MINNESOTA STATE PLAN FOR DOWNSIZING LARGE INTERMEDIATE CARE FACILITIES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS

Minnesota Department of Human Services
Division for Persons with Developmental Disabilities
April, 1991

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155-3815

April 22, 1991

The Honorable Jerome H. Hughes
President of the Senate
Minnesota State Senate
Room 328, State Capitol
Saint Paul, Minnesota 55155

The Honorable Robert Vanasek
Speaker of the House
Minnesota House of Representatives
Room 463, State Office Building
Saint Paul, Minnesota 55155

Dear Senator Hughes and Representative Vanasek:

Attached is the report to the Legislature required by Minnesota Statutes chapter 499, section 3 regarding a plan for downsizing large intermediate care facilities for persons with mental retardation and related conditions. You may recall that this statute was passed in the 1990 Legislature to require the commissioner of human services to develop a plan to stop discharges from regional treatment centers to larger community intermediate care facilities.

Implementation of the requirement to no longer place individuals from the regional treatment centers into large community facilities must go hand-in-hand with an orderly plan which accounts for the fiscal impact on these facilities, the development of smaller community-based homes, and assurances that the needs of affected individuals with developmental disabilities are adequately met. This report reviews various options to pursue and makes recommendations for specific legislative authorizations to downsize these larger facilities and establish smaller community homes for the individuals with

developmental disabilities currently served in them. I feel confident that as appropriations become available, this plan can provide a road-map for addressing the issues of large intermediate facilities. If there are questions, I will be happy to answer them or please call Shirley Schue, Division for Persons with Developmental Disabilities at 296-9139.

Sincerely,

NATALIE HAAS STEFFEN
Commissioner

Enclosure

cc: The Honorable Linda Berglin, Chair
Senate Health and Human Services
G-9 State Capitol

The Honorable Don Samuelson, Chair
Senate Health and Human Services, Division of Finance
124 State Office Building

The Honorable Alan W. Welle, Chair
House Health and Human Services
437 State Office Building

The Honorable Lee Greenfield, Chair
House Health and Human Services, Division of Appropriations
375 State Office Building

EXECUTIVE SUMMARY

The 1990 Legislature in Chapter 499, Sect. 3 required that "The commissioner of human services, in consultation with representatives of intermediate care facilities, parents, advocates, and other interested persons and organizations, shall develop a plan to eliminate discharges from regional treatment centers to larger community intermediate care facilities."

The overall policy direction of the Legislature and the Department of Human Services in recent years has been to close and downsize large facilities and serve individuals with mental retardation only in small, community homes. Various initiatives move to shift services in this general policy direction.

Current statute Section 256B.092 Subd.7 requires that as of July 1, 1991, no individual who currently resides in a regional treatment center for persons with mental retardation and related conditions shall be discharged into an intermediate care facility for persons with mental retardation (ICF-MR) of more than 15 beds. Implementation of this requirement has a fiscal impact on these facilities, a programmatic impact on individuals with mental retardation currently residing in them, and an effect on the community service options for residents of regional treatment centers. Hence, implementation of the 15-bed limitation must go hand-in-hand with an orderly plan and sufficient resources to provide for the needs of the individuals currently served in such facilities. If the Legislature does not fund the resources for smaller community alternatives for the people involved, the implementation of the 15-bed requirement should be postponed until such time as an orderly plan can be implemented.

Full implementation of the "15-bed" limitation would require a significantly large commitment of resources to develop small community alternatives for the individuals served. However, regardless of the 15-bed limitation, many facilities have closed in recent years. Closures will be occurring whether the 15-bed limitation is implemented or not, so the numerous pressures and demands on these facilities require that at least some immediate, planful actions be taken toward downsizing.

RECOMMENDATIONS

1. Continue use of voluntary closure of these facilities under Minnesota Statute Section 252.092.

2. Develop alternative services for residents in and close all class A facilities over 20 beds and the class B facilities that have aging physical plants.

3. Allow exceptions to the 15-bed limit for individual placements from the regional treatment centers into larger Class B facilities.
Exceptions would be allowed based on individual preference, the facility capacity to serve the individual, and the county case management process.

4. Implement a demonstration project in the next two-three years to document information needed before a more wide-scale downsizing plan is implemented.
This demonstration project would determine the costs and programmatic feasibility for downsizing larger class B facilities and for development of more creative options for community-based alternative services.

DEPARTMENT OF HUMAN SERVICES PLAN
FOR DOWN-SIZING LARGE ICF-MR FACILITIES

This plan is submitted in response to the following requirement:

Chap. 499, Sec. 3 (PLAN FOR DOWNSIZING INTERMEDIATE CARE FACILITIES)

The commissioner of human services, in consultation with representatives of intermediate care facilities, parents, advocates, and other interested persons and organizations, shall develop a plan to eliminate discharges from regional treatment centers to larger community intermediate care facilities.

I. HISTORY OF LEGISLATIVE INITIATIVES

Services to Minnesota citizens with developmental disabilities have rapidly changed in the last twenty years, and continue to do so. The shift from larger institutions and buildings to smaller, more individualized, community-based services reflects national trends, and Minnesota has been a leader in those trends. The 1990-91 State Plan identified the values on which services to individuals with developmental disabilities are based, and the values which new service designs strive to implement. These values include:

- Persons with developmental disabilities should live, work, and participate in leisure activities in age-appropriate, culturally typical and least restrictive environments.

- All programs and services for persons with developmental disabilities should promote independence, productivity, community integration, and opportunity, in safe, healthful environments.

Numerous initiatives over the last few years have served to make these values a reality, in various areas: supporting children in remaining at home with their families, in creating supported and integrated living and work arrangements, and in community leisure activities. In the critical area of residential support services, the state has made remarkable progress in implementing a wide variety of small, community homes. These initiatives include:

a. A decrease in the regional treatment center population from 2371 in 1982 to approximately 1250 people currently.

b. Implementation of the Title XIX (Medicaid) home and community-based waiver, which is now used to serve approximately 2350 total people in adult foster homes and small supervised group living arrangements, and children supported to remain at home with their families.

c. Passage by the Legislature in 1983 of the authorizing legislation for the Medicaid waiver and establishing a moratorium on ICF-MR beds. Under this moratorium, certain exceptions were allowed; one of the major criteria for any new ICF-MR construction is that new facilities are limited to 6 beds or less.

d. In semi-independent living services, an increase from 458 people in 1979 to 1350 people currently.

e. In adult foster homes, an increase from 411 people in 1979 to approximately 1850 people currently.

f. Significant strides in supporting children in remaining at home with their families. In 1980, 50 children received in-home services and 830 children received 24-hour out-of-home care; in 1990, 1827 children received in-home services and only 291 children received 24-hour out-of-home care.

g. A ten-year plan for decreasing the majority of the regional treatment center population, and relocating current residents to small state and privately-operated community homes.

h. Passage by the Legislature in 1987 for the Community Conversion project (Section 252.292), which allowed the Department to enter into plans with community ICF-MR facilities to close and move their residents to smaller community homes.

h. Downsizing of a number of small facilities, as they converted from "class A" to "class B" facilities (which included rate adjustment increases for more intensive programs and life safety code modifications).

An example of the programmatic and fiscal impact of support for smaller, more homelike settings is the family support program for children with developmental disabilities. In 1980, $20.4 million was spent to support 830 children in 24-hour out-of-home care, while only 50 children were supported to remain at home with their families, with an expenditure of $150,000. By 1990, 291 children were served in out-of-home care at a cost of $10.8 million, and 1827 children received in-home support at a cost of $13.4 million. Thus, in 1980 880 children were served at a total cost of $20.4 million. By 1990, with more support for in-home care, a total of 2118 children were served at a total cost of $24.2 million.

In addition, recent years have seen several proposed legislative bills regarding the down-sizing of large intermediate care facilities. Although none of these proposals have been passed, the intention of them has matched the general overall policy direction toward the closure of large facilities and movement of individuals into small community homes.

II. COMMUNITY-BASED INTERMEDIATE CARE FACILITIES (ICFs-MR)

A notable feature of the developmental disabilities services system in Minnesota is community-based Intermediate Care Facilities (ICFs-MR). Minnesota was one of the earliest users of this federal program, and continues to be one of its most significant users. Currently, there are 317 community ICF-MR facilities licensed under Rule 34, with over 4000 residents. Approximately 37% of those persons, or 1550 people, reside in facilities with 15 or more beds.

In recent years, the Department of Human Services has closely examined the quality of care in these facilities and has worked with counties and providers who voluntarily chose to close, downsize, and/or relicense their facilities as smaller community living residences. The net reduction in both regional treatment center and community ICF-MR beds in the last ten years is shown in the following table.

NUMBER OF CERTIFIED ICF/MR BEDS IN MINNESOTA

	Total ICFs/MR	Regional Treatment Centers (ICFs/MR)	Community ICFs/MR
1980	7196	3079	4117
1981	7345 (+160)	2849 (-230)	4507 (+390)
1982	7338 (-18)	2679 (-170)	4659 (+152)
1983	7559 (+221)	2617 (-62)	4942 (+283)
1984	7516 (-43)	2394 (-222)	5121 (+179)
1985	7518 (+2)	2315 (-80)	5203 (+82)
1986	7526 (+8)	2315 (-0)	5211 (+8)
1987	7022 (-504)	1950 (-365)	5072 (-139)
1988	6701 (-321)	1915 (-35)	4786 (-286)
1989	6395 (-306)	1894 (-21)	4501 (-285)
1990	6070 (-325)	1650 (-244)	4420 (-81)

Source: Survey and Compliance Section,
Department of Health

Since the fall of 1985, more than thirty community ICFs-MR have closed, 12 of which had more than 15 beds. These facilities ranged in size from 6 to 165 beds and included the largest community Intermediate Care Facility in the state. Many closed as a result of formal closure agreements with DHS. In addition, a number of other facilities have closed some beds. Facilities have closed for various reasons: significant health and safety risks, financial difficulties, and the Department placing some facilities in receivership. A indicated in the above table, up to March 1990, approximately 800 net community ICF-MR beds had been decertified and a comparable number of persons relocated to other settings. As of April 1991, another 100 beds have either been decertified or represent facilities with agreements to close over the next year. (A list of the community ICF-MR facilities which have closed and which have closure agreements is contained in Appendix A.)

In the last ten years, the average monthly population in the regional treatment centers has decreased from 2,632 in 1980 to 1,213 in 1991. The above table shows that since 1986, efforts to close community ICF-MR beds have been as agressive as efforts to close regional treatment center beds. From 1986 through March of 1990, 665 regional treatment center beds and 791 community ICF-MR beds were closed. (See updated information regarding closed and closing community ICF-MR facilities in Appendix A.)

The demand for community residences continues to increase, especially for small community homes. (Because of the ICF-MR moratorium, the Department has denied a number of need determination requests in the last five years.) To respond to this demand, the 1988 legislature approved the development of 150 beds for new, small community-based ICFs-MR during the 1990-91 biennium. The Department has worked with private providers and counties to establish these facilities in those areas of the state where the need is greatest. These facilities are limited to six beds, with some 4 and 5 bed facilities allowed.

To date, 17 facilities, serving a total of 90 people, are either open or are scheduled to open shortly.

Working with representative counties, providers, and consumer organizations, the Department has developed a ten-year plan to move most of the current regional treatment center population to small community homes, operated by both private providers and by the State (State-Operated Community Services). This plan was passed by the 1989 legislature. A separate reqirement that went hand-in-hand with this plan and the overall statewide trend toward smaller community-based homes was also passed by the 1989 legislature. This requirement was that as of July 1989, no resident of a regional treatment center could be admitted to a facility of more than 15 beds. This legislation was in effect for one year, and then implementation was suspended until July 1, 1991. Since implementation was suspended on July 1, 1990, at least six persons have been moved from regional treatment centers into intermediate care facilities of more than 15 beds, thus far this fiscal year. Current legislation requires that as of July 1, 1991 no regional treatment center residents can be admitted to a facility of more than 15 beds, and by 1993 to a facility of more than 10 beds. Implementation of this requirement affects all community intermediate care facilities which have more than 15 beds, and in 1993 those with more than 10 beds.

When the prohibition on placement from the regional treatment centers was in effect from July 1, 1989 to July 1, 1990, several problems were experienced and would continue as problems with the implementation of the 15-bed limit. First, many individuals, especially in the larger Class A facilities, could move to smaller homes in the community using the Medicaid waiver or other options. However, the waiver requires that if an individual moves to a waiver-funded alternative, an ICF-MR bed must be decertified. Since state reimbursement is based on a daily rate for the number of occupied beds, the facility often faces lost revenue in those cases of a decertified or unoccupied bed.

When an ICF-MR bed is vacated, it cannot be filled by an individual currently served by the waiver in the community (unless the individual was no longer funded by the waiver), nor could it be filled from the regional treatment center if the 15-bed requirement were in effect. With the 15-bed limit, a bed made vacant through death or a person moving to a non-waiver funded community alternative could only be filled by a person currently living in the community with non-waiver funding. However, many parents do not want their son or daughter to move from home into a large facility, and some do not want their child to move from the regional treatment center into a large facility. In addition, many of the individuals who are eligible to move into the facility are more difficult to serve than the individuals the facility is used to serving or is able to serve at their current per diem reimbursement level on a long-term basis. (Short-term funding is available via Rule 186, but the placement needs to be long term.) These systemic and funding factors contribute to a tendency on the part of some providers and case managers to "hold" current residents in order to maintain their ICF-MR population. With no admissions from regional treatment centers and limitations on placement in large facilities for individuals currently living in the community, implementation of the 15-bed limitation in July 1991 may result in serious fiscal difficulties for many of these facilities.

A. Current Status of Community ICFs-MR

Of the 317 licensed ICF-MR facilities in Minnesota, there are currently 41 which are licensed by Rule 34 for over 15 beds, and 98 which are licensed for 11 to 15 beds. (A list of the facilities over 15 beds by region is attached in Appendix B). Approximately 1500 people live in the facilities over 15 beds, 1400 in the facilities between 11 and 15 beds, and 1200 in the facilities between 4 and 10 beds.

Intermediate care facilities are licensed as either "class A" or "class B" facilities. Residents of class A facilities have been determined by the Department of Health to have the capacity to self-preserve, to exit the building under their own capacity in an emergency such as a fire. Residents of class B facilities typically do not have this capacity, and are typically more severely handicapped and/or physically impaired. Within the "class B" license, there are two categories: "Institutional B" refers to facilities, regardless of size, which are accessible and meet the "institutional" life safety standards. "Residential B" homes are for individuals who cannot self-preserve but do not necessarily need accessible housing; the homes are not accessible and meet the "residential" life safety standards. They are always 16 beds or under.

Of the 41 facilities over 15 beds, 12 are class A facilities. Three have more than 100 beds and nine have between 16 and 60 beds. There are a total of 29 class B facilities with over 15 beds. Eleven have between 43 and 64 beds, and 18 have between 16 and 35 beds. Of the 26 A and B facilities between 16 and 35 beds, 10 have 16 beds. (See charts in Appendix B.)

Each ICF-MR facility, no matter which of the three license types it holds, almost always has a mix of level of disabilities. That is, class A homes may have some individuals who are very severely impaired, and class B homes may have some individuals who are more mildly handicapped. Almost every facility, except some of the larger Class A facilities, has at least some individuals with significant impairments. Most of the more mildly handicapped individuals are in Class A facilities, although there are some persons with mild disabilities in many of the Class B facilities.

The charts in Appendix B describe the level of care of residents in all the facilities licensed over 15 beds. These levels of care were determined in the Quality Assurance Reviews by the Department of Health. In general, the class B ICF-MR facilities are used for persons with more significant levels of impairment; of all facilities, a total of 85% are in the moderate to maximum ranges of levels of care. The striking exception are the three largest facilities, all licensed as class A and all having more than 100 beds. A total of 46%, or almost half of these residents, have been classified in the two mildest ranges of levels of care.

B. Issues Currently Facing Facilities

Many of the large intermediate care facilities already face numerous problems. As indicated above, many have voluntarily chosen to close in recent years. These closures and some down-sizings are often in response to crises, or happen inadvertently. This pattern of closures will in the long run be more risky and costly than if planned efforts are undertaken. It is important to be deliberate and direct in planning, to maximize the best outcomes for individuals in the most cost-effective manner. These outcomes are more likely to occur if crisis responses are replaced with proactive, planned, deliberate action.

Many facility problems have been exacerbated by the 15-bed limitation on placements from the regional treatment centers. Some of these problems and issues include:

1. Safety and Aging Buildings

Several of these facilities are aging buildings, or are overcrowded. Although continuing to invest in additional renovations makes sense for some facilities, there are some for which major investment in capital expenditures would be unwise. Most are also close to being fully depreciated.

A second issue is that several larger class B facilities were originally built as children's facilities and were designed to house children with severe mobility impairments. Many children have grown up in these facilities and are now adults. At least some of their families would prefer they stay in the facility in which they are comfortable and in which they have grown up. However, the children are now young adults who have outgrown the facilities and their accommodations (bathrooms, etc.). These residents either need to move to a different facility or, if they remain in the current facility, physical features of the building may need to be modified to safely and appropriately accommodate them.

2. Privacy/Program Effectiveness

Several programmatic factors, including overcrowding, affect the number of people that should be in each bedroom. Many individuals with serious behavior difficulties may need to be in their own room, especially in consideration of the vulnerability of other residents; many individuals with these behavior difficulties have decreased their negative behaviors when they have their own rooms. Space considerations also affect how many individuals with complex medical equipment should be in the same bedroom. Increased active treatment demands by the federal government, habilitation requirements, size of household, and quality of life issues also affect the degree of privacy needed by most ICF-MR residents. These considerations have been incorporated into the plans for the development of the new state-operated community services (SOCS) homes and many of the new private sector homes.

3. Severity of Handicap

As smaller community homes have developed in the last 15-20 years, most of the individuals who left both the regional treatment centers and the larger intermediate care facilities were more independent and mobile. More recent admissions to the large intermediate care facilities from the regional treat-

ment centers and from the community have been individuals with more severe physical impairments, deficits in adaptive behavior, and more severe behavior problems. It is likely that the cost of developing and operating smaller, more individualized community homes for these individuals may initially be higher than the development of previous community alternatives; however, these individuals tend to be more expensive to serve no matter where they live.

4. Children

There is a large demand for residential capacity and for new options and services for all people, including children. Ideally, all children should have the opportunity to grow and develop in a family setting. If they do not have that opportunity within their natural family, for whatever reason, ideally another family setting should be available. The system in recent years has developed many new structures to support children in remaining at home with their own families or to live in other family settings; these new structures include family support and family subsidies, school programs for all children, and TEFRA.

As these other options have been developed, the need for out-of-home ICF-MR care for children has diminished. The regional treatment centers are no longer licensed to serve children, and many of the original children's ICF-MR facilities have changed to adult facilities as these children have grown up and remained in the same facility. Although all these trends have supported the best types of care, there is a small but persistent number of children who remain problematic. These are the children with quite severe and complex needs who are extremely difficult to serve in their own home or in a foster home. This number includes both young children with complex medical needs and a growing number of adolescents with severe behavior problems. Given the diminished capacity to serve children in ICF-MR programs, it has been difficult to locate the best and most cost-effective community living situations for them.

5. Need for Crisis and Short-Term Intervention Capacity

Many families who are serving their children at home experience the need for support in crises, and for temporary stays out of the home. Some of the types of crises these families experience with their children include extreme behavioral incidents and severe medical crises. From time to time, a small community program may also experience the need to have a resident move elsewhere for a short period of time or to have more intensive treatment in a different setting. Currently the only alternative for this type of crisis intervention is short-term placement in a regional treatment center, where it is impossible to provide the effective, community-oriented behavioral interventions required for successful re-entry to the community. Frequently the lack of crisis intervention results in the permanent placement of individuals in more expensive settings. Plans for alternative community services for the current ICF-MR population must include adequate development of crisis intervention and short-term care services.

6. The ICF-MR role for the future

Many community ICF-MRs have closed in recent years, including very large ones. The role of the remaining facilities, especially the larger Class B facilities, has evolved in recent years. As individuals who needed less care have

moved elsewhere, these facilities have come to serve a far more dependent and disabled population. Because studies and experience in Minnesota and elsewhere have documented both the dramatic progress of people in home-like settings and the cost-effectiveness of such alternatives, the overall thrust for the future is toward small, community homes for all individuals, even those with the most severe disabilities.

As the total number of ICF/MR beds is being reduced, tightly structured exemptions to the ICF/MR moratorium would continue to allow the state and counties to meet the needs of those persons with severe handicaps, as recommended in the January 1988 Department report on the assessment of the impact of the ICF/MR moratorium. Development of small ICF/MR programs should be considered after a county has fully utilized their waiver allocations, changed their existing ICF/MR capacities to the extent possible, and fully utilized semi-independent living services, family subsidies, personal care, and other generic social and medical services.

In the meantime, there may be limited options for the larger community ICF/MR facilities and/or the need to define a specific, interim role for the larger facilities which are accessible and can serve the more dependent and disabled population. In the near future, this interim role may be necessary as more small, individualized homes are realized for a gradually increasing number of people. For the far future, the entire system continues to face the challenge of developing more feasible and preferred, smaller alternatives without expending a great deal more funds than the system would have otherwise cost.

III. PROCESS TO DEVELOP THIS PLAN

As a result of the limitation on placements from regional treatment centers into large ICFs-MR, the Department was required by the Legislature to develop a plan for the downsizing of these facilities. **Implementation of this "15-bed rule" must go hand-in-hand with an orderly plan to account for the fiscal impact on these large community facilities, the development of smaller community-based homes, and assurances that the needs of affected individuals with developmental disabilities are appropriately met.**

A. Advisory Committee

In accordance with the legislation requiring the development of this Department plan, an advisory committee was formed to consult with the Department. This committee consisted of four executive directors of affected facilities, a director of a facility which had closed, three consumer/parent representatives, one county social services representative, a representative from the Department of Finance, and representatives from the Association of Residential Resources of Minnesota, a state-wide organization representing the majority of affected facilities. A list of members is contained in Appendix C. Although this committee did not always agree, they did provide a wide variety of valuable input to the Department in the generation of this plan.

This committee analyzed and discussed the relevant requirements affecting downsizing and closure, and defined the current issues facing large facilities. The Department and committee also generated various different alternative scenarios for downsizing and closure of facilities. To determine which avenue would most merit recommendation, the committee generated criteria to be used to evaluate the worthiness of any particular plan or avenue.

B. Where Are We Going?
(Long-Range Service System Goals)

The committee looked at overall principles and long-range goals for the service system, and visions and goals for services for the next decade. What is planned now regarding down-sizing should fit into appropriate long-range goals for the entire service system. If only short-sighted, immediate steps are taken, those steps could result in limited and less desireable change, and change which is more costly in some cases -- which will only require additional cycles of change and far more expense at a later date. If the service alternatives pursued now for the residents of downsized facilities are not centered around the values of state policy and do not support individually-designed homes, it is likely Minnesota will end up with even more buildings in 10-20 years that are unwanted and do not meet the needs of the people required to live in them. Many younger parents of children with developmental disabilities are already adamant in their views about accepting only small, individualized community homes. They are ardently rejecting the concept of "facilities" when placement of their children is proposed.

The advisory committee expressed the following principles as long-range goals for this plan and its relationship to how the overall service system should be designed, as reflected in the State Plan:

1. Individuals should live in homes that are as a typical as possible.

Individuals with developmental disabilities should live in homes not facilities. These homes should be as similar to those of other citizens as possible and include as wide a variety of environments and residences, such as single-family houses, duplexes, townhouses, apartments, farms, and people owning their own homes. Also, the supports and services which individuals need should be provided. Children should live in families and with other children, and natural families should also be supported in caring for their children with disabilities.

2. Living situations should be based on informed choice and individual planning.

The individual's preferences and their family's preferences should be the basis for deciding where the individual should live. Unfortunately, individuals with disabilities, their families, and the service system have become accustomed to making choices only based on the traditional or available options; people have been trained to "prefer" what they can get. The basis for decisions on placement must be informed choice that goes beyond information about only currently available options, but also includes development of options not yet available, and the expression of wants, desires, and preferences by the individual with disabilities and their family as freely as any citizen expresses those. Individuals should not be over-served, or served through means or programs that do not fit what is really needed. Meaningful, preferred homes and services that are designed around what individuals really need are the most cost-effective in the long run.

3. New, flexible living arrangements should be available, and should be based on money following people rather than facilities

There should be flexibility both in the funding stream and in regulations to support a wide variety of individual supports and housing options. New, more creative arrangements which could be utilized include consumer-owned housing, individuals living in their own homes and renting out rooms, shared rentals, and easier access to personal care attendants.

Alternative system designs should be promoted that will allow individuals and/or their guardians more flexibility in using money, with more individual control of the type of home developed and services used. The Medicaid waiver is a good example of funding which is tied to the individual and offers some degree of flexibility in implementation of living arrangements. However, many other program funds, including ICF-MR monies, are tied to beds or facilities, forcing individuals to choose between limited options of where beds are available.

These three overall goals for the future, long-range design of the service system were tied to development of criteria for evaluating different plans to down-size large community intermediate care facilities.

IV. CRITERIA FOR EVALUATION OF DIFFERENT PLANS

The advisory committee and DHS staff, in considering the many different issues involved in down-sizing, agreed on five criteria to consider in the evaluation of any down-sizing plan. These criteria reflect differing issues which should be weighed in determining the relative merits of any proposed action.

These five criteria are as follows:

1. Extent to which the option matches overall policy direction

Any action which is taken should match previously stated intentions of the Department and the Legislature. As expressed in the 1990-91 state plan, the overall intention and direction for services for persons with developmental disabilities is that individuals should live in as small, culturally typical and individualized settings as possible. The Legislature's requirement that individuals from the regional treatment centers should not be placed in facilities with more than 15 beds, and the limitation on new community ICFs-MR to 6 beds, both reflect this overall commitment to smaller living situations. This overall policy direction is also reflected in the three long-range goals for the service system generated by the Advisory Committee and described in the previous section.

2. Extent to which the option demonstrates respect for individual needs and allows implementation of individual choice

Individual needs must be respected in any downsizing or closure considerations, especially vulnerability and the more complex needs of an increasing number of individuals in the ICF-MR system. Consumer, family, and guardian concerns must also be respected. Alternative services that are developed should be real and creative, reflecting more flexibility and individuality than traditional models of care.

3. Extent to which the option addresses safety, privacy, and other programmatic issues

Safety and physical space issues in any given facility should be taken into account in considering down-sizing or closure. The issue of physical plants which were originally built for children but which now house adults must be addressed. In addition, the number of individuals to be accommodated in a bedroom must be planned in a way which addresses privacy and safety needs, resident choice, quality of life, and effective treatment and programming.

4. Extent to which the option appropriately redesigns overall community capacity

Any plans which affect the future capacity of the system, including ICF-MR space, must take into account the individuals who would be displaced, who are currently unserved or are on waiting lists, and the needs of families who are currently caring for their children at home. These populations include children with high behavioral and/or medical needs, and the many individuals with high needs who will need crisis intervention and short-term service alternatives. Given the continuing need and demand for smaller residential services, this is a critical issue.

5. Cost of each option

Consideration of any option must include consideration of all of the expenses involved. At a minimum, these costs include:

- interim rates for existing facilities while closing or downsizing
- costs to upgrade existing physical plants
- administrative costs to Department of Human Services and Department of Health (e.g., auditing, licensing and certification, etc.)
- development of alternative community services, including new ICF-MR, waiver, and other alternative services

There are also long-range cost implications. For instance, it is more cost-effective to downsize a facility only once. If a facility were downsized 20%, then another 20%, the costs would be much higher than if it were downsized just once at 40%. The more times a facility is downsized, the more fiscally unfeasible the actions become. Although it may appear to cost less to downsize a minimal amount in the near future, that action should not be taken if another cycle of downsizing is going to occur in the next biennium: the total costs will be greater than simply taking the desired step just once. Long-range planning and consideration of long-range effects is required.

Other long-range cost implications include the costs of continuing to fund the facilities as they are (i.e., the cost of doing nothing), and the ultimate negative effects if decisions are based solely on facility costs rather than the above-mentioned principles regarding individual need, respect for individual choice, and programmatic issues.

V. DOWN-SIZING PLAN OPTIONS

Given the issues facing ICF-MR facilities and the trends in service system design, there are multiple possible alternatives which could be generated for a down-sizing plan. From all of the possible options, the Advisory Committee generated the following four scenarios for the downsizing of large community ICFs-MR. **These scenarios were generated to help study all the issues involved, and range in aggressiveness of approach; these scenarios are not intended to foreclose on other options.** In brief, these four scenarios are:

SCENARIO I. Downsizing and/or closing all community ICFs-MR, to no more than 15 beds and no more than 10 beds by 1993.

SCENARIO II. Downsizing and/or closing all community ICFs-MR to no more than 15 beds.

SCENARIO III. Closing all class A facilities over 16 beds. Allowing a limited downsizing (up to 25%) of Class B facilities more than 15 beds for reasons of safety, overcrowding and privacy, and use of some space for crisis intervention and short-term stays. Scenario III is similar in some respects to the 1989 proposed downsizing legislation, reducing facilities with 24 or fewer beds to 15, and for facilities between 25 and 100 beds requiring a 25% reduction in beds.

SCENARIO IV. Allowing all facilities to move to the waiver any individual who can be served within the waiver average; closing beds and adjusting the rates of each facility as these planned moves occur.

Each scenario is laid out in the following table. Table A explains each scenario in more detail, and lists the number of facilities and number of people affected in each scenario.

Match of Each Scenario to Evaluation Criteria

To evaluate the relative merit of each scenario, it is important to consider each against the five evaluative criteria. The following chart shows the degree of match between each of the four scenarios with the five evaluation criteria, in relationship to each other. These degrees of match are as follows:

	Policy Direction	Individual Choice	Program Issues	Overall Capacity	Cost
Scen.I	Very High	Mixed	Very High	Mixed	Very High
Scen.II	High	Mixed	High	Mixed	High
Scen.III	Medium	Mixed	Medium	Mixed	Medium
Scen.IV	Low	Mixed	Medium	Mixed	Medium

TABLE A
DOWN-SIZING SCENARIOS

NUMBER OF PEOPLE NEEDING ALTERNATIVE SERVICES UNDER EACH SCENARIO

Facility:	Large 25+ Beds		Intermediate 16-25 Beds		11-15 Bed Facilities		TOTAL PEOPLE
Class:	A	B	A	B	A	B	
	7 facilities	16 facilities	5 facilities	13 facilities			
SCENARIO:							
I.	Close	Close	Close	Close	reduce to 10	reduce to 10	
	465 people	747 people	100 people	233 people	297 people		1842
II.	Close	Close	Close 20+ Beds Downsize 16 to 15 or less	Reduce to 15	----------		
	465 people	747 people	70 people	38 people			1320
III.	Close	Limited Downsize (25%)	Close 20+ Beds Downsize 16 to 15 or less	Reduce to 15	----------		
	465 people	187 people	70 people	38 people			760
IV.	Downsize through Waiver & Rate Adjustments		Downsize through Waiver & Rate Adjustments		----------		
	116 people	187 people	25 people	58 people			386

A more detailed explanation of the issues related to each of the five criteria in each of the four scenarios, the merits and limitations of each scenario, are more fully explained in Appendix D.

Costs

In brief, the estimated costs of each of the four scenarios is as follows.

TOTAL COST (in millions)

	SCEN. I	SCEN. II	SCEN. III	SCEN. IV
FY 92	.35	.25	.14	.37
FY 93	4.7	3.1	2.0	.78
FY 94	18.8	12.2	7.9	3.3
FY 95	34.7	22.4	14.6	6.2
FY 96	52.7	34.0	22.2	9.5

STATE SHARE (in millions)

	SCEN. I	SCEN. II	SCEN. III	SCEN. IV
FY 92	.35	.25	.14	.37
FY 93	3.0	2.0	1.2	.52
FY 94	10.7	7.1	4.4	2.1
FY 95	18.9	12. 4	7.8	3.9
FY 96	28.3	18.6	11.7	6.0

More specific cost explanations, and the cost assumptions used in developing these estimates, are contained in Appendix E.

VI. RECOMMENDATIONS

In comparing the cost of each scenario with the number of people that will be served (Table 1), it is evident that on a cost-by-individual case basis, it is less expensive in the long run to close facilities than to downsize them. (For example, the average per-person cost in 1996 in Scenario I, which closes all facilities over 15 beds is $15,364. In contrast, in Scenario IV no facilities are closed and the average per-person cost in 1996 is $15,579. Although Scenario IV is the least amount of total funds and the smallest number of people are impacted, the per-person cost is the highest. In the long run, this alternative would be the most costly.)

However, at this time, massive closings would require a large amount of state resources. If large resources were not immediately committed to such closings, interim actions are necessary for the short run.

Balancing the merits and difficulties of each of the above four scenarios, the Department recommends implementation of Scenario III, with some additions and modifications. The following recommendations were generated respecting the continuing need and demand by individuals, their families, and counties for smaller residential homes. Given that closures will happen, for a variety of reasons, the Department needs to do additional planning beyond responding to voluntary closure requests and emergency or crisis situations.

The following four recommendations and the recommendation for Scenario III take into account full consideration of each scenario against each criteria for evaluation, total cost, and degree of movement toward the long-range principles for the services system. The essential elements of the plan continue to move the overall system away from larger settings, and will enable more individuals to live in homelike environments. These recommendations balance implementation of the general policy direction of the Department and Legislature with total cost, and form a reasonable plan to move services toward desired outcomes in a manner that balances both individual need and current system realities. They represent significant strides toward implementation of desired outcomes, but in a manner that allows good planning based on individual needs and system capacity.

1. CONTINUE USE OF VOLUNTARY CLOSURE

Several facilities have indicated a desire to voluntarily close. The Department should continue to work with these facilities and counties to develop alternative community services for the residents of these facilities and to close them, as appropriations are made available for this purpose.

2. DEVELOP COMMUNITY ALTERNATIVES AND CLOSE THE LARGER A FACILITIES AND AGING CLASS B FACILITIES

The largest class A facilities (over 20 beds) should be closed. Many of the current residents of these facilities can be served by the Medicaid waiver, and the remaining could be served in new small ICFs-MR. Implementation of the 15-bed requirement and these closings should take place concurrent with the development of these new community alternatives, and a Legislatively approved plan and resources for the development of these services. The provider of the existing facility should also be given the opportunity to respond to requests for proposals to develop the new services.

If the ten largest class A facilities were closed (all the homes over 16 beds), new small community homes would have to be developed for approximately 535 people. We recommend the Department enter into closure agreements with these facilities and that all be closed within the next five years (1996). Certainly a reachable, less aggressive but yet reasonable goal is to close at least the three largest class A facilities (309 people) by 1996.

Estimated costs to close the three largest class A facilities:

	TOTAL COST	STATE SHARE (in millions)
1992	.32	.32
1993	.49	.33
1994	2.1	1.3
1995	3.8	2.3
1996	5.8	3.5

In addition, some class B facilities have very poor, aging physical plants, such as Lake Owasso, which will need to be replaced in any case. Facilities with deteriorating physical plants should be closed and replaced with small community homes, instead of recapitalizing these large facilities. In replacing these old buildings with new small community homes, the majority of the investment would be in program operating and administrative costs, rather than buildings. It is projected that after the dispersion of Lake Owasso residents into small community sites is completed, there would be an additional $700,000 a year in state costs.

3. MODIFY IMPLEMENTATION OF THE 15-BED LIMIT

The 15-bed limit on placements from the regional treatments centers is programmatically valuable and in full accordance with Department and Legislative policy direction toward small, community homes. However, full implementation would require a great degree of capacity building and change for individuals, families, and programs. In addition, implementation of the requirement without the accompanying resources to development community alternatives would be damaging to both the individuals served and the facilities. Recognizing the lack of accessible housing and often limited options for the most difficult individuals, we recommend that exceptions to the 15-bed limit be made on a case-by-case basis for individual placements in class B facilities on the basis of individual preference for that residential placement, the facility's capacity to serve that individual, and utilizing the county case management process.

4. IMPLEMENT A DEMONSTRATION PROJECT

Plans for the future are based on several critical factors, some of which should be demonstrated and documented. As these recommendations are implemented, a demonstration project would allow study of these several critical factors that are important in realizing a system based on more individualized, small community homes. This demonstration project would include the following two components:

a. Demonstrate the feasibility of downsizing the largest class B facilities

Many of the largest class B facilities are currently serving very difficult people. Although some of these individuals can be moved to smaller homes using the waiver and other ICF-MR funds, at this point in time it would be much more expensive to serve this entire group of people in smaller settings. No class B facility has been significantly downsized without closing, so the fiscal and prommatic impacts need to be determined.

These homes should be downsized at a fiscally and programmatically reasonable level (perhaps 25%), or as long as they can stay within the limitations in Rule 53. This downsizing would allow some facilities to develop crisis intervention and short term services, and to modify current space to impact programmatic effectiveness. Such modifications to use some beds for these new services would also require certain changes in funding rules.

For the demonstration project, we recommend that at a minimum two class B facilities be selected to downsize. These two facilities should be selected on the basis of safety, overcrowding and other programmatic issues, and their capacity to offer crisis intervention and short-term stay services. The demonstration project would provide the opportunity to determine the rule changes and fiscally feasible methods which need to be developed to allow the cost-effective utilization of these facilities for these purposes.

It is estimated that to downsize two Class B facilities 25% for a total of 100 beds would cost the state $630,000 annually for additional alternative services and rate adjustments.

b. Demonstrate feasibility of developing new alternatives and initiatives

Smaller community-based residential services within Minnesota have tended to rely almost exclusively on ICF-MR and Medicaid waiver funding. However, there are many other alternatives for services which have been successfully implemented in other states and in individualized cases within Minnesota, including vouchers, client-owned housing, and other options discussed above. We recommend that these options be encouraged and developed. As they are developing, various features of feasibility, cost-effectiveness, regulation, monitoring, and overall programmatic integrity need to be explored. Providers, counties, and the state need avenues to gain experience with these options before pursuing them on a more aggressive and wider scale. The costs, requirements, and programmatic methods to develop the new initiatives and alternatives would be studied within this demonstration project and provide sound experience for further expansion and/or modification of these options.

Part of the demonstration project could also include start-up monies to start experimental services. In addition, outside resources such as the University of Minnesota could be involved in the study of the various factors being explored in the demonstration project.

The Department would be open to developing a variety of alternative services and to use the state share of funding in creative manners. Responses to requests for proposals for services would be reviewed by members of the Commissioner's Task Force. It is estimated that the costs for this project would

be $100,000 for the biennium. This amount would include $25,000 in start-up grants to individuals or providers, and $25,000 to study and assess the costs and feasibility of these alternatives.

APPENDIX A

COMMUNITY ICF-MR
FACILITIES CLOSED IN LAST 5 YEARS
AND SCHEDULED TO CLOSE

CLOSED AND CLOSING ICFs/MR

FACILITY	DATE	BEDS	REDEVELOPED
Project Independence	11-1-85	8	No
Bronstein Home	3-5-86	10	No
Aneskarn-Rosslaer	4-14-86	28	No
Lakeview	8-1-86	7	No
Lake Park Wild Rice	10/31/87	55	No
Alice Haney	6-30-87	40	No
Champions	12-18-87	16	No
Hilltop	10-29-87	10	No
Madden-Haven	7-1-87	45	No
St. Elizabeth	8-1-87	14	No
Woodvale-Kassen	9-30-87	14	No
Ele's & Harsons	12-31-87	17	No
377 Main, Region 10	10-5-87	12	No
Hawthorne	3-31-88	23	No
REM-Waite Park	8-30-88	9	No
Dungarvin I	8-1-88	15	15
Dungarvin-Balbriggen	8-1-88	6	6
Dungarvin-Camara	8-1-88	6	6
Forestview-Logan	5-28-88	6	No
Greenbrier	5-31-88	165	No
Stevencroft	6-30-88	6	No
Valor-James	9-30-88	6	No
Wicklough	6-30-88	100	No
Family House	5-88	7	No
Petits Children	2-88	15	No
Resident. Alt, Wright	1-89	8	No
Urlingford	1989	15	6
Hammer	8-1-89	46	No
REM-Sauk Center	1989	7	No
Shelton	8-89	8	No
REM-Redwood	12-30-90	132	12
Valor-Aspen	8-31-90	6	6
Valor-Hemingway	7-31-90	6	6
Valor-Kentucky	7-31-90	6	6
Valor-Vincent *	7-31-90	6	6
Chai House	12-90	6	6
Valor-Minnetonka	7-31-90	6	6
Tikvah	12-90	6	6
Valor-Lexington	7-31-91	6	6
Valor-Sunlen *	7-31-91	6	6
Hearthside *	8-7-91	40	24
Dungarvin-Shire *	9-30-91	12	12
Woodvale III *	6-30-92	41	6
		1003	108

Net Reduction 895

* In process of closing

APPENDIX B

FACILITIES OVER 15 BEDS

&

RESIDENT LEVELS OF CARE

Number of Facilities by Size
(Number of Licensed Beds)

Number of Beds	1-10	11-15	16-40	41-75	76+	# People (beds) in facilities over 15
Region 1	10	2	1			33
Region 2	3	3				
Region 3	17	8	3			53
Region 4	24	2				
Region 5	3	5	1			16
Region 6	1	11	1	1		76
Region 7	12	9	3			79
Region 8	3	7	1	1		63
Region 9	11	11		1		44
Region 10	15	14	7	2		227
Region 11	79	26	9	7	3	954
	178	98	26	12	3	317 total facilities
# people (beds)	1235	1357	593	643	309	4137 total people

Over 15

41 facilities

1545 people

Source: Long Term Care Management Division
Division for Persons with Developmental Disabilities

Facilities with 76+ beds - 3

Region 11	A Beds
Portland Residence Inc.	101
Clara Doerr - Lindley Hall	103
Norhaven	105
Total	309

Facilities with 41-75 Beds - 11

Region-# of Facilities		A Beds	B Beds	Region Total
6-1	Kindlehope	60		60
8-1	Home for Creative Living		45	45
9-1	Harry Meyering		44	44
10-2	Hiawatha Children's		43	
	Vasa Lutheran		50	93
11-7	Dakota Children's		48	
	Phoenix Residence		51	
	Orvilla		54	
	Mt. Olivet Rolling Acres		56	
	Homeward Bound		64	
	Lake Owasso		64	
	Lutheran Hope & Home		64	401
	TOTAL	60	583	643

Note re: 2 additional facilities:
(REM Redwood Falls (67 beds) will be closed by 12/31/90)
Woodvale III (41 beds) has signed closure agreement

Facilities with 16-40 Beds - 26

Region-# of Facilities		A Beds	B Beds	Region Total
1-1	REM Roseau		33	33
3-3	Northome Nursing Home	16		
	Residential Serv. of NE MN II		16	
	Range Center		21	53
5-1	Oakridge Home		16	16
6-2	Group Living Home	16		16
7-3	Granite Care Home	23		
	REM - Fernwood Inc.		24	
	Madden Kimball Home	32		79
8-1	Prairie View Inc.		18	18
10-7	Adams Group Home		16	
	Fillmore Place		16	
	Inisfail, Inc.		16	
	Rainbow Residence		16	
	REM - Park Heights		16	
	Hiawatha Adult Home		22	
	Woodvale V		32	134
11-9	Greenwood Residence East		16	
	Demars Children's Home		20	
	Hammer Res. (Apt. & Annex)	21		
	Northeast House Inc.	24		
	St. Ann's Residence	30		
	Homeward Bound Brooklyn Park		32	
	People's Child Care Residence		32	
	REM - Pillsbury Inc.	34		
	Camilia Rose Group Home	—	35	244
	TOTAL	196	397	593

In addition, Trevilla of Robbinsdale has 132 nursing home beds, 32 of which are used for persons with developmental disabilities.

Residents by Level of Care in 40+ Bed Facilities

76+ Bed Facilities	Min.	Min.-Mod.	Mod.	Mod.-Max.	Max.	Total
Portland	23	8	46	10	7	
Norhaven	30	6	57	2	6	
Clara Doerr	64	5	30	1		
	117	19	133	13	13	295
	40%	6%	45%	4%	4%	

41-75 Bed Facilities							
6	Kindlehope	19		36	2	3	
8	HCL				34	10	
9	Harry Meyering	4		7	13	20	
10	Hiawatha Ch's.				35	8	
	Vasa Lutheran	2		27	6	15	
11	Dakota Ch's.			3	35	8	
	Phoenix			4	33	11	
	Orvilla	3	1	27	13	8	
	Mt. Olivet		1	21	21	12	
	Homeward Bound	1		4	55	9	
	Lake Owasso	2		22	10	30	
	Lutheran Hope & Home	3	3	29	6	11	
		34	5	180	263	145	627
		5.4%	1%	29%	42%	23%	
	TOTAL 40+	151	24	313	276	158	922
		16%	3%	34%	30%	17%	

Source: Quality Assurance Reviews, Department of Health, Division for Persons with Developmental Disabilities

Residents by Level of Care in 16-40 Bed Facilities

16-40 Bed Facilities	Min.	Min.-Mod.	Mod.	Mod.-Max.	Max.	Total
REM Roseau	1		2	20	6	
Northome Residential Services				9	4	
Range Center			5	9	7	
Oakridge			1	9	6	
Group Living Home				8	8	
Granite Care Home	8		12	1	2	
REM Fernwood			3	15	6	
Madden Kimball			12	6	10	
Prairie View				12	6	
Adams			2	9	5	
Fillmore			1		15	
Inisfail			1	10	5	
Rainbow				11	5	
REM-Park Heights			1	6	9	
Hiawatha				13	8	
Woodvale V	4	3	12	8	4	
Greenwood Res. East						
Demars Children's Home			3	10	7	
Hammer Res.	4	4	12			
Northeast House	12		8	4		
St. Ann's	2	1	18	7	2	
Homeward Bound				26	6	
People's				32		
REM-Pillsbury	8	2	22	1	1	
Camilia Rose	3	2	14	8	7	
	42	12	129	234	129	546
	8%	2%	24%	43%	24%	
TOTAL 16+	174	36	406	508	284	1408
	12.3%	2.5%	28.8%	36%	20.1%	

APPENDIX C

ICF-MR DOWNSIZING PLAN

ADVISORY COMMITTEE

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Downsizing Large ICFs/MR

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APPENDIX D

EVALUATION OF EACH SCENARIO ACCORDING TO CRITERIA

SCENARIO I

In Scenario I, all existing ICF-MR facilities over 10 beds would either close or be reduced in size until there were no facilities more than 10 beds.

A. Extent of Match with Policy Direction

This scenario is most consistent with overall policy direction.

It fully implements and complies with existing statutory language regarding 15-bed and 10-bed limitation on placements from regional treatment centers.

B. Respect for Individual Needs/Choice

Creates smallest and most individualized alternatives.

Limits choices for persons who want to stay in large facilities.

C. Extent of Address of Safety/Privacy/Programmatic Issues

More cost and more effort will be involved to address safety & staffing needs of individuals in new smaller facilities.

Will allow for most effective address of individual needs regarding safety, privacy, and other programmatic needs.

D. Extent of Redesign for Overall Community Capacity

Community alternatives would have to be developed for a larger number of individuals, many of which have higher needs.

Development of sufficient number of community alternatives will require intense provider, county, and state planning and commitment of resources.

Development of crisis/short term care services will likely be more difficult in smaller facilities.

E. Cost

Most costly.

SCENARIO II

In Scenario II, all facilities are decreased in size (either closed or downsized) to no more than 15 beds.

A. Extent of Match with Policy Direction

Consistent with overall policy direction, but less than Scenario I.

If 10-bed statutory limitation is in effect in 1993, forces another cycle of change in two years.

B. Respect for Individual Needs/Choice

Does create new community alternatives and choices for persons preferring smaller settings, but not as much as I.

Allows more choice than I and III for persons preferring to stay in existing intermediate-size facilities.

C. Extent of Address of Safety/Privacy/Programmatic Issues

Effort and resources involved to accommodate individuals' safety, privacy, and other programmatic needs not as extensive as I, more than III and IV.

D. Extent of Resdesign for Overall Community Capacity

Some current facilities could convert to accommodate individuals with higher needs.

A higher level of ICF-MR capacity is maintained as part of the service system (more existing facilities would stay in existence than I).

Some current facilities can be used to develop capacity for crisis and short term care.

E. Cost

Less costly than I, more than III and IV.

SCENARIO III

Scenario III is not as aggressive a change as Scenarios I and II, but offers significant change from the current system. In Scenario III, the largest A facilities are closed. Existing B bed facilities may be maintained at their current size. However, if a B facility wished to downsize without closure, they would be allowed to do so based on a per-facility determination. Downsizing on a limited basis (up to 25%) would occur if there was a need based on safety issues, such as conversion of former children's facilities to adult facilities, or to develop the capacity for crisis services and short-term stays. Any Class A facility over 16 beds would closed, and current 16-bed Class A facilities would be downsized to 15 or less.

A. Extent of Match with Policy Direction

15-bed requirement would have to be changed, or exceptions allowed.

Creates smaller 15-bed facilities and allows some large facilities to remain and become more specialized.

B. Respect for Individual Needs/Choice

Offers fewer choices for people who wish to leave existing B facilities for smaller alternatives.

More choices than I and II for those who wish to remain in existing B facilities. For those in intermediate size A facilities, fewer choices to stay in existing facilities, but offers more choice for those who wish to live in an ICF-MR.

C. Extent of Address of Safety/Privacy/Programmatic Issues

Costs involved would be to upgrade to allow existing large and intermediate class B facilities to accommodate safety, privacy, and other programmatic needs, due to changes in population toward those with higher needs.

D. Extent of Redesign for Overall Community Capacity

Current B facilities would need to be assisted to accommodate individuals with higher needs and those in need of crisis or short-term services.

Leaves more ICF-MR capacity and fewer small community homes in the system than Scenarios I and II, but more small homes than the current system. Some current class B facilities can be used to develop capacity for crises and short term stays.

E. Cost

Less expensive than Scenarios I and II. Some costs are in development of smaller community alternatives, and some in upgrading current facilities to accommodate individuals with higher needs.

SCENARIO IV

Scenario IV would allow each facility to downsize on an individualized schedule, basically by attrition and moving people to the Medicaid waiver. Everyone in either class A or class B facilities who could be served within the waiver fiscal limits would be given the opportunity to exit based on their desire. A mechanism would be adopted into Rule 53 allowing the restructuring of rates to account for the open bed requirement. The mechanism would be utilized on a timed basis and not every time that a person leaves. No facilities would be closed. If this movement to the waiver and down-sizing were made viable, the cost estimates in this option assume that these facilities would downsize.

A. Extent of Match with Policy Direction

Least match with overall policy direction. Does not allow implementation of 15-bed requirement. Does not close any facilities.

B. Respect for Individual Needs/Choice

Does provide options for individuals who wish to move to smaller community homes, but only those who can be served within the Medicaid waiver average. Allows the most choice for individuals who wish to remain in existing large homes.

C. Extent of Address of Safety/Privacy/Programmatic Issues

Physical plants could be modified to accommodate safety, privacy, and other programmatic needs as facilities gradually became smaller. Closed units could be modified for crisis intervention and short term respite stays in Class B facilities. Expenses would go to building modification.

D. Extent of Redesign for Overall Community Capacity

Could allow systematic planning for development of smaller community alternatives, but only those options fitting within the Medicaid waiver average.

E. Cost

May be least costly in terms of development of small community alternatives, but also projects least amount of savings to state through downsizing of current facilities. In addition, current facilities continue to remain

funded, and a significant proportion of total resources is going to readjusted rates. May be the most expensive to administer, in terms of rate adjustments. More dollars would be expended for existing facilities to serve fewer residents than would be expended on development of community alternatives. At some point of downsizing, it would also become more cost effective to simply close the facility and serve individuals in other settings than to adjust the rate to keep the existing facility operating.

APPENDIX E

PROGRAMMATIC AND COST ASSUMPTIONS
USED IN SCENARIO DEVELOPMENT

The programmatic assumptions used in the development of all scenarios and recommendations were:

1. Any major downsizing or closure effort will require appropriate statutory and rule authorizations. Use of building space and other issues will be addressed in the rate-setting and need determination processes.

2. Any downsizing or closure of any facility would go through need determination process, including host county and other counties in the region.

3. It is feasible for some intermediate and smaller facilities to downsize, as they do A to B conversions. In these conversions, a certain amount of downsizing is allowed, within administrative limitations and property limits.

4. 6 to 10 bed facilities are not covered in the legislation mandating the Department to develop an ICF-MR downsizing plan. They are already in compliance with the 15-bed rule. They can do A to B conversions to downsize.

The cost assumptions used in the development of these alternatives include:

1. Cost of continuing as is, no change -- deducted; only new costs represented.

Scenarios I and II:

2. New development:

60% of beds -- new small ICF-MR development; 6 bed homes; $162.65 per diem
40% of beds -- Medicaid waiver; $97.18 total per diem

For All Scenarios:

3. Cost of closure -- estimated at $60 above current average rate in that group for first year; increased by 6% inflation each year thereafter

4. Phase-in assumptions:

FY 92 -- spent planning; no facilities open until third quarter FY 93

For facilities downsizing with no closure - 8% savings for facilities downsizing up to 25%; 3% average savings used for smaller facilities downsizing less than 25%

5. Administrative costs:

Additional staff required in auditing, licensing and certification, etc.