 1986, in accordance with a plan to be developed by the Department no later than July 1, 1983. Carpeting or an alternative floor covering shall be installed no later than 1986, contingent upon legislative appropriation of funds.

84. If legislative approval has not been obtained for the carpet or alternative floor covering by May 1, 1984, plaintiffs will be allowed to seek further relief from the Court for these items.

85. At Fergus Falls State Hospital, after the Adult Achievement Center has completed its transfer to a renovated area, the residential areas for the Achievement Center for the Physically Handicapped will be altered to provide at least three households, unless the resident population of the Achievement Center for the Physically Handicapped at the time of the transfer is 45 or less.

86. At Fergus Falls State Hospital, the Department shall seek an appropriation to provide air conditioning (or an alternative form of ventilation if one is found to be more appropriate for the health and well-being of the residents) for the residential areas occupied by the Achievement Center for the Physically Handicapped. The air conditioning or alternative ventilation shall be provided by May 1, 1983, contingent upon legislative appropriation of funds.

87. If legislative approval has not been obtained for this air conditioning or ventilation by May 1, 1983, plaintiffs will be allowed to seek further relief from the Court for this item.

PART VII

LEGISLATIVE PROPOSALS

88. Prior to each session of the Legislature for the duration of this Decree, the Commissioner shall propose to the Governor for submission to the Legislature all measures necessary for implementation of the provisions of this Decree.

89. As part of the Governor's 1981 budget recommendation and legislative program the Commissioner will submit to the Legislature proposals addressing the following:

a. Semi-independent Living Services (SILS). The proposal will provide for no less than $1,700,000 for SILS. The funding can be provided from any combination of county, state and federal sources. (It is the intent of the parties that the $1.7 million dollars shall fund additional SILS placements in addition to those currently in existence.)

b. Need for additional capacity in community-based residential facilities and developmental achievement centers (DACs). The proposal will provide for the development of additional bed capacity and DAC capacity necessary to accommodate former residents of state institutions. The legislation shall address the funding mechanism for DAC programs, transportation, and building renovation necessary to serve former residents of state institutions.

c. Sheltered Workshops. These services are funded by the Minnesota Department of Economic Security. The Department of Public Welfare will testify on behalf of an anticipated proposal to increase the number of such workshops and will, by January 1, 1981, enter into an interagency agreement with the Department of Economic Security to clarify responsibilities with

respect to sheltered workshops, developmental achievement centers, work activity centers, and independent living programs.

d. Family Subsidy Program. It will be proposed that the statutory reference to "experimental" shall be stricken and that the funding be increased to no less than $924,000 for the biennium.

e. Start Up and Construction Grants-in-Aid. The Department will propose no less than $600,000 for the biennium for the funding of grants-in-aid and start up costs pursuant to Minn. Stat. §252.30. In addition, the Commissioner will study the feasibility of a start-up and construction revolving low-interest loan fund for profit and non-profit service providers and a long-term payment guarantee policy for use by providers in obtaining private financing. This report shall be provided to the monitor and plaintiffs' counsel within one year of the date of this Decree.

f. Financial incentives to place mentally retarded persons in state hospitals. The proposal will eliminate the financial incentives currently encouraging counties to place mentally retarded persons in state hospitals.

90. Legislation to be proposed by the Department as required by this Decree shall be developed in consultation with interested community groups such as Minnesota Association for Retarded Citizens, Minnesota Developmental Achievement Center Association, Association of Residences for Retarded in Minnesota, Society for Autistic Children, United Cerebral Palsy, Advocating Change Together, Minnesota Association of Counties, and plaintiffs' counsel. Preparation of legislation, including meetings with interested parties, shall begin forthwith.

PART VIII

APPOINTMENT AND RESPONSIBILITIES OF A MONITOR

91. Within thirty days of the date of this Decree, counsel for the parties shall, if they are able to agree, submit

to the Court for approval their joint nominee for a person qualified to serve as a monitor of the implementation of this Decree.

92. In the event that the parties cannot agree upon a joint nominee for the monitor position, counsel for the parties shall, within forty-five days of the date of this Decree, submit to the Court their nominee or nominees (no more than three monimations can be made by the plaintiffs or by the defendants) for the monitor position.

93. The monitor shall have the education and experience necessary to perform the duties specified in this Decree. The monitor shall be a person with experience in the field of mental retardation and with familiarity with community-based programs and institutional programs for persons who are mentally retarded.

94. The monitor's rights and responsibilities shall be limited to those specified in this Decree.

95. When approved by the Court, the monitor shall be appointed to perform the following functions in his or her professional capacity as a neutral officer of the Court:

a. The monitor shall review the extent to which the defendants have complied with this Decree.

b. The monitor may retain qualified consultants and support personnel necessary for adequate review of compliance by the defendants with this Decree.

c. The monitor shall report semi-annually to the Court and to counsel for the parties summarizing actions taken to fulfill the functions of a monitor and stating the extent to which the defendants have complied with actions required by this Decree.

d. The monitor shall receive and investigate reports of alleged non-compliance with the provisions of this Decree from counsel for the plaintiffs and from other interested persons. If the monitor has reason to believe that the defendants

have not complied with this Decree, the procedures established in subparagraphs (e) through (h) below shall be followed.

e. If the monitor believes that a provision of this Decree is not being complied with, the monitor shall forthwith provide notice to counsel for the parties, to the Commissioner, and to the appropriate Chief Executive Officer of the factual basis for the monitor's belief.

f. Subsequent to such notice, if the monitor determines that the Commissioner or the Chief Executive Officer has not taken appropriate steps to remedy with reasonable promptness the deficiency reported by the monitor in the notice, the monitor shall notify counsel for the parties of that determination and shall allow them two weeks within which to resolve the matter informally. If no resolution is reached the monitor shall direct counsel for the parties and appropriate Department of Public Welfare and institutional personnel to confer formally with him or her to establish the steps which should be taken to remedy the deficiency.

g. If either the monitor or either party is dissatisfied with the result of the formal conference held in accordance with subparagraph (f), above, the monitor shall conduct, or retain a qualified hearing officer to conduct, an evidentiary hearing regarding the question of compliance raised by the notice provided defendants pursuant to subparagraph (e) above. Evidence shall be received in accordance with the standard established by Minn. Stat. §15.0419 (1978). The monitor shall submit to counsel for the parties and to the Court findings of fact based upon the record presented at this hearing together with whatever recommendation regarding corrective action the monitor may deem appropriate.

h. Recommendations made by the monitor shall not be implemented except on motion by either of the parties or by the Court, after notice and an opportunity for all parties to be heard

by the Court. Reports, recommendations, and findings of fact made by the monitor may be received in evidence in any further proceedings in this action.

i. Notwithstanding any other provision of this Decree, all allegations of non-compliance and all disputes under this Decree must be taken to the monitor prior to submission to the Court, except that a failure to make the physical plant improvements required under Part VI and requests to replace the monitor may be brought directly to the Court.

j. The monitor shall provide reasonable advance notice to the appropriate Chief Executive Officer or other agency administrator of any visit to or inspection of an institution or community facility unless the monitor has reasonable and particular basis to conclude that effective monitoring of implementation of this Decree could not be accomplished if advance notice were given. If the monitor determines that no advance notice should be given, the monitor shall, nevertheless, upon arrival inform the Chief Executive Officer or administrator (or in the absence of such persons, other senior administrative staff persons) of his or her presence at the institution or agency.

k. The monitor shall establish and confer with, on a regular basis, a group composed of representatives of state hospital parent groups, organizations such as the Minnesota Association for Retarded Citizens, local Association for Retarded Citizens chapters, the Minnesota Developmental Achievement Center Association, the Association of Residences for the Retarded in Minnesota, Society for Autistic Children, United Cerebral Palsy, Advocating Change Together, and other interested persons. The Commissioner shall be notified in advance of the group's meeting and may send a representative.

l. The monitor may initiate proposals to the Court only as specified in paragraphs 96 (d) and 102 of this Decree.

96. The defendants shall cooperate with the monitor and any consultants retained by the monitor to assure that the functions of the monitor may properly and effectively be carried out. In this respect, the defendants shall take the following actions, which are intended to exemplify, but not to limit, the scope of their cooperation with the monitor:

a. Provide access to the grounds, buildings, and all pertinent records of the several institutions involved in this action.

b. Provide access to pertinent records and information at the Department of Public Welfare, including information which Department of Public Welfare employees must retrieve from data processing systems.

c. Assure that discharge and placement plans for state hospital residents include a provision that the monitor has access to records of individuals from state hospitals placed in community facilities and to the community facilities providing services to these individuals for the purpose of determining compliance with this Decree.

d. If there is a dispute as to the monitor's right of access to any information or documents, he or she shall confer with counsel for the parties. If no agreement is reached, the question may be submitted by the monitor to the Court for resolution after notice to counsel for the parties.

97. The Commissioner of Public Welfare shall provide funding for the monitor in an amount of $55,000 for the first year of service and an annual amount increased in subsequent years on the same basis as cost-of-living increases provided state employees. The method of providing this funding shall be approved by the Court after notice to counsel for all the parties. That method of funding shall be designed to provide, if at all possible, that the monitor shall be included in a group fringe benefit program. The method of funding shall also provide that

any funds not spent in one year shall be available for expenditure in subsequent years. The monitor shall not spend more money for his or her personal services, for consultant and support personnel, and for other expenses than is provided pursuant to this paragraph. The Commissioner shall provide office space and equipment, telephone service, and clerical support for the monitor and persons paid out of the monitor's budget. The monitor shall not be housed with Department of Public Welfare personnel subject to the obligations imposed by this Decree. The defendants and counsel for the plaintiffs shall cooperate with the monitor should the monitor seek to employ persons under any program which requires a state agency or a non-profit corporation to be the sponsoring agency for such employment.

98. The monitor shall serve at the pleasure of the Court. The monitor shall be appointed no later than November 1, 1980, and shall serve regular terms of no less than one year until July 1, 1987. Any party may move the Court for replacement of the monitor for failure to fulfill the functions specified in this Decree. Any replacement for the monitor shall be appointed by the Court in accordance with procedures similar to those provided in paragraphs 91 through 93, above.

PART IX

REPORTING REQUIREMENTS

99. Copies of all reports required to be made pursuant to this Decree shall be:

a. Submitted to counsel for the plaintiffs, and

b. Submitted to the monitor appointed pursuant to Part VIII of this Decree.

100. The parties shall confer with the monitor no later than thirty days after the monitor assumes that position to establish more detailed reporting requirements which the defendants must follow. To the extent feasible, internal management reports already developed or which may be developed at

the several institutions and at the central office of the Department of Public Welfare shall be used. Documents or other reports providing the information necessary to assess compliance shall be freely used in lieu of reports which would be prepared soley for the purpose of the reporting requirements of this Decree and any orders issued pursuant to it. Appropriate deference in establishing reporting requirements shall be given to the varied administrative and management structures of the several institutions.

101. The reporting requirements shall include information necessary to assess compliance with all provisions of this Decree. That information shall include, but is not limited to, regular reports on the following:

a. Reports showing the positions at the institution assigned to meet the staffing requirements of this Decree together with the total allocation of all positions at the institution;

b. Resident census by household;

c. Names of all residents admitted after the date of this Decree together with a copy of the admission summary;

d. Names of all residents discharged or transferred after the date of this Decree, the institution, agency, or other placement to which a discharge or transfer was made, and the county in which that placement is located;

e. Names of all persons placed in restraint, seclusion, or separation together with the number of times so placed and the length of time in restraint, seclusion, or separation;

f. Copies of all death reports and all incident reports regarding serious injuries to residents;

g. On at least a semi-annual basis a list of new residential and non-residential community based facilities developed or under development;

h. By December 15, 1980, and each December 15th thereafter, a copy of legislative proposals to be submitted to the Legislature pursuant to Part VII of this Decree;

i. Notification to the monitor and plaintiff's counsel in advance of each legislative hearing or committee meeting regarding all legislative measures proposed to implement this decree when the time or place of the hearing or meeting would not appear in information regularly available to the general public;

j. Copies of any document or report, other than a document or report which would be covered by the attorney-client privilege, regarding allocation of staff or funds to, limitations on employment of staff or on expenditure of funds at, or changes in the organization of residents or staff at any of the several institutions. (Such documents shall be submitted forthwith in the event that the action proposed or required by the document could reasonably be expected to have an immediate and substantial adverse effect on the implementation of this Decree.)

102. Any agreement on the specific reporting requirements reached by the monitor and the parties shall be incorporated in a proposed order submitted to the Court for approval within 60 days of the appointment of the Monitor. In the event that agreement cannot be reached by the monitor and the parties on the substance, format, or schedule for reporting, the monitor may, upon notice to all parties, submit proposed reporting orders to the Court for approval. Modifications in the reporting orders approved by the Court may be submitted by the monitor to the Court after providing the parties an opportunity to review and to comment on proposed changes.

PART X.

GENERAL PROVISIONS

103. The defendant Commissioner and the defendant Chief Executive Officers must not comply with any executive or

administrative order or directive which in any way interferes with or impedes compliance by them with all provisions of this Decree.

104. A copy of this Decree shall be posted in a prominent place in each building used by residents at the institutions involved in this action.

105. The obligations imposed upon the defendants under this Decree are not intended to relieve the defendants of any other obligations imposed upon them under any state or federal statute or regulation.

106. Counsel for the parties and the monitor shall not disclose information obtained pursuant to the reporting requirements of this Decree regarding individual residents of or employees at any state institution or community facility except to persons directly associated with them in seeking implementation of this Decree (who shall be subject to similar limitations on disclosure) or except when necessary in proceedings before this Court.

107. Counsel for the plaintiffs and others with their authorization must be allowed reasonable access to the grounds, buildings, and pertinent records at the state institutions and community facilities for purposes of observation and examination until further Order of this Court.

108. Within fifteen (15) days of the date of this Decree the defendants will cause payment to be made to Central Minnesota Legal Services the sum of $100,000 to cover costs and attorneys' fees for the prosecution of this action.

109. Effective as of July 1, 1981, the Consent Decree entered into with regard to Cambridge State Hospital on December 28, 1977, and all orders issued pursuant to that Decree are dissolved.

110. The provisions of this Decree shall not constitute an admission by the defendants as to the truthfulness of any of

the allegations in the Complaint or as to their liability in this action.

111. This Court shall continue to maintain jursidiction over this action until July 1, 1987. On that date jurisdiction over this action shall end if the defendants have substantially complied with the terms of this Decree. If the defendants have fully complied with all provisions of this Decree prior to July 1, 1987, they may move the Court, upon notice to counsel for the plaintiffs, for an earlier termination of jurisdiction.

UNITED STATES SENIOR DISTRICT JUDGE

DATED: September 15, 1980.

APPENDIX A

Staff Allocations

		MR	OTHER	MI-CD
1.	Anoka	0		364.4[1]
2.	Brainerd	378.25	206.1[2]	72.55
	MLC	55	---	0
3.	Cambridge	698.8	44.6[3]	0
4.	Faribault	926.2	65.6[4]	0
5.	Fergus Falls	242.25	157.25	184.4
6.	Moose Lake	147.73	138.9	200.27
7.	Rochester	125	187.3	154.9
	Surgical Unit		56.7	
8.	St. Peter	185.7	157.6	296.6
9.	Willmar	157	190.5	283.4
		2,915.93	1,204.55	1,556.52
		Protected	45% to MR[5] if reduced	Not Protected

1. Since Anoka serves only mentally ill and chemically dependent persons, any reduction in staff is not governed by this agreement.

2. The 1981 Salary Roster lists 175.5 positions as General Service (GS) and 30.6 positions for laundry. These two numbers are combined to give the 206.1. The same procedure is used with Willmar and St. Peter.

3. Cambridge is listed as having 743.4 positions. The 40 over-complement positions are not included here. There are 216.67 positions listed as General Services. Plaintiffs have agreed that 10 percent of this general service staff (21.6 positions) may be classified as "Other" so that 45 percent of the reductions from this portion of the staff will be reallocated to MR. The remaining 23 positions in the "Other" category are laundry workers.

4. Faribault follows the same procedure as Cambridge. Of the 206 general service workers, 10 percent (20.6) are classified as "Other" and 45 laundry workers are added to give a 65.6 total.

5. According to data from June, 1980, the hospitals serving more than one disability group (i.e., all except Anoka, Cambridge, and Faribault) had a population of approximately 3050 of which approximatley 1350 were mentally retarded. Based upon these population figures, 45 percent is used as a basis for pro-rating general service staff.

EXHIBIT F

Shirley J. Schue----------RESUME

Address: 2640 Werth Road
Alpena, Michigan 49707

Telephone: 517-356-4151 (Home)
517-356-2161 (Business)

PROFESSIONAL GOALS:

1. To promote the principles of normalization and the placement of the developmentally disabled into the least restrictive setting.

2. To persue positons related to community placement of the handicapped that allow for the growth of my professional abilities.

3. To perform my job in a knowledgeable and enthusiastic manner.

EDUCATIONAL BACKGROUND:

August 1977 — M.S. degree in Education
Indiana State University
Terre Haute, Indiana 47809

May 1973 — B.S. degree in Education
Indiana State University
Terre Haute, Indiana 47809

May 1970 — Washington High School
Washington, Indiana 47501

WORK EXPERIENCE:

Sept. 1980 to present — Northeast Michigan Community Mental Health
630 Walnut Street
Alpena, Michigan 49707

Position: Supervisor of Clinical and Casemanagement Services

Responsible for the supervision of all clinicians and case-management staff providing services to developmentally disabled clients. These services include placement from state facilities into a 145 bed specialized community placement program, children's placement and licensing of foster care homes, a 16 bed semi-independent training home, placement of individuals into nonspecialized adult foster care, outpatient services and coordination of training for direct care staff.

April 1976 to Sept. 1980 — Northeast Michigan Community Mental Health
630 Walnut Street
Alpena, Michigan 49707

Position: Skills Development/
Day Program Supervisor

Responsible for the supervision of programs and staff of two adult activity centers that service approximately 35 clients each of varying degrees of disability. I coordinated biannual team meetings and individual program plan meetings.

Sept. 1975 to April 1976 — St. Anne's Elementary School
Alpena, Michigan 49707

Position: Teacher

Taught half-time in the sixth grade. I covered the following subjects: reading, spelling social studies, English and music.

Sept. 1973 to May 1975 — Putnam-West Hendrix Special Ed. Cooperative
Bainbridge, Indiana

Position: Teacher

Taught trainable mentally impaired students in a self contained classroom. Ages ranged from 12 to 18 years of age.

CREDENTIALS:

Licensed as a social worker by State of Michigan
Allied staff privileges: Alpena General Hospital

VOLUNTEER/PROFESSIONAL ORGANIZATIONS:

Special Olympics Program
American Association on Mental Deficiency
Northern Michigan Conference on Developmental Disabilities (Chairperson)

EXHIBIT G

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 435, 436, 440 and 441

[BERC-182-F]

Medicaid Program; Home and Community-Based Services

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This rule amends the interim final Medicaid regulations published on October 1, 1981 that implemented section 2176 of the Omnibus Budget Reconciliation Act of 1981. The regulations permit States to offer, under a Secretarial waiver, a wide array of home and community-based services that an individual may need to avoid institutionalization. These final regulations: (1) Provide that certain facilities must meet standards, including those established under section 1616(e) of the Social Security Act, if waiver services are to be provided in the facilities, (2) revise the equation that States must use to determine the cost-effectiveness of their waiver programs, (3) clarify that these services are available, at a State's option, to both medically needy individuals and categorically needy individuals, (4) provide that all recipients who are eligible under a special income level will have their post-eligibility income treated in a comparable manner, (5) revise some aspects of the assurances and the documentation that States must provide in their waiver requests, (6) revise the effective date of an approved waiver, (7) established a federal financial participation (FFP) limit for expenditures for home and community-based services, and (8) specify the hearings procedures that apply to waiver terminations.

EFFECTIVE DATE: April 12, 1985. However, in § 441.304(a) the change specifying the effective date of an approved waiver is effective September 9, 1985. In § 441.303(g), the change requiring an independent assessment of a waiver applies only to waiver requests and requests for extensions that are received after April 12, 1985. In § 441.301(b)(6), the change requiring States to submit individual waiver requests for each target group applies only to new waiver requests that are received after April 12, 1985. Finally, the provisions discussed in section IV. of the preamble, *Applicability of Regulation Changes*, have other effective dates as specified in section IV.

FOR FURTHER INFORMATION CONTACT: Robert Wren, (301) 594-9691.

SUPPLEMENTARY INFORMATION:

I. Background

On October 1, 1981, we published an interim final rule with a comment period (46 FR 48532) implementing the provisions of section 2176 of Pub. L. 97-35, the Omnibus Budget Reconciliation Act of 1981. Those regulations established a waiver program under which States are reimbursed for providing home and community-based services to individuals who would otherwise require the level of care provided in a skilled nursing facility (SNF) or intermediate care facility (ICF).

II. Statutory Amendments

Section 2176 added a new section 1915(c) to the Social Security Act (Act) that authorizes the Secretary to waive certain Medicaid statutory requirements to allow a State to cover a broad array of home and community-based services provided to individuals as an alternative to institutionalization. It also provides that the Secretary may not approve the State's request for a waiver unless the State, at a minimum, provides satisfactory assurances to the Secretary that:

1. Necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of beneficiaries provided services under the waiver and to assure financial accountability for funds spent for the services;

2. The State will provide for an evaluation of the need for the inpatient services for individuals who are entitled to and who may require the level of care provided in an SNF or ICF under the State plan; and who may be eligible for care under the home and community-based waiver;

3. Any individuals who are determined to be likely to require the level of care provided in an SNF or ICF are informed of the feasible alternatives available under the waiver, and are given the choice of the inpatient services or the alternative noninstitutional services;

4. The average per capita expenditure estimated by the State in any fiscal year for medical assistance provided to these individuals under the waiver does not exceed the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for these individuals if the waiver had not been granted; and

5. The State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver on the type and amount of medical assistance provided under the State plan and on the health and welfare of its beneficiaries.

Additionally, the law specifically provides that a waiver granted under section 1915(c) of the Act may include a waiver of the requirements of sections 1902(a) (1) and (10) of the Act. Under section 1902(a)(1) of the Act, a State plan for medical assistance must be in effect throughout the State. Section 1902(a)(10) of the Act, as amended by section 2171 of Pub. L. 97-35 and section 137(b)(7) of Pub. L. 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), sets forth certain Medicaid eligibility and service coverage requirements. It requires the plan to provide the same services (in amount, duration, and scope) to all categorically needy individuals; and also requires that the services available to the categorically needy are not less in amount, duration, and scope than those available to medically needy beneficiaries. Under the waiver, home and community-based services do not have to be provided throughout the State. Also, a State can choose to provide home and community-based services to a limited group of eligibles, such as the developmentally disabled. The State is not required to provide the services to all eligible individuals who require an ICF or SNF level of care.

Waivers granted under section 1915(c) of the Act are for an initial term of three years and may be extended for additional three-year periods. The Secretary may approve waiver extensions if a State requests an extension, the extension request meets the waiver requirements for the extended period, and the Secretary determines that the State met all the assurances discussed above for the full three years of the initial waiver. Section 1915(d) of the Act, as added by section 2175 of Pub. L. 97-35 and redesignated as section 1915(e) of the Act by section 2176 of Pub. L. 97-35, provides that the Secretary shall monitor the implementation of the waivers granted to determine if the requirements of the waivers are being met. After giving the State notice and an opportunity for a hearing, the Secretary will terminate any waivers for noncompliance with the requirements.

Under the waiver, the State may exclude those individuals for whom there is a reasonable expectation that home and community-based services would be more expensive than the Medicaid services the individual would otherwise receive.

A waiver will also allow a State to provide for such services as case management, homemaker, home health aide, personal care, adult day health, habilitation, and respite care, and other services requested by the State and approved by the Secretary. The services must be consistent with plans of care that are subject to the State's approval.

Section 137(b)(7) of TEFRA added a new section 1902(a)(10)(A)(ii)(VI) to the Act that authorizes optional categorical eligibility to individuals who would be eligible under the State plan if they were in a medical institution and who would require the level of care provided in a hospital, skilled nursing facility or intermediate care facility but for the provision of home and community-based services described in section 1915(c) of the Act, the cost of which could be reimbursed under the State plan. Under this option, individuals must receive home and community-based services under a section 1915(c) waiver.

The report of the Conference Committee on Pub. L. 97-248 states that "The conference agreement makes explicit current law related to coverage of the optional categorically needy, as reflected in current regulations at 42 CFR 435.210 *et seq.* The conferees do not intend any change in current law through this recodification" (H.R. Report No. 97-760, p. 441). We have made technical revisions to the provisions of § 435.232, "Individuals receiving home and community-based services", and redesignated that section to reflect this statutory provision and to clarify that all categorically and medically needy recipients who would be eligible for Medicaid if institutionalized and who would otherwise require institutionalization, are eligible for services under this waiver. (See section III, *Regulation Changes*)

III. Regulation Changes

We received 32 comments on the interim final rule. We have considered those comments (discussed in detail in Section VI, *Public Comments*) and are making the following changes to the interim final rule.

A. Application of Section 1616(e) of the Act to Waivers

We are amending § 441.302(a) of the regulations to provide that board and care facilities must meet the standards established under section 1616(e) of the Act, if any waiver services are to be furnished in those facilities. Section 1616(e) of the Act, commonly referred to as the Keys amendment, requires States to establish and enforce safety and related standards for institutions, foster homes, or group living arrangements where a significant number of Supplemental Security Income (SSI) recipients are residing, or are likely to reside. This amendment was enacted on October 20, 1976 by section 505(d) of Pub. L. 94-566 as a result of concern over a series of fires in board and care facilities throughout the country. It became effective on October 1, 1977.

Section 1915(c) of the Act explicitly requires that a waiver may be approved only if the State provides us with satisfactory assurance that necessary safeguards have been taken to protect the health and welfare of the beneficiaries receiving the services. We received many public comments suggesting tighter standards, including a suggestion to devise national health and safety standards. While we remain committed to the principle of providing States with maximum flexibility, we also agree with the public comments suggesting the necessity of additional health and safety assurances. Accordingly, we have included the provision that States meet the requirements of section 1616(e) of the Act when home and community-based services are provided in facilities subject to the provisions of section 1616(e) of the Act. We believe this will assure some of the additional protection that we and the public believe is necessary. Since the requirement for Keys amendment certification has been in effect since 1977, we do not believe that we are imposing an undue burden on the States. Therefore, HCFA will not approve any waiver request where waiver services will be provided in facilities that are covered by section 1616(e) of the Act, unless the State provides us with copies of its standards applicable to those facilities and certifies in the waiver request that those facilities comply with applicable State standards.

For purposes of the home and community-based services regulations, we will impose the Keys amendment requirements on all facilities that are subject to the Keys amendment standards and that have residents who receive home and community-based services in such facilities (whether or not the services are provided by the facilities). Many of these facilities are primarily residential and do not provide health related services themselves. We believe the statutory provision requiring an assurance satisfactory to the Secretary that necessary safeguards have been taken to protect the health and welfare of individuals provided services under the waiver covers more than provider participation standards. We also want to minimize the possibility of States using the waiver to circumvent Federal health and safety standards because other avenues of care are less costly.

Further, these standards must conform to the requirements of the Keys amendment as prescribed in 45 CFR Part 1397. These provisions apply to all waivers and are effective beginning 90 days after the publication date of these final regulations. Failure to comply with the Keys amendment requirements could result in termination of the waiver under § 441.304(d) (the current § 441.304(b) has been redesignated as § 441.304(d) in these final regulations).

B. Average Per Capita Expenditures

In these final regulations, § 441.303(d) has been redesignated as § 441.303(f) and revised as noted below.

The statute and current regulations provide that the State, in its waiver request, must assure us that the average per capita expenditure for individuals under the waiver does not exceed the average per capita expenditure, as reasonably estimated by the State, that would have been made under the State plan had the waiver not been granted. The following factors were provided in the interim final regulations to compute the average per capita expenditures:

A=The estimated number of beneficiaries who would receive the level of care provided in an SNF, ICF, or ICF/MR under the waiver.

B=The estimated Medicaid payment per eligible Medicaid user of such institutional care.

C=The estimated number of beneficiaries who would receive home and community-based services under the waiver or other noninstitutional alternative services included under the State plan.

D=The estimated Medicaid payment per eligible Medicaid user of such home and community-based services.

F=The estimated number of beneficiaries who would likely receive the level of care provided in an SNF, ICF, or ICF/MR in the absense of the waiver.

G=The estimated Medicaid payment per eligible Medicaid user of such institutional care.

H=The estimated number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care.

I=The estimated Medicaid payment per eligible Medicaid user of the noninstitutional services referred to in H.

The following equation was provided in the interim final regulations to

compare average per capita expenditures with and without a waiver:

$$\frac{(A\times B)+(C\times D)}{F+H} < \frac{(F\times G)+(H\times I)}{F+H}$$

We are modifying the equation in § 441.303(f)(1) by revising some of the factors used by States to determine the cost-effectiveness of their waiver programs. We are also including additional factors in the equation to allow comparison of total Medicaid costs with and without the waiver. Finally, we are substituting "expenditure" for "payment" wherever the word appears in the equation to clarify that the cost estimates required mean the cost of services provided during the waiver year, regardless of the year in which payment is actually made.

- We have revised factors A and B to clarify that the estimates pertains only to expenditures for SNF, ICF, or ICF/MR care *with the wavier.*

A=The estimated number of beneficiaries who would receive the level of care provided in an SNF, ICF, or ICF/MR with the waiver.

B=The estimated annual Medicaid expenditure for SNF, ICF, or ICF/MR care per eligible Medicaid user with the waiver.

- We have corrected factor C to limit properly the data in that factor to home and community-based services.

C=The estimated annual number of beneficiaries who would receive home and community-based services under the waiver.

- We have revised factor D to clarify that the estimate pertains only to expenditures for home and community-based services.

D=The estimated annual Medicaid expenditure for home and community-based services per eligible Medicaid user.

- We have revised factor G to clarify that the estimate pertains only to expenditures for SNF, ICF, or ICF/MR care *in the absence of the waiver.*

G=The estimated annual Medicaid expenditure for SNF, ICF, or ICF/MR care per eligible Medicaid user in the absence of the waiver.

- We have included the word "annual" in all factor definitions to clarify that all estimates must be on an annual basis.

The following additional factors are being included in the equation used to compute the average per capita expenditures:

A'=The estimated annual number of beneficiaries referred to in A who would receive any of the acute care services otherwise provided under the State plan.

B'=The estimated annual Medicaid expenditure per eligible Medicaid user of the acute care services referred to in A'.

C'=The estimated annual number of beneficiaries referred to in C who would receive any of the acute care services otherwise provided under the State plan.

D'=The estimated annual Medicare expenditure per eligible Medicaid user of the acute care services referred to in C'.

F'=The estimated annual number of beneficiaries referred to in F who would receive any of the acute care services otherwise provided under the State plan.

G'=The estimated annual Medicaid expenditure per eligible Medicaid user of the acute care services referred to in F'.

For purposes of the equation, acute care services means all services otherwise provided under the State plan that are neither SNF, ICF, or ICF/MR services, nor the noninstitutional, long-term care services referred to in H.

The revised equation that States must use to determine the cost-effectiveness of their waiver programs is as follows:

$$\frac{(A\times B)+(A'\times B')+(C\times D)+(C'\times D')+(H\times I)}{F+H} < \frac{(F\times G)+(H\times I)+(F'\times G')}{F+H}$$

The main difference is that under the revised formula, with the additional factors, we will be able to compare total Medicaid costs with and without the waiver.

Congress was concerned that the total of all medical assistance for services provided to individuals who would qualify for home and community-based care under the State plan not exceed on an average per capita basis, the total expenditures that would be incurred for such individuals if home and community-based services were not available.

Accordingly, the statute and these regulations provide that the State, in its waiver request must assure us that the average per capita expenditure under the waiver does not exceed the average per capita expenditure, as reasonably estimated by the State that would have been made under the State plan had the waiver not been granted. Congress expected that this provision would assure that aggregate costs will not be greater than they would have been without these alternative services. (H. Rept. 97-208, p. 967)

Under the interim rules, the equation used to determine average per capita expenditures did not take into account the cost of acute care services covered under a State's plan, such as physicians services and inpatient hospital care, because we though these kinds of services would be unaffected by the waiver. However, it was pointed out in public comments we received, and reinforced by our own analysis that the calculation of average per capita expenditures without acute care services did not provide a sufficient demonstration that total or aggregate costs would not increase. Services covered under a waiver may be a relatively small part of the individual's total Medicaid costs. Moreover, an individual residing in the community and receiving waiver services may use more of acute care Medicaid services than he would have, had he been in a nursing home. Accordingly, we have revised the equation so that States will be asked to provide additional information that demonstrates the provision of waiver services will not result in overall expenditures in excess of those which would have been incurred absent the waiver. The cost of physician visits, hospitalization, prescription drugs, etc., that the individual would have received will be included in the States' estimates of Medicaid expenditures in addition to the cost of SNF or ICF care. States must provide estimates that demonstrate that the total aggregate medical assistance costs for these community-based care recipients will not be greater than they would have been without these alternative services.

For purposes of the equation in these final regulations, acute care services means all services otherwise provided under the State plan that are not SNF, ICF, or ICF/MR services, or the noninstitutional, long-term care services referred to in factor H of the equation.

If the State wishes to revise its estimates at some point after a waiver is approved for example, in order to adjust for an error in the estimates or for adding an unanticipated increase in the eligible population, other factors on both sides of the equation would also have to be adjusted as necessary and the comparison would be re-examined to determine if the waiver is still cost-effective. States whose waiver requests

were approved before or during the 90-day period following the publication date of these final regulations under the original formula will be evaluated under that formula if their estimates were submitted in that form. However, the revised formula will apply to any subsequent requests for extensions. Waiver requests that have not been approved by the 90th day after the publication date of these final regulations will be subject to the revised formula.

In developing the estimates of utilization necessary to complete the above computations, the State must continue to use actual data on nursing home cost and utilization and on cost and utilization of community-based services for the most recent year before the waiver takes effect. These figures must be adjusted by the State to reflect anticipated growth in the supply of nursing home beds, availability of community-based services, and inflation.

The State's experience with utilization and cost of home and community-based services provided under title XIX, title XX, and other programs should provide a useful basis for the necessary estimates. The data must be expressed in full-year terms, and it must represent unduplicated annualized recipient counts and not bed counts. The term *unduplicated* refers to unduplicated counts for each value in the formula specified at § 441.303(f). For example, a recipient who is an inpatient in a Medicaid long-term care facility on two occasions during the year and who also receives waiver services during the year, would be counted as one unduplicated recipient under formula value A and one unduplicated recipient under formula value C (and under the prime formula values as appropriate). However, when an individual is served under any single formula value category on multiple occasions during the year, he or she would only be counted as one unduplicated recipient in the applicable single formula value category. Since recipients may be counted more than once due to their particular circumstances during the year, States should supplement their estimates with data on the number of individuals who are counted in more than one formula value category.

We have also amended § 441.303(f) to explain that States must also submit documentation with their waiver requests, showing the number of beds in Medicaid certified SNFs, ICFs, and ICF/MRs by type, and evidence of the need for additional bed capacity in the absence of the waiver. States which propose a waiver population which would exceed the capacity of presently certified beds must produce viable certificates of need and other documentation that beds would actually be built (or have been built) and would be certified absent the waiver. Where the certificate of need process is no longer in effect or no longer viable, the State must provide other convincing data that construction would actually take place or evidence of State appropriations activity.

States must also provide data that show the occupancy rates for the beds in their Medicaid certified SNFs, ICFs, and ICF/MRs by type; whether there is any excess bed capacity for these facilities by type; and if so, the number of excess beds. If the State has waiting lists for admission to these facilities, it must provide data that show the number of persons awaiting admission to each type of facility. The State must also show how long people have to wait for admission from the time they are placed on the list. States requesting a waiver of the statewideness provision (§ 431.50) that requires a State plan to be in effect throughout the State must specify the political subdivisions in which waivered services will be offered.

In order to provide further assurance that the individuals who will receive home and community-based services require the level of care provided in an SNF, ICF or ICF/MR, we have added new documentation requirements under § 441.303(f)(4). These changes are a result of our experience in dealing with waiver requests and are needed to determine whether the State's estimates are reasonable. States will be required to specify in their waiver requests the number of recipients who will actually be deinstitutionalized from certified facilities as compared with those whose admissions would be deflected or diverted because they will be receiving waiver services. Where recipients are deflected, States will be required to provide a more detailed description of their evaluation and screening procedures for recipients to assure that waiver services will be restricted to persons who would otherwise receive institutional care. For example, more stringent assessment protocols or selection only after nursing home placement has been requested. States must also specify where the diverted individuals will be coming from and how many will come from each location, e.g., hospital patients awaiting SNF or ICF placement, or persons at home.

As under current rules, the State, in its waiver request, must provide HCFA with annual per capita expenditure estimates and describe how these estimates were derived. The State must also assure HCFA that the estimates for the product of factors C × D in the computation will not be exceeded and that FFP will not be claimed for home and community-based services expenses incurred in excess of the estimates. HCFA will review all estimates very closely to determine if they are reasonable and based on statistically supportable assumptions. Further, HCFA will compare all estimates with data the State must furnish annually on its actual experience. If the approved estimates for the home and community-based services are exceeded, the waiver may be terminated. HCFA will also begin to evaluate an approved waiver after it has been in operation for 28 months, on the basis of findings made by the Health Care Financing Administration's monitoring and assessment activities, on data the State submits annually on its waiver program for the first two years of its waiver, and the results of the independent assessment of the State's waiver program. This analysis and other information will be used to determine whether an extension of the State's waiver beyond the third year is indicated.

The current regulations require States to include information on estimated utilization rates and costs for all three types of institutional groups; that is, persons who require SNF, ICF, or ICF/MR care. We have reconsidered this requirement and have decided that data on all three categories are not necessary unless the waiver request provides services to each category. For example, there is no need for a State to provide data on persons who would need SNF and ICF care if the request is limited to individuals who would otherwise require an ICF/MR level of care. Similarly, if the request does not include persons who would otherwise require an ICF/MR level of care, a State would not be required to furnish data on that group. Section 441.303(f)(3) has been added to reflect this policy.

C. Applicability of Home and Community-Based Waivers

We have revised § 435.232 and redesignated that section as § 435.217 to clarify that all States may cover, as an optional categorically needy group, individuals who would be Medicaid eligible if institutionalized and who, but for the provision of home and community-based services, would require institutionalization in an SNF ICF, or ICF/MR facility and who will receive home and community-based

services under a waiver granted under section 1915(c) of the Act. The redesignation is necessary because §§ 435.230–435.232 relate only to aged, blind, and disabled groups of eligible individuals. The new placement in the regulations clarifies that States may include families and children in this option as well.

Section 137(b)(7) of TEFRA added a new section 1902(a)(10)(A)(ii)(VI) to the Act. This amendment did not expand, but only clarified the provisions under section 1915(c). Some commenters to the interim final rule pointed out that coverage under § 435.232 was limited to States that covered institutionalized individuals under a special income test at § 435.231.

Our revision and redesignation provides for the inclusion of individuals whose eligibility in an institutional setting would be based on requirements of either the Supplemental Security Income (SSI) program or the State's Aid to Families with Dependent Children (AFDC) program. Our revision and redesignation also permits States that have exercised the option under section 1902(f) of the Act (to use more restrictive Medicaid eligibility requirements for the aged, blind, and disabled than those used for SSI eligibility) to cover, under a home and community-based waiver, individuals who would be eligible for Medicaid under the State's more restrictive standards if they were in a medical institution.

Medicaid eligibility under § 435.217, as revised in these final regulations, is determined in accordance with State plan criteria pertaining to individuals in SNF, ICF, or ICF/MR facilities. Depending on the State plan, this could be criteria appropriate to coverage groups described at §§ 435.121, 435.132 435.231, 435.320, and 435.330 and any other groups who are eligible only when in an institutional setting. Also, individuals described at § 435.132 (institutionalized individuals who were eligible for Medicaid in December 1973) are deemed to meet the inpatient status requirement if they are receiving home and community-based services and continue to meet the other eligibility requirements of § 435.132 besides institutionalization.

In States that choose not to elect coverage under § 435.217, services under home and community-based waivers are limited to individuals who are Medicaid eligible under other coverage groups included in the Title XIX State plan.

We are also adding a new § 436.217 to specify that Guam, Puerto Rico, and the Virgin Islands may also cover the same individuals as an optional categorically needy group.

D. Assurances

We have revised § 441.302(b) to require a State to provide HCFA with an assurance that it will arrange for an independent audit of its waiver program and make this report available to the Secretary, the Comptroller General, and their designees. We are making this revision in response to a public comment that there was a need for additional fiscal controls and oversight of the State programs, and the suggestion that a specific audit requirement be included in the regulations. This requirement may be waived by us in particular cases; for example, if the cost of the audit will exceed the estimated savings of the State's waiver program. These assurances apply to all waivers and are effective beginning 90 days after the publication date of these final regulations. States that already have approved waivers are to submit these additional assurances within this 90-day time frame.

We have revised §441.302(e) to require that a State provide HCFA with assurance that the actual total expenditures for home and community-based services under the waiver will not exceed the agency's approved estimated expenditures and that the State will not claim FFP for expenditures exceeding the approved estimate. The agency's approved estimated expenditures are the same estimates required in the supporting documentation under § 441.303(f) and these assurances apply to each year of the waiver period. These assurances apply to all waivers and are effective beginning with services provided under the waiver 90 days after the publication date of these final regulations. States that already have approved waivers are to submit these additional assurances within this 90-day time frame.

Regarding these assurances, we have also redesignated current § 441.304(b) as § 441.304(d) and revised it to make it clear that HCFA may terminate a waiver, including those approved before the effective date of these final regulations, if it finds that actual expenditures exceed the agency's approved estimate. (See section G for a discussion of FFP limitations on estimated home and community-based expenditures which also presents the rational for the revised assurance requirements of § 441.302(b) and (e)).

We have further revised § 441.302(e) to require States to provide HCFA with an assurance that aggregate Medicaid expenditures for all services provided to individuals under the waiver do not exceed the aggregate Medicaid expenditures that would be incurred for these individuals in the institutional setting, in the absence of the waiver. Such services would include; for example, physician services, acute hospital services, dental care, and pharmaceutical supplies. This additional assurance is based on one of the public comments that we received on the interim final regulations and is supported by our own findings that certain acute care services may be provided more frequently (or with greater intensity) to individuals in the home and community setting than to those in the institutional setting. To the extent that this occurs, the home and community-based services would be less cost-effective than the estimates shown. Accordingly, we have also revised § 441.303(f), which contains the equation used to estimate the average per capital expenditures under the waiver, to require that such services be reflected in the State's estimates of cost and utilization.

States that already have approved waivers are to submit the additional assurance regarding aggregate Medicaid expenditures within 90 days after the publication date of these final regulations. If a State, including those with waivers approved prior to the effective date of these final regulations is found not to be in compliance with this requirement beginning 90 days after the publication date of these final regulations, HCFA may terminate the waiver. If a termination becomes necessary, HCFA will work with the State to ensure an orderly transition so that beneficiaries will not be without necessary services.

We will not grant a waiver and may terminate an existing waiver if the Medicaid agency does not provide the required satisfactory assurances within the applicable time periods.

E. Supporting Documentation

We have revised § 441.303(a) to require the State to submit a copy of the standards that it will enforce in those facilities covered by the Keys amendment when waiver services will be furnished in those facilities. We are making this revision in response to public comments that suggested closer scrutiny of the recipients' health and safety. This requirement applies to all waivers, and is effective beginning 90 days after the publication date of these final regulations. States that already have approved waivers are to submit the assurance required under § 441.302(a)(3) and a copy of the applicable standards within this 90-day time frame.

We have revised § 441.303(c) to include a requirement that the Medicaid agency furnish us with the procedures it uses to assure reevaluation of need at regular intervals. The requirement for a reevaluation was explained in the preamble to the interim final regulations (46 FR 48535) but was inadvertently omitted from the CFR text. We have included the additional requirement that it be done at regular intervals in response to a public comment. We have added a new § 441.303(d) that requires an agency to describe how it will meet the requirement that eligible beneficiaries be informed of the feasible alternatives available under the waiver and be permitted to choose either institutional services or home and community-based services. Finally, we have revised the assurance at § 441.302(d) to clarify that beneficiaries must be given the choice of *either* the institutional or home and community-based services.

We have added a new § 441.303(e) to require an agency to explain in its waiver request the post-eligibility treatment of income and resources for those individuals who are eligible under a special income level for home and community-based services. In the preamble of the interim final rule we stated that to insure equal treatment of institutionalized beneficiaries and beneficiaries receiving home and community-based services under a waiver, we would apply similar payment rules for those beneficiaries who are eligible for home and community-based services through use of a special income level. However, we inadvertently omitted from the CFR text, the information requirement that States tell us how they plan to treat the income and resources of those individuals receiving home and community-based services who are eligible under a special income level. Through this requirement, we will know more clearly how payment is being calculated (§§ 435.217, 435.726, and 435.735).

We have revised § 441.303(f) to require the State to provide the number of beds in Medicaid certified SNFs, ICFs and ICF/MRs by type, and evidence of the need for additional bed capacity in the absence of the waiver. The interim final regulations at § 441.303 required a State to furnish us with sufficient information to support all assurances, including the assurance concerning per capita expenditures. We have concluded that evidence of bed capacity is such an integral part of the agency's explanation of estimated per capita expenditures that no waiver request would be sufficient without this documentation. States that propose a waiver population that would exceed the capacity of presently certified beds must produce viable certificates of need and other documentation that beds would actually be built (or have been built) and would be certified absent the waiver. Where the certificate of need process is no longer in effect or no longer viable the State must provide other convincing data that construction would actually take place or evidence of State appropriations activity. Accordingly, we are specifying this information as an explicit documentation element in these final regulations. States must also provide data that show the occupancy rates for the beds in their Medicaid certified SNFs, ICFs, and ICF/MRs by type; whether there is any excess bed capacity for these facilities by type; and if so, the number of excess beds. If the State has waiting lists for admission to these facilities, it must provide data that show the number of persons awaiting admission to each type of facility. The State must also show how long people have to wait for admission from the time they are placed on the list. States requesting a waiver of the statewideness provision (§ 431.50) that requires a State plan to be in effect throughout the State must specify the political subdivisions in which waivered services will be offered.

This information is needed to determine whether a State would have the capacity to provide institutional care in the absence of a waiver to those individuals who will receive home and community-based services. If the State would not have adequate bed capacity to institutionalize these individuals, its estimates may be found unreasonable.

We have added a new § 441.303(f)(4) that requires States to specify the number of waiver clients actually being deinstitutionalized from certified facilities versus those diverted from admission. Where individuals are merely diverted, States must provide additional evaluation methods to assure that services will be restricted to persons who would otherwise receive institutional care. States must also specify where the diverted individuals will be coming from and how many will come from each location, e.g., hospital patients awaiting SNF or ICF placement, or persons at home. These changes are a result of our experience in dealing with waiver requests and are needed to determine whether the State's estimates are reasonable.

Finally, we have added a new § 441.303(g) that requires a State to provide for an independent assessment of its waiver program and make the results available to HCFA prior to the end of the three-year waiver period. The assessment must evaluate the quality of care provided to recipients, access to care, and the cost-effectiveness of the waiver, and cover at least the first 24 months of the waiver period. This requirement may be waived by us in particular cases; for example, if the State's waiver program is very small (such as a model waiver) and the cost of the assessment will exceed the estimated savings of the waiver. We are making this revision to provide more information about the impact of the waiver and to assist in determining whether a State's waiver should be extended beyond the third year. These requirements apply to all waiver requests and requests for extensions that are received after April 12, 1985.

F. Duration of Waiver

We have revised § 441.304(a) to provide that after September 9, 1985, the effective date for a waiver will be established by HCFA prospectively on or after the date of approval and after consultation with the State agency. This revision is based on our program experience that most waiver requests undergo considerable revision before final approval. Accordingly, we believe that States should not commence a waiver program until all issues are resolved and we are sure that the waiver program will be operated in accordance with applicable regulations. To facilitate a smooth transition, we are retaining our current policy for waiver requests received through September 9, 1985. Our current policy provides that a waiver becomes effective on the first day that the State meets the substantive requirements for approval as determined by HCFA and continues for a three-year period from that date. A retroactive effective date, however, cannot be earlier than the first day of the quarter in which an approvable waiver request is submitted, even though a State might have met all substantive requirements before the first day of that quarter.

We have also added new §§ 441.304(b) and 441.304(c) to clarify our policy concerning renewals of existing waivers. When we receive a request to review an existing waiver, we will determine whether that request is an extension of the existing waiver or a new waiver request. In general, if a State makes significant changes in its waiver program when it requests extension of the initial waiver, we will consider the request to be a new waiver proposal. Factors that we will use to determine whether a significant change

has been made will include changes in the eligible population, services provided, service area, and statutory sections waived. If a State submits a renewal request that would add a new group to the existing group of beneficiaries covered under the waiver, we will consider it to be two requests; one as a renewal request for the existing group, and the other as a new waiver request for the new group. When a renewal request is treated as a new proposal and we formally request additional information from the State, we *may* extend the State's waiver as initially approved for up to 90 days, if the waiver is about to expire. If a State intends to request a renewal of an existing waiver, it must submit the request at least 90 days before the third anniversary of the effective date of the waiver.

G. FFP Limits

The limitations on FFP in expenditures for home and community-based services contained in § 440.180(b) are being expanded and redesignated as a new § 441.310. This expansion expresses the intent of Congress that program effectiveness result from State assurances required under the statute. We are making these revisions based on a public comment (with which we agree) noting that under the waiver, there are no safeguards to protect against rising total costs. Clearly, it was not the intent of Congress that the home and community-based services provisions result in an increase of Medicaid long-term care expenditures. Accordingly, we are excluding from the definition of medical assistance under the waiver, payments for any expenditures in excess of the State's estimates. FFP will thus be available in these expenditures only up to the agency's approved estimate of the total expenditures for home and community-based services under the waiver. This estimate is contained in the supporting documentation required under § 441.303(f) and is expressed as the product of the estimated annual number of beneficiaries who would receive home and community-based services under the waiver (factor C) and the estimated annual Medicaid expenditure for home and community-based services per eligible Medicaid user (factor D). This FFP limit applies to all home and community-based services provided under the waiver beginning 90 days after the publication date of these final regulations.

To provide an additional control for enforcement of health and safety standards, these final regulations exclude from the definition of medical assistance, services provided in facilities that do not meet the standards required under § 441.302(a). Thus, FFP will not be provided for services furnished during any period in which the facilities are found, by the Secretary, not to be in compliance with the applicable State standards described in that section. All types of providers that furnish services under the waiver must meet State health and safety standards. However, to ensure that Medicaid beneficiaries receive quality care in a safe setting, we have made the FFP limit apply to all kinds of facilities where services are furnished. This includes residential facilities subject to the Keys amendment provisions, even when the facility itself does not furnish the service. This sanction applies to all facilities that are subject to health and safety requirements; facilities subject to the Keys amendment provisions and facilities subject to other State health and safety requirements. Further, this sanction applies to all waivers beginning 90 days after the publication date of these final regulations. This sanction resulted from public comments that FFP should not be provided if a facility fails to meet health and safety requirements. Finally, we note that the FFP limits regarding expenditures and the health and safety requirements apply specifically to home and community-based services. Regular Medicaid services are not affected.

H. Miscellaneous Changes

We are adding the word "legal" to the term "recipient's representative" in § 441.302(d) to clarify our original intent that a beneficiary or his or her legal representative is involved in decisions about feasible alternatives under a waiver. This change was suggested by one commenter and we agree that adding the word "legal" is necessary to clarify the intent of this provision. The term "legal" representative is not intended to imply that the representative must be an attorney, but that the representative must be designated in accordance with the laws of the State.

We have added a new § 441.306 to specify the regulations that govern the hearings procedures for States, as suggested in the public comments. The procedures described at 45 CFR Part 213 will apply to State requests for hearings on terminations. We decided to use these particular hearings procedures because States are familiar with them regarding other Medicaid provisions. The adoption of these particular hearings procedures for waiver terminations in no way implies that HCFA believes that waivers are State plan amendments or that an adverse decision would be appealable to the United States Court of Appeals under section 1116(a)(3) of the Act.

We have revised § 440.180 to clarify that home and community-based services are those services provided under the waiver that are not otherwise provided under the State's Medicaid plan. Home and community-based services are only those services that are in addition to the Medicaid services otherwise provided under the State plan. Accordingly, States submitting waiver applications should not request authority to provide services that are already authorized under their State plan. The waiver request should seek authority only for the actual home and community-based services that will be provided under the waiver.

Although we have still not mandated that any specific form or format be used by States when submitting waiver requests, we have made an administrative change to the waiver proposal procedure. We have revised § 441.301(b) to specify that each waiver request must be limited to one of the following target groups or any subgroup thereof that the State may define:

- Aged or disabled, or both.
- Mentally retarded or developmentally disabled, or both.
- Mentally ill.

We are requiring States to submit individual waiver requests for each target group (or subgroup) to expedite the waiver review process and to avoid the need to deny a waiver request involving more than one of the three target groups when there are problems that relate only to one of those groups.

We are making several technical changes in these regulations. We are modifying the language in § 441.302(c) to reflect more accurately our original intent and the intent of the legislation that States evaluate and periodically reevaluate the recipient's need for SNF or ICF services. We are updating an obsolete citation in § 435.3 and adding paragraph headings and designations within paragraphs in § 441.302. In addition, we are clarifying in § 441.302(a) our original intent that safeguards to protect the health and welfare of recipients apply to all types of providers who provide services under the waiver.

IV. Applicability of Regulation Changes

The changes implemented by these final regulations apply to all waiver applications and are effective 30 days after the publication date of these final regulations except as noted below:

A. Keys amendment provisions—Beginning 90 days after the publication date of these final regulations these provisions apply to all waiver requests and extensions that have been approved or that will be approved. This includes both the required assurances concerning facilities subject to the Keys amendment as well as the loss of FFP (§ 441.310) for any period in which a facility subject to health and welfare requirements is found to be out of compliance with State standards.

B. Revised formula for expenditure and utilization estimates—As previously indicated in Section III.B. of the *Regulation Changes*, States whose waiver requests were approved under the original formula before or during the 90-day period following the publication date of these final regulations, will be evaluated under that formula if their cost estimates were submitted in that form. States submitting waiver requests that have not been approved during the 90-day period following the publication date of these final regulations must submit the required estimates under the revised formula. States that request an extension of a waiver that was approved before or during the 90-day period following the publication date of these final regulations must also submit the required estimates under the revised formula.

C. Limits on FFP—These final regulations provide for FFP limits when the State's estimate of total expenitures for home and community-based services are exceeded (factors C x D in the cost-effectiveness formula). This FFP limit applies to all home and community-based services provided under the waiver beginning 90 days after the publication date of these final regulations. The FFP limit will be prorated and will not be applied retroactively because States were not aware of this requirement before these final regulations.

If a State exceeds its "C x D" estimate, it may, in addition to the FFP limit, be subject to waiver termination. Beginning ninety days after the date of publication, HCFA may terminate a waiver in any case where the State exceeds its approved estimates, even if the waiver was approved prior to the publication of these final regulations.

D. Requirement that States submit individual waiver requests for each target group—This requirement, which is specified in new § 441.301(b)(6), applies only to *new* waiver requests that we receive after April 12, 1985.

E. Assurances—The new assurances specified in §§ 441.302(a)(1), 441.302(a)(3), 441.302(b), 441.302(e)(2), and 441.302(e)(3) apply to all waivers and are effective beginning 90 days after the publication date of these final regulations.

F. Independent assessment—The new requirements for an independent assessment of a State's waiver program specified in § 441.303(g) apply to all waiver requests and requests for extensions that are received after April 12, 1985.

G. Duration of a waiver—Revised § 441.304(a) is effective after September 9, 1985, and applies to all waiver requests and requests for extension that are received after September 9, 1985.

V. Policy Clarifications

Since the publication of the implementing rules on October 1, 1981, several issues have arisen through internal staff discussions, outside correspondence and some waiver requests that were submitted. As a result, we are providing the following clarifications:

A. Coverage of Prevocational and Vocational Training and Educational Activities

Prevocational and vocational training and educational activities may not be provided under the home and community-based services waiver. Among other things, section 1915(c) of the Act requires that the proposed service may be provided only to individuals who would otherwise require the level of care provided in an SNF, ICF, or ICF/MR.

While many services could be construed as an aid to avoid institutionalization, we have concluded that qualifying services under section 1915(c) of the Act must be directly related to the ultimate goal of the home and community-based services; that is, enabling the recipients to accomplish those day-to-day tasks necessary for them to remain in the community and avoid institutionalization. We do not believe that prevocational and vocational training and educational activities are commonly furnished as a means of avoiding institutionalization. Individuals would not, in the absence of such services, require institutionalization. Therefore, in applying our regulations, which define home and community-based services, we have interpreted § 440.180 as excluding these services because they are not cost effective alternatives to institutionalization.

B. Deeming Methodology

The preamble of our October 1, 1981, interim final rule was silent as to the deeming of income when determining eligibility for home and community-based services. Deeming means that the income and resources of certain persons in an individual's family are considered as the income and resources of the individual even though not actually contributed. The following discussion is provided to clarify this issue.

In general, Medicaid institutional rules are governed by the Supplemental Security Income (SSI) eligibility rules. The SSI law requires that, when an eligible couple is separated due to institutionalization of one spouse, the resources of each spouse are considered mutually available for a period of six months after the month they cease to live together; however, the income of each is considered separately during this period. After this six-month period, the resources of each spouse are no longer considered mutually available. Rather, each spouse is treated as an individual in determining SSI eligibility and only the income and resources actually contributed by one spouse to the other are considered.

When a couple is separated due to institutionalization and only one spouse is eligible for SSI, the SSI deeming rules (which do not apply to members of an eligible couple) are applicable. These rules provide that, except for actual contributions, the income and resources of the ineligible spouse are no longer deemed available to the eligible spouse beginning with the month after the month in which they cease to live together.

Following the same deeming concept, when an eligible child is separated from his parents due to institutionalization, parental income and resources are no longer deemed available to the child and so do not affect the child's SSI eligibility beginning with the month after the month in which the child ceases to live with the parents.

Most States follow the SSI rules as required in section 1902(a)(17) of the Act of institutional deeming cases. The effect is that deeming of income and resources occurs for a relatively limited time period, thus creating an institutional bias. That is, individuals who reside in an institution are able to obtain Medicaid eligibility sooner than individuals living together in the community because of institutional deeming rules.

To reduce bias towards institutionalization, HCFA issued an interim instruction (AT 82-8) in May 1982, under which States were allowed to request a waiver to employ the deeming rules that apply to persons in institutions for the eligibility group at 42 CFR 435.232—aged, blind and disabled persons who would be eligible for

Medicaid in an institution under a special income level. This eligibility group was not a statutorily mandated group but was included in the interim final regulations published on October 1, 1981. (It has been revised and redesignated in these regulations as § 435.217.) Thereafter, section 1902(a)(10) of the Act was amended by TEFRA to specifically establish a new optional categorically needy group for home and community-based services (§ 435.217 of these regulations) that incorporated the group specified under § 435.232 into the law and expanded on it. Under this new option (§ 435.217), States have the choice of electing to cover for home and community-based services those categorically or medically needy persons who would be eligible under the State's Medicaid plan if in a medical institution. (A more complete explanation of the individuals to whom this option pertains can be found in section III.C. of the preamble.)

In determining eligibility under this new optional group, States are required to employ eligibility criteria that would be employed if the individual were in a medical institution (including the institutional deeming rules). Therefore, waivers are no longer necessary to employ the institutional deeming rules for individuals covered using the special income level. States that choose to cover individuals under § 435.217 for home and community-based services must now use the institutional deeming rules for these individuals in determining whether they would be eligible for Medicaid if they were in a medical institution. If the State wishes to apply more restrictive deeming rules to these individuals it may do so by framing the scope of the population eligible for the home and community-based services waiver under section 1915(c) of the Act in a manner that employs more restrictive deeming rules (such as those used when individuals reside in the community). This is consistent with the terms of section 1902(a)(10)(A)(ii)(VI) which applies only to individuals "who will receive home and community-based services pursuant to a waiver" under section 1915(c) of the Act.

States that cover the medically needy have an option to include medically needy individuals under § 435.217 providing those individuals would qualify for Medicaid in a medical institution as medically needy at the outset of their stay in the institution. Even if they do not exercise this option, the States may choose to employ institutional deeming rules through a waiver of section 1902(a)(10)(C)(i)(III) which requires that the methodologies of the most closely related cash assistance program be used to determine eligibility.

For groups other than those specified under § 435.217 and the medically needy, the applicable deeming rules are the rules derived from the relevant cash assistance program. For example, for SSI recipients in the community, the community deeming rules are the appropriate rules.

On September 1, 1983, we published a final rule that revised regulations at 42 CFR 435.121, 435.734, and 436.711 to reinstitute the deeming rules for categorically needy aged, blind and disabled spouses that were in effect in 1977 (47 FR 31899). The 1977 provisions prohibited section 1902(f) States from using any deeming rules that were more liberal than SSI or more restrictive than the rules in effect under the State's Medicaid plan on January 1, 1972. The 1902(f) States covering persons under the new optional categorically needy group (§ 435.217) will have to employ their institutional deeming rules. As is the case of States that have not selected the 1902(f) option, these States may apply more restrictive deeming rules (than their institutional deeming rules) for their home and community-based services populations by framing the scope of the eligible population under the section 1915(c) waiver in a manner that employs the more restrictive rules.

To assist States in utilizing the home and community-based waiver process to avoid unnecessary institutionalization and reduce expenses, a State may also submit a model waiver request in addition to or in lieu of a fuller home and community-based waiver request. Coverage under the model waiver is limited to blind and disabled children and adults who would otherwise be ineligible for Medicaid while living at home because of the SSI deeming rules. The model request relates specifically to those individuals who, as determined by the State, have or would have established eligibility for Medicaid services based on institutionalization. The sole purpose of the request is to provide authority for the State to furnish such individuals with services in the home and community setting. States are required to offer at least one home and community-based service under the model request, for example, case management services, in addition to those services that are now included in the State's Medicaid plan. Further, States are limited to a maximum of 50 cases for each model request.

We note that section 134 of TEFRA added a new section 1902(e)(3) to the Act to provide States with the Option of covering, under Medicaid, certain disabled children age 18 or under, who are living at home. These children could also be eligible for home and community-based services under a State waiver.

VI. Public Comments

We received comments from State Medicaid agencies, public and private interest groups, Congress, and individual citizens who work in the health field. Most of the 32 commenters on the interim final rule support the concept of a waiver program for home and community-based services, although many do suggest some revision to the regulations. Some commenters want the regulations to impose additional requirements before a State can qualify for a home and community-based services waiver. Although many of the comments we received are worthwhile, we do not want to impose additional requirements unless they serve a compelling Federal interest. While many of these suggestions are not incorporated in these regulations, we do anticipate that some States may, independently, decide to adopt them. In general, we believe that Congress intended to give the States maximum flexibility in operating their waiver programs. We expect this flexibility to foster initiative and to encourage States to administer cost-effective programs that meet specific local needs.

In view of the widespread interest in the home and community-based services waiver provision, we are soliciting and will give careful consideration to any comments received from the public. Comments received will be considered and may be used as the basis for future revisions of these regulations.

Statewideness

Comments: The statewideness provision, 42 CFR 431.50, requires that a State plan be in effect throughout the State; however, this requirement may be waived in the context of a home and community-based waiver program. One commenter suggests that HCFA identify the specific circumstances when single community waivers will be granted rather than waivers covering the entire State. Another commenter asserts that Congressional intent was to allow only a one-time waiver of the statewideness requirement.

Response: Section 1915(c) of the Act provides the Secretary with waiver authority to permit States to include as medical assistance (eligible for Federal financial participation) the cost of home or community-based services which meet certain conditions. Section 1915(c)(3) provides that a waiver "may

include a waiver of the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)." It further provides that the waiver "shall be for an initial term of three years and upon the request of a State, shall be extended for additional three-year periods" unless the Secretary determines that for the previous period certain assurances were not met. This language clearly suggests that the "statewideness" waiver could continue for more than the initial three year term of the waiver. Consequently, we do not believe that the Conference Committee Report's general reference.

"The conference agreement follows the House provision," should be viewed as an endorsement of the "one-time waiver of Statewideness" which was part of the House bill. See H.R. Rept. No. 97-208, p. 968. Indeed, the House bill contained specific language which provided, "During the 12-quarter period beginning on October 1, 1981, the Secretary may waive the requirement of section 1902(a)(1) as it applies to the administration of community care plans approved under this section." This three year limit in the House bill (which is consistent with the comment) was omitted from the legislation which was passed. Therefore, we do not adopt the comment, which we believe is contrary to the statute's provision for renewal of the waiver.

We also do not believe it is appropriate to identify the specific circumstances under which statewideness will be waived. Especially, because of the differences in resources among States and the constraints inherent in meeting the statutory assurances, we believe it is appropriate to evaluate statewideness waiver applications on a case by case basis.

Objective Standards for Service Packages

Comments: One commenter recommends that States be required to develop objective written standards to determine the appropriate service package for each individual within a group.

Response: We believe this is an unnecessary requirement since we already require the States to provide a written evaluation and plan of care that must be supported by appropriate documentation.

Health and Welfare Standards

Comments: Some commenters recommend additional requirements concerning the standards for services and for those who provide the services. One commenter wants clarification as to how HCFA will ensure that all requirements are being met.

Response: Section 1915(e) of the Act specifically places the responsibility for monitoring waiver programs with the Secretary. HCFA, having the delegated authority to administer the waiver program, recognizes its obligation to ensure the establishment of necessary additional standards and compliance with all health and welfare standards required under this section of the law as well as under section 1616(e) of the Act. We believe that the regulations, as modified, contain sufficient assurances to ensure adequate compliance by virtue of the requirements for State licensure or participation standards for all providers furnishing services under the waiver (§ 441.302(a)) and the additional FFP restriction applicable to services in facilities which do not meet the standards (§ 441.310(a)).

We do not want to limit State flexibility or initiative unnecessarily by imposing requirements that result in unnecessary and expensive administrative burdens. Therefore, we have given States as much authority as possible for establishing the standards for provider participation. Each State must develop the safeguards necessary for its particular program.

However, in light of public comments received, we have added a requirement that States must meet the standards of section 1616(e) of the Act when home and community-based services are provided in facilities that fall under the purview of that provision. Those standards apply to institutions, foster homes, or other group living arrangements where a significant number of SSI recipients are residing, or are likely to reside.

Waiver Requests—General

Comments: One commenter asks if States can submit sequential or serial waiver requests. Others recommend that all waiver requests be published in the **Federal Register** with a comment period and that the Department issue a periodic report on approved waivers.

Reponse: States may submit more than one waiver request. Further, we could not publish waiver requests in the **Federal Register** and still make a Secretarial decision within the statutory 90-day period (section 1915(f) of the Act). We will, however, consider publishing a periodic report in the future. We will also determine whether there are alternate ways of making this information available. Currently, we are concentrating our resources on reviewing and processing the actual waiver requests.

Termination of Waiver

Comments: Some commenters are opposed to the threat of termination of a waiver if the program is not cost-effective in one particular year. They suggest that States should be allowed to experiment and reconcile any problems over the full three-year period.

Response: We believe that a one-year period is an equitable time frame to measure compliance with the requirements of the waiver and to terminate or continue the waiver based on our findings. By law, States must provide the Secretary with information on the impact of the waiver annually, and the law authorizes us to terminate a waiver if we find non-compliance (section 1915(e) of the Act).

We have added a new § 441.306 to specify that the procedures described at 45 CFR Part 213 will apply to State requests for hearings on terminations. We chose these particular hearings procedures because States are already familiar with them regarding other Medicaid provisions.

Definitions of Services

Comments: Some commenters want Federal criteria and guidelines issued for the definitions of services. These commenters fear that the lack of uniform standards will lead to overlapping services, low quality services, and poor fiscal accountability.

Response: The legislation is intended to provide States with the flexibility to develop and implement waiver programs that meet local needs. Although we have offered suggested definitions of services in the interim final regulations (46 FR 48533), we do not believe that it is appropriate to mandate these definitions. Further, we believe that the program contains sufficient safeguards against the possible abuses that these commenters have cited.

Services—General

Comments: Many commenters suggest that we specifically list various qualifying services in the regulations to encourage States to provide them in their waiver programs. These commenters believe that this is necessary to ensure the availability of a full range of services under the waiver program.

Response: It is not necessary nor possible to list all services in the regulations. States are free to include any type of appropriate service in their programs—hospice services, home adaptations to increase safety, nutritional assessment, counselling, etc. The law does not restrict the coverage

of appropriate services as long as the State:

(1) Demonstrates that the services are cost-effective;

(2) Demonstrates that the services are necessary to avoid institutionalization;

(3) Includes and defines the services in its waiver request; and

(4) Obtains HCFA approval.

Finally, it is not appropriate for us to encourage or discourage the use of a particular service. Each State decides what combination of services is appropriate for its particular program.

Room and Board

Comments: One commenter suggests that Medicaid should pay for room and board under residential care using the six-month limitation in title XX of the Act; and that the policy for room and board should be the same for all services. The six-month limitation under title XX of the Act provides for FFP for a maximum of six months when room and board is determined to be an integral but subordinate part of another covered service. Another commenter wants the regulations to clarify that the prohibition against payment for room and board does not apply to the medical and personal care services of foster care programs.

Response: Section 1915(c)(1) of the Act specifically excludes payment for room and board under home and community-based services. As indicated in the preamble of the interim final rule, the only exception to this prohibition that is authorized by the statute is for respite care. We see no need to include in these regulations a clarification of the status of room and board in foster care programs. The prohibition against room and board in these regulations is clearly in the context of the home and community-based services waiver programs.

Cost-Effectiveness

Comments: Besides the specific categories of qualifying services, the regulations (§ 440.180) state that other services requested by the Medicaid agency can qualify if approved by HCFA as cost-effective. One commenter recommends that HCFA approval not be required for these "other services" since the statute does not contain this requirement. The commenter suggests that the statute provides that the entire plan must be cost-effective not any particular service requested by a Medicaid agency.

Response: The statute gives the Secretary broad discretion regarding the criteria that services must meet to be considered qualifying services; particularly, those services not specifically mentioned in the legislative history. We believe it is appropriate to impose criteria for these additional services, that will ensure conformance with the statutory intent to reduce Medicaid expenditures by providing lower-cost non-institutional services under the waiver. Accordingly, we are requiring HCFA approval for "other services" on the basis of cost-effectiveness and the necessity of the service to avoid institutionalization.

Evaluation of Need

Comments: Some commenters recommend additional restrictions for the process of evaluating an individual's need for an SNF or ICF level of care. For example, one commenter wants the regulations to specify that only a State agency can perform the evaluation. One commenter wants the regulations to require periodic reassessments of the need for care. Another commenter suggested that the evaluation must include an assessment of the recipient's total needs. These commenters believe that additional restrictions will make the evaluation process more effective by maintaining uniform standards, promoting consistent application of the standards, and eliminating possible conflicts of interest in the case of private evaluations.

Response: States are required to describe their evaluation procedures and to submit their screening documents with their waiver request. They are also required to maintain written documentation of their evaluations and to have this documentation available for review.

The Congressional intent, as evidenced by House Report No. 97–158, Vol. II, pp. 319–320, is to allow the States flexibility in the development of appropriate evaluation procedures and in their implementation. We believe that the regulations provide this flexibility. States may decide who develops and conducts the evaluation of need and they may use whatever evaluation instruments are appropriate.

While we do not believe that extensive limitations on a State's options are warranted, we do agree that a periodic reevaluation of the need for care should be explicitly required in the regulations. Section 441.302(c) has been revised accordingly. We note that those States already filing waiver requests have, in fact, provided for this reevaluation in their waiver requests. To date, all of the waiver requests we have received included a provision for a fairly complete assessment of the individual's total needs.

Plan of Care

Comments: One commenter recommends that the plan of care be developed by a physician, nurse, or licensed staff member of the facility or agency. The commenter feels that this would protect recipients against inadequate care. Others suggest that the State be allowed to review the individual case plans on a sample basis to avoid unnecessary administrative expenses, and that the waiver requests contain specific and detailed information on plans of care, services, and case management to ensure efficient, effective programs.

Response: The purpose of the regulations is to give States the maximum opportunity for innovation with a minimum of Federal intervention. Accordingly, we believe that the States should decide who is responsible for developing the plan of care. The States do not have to approve the plans in advance nor review every plan. Since the States have the authority to develop their own approval process, they can indeed choose to review plans on a sample basis. As for the information in the waiver request, the preamble of the interim final regulations discussed the general nature of the information required. However, the actual material in the waiver request must contain specific, detailed, and complete information on all services, procedures, etc.

Comments: One commenter wants to know why institutions for mental diseases (IMDs) are excluded.

Response: The Congressional Committee Reports do not discuss IMDs. Section 1915(c)(1) of the Act, however, clearly limits eligibility to persons who would require SNF or ICF level of care, the cost of which would be reimbursed under the State plan. Mentally ill persons who require SNF or ICF level of care can qualify for home and community-based services. However, individuals who are between the ages of 21 and 65 and who would otherwise receive services in a hospital, skilled nursing facility, or intermediate care facility that is an IMD are not eligible to receive services under the waiver because Medicaid coverage in IMDs is not authorized for these individuals.

Choice of Alternatives

Comments: Some commenters suggest States be required to document that beneficiaries were informed of alternatives and that beneficiaries were permitted to choose the type of service desired. Others recommend that persons in institutions be allowed to request

waiver services. One commenter recommends that "representative" be changed to "legal representative" in § 441.302(d).

Response: We agree that "representative" should be changed to "legal representative" and have revised § 441.302(d) accordingly. However, we also believe that requiring States to document that beneficiaries were informed of alternatives is unnecessary and overly burdensome. The State must assure HCFA in its waiver request that the beneficiary choice requirement will be met. We have also added a new § 441.303(d) requiring that the State furnish to HCFA a description of how the beneficiary choice requirement will be met. Further, a beneficiary can request a fair hearing if he or she is denied a choice of services.

Although the regulations state that services can be furnished only to recipients who are not inpatients; this does not preclude a State from including currently institutionalized persons as one of the groups of individuals who will be offered waiver services, if this will permit these individuals to leave the institution. This option can allow certain individuals to leave the institution and receive the necessary services in the home, at a lower cost to Medicaid.

Limitation of Costs

Comments: One commenter recommends that expenditures under the waiver be permitted to exceed the limitation of comparable, institutionalized care. The commmenter states that there are many advantages in maintaining a person at home, even if it is more expensive than an institution. Other commenters are concerned about the potential for accelerating total or aggregate costs despite the average per capita limitation in the regulations. One commenter suggests that the State methodologies concerning average per capita expenditures be made part of the public record.

Response: Congress specifically included a cost limitation in the legislation. However, the legislation does provide some flexibility since the limitation is based on average per capita expenditures. This permits States to include some individuals whose maintenance costs are actually higher than the cost of comparable services in an institution.

We agree with the comment that the current requirements for a waiver do not contain adequate safeguards to protect against an increase in total Medicaid costs as a consequence of the waiver. Clearly, it was not the intent of Congress that the home and community-based services provision result in an increase in Medicaid long-term care expenditures. Therefore, the limitations on FFP in expenditures for home and community-based services contained in § 440.180(b) are being expanded and redesignated as a new § 441.310 to express the intent of Congress that program effectiveness result from State assurances required under the statute.

Under these final regulations, FFP is available in these expenditures only up to the agency's approved estimate of the total expenditures for home and community-based services under the waiver. We have also revised § 441.302(e) to require a State to provide HCFA with an assurance that aggregate Medicaid expenditures for all services provided to individuals under the waiver do not exceed the aggregate expenditures that would be incurred for these individuals in the institutional setting, in the absence of the waiver. Also, we have revised § 441.303(f) to require a State to include all Medicaid expenditures in its computation of average per capita expenditures.

Regarding the comment on State methodologies, we believe that publication is unnecessary. This information can be requested directly from the States that have submitted waiver requests.

Annual State Reports

Comments: One commenter recommends that certain specific items be included in the information that the State must submit in the annual reports. Another recommends that the State reports be available to providers and consumers.

Response: We have developed a data collection plan that will be used by the States. The plan permits us to compare a State's actual expenditures with its estimated expenditures and determine whether the State has met its assurances. Our objective is to limit State reporting requirements as much as possible, yet assure that basic program requirements are met. As we gain experience with the annual reports, we may wish to request some of the specific items that the commenter suggested.

Regarding the availability of State reports, providers and consumers could request this information directly from the State. Copies of State reports will also be subject to disclosure under the Freedom of Information Act.

Computation of Average Per Capita Expenditures

Comments: Some commenters suggest that States be permitted to use their own methods of computing average per capita expenditures, as long as they are able to demonstrate that the aggregate cost of long-term care will be reduced. Others suggested that other items such as State administrative costs be considered in the computation.

Response: As previously discussed in section III.B. of this preamble, we have made various revisions to the computation. We believe that the computation in the regulations is an appropriate reflection of Congressional intent. We also believe that it is necessary for all States to use the same computation method to meet this particular legislative requirement. To monitor the waiver programs effectively, HCFA must have the necessary information from each State in a consistent format.

The computation for average per capita expenditures should include only those cost items specifically relating to medical assistance that is covered under the Medicaid program. Cost items that may have an indirect relationship to covered medical assistance cannot be considered in the computation. We agree that items such as the following should be part of the computation—

- Cost of patients in hospital awaiting nursing home or community care placements; and
- Reduced community Medicaid costs—An agency that has other means available to cover certain services may decide not to provide these services (for example, reimbursement for prescription drugs) under the Medicaid waiver, thus lowering the average per capita cost under the waiver.

We do not believe that items such as the following should be included—

- Average per capita State agency administrative cost—These costs would generally be the same whether they were incurred in connection with institutional care or home and community-based services and would not affect the computation of per capita expenditures. Therefore, it is not necessary that they be included in the computation;
- Certain in-home costs that are part of institutional costs—Costs attributable to individuals who are not currently covered by Medicaid and who are in the home, waiting for admission to an institution. We do not at this time propose that such services be reflected in the State's estimates of cost and utilization. We believe this would result in an unnecessary burden to the States since we do not know precisely the incidence or potential cost of such an occurrence. (We will be able to develop this information more fully once we determine the impact of the waivers by analyzing the annual reports that the States must submit.) However, we do

believe that an assurance is needed from the State that the aggregate costs of all services furnished to an individual in the home or community setting will not exceed the aggregate costs that would be incurred by the individual in the institutional setting, in the absence of the home and community-based waiver. Accordingly, we have amended § 441.302(e) to require such an assurance; and

• Medicare savings—For example, when a covered individual can be discharged from a hospital to a community setting rather than remaining in the hospital to await an available bed in a long-term care institution. It is not appropriate to consider Medicare saving in the computation. The statute provides that the State's estimate of average per capita expenditures is to be limited to the cost of Medicare services.

VII. Impact Analysis

Executive Order 12291

We have determined that neither the October 1, 1981 interim final regulations nor these final regulations meet the criteria for a "major rule", as defined by section 1(b) of Executive Order 12291. That is, neither will—

• Have an annual effect on the economy of $100 million or more;

• Result in a major increase in costs or prices for consumers, any industries, any government agencies or any geographic regions; or

• Have significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or import markets.

Our actuaries cannot estimate the economic effect caused by these provisions due to the uncertainties regarding the number of States that will ultimately apply for waivers; the number of waivers that will be requested; the nature of the waivers; and whether the waivers will result in reduced costs or the provision of more services for the same costs.

The costs or savings resulting from these provisions are a function of the balance between deinstitutionalization (some current residents of nursing homes could be returned to the community for less money) and new demand (some people who currently receive care from family and friends despite a medical need for nursing home care will become eligible for Medicaid outside the nursing home setting), and the number of States that choose to exercise the option. Congress indicated (H.R. Report No. 97-208, p. 967) that it expected the provisions concerning per capita costs would assure that aggregate costs are not greater than what they would have been without the home and community-based services. Moreover, the purpose of the legislative amendment was to provide the States with sufficient flexibility to develop more economical alternatives to the high cost of long-term care institutional services. To the extent that this purpose is achieved, the cost of providing the home and community-based services under the waiver will offset the cost of institutional care that would otherwise have been required. Further, by facilitating the use of other providers of care, more competition should be generated.

Regulatory Flexibility Act

The Secretary certifies under 5 U.S.C., 605(b) enacted by the Regulatory Flexibility Act (Pub. L. 96-354), that neither the interim final regulations nor these final regulations, which amend and clarify the interim regulations, will result in a significant economic impact on a substantial number of small entities.

The primary impact of the interim final and these final regulations is on the States and beneficiaries, which are not "small entities" within the meaning of the Act. Any impact upon providers will be the result of individual State decisions, as developed in the waiver requests. We would encourage States that are developing waiver requests under these provisions, to consider their effect on small entities and to analyze alternative choices. We believe that States are best qualified to determine whether a given adverse effect on small entities is appropriate in view of the benefits offered by a waiver request that is consistent with the provisions of these regulations.

Further, in view of the provisions of section 1915 of the Act, while a State may consider the effect on small entities before submitting a request, we do not consider this effect in reviewing these requests. Therefore, a regulatory flexibility analysis is not required.

Reporting and Recordkeeping Requirements

Sections 441.302 and 441.303 contain reporting and recordkeeping requirements that are subject to the provisions of the Paperwork Reduction Act of 1980 (44 U.S.C. 3507). As required by that act, HCFA requested Office of Management and Budget (OMB) approval of these requirements. OMB has approved the data collection plan requirement in § 441.302.

The OMB approval number for the data collection plan required by § 441.302 is 0938-0268. The OMB approval number for the requirements under the model waiver request that States have the option of submitting is also 0938-0268. (The model waiver request is discussed in Part V. of the preamble, *Policy Clarifications*.)

The other reporting and recordkeeping requirements contained in §§ 441.302 and 441.303 are not effective until OMB approves them. We will publish a notice in the **Federal Register** when approval is obtained from OMB, giving the OMB approval number and the effective date of the requirements.

List of Subjects

42 CFR Part 435

Aid to Families with Dependent Children, Aliens, Categorically needy, Contracts (Agreements—State Plan), Eligibility, Grant-in-Aid program—health, Health facilities, Medicaid, Medically needy, Reporting and recordkeeping requirements, Spend-down, Supplemental security income (SSI).

42 CFR Part 436

Aid to Families with Dependent Children, Aliens, Contracts (Agreements) Eligibility, Grant-in-Aid program—health, Guam, Health facilities, Medicaid, Puerto Rico, Supplemental security income (SSI), Virgin Islands.

42 CFR Part 440

Clinics, Dental health, Drugs, Grant-in-Aid program—health, Health care, Health facilities, Health professions, Hearing disorders, Home health services, Inpatients, Laboratories, Language disorders, Lung diseases, Medicaid, Mental health centers, Occupational therapy, Personal care services, Physical therapy, Prosthetic devices, Outpatients, Opthalmic goals and services, Rural areas, Speech disorders, X-rays.

42 CFR Part 441

Abortions, Aged, Early Periodic Screening Diagnosis and Treatment (EPSDT), Family Planning, Grant-in-Aid program—health, Health facilities, Infants and children, Institutions for mental diseases (IMD), Kidney diseases, Maternal and child health, Medicaid, Mental health centers, Opthalmic goods and services, Penalties, Psychiatric facilities, Sterilizations.

42 CFR Part 435, 436, 440 and 441 are amended as follows:

PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA AND THE NORTHERN MARIANA ISLANDS

The authority citation for Part 435 reads as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

A. 42 CFR Part 435 is amended as follows:

1. a. In the table of contents under Subpart C, Options for Coverage as Categorically Needy, a new § 435.217—"Individuals receiving home and community-based services." is added under the center headings, *Options for Coverage of Families and Children and the Aged, Blind, and Disabled.*

b. Also, § 435.232 is removed.

2. Section 435.3 is amended by revising the last citation of 1902(a) to read as follows:

§ 435.3 Basis

* * * * *

1902(a) (second paragraph after (44)) Eligibility despite increased monthly insurance benefits under title II.

* * * * *

§ 435.232 [Redesignated as § 435.217]

3. Section 435.232 is redesignated as § 435.217 and revised to read as follows:

§ 435.217 Individuals receiving home and community-based services.

The agency may provide Medicaid to any group or groups of individuals in the community who—

(a) Would be eligible for Medicaid if institutionalized;

(b) Would require institutionalization in the absence of home and community-based services under a waiver granted under Part 441, Subpart G, of this subchapter; and

(c) Receive the waivered services.

§§ 435.726 and 435.735 [Amended]

4. Sections 435.726(b) and 435.735(b) are amended by removing the reference to "§ 435.232" and inserting "§ 435.217" in its place.

PART 436—ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS

The authority citation for Part 436 reads as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

B. 42 CFR Part 436 is amended as follows:

1. In the table of contents under Subpart C, *Options* for *Coverage as Categorically Needy*, a new § 436.217—"Individuals receiving home and community-based services." is added under the center heading,

Options for Coverage of Families and Children and the Aged, Blind, and Disabled

2. A new § 436.217 is added to read as follows:

§ 436.217 Individuals receiving home and community-based services.

(a) The agency may provide Medicaid to any group or groups of individuals in the community who—

(1) Would be eligible for Medicaid if institutionalized;

(2) Would require institutionalization in the absence of home and community-based services under a waiver granted under Part 441, Subpart G, of this subchapter; and

(3) Receive the waivered services.

PART 440—SERVICES: GENERAL PROVISIONS

The authority citation for Part 440 reads as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302), unless otherwise noted.

42 CFR Part 440 is amended as follows:

C. Section 440.180 is amended by removing the paragraph designation for paragraph (a) and revising the contents of that paragraph. Paragraph (b) is revised and redesignated as § 441.310. As revised § 440.180 reads as follows:

§ 440.180 Home or community-based services.

"Home or community-based services" means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of Part 441, Subpart G of this subchapter. Except as provided in § 441.310 the services may consist of any of the following services as defined by the agency that meet the standards specified in § 441.302(a):

(a) Case management services;
(b) Homemaker services;
(c) Home health aide services;
(d) Personal care services;
(e) Adult day health services;
(f) Habilitation services;
(g) Respite care services;
(h) Other services requested by the Medicaid agency and approved by HCFA as cost-effective.

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

The authority citation for Part 441 reads as follows:

Authority: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302).

D. 42 CFR Part 441 is amended as follows:

1. The Table of Contents for Part 441 is amended by adding new §§ 441.306 and 441.310 as follows:

* * * * *

Subpart G—Home and Community-Based Services: Waiver Requirements

* * * * *

Sec.
441.306 Hearings procedures for waiver terminations.
441.310 Limits on Federal financial participation (FFP).

* * * * *

2. Section 441.301 is amended by revising paragraphs (b)(4) and (5), and adding a new paragraph (b)(6) to read as follows (the introductory language of paragraph (b) is reprinted without change for the convenience of the reader):

§ 441.301 Contents of request for a waiver.

* * * * *

(b) If the agency furnishes home and community-based services, as defined in § 440.180 of this subchapter, under a waiver granted under this subpart, the waiver request must:

* * * * *

(4) Describe the services to be furnished;

(5) Provide that the documentation requirements regarding individual evaluation, specified in § 441.303(c), will be met; and

(6) Be limited to one of the following target groups or any subgroup thereof that the State may define:

(i) Aged or disabled, or both.

(ii) Mentally retarded or developmentally disabled, or both.

(iii) Mentally ill.

3. Section 441.302 is revised to read as follows:

§ 441.302 State assurances.

HCFA will not grant a waiver under this subpart and may terminate a waiver unless the Medicaid agency provides the following satisfactory assurances to HCFA:

(a) *Health and Welfare*—Assurance that necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those safeguards must include—

(1) Adequate standards for all types of providers that provide services under the waiver;

(2) Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver; and

(3) Assurance that all facilities covered by section 1616(e) of the Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

(b) *Financial accountability.*—The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

(c) *Evaluation of need.*—Assurance that the agency will provide for an evaluation (and periodic reevaluations) of the need for the level of care provided in an SNF, ICF, or ICF/MR, as defined by §§ 440.40 and 440.150, respectively, when there is a reasonable indication that individuals might need such services in the near future but for the availability of home and community-based services.

(d) *Alternatives*—Assurance that when a recipient is determined to be likely to require the level of care provided in an SNF, ICF, or ICF/MR, the recipient or his or her legal representative will be—

(1) Informed of any feasible alternatives available under the waiver; and (2) given the choice of either institutional or home and community-based services.

(e) *Expenditures*—Assurance that—(1) The average per capita fiscal year expenditures under the waiver will not exceed the average per capita expenditures for the level of care provided in an SNF, ICF, or ICF/MR under the State plan that would have been made in that fiscal year had the waiver not been granted. (i) These expenditures must be reasonably estimated by the agency; and (ii) The estimates must be annualized and must cover each year of the waiver period.

(2) The agency's actual total expenditures for home and community-based services under the waiver and its claim for FFP in expenditures for the services will not exceed the agency's approved estimates for these services, expressed as the product of (C×D) in the supporting documentation required under § 441.303(f), for each year of the waiver period.

(3) The agency's actual total expenditures for home and community-based and other Medicaid services provided to individuals under the waiver will not, in any year of the waiver period, exceed the amount that would be incurred by Medicaid for these individuals in an SNF, ICF, or ICF/MR, in the absence of a waiver.

(f) *Reporting.*—Assurance that annually, the agency will provide HCFA with information on the waiver's impact. The information must be consistent with a data collection plan designed by HCFA and must address the waiver's impact on—

(1) The type, amount, and cost of services provided under the State plan; and

(2) The health and welfare of recipients.

4. Section 441.303 is amended by revising and redesignating paragraph (d) as paragraph (f), adding new paragraphs (d), (e), and (g), and revising paragraphs (a) and (c), as follows:

§ 441.303 Supporting documentation required.

The agency must furnish HCFA with sufficient information to support the assurances required by § 441.302. Except as HCFA may otherwise specify for particular waivers, the information must consist of the following, at a minimum:

(a) A description of the safeguards necessary to protect the health and welfare of recipients. This information must include a copy of the standards established by the State for facilities that are covered by section 1616(e) of the Act.

* * * * *

(c) A description of the agency's plan for the evaluation and reevaluation of recipients, including—(1) A description of who will make these evaluatins and how they will be made; (2) A copy of the evaluation instrument to be used; (3) the agency's procedure to ensure the maintenance of written documentation on all evaluations and reevaluations; and (4) the agency's procedure to ensure reevaluations of need at regular intervals.

(d) A description of the agency's plan for informing eligible recipients of the feasible alternatives available under the waiver and allowing recipients to choose either institutional services or home and community-based services.

(e) An explanation of how the agency will apply the applicable provisions regarding the post-eligibility treatment of income and resources of those individuals receiving home and community-based services who are eligible under a special income level (included in § 435.217 of this chapter).

(f) An explanation with supporting documentation satisfactory to HCFA of how the agency estimated the per capita expenditures for services. This information must include but is not limited to the estimated utilization rates and costs for services included in the plan, the number of actual and projected beds in Medicaid certified SNFs, ICFs, and ICF/MRs by type, and evidence of the need for additional bed capacity in the absence of the waiver.

(1) The annual average per capita expenditure estimate of the cost of home and community-based and other Medicaid services under the waiver must not exceed the annual average per capita expenditures of the cost of services in the absence of a waiver. The estimates are to be based on the following equation:

$$\frac{(AxB) + (A'xB') + (CxD) + (C'xD') + (HxI)}{F+H} < \frac{(FxG) + (HxI) + (F'xG')}{F+H}$$

where:

A = the estimated annual number of beneficiaries who would receive the level of care provided in an SNF, ICF, or ICF/MR with the waiver.

B = the estimated annual Medicaid expenditure for SNF, ICF, or ICF/MR care per eligible Medicaid user with the waiver.

C = the estimated annual number of beneficiaries who would receive home and community-based services under the waiver.

D = the estimated annual Medicaid expenditure for home and community-based services per eligible Medicaid user.

F = the estimated annual number of beneficiaries who would likely receive the level of care provided in an SNF, ICF, or ICF/MR in the absence of the waiver.

G = the estimated annual Medicaid expenditure per eligible Medicaid user of such institutional care in the absence of the waiver.

H = the estimated annual number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care.

I = the estimated annual Medicaid expenditure per eligible Medicaid user of the noninstitutional services referred to in H.

A' = the estimated annual number of beneficiaries referred to in A who would receive any of the acute care services otherwise provided under the State plan.
B' = the estimated annual Medicaid expenditure per eligible Medicaid user of the acute care services referred to in A'.
C' = the estimated annual number of beneficiaries referred to in C who would receive any of the acute care services otherwise provided under the State plan.
D' = the estimated annual Medicaid expenditure per eligible Medicaid user of acute care services referred to in C'.
F' = the estimated annual number of beneficiaries referred to in F who would receive any of the acute care services otherwise provided under the State plan.
G' = the estimated annual Medicaid expenditure per eligible Medicaid user of the acute care services referred to in F'.

(2) For purposes of the equation, acute care services means all services otherwise provided under the State plan that are neither SNF, ICF, or ICF/MR services, nor the noninstitutional, long-term care services referred to in H.

(3) Data on the estimated annual number of beneficiaries and expenditures for those who would otherwise receive an SNF, ICF, or ICF/MR level of care is required for all three types of institutions only if the waiver request provides that each of these groups will be offered home and community-based services. For example, if the request does not include persons who would otherwise receive an ICF/MR level of care, the State is not required to furnish data on that group.

(4) The data must show the estimated annual number of beneficiaries who will be deinstitutionalized from certified SNFs, ICFs and ICF/MRs because they would receive home and community-based services under the waiver, and the estimated annual number of beneficiaries whose admission to such institutions would be diverted or deflected because of the waiver services. For the latter group, the State's evaluation process required by § 441.303(c) must provide for a more detailed description of their evaluation and screening procedures for recipients to assure that waiver services will be limited to persons who would otherwise receive the level of care provided in an SNF, ICF, or ICF/MR.

(g) Except as HCFA may otherwise specify for particular waivers, the agency must provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-effectiveness. The results of the assessment must be submitted to HCFA at least 90 days prior to the third anniversary of the approved waiver period and cover at least the first 24 months of the waiver.

5. Section 441.304 is revised as follows:

§ 441.304 Duration of a waiver.

(a) The effective date for a waiver of Medicaid requirements to provide home and community-based services approved under this subpart is established by HCFA prospectively on or after the date of approval and after consultation with the State agency.

The waiver continues for a three-year period from the effective date. If the agency requests it, the waiver may be extended for additional three-year periods, if HCFA's review of the prior three-year period shows that the assurances required by § 441.302 of this subpart were met.

(b) HCFA will determine whether a request for extension of an existing waiver is actually an extension request or a request for a new waiver.

(1) Generally, if a State's extension request proposes a change in services provided, eligible population, service area, or statutory sections waived, HCFA will consider it a new waiver request.

(2) If a State submits an extension request that would add a new group to the existing group of beneficiaries covered under the waiver, HCFA will consider it to be two requests; one as an extension request for the existing group, and the other as a new waiver request for the new group.

(c) HCFA *may* grant a State an extension of its existing waiver for up to 90 days to permit the State to document more fully the satisfaction of statutory and regulatory requirements needed to approve a new waiver request. HCFA will consider this option when it requests additional information on a new waiver request submitted by a State to extend its existing waiver or when HCFA disapproves a State's request for extension.

(d) If HCFA finds that an agency is not meeting any of the requirements for a waiver contained in this subpart, the agency will be given a notice of HCFA's findings and an opportunity for a hearing to rebut the findings. If HCFA determines that the agency is not in compliance with this subpart after the notice and any hearing, HCFA may terminate the waiver. For example:

(1) If HCFA finds that the agency's actual total expenditures for home and community-based services under the waiver exceed the agency's approved estimates for these services, expressed as the product of (C × D) in the supporting documentation required under § 441.303(f), for any year of the waiver period, the waiver may be terminated; or

(2) The waiver may be terminated if HCFA finds that the agency's actual total expenditures for home and community-based and other Medicaid services provided to individuals under the waiver exceed, for any year of the waiver period, the amount that would be incurred by Medicaid for these individuals in an SNF, ICF, or ICF/MR, in the absence of a waiver.

6. A new § 441.306 is added to read as follows:

§ 441.306 Hearings procedures for waiver terminations.

The procedures specified at 45 CFR Part 213 are applicable to State requests for hearings on terminations.

7. A new § 441.310 is added to read as follows:

§ 441.310 Limits on Federal financial participation (FFP).

(a) FFP for home and community-based services listed in § 440.180 of this chapter is not available in expenditures for—

(1) Services provided in a facility subject to the health and welfare requirements described in § 441.302(a) during any period in which the facility is found not to be in compliance with the applicable State standards described in that section;

(2) Home and community-based services that exceed the agency's approved estimated total expenditures for these services, expressed as the product of (C × D) in the supporting documentation required under § 441.303(f) for each year of the waiver period; and

(3) The cost of room and board except when provided as part of respite care in a facility approved by the State that is not a private residence. For purposes of this provision, "board" means three meals a day or any other full nutritional regimen and does not include meals provided as part of a program of adult day health services.

(b) On or after June 11, 1985, the limits specified in paragraphs (a)(1) and (a)(2) of this section are applicable to all existing and future waiver programs under this part.

(Catalog of Federal Assistance Program No. 13.714, Medical Assistance Program)

Dated: November 26, 1984.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: January 7, 1985.

Margaret M. Heckler,

Secretary.

[FR Doc. 85-5715 Filed 3-12-85; 8:45 am]

BILLING CODE 4120-01-M

EXHIBIT H

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

OFFICE OF THE COMMISSIONER
612/296-2701

GENERAL INFORMATION
612/296-6117

PLEASE REPLY TO_____

INSTRUCTIONAL BULLETIN #81-53 July 20, 1981

TO: Chairperson, Board of County Commissioners
Attention: Director

Chairperson, Human Services Board
Attention: Director

Chairperson, Area Mental Health Board
Attention: Director

State Hospitals
Attention: Chief Executive Office

Developmental Achievement Centers
Attention: Director

Rule 34 Facilities
Attention: Director

SUBJECT: County Utilization of State Hospital Services, and Resources for Developing Community Services for Mentally Retarded Persons, Effective F.Y. 1982

Part I: County Utilization of State Hospital Services

Part II: DPW Rule 23, Appropriation and Semi-Independent Living Services

Part III: Mental Retardation Construction Grants for Community Residential Facilities Serving Mentally Retarded and Cerebral Palsied Persons

Part IV: Mental Retardation Family Subsidy Program

Part V: Policy on Sheltered Workshop and Work Activity Placements for Mentally Retarded Persons Affected by Welsh v. Noot

Part VI: Technical Assistance Availability to Counties, Human Service Boards, Residential and Day Program Developers and Operators

The purpose of this bulletin is to inform County and Human Service Boards and affected agencies of new policies and procedures developed as a result of the 1980-81 Legislature and the Welsch v. Noot Consent Decree relating to

4. Procedure:

Technical Assistance can be secured by writing the Department as to the nature of assistance required, the immediacy of the need and the agency and/or individual requesting the assistance. Please address all requests to:

Warren H. Bock
Mental Retardation Division
Department of Public Welfare
St. Paul, MN 55155
612/296-4421

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

OFFICE OF THE
COMMISSIONER
612/296-2701

GENERAL
INFORMATION
612/296-6117

PLEASE REPLY TO_____

INSTRUCTIONAL BULLETIN #81-53 July 20, 1981

PART I: County Utilization of State Hospital Services

1. Purpose.

The purpose of this section of the bulletin is to describe the policy on county utilization of state hospital services, the rationale for the policy and the process by which it was formulated.

2. Background.

The Welsch v. Noot Consent Decree (effective September 15, 1980) requires an approximate thirty (30) percent reduction of the number of mentally retarded persons residing in the state hospitals from a current population of approximately 2,600 to 1,850 persons by July 1, 1987. Given that Decree and since DPW Rule 185 and the Community Social Services Act authorizes the county boards to be responsible for case management, service planning and coordination, service provision and evaluation, it is necessary that state hospital utilization levels be established on a county-by-county basis.

Request Bulletin #81-6 (dated February 25, 1981) requested reaction from affected and interested agencies on a proposed per capita utilization formula (labeled Formula I) for state hospital services. Based on the county response to that bulletin, two alternative formulae were developed. These alternative formulae represented a straight thirty percent reduction of state hospital utilization by county (Formula II) and a compromise formula (III) based on a fifty percent per capita utilization weighting and a fifty percent of a straight thirty percent reduction by county. The two alternative formulae, along with the original formula were presented to county directors on April 30, 1981 at their regular meeting for ranking. To ensure that all county directors had an opportunity to rank each of the formulae, the three formulae (with their accompanying methodologies) and a ranking form were sent to all directors not present at the meeting. All county directors were requested to return the form by May 15, 1981. Sixty counties returned the ranking form. The results revealed that the counties were sharply divided between Formula I and II, but were willing to compromise on Formula III.

3. Policy Statement.

On June 1, 1981, Formula III was adopted by DPW Cabinet as the Department policy governing county utilization of state hospital services for mentally retarded persons. Formula III below represents the compromise between the per capita formula and the straight thirty percent reduction formula.

At several of the meetings on the issue of state hospital reduction, a number of counties indicated that they would like to work collectively with neighboring counties to achieve their reduction. For example, two or more counties may agree "to pool" their respective net quotas and resources and "barter" for state hospital utilization level. The Department encourages this type of local initiative to ensure that needed services are provided in the most cost efficient and program effective manner possible.

The department will publish reports on individual county state hospital utilization levels in January and July of each year to assist in planning and to monitor compliance with this policy. The first update on individual county utiliza-tion will be distributed in July 1981. This update will restate each county's biennial utilization target for July 1, 1983 and will indicate your county utilization as of June 30, 1981 showing the difference between the proposed utilization levels and the actual utilization levels. This information will provide you with a clear status of your progress in reaching the biennial benchmarks indicated for your county.

If you intend to work jointly with other counties in combining state hospital utilization levels and net reduction levels, please inform the Mental Retardation Division of your actions and how you plan to jointly proceed with state hospital reductions. If you have further questions, contact:

Robert F. Meyer
Mental Retardation Division
Department of Public Welfare
Centennial Office Building
St. Paul, MN 55155
(612) 296-2147

Formula III: Goals for County Utilization of State Hospitals

COUNTY	State Hospital Utilization 6/30/80	1987 Net Reduction	1987 Utilization Level	Biennial Net Reduction 83	85	87	Biennial Utilization Levels 83	85	87
1 Aitkin	15	7	8	3	2	2	12	10	8
2 Anoka	53	8	45	3	3	2	50	47	45
3 Becker	20	7	13	3	2	2	17	15	13
4 Beltrami	28	11	17	4	4	3	24	20	17
5 Benton	17	5	12	2	2	1	15	13	12
6 Big Stone	5	2	3	1	1	0	4	3	3
7 Blue Earth	54	24	30	8	8	8	46	38	30
8 Brown	35	16	19	6	5	5	29	24	19
9 Carlton	25	9	16	3	3	3	22	19	16
10 Carver	21	5	16	2	2	1	19	17	16
11 Cass	29	14	15	5	5	4	24	19	15
12 Chippewa	13	5	8	2	2	1	11	9	8
13 Chisago	7	1	6	1	0	0	6	6	6
14 Clay	32	10	22	4	3	3	28	25	22
15 Clearwater	2	0	2	0	0	0	2	2	2
16 Cook	2	0	2	0	0	0	2	2	2
17 Cottonwood	13	5	8	2	2	1	11	9	8
18 Crow Wing	50	23	27	8	8	7	42	34	27
19 Dakota	62	10	52	6	2	2	56	54	52
20 Dodge	10	3	7	1	1	1	9	8	7
21 Douglas	26	10	16	4	3	3	22	19	16
22 Faribault	See Martin County		-	-	-	-	-	-	-
23 Fillmore	23	9	14	3	3	3	20	17	14
24 Freeborn	30	12	18	4	4	4	26	22	18
25 Goodhue	24	7	17	3	2	2	21	19	17
26 Grant	9	4	5	2	1	1	7	6	5
27 HENNEPIN	564	170	394	57	57	56	507	450	394
28 Houston	16	6	10	2	2	2	14	12	10
29 Hubbard	13	5	8	2	2	1	11	9	8
30 Isanti	9	1	8	1	0	0	8	8	8
31 Itasca	30	10	20	4	3	3	26	23	20
32 Jackson	6	1	5	1	0	0	5	5	5
33 Kanabec	6	1	5	1	0	0	5	5	5
34 Kandiyohi	14	2	12	1	1	0	13	12	12
35 Kittson	12	6	6	2	2	2	10	8	6
36 Koochiching	20	9	11	3	3	3	17	14	11
37 Lac qui Parle	7	2	5	1	1	0	6	6	6
38 Lake	15	7	8	3	2	2	12	10	8
39 Lake of the Woods	5	2	3	1	1	0	4	3	3
40 LeSueur	25	11	14	4	4	3	21	17	14
41 Lincoln	See Lyon County		-	-	-	-	-	-	-
42 Lyon	27	8	19	3	3	2	24	21	19
43 McLeod	20	6	14	2	2	2	18	16	14
44 Mahnomen	7	3	4	1	1	1	6	5	4
45 Marshall	14	6	8	2	2	2	12	10	8
46 Martin	42	29	13	10	10	9	32	22	13
47 Meeker	15	5	10	2	2	1	13	11	10
48 Mille Lacs	12	3	9	1	1	1	11	10	9
49 Morrison	26	17	13	6	6	5	30	24	13
50 Mower	41	18	23	6	6	6	35	29	23
51 Murray	See Lyon County		-	-	-	-	-	-	-
52 Nicollet	13	2	11	1	1	0	12	11	11
53 Nobles	8	1	7	1	0	0	7	7	7
54 Norman	14	7	7	3	2	2	11	9	7
55 Olmsted	37	15	22	5	5	5	32	27	22
56 Otter Tail	53	23	30	8	8	7	45	37	30
57 Pennington	13	3	7	1	1	1	9	8	7
58 Pine	20	8	12	3	3	2	17	14	12
59 Pipestone	7	2	5	1	1	0	6	5	5
60 Polk	37	17	20	6	6	5	31	25	20
61 Pope	12	5	7	2	2	1	10	8	7
62 RAMSEY	306	103	203	33	34	36	273	239	203
63 Red Lake	13	7	6	3	2	2	10	8	6
64 Redwood	28	8	20	3	3	2	25	22	20
65 Renville	11	2	9	1	1	0	10	9	9
66 Rice	41	16	25	6	5	5	35	30	25
67 Rock	6	1	5	1	0	0	5	5	5
68 Roseau	19	9	10	3	3	3	16	13	10
69 ST. LOUIS	146	47	99	16	16	15	130	114	99
70 Scott	23	4	19	2	1	1	21	20	19
71 Sherburne	13	2	11	1	1	0	12	11	11
72 Sibley	15	6	9	2	2	2	13	11	9
73 Stearns	62	15	47	5	5	5	57	52	47
74 Steele	17	4	13	2	1	1	15	14	13
75 Stevens	8	2	6	1	1	0	7	6	6
76 Swift	7	1	6	1	0	0	6	6	6
77 Todd	36	18	18	6	6	6	30	24	18
78 Traverse	6	3	3	1	1	1	5	4	3
79 Wabasha	21	9	12	3	3	3	18	15	12
80 Wadena	18	9	9	3	3	3	15	12	9
81 Waseca	15	6	9	2	2	2	13	11	9
82 Washington	27	4	23	2	1	1	25	24	23
83 Watonwan	See Martin County		-	-	-	-	-	-	-
84 Wilkin	14	7	7	3	2	2	11	9	7
85 Winona	30	10	20	4	3	3	26	23	20
86 Wright	14	2	12	1	1	0	13	12	12
87 Yellow Medicine	12	5	7	2	2	1	10	8	7
Total	2710	918	1792	336	307	275	2374	2067	1792

EXHIBIT I

ICF/MR Beds Per 10,000 Population*
With Moratorium

Region	1981	1986**	Difference
1	12.7	15.5	2.8
2	11.1	10.4	.7
3	9.9	11.3	1.4
4	11.2	9.0	2.2
5	3.0	7.3	4.3
6	17.0	18.9	1.9
7	9.0	10.4	1.4
8	23.0	24.7	1.7
9	9.8	12.8	3.0
10	11.4	15.1	3.7
11	10.3	11.1	.8
State	10.8	12.1	1.4

* 1980 and 1986 census information was used to calculate the 1981 and 1986 per capita values respectively.

** 1986 per capita figure includes existing ICF/MR beds and those ICF/MR beds authorized prior to March, 1983.

THIS TABLE WAS PREPARED AS PART OF AN ASSESSMENT OF THE IMPACT OF THE ICF/MR MORATORIUM BY THE STAFF OF THE MENTAL RETARDATION DIVISION OF THE DEPARTMENT OF HUMAN SERVICES.