



PLAN FOR ICFs/MR IN MINNESOTA
(INTERMEDIATE CARE FACILITIES
FOR PERSONS WITH MENTAL RETARDATION)

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Minnesota Department of Human Services

This report is submitted to the Minnesota Legislature pursuant to Minnesota Statutes 2006, Chapter 282, Article 20, Section 34 to develop a stakeholder plan and legislation concerning the future services provided to people served in ICFs/MR.

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EXECUTIVE SUMMARY

The legislature required the Minnesota Department of Human Services (Minnesota Statutes 2006, Chapter 282, Article 20, section 34) to develop a stakeholder plan and legislation concerning the future services provided to people served in ICFs/MR by December 15, 2008.

Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR) are part of the Minnesota service delivery system for individuals with mental retardation and related conditions (developmental disabilities). Planning future ICF/MR services will be based on the vision, core beliefs and values of the Department of Human Services (DHS) Continuing Care Administration for persons with long-term support needs. We envision a future where Minnesotans live as independently as possible, in safe, affordable places. The priorities of the Disability Services Division include continuing to expand community living options, consumer-directed services, and housing options. DHS is committed to promoting, for each Minnesotan with disabilities, six “domains of a meaningful life,” which has an acronym of “CHOICE”:

- **Community membership** grounded in both participation and actual group membership
- **Health, wellness and safety** with an emphasis on communication, relationships and trust
- **Own place to live** where people choose both the place and whomever lives or provides support in their home – roommate and direct support staff
- **Important long-term relationships** that are reciprocal and provide for safety
- **Control over supports** including control over the funding for personal supports, housing and transportation
- **Employment earnings and stable income** with jobs, self-employment, or stable income from public and private sources

ICFs/MR are residential services that support persons with mental retardation and related conditions who require a 24 hour plan of care with habilitation and who choose such services. These facilities are reimbursed at 50% federal funds, and are regulated by numerous federal regulations regarding the quality and type of care. Currently in Minnesota there are 218 facilities with 1936 beds. Facilities range in size from four to 64 beds, and in 2007 cost \$66.2 million in state dollars and \$3.6 million in county funds. Over 74% of the Minnesotans who currently live in an ICF/MR are over age 40.

Due to numerous fiscal and funding formula changes since 2000, there is stakeholder concern that retaining ICF/MR care as a viable part of the services system is at risk. In addition, these recent changes in funding regulations have limited provider flexibility to accommodate individual resident needs.

While the community care system has diversified with Medicaid-waiver funding, independent and semi-independent living services, and consumer-directed support, there is a consensus among counties, providers, and families to retain ICFs/MR as part of the care system for the foreseeable future. Stakeholders identified four current priorities:

1. Maintain the ICF/MR system as a viable option in the marketplace

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2. Create a funding process to allow ICFs/MR to be downsized/remodeled so spaces are compliant with the Americans with Disabilities Act, offer privacy, and better meet individual needs
3. Change legislation regarding variable rates to respond to individual consumer medical/behavioral needs, to allow equal access to facilities
4. Fund Services during the Day with entire Day Training & Habilitation funds

The process of obtaining stakeholder input resulted in numerous recommendations for the improvement of the system. Recommendations were considered in three categories:

- (a) No-cost policy changes
- (b) Cost-neutral changes and
- (c) Changes that would require additional funding and investment.

Most of the “no cost” and “cost-neutral” recommendations require DHS and Minnesota Department of Health (MDH) to work together to improve and streamline processes, and/or DHS to negotiate with federal Centers for Medicaid and Medicare Services (CMS) for more person-centered, individualized flexibility. Four of the recommendations in these two categories require legislation, including establishing a stakeholder workgroup to design a new ICF/MR reimbursement system, updating language in Rule 53 to reflect current rate-setting methods, and allowing both variable rates and provider negotiations in cost-neutral or cost-saving situations.

DHS must consider a wide range of options as part of a comprehensive planning process for the entire care system for persons with long-term support needs, before it can support any specific stakeholder recommendation(s). Resources for ICF/MR care cannot be considered in isolation from other DHS initiatives and service priorities for this population. Comprehensive planning includes addressing an array of services such as home and community-based services (Medicaid waiver programs), semi-independent living services, state plan services such as home care, as well as ICF/MR services. In addition, long-term planning includes addressing the aging of the ICF/MR population, the changing market demands of incoming younger consumers, and regional capacity.

Estimates for additional funding and investment to maintain the ICF/MR system and to increase flexibility for meeting individual consumer needs range from approximately \$59,000 to \$4,400,000 in annual state costs. Specific recommendations for investments in ICF/MR care will be taken into consideration as one element in current planning efforts for the overall services system for Minnesotans with developmental disabilities.

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I. BACKGROUND

The Legislature required the Minnesota Department of Human Services (Minnesota Statutes 2006, Chapter 282, Article 20, section 34) to develop a stakeholder plan and legislation concerning the future services provided to people served in ICFs/MR by December 15, 2008.

This plan will be developed consistent with the vision, values and core beliefs of DHS for services for Minnesotans with disabilities. DHS Continuing Care Administration envisions a future where Minnesotans with disabilities live as independently as possible, in safe, affordable places. The priorities of the Disability Services Division include continuing to expand community living options, self-directed services, and housing options. DHS is committed to promoting, for each Minnesotan with disabilities, six “domains of a meaningful life,” which has an acronym of “CHOICE”:

- **Community membership** grounded in both participation and actual group membership
- **Health, wellness and safety** with an emphasis on communication, relationships and trust
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These core beliefs provide the framework for future plans for Intermediate Care Facilities for Persons with Mental Retardation, in the context of all services for this population.

A. HISTORY OF COMMUNITY-BASED CARE FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Prior to 1971, Medical Assistance (MA) was only available to fund medical services and nationally, state institutions and nursing facilities were the primary locations for serving persons with mental retardation outside of their family homes. Federal legislation and funding for Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR) began in 1971 and was the first time federal Medicaid dollars became available for services. With the federal government providing matching funds at 50% of the cost for these services, Minnesota was a pioneer and leader in developing these in local communities and also funded state institutions as ICFs/MR.

In 1978, Minnesota had more than half of all ICFs/MR in the country. With the Welsch class action suit in the early 1970’s requiring one-third of institutionalized individuals to be moved to the community, community based ICFs/MR were considered a cost-effective model to move people out of institutions. During the 1980’s and early 1990’s, smaller sized ICFs/MR in

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addition to the rapid expansion of the HCBS waiver played a significant role as alternatives to institutions. Large community-based ICFs/MR also began to close.

ICFs/MR operate with detailed federal regulations, and in some states are called ICF/DD. They are surveyed annually by the Department of Health in areas specific to ICFs/MR, including active treatment, health care, dietetic services, and physical environment. Services are a pre-designed package and include room and board, active treatment, transportation, related medical services, and Services during the Day as an alternative to Day Training and Habilitation (DT&H) in some circumstances

For a person to receive ICF/MR services, among other requirements, they must have mental retardation or a related condition, require the level of oversight provided, and must be in need of continuous “active treatment” services. Specifically, in order to be eligible for ICF/MR services, a person must:

- Have mental retardation or a related condition (MR/RC)
- Require a 24-hour plan of care
- Require active treatment
- Meet Medical Assistance (MA) income and asset requirements and
- Request ICF/MR services

Minnesota also has two classes of facilities -- Class A and B. Class A facilities provide services for persons who are able to self preserve in emergencies. Class B facilities provide services for persons who are not able to independently or with very limited prompting evacuate the building. Class B facilities provide a higher level of safeguards, such as sprinklers for fire protection.

As the service system developed toward smaller and more individualized care options, in the early 1980's, Medicaid home and community-based service waivers (HCBS) became available to permit states the flexibility to develop alternatives to placing Medicaid-eligible persons in hospitals, nursing facilities, or ICFs/MR. In Minnesota, the “waiver” allowed people to be served in their own homes and required residential facilities to be no more than four beds.

Waiver programs are designed to meet the needs of targeted populations and people must meet the eligibility requirements specific to the waiver. Waiver programs are not considered an entitlement program. Minnesota's Developmental Disability (DD) Waiver provides home and community-based services necessary as a cost effective alternative to institutionalization. These services promote the optimal health, independence, safety and integration of a person who meets the eligibility criteria and who would require the level of care provided in an ICF/MR without the waiver.

To qualify for DD Waiver services, a person must meet all of the following criteria:

1. Is eligible for Medical Assistance (MA) based on disability diagnosis.
2. Has a diagnosis of mental retardation or a related condition.

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3. Resides in an ICF/MR and will continue to require an ICF/MR level of care; or, the screening team determines the person would be placed in an ICF/MR if home and community based services were not provided .
4. Requires daily interventions, daily service needs and a 24-hour plan of care that is specified in the plan of care.
5. Has made an informed choice of waiver services instead of ICF/MR services.
6. Has an assessed need for supports and services over and above those available through the MA State Plan.

Initially, in the 1980's, people moved from ICFs/MR to waiver programs at the rate of 200 people a year. Many large Minnesota ICF/MR facilities have closed, including all of the 100-plus bed facilities and many others over 30 beds.

B. CURRENT ARRAY AND COSTS OF SERVICES

After the initial DD (MR/RC) Waiver for children and adults with developmental disabilities (DD) in 1983, several other waivers were developed in Minnesota, and they comprise the Home and Community-Based Services (HCBS) waivers. HCBS services are services not normally covered by Medicaid, which are covered under a 1915(c) federally funded waiver program or through state funds. HCBS waivers allow states flexibility to cover virtually all long-term care services that persons with disabilities need to live independently in home and community settings. States may operate several 1915(c) HCBS waiver programs at once, each offering a distinct package of services and supports to a different group of persons.

In Minnesota, the other waivers besides the DD Waiver are:

1. Community Alternative Care (CAC) – funding for home and community-based services funding for children and adults who are chronically ill. This waiver is designed to serve persons with disabilities who would otherwise require the level of care provided in a hospital.
2. Community Alternatives for Disabled Individuals (CADI) – provides funding for home and community-based services for children and adults with disabilities who would otherwise require the level of care provided in a nursing facility.
3. Traumatic Brain Injury (TBI) – funding for home and community-based services for children and adults who have an acquired or traumatic brain injury.
4. Elderly Waiver (EW) – funding for community-based services for the elderly (over the age of 65) who would require the level of medical care provided in a nursing home.

Today, over 14,000 persons with DD receive HCBS services in Minnesota. The growth of HCBS services can be attributed to a number of factors that include:

- Individual as well as family preference for home and community-based services
- Closure of large community based ICFs/MR due to lack of admissions
- Statewide initiatives to reduce reliance on nursing facilities

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- Greater flexibility in HCBS waiver services that allow for self direction leading to greater choice and control, allowing persons to manage their services through the Consumer-Directed Community Supports (CDCS) waiver service
- Federal governmental support for HCBS based on states interest and long term commitment to the expansion of community based services rather than institutional congregate care services

Besides ICF/MR and waiver-funded support, people with developmental disabilities are also supported through several other funding streams:

1. **Home care** provides medical and health-related services and assistance with day-to-day activities to people in their home. Home care can be used to provide short-term care for people moving from a hospital or nursing home back to their home, or can also be used to provide continuing care to people with ongoing needs. Home care services may be provided outside the person's home when normal life activities take them away from home.

Medical Assistance covers the following home care services:

- Equipment and supplies, such as wheelchairs and diabetic supplies
- Home health aide
- Personal care assistance
- Skilled nursing visits
- Therapies (occupational, physical, respiratory and speech)

2. **Semi-Independent Living Services (SILS)** are services that include training and assistance in managing money, preparing meals, shopping, personal appearance and hygiene and other activities needed to maintain and improve the capacity of an adult with mental retardation to live in the community. A goal of SILS is to support people in ways that will enable them to achieve personally desired outcomes and lead self-directed lives. SILS supports are typically provided to people who live in their own home or apartment.

3. **Family Support Grant (FSG)** is available to prevent the out-of-home placement of children with disabilities and promote family health and social well-being by assisting families with access to disability services and supports. The FSG provides cash grants to eligible families with children who have certified disabilities. The majority of children receiving FSG have a developmental disability.

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Figure 1 provides a summary from fiscal year 1991 to fiscal year 2008 of the yearly average census for the DD Waiver and ICF/MR services

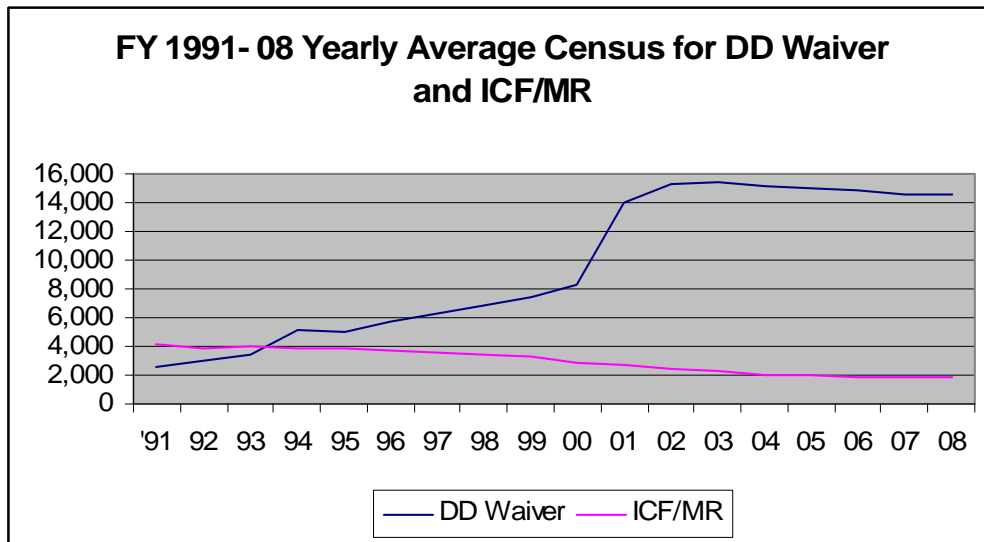
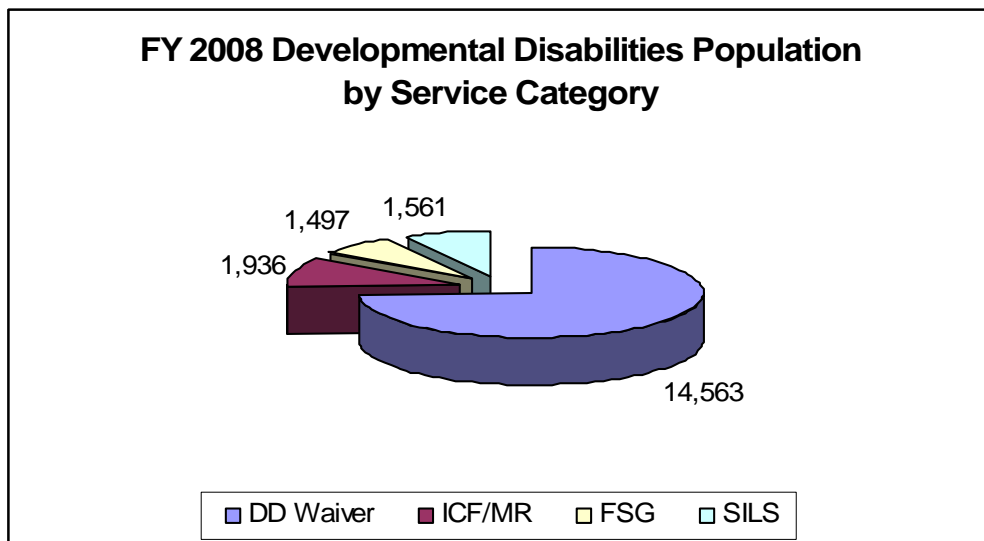
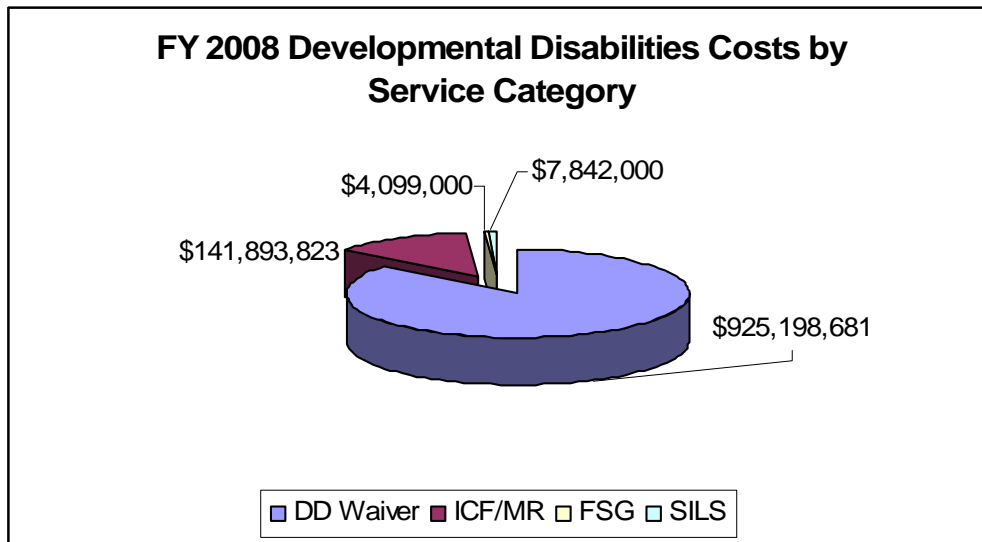


Figure 2 illustrates the array of services provided to persons with developmental disabilities in fiscal year 2008.



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Figure 3 provides fiscal year 2008 payments for community services for persons with developmental disabilities.

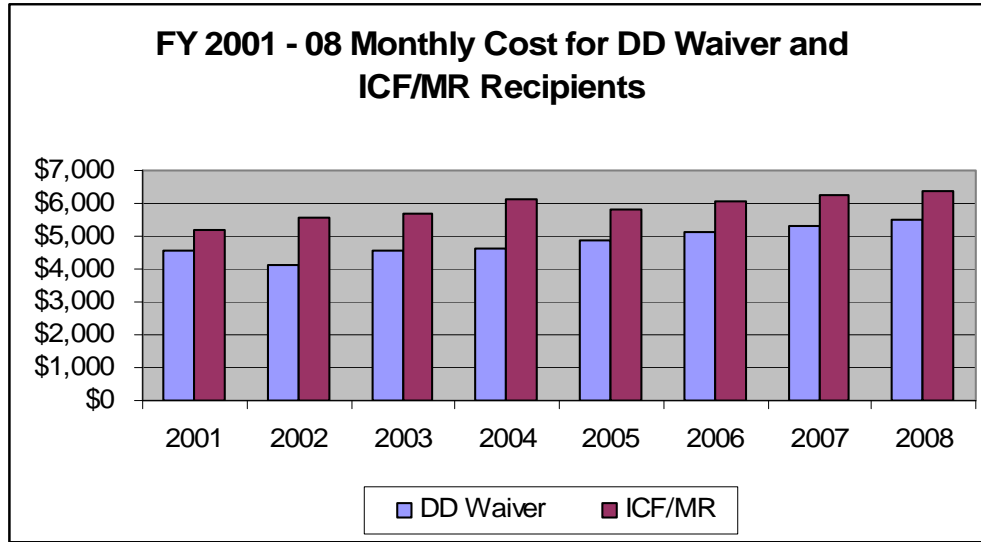


The total spent on ICF/MR care in Minnesota in 2007 was \$139.5 million, of which \$69.7 million was federal dollars, \$66.2 million state dollars and \$3.6 million county funds. This total included costs for day programs for which ICFs/MR provide oversight; these costs were \$1.3 million in 2008.

As legislative and funding mechanisms have been provided to reduce and downsize many ICFs/MR in Minnesota, costs associated with long-term care have been controlled. In 1991, the monthly individual average cost in an ICF/MR was \$3,500 versus \$2,050 dollars for DD Waiver, a difference of \$1,450. The fiscal year 2008 monthly average per-person cost of ICF/MR services was \$6,392 versus \$5,495 for DD Waiver services, a difference of \$897 per individual.

Figure 4 shows average monthly costs between ICF/MR services and DD Waiver services from fiscal years 2001 to 2008. Figures 3 and 4 do not include DT&H Costs.

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As in most states, Minnesota's care system has become and will likely continue to become even more diverse and include more individualized support options that promote self-direction. Over time, the community care system has also continued to become more competent at providing individualized support to the full spectrum of Minnesotans with developmental disabilities, physical disabilities, chronic health conditions, mental disorders as well as persons who have sustained a traumatic head injury.

C. ICF/MR POPULATION DEMOGRAPHICS AND TRENDS

ICFs/MR had the capacity to serve 1,936 individuals as of the end of Fiscal Year 2007 (June 30, 2007). In terms of regional distribution, over 50% of ICF/MR beds are located in the seven county metro area (Region 11) and there is over 95% occupancy of available beds, as seen in Table 1 below. A map showing where regions are located is attached as [Appendix A](#).

Table 1: ICF/MR Regional Population Distribution

Region	Population (Occupied Beds)	Licensed Beds
1	23	24
2	15	15
3	59	86
4	46	44
5	28	30
6	59	64
7	107	92
8	127	132
9	166	167
10	247	275
11	997	1,007
Totals	1,874	1,936

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Table 2 provides a comparison of the age distribution between residents of ICFs/MR and persons supported by the DD Waiver. As shown in this table, ICFs/MR currently serve proportionately an older population than those served with the DD Waiver. Over 74% of the current ICF/MR population is over the age of 40. Of all DD Waiver participants, 41% are over the age of 40. However, it should be noted that the DD Waiver currently serves over four times the number of persons over the age of 65 than are supported in ICFs/MR.

Table 2: Persons Served in ICFs/MR and DD Waiver Age Distribution

Age Ranges	ICF/MR	ICF/MR %	DD Waiver	Waiver %
0 – 12	6	0.3 %	949	7 %
13 – 17	27	1.4 %	1,181	9 %
18 – 22	74	4 %	1,365	10 %
23 – 39	374	20 %	4,773	34 %
40 – 64	1,143	61 %	4,851	35 %
65 +	248	13 %	835	6 %
Totals	1,872		13,954	

Trends over the last several years reflect a movement to and consumer preference for smaller, more home-like environments including support services provided in a consumer’s own home. The small number of ICF/MR residents under age 18 reflects the system-wide commitment to keep children at home or in family-like settings. Many families receive support through the DD Waiver to support their children at home. Additional historical information about ICF/MR usage is attached in Appendix B

Besides the total ICF/MR population decreasing, the size of ICF/MR facilities has also decreased. Table 3 provides a summary of trends in facility size over the past twenty years.

Table 3: ICF/MR Facility Size Trends

Licensed Bed Capacity	1977	1997	2007
1 – 6 beds	286	837	843
7 – 15 beds	911	1,436	655
+16 beds	4,985	1,331	438
Totals	6,182	3,604	1,936

Table 4 shows the number of closed facilities and decertified beds in each of the last 10 years. Although many facilities have downsized and closed, the decertification of beds has fluctuated over the last 10 years due to specific events. For example, in 2003, counties were required to pay a portion of ICF/MR costs for the first time. They were required to pay 20% of the state’s share (10% of total costs) for facilities with seven or more beds. This resulted in many facilities closing and licensed bed capacity in larger facilities substantially decreasing. Another example is

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that during the three-month “open enrollment” period in 2001 for waiver services, 5, 537 people were enrolled for waiver services, also contributing to ICF/MR bed decertification in ensuing years.

Table 4: ICF/MR Beds Decertified in Last 10 Years

Year	Total Number of Facilities Closed	Total Number of Decertified Beds
1997	11	129
1998	17	346
1999	18	178
2000	14	281
2001	10	179
2002	23	244
2003	14	215
2004	6	172
2005	12	158
2006	4	57
2007	2	19
Totals	131	1,978

In 2007, the required county portion of payment for facilities with seven beds and over was decreased by 50%. Since that occurred, the annual number of decertified beds has dramatically decreased. The slow-down in the number of decertified beds in the last two years comes after an aggressive nine-year downsizing/closure effort facilitated by counties.

While there might be a stabilization in the number of ICF/MR beds after these declines, it should also be noted that 274 ICF/MR residents are on the waiting list for waiver services that is likely a conservative number. Given the aging of the current ICF/MR population, decreased demand from younger consumers for ICF/MR placement, and other market factors, it is likely that there will continue to be a slow attrition and some number of beds decertified each year.

However, it is difficult to predict the number of decertified beds and facilities over the next five to ten years due to a variety of factors such as economic conditions, workforce stability, housing stock availability, and transportation accessibility. Based on feedback from families who provided input in surveys and meetings for this report, many family members expressed a desire to continue to have ICF/MR services available in their choice of services. Without a significant change in alternative community-based service options or some other event promoting closures, it is unlikely there will be a dramatic decrease in ICF/MR bed capacity in the next few years.

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D. RECENT PROGRAMMATIC AND FISCAL HISTORY

Prior to October 2000, ICFs/MR were reimbursed under Rule 53, a cost-based reimbursement system. As a result of a 1998 task force to develop a new payment methodology, changes in 2000 eliminated Rule 53 and simplified the payment system, originally intending to allow funding to track more closely with consumer needs. The payment system proposed at that time subsequently evolved between 2000 and 2007. These were some of the key changes in this recent time period:

1. One-Time Rate Adjustments, facility-based rate changes for additional staff to support consumer needs, were eliminated in 2000. Facilities no longer had the capability to make changes in their rates, except there was an original “one time” funding allocation of two million dollars awarded in 2000 to fund occupancy adjustments for two years. What was eliminated was any ability to change rates permanently, based on changes in a facility’s population, residents’ medical conditions, facility renovations, purchasing of additional equipment, or staffing changes required to meet individual resident needs.
2. Cost-based rate increases were eliminated. Facility rates were to be adjusted yearly based on the inflation price index.
3. Comprehensive cost reporting by provider agencies was eliminated.
4. Rule 186, a person-based Special Need rate, was essentially eliminated.
5. In 2000, the plan was that resident profile changes would automatically pay facilities \$50 a day when the screening document implemented in 2001 indicated that a consumer’s medical or behavioral needs had increased. This plan was eliminated by 2004, because the individual resident profile data system had not been designed as a payment indicator system and did not sufficiently identify the changes in people’s conditions and care needs, which would require reimbursement changes.
6. Variable rates were established. The resident profile variable rates established in 2000 were supposed to allow any facility to obtain a variable rate based on an individual consumer’s needs. However, this was changed in 2002 to a new system. Only if a facility had rates below the 50% per diem average in their ICF classification of home (Class A or Class B), could the facility get variable rates for individual needs.
7. Legislative relief to facilities on Skilled Living Facility (SLF) rules was supposed to be implemented in exchange for ICF/MR facilities implementing quality improvement system reporting. Negotiations concerning this issue remain unresolved, and these requirements have never been implemented.
8. Alternative day services systematically became available when “Services during the Day” was implemented in 2003, utilizing dollars already in the system for DT&H programs. These services allowed some consumers to retire, and also provided more choices for younger

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consumers who needed day programs at home, which were alternative to typical DT&H programs. The reimbursement rate was established at 75% of the DT&H rate, since ICF/MR facilities did not have the physical building overhead of DT&Hs.

9. Open bed payments up to 90 days and then 75 days were eliminated except for 25 crisis beds at various locations throughout the state.
10. During the 2003 state budget crisis, a 20% county share of the non-federal share of ICF/MR costs for facilities with seven or more beds was implemented (i.e., 10% of the state share). This resulted in a marked increase in downsizing and closures as individuals were moved to less costly options, usually waiver-funded homes. The number of ICF/MR facilities decreased from 264 in 2000 to 218 in 2008, and the number of beds decreased from 2749 to 1936. At stakeholder meetings held for this report, participating counties reported that this 20% charge had an impact on county budgets for all types of services for people with developmental disabilities, and in some counties affected the overall county levy. As noted above, in 2007, the county rate was cut from 20% to 10% of the non-federal share for facilities seven beds and larger, and downsizing/closures have slowed.

The result of all these changes since 2000 is that ICF/MR providers report that their ability to sustain ICF/MR services is increasingly challenged. There is virtually no additional funding to individualize additional support as consumer needs change. At the same time, waiver funding is also challenged due to unpredictable growth and changes in budgeting have made it difficult for counties to conduct longer term planning.

II. STAKEHOLDER PROCESS AND RECOMMENDATIONS

The legislature directed DHS in Minnesota States 2006, Chapter 282, Article 20, section 34 to develop a stakeholder plan concerning the future services provided to people served in ICFs/MR.

A. STAKEHOLDER PROCESS

There were several steps taken to obtain stakeholder input.

1. Surveys

a. Public and Professional Organization Surveys

A survey was developed concerning the barriers and opportunities of ICF/MR and alternative services. These surveys were distributed between January and March 2008 and were sent to:

- The Association of Minnesota Counties
- The Minnesota Disability Law Center
- The advocacy organization Arc of Minnesota and
- The professional organizations AFSCME (American Federation of State, County and Municipal Employees) and ARRM.(Association of Residential Resources in Minnesota)

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A random sample of both Class A and Class B ICF/MR providers was also surveyed, with 198 responding – 73 Class A and 125 Class B facilities.

b. Family Surveys

During May and June 2008, family members of ICF/MR residents were mailed surveys concerning ICF/MR and alternative services. Of the 85 family members sent surveys, 77 returned them.

2. Analysis/Review of County Local Systems Needs Plans

In February 2008, all county plans were reviewed and analyzed to identify needs for increases or decreases in ICF/MR capacity, which counties and regions had identified. .

3. ICF/MR Provider Work Group

This was a small work-group of representatives of eight provider organizations which met with DHS staff from December 2007 until October 2008 to identify issues, provide recommendations, assist in facilitating small group discussions at regional stakeholder meetings, communicate with family members, and provide feedback to the various recommendations obtained during the last year.

4. Regional Stakeholder Meetings

Seven regional meetings of all categories of stakeholders were held in May and June of 2008 in Fergus Falls, Hibbing, two meetings in Metro Area, Redwood Falls, Rochester, and Willmar. These meetings were attended by more than 400 people, including families, providers, counties, and advocates.

5. Statewide Meeting to Select Priorities

A stakeholder meeting on Sept 22, 2008, was attended by more than 50 people, including providers, counties, and advocates. Out of all the recommendations made at the seven regional meetings, this group selected the priority recommendations.

6. Additional Stakeholder Feedback on Prioritized Recommendations and Draft Report

Additional input was obtained at an ICF/MR provider organization meeting on November 12, 2008. The draft of this ICF/MR legislative report was also sent to over 100 persons who expressed interest in obtaining a copy prior to the submission of the final report; these individuals provided feedback and input through a Web-based survey process.

B. NEEDS AND ISSUES IDENTIFIED BY STAKEHOLDERS

County feedback concerning ICFs/MR note that many facilities are quality sites with excellent programs, which serve persons with difficult medical and/or behavioral conditions. ICFs/MR provide end of life care that may otherwise in some parts of the state have to be provided in a nursing home. The stakeholders who responded to surveys participated at seven regional

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meetings and one statewide meeting, identified two general needs as well as seven specific issues that impact ICF/MR services. These are the two general needs:

1. Given the continuing impact on provider ability to sustain ICF/MR services, stakeholders are concerned changes are needed to retain ICF/MR level of care as a viable part of the system.
2. There is a lack of flexibility to meet individual resident needs, such as accessibility and privacy. There is a need to:
 - a. Convert existing beds and/or facilities for specific persons – e.g., residents who are aging and need more care or individuals with specific health or behavior concerns
 - b. Down-size facilities to increase accessibility, privacy (people having their own bedroom), and meet requirements of the Americans with Disabilities Act (ADA)

The seven specific issues, which were identified, include:

1. No or limited reimbursement for vacant beds.
2. No ability to request a facility per diem rate adjustment. There are limitations on a facility's capacity to adjust rates if staffing needs change based on residents needing more support.
3. Variable rates provide a short-term solution, but only 50% of ICFs/MR are eligible.
4. Little flexibility to and facilities are unable to make the financial commitment to upgrade their ICF/MR to accommodate handicapped accessibility, costly adaptive equipment, and individual bedrooms.
5. Short-term stays for respite or crisis are administratively cumbersome.
6. Some small provider corporations are finding it difficult to survive.
7. For persons who want or choose ICF/MR services, regional capacity is being down-sized or eliminated.

C. RESULTS OF STAKEHOLDER INPUT

In the current service system continuum and reimbursement options, stakeholders who provided input for the preparation of this report via surveys and stakeholder meetings feel that ICFs/MR are important to retain as an alternative of choice for families and counties.

There is stakeholder consensus to maintain ICFs/MR as part of the service system for persons with developmental disabilities, for the foreseeable future. In a longer-range future, if and when services alternative to ICF/MR care are developed, there would be a need to provide for shifts in county, state and federal fiscal resources and significant transition planning. A process would be needed similar to the planning and relocation processes that occurred when regional treatment center placement for persons with developmental disabilities was phased out of the service system over a period of several years throughout the 1980's and early 1990's.

For the foreseeable future, the purpose of ICFs/MR is to serve individuals who, for a variety of reasons, prefer or choose ICF/MR care. Among these reasons are the following:

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- Individuals who have long-term residency in the same facility
- Individuals for whom proximity to family in the area is important
- Individuals for whom ICFs/MR provide specialized care

Stakeholders felt that ICFs/MR generally have 24-hour nursing available and more access to therapy specialists. These facilities also often have more specialized equipment, allowing for the cost of such equipment to be shared among more individuals with similar needs. In addition, some stakeholders felt that ICF/MR staff ratios are higher than in waiver services; however, other stakeholders felt that DD Waiver services provide as high or even higher staff ratios, affording greater flexibility and choice.

The current ICF/MR capacity in Minnesota is 1,936 beds. Expressed capacity needs by counties include conversion of existing beds or facilities for specific purposes, such as for individuals who are aging and increasing in their level of physical disability, or those with behavior issues. Also there is a need to downsize some facilities so individuals can have their own bedroom.

From the county perspective, there are at least two potential incentives for counties to maintain ICF/MR services:

1. ICFs/MR offer the capacity and long term stability/history to provide for some specific consumer needs, such as on-site nursing, available night staff, accommodating special dietary needs.
2. ICFs/MR are highly regulated services with health and safety certifications, licensing requirements and regular inspections to insure compliance with both state and federal standards.

In addition, there is currently limited new waiver funding available. At the same time as these limitations on new waiver funding are in place, there is an increased demand for waiver services, especially since Consumer Directed Community Supports became available. Currently over 4,000 persons with developmental disabilities are waiting for waiver services while receiving either ICF/MR or state plan services such as home care.

Counties expressed another issue compounding current limitations on their capacity to add new waiver services. In the past, counties would often under-spend their authorized waiver funds to maintain available dollars for emergencies, as well as to make sure they did not overspend and be required to pay back over-spent dollars. Legislative action in 1999 allowed counties to aggressively spend their total authorized waiver service amounts. However, budgetary constraints in 2003 limited this option due to an economic downturn. Counties have been cautious about adding new recipients, except those who were the highest priority for receiving waiver services or to serve individuals whose ICFs/MR were closing or downsizing.

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D. STAKEHOLDER PRIORITIES

Based on stakeholder input from all sources, there are four long-range priorities:

1. Maintain the ICF/MR system as a viable option.
2. Change legislation regarding variable rates to allow equal access for all providers to respond to individual consumer medical/behavioral needs.
3. Create a funding process to allow both Class A and Class B ICFs/MR to be downsized and/or remodeled so that individual spaces are ADA compliant, offer privacy, and meet individual needs.
4. Fund Services during the Day with the entire DT&H budget.

E. STAKEHOLDER RECOMMENDATIONS

During the regional meetings and state-wide stakeholder meeting, recommendations were presented in three categories:

I. No-Cost Policy Changes -- no cost; would require changes in DHS, MDH or CMS policy; would require additional DHS administrative staff resources.

II. Cost Neutral Changes --_may have initial cost, but will be cost-neutral in any given biennium as determined by stakeholders.

III. New Funding or Investment -- would require initial costs or expenditures, or an increase in costs.

While there were many recommendations made, the following were selected by stake-holders as the highest priorities.

These recommendations are also summarized in Appendix C in [Table I](#), [Table II](#), and [Table III](#). These tables indicate which agencies would have to be involved in implementation efforts, whether legislation is required, and estimated costs for new investments. Table III also contains information on how cost estimates were determined for new investments.

I. NO-COST POLICY CHANGES

Some recommendations require changes in DHS, MDH, or federal CMS policy and require additional DHS administrative staff resources to implement. See also [Appendix C, Table I](#).

RECOMMENDATIONS NOT REQUIRING LEGISLATION

1. DHS and MDH work together to develop a more streamlined approach to licensing and certification, including consolidation of data requests and elimination of dual licensing procedures. Implement Minnesota Statute [256B.5011, subd. 2\(b\)](#) that requires DHS and

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MDH to collaborate in rule making and/or the waiver of current rules to eliminate duplication of, or increase in, regulatory requirements.

2. DHS should work with both MDH and CMS to revise support standards and their interpretation from a traditional medical model and active treatment approach to standards that reflect a more individualized, person-centered approach to support. These revisions should particularly address the individualized needs of consumers in retirement, who have significant medical needs, and/or who have needs for significant behavioral support.
3. DHS and MDH should work together to negotiate definitions, practices and training that will simplify the process for investigation and resolution of suspected abuse, neglect and exploitation of vulnerable adults, and make that process consistent across all licensed programs serving individuals with disabilities.
4. DHS should establish a tracking and monitoring system to ensure that consumer choice is being honored in out-of-county placements and in the implementation of current requirements for host-county concurrence. This tracking and reporting review system should ensure consistent practices are being followed regarding consumer choice in admissions and county concurrence, and should address relevant issues when a county declines an admission. (Reference MN Statutes, section [256B.0926 Subd. 3 and 4](#)).
5. DHS should apply to CMS for a variance for all ICF/MR external Utilization Reviews to eliminate the requirement. These reviews are duplicative with the admissions review team oversight and MDH licensing review utilization. (Apply for the Utilization Plan waiver allowed under [Code of Federal Regulations, title 42, part 456.505](#), per [MN Rule 9505.0180](#)).
6. DHS should simplify documentation requirements for variable rate adjustments. Much of the information requested regarding resident need is already documented through licensing requirements (Reference MN Statutes, section [256B.5013](#)).

RECOMMENDATIONS REQUIRING LEGISLATION

1. A stake-holder workgroup should be established to design a new reimbursement system to address long-term stabilization of ICFs/MR and changing consumer needs. The new system designed by this group would consider profiles, One Time Rate Adjustments (OTRA's), special equipment, building modifications, and Life Safety Code adjustments.
2. MN statutes 256B.5013 and 256B.501 language should be amended to reflect the current, actual reimbursement system. The statutory updates reflect that Rule 53 was repealed, but the current statutes reference rate-setting procedures from Rule 53 that no longer exist.

II. COST NEUTRAL RECOMMENDATIONS

These changes may have an initial cost, but will be cost-neutral, especially in this biennium. See also [Appendix C, Table II](#).

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RECOMMENDATIONS NOT REQUIRING LEGISLATION

DHS should work with other states and CMS to allow for the use of technological support when such support can adequately address and fulfill care requirements and individual needs (e.g., substitute technology to fulfill requirements for RN/LPN staffing, awake night staff, etc.) **Current CMS regulations limit the use of such monitoring and surveillance technology.**

RECOMMENDATIONS REQUIRING LEGISLATION

1. Eligibility for variable rate funds should be allowed on a new admission to any facility when overall system costs will remain neutral or there will be cost savings.

Stakeholders expressed that many individuals requesting new ICF/MR admission have needs beyond the current ICF/MR per diem. With the ability to add individualized additional funding, the person could be served. Variable rate funding could support the consumer during transition or provide support for their long-term medical or behavioral needs. As long as the overall system costs did not exceed the previously allocated service costs for that individual, such placements and individualized funding would be cost-neutral. It is expected that expanding variable rate funding would however increase administrative costs due to the need to analyze on a case by case basis.

2. DHS should develop a more facility-specific rate structure for individual providers to negotiate any cost neutral ICF/MR adjustments, and allow for re-balancing an individual provider's service rates to better reflect actual expenses and revenues.

These adjustments would be contingent on that provider's history of certification, licensing compliance, and ability to provide the needed services.

III. NEW COSTS/INVESTMENTS

These recommendations would require initial costs or expenditures, or increase costs. Stakeholders expressed that new investments need to be pursued to assure the long term future capability of the ICF/MR system. Due to current state fiscal forecast, these recommendations are not currently included in the Governor's budget. See estimated costs in Appendix C, Table III. Note that these costs are based on estimates given the current ICF/MR capacity, not a reduced capacity.

If funding was made available, the priorities are:

1. Variable rates should be made available to all facilities to support any individual who is eligible, for either short-term or long-term needs, including new admissions. Variable rates should also be available to all facilities for equipment, technology, and building modification needs.

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2. Provider ability to apply for One Time Rate Adjustments (OTRAs) should be re-instated for staffing and building needs, based on changing needs of consumers.
3. Services during the Day should be funded at 100% of DT&H rate, including transportation. Currently Services during the Day is funded up to 75% of the DT&H rate. In addition, any ICF/MR should be allowed to get variable rate for an individual who is retired.
4. The 10% county payment (of non-federal share) for facilities seven beds and larger should be reduced or eliminated.
5. Total ICF/MR costs should be reimbursed when a vacancy exists to maintain current-level services for the remaining individuals.
6. Special funding mechanisms, rate adjustments, and incentives should be established to downsize and/or close ICFs/MR when this cannot be accomplished with existing funding structures.

If these recommendations were to be implemented in the next biennium, the estimated annual and biennial costs are presented in Appendix C, Table III, as well as the methods of determining estimated costs.

III. CONCLUSION AND NEXT STEPS

DHS has received a [three-year Systems Change grant](#) from CMS, part of which includes developing a Minnesota Long-Term Care Profile. The profile is a description of Minnesota's overall system of services and programs to support persons with long-term needs, across population groups. This project is being implemented across the Aging and Adult Services, Mental Health Division and the Disability Services Division. Part of profile development includes assistance, input and feedback from an HCBS Expert Panel, which has representatives of various stakeholder groups from throughout the state. During the next six months, DHS will incorporate the input from the over 400 stakeholders who provided input for this ICF/MR report as part of this systems change comprehensive analysis and planning process.

DHS will consider the stakeholder recommendations made in Category I (no-cost policy changes) as part of this three-year systems change effort and will also be seeking input and assistance from the Expert Panel members. These members have been asked to help identify and select priorities for the overall services system. DHS priorities are those, which promote the core beliefs of DHS and values for all persons with disabilities, including that all people with disabilities:

- Have a safe place to live
- Lead as healthy a life as possible
- Have control over decisions that affect their lives

And that services and supports:

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- Incorporate and result in increased choice, flexibility, portability and sustainability
- Permit access to transportation
- Enhance access to real jobs that promote self esteem, and provide wages

Upon completion of the comprehensive analysis, and receiving input from both external and internal stakeholders, a work-plan will be created which prioritizes activities designed to achieve CHOICE outcomes for persons with developmental disabilities, physical disabilities, chronic health conditions, traumatic brain injury as well as persons with co-occurring conditions including chemical health and mental health. The Category I recommendations from this report will be given the strongest consideration in the work-plan as part of addressing the entire services support system. In addition, this work-plan will be considered as part of both current and planned regional initiatives so as to complement locally based efforts to ensure quality outcomes. Also, there are several other sources for stakeholder input in future planning efforts, including:

- a) CAN-DO initiatives – Collaborative Action Network Development Opportunities initiatives brings together a variety of talented individuals and committed groups around the state in grass roots efforts to formulate and take action to improve the lives of people with disabilities.
- b) Statewide GAPS Surveys -- Every two years, DHS gathers local (county) information about the current capacity and gaps in services and housing needs to support older persons and persons with disabilities.
- c) Web-based surveys

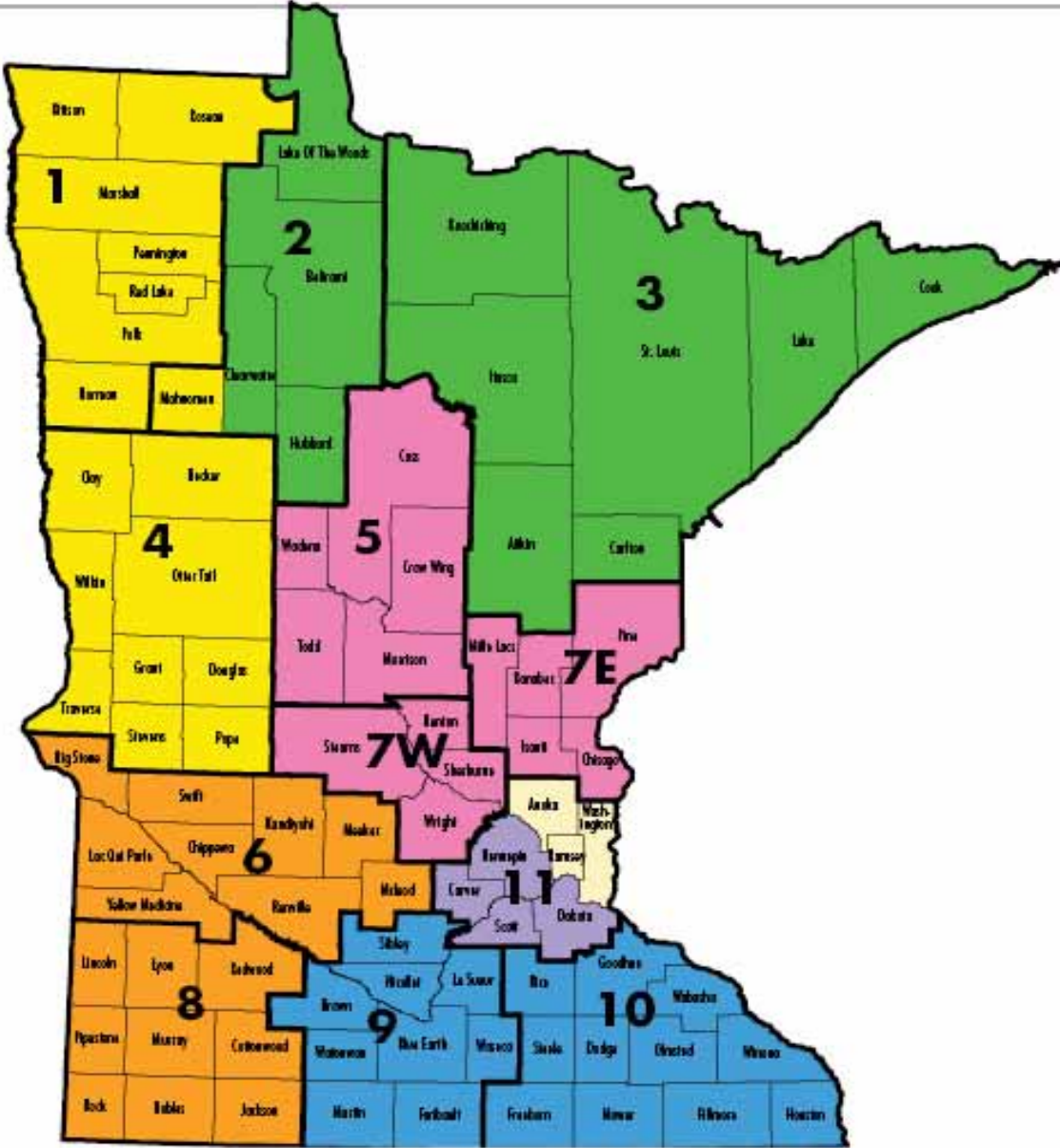
In the longer term, stakeholder recommendations in this report for cost neutral as well as new costs and investments for ICF/MR care (Category II and III stakeholder recommendations) cannot be considered in isolation from other components of the services system. New funding for ICF/MR care will have to be taken into account and balanced with other initiatives for investments in Medicaid waiver, consumer-directed supports, day training and habilitation administrative simplification, and other types of care in the future. Important elements to be taken into account are the aging of the ICF/MR population, and changing market demands since in-coming younger consumers are more likely to choose waiver-funded rather than ICF/MR care. In addition, regional planning efforts will be important to address regional ICF/MR capacity. Future systems change efforts and planning for overall system capacity will continue to be addressed in the context of DHS' mission, vision and values for Continuing Care, which are centered on promoting choice and independence, and will continue to be incorporated into future systems change efforts.

Proceeding on stakeholder recommendations regarding ICF/MR care will of course continue to involve all stakeholder groups in the process. As individual needs, system capacity, and models of care continue to change and evolve, Minnesota is committed to continuing to provide the best services possible for all its citizens with developmental disabilities.

APPENDIX A



Minnesota Department of **Human Services**
Disability Services Division
Main Number: (651) 431-2400 or (800) 747-5484



APPENDIX B: HISTORY

	2000	2001	2002	2003	2004	2005	2006	2007	2008
ICF FACILITIES	264	254	235	224	222	221	220	218	218
ICF BEDS	2749	2631	2456	2275	2074	1991	1956	1942	1936
ICF RECIPIENTS									
DOWNSIZINGS									
- FACILITIES		12	8	11	23	8	9	3	3
- BEDS		40	27	61	133	22	11	3*	6
* 1 bed variance increase									
CLOSURES									
- FACILITIES		10	19	11	7 *	8 **	4***	2	0
- BEDS		78	148	120	68	61	24	12	0
* 5 facilities added									
** 7 facilities added									
*** 3 facilities added									
VACANT BEDS (occupancy %)		95.1%	94.5%	93.2%	94.5%	94.2%	95.4%	95.5%	94.2%
- 6 OR LESS		97.1%	97.4%	96.9%	96.7%	96.0%	97.0%	96.5%	95.9%
- OVER 7		94.4%	93.4%	91.7%	93.3%	93.0%	94.1%	94.8%	92.8%
186 FUNDING							\$67,688	\$19,260	\$55,593
SERVICES DURING THE DAY									
- NUMBER								87	121
- COST								\$993,383	\$1,345,926
VARIABLE RATES									
- COST				\$244,944	\$662,557	\$597,030	\$699,667	\$633,540	\$1,164,024 *
* Requested, not billed									
CURRENT PRIVATE PAY		7 beds							
CURRENT SOCS BEDS		90 beds							

APPENDIX C: Table 1

I. NO COST ICF/MR POLICY CHANGE RECOMMENDATIONS Agency Involvement & Legislation Requirements				
Recommendation	DHS	DHS & MDH	DHS, MDH & CMS	Legislation Required
1. More streamlined approach to licensing/certification		XX		
2. Revise standards to reflect more person-centered approaches			XX	
3. Simplify and standardize abuse and neglect process		XX		
4. Track and monitor host-county concurrence placements	XX			
5. Variance to waive external Utilization Reviews			XX	
6. Simplify documentation requirements for variable rate adjustments	XX			
7. Stakeholder workshop for new reimbursement systems		XX		XX
8. Amend out-dated Rule 53 language to reflect current system	XX			XX

APPENDIX C: Table II

II. COST NEUTRAL ICF/MR CHANGE RECOMMENDATIONS				
Agency Involvement & Legislation Requirements				
Recommendation	DHS	DHS & MDH	DHS, MDH & CMS	Legislation Required
1. Variable rate funds for any facility on a new admission when costs will be neutral or there will be cost-savings	XX			XX
2. Mechanism for individual providers to negotiate cost-neutral rate adjustments within scope of service, rebalance service rates to reflect actual expenses and revenues	XX			XX
3. Allow use of technology to substitute for some care/staffing requirements			XX	

APPENDIX C: Table III

III. ICF/MR RECOMMENDATIONS: NEW COSTS/INVESTMENTS			
PROPOSAL	ANNUAL COST ESTIMATE	BIENNIUM COST ESTIMATE	COST ESTIMATE DETERMINED BY
1. Variable rate available to all facilities to support any eligible individual. Variable rates available for all facilities for equipment, technology, and building modification.	\$655,194	1,310,388	Current variable rate estimate is \$1,164 million. If the 29 of 102 newly eligible homes which lost money applied, minimum amount would be \$286,068. Estimate is based on average between costs for minimum and maximum for all newly eligible facilities.
2. Re-instate One Time Rate Adjustments (OTRAs) for staffing and building needs	\$2,550,000	\$5,204,550	Number of OTRA applications based on total number of calendar year 2000 OTRA applicants(51), using conservative estimate of \$50,000 per facility. Second year costs estimated for 4.1% projected inflation.
3. Fund Services During the Day at 100% of DTH rate, including transportation. Allow ICFs to get variable rate for retirement.	\$448,667	\$1,054,367	Current costs at 75% = \$1,346,000. Estimated cost at 100% is \$1,794,667. Amount of funding increased 35% between 2007 and 2008. Assuming same percentage increase the second year, first year costs would be \$448,667 and second year would be \$605,700
4. Reduce or eliminate the 10% county payment for facilities larger then seven beds.	3,500,000	\$7,000,000	Fiscal year 2007 amounts
5. Allow for total ICF/MR costs when a vacancy exists	\$1,438,992	\$2,877,984	2007 occupancy percentages and estimating annual vacant beds. For each facility under 100% occupancy, multiplying number of beds by 1 minus occupancy percentage. Multiplying that amount by per diem and then by 180 days (limit allowed of 15 days a month). Facilities with short-term stay beds are excluded.
6. Create adequate funding mechanisms and incentives to promote closures and down-sizing's	\$1,825,679	\$3,651,358	Using facilities that had one bed or more vacant in 2007, multiplying per diem by 365 to get annual amount which these vacancies cost provider. Based on assumption that DHS would adjust their per diem upwards to compensate for a decertified bed. Three providers could decertify two beds, so their amounts were doubled.

THANKS TO ALL THE CONTRIBUTORS:

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Alex Bartolic	DSD
Peg Booth, Ph.D	DSD
Wendy Hassinger	DSD
Gerald Nord	DSD
Glenn Smith	DSD

In Memory of Barbara Nelson

Barbara Nelson, an employee of the Department of Human Services for over 35 years served as the ICF/MR Policy Lead working on this legislative report passed away on September 27, 2008. Ms. Nelson initiated the ICF/MR Legislative Report work plan and other early efforts including developing provider, county, family member surveys, organizing and facilitating stakeholder work group and regional meetings until her health prevented her from continuing her work on this project early this summer.

Ms. Nelson will be missed by her many friends and colleagues in both the private and public sector of service delivery.