DEPARTMENT OF ADMINISTRATION

MEDICAID COST CONTAINMENT AND LONG TERM CARE IN MINNESOTA

VOLUME 2

MANAGEMENT SERVICES DIVISION

CHAPTER V

ANALYSIS OF LONG TERM CARE COST-CONTAINMENT ALTERNATIVES

A. Deinstitutionalizing the Mentally Retarded

Introduction

Alternatives 1-4 represent successive phases in one overall approach to deinstitutionalizing additional MRs from SHs: These alternatives are:

1) DI all MRs (borderline, mild, moderate, severe, profound, indeterminate, and unknown);

2) DI borderline and mildly retarded;

3) DI borderline, mild and moderately retarded; and

4) DI borderline, mild, moderate and severely retarded.

For each alternative, we estimate cost, staff, and local economic impacts.

The approach used, DI by mental level, was chosen because:

- Community facilities often specialize by mental level (and age);
- Mental level with age is a good indicator of what special program will be required for the individual - DAC, SW or public school; and
- Data on mental levels are available. Thus it makes rational planning sense to talk of mental levels.

Behavioral and special medical problems are additional considerations which may make DI more difficult or more costly. However, facilities could be equipped to handle the behavioral and/or medical problems. Thus, DI of all SH residents is possible. Further, today's drugs can control many conditions (e.g., epilepsy), thus decreasing the need for hospitalization.

1. Alternative 1: DI all MRs

As of 6/30/75, there were 3255 retarded residents of SHs. If all were DI'd, the number of SH patients/residents would be decreased by 60%.[1] Table 5.1 summarizes the age

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[1] In State Hospitals, MRs are known as residents, while MIs and CDs are referred to as patients.

and retardation level of these residents. Of all residents, 5.1% are borderline and mildly retarded, 10.1% are moderately retarded, 31.0% are severely retarded and 50.0% are profoundly retarded. Very few (0.6%) SH residents are younger than 5 years of age, 18.4% are between 5 and 17 years of age, 26.3% between 18 and 24 years, 52.8% between 25 and 64 years, and 1.8% over 65 years of age. It would seem the very young and the old are cared for elsewhere, the young probably at home and the old in nursing homes.

Where Are the MRs Now?

Table 5.2 shows the number of MRs residing at each SH and their percent of overall hospital population. If none of the remaining patients (MI or CD) were moved, Alternative 1 would: completely close two hospitals, Faribault and Cambridge; not affect Anoka or Hastings at all; virtually close Brainerd; and affect the remaining five to varying degrees. However, if all MRs were DI'd, up to 6 or 7 state hospitals could be shut, moving the remaining 2200 (approximately) MIs and CDs to 3 or 4 SH campuses.

Where Would MRs Go and What Services Would They Need?

For this analysis, it is assumed all MRs would still require residential care in CBFs. It is also assumed MRs would be DI'd to their county of settlement (home county). Figure 5.1 shows the number of SH MRs from each county.

Several counties do not have enough MR SH residents to make care in the county of residence feasible, particularly since CBFs frequently specialize in care by age or mental level. Fourteen Minnesota counties have fewer than 10 MR residents in SHs and twenty-nine counties have between 10 and 19 residents in SHs. However, care in an adjacent county or a regional center is possible. Thus, Table 5.3 aggregates each SH MR's county of residence by region.[2]

Table 5.4 displays the regional distribution of existing CBFs. In June 1976, there were 120 community facilities with about 2890 beds.[3] Because most CBFs are nearly full[4],

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[2]EDC Region is used because of its similarity to Planning Regions.

[3]These numbers should be taken as close estimates: Licensing data from DPW and MDH differ slightly as to number of facilities and beds. New facilities and changes in the numbers of licensed or certified beds make an exact number hard to calculate.

[4]For those on which cost data were available, the median occupancy was 96%.

Table 5.1

Age and Retardation Level of SH MR Residents[1] as of 6/30/76

Retardation Level	Age						
	Pre-school	5-17	18-24	25-64	65+	Age Not Reported	Total
	(numbers)						
Borderline and Mild	0	36	41	86	3	0	166
Moderate	0	37	68	214	10	0	329
Severe	8	133	263	587	19	0	1010
Profound	1	338	470	794	23	1	1627
Undetermined	10	42	12	21	1	1	87
Not Reported	0	13	3	17	1	2	36
Total	19	599	857	1719	57	4	3255

[1]Data Source: Research and Statistics, Office of Evaluation, Mn. Dept. of Public Welfare

Table 5.2

MRs in SHs: Numbers and percents of total SH populations

SH	MRs	
	% MR in SH[2]	Number of MRs[1]
Anoka	0	0
Brainerd	86.7	577
Cambridge	100	622
Faribault	100	993
Fergus Falls	55.7	299
Hastings	0	0
Moose Lake	31.2	150
Rochester	32.9	160
St. Peter	46.1	266
Willmar	37.3	184
		3251

[1]As of 6/30/76 - Table 5.1 shows 3255 total MR residents. Total Ns will vary a little due to missing data on variables.

[2]March 1976 SH population data.

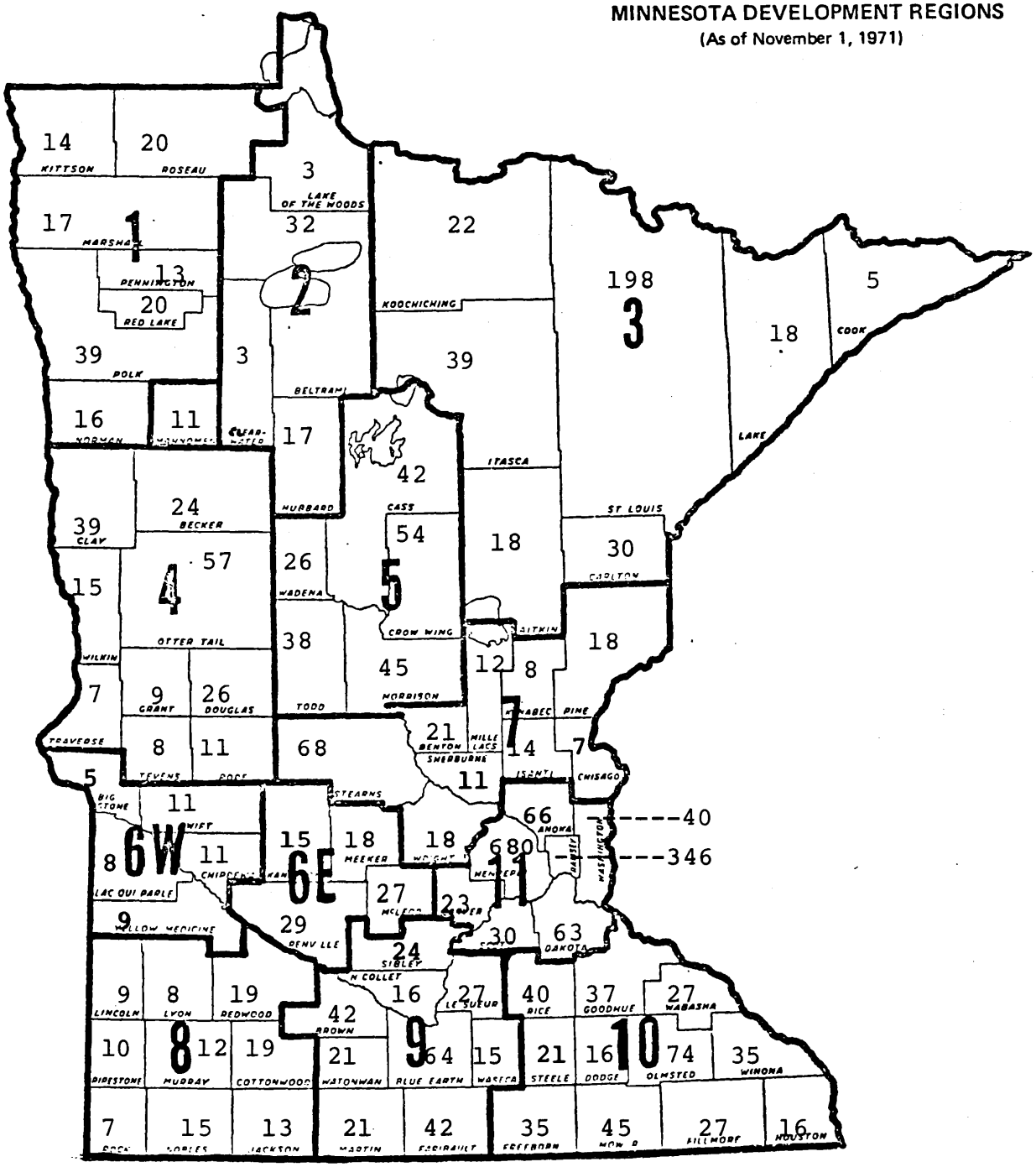

Figure 5.1 SH MRs: Home Counties

Table 5.3

Region of Settlement for SH MR Residents (6/30/76)

Region	Number of SH MRs
1	139
2	66
3	330
4	196
5	205
6E	89
6W	44
7E	59
7W	118
8	112
9	272
10	373
11	1248
Total	3251

Note: 4 MRs have out-of-state residence.

Table 5.4

Number of Existing CBFs and Beds by Region of Location[1]

Region	CBFs	# Beds
1	4	77
2	3	39
3	19	315
4	9	141
5	0	0
6E	6	158
6W	2	30
7E	2	23
7W	11	181
8	8	255
9	5	89
10	11	231
11	40	1351
Total	120	2890

[1]Used DPW 4/76 list excluding closed and uncertified facilities as of 9/76.

the number of beds in CBFs would have to more than double to accomodate SH MRs. Given the Medicaid reimbursement system (reimbursement of reasonable costs for CBFs determined prospectively) and the growth of these facilities,[5] the alternative of DI'ing all MRs is within the realm of possibility, although it would take time -- several years would probably be needed.

Other Needed Services

Community facilities for the mentally retarded provide residential care and related supportive services. Program services are provided by the public school system, Day Activity Centers and Sheltered Workshops; medical services are provided by community resources on a fee-for-service or contractual basis.

Presently, the law provides for the public education of all trainable mentally retarded between the ages of 5 and 24 years. On 6/30/76 there were 1456 SH MR residents between 5 and 24 years. Of these, 1175 (84%) participate in TMR Public School Education.[6] This program would need to move into or expand in local communities where additional residential facilities are located. However, we would hypothesize that because of differing financial incentives, more of the 19-24 year old MRs in the community would be in SWs or DACs instead of in school.

Day Activity Centers are presently located in every region and nearly every county in Minnesota. The expected FY '76 participation was 3,747.[7] If it is assumed that 1) all preschoolers, 2) all severely and profoundly retarded adults, 3) the school-age children and adults not in the TMR program, 4) some portion of the mildly and moderately retarded for whom a sheltered workshop is inappropriate would all need a DAC program, and 5) some portion of the 19-24 year old SH MRs currently in TMR programs would probably be placed in DAC or SW programs. Assumptions 1 through 3 above would add at

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[5]The MDH Directory: Licensed and Certified Health Care Facilities: 1975 lists 68 community facilities with 1683 beds as certified as of 3/15/75. Table 5.4 indicates that about one year later, the number of facilities and beds had increased 42%.

[6]Memo 5/25/76.D. Buelow "Information on TMR Programs".

[7]Memo 2/24/76 Ed Constantine to Vera Likins "1975-76 Status Report-DAC Grant-in-Aid"

least 1713 participants to the DAC program. Assumptions 4 and 5 above might increase the total to 2000, thus requiring an increase of about one-half in the state's present DAC program capacity.

There are 313 mildly and moderately retarded adults 25 years or older presently in SHs. If DI'd, many of these people could participate in a Sheltered Workshop. In August 1976, there were 1700 employees of SWs.[8] If all 313 of these SH MRs participated in a SW, this would increase program participation by about one-fifth.

Cost Impact: Alternative I

We now present probable costs of DI'ing SH MRs as outlined above. First, we detail our cost projection methodology, with special emphasis on our assumptions and the limitations on our estimates. The assumptions and limitations stated are based on findings discussed earlier in the report.

Our estimates of the current costs of caring for MRs in CBFs and in SHs are based on analyses reported in Chapter IV B of this report. Our projections which follow are based on total monthly costs of care as distributed across levels of government.

Before we estimate the costs of moving MRs from the SH system into CBFs, we describe the current SH Medicaid MR population in terms of severity of mental retardation and age. Table 5.5 shows the distribution. Borderline and mildly retarded MRs were combined in this table. The 3030 MRs in Table 5.5 are, as the table title indicates, Title XIX recipients and constitute 96% of SH MRs. The remaining 4% (N=100) are all under 18 years of age and are not Title XIX recipients but rather "Cost of Care" recipients.

For cost of care recipients, the parents pay up to $60 per month for the cost of care, with the state assuming the remainder of the monthly costs. These 100 individuals are assumed, in our analysis, to be in the 5-19 age group. Since the majority of the 5-19 age group are in the Severe and Profound categories, we assume in our cost estimates that 50 of them are severely retarded and 50 are profoundly retarded. Table 5.6 shows the total current SH MR population, including the cost of care recipients. Table 5.6 forms the basis for our estimates of the costs of moving SH MRs into CBFs.

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[8] DVR memo - August Gehrke.

Table 5.5

SH MRs who are Receiving Medicaid: Severity of Retardation by Age Group, June 1976[1,2]

Age Group	Severity of Retardation				
	Mild	Moderate	Severe	Profound	Total
			(numbers)		
0- 4	-	-	10	-	10
5-19	50	55	145	410	660
20-65	110	265	790	1140	2305
66 and over	-	10	20	25	55
Total	160	330	965	1575	3030

[1]Source: Research and Statistics Division, DPW.

[2]Numbers were rounded to the nearest multiple of 5, to facilitate calculation of cost impacts in this section. These numbers excluded those 124 SH MRs having "indeterminate" or "unreported" levels of retardation or unknown ages.

Table 5.6

All Current SH MRs: Severity of Retardation by Age Group, June 1976[1,2]

Age Group	Severity of Retardation				
	Mild	Moderate	Severe	Profound	Total
			(numbers)		
0- 4	-	-	10	-	10
5-19	50	55	195	460	760
20-65	110	265	790	1140	2305
66 and over	-	10	20	25	55
Total	160	330	1015	1625	3130

[1]Source: Research and Statistics Division, DPW.

[2]Numbers have been rounded to the nearest multiple of 5 to facilitate calculation of cost impacts in this section. Numbers exclude those 124 SH MRs having "indeterminate" or "unreported" levels of retardation or unknown ages.

We assume that the Title XIX LTC per diem reimbursement rates for these individuals, if moved to CBFs, would be as shown in Table 5.7.

We assume that the current SH MRs, if moved to CBFs, would receive services in the community according to the utilization patterns shown in Table 5.8.

We assume that the mildly and moderately retarded MRs currently in the SH system, if they moved to CBFs, would use the patterns of services, by age group (for ages of current SH MRs), as shown in Table 5.9.

We assume that the severely and profoundly retarded MRs currently in the SH system, if they moved to CBFs, would use the patterns of services, by age group, as shown in Table 5.10.

On the basis of our Case Study findings, we assume that current SH MRs, if they moved to CBFs, would use Title XIX Non-LTC services in the monthly amounts shown in Table 5.11.

We assume the total monthly costs per person in Day Activity Centers (DACs) and Sheltered Workshops (SWs) to be as shown in Table 5.12.

Table 5.13 presents funding ratios, by government level, for the services enumerated above. Special education costs are excluded from this table since the home school district is responsible for the local funding share of special education costs regardless of where the MR individual resides; the state is responsible for the remainder of special education costs. SSI monthly $25 personal needs allowances, paid to eligible MRs in both SHs and CBFs, are also excluded.

Tables 5.7 through 5.13, combined, provide information on total monthly costs of care for MRs in CBFs. Table 5.14 contrasts this information with the total monthly cost for MRs in SHs, by government level sources of funding.

Table 5.15 estimates the monthly costs of caring for current Title XIX SH MRs in the community, by age-group and severity of retardation. Monthly costs are also detailed by governmental level. For the 100 current Cost of Care MRs, the distributional costs would be slightly different for residential and Non-LTC medical costs, but the same for program costs. We assume that the state would pay the full LTC cost less $60 but that parents would pay the Non-LTC costs.

Table 5.7

Title XIX Per Diem Reimbursement Rates in CBFs, by Level of Retardation

Severity of Retardation	Title XIX LTC Per Diem Rate in CBFs
Mild	$15
Moderate	$20
Severe	$30
Profound	$30

Table 5.8

Community Services Utilization Patterns for SH MRs if they moved to the Community, by Age Group

MR Age Group	Service Utilization Patterns
• 0-4	• Preschool DAC program,[1] Title XIX LTC, Title XIX Non-LTC services.
• 5-19	• Special Education, Title XIX LTC, Title XIX Non-LTC services.
• 20-65[2]	• For mild and moderate MRs; Sheltered employment, Title XIX LTC, Title XIX Non-LTC services. For severe and profound MRs; Adult DAC program, Title XIX LTC, Title XIX Non-LTC services.
• 66 and over	• Adult DAC program, Title XIX LTC, Title XIX Non-LTC services.

1 We assume that the current SH MRs in the 0-4 age group, if they moved to CBFs, would use only preschool DAC programs and not homebound DAC programs.

2 While some of the 20-24 year olds will be in Special Education, for purposes of estimating costs, we consider them to be SWs or DACs.

Table 5.9

Probable Community Service Utilization Patterns for Mildly and Moderately Retarded Current SH MRs, by Age

Retardation Level	Service Utilization Patterns
Mildly Retarded:	
• Ages 5-19 (N=50)[1]	• Title XIX LTC and Non-LTC, and Special Education
• Ages 20-65 (N=110)[1]	• Title XIX LTC and Non-LTC, and Regular Employment
Moderately Retarded:	
• Ages 5-19 (N=55)[1]	• Title XIX LTC and Non-LTC, and Special Education
• Ages 20-65 (N=265)[1]	• Title XIX LTC and Non-LTC, and Sheltered Employment
• Ages 66 and over (N=10)[1]	• Title XIX LTC and Non-LTC, and Adult DAC program.

[1]Ns refer to the number of current SH MRs in each group.

Table 5.10

Probable Community Service Utilization Patterns for Severely and Profoundly Retarded Current SH MRs, by Age

Retardation Level	Service Utilization Patterns
Severely Retarded:	
• Ages 0-4 (N=10)[1]	• Title XIX LTC and Non-LTC, and Preschool DAC program
• Ages 5-19 (N=145, plus 50 Cost of Care)[1]	• Title XIX LTC and Non-LTC, and Special Education
• Ages 20-65 (N=790)[1]	• Title XIX LTC and Non-LTC, and Adult DAC program
• Ages 66 and over (N=20)[1]	• Title XIX LTC and Non-LTC, (and retirement)
Profoundly Retarded:	
• Ages 5-19 (N=410 plus 50 Cost of Care)[1]	• Title XIX LTC and Non-LTC, and Special Education
• Ages 20-65 (N=1140)[1]	• Title XIX LTC and Non-LTC, and Adult DAC program
• Ages 66 and over (N=25)[1]	• Title XIX LTC and Non-LTC, (and retirement)

[1]Ns refer to the number of current SH MRs in each group

Table 5.11

Title XIX Non-LTC Estimated Monthly Costs for Each CBF MR, by Severity of Retardation

Severity of Retardation	Title XIX Non-LTC Estimated Monthly Costs
Mild	$15
Moderate	$15
Severe	$20
Profound	$20

Table 5.12

Total Monthly Cost Per Person in DACs and SWs

Program	Average Total Monthly Cost Per Person
DAC:	
a. Preschool	$386
b. Adult	$217
SW	$170

Table 5.13

Funding Ratios, by Government Level, for Services Received by MRs in the Community

Services	Funding Ratios by Government Level			
	Federal	State	Local	Total
Day Activity Centers	-	52%	48%	100%
a. Transportation	-	100%	-	100%
Sheltered Workshops	37.5%	37.5%	25%	100%
Title XIX	57%	39%	4%	100%
"Cost of Care"	-	100%	-	100%

Table 5.14

Total Monthly Costs Per Person: Community Services and SHs, by Government Level Sources of Funding

Service	Government Level Funding Source			
	Federal	State	Local	Total
DAC:				
a. Preschool	-	$232.00	$154.00	$386.00
b. Adult	-	129.60	88.20	217.80
Sheltered Workshop	$64.00	64.00	42.00	170.00
Title XIX LTC:				
Mild ($15.00 per diem)	$256.50	175.50	18.00	450.00
Moderate ($20.00 per diem)	342.00	234.00	24.00	600.00
Severe and Profound ($30.00 per diem)	513.00	351.00	36.00	900.00
Title XIX Non-LTC Services:				
a. Mild and Moderate MRs	8.55	5.85	.60	15.00
b. Severe and Profound MRs	11.40	7.80	.80	20.00
State Hospital Care[1]				
a. Title XIX per diem: $45/day	769.50	526.50	54.00	1350.00
b. Cost of Care: (Assume parents pay $60/monthly)	-	1290.00	-	1290.00

[1] SH per diem rate of $45 applies to all residents, both Title XIX and Cost of Care, and includes total costs of all services provided.

In our following discussion of Long Term Care alternatives, we contrast the cost estimates presented in Table 5.15 with average monthly state hospital costs which are as follows:

State Hospital Monthly Costs:	Federal	State	Local	Total
	$769.50	$526.50	$54.00	$1,350.00

Table 5.15 provides the estimated costs of care in a community setting which we use to project total costs of moving current SH MRs to CBFs in Alternatives #1 through #4 (below). Before we present these projected costs however, we note the following additional assumptions and limitations of our estimates:

1) Estimates of administrative and licensing costs were beyond the scope of our project and thus were not estimated.

2) We have assumed that the supply of CBFs and community services would increase to meet the demand.

3) We cannot predict the cost to the state of those MRs who might come "out of the woodwork" and into newly-available CBFs, e.g., MRs who at age 18 may become eligible for Medicaid based on their own income.

4) While this is a point-in-time analysis, we assume that the current dollar figures used will increase proportionately with inflation.

5) Except for level of retardation and age, no usable information was available on other cost-related patient-characteristics (such as physical disabilities and behavior disorders) of individual SH MRs. There is also no information on how these characteristics affect the costs of caring for MRs in CBFs. Therefore, while we recognize the potential importance of these characteristics, we cannot include them in our analyses.

All of the following projections are based upon these assumptions and limitations.

Alternative #1: Moving All MRs from SHs to CBFs; Cost Projections:

This alternative involves DI of the 3130 MRs with known levels of retardation and ages from the SH system.

Table 5.15

Estimated Total Monthly Costs of Care Per Person in the Community, by Government Level, Age Group, and Level of Retardation, for Current Title XIX MRs in SHs

Age Group and Severity of Retardation	Government Level			
	Federal	State	Local	Total
0-4 Age Group:				
Severe	$524.40	$590.80	$190.80	$1306.00
5-19 Age Group:				
Mild	265.05	181.35	18.60	465.00
Moderate	350.55	239.85	24.60	615.00
Severe	524.40	358.80	36.80	920.00
Profound	524.40	358.80	36.80	920.00
20-65 Age Group:				
Mild	265.05	181.35	18.60	465.00
Moderate	414.55	303.85	66.60	785.00
Severe	524.40	488.40	125.00	1137.80
Profound	524.40	488.40	125.00	1137.80
66 and Over Age Group:				
Moderate	350.55	369.45	112.80	832.80
Severe	524.40	358.80	36.80	920.00
Profound	524.40	358.80	36.80	920.00

Total SH costs for any given month are compared with the total costs of caring for these individuals in the community setting in Table 5.16.

These total costs are detailed by governmental level. Cost increases are indicated by a "+" while cost savings are denoted by a "-". Cost estimates for Alternative #1 were rounded to the nearest ten-thousand. All of the cost estimates involve the total monthly costs of care for each setting (delineated by governmental level) for the number of MRs involved in a given alternative. Table 5.16 includes the estimated costs of moving the 100 SH MRs in the "Cost of Care" program; these estimates were obtained by multiplying 100 by the $1290 per month state responsibility in caring for these individuals.

The total cost estimate shown in Table 5.16 reveals monthly cost savings of about $1 million in total public spending.

It can be seen that the implementation of Alternative #1 would involve savings for both the federal and state governmental levels with cost increases for local governmental levels.

In view of the fiscal problems faced by many local governmental units, any serious consideration of Alternative #1 would have to address the issue of funding arrangements.

Staffing Impact: Alternative 1

A questionnaire mailed to all SHs in October, 1976, asked for total staff complement and numbers of direct care staff assigned to MR, MI and CD programs respectively. If Alternative 1 were implemented, all MR direct care staff and some portion of the indirect care staff would be eliminated. If we assume indirect care staff would be reduced by the percent that MRs are of each SH's population (Table 5.2), then Table 5.17 details the number of positions which would be eliminated at each SH. Table 5.17 also shows the number of staff, assigned to the MI and CD programs, which would remain at each SH. Alternative 1 would eliminate 61% of the staff positions in the SH system. Section IV B showed that staff other than SH complement employees provide care for MRs; under Alternative 1 these should be unnecessary. Table 5.18 details the numbers and kinds of positions. A total of 773 non-complement positions would be eliminated. In all, slightly more than 4000 FTE jobs would be affected by Alternative 1.

Table 5.16

DI Alternative #1: Comparative Total Monthly Costs of Caring for All Current SH MRs in the Community, by Government Level

Level of Government	Total Monthly Cost		
	Monthly SH Costs	Monthly Community Cost	Monthly Cost Difference
Federal	$2,330,000	$1,510,000	- 820,000
State	1,720,000	1,380,000	- 340,000
Local	160,000	290,000	+ 130,000
Total	$4,210,000	$3,180,000	-1,030,000

Table 5.17

Direct and Prorated Indirect Positions Assigned to the SH MR Program

	Direct Care Positions	Prorated Indirect Care Positions	Total MR Care Positions	MI and CD Program Positions[1]
Anoka	-	-	0	330
Brainerd	341	224	565	89
Cambridge	375	225	600	0
Faribault	659	291	950	0
Fergus Falls	212.0	76	288	195
Hastings	-	-	0	186
Moose Lake	94.5	49	143.5	302.5
Rochester	113	72	185	340
St. Peter	180	119	299	265
Willmar	108.5	105	213.5	359.5
Total	2083	1161	3244	2067

[1]Includes direct and indirect care positions

Table 5.18

Number of Non-SH Staff Positions Eliminated if MRs were Removed from SHs

SH	Non-SH staff serving SH MRs				
	School System	CETA	Foster Grand-parents	Other[1]	Total N
Brainerd	76.0	13.0	27.5	36.1	152.6
Cambridge	85.3	50.0	27.0	0.5	162.8
Faribault	146.0	33.0	29.5	8.8	217.3
Fergus Falls	33.0	32.5	18.5	13.0	97.0
Moose Lake	-[2]	5.0	7.0	4.0	16.0
Rochester	33.0	5.0	15.5	-[2]	53.5
St. Peter	19.2	-[2]	0	6.2	25.4
Willmar	26.5	9.0	11.0	2.0	48.5
Total N	419.0	147.5	136.0	70.6	773.1

[1]Vocational Rehabilitation, Consultants and Special Grants

[2]Not reported

Taking the total number of staff working with MRs from Tables 5.17 and 5.18 and dividing by number of MR residents in Table 5.1, it can be seen that a total of about 1.2 jobs [9] exist to care for each SH MR. Assuming little difference in the efficiency and philosophy of care in the SH and community systems, it can be assumed approximately the same number of staff would be required to provide community residential care. However, these staff would be employed by community programs--residential, DAC, SW--and not the State system. Further, only one-eighth of SH MRs have residence in a SH host county so the location of most (seven-eighths) of these 4,000 positions would change. Rather than being concentrated in eight localities, jobs caring for the mentally retarded would be dispersed throughout the state. If community staffing patterns follow SH patterns, three-fourths of these jobs will involve direct care (residential care and program services) and about one-fourth support services (medical, dietary, administration, and maintenance).[10] Of the direct care positions, two-thirds of the staff needed are non-professional (Aides, Human Service Technician) and one-third professionally trained staff (nurses, teachers, therapists). Staff, particularly professionally trained nurses and therapists, are in short supply in many counties. Thus, comprehensive planning would be needed to ensure that needed resources were available before further massive DI were to take place. The 3244 state employees plus 773 other staff would be available resources. However, they may not be located where needed.

If Alternative 1 were implemented, the state system would be hard-pressed to find equivalent jobs for the 3244 displaced state employees. Some would leave the state system but this would not absolve the State of planning for each staff's future. The process would require extensive planning. Sub-section 6 of this Section discusses staff considerations when closing SHs.

Local Economic Impacts: DI Alternative I

DI'ing 60% of the SH residents, an action which would close at least 2 and possibly up to 7 SHs, would have local economic impacts (losses) on communities in which SH

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[9] 4017 FTE Jobs/3255 MR residents = 1.2 FTE Jobs/resident.

[10] Refer to Section IV B.

facilities would be shut or substantially geared down. Sub-section 6 of this Section proposes a framework for looking at these losses, using county as the local economic area. Other communities in the state would have gains as jobs were created to care for DI'd MRs. Losses would be concentrated in areas presently having SHs, while gains would be diffused throughout the state.

All counties other than the eight host counties of MR-serving-SHs would gain additional MRs and the jobs created in caring for MRs. Figure 5.1, presented earlier, shows the magnitude of each county's gains. The big gainers would be Hennepin (680 MR residents), Ramsey (348 MR residents), and St. Louis (198 MR residents) counties. Applying the framework, one may estimate that 1224, 626, and 356 jobs,[11] respectively, would be created. Table 5.19 shows the estimated change in jobs directly resulting from Alternative 1, by economic development region. Region 11, the Twin Cities Metropolitan Area, would gain the most jobs - nearly 40% of all the jobs caring for MRs. Region 10, southwestern Minnesota (where both Faribault and Rochester State Hospitals are located), would lose nearly 1000 jobs; Region 7E, immediately north of the Twin Cities Metro Region (where Cambridge State Hospital is located), would lose nearly 700 jobs; and Region 5, in northcentral Minnesota (where Brainerd State Hospital is located), about 475 jobs.

2. Alternative 2: DI all borderline and all mildly retarded from SHs.

As of 6/30/76, 166 SH residents were classified as borderline and mildly retarded. This represents about 5% of all MR SH residents. Table 5.20 details this group by hospital of residence.

Of the borderline and mildly retarded, 22% are under 18 years of age, 24.7% are between 18 and 24 years of age, 51.8% are 25 to 64 years, and 2% are over 65 years.

Where Would They Go?

Once again, it is assumed SH MR residents would be DI'd to their home county or region (of settlement) and still require residential, program, and supportive services. DI'ing 166 residents would require 5.7% increase in CBF beds (from Table 5.4) plus a creation of up to 77 slots in local school special education programs for those 5 to 24 years of age and 89 to 130 slots in sheltered workshops for other. It is possible that expansion of existing programs could handle this increase.

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[11] 1.2 times number of MRs, plus the indirect effect (about .5 service industry jobs for each basic industry job).

Table 5.19

Estimated Job Impact of Alternative 1, by Region

Region	Impact		
	# SH-Related Jobs Lost[1]	Estimated New Community Jobs[2]	Net Regional Change
1	0	171.5	+ 171.5
2	0	81.5	+ 81.5
3	159.5	407.3	+ 247.8
4	385.0	241.9	- 143.1
5	717.6	253.0	- 464.6
6E	262.0	109.8	- 152.2
6W	0	54.3	+ 54.3
7E	762.8	72.8	- 690.0
7W	0	145.6	+ 145.6
8	0	138.2	+ 138.2
9	324.4	335.7	+ 11.3
10	1405.8	460.3	- 945.5
11	0	1540.1	+1540.1
Total	4017.1	4012.0[3]	

[1]Combination of Tables 5.17 plus 5.18 by region.

[2]Assuming 1.234 jobs caring for each MR. Thus these numbers were obtained by multiplying Table 5.3 data by 1.234.

[3]5 jobs would be created out-of-state to care for the 4 out-of-state SH residents.

Table 5.20

SH of Residence for Borderline and Mildly Retarded (6/30/76)

SH	Number	% of SH's Total MR Population
Brainerd	30	5.6
Brainerd MLC	31	83.8
Cambridge	21	3.4
Faribault	27	2.7
Fergus Falls	18	6.0
Moose Lake	8	5.3
Rochester	3	1.9
St. Peter	24	9.0
Willmar	4	2.2
Total	166	5.1

Table 5.21 summarizes the region of settlement for the borderline and mildly retarded SH residents.[12] Nearly one-third of the borderline and mildly retarded are from the Twin Cities regional area.

Cost Impacts: Alternative 2

Table 5.22 presents the projected costs by government level, with numbers rounded to the nearest thousand. These projections were developed using the same methodology as discussed in Alternative 1 above.

Alternative #2 involves monthly cost savings for all governmental levels, with the largest cost savings accruing to the federal level and the smallest cost savings sustained by local governmental units.

Staffing Impacts: Alternative 2

Fewer staff would be required to provide the same level of care to remaining residents. The following assumptions can be used to estimate probable staff reductions:

1) The Minnesota Learning Center's staff would be reduced by the percent borderline and mild MRs are of all MLC residents.

2) Resident Living staff would be decreased by a staff to resident ratio of 1-to-5 for the 135 non-MLC residents.[13]

3) Support and Medical Staff would be reduced by the percent borderline and mildly retarded are of all MRs in SHs.

4) To calculate SH program staff reductions, it is assumed the 1175 SH residents in the TMR program utilize no SH program staff. It is assumed that all (578) the borderline, mild, moderate, and severely retarded persons between the ages of 5 and 24 are in the TMR program. The other 597 residents receiving TMR are assumed to be profoundly retarded persons between ages 5 and 24. (This amounts to 68% of the profoundly retarded in that age group.)

   The 2080 SH residents not in the TMR program

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[12] Because of the small number, individual county information is not presented.

[13] Following the 1977 Federal ICF/MR regulations. For analysis, it is assumed all borderline and mildly retarded residents are Group C residents - requiring a 1-to-5 staff-to-resident ratio.

Table 5.21

Number of Borderline and Mildly Retarded SH Residents by Region of Settlement (6/30/76)

Region	Number of Borderline and Mild
1	7
2	5
3	17
4	16
5	14
6E	4
6W	0
7E	2
7W	7
8	8
9	16
10	17
11	53
Total	166

Table 5.22

DI Alternative #2: Comparative Total Monthly Costs of Caring for Only Mildly Retarded Current SH MRs in the Community, by Government Level

Level of Government	Total Monthly Cost		
	Monthly SH Cost Cost	Monthly Community Cost	Monthly Cost Difference
Federal	$123,000	$42,000	-81,000
State	84,000	29,000	-55,000
Local	9,000	3,000	- 6,000
Total	$216,000	$74,000	-142,000

are assumed to share proportionately the time of the 479.5 FTE program staff.[14]

So, given Alternative 2, program staff would be reduced as follows:

- For the 77 residents less than 25 years of age, there would be no program staff reduction other than that in MLC (Assumption 1), since these residents are in the Public School System program.

- For the 89 residents 25 years and older, program staff would be reduced by the percent borderline and mildly retarded are of all non-TMR residents.

Regularly available data on staff do not distinguish among residential, program, medical, and support staff; however, a study done in the fall of 1975 does distinguish job categories.[15] Data from this study were reported earlier in Section IV B, and are used again here.

Using assumptions 1 to 4, 48.7 FTE MLC positions, 27.0 Residential Living Unit positions, 20.6 program, 3.6 medical, and 47.1 support positions, or 147.0 total FTE positions could be eliminated. This represents about 2.8% of the FY '76 authorized complement.[16] Natural staff attrition could probably handle a reduction of this magnitude, although the maintenance of proper distribution would have to be assured.

Some percent of the non-state-hospital staff positions detailed in Table 5.18 would also be unneeded. If one assumes reductions of Public School Staff proportional to the TMR program (77/1175), and reductions of other additional staff by percent the borderline and mildly retarded are of all SH MRs (5.1%), then 27.5 school and 17.8 other, or 45.3 FTE positions could also be eliminated.

Local Economic Impacts of Alternative 2

Reducing the SH population by 5% will have little impact on the local economic situations. SH sizes have been

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[14]Figure obtained from Chapter IV B.

[15]Bock, Roberts, Libby. "A Study of Midwest Institutions for the Mentally Retarded." 11/75, DPW.

[16]147/5267: Lake Owasso's positions are not included.

reducing at a more rapid rate over the past ten to fifteen years.

3. Alternative 3: **DI All Borderline, Mildly, and Moderately Retarded From SHs**

On 6/30/76, there were 495 borderline, mildly, and moderately retarded SH residents (329 moderately and 166 borderline/mildly). This represents 15% of all SH MR residents. Individual hospital MR populations range from 10% at Cambridge to 32% at St. Peter and 95% at the Minnesota Learning Center. Table 5.23 displays this information. Overall, 14.7% of the residents are between the ages of 5 and 18 years, 22.0% between 19 and 24 years, 60.6% between 25 and 64 years, and 2.6% over 65 years.

Where would they go?

DI'ing the borderline, mild, and moderately retarded would require a 17.1% increase in CBF beds (from Table 5.4) plus the creation of up to 182 slots in local public school special education programs for those 5 to 24 years and slots in sheltered workshop programs for all others.[17] If DI to region of settlement were to take place, Table 5.24 represents where the borderline, mild, and moderate MRs would go.

Cost Impact: Alternative 3

Cost estimates for Alternative 3 are presented in Table 5.25, with numbers again rounded to the nearest thousand. These estimates were developed using the same methodology as discussed under Alternative 1. As Table 5.25 shows, all government levels would experience monthly cost savings.

Staffing Impacts: Alternative 3

The following assumptions can be used to estimate the SH staff reductions if borderline, mild, and moderately retarded MR residents were DI'd:

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[17]Some percent of these may require a DAC because of special physical or behavioral problems. For our purposes, it is assumed that most can go to an SW.

Table 5.23

SH of Residence for Borderline, Mildly and Moderately Retarded (6/30/76): Numbers and Percent of Total SH MR Populations

SH	Total Borderline, Mild, and Moderate	% of SH MR Population
Brainerd	75	13.9
Brainerd MLC	35	94.6
Cambridge	62	10.0
Faribault	113	11.4
Fergus Falls	56	18.7
Moose Lake	25	16.7
Rochester	20	12.5
St. Peter	84	31.6
Willmar	25	13.6
Total	495	15.2

Table 5.24

Number of Borderline, Mild, and Moderately Retarded SH Residents by Region of Settlement (6/30/76)

Region	Number Borderline and Mild	Number Moderate	Total
1	7	13	20
2	5	10	15
3	17	30	47
4	16	26	42
5	14	15	29
6E	4	16	20
6W	0	5	5
7E	2	7	9
7W	7	12	19
8	8	18	26
9	16	38	54
10	17	38	55
11	53	101	154
Total	166	329	495

Table 5.25

DI Alternative #3: Comparative Total Monthly Costs of Caring for Mildly and Moderately Retarded Current SH MRs in the Community, by Government Level

Level of Government	Total Monthly Cost		
	Monthly SH Cost	Monthly Community Cost	Monthly Cost Difference
Federal	$377,000	$175,000	-202,000
State	258,000	126,000	-132,000
Local	26,000	23,000	- 3,000
Total	$661,000	324,000	-337,000

1) Figures for the 166 borderline and mildly retarded stand as calculated in Alternative 2. (147.0 FTE positions)

2) MLC staff would be further reduced by percent moderately retarded are of all MLC residents.

3) Residential living staff would be further reduced by a staff-to-resident ratio of 1-to-2.5[18] for 325 non MLC moderately retarded residents.

4) Medical and support staff would be further reduced by the percent moderately retarded are of all MRs.

5) Program staff would be further reduced as follows:

   - No reduction for 105 moderately retarded residents 5 to 24 years of age (other than that for MLC), since they are assumed to be in the Public School TMR program.

   - Proportionate reduction for the 224 other moderately retarded residents.

Using assumptions 1 to 5, Alternative 3 would result in a reduction of 434.5 FTE positions in SHs. This includes 157.0 FTE residential living positions, 72.4 FTE program positions, 10.7 FTE medical, 139.4 FTE support and 55.0 FTE MLC positions. This represents 8.2% of the FY '76 authorized complement.

Other non-complement positions could also be eliminated. If the same assumptions as in Alternative 2 are used (school staff reduction proportional to TMR participants and others proportional to all MRs in SHs) then 33.5 FTE school and 34.9 FTE other positions could be affected. Added to those in Alternative 2, this means that a total of 113.7non-complement FTE positions in SH-related jobs could be reduced.

Finding alternative employment for 434 FTE state employees is a manageable task, given natural turnover, other state agencies which can absorb some SH staff, and non-state employment opportunities. Of course, careful planning would be needed.

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[18]Following the 1977 Federal ICF/MR regulations. For analysis it is assumed all moderately retarded are Group B residents requiring a 1-to-2.5 staff-to-resident ratio. Some of these people will have physical or behavioral conditions which place them in Group A, requiring a 1-to-2 ratio. Thus the analysis will underestimate residential staff reductions possible.

Local Economic Impacts: Alternative 3

DI'ing 15% of the SH MRs would reduce the total SH patient population by 8%[19] and reduce overall staff needs by about 8.2% (434.5 FTE positions). This is more than the total staff at Anoka or Hastings hospitals and nearly all the staff of Fergus Falls or Moose Lake hospitals. Thus, the closing of a SH could occur with the adoption of Alternative 3. If so, and assuming remaining patients/residents were equally distributed among the remaining SHs, then the local economic impact would be localized to the one area in which a hospital is closed. Subsection 6 of this Section looks at what the direct, indirect, and mitigating effects for each of the ten SHs might be.

If, rather than closing, the populations of the eight SHs serving MRs were allowed to simply drop (Table 5.23 shows how much each SH's MR population would drop), then the effect of DI would be spread among all eight SHs serving MRs. No one local area would suffer a substantial loss, although each SH's efficiency may be lowered by running the facility even further below capacity. The direct and indirect effects could be minimal if alternative state employment in the local area were available for displaced SH employees--particularly if they were new state jobs. Effects could also be minimal for local areas in which the work force is growing: the direct and indirect job losses of Alternative 3 would be quickly absorbed.

If Alternative 3 were adopted, Regions 9, 10, and 11 would enjoy the greatest growth in community-based jobs caring for MRs. 53% of the borderline, mildly, and moderately retarded are from these three regions.

4. Alternative 4: DI all borderline, mildly, moderately, and severely retarded from SHs.

On 6/30/75, 1505 SH residents were classified as borderline, mildly, moderately, or severely retarded including 166 borderline/mild, 329 moderate, and 1010 severely retarded. This accounts for 46.2% of all SH MR residents. Table 5.26 displays the distribution by SH. Overall, 0.5% of these 1505 residents are under 5 years of age, 16.1% are between 5 and 17 years, 24.7% are between 18 and 24 years, 58.9% are between 25 and 64 years, and 2.1% are 65 years or older.

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[19]Alternative 2 represents 15% of the MR population and 8% of the total SH population.

Table 5.26

SH of Residence for Borderline, Mildly, Moderately and Severely Retarded (6/30/76)

SH	Number	% of SH's Total MR Population
Brainerd	205	38.0
Brainerd MLC	36	97.3
Cambridge	324	52.1
Faribault	415	41.8
Fergus Falls	147	49.2
Moose Lake	49	32.7
Rochester	73	45.6
St. Peter	183	68.8
Willmar	73	39.7
Total	1505	46.3

Where Would They Go?

Assuming the 1505 residents returned to their county or region of settlement, Table 5.27 aggregates, by region, where additional facilities and services would be required. DI would require a 52% increase in available CBF beds - 214 for children 0 to 17 years old and 1291 for adults. TMR programs, SWs, and DACs would have to be provided as appropriate for these MRs. Facility and program increases of this magnitude would require a careful planning and implementation process.

Table 5.27

Numbers of Borderline, Mild, Moderately, and Severely Retarded SH Residents by Region of Settlement (6/30/76)

Region	Borderline, Mild and Moderate	Severe	Total
1	20	36	57
2	15	12	26
3	47	63	110
4	42	59	101
5	29	51	80
6E	20	22	42
6W	5	17	22
7E	9	29	38
7W	19	48	67
8	26	30	56
9	54	85	139
10	55	122	177
11	154	434	588
Total	495	1008	1503[1]

[1]Plus 2 with out-of-state residence equals 1505.

Cost Impacts: Alternative 4

This alternative involves DI'ing 1505 SH MRs, including the 50 severely retarded "Cost of Care" residents; the procedure for estimating the costs involved was the same discussed for Alternative #1.

Table 5.28 presents cost estimates, with number rounded to the nearest thousand. Table 5.28 shows that, as in Alternative #1, Alternative #4 would result in federal and state government levels experiencing cost savings while local government units would experience cost increases, although overall there would be a cost savings in terms of total government spending.

Staffing Impacts: Alternative 4

The following assumptions can be used to estimate probable SH staff reductions if the 1505 borderline, mildly, moderately, and severely retarded SH residents were DI'd:

1) Figures for SH staff reductions associated with DI'ing the borderline, mildly, and moderately retarded are as calculated in Alternative 3.

2) MLC staff would be further reduced by the percent severely retarded residents are of all MLC residents.

3) Residential living staff for the 1007 severely retarded residents not in the MLC would be further reduced by a staff-to-resident ratio of 1-to-2.[20]

4) Medical and support staff would be reduced proportionately for all 1008 severely retarded residents.

5) Program staff would be reduced as follows:

   - No reduction for the 396 residents age 5 to 24 years, since they are assumed to be in the Public School TMR program.

   - Proportionate reduction for the 612 others. (612/2080 equals 29.4% of program staff.)

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[20]Following the 1977 Federal ICF/MR regulations. For analysis, it is assumed all severely retarded are Group A residents requiring a 1-to-2 staff-to-resident ratio.

Table 5.28

DI Alternative #4: Comparative Total Monthly Costs of Caring for Mildly, Moderately, and Severely Retarded Current SH MRs in the Community, by Government Level

Level of Government	Total Monthly Cost		
	Monthly SH Cost	Monthly Community Cost	Monthly Cost Difference
Federal	$1,120,000	681,000	-439,000
State	830,000	620,000	-210,000
Local	79,000	130,000	+ 51,000
Total	$2,029,000	1,431,000	-598,000

Using the five stated assumptions, Alternative 4 would result in a staff reduction of 1395 FTE positions or 26.5% of the overall staff complement. This includes 660.5 FTE residential staff, 213.4 FTE program staff, 33.0 medical staff, 431.5 FTE support staff, and 56.8 FTE MLC staff.

Using assumptions stated in Alternative 2, an approximate number of non-complement jobs (e.g., School system, CETA) affected by Alternative 4 can be calculated. This would be 367 additional non-complement FTE positions. Thus a total of about 1760 jobs caring for MRs in SHs would be no longer required.

Phasing out nearly 1400 State jobs, given a SH employee's guarantee of another equivalent State job, would require substantial planning and probably at least 2 or 3 years lead time. Previously, it was noted the development of sufficient community facilities and programs would require time. These processes should be simultaneous.

Local Economic Impacts of Alternative 4

Alternative 4 would DI slightly more than one-fourth of all SH residents and would reduce overall staff complement requirements by the same amount. Local economic effects will depend on whether one or more SHswould be closed and all others remain close to their present size, or whether all SHs would remain open with decreased populations. Subsection 6 of this Section deals with the former option, discussing aspects of closing each SH.

If the populations of all MR-serving hospitals were simply allowed to drop, Table 5.26 indicates the loss each SH would incur.

Table 5.27 showedwhere DI'd MRs would go and, thus, where community jobs will be created. As in Alternative 3, Regions 9, 10 and 11 account for the residence of 60% of the borderline, mildly, moderately and severely retarded.

5. DI and Medicaid Cost-Containment

The estimates of the probable cost impacts of our four MR DI alternatives,which we have presented thus far in this Chapter, were overall costs to the taxpayer, detailed by level of government.

These estimates included the costs of not only Medicaid, but also the other tax-supported programs provided for the retarded, such as Day Activity Centers and Sheltered Workshops. Inclusion of these total public costs was essential, since the state would continue to be responsible for services to the retarded even if they were moved from SHs to community residences. Thus the Medicaid program operates within the context of the state's overall responsibility for the mentally retarded. However, since the focus of this study is on Medicaid cost-containment, we now estimate the impacts of the four DI alternatives on Medicaid program costs only. These estimates, we repeat, are not to be construed as total savings to the Minnesota taxpayer: these overall tax savings were discussed earlier in this chapter.

To estimate Medicaid costs of community care for current SH MRs were they to be moved to the community, we compared the following:

- Current SH per diems ($45) for Medicaid recipients only (as discussed earlier), and
- Costs of only those community services which are currently Medicaid-reimbursed (i.e., LTC residential costs plus estimated costs of non-LTC services such as physician visits). Based on our findings, we assumed LTC per diems to be $15 for the mildly retarded, $20 for the moderately retarded, and $30 for the severely and profoundly retarded. Also, based on our findings, we assumed non-LTC monthly Title XIX costs to be $15 for the mildly and moderately retarded and $20 for the severely and profoundly retarded.

The estimated monthly Medicaid-reimbursed costs of community care which our study found and on which our comparative cost projections were based range from $465 to $920 per month, depending on severity of retardation. By level of government, these costs are:

Severity of Retardation	Monthly Costs By Government Level			
	Federal	State	Local	Total
Mild:	$265.05	$181.35	$18.60	$465.00
Moderate:	350.55	239.85	24.60	615.00
Severe:	524.40	358.80	36.80	920.00
Profound:	524.40	358.80	36.80	920.00

Table 5.29

Comparative Annual Cost Savings in Total Government Spending and in Medicaid Program Costs Only, for Four DI Alternatives for the Mentally Retarded, by Level of Government

Alternatives	Annual Savings[1]	
	Total Government Savings	Medicaid Savings Only
Alternative 1:		
Total Saved	$12.6 million	$17.7 million
Federal	9.9 million	10.1 million
State	4.2 million	6.9 million
Local	- 1.5 million	0.7 million
Alternative 2:		
Total Saved	1.7 million	1.7 million
Federal	1.0 million	1.0 million
State	0.7 million	0.7 million
Local	0.07 million	0.07 million
Alternative 3:		
Total Saved	4.0 million	4.6 million
Federal	2.4 million	2.6 million
State	1.6 million	1.8 million
Local	0.04 million	0.2 million
Alternative 4:		
Total Saved	7.2 million	9.6 million
Federal	5.3 million	5.5 million
State	2.5 million	3.7 million
Local	-0.6 million	0.4 million

[1]All figures have been rounded.

Table 5.29 presents our estimates of the annual cost savings, by level of government, for the four DI alternatives described earlier. The estimated monthly total government cost differences presented earlier in this Chapter have been multiplied by 12 and are presented in this table along with estimates of annual savings to the Medicaid program only. Table 5.29 reveals that if current SH MRs were moved to the community, the Medicaid program would in general realize more savings than would government programs overall, since other government programs with different funding ratios would have to pay for community services to MRs which Medicaid currently pays for in SHs but would not continue to pay for in the community. The largest difference between total annual government savings and Medicaid savings would occur under DI Alternative #1, in which all SH MRs would be moved to community residences: Medicaid alone would save $17.7 million annually, but the overall net savings to the taxpayer for all government programs would be $12.6 million because other public programs would, in some cases, have to pick up where Medicaid left off. However, $12.6 million is a substantial annual savings, in any event. This $12.6 million estimate is, of course, subject to the same assumptions and qualifications as discussed earlier in this Chapter.

6. Implications of DI

In summary, we have estimated the costs, the potential staff reductions, and the local economic impacts of four policy alternatives involving the deinstitutionalization of the SH system's mentally retarded population. We have seen that the federal level would experience the largest cost savings for each of the alternatives. The state level also would experience cost savings with the implementation of each alternative. However, we have seen that local governmental units would experience either cost savings (Alternatives #2 and #3) or cost increases (Alternatives #1 and #4). We have ascertained that within the context of our assumptions, each alternative would result in cost savings in terms of overall governmental spending.

These savings would have to be weighed against the impacts on SH staff, on local economies, and on community acceptance of new CBFs. In addition, any alternatives which suggest DI'ing additional SH residents naturally raise the issue of closing SHs. This issue has been raised before in response to decreasing patient/resident populations (in the past fifteen years, populations have declined from 16,267 residents in 1959 to 5,962 in June 1974.)[21]

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[21] DPW. Report to the 1975 Legislature - Comprehensive Plan, 12/74 P. 35.

One plan for closing SHs was advanced by DPW in its 1975 Comprehensive Plan. It called for devolving the State of direct operational responsibility for Lake Owasso Childrens Home, Hastings, Fergus Falls, Anoka, and St. Peter SHs by 1980,[22] although Hastings was the only hospital clearly recommended to be closed.

DPW's recommendation was based upon the philosophical stance that, ultimately, the State should not directly operate any residential facilities.[23] Further, the report claims, "care, treatment and educational services traditionally provided by residential facilities under the administrative direction of the Department could better be provided through community-based facilities and programs."[24]

This is based on philosophical grounds rather than empirical evidence. Our study (See Chapters III C and Chapter IV C) found no empirical evidence to support the notion that community operated facilities inherently provide better quality of care or can better administer programs.

Another reason sometimes proposed for closing SHs is that, as resident/patient populations decline, consolidation is necessary to maintain economies of scale. To allow each SH to operate below capacity is inefficient.

Intuitively, one would guess economies of scale must exist, but it is not clear in what service areas (e.g., in food preparation, in laundry, in housekeeping, in medical care, or in program) and at what resident populations these economies are achieved. Evidence of possible economies of scale in laundry processing is presented in the November 1974 Laundry Study.[25] The study projected that $777,800 of expected expenditures and 22 staff positions could be saved by closing laundry facilities in four SHs and consolidating laundry processing to four laundry centers.[26] Another study by

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[22]Ibid, P. 41.

[23]Ibid, P. 34.

[24]Ibid, P. 34.

[25]Foussard, Rossmen and Assoc. Inc. Laundry Study, Part 1 - Recommendations, November 1974.

[26]The 1975 Legislature closed laundries at three of the four recommended sites, consolidating into five laundry centers - Brainerd, Cambridge, Faribault, St. Peter and Willmar.

Ronald Conley[27] found economies of scale to exist, achieving the maximum effect at about 500 residents. Undoubtedly this would vary by SH. Even though a SH runs below capacity, staffing, program, and other residential services may be delivered efficiently if resident population is fairly stable. Whether plant services--heating, groundskeeping, etc., -- can be delivered efficiently, once again, will probably vary by SH. It is not clear how economical a policy of closing SHs would be, as opposed to a policy of keeping all hospitals open but gearing down programs and staff complement, consolidating services like laundry, and declaring as surplus any unneeded buildings. Even though evidence reviewed by this project regarding philosophical and economic reasons for closing SHs is not definitive, policy planning must address the future of our large, state-operated LTC institutions (the ten SHs and two state nursing homes).

Should they all be kept open? If so, can a desirable staff mix and quality of care be assured? Is closing some institutions, possibly consolidating residents, the answer? If so, which facilities should be closed, using what time table, and with what step-by-step plan? Would some decrease now, with later closing of some institutions, be the answer? Also, at what point do we stop decreasing and start closing? Should the State be moving towards divesting itself of operational responsibilities for these institutions? Are they best funded by the State but operated privately or by another public agency?

The balance of this section examines the issues of reducing and closing state facilities. No assumption is made as to which facilities should be closed, so information is, of necessity, general in nature.

a. Implications of DI for Staff of SHs

Once a decision to shut (or substantially phase down) a state institution(s) has been made, a primary consideration is what to do with the institutions's surplus staff. In its 1975 session, the Minnesota State Legislature

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[27]Conley, Ronald. "The Economies of Mental Retardation," 1973.

guaranteed that no state employee would lose his/her job as a result of closing an institution.[28] The legislature guaranteed transfer to other state institutions or reemployment in another state job at no loss in pay. Further, the State would pay any moving expenses incurred.

Even so, if an institution closes, many staff would be unwilling to move. These people would have to find alternative employment in the local area. This might include employment in a community residential facility, community service agency, or a community health program.

Experience of Other States

The experience of other states reveals that the process by which staff are handled is critical.

For example, when Massachusetts closed Grafton State Hospital,[29] it allowed a two year close-out period. During that time, it conducted tours of possible transfer facilities, seminars for employees to talk out their concerns, group counseling, and state-funded training and re-training of staff. Similarly, when Cleveland State Hospital (CSH) was closed, "the hospital administration drew staff into decision-making roles on both their own and their patients' behalf."[30]

Staff problems in closing CSH were minimized by the fact that four other state institutions were in the metropolitan area and transfer did not usually require moving.

The closing of DeWitt State Hospital in California provides an example of less than successful closing. A study by the Stanford Research Institute[31] indicated that lack of information led to uncertainty and confusion on the part of staff. The ever-present possibility that the

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[28]Session Laws of the State of Mn. Sixty-ninth Legislature - 1975 Regular Session. Chapter 434 Section 21,23.

[29]"State Hospital in Transition - Impact on Staff." Currents, Summer 1975. P.5.

[30]Ibid P.3.

[31]Weiner, Samuel, Barbara Bird and Arthur Bolton Associates, Process and Impacts of Closing De Witt State Hospital, Stanford Research Institute, 1973.

county would take over the hospital contributed to two responses -- denial and anxiety.[32] Many employees refused to accept the fact that the hospital was closing -- even after they received their 60 day notice, and most reported they were anxious and depressed over the possibility of moving, loss of income, disruption to families, and so on. Their feelings were not alleviated by the hospital administration which, in employees' opinions, did not have adequate information on transfer procedures or transfer options. Further, the hospital administration/staff communication was poor. In such an environment, considerable staff time was spent discussing rumors rather than caring for patients. Dewitt's ultimate resolution -- closing with no county take-over, resulted in hard feelings by many staff.

The most frequent employee-suggested change, for future closings, was that there be decisiveness in initiating the closure.[33]

Psychiatric Technicians and older workers with less than 10 years to retirement were cited by the DeWitt study as two groups most adversely affected by closure. Of Psychiatric Technicians, the study concluded "(the) position is unique to California, and the pay scale is too high, relative to formal educational background, for psychiatric technicians to easily get positions outside the Department of Mental Hygiene with equivalent pay. This is especially true for female psychiatric technicians..." [34]

Frequently, state hospital closings are coupled with the development of community based facilities. These facilities, including residential and non-residential care, are alternative placements for patients and staff. Reports on the closing of Grafton State Hospital noted two problems with this option: attitudinal and monetary.[35] Often staff have trouble adjusting to the 'community philosophy' and require retraining to learn and adapt. Further, in Massachusetts, state employees were generally better paid than community

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[32]Ibid. P. 83.

[33]Ibid. P. 91.

[34]Ibid. P. 93.

[35]"State Hospitals in Transition", P. 5.

facility staff with similar jobs.

Application to Minnesota

The inconveniences to staff of shutting a state institution should not be minimized. Staff were not hired with the assumption they might be transferred and, in particular, moved. Many have employed spouses and/or children in school. Relocation could cause considerable upset. By guaranteeing another equivalent job and reimbursement for moving expenses, the state has tried to minimize financial losses. A potential uncovered financial loss would be loss of a spouse's income. By allowing State agencies to exceed their authorized complements to accommodate displaced institutional employees, the State has tried to make sure that as many staff as possible can stay in their locality (if other branches of government exist there) or move to a location of choice.

If a state institution were to shut, the State could also make efforts to re-employ in the community employees not wishing to move. One would anticipate the development of community facilities in the hospital's receiving district to care for residents not transferred to another state hospital. These new community facilities could be potential employers of former state hospital staff. Perhaps the state could even find a way to guarantee jobs, by public ownership of some small group-home-type facilities.

Salaries

One problem with employing state employees in community facilities, cited earlier, is that community employees are paid less. In Minnesota, evidence that this does exist can be obtained by pulling together data from several sources. This is displayed in Table 5.30. One set of information missing and not obtainable is data on the salaries paid in CBFs and group homes for the mentally ill and chemically dependent. However, the comparison with average salaries paid acute care hospital employees, nursing home employees, and employees of Day Activity Centers substantiates

Table 5.30

Average Monthly Salaries: State Civil Service vs Other Comparable Settings by Job Title

Job Title	State Civil Service Salary[1]	Median Nursing Home Salary[2]	Median Acute Care Hospital Salary[3]	Average DAC Salary[4]
Nurse General[5]	$855[6]	$780	$871	-
Head Nurse	935[6]	-	986	-
Nurse Director	1408	-	1025	-
LPN	703	581	610	-
Dietition (Chief)	1113	1247	1041	-
Cook	627	421	453	-
Janitor	702[6]	470	574	472
Exec. Housekeeper	914	477	525	-
Stationary Engineer	994	-	993	-
Laundry	580	390	-	-
Switch Board Operator	590	435	501	-
Psych Tech	652[6]	-	633	-
PT	1258[6]	1131	967	984[7]
PTA	727	549	595	-
OT	915	520	914	984[7]
COTA	727	-	600	-
Social Worker I	914	-	900	-

(continued)

(Table 5.30 continued)

Job Title	State Civil Service Salary[1]	Median Nursing Home Salary[2]	Median Acute Care Hospital Salary[3]	Average DAC Salary[4]
Social Worker II	1227[6]	-	1294	-
Teacher (Certified)	1024	-	-	749
Teacher (Not Certified)	766	-	-	791

[1]From Minnesota State Civil Service Salary Schedule effective 3/1/75. In classifications with an odd number of steps we used the salary of the middle step. For those with an even number of steps we used an average of the two middle steps.

[2]Source: 1975 Minnesota Salary Survey: Hospitals and Nursing Homes by District, Mn Dept. of Employment Services - Research and Planning Branch. Surveyed 414 nursing homes employing ten or more persons (95% of population).

[3]Source: Same as 2. Surveyed 173 general hospitals, four federal hospitals, and the Mayo Clinic.

[4]Source: Mn. Day Activity Center Association; DAC Salary Report 1975-76. Data obtained from 1975 grant application.

[5]RN not a requirement.

[6]Includes the average of two or more civil service classifications.

[7]Salary represents a category called "Therapists" - includes physical, occupational, vocational, and recreational therapists.

the viewpoint that, by and large, civil service has higher wage levels than acute care hospitals, nursing homes, or DACs. One general exception is that professionals employed by all hospitals (nurses, dietitians, social workers, and OT's) can obtain fairly comparable salaries in acute care hospitals.[36] Substantial differentials exist in the support categories - cooks, janitors, laundry, and housekeeping staff. It would appear that civil servants in these categories are much better paid than their non-civil service counterparts, but before definite conclusionscan be made, it would be necessary to substantiate an assumption which we were forced to make in the absence of readily-available information, namely that the median step in a civil service job classification accurately represents the average salary actually paid individuals in the classification. This would lead to the tentative conclusion that professionals would be more likely to find equivalent paying jobs than non-professionals in the same industrial sector. Non-professionals have skills that could be used for re-employment outside the hospital/institutional care industry. The potential for such would depend on the local employment picture. For many, the maintenance of a job of equivalent pay will require transfer within the State system.

Experience of Owatonna and DPW Survey

Anticipating institutional closings, DPW undertook a survey of some state hospital staff in 1975. This and the decisions of staff when Owatonna State School shut, provide indications of options staff would choose if an institution closed. When Owatonna State School shut, 100 of the employees transferred, 30 retired, and 20 found alternative non-state employment.[37] State funded training was available as needed. Of those transferring, 86 stayed in DPW and 14 transferred to another state agency. Owatonna is located sufficiently close to Faribault (17 miles) for staff to commute. However, none of the remaining 10 SHs could be considered within commuting distance of each other (considering 25 miles or less as commuting distance).

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[36]Two exceptions are the nursing director and physical therapist.

[37]Memo from W. Restad to G. Perpich, Chairman, Special Subcommittee HCC-Institutional Closing - 2/10/75.

Surveys conducted by DPW in 1975 indicated 33% of Hastings staff and 36% of Lake Owasso staff were interested in transfers.[38] The possibility of employment in the veterans hospital in Hastings' case and a county run facility in Lake Owasso's case may make this an underestimate. A survey of the Minnesota Security Hospital staff found 88.5% of the staff would be interested in continued employment if the Security Hospital were simply turned over to the Department of Corrections and remained in St. Peter, but only 42.5% would be interested if the security hospital were relocated.

Based upon this information, it is hard to predict how many employees would ultimately seek a transfer if a state institution were closed. Would it be the 33%-42% indicated by Hastings, Lake Owasso, and the Minnesota Security Hospital or would it be 67% as indicated by Owatonna? The answer probably is that it depends on the alternatives. For hospital/mental health professionals, Human Services Technicians, and other direct care staff, most would probably prefer employment in community residential facilities, general hospitals, community mental health centers and other health-related employment settings at the same salary level (or a slightly reduced salary level). If such employment were not available, then transfer to another state institution would be chosen. For other staff (indirect care), the first choice would probably be a transfer to another state job in the same locality (e.g., a Highway Department office). If that were not available, individual circumstances and other local employment opportunities would determine whether transferring within the state system or leaving state employment would be chosen.

If the findings from closing DeWitt State Hospital hold true in Minnesota, older employees and those in the Human Services Technician classification (psych. tech.) would be the hardest to reemploy in non-state hospital jobs. They would also be largely non-mobile, secondary breadwinners or settled--not wanting to move, or close to their retirement. A survey by the Minnesota Department of Employment Services[39] of all general and federal hospitals in Minnesota and the Mayo Clinic found only 407 employees classified as psychiatric technicians. By contrast,

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[38] Ibid.

[39] Minnesota Department of Employment Services, 1975 Minnesota Salary Survey: Hospitals and Nursing Homes, by District.

the ten state hospitals employ 2206 persons in the four-step Human Services career ladder.[40] It should be noted that 170 of this number are classified as Human Service Specialists. HSS's include Physical Therapy Assistants (PTA's), Recreational Therapy Assistants, Social Work Assistants, Teachers Aides and others with Associate-type degrees. Since these people have formal training, the questions of alternative employment may be similar to other skilled staff. However, all HSS's represent only about 8% of those in the Human Services ladder. For the others, alternative employment at comparable pay may be a problem - particularly in rural areas.

Summary

Closing one or more state institutions will cause hardships on some staff, even though another job of equal pay in the State System and relocation expenses are guaranteed. The experience of other states indicates these hardships can be mitigated by:

- A clear decision to shut the institution and a known phase-out timetable.
- Careful planning for staff, which involves staff directly, and open communication.
- Training/retraining, at state expense, for staff seeking it.
- Assisting staff seeking employment outside the state system, possibly by contracts with potential employers.
- Giving special attention to older employees, (offering early retirement options) and to those in the Human Services career ladder.

b. Implications of DI for Local Economies in SH Communities

When an SH is closed, presumably former residents will need care in another SH or in a community setting. Thus, overall, neither the number of residents, the kinds of residents, nor the total amount of money spent on residential care in the State will probably change dramatically. However, where the jobs are and where the money is spent may well change. Thus, one of the main impacts of closing state institution(s) is on the local economic market.

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[40] Data from reported 4/1/76 authorized staff complement.

Local impacts include the loss of money that state institution employees would spend in the local area, loss of money the institution would spend, and loss of money patients would spend. These are direct economic losses. In addition, community jobs generated to service institutional employees and patients will be lost. Such losses are indirect economic losses. The sum of direct and indirect losses would be the total economic loss to the local community.

Losses may be mitigated or eliminated by growth in other industrial sectors. The first paragraph assumed former state hospital residents could be cared for in community facilities; this would create jobs. Another industry may come in to take over the SH's campus. Or another industry may enter the local market. To consider all these possibilities, weighing their effects, would require extensive primary data collection and a case study of each institution.

Analysis of this sort is beyond the scope of this project and probably would be warranted only if a policy decision had been made to shut one or more institutions, and the only question was, "which one(s)?"

Questions that such an analysis would address include:

1. What are the direct economic losses? Where and how do SH employees spend their money? How much of SH payroll is spent in the local area? What items are purchased in the local area? What is purchased outside the local area? What about the hospital itself and patients?

2. What are the indirect economic losses? How many non-state community jobs might be lost? What impact would this have on the local economic sector?

3. What is the overall economic industrial picture for the local area? Unemployment rates? Industrial growth? How large a role does the SH play in the local economic sector? Does it employ a fraction or a substantial portion of the local areas's labor force?

4. What might be the overall economic impact of closing state institutions?

Secondary data sources can be used to address these questions, and are sufficient for providing general estimates about the ten SHs and two state nursing homes and their communities, as we attempt to do in this section.

A Note on the Local Economic Unit

Secondary data sources generally use the county as their reporting unit. Thus, the state institution's host county will be considered the local economic area. It might be argued that this may not always be appropriate: for those hospitals in the Twin Cities SMSA (Anoka and Hastings), it could be argued the entire SMSA should be considered the local economic area. When the city in which a state institution is located borders on two counties, as St. Peter does, one might argue that both counties should be considered. It could be argued that the city, not the county, is the local area. However, once again, county is the unit used by secondary data sources. Adjustments or qualifications in the analysis will be made as necessary.

1. What are the direct economic losses?

   Table 5.31 displays the payroll of each SH and the two state nursing homes. For FY 1976, the legislature authorized complement of 5318 FTE state hospital positions and 610 FTE state nursing home positions. This means the average salary paid a FTE employee was $11,302 per year; $11,435 for SH employees and $10,164 for state nursing home employees.

   However, total payroll would be an overestimate of direct economic losses to the local community because some portion of the payroll is spent outside the local area. Two determinants of this amount are:

   1) Where state institution employees live, and

   2) Where state institution employees shop.

   Where they live

   Some employees will commute to the institution from other local economic areas, for example, some Faribault State Hospital staff may commute

Table 5.31

F Y. 76 Payroll for Ten Minnesota SHs and Two State Nursing Homes[1]

State Institution	Payroll Costs (in millions of dollars)
Anoka	$4.3
Brainerd	7.1
Cambridge	6.8
Faribault	10.8
Fergus Falls	5.3
Hastings	2.6
Moose Lake	4.6
Rochester	6.5
St. Peter	6.9
Willmar	5.9
Ah-Gwah-Ching	2.9
Oak Terrace	3.3
Total	$67.0

[1]The two Braille and Sight Saving Schools and the Regional Library for the Blind are excluded.

from Owatonna. Their salaries will be taken and presumably spent outside the SH host county's economic area. Thus, the local economic loss caused by eliminating the job of the person who lives in Owatonna but works in Faribault would be felt in Steele County (Owatonna's county), not Rice County (Faribault's).

Table 5.32 displays what percent of each institution's employees live in the institution's host county. As an additional measure the percent of staff living within fifteen miles of the institution is also shown. This latter measure represents an alternative way to measure where staff would spend their salaries. It assumes that if staff live within 15 miles of the institution, no matter the county, they will spend in the institution's local economic area. Table 5.32 shows that, for each institution, the two measures give similar[41] indicators, with the exception of St. Peter, Moose Lake, and Anoka. For all three exceptions, the SH town borders on two counties. Those staff living just east of St. Peter will live in LeSueur county, those living just south of Moose Lake will be in Pine County, and those south and west of Anoka will be in Hennepin County. Anoka, Moose Lake and St. Peter should probably be considered separately. For these cases, the percent living within 15 miles will probably give a truer picture of what the local economic losses to the institution's host county will be.

For all institutions except Anoka and Cambridge, at least three-fourths of the staff either live in the SH's host county or within 15 miles of the institution. For those with three-fourths or more, the direct economic losses would be felt almost entirely by the state institution's local economic area. At Anoka, 35% of the staff live in other Metropolitan counties. For Cambridge staff, 11% come from Metropolitan counties and 29% from five other counties adjacent to Isanti. For these latter two state hospitals, direct economic losses would be diffused, being felt in several counties.

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[41] We consider similar to be within ten percentage points of each other.

Table 5.32

Proximity of Home to Work for State Institution Employees[1]

Institution	Total Number of Staff[2]	% Living in Host County	% Living within 15 miles of institution
Anoka	334	55.4	67.7
Brainerd	672	90.3	81.8
Cambridge	693	59.0	56.9
Faribault	977	81.3	86.3
Fergus Falls	506	95.7	86.5
Hastings	201	75.1	66.7
Moose Lake	428	61.2	78.5
Rochester	544	86.9	85.1
St. Peter	581	58.9	86.2
Willmar	555	96.0	96.4
Ah-Gwah-Ching	301	73.1	77.1
Oak Terrace	351	89.1	81.7

[1]Data for this table were obtained from a DPW survey of the institutions in October, 1976.

[2]This is the actual number of part and full-time staff members, not FTE complement employees.

Where they shop

Even though SH employees live in or close to the host county, they may spend substantial portions of their incomes outside the local area. In the extreme, it is possible that no more than day-to-day groceries are purchased in the local area. Cars, clothes, food stuffs, appliances , furniture, and even a house mortgage may be purchased from a close-by regional or metropolitan shopping center. Intuitively, one might guess that the larger Twin Cities shopping area would affect expenditures of Hastings, Anoka, and Cambridge staff; Mankato would affect St. Peter; and Duluth would affect Moose Lake.

Once again, without primary data collection, exact patterns cannot be determined. However, data from the Bureau of Labor Statistics on the expenditures of an average four-person family can be used to determine ranges, as follows:

If it is assumed that SH employees purchase only food eaten at home, and shelter, in the local area, this would account for between 31% and 44% of total family income, depending on the family's location (Twin Cities SMSA or non-metropolitan)[42] and income (low, intermediate, high).[43]

If, at the other extreme, SH employees were assumed to spend their entire income, excluding taxes, in the local area, this would account for between 74% and 86% of total family income. Thus, depending on where alternative shopping opportunities are located, between 31% and 86% of the payroll could be direct economic losses to the local community.

Table 5.33 combines the two indicators -- where

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[42]Non-Metropolitan includes all cities in the North Central Region with populations between 2,500 - 50,000.

[43]Low budget income is $9593 for Twin Cities, $9187 for non-metro; intermediate budget is $15,709 for the Twin Cities, $14,022 for non-metro; high budget is $22,993 for TC, $18,741 for non-metro. The average SH salary ($11,435) falls between the low and high. However, many employees may come from families with more than one wage earner. Thus, SH employees' family income could fall in any category.

Table 5.33

Direct Dollar Loss to Local Economic Area If State Institution Payroll were Eliminated[1]

Institution	Direct Dollar Loss in Millions		
	Low Estimate[2]	High Estimate[3]	100%[4]
Anoka	0.9	2.5	2.9
Brainerd	2.0	5.5	6.4
Cambridge	1.2	3.4	4.0
Faribault	2.9	8.0	9.3
Fergus Falls	1.6	4.4	5.1
Hastings	0.6	1.8	2.1
Moose Lake	1.1	3.0	3.5
Rochester	1.8	4.9	5.6
St. Peter	1.8	5.1	6.0
Willmar	1.8	4.9	5.7
Ah-Gwah-Ching	0.7	1.9	2.2
Oak Terrace	0.9	2.5	2.9

[1]Estimates derived from Table 5.31 (payroll) and Table 5.32 (percent of staff living within Host County or 15 miles).

[2]Low Estimate = .31 x (payroll) x (percent living in host county or percent living within 15 miles, whichever is higher).

[3]High Estimate = .86 x (payroll) x (percent living in host county or percent living within 15 miles, whichever is higher).

[4]100% = 1.0 x (payroll) x (percent in county or 15 miles).

state institution residents live and where they shop -- to calculate some estimates of what the direct economic losses to the institution's local economic area would be if the state institution were closed. In reading the estimates, one would be more likely to pick the high estimate if one believed staff spent most of their income in the local area. For instance, in Willmar, if it was believed most staff spent their income in the local area, the $4.9 million figure would be used. If, on the other hand, one believed Willmar staff spent substantial portions of their income in other counties (say in adjacent Meeker county), then one would pick a lowerfigure closer to the $1.8 million figure.

The Stanford Research Institute's study of closing California's DeWitt State Hospital[44] did solicit from employees information on where major commodities (food, clothing, applicances, furniture, and automobiles) were purchased. Other items (personal care, housing, travel, medical care, recreation, and education) were assumed to be purchased in the local area. Based upon this information and estimation of taxes, the study found $4.8 million of the $7.2 payroll[44] (66.7%) was spent in the local area. While there is no reason to believe that the DeWitt findings are applicable to Minnesota, the study does give an indicator.

Other direct losses

The DeWitt study found that the amount spent by the hospital and patients in the local area was small; the hospital received most of its supplies through a central service. Minnesota's SHs are similar in this respect. Estimations showed the hospital spent $174,000 per year in the local economic area and the patients $204,000. When compared with the estimated payroll expenditures, it is a small percentage (one-half of one percent in DeWitt's case).

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[44]Stanford Research Institute. "Process and Impacts of Closing DeWitt State Hospital." P. 109.

Data just presented are suggestive of considerations which may affect where SH employees spend their salaries and how much money is spent by the hospital and its patients in the local economic area. While nothing definitive can be concluded, it is clear that total SH payroll or total SH budget will considerably over-estimate the local economic loss. Depending on where the SH is located and where alternative shopping opportunities are located, it is estimated between 31% and 86% of the payroll (seen in Table 5.31) going to employees living in or close to the host county (seen in Table 5.32) would be lost to the local economic area. The ranges represented are shown in Table 5.33.

Adding a small amount representing hospital and resident expenditures in the local area would yield the total income loss to the local economic area.

The reader is cautioned that these figures are merely suggestive. Primary data collection, noting where institutional employees spend their salaries, would be required for a true picture.

2. What are the indirect effects on a local economic area of closing a SH?

The local effect of lost income is greater than just the income itself. A dollar spent by the hospital, its employees or residents goes to someone else who spends it again and so on, or, to use economists' jargon, the original dollar has a "multiplier effect" on the generation of additional community income.

Without knowing more precisely how much is spent in the local area by employees, the hospital, and patients, the indirect income effects or "income multiplier" cannot be measured. Alternatively, however, a technique using employment figures to calculate an "employment multiplier", can be used.[45] This

[45] The SRI study of DeWitt considered an employment multiplier to be more useful than an income multiplier. p. 112.

would tell us, for each SH job eliminated, how many additional jobs in the community could be lost. The first step in determining an employment multiplier is the calculation of a location quotient.[46] The location quotient (L.Q.) assumes each industry in an area can be classified as either a basic or service industry. Basic industries produce more goods or services than can theoretically be used in the local area; thus they can be thought of as exporting their product. It is these industries which determine the growth or decline of an area. Service industries exist as consequences of employment in the basic industries. Comparison of local to national employment is used to determine basic and service industries. If the local area employs a greater percent of its labor force in Industry X than the nation as a whole, the local area is thought to be exporting the product and it is considered "basic." If the local area employs a lesser percent of its labor force in Industry X than the nation as a whole, the industry is considered "service."

The exact ratio used is:

$$\text{Location Quotient ("L.Q.")} = \left[\frac{\#\text{ persons employed in Industry X in the area}}{\#\text{ total persons employed in the area}}\right] \div \left[\frac{\#\text{ persons employed in Industry X in USA}}{\#\text{ total persons employed in USA}}\right]$$

If the resultant ratio is greater than 1, Industry X is considered basic. If the ratio for Industry X is 1 or less, it is considered a service industry.

The second step, once location quotients for all industries are calculated, is to determine the total number of people employed in basic industries and divide this figure into total county employment.

[46]Techniques for calculation are those used in "The Employment Impact of Reserve Mining Company on the Arrowhead Region of Northwest Minnesota plus Douglas County, Wisconsin". by Wayne A. Jesswein and Richard Lichty (undated). This same technique is also used in "Utilizing Economic Base Theory to Determine the Economic Impact of Closing the (Fergus Falls) State Hospital," by Marilyn Moen and David Aanes, Dec. 1974.

Employment Multiplier ("E.M.") =

[# people employed in area] ÷ [# people in area employed in basic industries]

If the resultant employment multiplier is 1.5, it would mean that for each basic industry job, .5 additional jobs are created in the local area. The reverse logic can be used for each basic industry job lost.

The advantages of this approach are that it uses secondary data sources and it is relatively simple to calculate. A study of the impact of Reserve Mining on the Arrowhead Region calls calculation of an employment multiplier "a speedy method available by which reasonably accurate results can be obtained in the short run."[47] The technique is not without its drawbacks: it is a static measure, determining only short-run immediate effects;[48] it does not consider potential growth in other industries, for example, closing state hospitals will create jobs in community facilities; it assumes that the employment picture in the area under consideration is similar to the nation as a whole; and it assumes that the local aggregate picture of an industry is representative of all firms. Without accommodating for local deviations, an overestimate of service employment can result.[49]

The employment multiplier for the host county of each state institution is presented in Table 5.34. Employment multipliers for the Minnesota state hospital and state nursing home host counties range from 1.4 to 2.0.

The previously-cited DeWitt Hospital study states that employment multipliers usually range from 1 to 2, varying by the local situation;[50] in general, 1.5 is considered

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[47] Jesswein and Lichty, p. 9.

[48] Ibid. p. 8. Also see Isard, Walter, Methods of Regional Analysis: An Introduction to Regional Services, p. 199-203

[49] Isard, p. 196.

[50] SRI, p. 111.

'average'.[51] The ratios generated in Table 5.34 conform to these norms and ranges.

To calculate local jobs lost, the number of each institution's employees living in the host county can be multiplied by the employment multiplier. Table 5.35 presents this information.

Another indirect effect of the loss of jobs, which is mentioned but not calculated, is loss of tax revenue. Not only do residents pay local property taxes, but state and federal revenues returned to the local area are often dependent on the amount the area pays in originally.

3. What is the local economic area's overall economic picture?

Table 5.36 displays two indicators of a local area's economic picture: growth in labor force over the past six years and present unemployment rate.

In six of the host counties (Isanti, Otter Tail, Olmsted, Nicollet/Blue Earth/LeSueur, Kandiyohi, and Cass) the labor force has expanded more than the state average. Only one county, Carlton, had a growth rate considerably below the state average.

Seven of the host counties had unemployment rates below the state average for July 1976--Crow Wing, Rice, Otter Tail, Olmsted, Blue Earth/Nicollet/LeSueur, Kandiyohi, and Cass. Anoka and Hennepin counties' unemployment rates are considerably above the state norm.

This information would indicate that five host counties (Otter Tail, Olmsted, Nicollet/Blue Earth/LeSueur, Kandiyohi, and Cass) have been able to keep unemployment rates below the state average while their labor forces have expanded faster than the state average. On this basis, one would assume industry in these areas is expanding. New jobs are being created and in-migration has probably occurred. Two

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[51]Ibid. p. 111, and personal conversations with Fred Post.

Table 5.34

Employment Multiplier for Each State Institution's Host County

Institution & (County)	Employment Multiplier
Anoka (Anoka)	1.9
Brainerd (Crow Wing)	1.4
Cambridge (Isanti)	1.4
Faribault (Rice)	1.7
Fergus Falls (Otter Tail)	1.5
Hastings (Dakota)	2.0
Moose Lake (Carlton)	1.8
Rochester (Olmsted)	1.6
St. Peter (Nicollet)	1.9
Willmar (Kandiyohi)	1.6
Oak Terrace (Hennepin)	1.4
Ah-Gwah-Ching (Cass)	1.5

Table 5.35

Estimate of Local Jobs Lost Using an Employment Multiplier

Institution & (County)	A Multiplier	B # Employees Living in or close by Host County[1]	Jobs Lost to Host County (A x B)
Anoka (Anoka)	1.9	226	429.4
Brainerd (Crow Wing)	1.4	607	849.8
Cambridge (Isanti)	1.4	409	572.6
Faribault (Rice)	1.7	843	1433.1
Fergus Falls (Otter Tail)	1.5	484	726.0
Hastings (Dakota)	2.0	151	302.0
Moose Lake (Carlton)	1.8	336	604.8
Rochester (Olmsted)	1.6	473	756.8
St. Peter (Nicollet)	1.9	501	951.9
Willmar (Kandiyohi)	1.6	535	856.0
Oak Terrace (Hennepin)	1.4	313	438.2
Ah-Gwah-Ching (Cass)	1.5	232	348.0

[1]Used numbers living in host county or number living within 15 miles, whichever is greater (from Table 5.32).

Table 5.36

Growth in Labor Force 1970-76 and Unemployment Rates for Host County of Each Institution[1]

Institution & (County)	Increase in County Labor Force 1970 - 1976	1976 Increase as a Percent of 1970 Labor Force	July 1976 Unemployment Rate
Anoka (Anoka)	11,868	19.6	6.8
Brainerd (Crow Wing)	2,002	16.8	4.6
Cambridge (Isanti)	2,244	37.5	5.4
Faribault (Rice)	3,085	19.0	4.0
Fergus Falls (Otter Tail)	6,903	40.9	4.4
Hastings (Dakota)	10,148	18.5	5.1
Moose Lake (Carlton)	933	9.4	5.1
Rochester (Olmsted)	9,407	26.1	2.8
St. Peter (Nicollet/ Blue Earth)	8,144	26.2	3.1
(LeSueur)	2,831	36.3	4.4
Willmar (Kandiyohi)	4,494	38.2	3.7
Oak Terrace (Hennepin)	89,626	20.0	7.2
Ah-Gwah-Ching (Cass)	3,427	65.8	3.7
State Total	352,990	23.1	5.0

[1]Data Sources: July 1976 statistics from estimates of the Mn. Dept. of Employment Services and 1970 Census Data.

counties, Rice and Crow Wing, have unemployment rates below the state average, but their labor forces have grown at less than the state average. One county, Isanti, has a labor force expanding faster than the average but unemployment is high. Industry has not expanded fast enough to meet the growing labor market. Finally, the metropolitan counties, Dakota, Anoka and Hennepin, along with Carlton county, have labor forces with growth rates below the state average and unemployment rate slightly above the state average. Out-migration is probably occurring in these counties.

How big an employer is the state institution?

The first column of Table 5.37 displays the percent all SH and state nursing home employees living in the county or within 15 miles of the SH represent of the county labor force. The second column of Table 5.37 shows the total percent of the county labor force which would be affected by an institutional closing ((Employees living in host county or close by, x employment multiplier)/ county labor force). From Table 5.37 it can be seen that the two SHs and one nursing home in the Metro area account for a small percent of the county labor force. For others, the range is from a low of 1.1% in Olmsted county to a high of 5.0% in Isanti county.

When the employment multiplier is applied, between 1.7% and 7.4 % of a host county's labor force in non-metro areas is affected. If no new employment were to occur in the local area, this would represent the percent decline in the labor force due to the state institutions closing. Since state employees are guaranteed another state job (if they are willing to transfer), it would not be appropriate to add this percent to each county's unemployment rate to get a projected unemployment rate if the institution were to close. However, the lost jobs represent a real loss of employment opportunity in the county.

Non-state jobs lost could add to the un-

Table 5.37

Percent State Institutional Employees Are of County Labor Force and Estimated Percent of Total County Labor Force Affected if Institution were Closed[4]

Institution & (County)	Employees/ Labor Force[1]	Job Affected[2] Labor Force
Anoka (Anoka)	0.3	0.6
Brainerd (Crow Wing)	4.4	6.1
Cambridge (Isanti)	5.0	7.0
Faribault (Rice)	4.4	7.4
Fergus Falls (Otter Tail)	2.0	3.1
Hastings (Dakota)	0.2	0.5
Moose Lake (Carlton)	3.1	5.6
Rochester (Olmsted)	1.1	1.7
St. Peter (Nicollet)	1.3[3]	2.4[3]
Willmar (Kandiyohi)	3.3	5.3
Oak Terrace (Hennepin)	0.06	0.08
Ah-Gwah-Ching (Cass)	2.7	4.0

[1]Employees living in host county or within 15 miles.

[2]Number of Employees times employment multiplier.

[3]As a percent of Nicollet plus Blue Earth counties' labor force.

[4]Data Source: Information from Bureau of Residential Services and Mn Dept. of Employment Services.

-employment statistics. In addition, some SH employees unwilling to transfer will not be able to obtain another state job in the local area and may add to unemployment statistics.

Summary

Direct local economic losses of shutting a state institution are the money employees, patients, and the hospital spend in the local economic area. The amount spent by patients and the hospital is minimal; the amount spent by employees will be a percentage of the total institution's payroll. Many factors -- where employees live, where they shop, their family income level -- will determine what the percentage actually is. This analysis determined the minimum percentage to be about one-fourth of the payroll and the maximum about three-fourths of payroll.

Indirect economic losses of shutting a state institution depend on the local industrial picture. Statistical techniques to estimate indirect losses from secondary data sources indicate that, depending on the local area, between .4 and 1.0 additional jobs would be lost for each lost state institution job in Minnesota.

The sum of direct and indirect losses gives the absolute economic loss to a local area. Because the payroll associated with indirect jobs cannot be determined in this analysis, direct plus indirect losses must be measured in jobs lost. However, the relative loss will depend on what percent of the local labor force the state institution employs, the area's overall economic picture, and other alternative employment in the local area. Table 5.38 summarizes four indicators -- an estimate of local jobs lost if any of the state hospitals or state nursing homes closed, the percent those jobs represent of the county labor force, current unemployment rates, and labor force growth between 1970 and 1976. Table 5.38 showsthat institutions in the metro area (Anoka, Hastings and Oak Terrace) employ a small percent of the total labor force. However, the metro area has a higher unemployment rate and less growth in their labor force than the state average.

Table 5.38

Summary of Indicators of Local Economic Effects

State Institution	Estimate of Direct and Indirect Jobs Affected	Direct and Indirect Jobs as a Percent of Labor Force	Unemployment Rate	1970-1976 Percent Increase In Labor Force
Anoka	429.4	0.6	6.8	19.6
Brainerd	849.8	6.1	4.6	16.8
Cambridge	572.6	7.0	5.4	37.5
Faribault	1433.1	7.4	4.0	19.0
Fergus Falls	726.0	3.1	4.4	40.9
Hastings	302.0	0.5	5.1	18.5
Moose Lake	604.8	5.6	5.1	9.4
Rochester	756.8	1.7	2.8	26.1
St. Peter	951.9	2.4[1]	3.1	26.2
Willmar	856.0	5.3	3.7	38.2
Oak Terrace	438.2	0.1	7.2	20.0
Aw-Gwah-Ching	348.0	4.0	3.7	65.8
	7776.2	3.4	5.0[2]	23.1[2]

[1]As a percent of Nicollet and Blue Earth Counties.

[2]Figures are an average for the State, not just the local economic areas in the Table.

Other insitutions are most frequently located in medium-sized towns in rural areas where the institution employs a substantial percentage of the work force. St. Peter, Willmar, Ah-Gwah-Ching, Rochester, and Fergus Falls are all located in economic areas with lower unemployment and more rapid labor force growth than the state average. In these areas, those jobs indirectly lost would probably be quickly regained as other labor force jobs were created, or alternative employment would be available since unemployment is low. For Brainerd and Faribault with a substantial portion of the labor force affected and labor force growth below the state average, considerable local economic hardship would probably result from an institutional closing. For Cambridge and Moose Lake, with above average unemployment and below average growth, the relative local economic losses would probably be most severe.

The statistics presented in this section are 'static,' i.e., they assume that alternative employment does not currently exist and that no new firms will enter the local market to absorb some of the effects of job loss. Yet part of the assumption of closing SHs is that more community alternatives will develop to handle former residents. Some of these could be in the host county of the closed facility or close-by. Table 5.36 showed several counties had work forces expanding faster than the state average. Such situations may be able to absorb the effect of an institutional closing in a relatively short time. The possibility of another firm taking over the facility (as the Veterans Home is scheduled to do for part of Hastings) might absorb the loss of the state institution and even create new jobs. Finally, the state might aggressively recruit an industry to the area to replace the loss of the institution.

The purpose of this section was not to suggest which state institution(s) ought to be closed. It simply presents information which is of use when considering the local economic impacts of shutting a state institution.

c. Implications of DI: Community Acceptability

An important factor in DI is the attitude of persons affected by the system, but not directly involved in the provision of services. For instance, a DI alternative could be more or less feasible politically, and more or less acceptable to consumers, provider groups, and communities.

Factors which might influence community acceptability of CBFs should be identified. The rapid growth of CBFs in recent years has intensified the possibilities for conflict. Planners and decision makers need to be aware of possible areas of resistance on the part of the community. A study[52] of the neighborhood impacts of 46 Twin Cities CBFs found four major reasons for neighborhood opposition:

1. property values and economic reasons,

2. land use compatibility reasons,

3. quality of life/neighborhood compatibility reasons, and

4. program evaluation reasons.

The owners of property surrounding CBFs often fear a decrease in property values.[53] Land use reasons for opposition to CBFs in the city center mainly on arguments of saturation or overconcentration of CBFs in one area. The suburbs tend to fear that the zone changes necessary for CBF development would open the way for other "noxious" types of buildings. Both concerns are mainly expressions of the fear that CBFs will change the residential character of a neighborhood. Carrying these fears a step further, communities are often afraid that the quality of life in the neighborhood will suffer if a CBF locates in the community, and are also concerned for personal safety. The residents of a CBF are viewed as different and therefore potentially threatening to community residents. A survey by the Association of Residences for the Retarded in Minnesota not only revealed property devaluation fears, but also lingering prejudices against the retarded based on supposed emotional

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[52]A.S. Friedlob, and T.L. Anding, "Community-Based Residential Facilities in the Twin Cities Metropolitan Area", University of Minnesota Center for Urban and Regional Affairs (CURA) Dec., 1975 pp 21, 22. This study included not only CBFs for MRs but also juvenile delinquents and adult offenders.

[53]The explanations of the categories are based on Friedlob, pp 25-36.

or sexual aberration.[54] The final category of reasons for community opposition hinges on the relative newness and unknown nature of a CBF. The members of the CBF host community are unsure about the supervision within the CBF, who is responsible for CBF residents, the qualifications of those responsible, and the financial stability of the facility. This fear particularly affects parents of MRs. The uncertainty about the quality of the relatively new CBFs and fear about the stability of the facility creates an unwillingness among some parents to place MR children in the community. To some parents, SHs offer a permanency that can ensure care for their MR child once the parents die.[55]

Some of these issues can be exacerbated on the one hand, or eased on the other, by the form of control a particular state or local governmental unit exercises through zoning or other requlations.

We now examine briefly DI experiences in other states to give an idea of problems they have had with community acceptance. California had some specific community and political opposition to a DI effort, when DeWitt State Hospital closed.[56] Community and staff resistance, intensified by political maneuvering and misunderstandings, was intense enough to create a general furor and thus delay the closure several times. In a survey of nationwide experience with community resistance,[57] nineteen of the 30 states which responded reported no significant problems with community acceptance, twelve reported mixed experience with the communities, and four states reported significant problems with community acceptance. Some of the factors reported to be associated with positive community responses were: good public educational efforts by staff and citizen groups; quality programs with adequate support services; local control of programs; and legislative, administrative and citizen actions. Factors reported as contributing to problems included: zoning ordinances; lack of state level encouragement; fear of the unknown; lack of support

[54]As reported in CAIR, P. 24.

[55]CAIR. P. 28.

[56]S. Weiner, B. Bird, and Arthur Bolton Associates. Process and Impacts of the Closing of DeWitt State Hospital. Stanford Research Institute, California: 1973.

[57]Horizon House Institute for Research and Development. The Future Role of State Mental Hospitals: A National Survey of Planning and Program Trends, July 1975. pp 142-144.

services; and perceived lack of quality programs. A survey of community-based residential programs[58] received reports from 68 facilities indicating that community resistance caused an average delay of 11.7 months in opening CBFs.

It is evident from other states' experiences that community resistance, while not always a problem, can be a powerful deterrent to DI efforts unless ameliorated by assurances of quality and continuity, education, involvement of those affected, and adequate planning efforts.

Another method of approaching the problem is to develop a model to systematize the elements of the process. A diffusion model[59] has been proposed, which holds that acceptance of new ideas (CBFs) hinges on movement through individual states of acceptance: (1) awareness, (2) interest, (3) evaluation, (4) trial, and (5) adoption. To apply this model in determining what positive efforts are necessary to deflect potential opposition, it would first be necessary to determine the initial stage level of the community and proceed accordingly.

Community acceptance is an important element in the DI process, particularly where any drastic or innovative steps are being attempted. Several of the factors related to community resistance have been enumerated here. Community resistance, if not ameliorated, can lead to political problems and block DI efforts. The planning process must include awareness of possible effects on community attitude and methods to work through opposition. While our study did not attempt to quantitatively measure community acceptance and the feasibility of various alternatives, we did assess the probable areas of contention along these issues as we examined the alternatives. Such assessments are found in the discussions of the viability of the alternatives.

[58]Horizon House Institute for Research and Development. A National Survey of Community-Based Residential Facilities. 1975.

[59]A.Z. Soforenko, H. A. Stevens. "The Diffusion Process: A Model for Understanding Community Program Development in Mental Retardation" Mental Retardation. June 1968, pp. 25-27.

B. In-Home Services for the Mentally Retarded

One alternative to institutional care for MRs is to provide services to them in independent living situations. These services would be aimed at aiding MRs to fulfill their own needs, which involves providing access to developmental services (e.g., habit training, work activities, therapies, etc.) while at the same time allowing the appropriate level of independence.

For MRs functioning at higher levels, this concept has been implemented through supervised apartment living, etc., which allows greater self-sufficiency while offering necessary aid. For MRs who are not able to live even semi-independently, services that enable them to live at home become those that aid the care-giver. By providing transportation services, respite and relief care, financial aid, etc., to the care-giver, the MR can remain in the home, the more "normal" environment. This kind of in-home service (provided to the care-giver) has not been developed to a great extent. County welfare departments have offered respite care by allowing temporary placement of an MR child in an SH or CBF with parents paying 10% of the cost. Other services such as counseling, DACs, etc. have been available to parents on the local or county level, but not until recently has aid to parents been conceived of as both a way to save state money and improve care to MRs. An experimental program in Minnesota, called the Family Subsidy Program, can serve as an example of this type of in-home service. We now describe its purpose, structure, operations, and preliminary results.

FAMILY SUBSIDY PROGRAM

Minnesota's Family Subsidy Program was conceived to:

> ". . . determine the effectiveness of the family unit in providing alternative living arrangements and providing or arranging for the training and developmental opportunities provided in a state hospital or a licensed community residential facility,. . ."[60]

The program, operated by DPW's MR program division, serves families with MR children under age 18 who are eligible (eligibility is discussed later in this section) and who otherwise might require SH or CBF placement. The aim is to aid the families by supplying financial assistance for those costs of keeping an MR child at home that are above and beyond normal maintenance costs. In this way, families who wish to keep their children at home are able to do so, at the same time saving the state money through subsidy of only extraordinary costs, not the total costs of maintenance. A 1975

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[60] Minnesota Statutes, Section 252.27, Subdivision 4.

study proposed that the only significant cost savings in LTC of the developmentally disabled come from keeping the DD at home and providing liberal support.[61] In addition, it is felt that if a family wishes to care for the MR, and if the home situation is such that the child can receive the developmental services needed, there are benefits in keeping the child at home. The home is the most "normal" environment for a child, as most children live in a home setting. Benefits that accrue from staying in the normal home setting are not fully documented but are expected to include progress for the child through the loving, secure base as well as rising expectations and freedom for the family, as the burdensome aspects of the care are removed and as they see the child progressing.

Program Structure

The program is a one-year experimental project. The first families entered the program in March, 1976, with the majority of families enrolled by June. Thus, the program has been fully operational for only several months. Families must apply for the program and must meet the requirements of DPW Rule 19.[62] To be eligible, the child must reside in Minnesota, either in an SH or CBF or at home, with potential eligibility for residential placement. Because it is an experimental project, parents must agree to participate in assessment on the MDPS scale (assessment of the MR) and evaluation of Individual Program Plan (IPP) progress. A team, consisting of the parents, county social worker, and teacher or therapist, with DPW administrative participation, is responsible for the assessment, development, and evaluation of IPPs and may participate in MDPS pre-and post-assessments on the functioning level of the child. Parents must also furnish sociodemographic data on the home. An attempt was made to obtain a cross-section of the population along several dimensions which include: the extent of handicap, the degree of retardation, socioeconomic status, age, and level of education in the family. The program does not base eligibility on level of income, but rather on the degree of need in the family and potential for greatest benefit, which takes into account both financial and emotional stresses. In this way, families with marginal or middle income are not forced to exhaust their finances by keeping the child at home.

Once a family becomes a part of the program, they receive a subsidy of up to $250/month from the local county welfare/human service board which then is reimbursed by DPW. The amount of

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[61] T. Mayeda and F. Wai, "The Cost of Long Term Developmental Disabilities Care." U. of California, Los Angeles, and Neuropsychiatric Inst. Research Group of Pacific State Hospital, Pomona, California. July 1975. pp. 7,8.

[62] DPW Rule 19 entitled "Experimental Program for the Home Care and Training of Children who are Mentally Retarded."

the subsidy is determined by an assessment of family need for services. These needs can include: medical; medication; education (if needed above and beyond what is provided by the school system); babysitting; respite care; "special" clothing, food, and equipment; transportation; counseling; and other needs unique to the MR.

Program Operation[63]

As of the end of September, there were 54 families participating in the program and receiving an average subsidy of $225/month/family, ranging from around $100/month to the maximum of $250/month. There are no specific data available yet on family and child characteristics, but DPW staff involved report that there appears to be a range on almost every variable. The age range of the children is from 1-16 years, the range in the extent of handicap and degree of MR is considered to be close to the distribution of MRs in the population, and there is a definite range in socioeconomic status and educational level of families. A rough estimate of the handicaps of the children reveals some physiological dysfunctions, several deaf children, several blind children, many with cerebral palsy, several hydrocephalics, some hyperactive children, several children with autistic behavior, and several with uncontrolled epileptic seizures.

Most of the children came from home settings and had had no previous institutionalization. Two children had previously been in foster placement, three in CBFs, and three in SHs. Nine children had been on official waiting lists for residential care. The original intent had been to have a 50-50 split of children from home and children who would move home from SHs and/or CBFs. This proved difficult, however. There was a problem in recruiting parents of children already in SH or CBF placement for participation in the program, partly due to the experimental nature of the program: there were no guarantees of results and the funding was only secure for one year. Families who had already made the decision to place the child in a residential facility did not want to try again in the home solely on an experimental basis. In the case of CBF placement, many families had been on long waiting lists and were not willing to give up the placement and run the risk of having to wait again for another opening. Many of the children in SHs seemed to have come from deteriorated families in crises situations which could not have provided viable placements even with financial assistance.

Two families have dropped out of the program and placed their children in residential placement settings. In both cases, mitigating personal circumstances (e.g., divorce, death), rather than dissatisfaction with the program, dictated the choice.

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63 Information on the operation of the program obtained in interviews with Ardo Wrobel, Director, and Tanya Kellner, Program Coordinator, DPW MR Program Division, 9-30-76 and 10-4-76.

The biggest area of need discovered so far in this program is in the area of financial aid to cope with exorbitant medical costs. Many of the families were strained emotionally as well as financially, due to the costs of medical visits, prescriptions, etc. Other areas of major need include "special" equipment and respite care. Equipment needed has varied from wheelchairs and other self-help devices to fences that aid in supervision and safety. Respite care has varied with family needs. In some cases, the 10% parental share of the county respite care program is paid by the subsidy; in other cases a different respite program is arranged, including the use of babysitters or "tutors" who come into the home and train the child in activities of daily living while the family is present. The latter program is especially helpful when there are other children in the family, since it frees the parents to devote time to other family members and activities without fear that the MR child is being neglected.

The Family Subsidy Program is dependent on the resources in each community. Some special services, such as those that deal with behavior problems, are not present in the community, necessitating extensive traveling. So far in the program, it has not been necessary to subsidize "special" foods or counseling. (Counseling services are generally available free of charge through the counties.) Family situations vary greatly on all variables, including network of friends or relatives that can be tapped for babysitting, etc. It has been necessary to provide for supplemental therapies and educational services to fill in, since some communities have only a half day DAC program or other educational service.

Preliminary Results

The expectation of those involved in the program is that true outcomes of this project will not be available until the program has been in operation for a long time period. Mechanisms have been set up to measure outcomes, primarily through the administration of the MDPS tool for measuring functioning. A preliminary report from the project, expected in mid-December, will detail the characteristics of the families and children as well as some preliminary discussions of results, particularly in relieving the burdens of care from the family.

It is anticipated that the quality of care for MRs will improve as a result of this program. The care-givers will be offered relief from financial and emotional strains associated with care of an MR child and thus will be able to relax and spend more time in actual training or sharing sessions. There are also some quality checks built into the program by having the parent(s), teacher, social worker, and DPW overseers involved. This not only ensures that all needed services will be provided, but also that the most suitable, appropriate, or "best" service can be found, given the constraints of community availability.

Keeping or moving MR children to their homes in the community appears to mitigate some of the resistance met by residential CBFs. Problems brought on by the fears of inadequate supervision, lowered property values, etc., would not arise if a child remained at home. In terms of acceptability to MR consumer advocates, this type of program meets several of their main objectives. Since the home is the most nearly normal place for a child to live, the project meets the goals of normalization; this project also serves to supplement a part of the continuum of services and residential environments ideally perceived as necessary in an MR care system. For these reasons, a program aimed at helping families keep children at home seems to make logical sense in the absence of any as-yet quantifiable results. The program removes financial considerations from the decision to place a child, and thus prevents unnecessary institutionalization that would have been based on family finances and strains rather than on what might be best for the child.

A major benefit of this program is the cost saving possibility for the Medicaid LTC system. By experimenting with methods that will enable an MR to be placed in the home for a longer time, Medicaid cost savings can be expected. By preventing unnecessarily early placements in the system and only supplying supplementary dollars to the care-givers, the basic maintenance costs are saved. Parents would be expected to supply maintenance support for all children they may have, so by continuing to expect this and making up the difference in costs due to MR diagnosis and/or handicap, an effective care environment can be maintained by the parents without the expense.

As explained in the discussion of LTC costs, SH costs include the cost of DACs, therapies, etc., so SH costs are not completely comparable to costs of an in-home subsidy program in which the subsidized child is receiving additional community-supported services, such as DACs. The services of the CBFs and the in-home subsidy program are not completely comparable, but gross cost comparisons can be made. The average per diem of a CBF is approximately $17.00/per day, or about $510 per month per resident, and includes residential costs, some training and therapy costs, some transportation costs, staff, etc., but does not include all medical costs. The Family Subsidy Program, however, averages $225/month/family and includes the costs of all special equipment, therapies, transportation, etc. The parents are responsible for the residential costs, as they are with non-MR children. For one year, without looking at the DAC, Special Education, or other outside service costs, it would cost the LTC system (with no attempt to break out state, local and federal shares) about $6120 for one MR child in a CBF and only about $2700 for a child receiving an in-home subsidy. The $2700 can include substantial medical costs which are not included in the $6120 attributed to CBFs.

Conclusions

While the Family Subsidy Program is still in the embryonic stage, operations so far show that such a program has great potential, not only as a cost savings mechanism, but as a method of improving quality of care to MRs by providing them with a normalized environment with responsible, vested caregivers. The possible perils of any type of institutional placement are avoided and families are helped to stay solvent and participate more freely in the care of the MR child.

A total evaluation of all the benefits of a program like the Family Subsidy Program is not possible at this time. It is presented here as an example of the possibilities for quality and cost benefits in the LTC system. By using a resource that is already present--the home--quality care can be provided with a minimum of new organizational effort. No new construction of residential facilities would be required and no new standards or enforcement bodies would be necessary.

In-home services would not be a substitute for long term residential care, but rather another piece in the continuum of services with definite advantages in terms of both quality of service and potential cost containment. Community resistance would most likely not be forthcoming, and parents would not have to make a placement choice based on financial burdens. The system, as it stands now, leads parents towards totally tax supported residential care. The Family Subsidy Program is the first Minnesota effort to use tax dollars as an incentive to keep children at home through aid other than for maintenance care, eliminating a large portion of public support. Other in-home services merit further study, as means to encourage self-sufficiency in a less costly manner.

C. Deinstitutionalizing the Elderly

The Problem of Inappropriate Placement in Nursing Homes

A 1972 GAO report revealed a consensus among health care authorities that approximately 25% of the nursing home patient population are receiving nursing home care that exceeds their needs.[64] Various studies, employing different methodologies, have confronted the issue of the appropriateness of nursing home care, and the results have shown that on any given day, a range of 14-40% of the residents do not require the level of care being reimbursed by federal dollars.[65]

Reasons for Inappropriate Placement

The cost and quality of care issues stemming from inappropriate placement of nursing home residents are crucial aspects of the total picture of LTC. Four basic reasons exist for the situation:[66]

- availability of beds,
- nursing home preferences for certain patients,
- patient and family preferences for certain facilities, and
- attending physician's role.

- **Availability of Beds:** With a statewide average occupancy of 92.10%, choice of nursing home placement is limited. The degree of the problem varies little by region (regional average occupancy rates range from 88.7% to 97.7%), but varies considerably by facility (facility average occupancy rates range from 39.6% to 106.4%).

  There is no standard for the number of total nursing home beds needed. Neither are there standards for the numbers of SNF and ICF beds needed by the elderly population; there is little quantitative information on which to base a decision on the need for facility construction or modification. Table 5.39 displays the distribution of nursing home beds per 1,000 elderly population, by level of care and by geographic area in Minnesota.

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[64] House report, January 1976, p. 23.

[65] House report, November 19, 1975, p. 5.

[66] This discussion of reasons for inappropriate placement is based on information provided in a phone conversation with Dr. Winston Miller, Minnesota Dept. of Health, 11/19/76.

Table 5.39
Minnesota Nursing Homes:
Number of Beds by Level of Care,
Per Thousand Elderly by Region[1]

Region	Number NH Beds Per 1,000 of 65+ Population		
	SNF	ICF	Total
Northwest	25	55	80
Northeast	39	27	66
West Central	21	59	80
Central	32	43	75
Southwest	21	57	78
South Central	24	44	68
Southeast	47	27	74
Metro	48	50	98
State Total	38	45	83

[1]Source: QA&R, 1975, p. 48.

Table 5.40 shows a strong correlation between the percentages of SNF beds and the percentages of SNF patients in all regions of the state. It is not clear from these data alone whether the demands for care in each region vary so significantly as to create this pattern or whether in fact the availability of beds imposes an artifical SNF demand. However, the QA&R data found inadequate regional differences in patient characteristics to explain such a range of SNF patient classification rates. We conclude from these data that placement is more a function of the availability of a given level of care than of patient care needs.

25 of the 87 counties in the state and 168 towns provide only one (either SNF or ICF) level of care. There are 53 towns in Minnesota which provide only SNF care and 115 towns which provide only ICF care.[67] In many cases, it seems, the availability of beds, rather than individual needs, determines placement.

- Nursing Home Preferences for Certain Patients: High occupancy rates and waiting lists allow facilities to exercise selectivity in admissions. Problem cases or psychiatric patients, for example, can be rejected and easy cases accepted (e.g., an SNF may select only the easiest Medicaid-certified SNF patients and may also admit private pay patients requiring less than SNF care, since private pay patients need not be certified).

- Patient/Family Preferences for Certain Facilities: Another factor in the placement process is the patient/family preference for certain nursing homes. The patient/family are not likely to be well enough informed of SNF/ICF distinctions to make this a primary consideration. They probably base their decision on the more visible aspects of the homes (e.g., cheerfulness of staff and other residents, menu, activity program, etc.), and on costs. Another important criterion is distance of the facility from the family. Attention to these factors alone may result in inappropriate placement.

- Role of the Attending Physician: When Medicaid assumes the responsibility for payment of LTC, the patient's attending physician determines the level of care needed by that individual, using a standard DPW form. However, use of this form

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[67] QA&R.

Table 5.40

Minnesota Nursing Homes: Percentages of Beds Certified as SNF and Percentages of NH Medicaid Patients Certified as SNF, by Region[1]

Region	Percent of Beds SNF	Percent of Pts. SNF
Northwest	31	28
Northeast	60	61
West Central	26	25
Central	43	38
Southwest	27	27
South Central	35	30
Southeast	64	58
Metro	49	45
State Average	45	43

Coefficient of Correlation = +0.98

[1]Source: QA&R, 1975, p. 156.

does not prevent inappropriate placement, for the following reasons:

1) While the physician is supposed to assess the patient's needs using the form, sometimes the form is completed by the nursing home and merely signed by the physician.[68] Neither Medicaid nor Medicare will reimburse medical personnel for the level of care evaluation;

2) It is also necessary that the physician be somewhat knowledgeable about the nursing home system, e.g., what bearing the SNF/ICF distinction has on patient care. The level of care evaluation form offers little direction in this regard. A list of nursing care services is provided, though this offers no definitions as to which of these or how many of these needs combine in order to require skilled care; and

3) The alternatives available within a reasonable distance. It would be unrealistic for the doctor to specify a level of care for the patient if such beds were unavailable.

Incidence of Inappropriate Placement in Minnesota

The Medicaid program requires each state to review its MA LTC patients for appropriateness of placement. The objective of the Quality Assurance and Review (QA&R) program is to assure the quality, quantity, and appropriate level of care for each Medicaid recipient in LTC facilities. The 1975 QA&R Survey determined that 2,106 SNF, ICF-I and ICF-II patients, or 9.4% of all MA nursing home residents in Minnesota, were inappropriately placed.[69] The QA&R description appears in Table 5.41. As shown in Table 5.41; QA&R found:

- 20,352 nursing home residents, or 90.62% of the total population, were appropriately placed;

- 684 ICF residents, or 5.31%, needed a higher level of nursing home care; and

- 1,062 SNF residents, or 11.09%, required a lower level of nursing home care.

The net effect of implementing these recommendations would be as follows:

- To reduce the SNF population by 456 patients, or 4.76%;

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[68]Phone interview with Miller 11/19.

[69]Derived from QA&R data, p. 128.

Table 5.41

1975 Quality Assurance and Review (QA&R) Determinations of Appropriateness of Nursing Home Care in Minnesota[1]

	# of Patients Reviewed: Level of Care at Time of Review			
Recommended level:	SNF	ICF-I	ICF-II	**TOTAL**
Total reviewed:	9,580	11,066	1,812	22,458
SNF	8,440	665	19	9,124
ICF	1,062	10,201	1,711	12,974
ICF/MR	56	158	68	282
Psychiatric Hospital	7	9	4	20
Acute Hospital	6	6	1	13
Home or Apartment	9	27	9	45
Total recommended to different level:				
Number	1,140	865	101	2,106
Percent	11.82%	7.82%	5.57%	9.38%

[1]Source: QA&R Report, 1975

- To increase the ICF population by 96 patients overall, or 0.75%;

- To move 302 residents, or 1.34% of the total population, into more specialized types of LTC, e.g., ICF/MRs and psychiatric hospitals; and

- To remove 58 patients, or 0.26%, from the LTC system entirely: 13 to acute hospitals and 45 to independent living.

These QA&R findings may underestimate the actual incidence of inappropriate placement: if a patient is receiving the higher level of care needed, even if in a lower level of care facility, the QA&R team may not have recommended a change; based upon information available, the QA&R team may conclude that change would be harmful and thus not recommend it; if the team knows that the patient has no home or family to go to and/or necessary home health services available; and if there is no appropriate alternative facility nearby.

Follow-up of QA&R Recommendation

When the review team recommended a change in the level of care, a follow-up effort asked the facility whether the recommended changes had taken place, and if not, why not. For those cases in which the recommendation had not been implemented, the 1975 results showed:

Reason	% Distribution
1) Discharge planning needed.	10%
2) Physically, psychologically, or socially harmful to the patient to be relocated.	29%
3) No satisfactory facility available without moving patient too far from family, friends, and community	10%
4) No reason is discernible.	48%
5) Other	3%

The second and third reasons were considered by QA&R to be justifiable excuses for failure to transfer.

Even after placement changes are recommended by the review teams, there is some unwillingness to implement them. Because appropriate level of care is never precisely defined, there is a 'gray zone' between SNF and ICF care

where patient care needs overlap. For example, although half of all ICF patients and 39% of the SNF patients recommended for change from SNF to ICF have some mental or emotional/behavior dependencies, many physicians and other providers contend that all such persons should be classified as SNF if that level is available. There is thus some reluctance to reclassify those patients, despite QA&R advice.[70]

QA&R teams also make study topic recommendations to facilities pursuant to their objectives of assuring quantity, quality, and appropriate level of care to Title XIX LTC patients. In 1975, it was suggested to fourteen single-level SNF or ICF facilities, most of which were isolated geographically, that they study the need to broaden their care provision to two or more levels rather than one. Such suggestions were not well received by most of the facilities in question and this is unfortunate from overall perspectives of cost and quality of care. Single level SNFs (45% of the total of SNF facilities) which would reclassify some beds as ICF would be effecting a cost savings to Medicaid (the cost difference between the two levels of care times the number of patients who could be adequately treated at the lower level). However, reclassification of some beds to a lower level of care, while a cost savings to the Medicaid program, could result in a monetary loss to the facility through a change in the reimbursement rate received. An impact on the quality of care is that staff would be freed from providing the required attention of SNF care to those not needing it and thus be able to better balance their resources. A sensitivity to efficient manpower usage is especially crucial in the outstate, geographically-isolated areas where acquiring trained personnel has sometimes been difficult.

Reclassification of single-level ICF beds to the higher level of care, however, would entitle the facility to a possible increase in the reimbursement rate. Although, in isolation, this may increase the state Medicaid burden, the move is recommended for several reasons: 1) most of these facilities are in rural areas where the overall costs are relatively low; 2) the difference between the costs of the former ICF beds and the new SNF beds would not be great because the facilities may have been providing more care to those requiring it, which was raising the overall cost; and 3) the quality of care would be improved for those patients who should be receiving SNF care but currently are not. The problem of reclassification in the case of ICFs is the necessary increase in manpower defined in the regulations.

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[70] QA&R p. 131.

Because of the tangible and intangible costs which may be incurred by the facilities in bed reclassification, it may be in the state's best interests to provide a temporary economic incentive for providing multiple levels of care in those areas where no choice of care is available. This assumes that there is actually a demand for all levels of care throughout the state. A multiple-level incentive could be incorporated into Rule 49, to remain in effect during some transition and adjustment period, and to apply only to already existing one-level facilities in isolated areas.

Costs

The average 1975 Medicaid reimbursement rates for all certified nursing homes are as follows:[71]

SNF: $19.71 ICF-I: $15.70 ICF-II: $10.10

ICF: $14.91

According to the QA&R data, the recommended patient transfers within the nursing home system are:

from SNF to ICF: 1,062 patients
from ICF to SNF: 1,369 patients.

Applying these average reimbursement rates, these changes would affect the system by the following amounts:

from SNF to ICF: (1,062 x (19.71-$14.91)
= 1,062 x $4.80
= $5,097.60 MA cost savings per diem.

from ICF to SNF: (665) x ($19.71-$15.70)
= 665 x $4.01
= $2,666.65 MA cost increase per diem.

from ICF-II to SNF: (19) x ($19.71-$10.10)
= 19 x $9.61
= $182.59 MA cost increase per diem.

Implementing the QA&R recommendations involving SNF - ICF transfers, the net effect of transferring persons within the nursing home system would be $2,248.36 in savings ($5,097.60 - (2,666.65 + 182.59)) per diem. Over a one year period, this would amount to $820,651.14. The potential Medicaid impact, however, extends beyond this analysis. QA&R data recommended a total transfer

[71] Derived from DPW Nursing Home Statistics.

of 282 patients from nursing homes to ICF/MRs, 20 patients from nursing homes to psychiatric hospitals, and 13 from nursing homes to general hospitals. An additional 45 patients were recommended for independent living.

Despite some economic advantages, a policy of patient transfer is not the ideal solution to inappropriate placement, especially if it entails movement to a different facility. The ultimate solution is to revise the system so that the initial placement is appropriate.

The first step in appropriate placement should be to determine, through a planning and needs assessment study, the necessary number of NH beds at each level of care per 1,000 elderly. Once this was established, the facility need determination process could reflect a realistic guideline in planning for regional health needs. Secondly, the option of levels of care must be available in each county. A reimbursement incentive could provide the initial boost in this direction, and the review for certificate of need could help to balance new facilities to the area demand so that a choice could always be available within the vicinity of the patient's home.

A third element of change would allow this choice to be made with adequate information about the patient and a concern for his/her needs. A comprehensive, reimbursable, pre-placement medical evaluation would alert the patient, attending physician, facility staff, and family to the level of nursing care required. This process could involve a type of patient certification, with periodic reevaluation by a physician.

Currently, the Medicaid system certifies beds within facilities. Thus, if the standards are met, that facility becomes certified for a set number of beds in one or more levels of care. An alternative would be to certify beds as well as patients. Under this system, a facility could be certified for one level of care with the established number of beds, or for more than one level with a set number of beds in each plus a certain number of "flexible" beds. In this way, the facility could adapt to meet the changing needs of its own residents and of the community. If the periodic patient reevaluations[72] revealed changes in the required level of care, these transfers could be easily accommodated through flexible beds.

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[72]Not necessarily as thorough or as costly as the pre-placement examination.

One advantage of double certification is that the assessment of patient needs would be a prerequisite to nursing home placement. Pre-placement screening of MA patients will not, however, solve the entire placement problem. This evaluation could only be required of those admissions relying upon public funding. Patients whose funding source switches after a period of residency will be least affected. For example, private pay patients are subject to no restriction on level of care. If willing, or ignorant of the matter, the private pay patient may select a level of care exceeding his/her needs. Administrative and staff efforts to dissuade such situations are certainly unlikely in proprietary facilities, but if these patients eventually resort to public resources and the level of care is found to be unwarranted, proper placement may mean transferral and consequently, related health risks in certain situations.

D. In-Home Services for the Elderly

Over the last decade, costs of NHs have been increasing as has the number of elderly persons residing in NHs. This double increase has placed substantial and continually increasing cost burdens on governments who have now begun asking 'What alternatives to NHs might cost less?' Today the most frequently proposed answer is 'in-home services'.

The concept of 'in-home services' as an alternative to institutionalization is based upon the belief that with an adequate structure of support services an elderly person (or his family) will choose to remain in his home as long as possible. Further, this is generally better for the person and cheaper to whoever pays for the care.

Considerable effort is presently going into designing and implementing programs. Other efforts are currently underway, attempting to evaluate the cost and effectiveness of in-home services. This section discusses the need, programs, funding and impact of in-home services for the elderly.

The Need for In-Home Services

A January, 1975 nationwide study conducted by HEW indicated that between 144,000 and 260,000 people, or between 14-25% of the approximately 1,000,000 elderly in SNFs and ICFs may be unnecessarily in institutional environments.[73] Three explanations for the inappropriate use of institutional placement have been suggested:

- The incomplete community health and social service structure which does not provide maintenance care in the community for all elderly and disabled adults needing home care services;[74] ". . . somewhere in the order of one out of six Americans who are not in institutions are in need of direct social and health services if they are to be able to manage their own affairs and remain in their own homes and communities."[75]

- The prohibitive costs to the individual and/or family where such services currently do exist,[74] and

[73]"New Perspectives in Health Care for Older Americans" - House Select Committee on Aging, Jan. 1976.

[74]Nov. 19 testimony, p. 5.

[75]House subcommittee testimony, Nov. 19, p. 3.

- The relative ease of arranging public payment for institutional care, in contrast to the difficulty in obtaining public funding for home care services, even if home care costs less.[74] These payment policies have created a spiral effect - they provide generously for active treatment, modestly for basic shelter, and nothing for "natural life system arrangements to which the disabled can turn in their own communities."[76]

The Services and the Providers

Independent living may depend upon availability of a wide variety of supportive services and a broad concept of home health:" . . . that component of comprehensive health care whereby services are provided to individuals and families in their places of residence for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability."[77] Among the services provided, as appropriate, are: medical care, dental care, nursing, food preparation or delivery, physical therapy, speech therapy, occupational therapy, social work, cleaning, shopping, home maintenance, and transportation. In-home service providers can be public agencies, private agencies, single-purpose, multi-purpose, consortiums, or institution-based (e.g., hospital, nursing home, church, or school based).

The Minneapolis Age and Opportunity Center (MAO) is a nationwide model of a multipurpose outpatient center providing in-home health and support care services to the elderly. MAO, a non-profit, works in conjunction with federal, state, local and private partners in offering an alternative to institutional care. MAO serves that portion of the elderly population not needing 24-hour care. According to Daphne Krause, Executive Director of MAO, at any one time on average, that organization is making available 'medi-supportive' services to 8,000 people, voluntary action programs to 29,000 people, and clinical services to 3,800 people. In addition, there are over 5,000 elderly waiting to receive services, and an unknown number who may be in

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[76]Senate Committee, Oct. 1, 1971, p. 5.

[77]House Subcommittee, Feb. 24, 1976, Testimony of John Byrne, President of the National Association of Home Health Agencies.

need but have not contacted MAO.[78] Among the services provided by MAO are: home delivered meals, employment services, home care services, handyman services, transportation, legal services, counseling, information and referral, special health services, facilitation of health services, and decentralized miniclinic services.

The Community Care Organization, an alternative system in LaCrosse, Wisconsin, is a "supermarket of social and medical services."[79] Services available include: health services (home visits by nurse or physician); outpatient services at hospitals, clinics, and nursing homes; personal care; home maintenance; nutrition; transportation; social, environmental and physical security; psychological support; and housing alternatives. The aim of this demonstration program is to "determine whether Medicaid costs can be reduced and quality of care and life improved through the provision of health and social services to the elderly and functionally disabled in their own homes."[80] Because Medicaid does not ordinarily cover non-medical services, a waiver for the project had to be obtained.

The Community Care Organization, founded April 1, 1976, acts as a broker of services rather than a supplier, and coordinates ten major providers of services. In addition, a labor pool performs housekeeping tasks in the homes of the elderly.

The outreach effort to the elderly in the LaCrosse area focuses on achieving an urban/rural mix of clients. By April of 1980, the program expects to be serving 3,500 elderly persons. The target population encompasses Medicaid-eligible, chronically ill, elderly, or other disabled adults, who: 1) are residents of LTC facilities but for whom institutional care has been deemed inappropriate, 2) will soon be discharged from a hospital and face placement in an LTC setting if a suitable day program is not available, and 3) currently reside in the community but may soon be institutionalized.

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[78] New Perspectives in Health Care for Older Americans. Report of Subcommittee on Health and Long Term Care of the House Select Committee on Aging, Jan. 1976, p. 6.

[79] The Social and Rehabilitation Record. July/August, 1976, "Can They Go Home Again?" Don Kent, p. 11.

[80] Ibid.

Currently in Minnesota, there are 65 Medicaid/Medicare - certified home health agencies. These agencies are concentrated in the urban areas of the state.

Public Funding Sources

Home health services are provided under Social Security Titles XVIII and XIX which reimburse for services to eligible recipients. Other in-home services are also provided by public programs, such as Administration on Aging (under Titles III and VII of the Older Americans Act) and Title XX (Social Services) of the Social Security Act; these programs provide direct grants to providers to establish services.

Reimbursement for Services to Recipients :

- Title XVIII (Medicare)

Medicare provides home health services under both Part A (hospital insurance) and B (supplementary medical insurance). Both Parts A and B provide the following services to homebound eligible persons under the care of a physician: part-time skilled nursing care, physical therapy, speech therapy, occupational therapy, medical social services, medical supplies and appliances, and part-time or intermittent services of home health aides. Service providers must be certified vendors.

Part A provides for 100 visits during the year following three days or more of hospitalization or extended care.

Part B, which has a $60/year deductible, provides home health services for those who choose to buy in to the program, up to 100 visits per year.

Under Medicare, Part A, home health bills in 1974 for the over-65 group totaled $78 million, or about 1% of the $7.3 billion Part A expenditures. Under Part B, home health costs were $35 million, approximately 1% of the $4 billion Part B expenditures.[81]

Thus, more Medicare hospital insurance (Part A) dollars are utilized for home health. Although Part B has broader eligibility (i.e., no prior hospitalization is required), home health care is usually associated with hospital stays; hence, Part A benefits are used more often.

- Title XIX (Medicaid)

Title XIX or Medicaid (MA) requires that all states provide home health care to persons entitled to SNF care. States may restrict coverage to services provided by certified home

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[81]House Subcommittee, Nov. 19, 1975, p. 3

health agencies. To be eligible for Medicaid reimbursement, home health services must be prescribed by a physician but do not require prior hospitalization.[82] Home health services provided by Medicaid are generally similar to those provided under Medicare. For FY 1976, $1 million or 0.3% of Medicaid expenditures were for home health services; no information is available on percent of this spent on the elderly.

Experimental Medicaid funds are available to establish temporary projects for testing various in-home services. MA authorization for waivers on state organization, amount, duration, and scope of service of the state Medicaid plan, or statewideness of the Social Security Act was instituted under Section 1115 of that act. These experimental funds are not available, however, as a continuing source of support.

Direct Grants to Providers to Establish Programs

-Administration on Aging (AOA):

Special Programs for Aging (Titles III, VII), administered by Administration on Aging (AOA) disburse formula grants in support of state and area planning and service programs for non-institutionalized older citizens. State and area agencies on aging were established in 1973 to plan and fund (rather than directly deliver) such services as transportation, recreation, advocacy, homemaker, home repair, job counseling, consultation and education, day care, day activities, and meal service. In addition, AOA provides grants for implementing and evaluating experimental in-home service programs.

-Social Services (Title XX):

Under Title XX, states have considerable latitude in determining their own social services programs. Formula grants are provided for social services to current and potential recipients of public assistance to reduce their dependency and prevent unnecessary institutionalization. Title XX services available to Minnesota's

[82]Home Health Care Benefits Under Medicare and Medicaid, Reports to the Congress, prepared by the Comptroller General of U.S., July 9, 1974, p. 11.

elderly include: chore service, counseling, adult day care, health service arrangement, home delivered and congregate meals, homemaking, housing service, legal service, protection, social and recreational service, and transportation.

Other public programs potentially available to elderly citizens who live independently include: various other federal income maintenance and income transfer programs, e.g., food stamps, social security, SSI, and Veterans Administration benefits; and community mental health services.

Potential Impacts of In-Home Services for the Elderly:

- Costs of In-Home Services for the Elderly
  Proponents of in-home services claim that these services are cheaper than nursing home services. Thus they claim that government policy ought to support in-home services as a cost-containment mechanism. In order to validly compare costs and other impacts of in-home services vs nursing homes, it is necessary to control for several important cost-related variables, such as: individual characteristics (impairment level, family presence), agency characteristics, and funding mechanisms.

-Individual Characteristics

To compare costs between in-home services and nursing homes, it is necessary to control for characteristics of the populations served. Without these controls, it would be impossible to determine whether cost differences are due to the service mode or the type of client.[83]

Two important individual characteristics to be considered are: 1) impairment level, and 2) presence or absence of family help.

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[83]Jay Greenberg. "The Costs of In-Home Services." In A Planning Study of Services to Non-Institutionalized Older Persons in Minnesota, p. 9.

Various research studies have claimed an actual or potential cost savings using in-home care as an alternative to nursing home care, but the meaning of these claims is unclear: "Do they mean that it is less expensive to care for patients at home regardless of initial impairment, or do they mean that up to a certain level of initial disability it is less expensive to care for patients in their homes?"[84] Figures 5.2 and 5.3 illustrate the issue.

If Figure 5.2 represents reality, that is, if home care is always less expensive than nursing home care regardless of initial disability level, then a policy decision based on cost alone would obviously favor home care. If, however, there is a disability level beyond which the cost of home care exceeds the cost of nursing home care (as in Figure 5.3), then the policy decision is not so simple. The intersection point must be determined if dollar resources are to be employed for maximum efficiency, and only persons with less severe disabilities (to the left of Point X on Figure 5.3) should be considered for in-home services.

A second variable is presence or absence of family help. It is logical to assume that elderly persons with family assistance available (e.g., transportation and home maintenance) will require fewer agency services and hence cost less. Such a comparison must control for the initial impairment level. This is displayed graphically in Figure 5.4.[85]

Thus, identification of individuals for whom in-home services would be cheaper involves several steps: 1) distinguishing those persons who could, given necessary services, be serviced at home; 2) segregating from this group the elderly who could be cared for at home less expensively than in a nursing home; 3) determining who, among this subgroup, would be best serviced at home according to other specified criteria (e.g., social factors, emotional adjustment, etc).[86]

-Agency Characteristics

Because of the broad diversity of agencies offering

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[84]Ibid, p. 8.

[85]Ibid, p. 6.

[86]Ibid, p. 43.

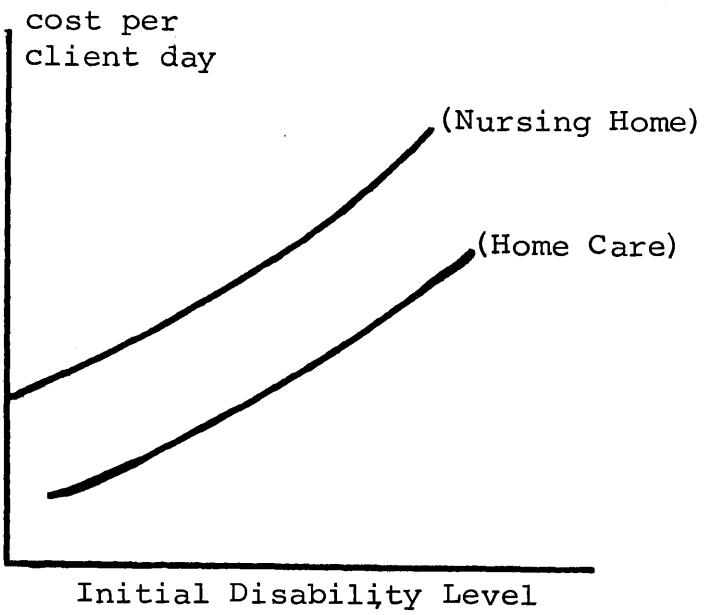

Figure 5.2 Costs of Home Care vs NH Care for the Elderly, Assumming Home Care is Less Expensive[1]

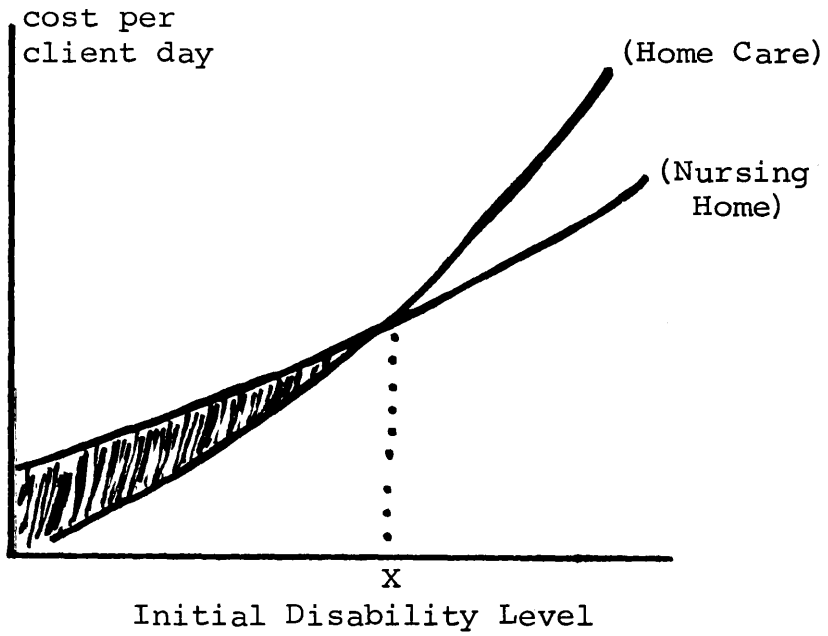

Figure 5.3. Costs of Home Care vs NH Care for the Elderly, Assuming Costs of Home Care Exceed Costs of NH Care Beyond a Certain Point[1]

[1]Jay Greenberg. "The Costs of In-Home Services." In A Planning Study of Services to Non-Institutionalized Older Persons in Minnesota, p. 8.

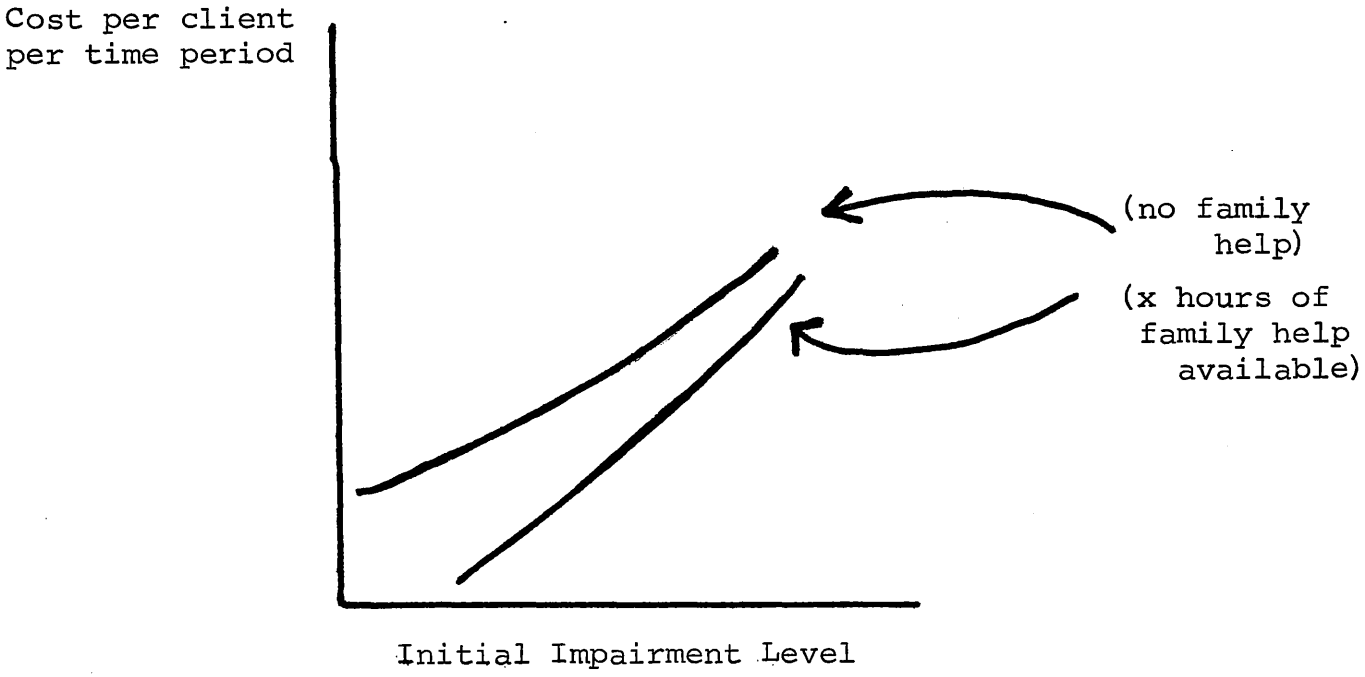

Figure 5.4. Costs of Home Care vs NH Care for Elderly, With and Without Family Help Available [1]

[1] Jay Greenberg. "The Costs of In-Home Services." In A Planning Study of Services to Non-Institutionalized Older Persons in Minnesota, p. 6.

in-home services, home care costs and nursing home costs cannot be directly compared. Some factors affecting the cost of home services are: a) geographic and demographic agency characteristics (e.g., it would be expected that the more geographically dispersed the target population, the higher the per unit cost of meals on wheels programs); b) size of service organization (i.e., do economies of scale operate?); and c) degree of service integration (e.g., a unified agency able to deliver all the necessary services may be more or less costly than other arrangements).[87]

-Funding Mechanisms

Nursing home costs reported by DPW include only costs reimbursed through Rule 49. Other significant expenditures are not recorded in Rule 49 reports: physician services, pharmacy, physical therapist, diagnostic laboratory, etc. Thus, in using DPW Rule 49 figures to compare NH and in-home services, certain Medicaid outlays would be overlooked.

Case Studies, Empirical Results

Despite the problems in making valid cost comparisons, various estimates and comparisons have been documented. For example, MAO[88] reports that, in one case, MAO spent $279 on in-home services to an elderly woman for a 3-month period. Assuming that the woman had been in a nursing home during this period, Medicaid's net cost for services would have been $996. Therefore, even if Medicaid had reimbursed MAO for all its expenses, $717 would have been saved. MAO has many other examples of cost savings for other types of individuals in other situations.[89]

Another cost comparison involved a prepaid group practice experience of the Kaiser Foundation in Portland, Oregon, in 1972. Home health and SNF benefits were included in the plan to "determine the most appropriate and economical means of satisfying medical care needs"

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[87]Ibid, p. 6-7.

[88]New Perspectives of Health Care for Older Americans. Report of Subcommittee on Health and Long-Term Care of the House Select Subcommittee on Aging, Jan. 1976, pp. 17-20.

[89]Ibid.

and to test the concept of "offering a means of reducing the cost of medical care by substituting, in appropriate situations, less costly facilities and less skilled personnel than are required in acute care." Findings showed that in-home services can contribute to overall medical care cost containment.[90]

A 1971 Massachusetts study of the local experience with homemaker health aides showed that the average client received ten hours per week of service at $3-4 per hour, including administrative costs. "The estimated average monthly cost for maintaining a welfare client in a skilled nursing home is $512 per month. By contrast, the maximum basic budget available to Old Age Assistance recipients is approximately $230 per month in Massachusetts. The margin of $280 between nursing home and basic relief costs should be more than sufficient to support the organization of an improved range of services needed to maintain welfare recipients in non-institutional community settings."[91] Because the study does not consider the important cost-related controls which we discuss earlier, it seems to be an overly simplistic analysis.

A detailed study of monthly costs of Minnesota elderly living at home was conducted by Greenberg.[92] Estimates resulting from this study are presented in Table 5.42. This table shows that total costs of living at home increase with level of impairment, and that for all impairment levels, living with someone reduces the per-person costs, as would be expected. However, when total at-home costs were compared with nursing home costs, there was found to be a point above which at-home care cost more than nursing home care. This point appeared only for those most impaired (i.e., with Global Scores of 4 as shown on Table 5.42), whether living alone or with someone.

MA Cost Savings

In the 1975 QA & R review, 903 Medicaid nursing home

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[90]Marie Callender and Judy LaVor. Home Health Care Development, Problems, and Potential. Office of Social Services and Human Development, HEW. April 1975.

[91]"Alternatives to Nursing Home Care: A Proposal." Senate Special Committee on Aging, October, 1971, p. 19.

[92]Greenberg, p. 33.

Table 5.42

Per Month Cost of Living at Home by Living Arrangement and Disability Level[5]

	N	Global[4] Score	Average hrs. per month of homemaker/ health aide	Homemaker/[1] home health cost per month	Average visits of home nursing per month	Home nursing[2] cost per month	Low Housing[3] Budget	High Housing[3] Budget	Food cost	Total Cost with Low Housing Budget	Total Cost with High Housing Budget
Living Alone	4	1	7.525	$31.60	0	0	$125.00	$155.00	$52.46	$209.06	$239.06
	6	2	36.335	152.60	(6) 4.26	85.00	125.00	155.00	52.46	415.06	445.06
	3	3	44.333	186.20	(1) 0	0	125.00	155.00	52.46	363.66	393.66
					(2) 6.4	128.00	125.00	155.00	52.46	491.46	521.46
	1	4	75.035	315.15	(1) 4.12	82.30	125.00	155.00	52.46	574.91	604.91
Living with Someone	2	1	4.3	18.06	0	0	$ 72.50	$ 87.50	$52.46	$143.02	$158.02
	16	2	21.371	89.76	(10) 0	0	72.50	87.50	52.46	214.72	229.72
					(6) 6.45	129.00	72.50	87.50	52.46	343.72	358.72
	9	3	39.947	167.78	(4) 0	0	72.50	87.50	52.46	292.74	307.74
					(5) 6.88	137.6	72.50	87.50	52.46	430.34	445.34
	6	4	60.071	252.30	(6) 9.55	190.92	72.50	87.50	52.46	568.18	583.18

N = 47

[1] Based on $4.20 per hr.

[2] Based on $20.00 per visit

[3] Includes $20.00 per month utilities for persons living alone and $15.00 per month utilities for persons living with someone else.

[4] The global scale from 1 to 4 measures the clients' ability to function independently.

[5] Source: Jay Greenberg. "The Costs of In-Home Services," in A Planning Study of Services to Non-Institutionalized Older Persons in Minnesota, p. 33.

patients (4.02% of the total) were found to have had no medical or nursing reasons for being in a nursing home.[93] These NHs represent the following levels of care:

Care Level	Number	Percent of Total MA NH Population With No Medical or Nursing Reason for Being in an NH
SNF	133	0.59%
ICF-I	614	2.73%
ICF-II	156	0.69%
Total	903	

For these 903 elderly people, nursing home placement was a solution to primarily social problems. In the majority of such cases, a discharge recommendation was not made because there was no realistic alternative living situation available to the people outside of the institution: either alternative living situations and necessary supportive services did not exist or the person could not afford these services.[94] Earlier in this Chapter we noted that only 45 persons were recommended by QA&R in 1975 for discharge from NHs. The above shows a pool of at least 903 who, given adequate supportive services, could function in an independent or semi-independent living arrangement if such were available.

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[93] QA&R, p. 146, showed that the 903 patients were identified on the basis of the following characteristics: length of stay less than 24 months; relative living within 20 miles; no unstable medical conditions; no disability in Mental, Emotional/Behavioral, or Bowel and Bladder Functioning; fewer than 10 total disability points, i.e., disability in only one or two of the other ADL's; no injections or special nursing treatments; general conditions static or improving; mental retardation, if present, must not be severe or profound; and mental illness, if present, must not be severe or very severe and there must be no special psychiatric behavioral problems.

[94] The majority of these NH elderly have probably reached the spend-down limit of $750 on liquid assets in order to qualify for Medicaid. This means that they have no home or major possessions to which to return, and thus face the choice (if it exists) of moving in with relatives or friends, or finding a totally new setting in the community.

If it were possible to discharge all 903 nursing home residents who display no medical need for nursing home care, the Medicaid cost savings would be substantial:

SNF: 133 patients x $19.71 average NH per diem reimbursement = $2621.43 average NH per diem savings;

ICF-I: 614 patients x $15.70 average NH per diem reimbursement = $9639.80 average NH per diem savings; and

ICF-II: 156 patients x $10.10 average NH per diem reimbursement = $1575.60 average NH per diem savings.

Over a one year period, the potential cost savings to the Medicaid program would appear at first glance to be $5,050,442.90. However, this estimate is unrealistic for several reasons:

- It is still difficult to estimate the cost of the in-home services that would be needed upon discharge. The costs of services would vary with each individual and living situation; and

- At this time, the effects of a policy of increased home health care upon nursing homes are uncertain. If persons not requiring institutional care were returned to the community, possible repercussions for nursing homes might include higher costs. Removal of patients with lowest impairment would raise the average disability level of remaining NH patients and, in turn, the average cost would increase. In addition, underutilization of current NH capacity might well increase the cost per person in NHs.

- Medicaid savings may not represent real savings, but merely redistribution of costs.[95] Medicaid savings may reflect a shift in costs to other programs, with no net relief to the state.

For all these reasons, it is not possible to estimate the true costs and true savings of a home health or in-home supportive services alternative at this point.

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[95]Greenberg, p. 15.

However, the evidence presented does indicate that for some NH residents, an adequate LTC system would permit DI and for some non-NH residents, in-home services could prevent NH placement, thus reducing overall costs. Another complicating factor is the unknown effect on costs of increasing the supply of in-home services: would an increased supply increase the demand for these services from persons not now identified as potentially in need of such services, i.e., would the "woodwork theory" apply?

- Other impacts:

  In addition to money costs, it is also important to consider the impacts of in-home services on the individual, on significant others, and the job market.

-Impacts on the Individual

While it has been said that, "...they (older people) are much happier and respond much better to the medical care that they receive at home,"[96] there is evidence of an emotional state called 'institutional syndrome' that can develop rapidly after admission to a nursing home. Under this condition, people become unnecessarily dependent on the institution for services that they could have possibly performed for themselves had they remained in their own homes.[97] Also important are the risks of increased mortality, morbidity, and social isolation in changing residence.

-Impacts of Significant Others

With any public program, acceptance by families and service providers is critical. Some may be reluctant to cooperate with in-home services because:

-Convalescent homes in the area may not be full, and thus might have pressured physicians to refer

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[96]"Field Delivery of Home Health Services." Hearing before Subcommittee on Health and Long Term Care of the House Select Committee on Aging. February 24, 1976. Testimony of Grace M. Braden.

[97]"New Perspectives in Health Care for Older Americans," Subcommittee on Health and Long Term Care of House Select Committee on Aging, Jan. 1976. Testimony of Peter Franklin, Special Assistant to Secretary of HEW. p. 11.

patients to them in lieu of using home health care;

-Families might resist home care, since they would face a greater burden than if the older person were in an institution;

-Since, in general, current services to the elderly are based on the medical model, and in-home services are not integrated into such a model, physicians and other medical personnel may be reluctant to use these services.

-Impacts on the Job Market

An in-home services program would draw upon a cross section of the labor market in filling its needs: skilled professionals, trained para-professionals, full-time non-skilled, part-time non-skilled.

Problems could arise because of maldistribution of health professionals, although we would expect a positive impact on the local unskilled labor sector. Careful planning would be required, including the provision of education and training for all job levels.

Thus we conclude that although in-home services for the elderly are not widespread, and all of their impacts are not clear, it would appear that Medicaid costs would be contained if some of the current NH population were DI'd and given in-home services.

E. Alternative Funding For LTC of MRs

Minnesota's pioneering decision to fund MR community residential services with Medicaid funds continues to be a subject of some debate. The basic question revolves around the appropriateness of Medicaid's medical model emphasis in a field geared towards a developmental model. In this section, we explore several possible alternative sources of funding for MR residential services from the perspectives of appropriateness and problems or benefits that might be associated with implementing a change in the source of funding.

There are only two major governmental programs that can be considered as possible alternative funding sources for MR residential care. The two programs, Title XX (social services) and Supplemental Security Income (SSI), have different methods and mechanisms for funding. Title XX supplies funding to counties for the provision of certain social services. SSI and Minnesota's supplement to SSI, Minnesota Supplemental Aid (MSA), are cash grant programs to eligible recipients. These two programs have been used by other states instead of Title XIX in funding MR residental services, particularly CBFs. Both programs will be discussed in turn, to briefly outline how such a switch would affect costs and quality. We also present general comments on the feasibility and acceptability of the two programs.

1. Title XX

Brief Description

Title XX of the Social Security Act was established in January, 1975. The purpose of the program is to provide grants to states for social services for low income persons. This title combined into one program several other titles previously dealing with social services. The goals of Title XX include those of:

> "I. Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency.

II. Achieving or maintaining self-sufficiency, including reduction or prevention of dependency.

III A. Preventing or remedying neglect, abuse, or exploitation of children or adults unable to protect their own interests.

III B. Preserving, rehabilitating, or reuniting families.

IV. Preventing or reducing inappropriate institutional care by providing for community-based care, or other forms of less intensive care.

V. Securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions."[98]

These goals, particularly I, II, and IV, are compatible with many of the goals of the MR field, e.g., normalization, developmental training, etc.

Twenty-two services can be covered by Title XX (see Appendix G for a listing of these social services). Under Title XX the state can determine which services it will provide and who is eligible to receive such services, within certain guidelines. Counties can also make choices on services and eligible recipients. Certain services are mandatory and certain categories of people are eligible, but basically counties and states have flexibility through development of the comprehensive Annual Service Plan. Citizen participation is encouraged in the development of the plan through public review and comment periods.

When counties provide eligible services to eligible recipients, they are reimbursed by Title XX for a portion of costs determined by the formula. The program is intended to be 75% federal. However, federal funds available for social services have been limited since 1972 to 2.5 billion to be allocated to the states

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[98]As listed in: State of Minnesota, Dept. of Public Welfare. Final Plan. Title XX. Plan year: October 1, 1976 to September 30, 1977 p. 4. (Source: § 228.0, 45 CFR 228).

according to population. Minnesota is currently allocated $46.35 million for Title XX services and has used its full allocation since 1973. The effect of this ceiling, or "cap," is that many services are provided that do not receive federal reimbursement at all. In Minnesota from 10-1-76 to 9-30-77 the following sources of funding are planned:[99]

Federal XX	$46,350,000
Federal IV-B	964,392
Federal Other (WIN)	2,822,456
State	20,701,168
Local	62,091,179
Fee[100]	145,895
Certified Public Expenditure[101]	552,806
Other	463,913
	$134,108,876

As can be seen from the above chart, Title XX covers only about 35% of the service expenditures as a result of the cap on total Title XX dollars. This overmatch on the part of state and local governments effectively negates the supposed 75%-25% match possible before the cap. In comparison, the federal Title XX share covered approximately 40% of service expenditures in FY 76.[102]

EFFECTS OF A FUNDING SWITCH TO TITLE XX

The rationale offered for a proposed switch in MR residential care funding from Title XIX to XX centers on the appropriateness of a medical assistance program for services that are developmental in nature. When Minnesota made the decision (in FY 1974) to use Medicaid for CBFs, it was predicated on knowledge of the cap on social service funding. Medicaid was considered appropriate because it includes the ideas of MR

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[99]State of Minnesota, Dept. of Public Welfare. Comprehensive Annual Services Program Plan. Final Plan. Title XX. Plan year: Oct.1, 1976 to Sept. 30, 1977, p. 220.

[100]Fees are charged according to the Title XX Final Plan fee schedule for those earning between 60 and 115% of the state median income.

[101]Payments to other state agencies such as Vocational Rehabilitation.

[102]Interview with G. Haselhuhn, Director, Social Services, DPW, and H. Cashdollar, Social Services, DPW, Oct. 20, 1976.

normalization and developmental services along with the medical requirements for supervision, preventive health care, and medication. A switch to the Title XX program now would raise many problems, primarily in cost and quality areas. We now elaborate on these potential problems.

Cost Factors

The obvious difficulty that would immediately be encountered in a switch of funding source would be the already strained nature of funding in the social service area. The cap, as described above, has made it necessary for the state and especially the local governments to absorb a large part of the cost of social services as specified in Title XX. Ostensibly, the federal match in Title XX is higher-- 75% --than it is in the Medicaid program-- 56.84%. However, when the effect of the cap is taken into consideration, the federal Title XX share essentially drops to 35% of social service expenditures. The Minnesota Medicaid program expends over $10 million on residential care for MRs in community ICF/MRs alone.[103] To switch this over to Title XX would overburden an already strained funding source. The local share would increase dramatically. The state share would also rise, especially as local governmental units reached the saturation point in absorbing increases. The addition of a mandatory service would serve to reduce county options. Inasmuch as the federal regulations governing ICF/MRs would no longer be in effect, costs solely attributable to meeting the rather stringent regulations would not be encountered were the funding switch to occur. No state or local savings would accrue from the discontinuance of ICF/MR certification inspection and review procedures, however: the federal Medicaid share for the costs of ". . . compensating and training long term care facility inspectors"[104] presently in effect is 100%. Other cost factors that would be associated with a funding switch include those related to different eligibility requirements and different coverage of service and/or facilities.

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[103]This does not include state hospitals, or MRs in nursing homes.

[104]§21,820, 45CFR, 25.120 3(d).

Coverage differences between Titles XIX and XX include definition differences. Title XX defines residential treatment service in the following manner:

> "Arrange and provide a therapeutic experience including an interrelated set of activities within a controlled 24-hour per day live-in setting, including integral but subordinate medical and remedial care and integral but subordinate room and board, as well as pre-placement medical examinations and medical reevaluation.
>
> Subgroups:
> 1) Emotionally Disturbed Children;
> 2) Primary Treatment/Extended Rehabilitation - Chemical Dependency;
> 3) Half-way House - Chemical Dependency and Mentally Ill;
> 4) Correctional - Children
> 5) Mentally Retarded Children and Adults".[105]

This residential treatment service is mandatory for all Title XX-eligible MRs. The definition of "integral but subordinate" medical and remedial care and room and board is defined by federal regulation. Medical and remedial care is "integral but subordinate" only if less than 25% of the cost of care, room and board only if less than 40% of cost of care. If medical and remedial is over 25% and/or room and board is over 40% of cost of care, residential care will not be covered at all by Title XX reimbursement.[106]

With the nursing, other medical, and remedial services required by current ICF/MR regulations (see Table 2.17), it is conceivable that many ICF/MRs would not meet the

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[105] Final Plan. p. 5b.

[106] Interview with G. Haselhuhn, Director, Social Services, DPW, and H. Cashdollar, Social Services, DPW, Oct. 20, 1976.

40% or 25% requirements. The effect of this would either be that many MRs would not be covered at all, or that the ICF/MRs would have to change rapidly and in some cases quite drastically. These changes would include dropping many service features such as nursing supervision. Whether the changes would necessarily be "good" or "bad" is not easily discerned. Costs would seemingly drop, but awareness and planning would be necessary to avoid the quality problems that can accompany sudden change.

Eligibility differences between Titles XIX and XX center mainly on Medicaid recipients who have become eligible through the spend-down provision.[107] Title XX eligibility is based on income and includes no spend-down provision. As defined by the Minnesota Title XX plan:

> "Persons who are recipients of Income Maintenance programs, i.e., Aid to Families with Dependent Children, Aid to Families with Dependent Children - Essential Persons, and Supplemental Security Income - Minnesota Supplemental Assistance, are eligible for services available and financed by Title XX. Reimbursement status of recipients of Medical Assistance is determined on the basis of family income."[108]

Thus, persons eligible for Medicaid through the spend-down provision would not be eligible for Title XX-financed MR residential services. Title XX service could be obtained for a fee, if the income is below 115% of the state median income, according to the fee schedule in the comprehensive Title XX plan.[109] As is evident, MR residential costs would reflect the eligibility differences, if funding were switched to Title XX. This would primarily affect MR children, whose families' incomes are considered in determining eligibility. The eligibility difference would reduce the cost to the funding sources, but would have a possibly disastrous effect on families of MRs.

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[107]The spend-down provision allows persons with income in excess of Medicaid maximum income, to reduce income to the maximum by applying the excess income to current medical services.

[108]State of Minnesota. Final Plan. Title XX, p. 7.

[109]State of Minnesota, Final Plan, Title XX, pp. 7-13.

Quality Factors

Many of the cost factors discussed above could be considered to have effects on quality of care. Varying levels of eligibility and coverage will leave some previously funded persons without a funding source. Admittedly, these effects can only be proposed in a speculative manner, as they are not measurable and are dependent on arrangements that might be made in a planning process.

The other major quality factors are the differences in regulations pertaining to MR residential facilities. In a funding source switch from Title XIX to XX, different requirements would have to be met. Title XX has, at this time, no federal regulations on quality control of the facilities. The ICF/MR regulations of Title XIX would not apply. State licensure, both facility and programmatic, would be the basic quality control mechanisms. As can be seen on Table 2.17, some areas of regulation in the ICF/MR regulations are more and some are less stringent than the state requirements. This is particularly evident in the area of nursing services and other medical services. Nursing requirements in Rule 34[110] and BCH[110] are nonexistent and are very limited in SLF[110] requirements, in contrast to the specific nursing qualifications and duties listed in ICF/MR regulations. Other medical services are also more specific in the ICF/MR regulations, particularly in personnel qualifications. Staff ratios are specified in the ICF/MR regulations that are not present in the state requirements; and services such as the various therapies, social services, and psychological services are not specified in the state requirements.[111] In sum, the differences between federal and state quality control items would not necessarily mean that quality would be "worse" or "better" under Title XX, but, as can be readily seen, there would be different requirements that would lead to a different configuration of services and facilities.

Conclusions - Title XX

There would be many differences in the delivery of residential services for MR, if Title XX would replace

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[110]See glossary.

[111]See Chapter II D3 for further explanation of the requirements and the interface of the requirements.

Title XIX as the funding source. Many of the points of difference explained in the sections on cost and quality factors do not definitively point out unsolvable problems but rather suggest potential problem areas. The most cogent argument for using Title XX funds for MR residential care is that the goals and coverage of Title XX are more compatible with the goals and philosophies embodied in normalization and developmental foci.

One of the most cogent arguments against the use of Title XX is the overmatch factor. As already detailed, a considerable part of the money expended on Title XX - type services goes unmatched by Federal dollars. To get a rough picture of how Minnesota compares with some other states on extent of overmatch, Table 5.43 is useful, even though provision of this information by the states was optional. Eight states, including Minnesota, indicated social services delivered without federal matching dollars.[112]

As is evident from Table 5.43, of the reporting states, Minnesota serves the most clients without federal dollar match. While this is not a definitive list of all states and numbers of persons served unmatched, it does show the effects of the national cap on Title XX funds in Minnesota.

In the area of residential care and treatment services for MRs, Minnesota's expenditures for Title XX - type social services Oct., 1975 - Sept. 30, 1977, are estimated to be $3,128,655 for 4,169 persons.[113] The funding is expected to come from the following sources:

Federal Title XX	$ 505,463
Federal Other	9,182
State	1,030,991
Local	1,512,840
Donation	15
Fees	10,400
Other	59,764
	$3,128,655

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[112]The table is from U.S. Department of HEW, SRS, National Center for Social Statistics. Social Services U.S.A., Oct.-Dec. 1975. Washington D.C. Table 6, pp. 55-57.

[113]State of Minnesota. Final Plan. Title XX, pp. 203, 204. Current MR residential Title XX money goes mostly to MRs in small group homes, or any larger community group home not receiving Title XIX monies.

Table 5.43

Title XX Clients Served Without Federal Matching Support

NATIONAL SUMMARY OF STATE SERVICES TO PRIMARY RECIPIENTS

Quarter Ending: DEC. 1975

SERVICES	STATES					
	ALASKA		COLORADO		IOWA	
	No. Adults	No. Children	No. Adults	No. Children	No. Adults	No. Children
Adoption Services					173	33
Case Management Svcs					2	4
Chore Services						
Counselling Services			5		2	2
Day Care - Adults						2
Day Care - Children		7	9			
Day Care - Various						
Diag. & Eval. Services						
Educ. & Training Svcs			9			
Emergency Services						
Employmt Rel. Med. Svcs						
Employment Services			6			1
Family Planning			2			3
Foster Care - Adults					49	1
Foster Care - Children						71
Foster Care - Various					17	36
Health-Related Services			70		3	11
Home Deliv./Cong. Meals						
Homemaker Services			58		82	6
Home Management			66		28	32
Housing Improvement			15		1	1
Information & Referral						
Legal Services			4		1	
Placement Services		23			12	1
Protective Svcs-Adults						
Protective Svcs-Childrn						
Protective Svcs-Various			23			
Recreational Services						
Res. Care & Treatment					1	
Unmarried Parents Svcs						
Socialization Services						
Sp. Svcs-Alcohol & Drug						
Sp. Svcs-Blind						
Sp. Svcs-Child. & Youth						
Sp. Svcs-Disabled					14	7
Sp. Svcs-Juvenile Dels.					1	15
Transitional Services						
Transportation			25		4	
Vocational Rehab.						
WIN Medical Exam						
Other					633	10

NATIONAL SUMMARY OF STATE SERVICES TO PRIMARY RECIPIENTS

Quarter Ending: DEC. 1975

SERVICES	STATES					
	KENTUCKY		MINNESOTA		OREGON	
	No. Adults	No. Children	No. Adults	No. Children	No. Adults	No. Children
Adoption Services						
Case Management Svcs	92	162				
Chore Services			1,220		169	
Counselling Services		1	5,680			
Day Care - Adults			1,220		22	
Day Care - Children						
Day Care - Various						
Diag. & Eval. Services						
Educ. & Training Svcs			1,080		170	
Emergency Services						
Employmt Rel. Med. Svcs						
Employment Services			2,100		93	
Family Planning			260		15	
Foster Care - Adults			1,610			
Foster Care - Children		6				
Foster Care - Various					319	
Health-Related Services			7,810		1,293	
Home Deliv./Cong. Meals			250		20	
Homemaker Services			550		3	
Home Management	3		740		27	
Housing Improvement			860		122	
Information & Referral						
Legal Services			880			
Placement Services						
Protective Svcs-Adults			1,430			
Protective Svcs-Childrn			370			
Protective Svcs-Various	5	6			86	
Recreational Services			180		28	
Res. Care & Treatment		4	1,660			
Unmarried Parents Svcs						
Socialization Services					87	
Sp. Svcs-Alcohol & Drug						
Sp. Svcs-Blind						
Sp. Svcs-Child. & Youth						
Sp. Svcs-Disabled						
Sp. Svcs-Juvenile Dels.	5	56				
Transitional Services						
Transportation			410			
Vocational Rehab.						
WIN Medical Exam						
Other					706	

SERVICES	STATES			
	TENNESSEE		UTAH	
	No. Adults	No. Children	No. Adults	No. Children
Adoption Services	183	308	1	1
Case Management Svcs				
Chore Services			1	1
Counselling Services			7	
Day Care - Adults				3
Day Care - Children				
Day Care - Various				
Diag. & Eval. Services			29	151
Educ. & Training Svcs				
Emergency Services	2	77		
Employmt Rel. Med. Svcs			7	2
Employment Services			1	
Family Planning				
Foster Care - Adults			1	15
Foster Care - Children				
Foster Care - Various		83	2	2
Health-Related Services				
Home Deliv./Cong. Meals			2	9
Homemaker Services				
Home Management				
Housing Improvement				
Information & Referral				
Legal Services				
Placement Services	66	82		
Protective Svcs-Adults			9	
Protective Svcs-Childrn				
Protective Svcs-Various				
Recreational Services				
Res. Care & Treatment				
Unmarried Parents Svcs	19	22		
Socialization Services				
Sp. Svcs-Alcohol & Drug				
Sp. Svcs-Blind				
Sp. Svcs-Child. & Youth				
Sp. Svcs-Disabled				
Sp. Svcs-Juvenile Dels.				
Transitional Services				
Transportation			1	2
Vocational Rehab.				
WIN Medical Exam				
Other				

If the cost of caring for the MRs currently in the ICF/MR system becomes a Title XX responsibility, either the local and state share would increase dramatically, or funding for other services would suffer. As Table 5.43 shows, Residential Care and Treatment does not represent the largest-usage Title XX service nationwide. The category of residential care and treatment listed here includes all five groups (emotionally disturbed, CD, MI, MR and corrections). Both Minnesota and national totals are shown in Table 5.44.[114]

Another argument against using Title XX is the different program elements that would be required if a funding switch occurred. The program elements would have to be changed not because of a determination that one element was "better" than another, but because funding would not be available without the changes.

In short, Title XX could be used as an alternative funding source, but only at the risk of leaving gaps in MR coverage and eligibility as well as the potential for large increases in local and state expenditures for MR residential services, along with a probable concomitant limiting of local options concerning quality and availability of other Title XX services. It can be hypothesized that all of these factors would cause extreme reactions in the community, particularly among the active MR advocates, including parent groups, MR professional associations, provider groups, and others. This anticipated reaction would serve to make any proposed switch to Title XX essentially unfeasible due to political pressures.

2. SSI/MSA

Supplemental Security Income (SSI or Title XVI), in addition to Title XIX and Title XX, is another possible funding source for paying monthly charges for individuals residing in residential facilities. The SSI Program provides monthly cash payments to eligible MR recipients. The limitations of SSI as a primary funding resource for individuals residing in MR residential facilities are discussed below.

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[114]U.S.D.H.E.W./S.R.S. Social Services U.S.A., from Table 4, pp. 33-46.

Table 5.44
Utilization of Title XX Services

NATIONAL SUMMARY OF SERVICES PROVIDED TO PRIMARY RECIPIENTS

Quarter Ending: DEC. 1975

SERVICES	NATIONAL TOTALS		MINNESOTA
	No. of States Delivering Svc	Total No. of Recip. of Svc	No. Recipients
Adoption Services	41	37,948	6,563
Case Management Svcs	10	170,850	0
Chore Services	34	126,898	7,094
Counselling Services	38	396,386	40,804
Day Care - Adults	34	36,484	15,518
Day Care - Children	48	403,424	13,151
Day Care - Various	5	29,102	0
Diag. & Eval. Services	11	28,880	0
Educ. & Training Svcs	43	197,703	8,709
Emergency Services	13	8,133	0
Employmt Rel. Med. Svcs	28	10,310	0
Employment Services	37	145,332	25,541
Family Planning	49	173,131	1,114
Foster Care - Adults	23	25,554	2,488
Foster Care - Children	29	195,272	26,127
Foster Care - Various	10	26,113	0
Health-Related Services	43	489,368	27,515
Home Deliv./Cong. Meals	26	22,008	1,520
Homemaker Services	46	144,183	7,508
Home Management	41	117,997	7,703
Housing Improvement	42	83,246	3,926
Information & Referral	14	77,371	0
Legal Services	27	136,861	5,950
Placement Services	22	51,698	0
Protective Svcs-Adults	33	110,695	14,170
Protective Svcs-Childrn	35	362,876	30,161
Protective Svcs-Various	10	83,481	0
Recreational Services	20	40,570	2,490
Res. Care & Treatment	22	107,093	18,806
Unmarried Parents Svcs	14	15,092	0
Socialization Services	19	52,596	0
Sp. Svcs-Alcohol & Drug	9	9,564	0
Sp. Svcs-Blind	0	4,514	0
Sp. Svcs-Child. & Youth	0	15,860	0
Sp. Svcs-Disabled	7	7,187	0
Sp. Svcs-Juvenile Dels.	9	5,341	0
Transitional Services	3	3,497	0
Transportation	47	147,067	5,061
Vocational Rehab.	27	9,583	0
WIN Medical Exam	20	3,647	0
Other	13	46,978	0

The 1972 Amendments to the Social Security Act (Public Law 92-603) created the Supplemental Security Income Program, effective January 1, 1974. This program, to be federally administered, replaced the existing state/county administered adult programs of Old Age Assistance, Aid to the Permanently and Totally Disabled, and Aid to the Blind.[115] The program provided for a monthly base maintenance payment of $140 to the aged, blind, and disabled. Realizing the probable inadequacy of the basic monthly payment, the federal legislation provided each state the option of enacting a supplement program. In July, 1973, Public Law 93-66 was passed, which modified this optional supplement provision by creating a mandatory supplement program to be provided at state expense to assure that recipients converted to SSI from the existing adult programs would be maintained at the same income level that they were receiving in December, 1973. States could elect to provide further SSI supplements on an optional basis, and as of October, 1975, only thirteen states had not enacted some form of optional supplementation program.[116] States may elect to have the Social Security Administration administer either or both of its mandatory and optional supplement payments. Under federal administration of these supplement payments, a single check, issued monthly to the SSI recipient, includes the basic federal SSI payments and also the state supplement amounts. The state is required to advance to SSA on the first of each month sufficient monies to cover all supplement payments that SSA will pay in that month on the state's behalf. An advantage to the state of electing federal administration of these supplement payments is that the federal government will assume the administrative costs of issuing the payments.[117] However, this advantage has diminished as former administrative costs

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[115]Information in this paragraph from Neil McKellips, DPW Bureau of Income Maintenance. November 5, 1976.

[116]U.S.D.H.E.W. Social Security Administration. Office of Research and Statistics. The Supplemental Security Income Program for the Aged, Blind, and Disabled. Selected Characteristics of State Supplemental Programs.

[117]U.S. Congress. Joint Committee Print. Studies in Public Welfare. Paper No. 20. Handbook of Public Income Transfer Programs: 1975. A staff study for the Subcommittee on Fiscal Policy of the Joint Economic Committee, pp. 113-139.

have been redefined as non-administrative costs, and charged to the states.[118]

The 1974 Minnesota Legislature enacted the Minnesota Supplemental Aid Program (MSA), effective April 1, 1974. MSA provides for both mandatory and optional supplement payments to eligible individuals. Minnesota chose to have federal administration of its mandatory supplement payments from January 1, 1974, through September 30, 1975. The optional supplement payments for this period were administered by the 87 county welfare or social service agencies in Minnesota. On October 1, 1975, Minnesota changed from federal to state/county administration of the mandatory supplement payments. The eligibility factors and standards to be used in determining initial and continuing eligibility and grant amount are identical for the mandatory and optional supplement payments. The identical nature of the two programs provides assurance to the converted recipient that he will be maintained at his December, 1973, income level. Identical criteria and standards enable the local administering agencies, with SSA approval, to combine the mandatory and optional components of the monthly MSA grant to the recipient (possible since Oct. 1, 1976).

The program is an available resource to those individuals who are over 65 years of age, who are blind, or disabled as defined by the Social Security Act. SSI is a means - tested welfare program intended to defray ordinary living costs, not medical care costs. Income and resources must be taken into account in establishing initial and ongoing SSI eligibility and payment amount. We discuss only the features of SSI relating specifically to residents of facilities that serve MRs.

If an individual with no income is a resident of a "public institution" or of a non-public institution (as determined by SSA) in which Title XIX pays 50% or more of his care, he/she is eligible for a $25 SSI monthly payment. If Medicaid pays for less than 50% of an individual's care while a resident of a "public institution," then he/she is not eligible for an SSI

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[118]Neil McKellips interview. Nov. 19, 1976.

payment. A resident of a non-public institution with no income and with Title XIX paying less than 50% of the monthly charge could be eligible for an SSI payment up to the maximum monthly payment of $167.80 depending to some extent upon the other types of funding resources. A general guide that can be used is that, if an individual resides in a facility and receives 50% or more in Medicaid support, and has unearned income only of $45 or more, he is not eligible for an SSI payment. If this same individual has only earned income of $135 or more, he would also be ineligible for an SSI payment.

As is apparent from the above explanation, SSI and Medicaid have a close inter-relationship. In 33 states and Washington, D.C., SSI-eligible persons are automatically eligible for Medicaid. In Minnesota and 15 other states, SSI recipients who were converted to SSI from the prior adult programs continue to be eligible for Medicaid so long as they continuously receive SSI. New SSI recipients since January 1, 1974, must apply for Medical Assistance and have their eligibility determined based on January, 1972, program standards. The "spend-down" provision is, of course, included in these standards.

Quality of care in facilities is not regulated by SSI; SSI makes monthly maintenance payments directly to eligible individuals. SSI cannot be paid to an individual residing in a facility which provides medical services which are Title XIX eligible and which could be paid from that source if the facility were Title XIX-certified. A resident of a previously MA-certified facility which has elected to drop its MA certification can only continue to be eligible for SSI if it can be documented that the facility is providing nothing more than board, lodging, and laundry. Put another way, any reflection of medical services in the facility's per diem rate or monthly rate would probably result in a review of the individual's continued eligibility for the SSI payments.

In a non-medical facility, MSA can only supplement SSI up to the clearly identified monthly maintenance rate charged by the facility. In such a facility, certain types of other funding sources, particularly if they are vendor payments, could affect the amount of the SSI payment, but Title XX funds are excluded from this consideration. An individual residing in such

a facility can be eligible for Medicaid in the same manner as other individuals in independent living arrangements.

Probable Effects of Primary Dependence on SSI/MSA

It is evident from the description of SSI and MSA, that use of these programs as primary funding sources for CBFs would cause problems. If Minnesota had chosen not to use Medicaid for MR facilities, or if such a decision by the state were to be made now, vast changes in the present ICF/MR system would result. Medical components of current ICF/MR programs could adversely affect SSI eligibility of the residents. Even if the programs where changed to avoid such problems, SSI would supply a set amount to the resident with MSA supplementing only for the maintenance portion of the cost of care. Facilities would thus have to depend on other sources of funding as well as SSI/MSA that residents could receive, if eligible. The primary option, Title XX funds, would not be a viable option, as discussed earlier in this chapter.

Medicaid funding has made the development of the ICF/MR system possible. Any drastic change in the system and its program offerings, such as would occur in a switch to Title XX or Title XVI as primary sources, would meet with great community and advocate resistance, rendering such a change virtually impossible.

3. HUD

A regional HEW publication[119] and a communication from the Dallas Regional HUD office indicate the availability of certain HUD - financed programs for MR community residences. These programs include mortgage insurance for nursing homes and related care facilities, section 8 low income housing programs, section 202 housing for the elderly and handicapped, and the community development block grant program. Some of these programs are currently being used to some extent in Minnesota for MR programs; some are not. In this section we briefly describe these funding programs and indicate the usage or possible usage of such a

[119] Region V Task Force on Alternatives to Institutionalization. "Alternatives to Institutional Care." Staffed by Office of Regional Director, HEW Region V, Chicago, Illinois.

funding source in Minnesota.[120]

Community Development Block Grants:

The Community Development Block grant program of HUD (Title I of the Housing and Community Development Act of 1974, P.L. 93-383) gives grants to local units of government and the state to help develop viable urban communities through housing and economic development projects in locally-determined priority areas. The Housing Act of 1976 expands this program to include centers for the handicapped as eligible projects. This new provision is the basis for our considering this program as a potential source for MR programs.

This is not a very viable possibility, however. Traditionally, services deemed community-wide are ineligible for funds through this program. Group homes and halfway houses are considered, according to regulation, to be community-wide rather than neighborhood-wide and are therefore ineligible. Generally, residential structures are not eligible and in particular, medical facilities are excluded from eligibility. Possible uses might include funding for sheltered workshops as a part of a public center for the handicapped. This provision is relatively new (final regulations have not been issued; interim regulations are printed in the Oct. 4, 1976, Federal Register) and therefore there is no experience with the program as of now. The local governmental unit would still be responsible for determining how community development funds are spent, so any possible use would be dependent on their decision as well as HUD's determination of eligible programs.

Mortgage Programs:

Of the many HUD mortgage insurance programs, one is available for nursing homes and related care facilities. This mortgage insurance is for financing

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[120]Information on these programs from the HEW publication, Dallas Region HUD office, the Code of Federal Regulations. Information on usage and potential from various persons at HUD area office, DPW, SPA, FHA and State Coordinators of Mental Retardation programs.

construction of nursing homes and other long term care facilities. Minnesota's State Housing Finance Agency administers this program, which is now being used in Minnesota as a source of funding for ICF/MRs and other group homes.

In his 1975 Budget Message, Governor Anderson indicated an emphasis on construction of residential facilities for MIs, MRs and CDs. He requested that $10 million be set aside by the Housing Finance Agency for this purpose. In amendments to Chapter 462A, Minnesota Statutes, the 1976 Laws formalized this proposal by stating the need for adequate financing for construction, renovation, or rehabilitation of residential care facilities. Of the $10 million set aside for this purpose, approximately $6 million has been spent to finance construction, etc., of CBFs.

Another HUD-based program that can be used for financing construction or rehabilitation of housing and related facilities for the handicapped is Section 202, Housing for the Elderly and the Handicapped. Through this program, non-profit agencies can apply for 40-year loans to finance construction or rehabilitation. This money is very limited, however. Of the 1,500 project applications that the HUD central office received, only 136 projects were approved (and not until 1976). Only the most experienced and financially capable sponsors are chosen, selected on the basis of demonstrated financial and managerial capabilities.

Section 8 Programs:

Section 8, or low-income housing assistance programs, can be available to a limited extent for MRs. Section 8 programs are designed to provide housing for low income persons and/or families at affordable rents. Persons pay between 15 and 25% of income to the owner who in turn receives the difference between this and the fair market rent from HUD through the local housing agency. Each state is allocated a certain number of units which must be allocated to eligible low income persons. Space can be provided for eligible handicapped (including MRs) at the local and state housing agencies' discretion.

A few states (such as Michigan, New Jersey, and Virginia) have been successful recently in getting approval for

section 8 units devoted to the handicapped. Currently, the Minnesota Housing Finance Agency does not consider group homes for MRs to be a wise use of these funds, partly because each person is counted as taking one family unit, even though the MR could share the actual space allotted. Another reason is the amount of money currently available for MR care in Medicaid facilities.

Section 8 is not intended to be used for health care, so it would be a viable source for those MRs who might reside in supervised or independent living. There are potentially eligible MRs in the community. In addition, there are estimates of approximately 190 MRs presently in Medicaid long term care that have potential for discharge to the home or other independent living situation.[121] There are others who could live in supervised, but non-medical residences. Income limitations could adversely affect working MRs' eligibility but there is some potential in this program that should be looked into as a possible source of aid to living support.

Summary

There are certain HUD programs available for MR housing needs. Each program has specific provisions and requirements that can be complex. Some programs are funded on a periodic basis, so the application process is dependent on periodic notices appearing in one publication. Application procedures often involve the support and approval of local and state units of government as well as final HUD approval. However, the programs briefly described here warrant close scrutiny both for possible state use and for information to pass on to individual developers and/or agencies. The possibilities have ramifications for Medicaid cost savings and increased possibilities for further development of the MR continuum of care.

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[121] QA&R p. 99.

F. Improvements in the Reimbursement System

1. DPW Rule 49

The overall purpose of Rule 49 is to monitor the costs which are reimbursed to nursing homes by federal and state funds while maintaining adequate limits for quality care and fair return to providers. The limitations and cost principles implemented to further these ends, however, include subtleties and repercussions which may have unintended negative impacts on Medicaid cost-containment efforts. Based on our study, we now discuss some of these features of Rule 49 and recommend improvements:

a. In calculating maximum rate limitations, all nursing homes within Regions 3 and 11 of a given level of care and type of ownership are averaged together. The rationale is that these regions are urban and should be distinguished from the other predominantly rural regions. Although the majority of the homes in Region 3 are located in urban St. Louis county, the seven-county area encompasses the entire northeast corner of the state and some of the most sparsely populated land. Even Region 11 (Hennepin, Ramsey, Scott, Dakota, Anoka, and Washington counties) includes large non-urban areas.

To average together all nursing homes of a given level of care and type of ownership within these regions is to discriminate against the truly urban facilities that experience higher costs due to their location, and to give a bonus to rural facilities which happen to be located in an "urban" region. For example, both Hennepin and Koochiching are considered urban counties and averaged together for rate-setting purposes. Aggregating nursing home costs from Hennepin and Koochiching counties allows the rural facilities a higher maximum limitation than they would receive were they averaged with other rural homes only.

An alternative to this method of rate determination would be modification or abandonment of the regional lines. Using a partial regional basis, that is, averaging in general by region but distinguishing exceptional counties (perhaps by SMSA), would seem to create more havoc than equity. Averaging totally by urban/rural counties may be preferable only if the lines could be fairly drawn. The problem that arises is that a county cannot be labeled on the basis of isolated demographic statistics. Complicating this designation are such factors as labor force and consumer activities of neighboring counties. A primarily rural area may actually face the same economic conditions as an urban area when considering the total picture. Because of the controversy involved with urban/rural designations, DPW has adhered to the regional principle.

b. The maximum rate limitation currently takes into account only the total facility cost with maximums in the broad category of indirect and direct care. Therefore, costs in several categories may vary greatly from costs in comparable facilities, but if the total figure of indirect, direct or total costs does not exceed the limitation, no action need be taken. It is possible, however, that DPW auditors, in reviewing such reports, may be familiar enough with ranges of each category to recognize such aberrations and to suggest reasonable maximums for the various cost categories. Establishment of cost category maximums might facilitate cost containment. Clearly, greater efficiency would be encouraged, as facilities would no longer be able to balance higher costs with lower costs (at least not between direct and indirect care, though still within these categories).

c. The investment per bed limitation in effect defines a luxury level for the Medicaid program. Those facilities which exceed the investment limitation are operationally defined as operating excessive homes, however the maximum would appear to be unnecessarily high and could be reexamined.

d. By the criterion of top management cost limitation alone, it is more economical to the MA program for beds to be located in larger facilities where the cost allowance for top management is much less. In isolation, this fact would seem to be justification for recommending the use of larger facilities; however, the largest facilities do not have the lowest overall costs, indicating the importance of many other factors.

e. Occupancy inducements operating in Rule 49 are not consistent. While the anticipated occupancy incentive rewards homes which function above 93% of capacity by affecting allowable costs, there is an occupancy disincentive at work in the limitation on cost of capital. In this case, non-proprietary facilities are eligible for the maximum earnings allowance of $.35 per patient day if operating above 93% occupancy, while those below this percentage receive allowance reduced by the amount of occupancy incentive. The effect of this is to provide all non-proprietary homes with a $.35 daily allowance, from different provisions of the rule depending on the particular occupancy rate. Non-proprietary homes thus have no reimbursement incentive to operate at maximum occupancy. The rationale for this policy relates to revenue sources. In an effort not to discourage the use of charitable donations by non-proprietary facilities, DPW grants depreciation allowances for capital assets purchased with these revenues. In fairness to the proprietary

homes, constraints were placed on occupancy incentives and cost of capital limitations for non-proprietary facilities.[122]

Although inducing nursing homes to maximize occupancy is economically efficient in the short run, the incentive may promote admissions for financial rather than for medical reasons. In the long run, high occupancy rates may be a greater financial burden to the Medicaid dollar than low occupancy rates resulting from careful patient screening.

f. The proposed rule change affecting interest and earnings allowances will improve some undesirable effects of Rule 49. Under the present principles, providers who have been in business for a considerable length of time, and who thus realize low interest, were disfavored. The advantage was given to new providers who begin with a small down payment and extend a large interest rate over a long period of time. The rule change will help to rectify this discrepancy, which is a particular problem during change in ownership.

g. In Minnesota, the reimbursement system recognizes three levels of care, SNF, ICF-I, and ICF-II, despite the fact that the federal Medicaid program recognizes only two, SNF and ICF. State licensure of nursing care facilities also recognizes two types of home, but they are not consistent with the federal types. Thus, facilities certified for ICF care but licensed by the state as BCHs are reimbursed at a lower rate than other facilities meeting the same federal ICF requirements but state-licensed as NHs. Our study found ICF-IIs to cost about $5/day less than ICF-Is; thus differences between these two levels of care do exist. This situation is illustrative of the types of problems encountered when attempting to coordinate a program between two levels of government. Whether these distinctions introduce real or artificial cost savings into the Medicaid program deserves further investigation. Certainly it would be administratively easier if federal and state guidelines meshed.

h. Rule 49, section 4922 b allows nursing homes to purchase services or products from a private business owned by the nursing home operator, as long as the private business sells at least 25% of the products or services to "outsiders." Thus it is possible for the private business to charge inflated prices. To ensure that the operator is not operating the private business solely to service the nursing home, the 25% criterion should either be raised or the practice prohibited.

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[122]Bob Rau, interview 11/24/76.

In summary, we have examined Rule 49 and recommend the following changes to enhance cost-containment:

- Although the current averaging of all NHs within the urban and all NHs within the rural regions has equity problems, none of the proposed alternatives seems any better; we recommend no change at present;

- Prohibit a nursing home from purchasing services or products from a private business owned by the nursing home operator, or require that the private business do substantially more than 25% of its business with "outsiders."

- Maximums be established for the various cost categories in addition to maximums on total facility cost and indirect or direct costs as at present, if they appear cost effective; and monitor the implementation of the indirect and direct maximums;

- Re-examination of the limitation on per-bed investment; it may be unnecessarily high;

- Re-examine the appropriateness of the current occupancy incentives in the light of Medicaid cost-containment. The encouragement of high occupancy rates should be tempered by a requirement for more rigorous patient screening based on the need for nursing home care;

- Examination of the impacts of the State reimbursing ICF-I and ICF-II care differently: our study found distinctions in costs and clients for the two levels. Should the Medicaid patient certification process distinguish between ICF-I and ICF-II?

2. DPW Rule 52

DPW Rule 52 is the prospective cost reimbursement mechanism employed by the State of Minnesota to reimburse community ICF/MRs (not ICF/MR units in state hospitals).[123]

Although prospective reimbursement has been hypothesized to induce cost-consciousness among Title XIX providers, there is no systematic evidence to confirm this. In essence, prospective cost-reimbursement mechanisms such as DPW Rule 52 require a Title XIX provider to estimate costs for the next fiscal period (with a limitation of a 15% cost rise) based upon costs in the previous fiscal period.[124]

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[123]Regulations of the Minnesota Department of Public Welfare for Determining Welfare Per Diem Rates for ICF/MR Providers under the Title XIX Medical Assistance Program, DPW Rule 52, revised 1/1/76.

[124]Ibid, p. 8.

A Title XIX provider, then, must keep costs under or equal to this prospective reimbursement rate for the next fiscal period. If costs exceed this rate, the provider must absorb the deficit.

Based on our study, we submit that DPW Rule 52 can be made more responsive in an attempt to reduce costs, yet retain quality of care, by:

a. Reducing the 15% annual allowable cost increase. It has been hypothesized that the prospective rate-setting mechanism forces the provider to keep costs within the prospective rate. However, the 15% allowance for known cost changes may be excessively high. In the period of July, 1975, to July, 1976, the consumer price index had risen 5.4% for all goods and services, with medical care prices rising 9.2% and housing prices increasing at an annual rate of 6.2%.[125] Clearly, these figures would indicate that inflationary pressures could be easily overcome with a 10% overall rate limitation.

b. More field auditing of ICF/MRs to ensure more provider accountability in the area of costs, especially staffing and program costs. DPW staff now have little time for field audits.

c. Elimination of the DPW Rule 52 section which allows "an unidentified cost increase equal to 1% of the average historical cost per day for the metropolitan area."[126] There is no economic justification for the existence of a provision which can only be viewed as inflationary.

d. The implementation of an economic incentive in Rule 52 to increase occupancy rates, similar to a provision already in existence in DPW Rule 49, which states: "Excess capacity is eliminated from the Welfare (Title XIX or Medicaid) rate through use of patient days at 93% of licensed capacity for calculating cost per patient day for administration, depreciation, interest, property taxes and earnings allowance."[127] Thus, there would be an economic incentive for ICF/MR providers to maximize occupancy levels and eliminate "excess capacity" or facility assets which are being misallocated. Title XIX rates for those facilities operating over 93%

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[125]Consumer Price Index, CPI Detailed Report for July 1976, printed September 1976, pp. 1, 10, 12.

[126]Regulations of the Minnesota Department of Public Welfare for Determining Welfare Per Diem Rates for ICF/MR Providers under the Title XIX Medical Assistance Program, DPW Rule 52, revised 1/1/76, p. 5, Section II A. 3. a. (12).

[127]Provider Manual, Minnesota Department of Public Welfare, Rule 49, 3rd ed., May, 1976, p. 3.

occupancy would thus be higher than otherwise, while those facilities operating below 93% occupancy would receive lower rates than otherwise. Occupancy rates are generally high, but the rapid increase in CBFs may change this trend in the future. Adoption of this economic incentive would permit Section IV. B. 7 of the Rule 52 regulations to be eliminated (this provision allows reimbursement of costs incurred in community ICF/MR advertising to maximize occupancy); the incentive for maximum occupancy would be built-in, were the economic incentive adopted.

e. Appel and Schlenker have advocated the use of special needs measurement as a basis for reimbursing Title XIX facilities.[128] In essence, Appel and Schlenker advocate relating patient characteristics to costs for Title XIX facilities through the formulation of a measurement system which measures patient characteristics and relates these unit measurements to costs. In the area of ICF/MRs, patient characteristic measurements could include the measuring of severity of mental retardation, age, and degree of ambulation. These patient characteristics measures could then be used to categorize Title XIX facilities by their clientele. Appel and Schlenker also advocate case studies of a facility in a given prearranged category in order to more precisely relate costs to patient characteristics. With this, dollars expended on medical care and programs would be far more efficiently used than at present, where Title XIX rates bear no relationship to the special needs or patient characteristics of clientele served in nursing homes or ICF/MRs.

f. Section III. B. 1. of the Rule 52 regulations[129] should be changed because of possible monopolistic implications. This provision allows an ICF/MR to reimburse a separate organization owned by the ICF/MR owner for services or products provided, as long as the other organization (private business) sells at least 25% of its products to "outsiders." Thus it is possible for the private business to charge the ICF/MR inflated prices. To ensure that the operator is not operating the private business solely to service the ICF/MR, the 25% criterion should either be raised or the practice prohibited.

g. Rule 52 does not clearly separate out salary costs.[130] The Rule 52 allocation of staff time should be indicated by functional criteria (i.e., program, general support

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[128]Gary L. Appel and Robert E. Schlenker, "Facility Costs Versus Patient Care Costs," December, 1975. Presented at the Third Conference on Long-Term Care Reimbursement, sponsored by the National Center for Health Services Research, Chicago, Illinois, December 8-9, 1975.

[129]DPW Rule 52 Regulations, p. 12.

[130]Ibid., pp. 12-14., Section III. C. 1. a.-i.

or medical care areas), thus enabling auditors to acquire a more precise view of how staffing costs should be allocated between categories and what staffing costs may be unallowable.

h. Section IV. A. 9. should also be revised.[131] This provision concerns community ICF/MR management compensation limitations. CBF administrators can earn more than SH CEOs even though the facilities are smaller, because: the job duties are not defined, there are no requirements for full-time on-site work (part-time work does not have to be prorated), there are no limits on the number of CBF facilities a person can administer or consult with, and there is confusion as to whether or not the top management limit of $35,000 is for the top administrator alone or for the top level of administrative staff.

i. Cost data from Rule 52 could be better utilized if on an EDP system similar to that used for nursing homes.

j. Closer scrutiny of facility costs in meeting federal, state or local regulations. As we discuss earlier, Rule 52 allows reimbursement of ICF/MR facilities for their projected real costs, but only for costs which are "allowable" in one of the ten cost categories. Furthermore, these costs may not exceed costs of the previous year by more than 15%, and the full amount of the projected costs must be justified in the Rule 52 report. There is one important exception to this limit on reimbursable costs: "pass through" costs.[132] This concept is designed to allow facilities to recover expenditures made "to maintain minimum and immediate requirements" in meeting federal, state, or local regulations.

Deficiencies cited during the certification/licensure procedure must be corrected. For corrections requiring additional expenditures by the facility, costs may be "passed through" and reimbursed, even if this results in a cost increase of more than 15%. In fact, there is no limit to the amount that can be passed through during a given year.[133] The total cost of making these corrections is added to the total projected costs in the 10 categories; this total facility cost is then divided by the projected number of resident days at the per diem cost. The following year, the total cost figure (10

[131] DPW Rule 52 Regulations, pp. 16-17.

[132] This information obtained from Tom Neumann, DPW.

[133] See DPW Rule 52, Section II, D. 2.4.

allowable cost categories plus "pass through" costs) is considered the historical cost which may be increased by 15%. Thus, costs which are "passed through," which may reflect a one-time correction effort, have both current and continuing effects on reimbursement rates. Again, there is no dollar or percentage limit on costs which may be "passed through."

To investigate further the extent and cost impact of "pass-throughs" on Medicaid costs, we obtained data on "pass-throughs" for 79 ICF/MRs which had one or more annual cost reports on file as of December, 1976, and had the opportunity to claim costs as "pass throughs." These data are described in Table 5.45. 16 ICF/MRs which had only one cost report on file had not claimed any "pass-through" expenditures; 6 others which had 2 cost reports on file claimed no "pass-through" costs; one facility had cost reports for 3 years without claiming any pass-throughs. The other 56 ICF/MRs had a total of 129 cost reports on file; "pass-through" costs were included on 103 of these reports. The amounts claimed as "pass-through" costs added from $.01 to $10.01 to the per diem cost of the ICF/MR facility. The 103 reports claiming "pass-through" costs requested a total of $174.81, or an average of $1.70 to be added to per diem reimbursement.

Thus we conclude that the Rule 52 "pass-through" situation deserves serious attention and recommend the following:

-If possible, eliminate pass-throughs completely. They may have been justified in order to encourage development of ICF/MRs during the past few years; such encouragement seems unnecessary at the present time. They may also have been justified to enable facilities to meet the new March, 1977, ICF/MR regulations; needed structural changes should have been implemented by now or if not, should be financed out of the 15% allowable cost increase.

-If it is not possible to completely eliminate the pass-through, then its use should be severely limited, by:

- Putting a cap on amount that can be passed through;
- Not adding capital expenditure pass-throughs to the historical costs upon which future per diems are based or upon which the 15% increment is calculated. Since most of these are one-time only efforts to meet regulations, it seems unreasonable to build these into historical cost figures. Staff cost pass-throughs should probably be added to historical costs, however;
- Limit the number of times a facility can use "pass-throughs." We found that a number of facilities had "pass-throughs" every year;

TABLE 5.45

Description of Cost "Pass-Throughs" for 79 ICF/MRs Having One or More Annual Rule 52 Cost Reports as of December, 1976

Descriptors	Number of Facilities	Number of Cost Reports on File	Number of Pass-Through costs	Amount Pass-Through added to per diem cost: range	Total Added to per diem cost	Average Amount to be added to per diem cost
ICF/MRs with no pass-throughs:						
One cost report on File	16	16				
Two cost reports on File.	6	12				
Three cost reports on File	1	3				
Total with no pass-throughs	23	31				
ICF/MRs with pass-throughs:	56	129	103	$.01 to $10.01	$174.81	$1.70
Total	79	160				

- Closer coordination among all appropriate inspectors and regulators, including MDH, local and state Building Code inspectors, local and state Fire Marshal, and DPW, to ensure that staff, plant, and plans for MR resident care and services have been inspected and are in compliance with all standards which can be applied before operations actually begin, before advance certification is given and before any residents are admitted. Before the ICF/MR is allowed to open, it should be required to document the availability of needed staff resources;

- Use "pass-throughs" only for costs of meeting new regulations, not for costs of meeting deficiencies based on current regulations; and

- Require facilities to repay any money passed through to correct deficiencies which were not actually corrected.

In summary, we have recommended cost-containment changes in DPW Rule 52 as follows:

- Reduce the 15% annual allowable cost increase, to perhaps 10%;

- More field audits of ICF/MRs by DPW Staff;

- Eliminate the 1% annual "unidentified cost increase" for the metropolitan area;

- Add an economic incentive to increase ICF/MR occupancy rates, similar to that currently in Rule 49 for nursing homes;

- Relate Medicaid reimbursement rates to patient characteristics, i.e., categorize ICF/MRs by their clientele for reimbursement purposes and establish reasonable cost maximums for each type of client;

- Prohibit an ICF/MR from purchasing services or products from a private business owned by the ICF/MR operator, or require that the private business do substantially more than 25% of its business with "outsiders;"

- Clearly separate staff salary costs by functional area;

- Revise the Rule 52 limitation on top management salary for ICF/MR administrators as follows:
  a) The maximum salary should be paid only for full-time, on-site work; part-time administrative work should be prorated.
  b) Job duties for an ICF/MR administrator should be specified.
  c) The salary limitation should clearly limit both the salary of the top administrator and the total administrative salaries for a facility, and should relate total administrative salaries to the size of the facility.
  d) Maximum compensation for an administrator of a CBF should be significantly lower than the salary of an SH CEO, perhaps $20,000. Any person who considers his/her administrative abilities worth more than those of a CEO should not waste excessive talents on a small facility;

- Eliminate or severely restrict use of "pass-throughs" for costs of meeting federal, state, or local regulations; and

- Place Rule 52 cost data on an EDP system similar to that for nursing home cost data, to facilitate cost analysis.

CHAPTER VI
ANALYSIS OF OTHER COST-CONTAINMENT ALTERNATIVES

A. Medicaid Cost-Containment in Other States

In an attempt to learn from the experiences of other states in containment of their Medicaid program costs, we turned first to the budget documents from the 50 states. Our review of these documents revealed that (1) most of the cost-containment efforts mentioned in the budget documents (most of them at least a year old) were proposals rather than implemented changes and (2) the information they did contain was not standardized enough to permit comparisons. Thus we determined, in early 1976, that a systematic survey was needed in order to determine what cost-containment efforts had been undertaken by the 50 states, what had been learned by the states from these efforts, and how much had actually been saved.

The National Association of State Budget Officers (NASBO) Committee on Systems, Techniques, and Data, agreed to sponsor the survey, using a questionaire designed by our project staff. The questionaire was mailed to the 50 states in Spring, 1976.

Thirty-six responses were received. A copy of the survey form, a summary of findings from the 50 states, and a preliminary tabulation of the survey responses are included in Appendix H. Because the reader can find the detail in Appendix H, we present only the highlights of the survey findings here.

Table 6.1 displays actual annual state dollar savings of $1 million or more which survey respondents reported had resulted from specific Medicaid cost-containment efforts. These results are rank ordered by reported amount of state dollar savings per year. As Table 6.1 indicates, all of the cost-containment efforts which resulted in savings of $1 million or more were either attempts to control consumer demand or administer Medicaid more efficiently; none were results of efforts to impact producer supply of Medicaid services. The 31 cost-containment efforts listed in Table 6.1 represent only four general categories, as follows:

Response Category	Number of times it appears in Table 6.1
Alter services	12
Reduce state payment	11
Control fraud and error	7
Reduce overhead	1

TABLE 6.1
ACTUAL ANNUAL STATE DOLLAR SAVINGS
OF $1 MILLION OR MORE

	Actual annual state savings	State	Cost-containment effort
1.	$35 million	Virginia	Editing provider files for duplicate billing and recipient files for service limitations
2.	$34.8 million	New Jersey	Third party benefits recovery
3.	$22.6 million	Florida	Reduction of allowable optometrist rates
4.	$12-15 million	New York	Fraud investigations and prosecutions
5.	$14 million	New Jersey	Reducing provider fees by 10%
6.	$11.2 million	Virginia	Limiting inpatient days to 14.
7.	$10 million	Washington	Controlling hospital rates
8.	$4.5 million	Minnesota	Third party benefits recovery
9.	$4.3 million	Virginia	Eliminating the "growth and development" factor for nursing homes
10.	$4 million	New Jersey	Allowing only half the normal inflationary increase in nursing home per diems
11.	$3.4 million	Florida	Establishing a flat, all-inclusive rate for physician visits
12.	$3.3 million	Virginia	Eliminating coverage for non-legend drugs
13.	$3 million	Florida	Placing a cap of $20/month per recipient
14.	$3 million	Virginia	Changing fiscal agents
15.	$3 million	Florida	Reducing coverage of prosthetic devices with required services
16.	$2.85 million	Oregon	Level of care planning for long term care

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	Actual annual state savings	State	Cost-containment effort
17.	$2.5 million	Nebraska	Field nurses review placement of nursing home patients
18.	$2.4 million	Florida	Reduce annual hospital out-patient services
19.	$2.1 million	Virginia	Drug co-payment
20.	$2 million	New York	Control and decertification of beds
21.	$2 million	Georgia	Reduced adult dental services
22.	$1.9 million	Virginia	Limit dental services
23.	$1.6 million	Florida	Reduced inpatient hospital days from 45/yr. to 30/yr.
24.	$1.5 million	Washington	Curtail elective surgery
25.	$1.5 million	New Jersey	Drug copayment of 25¢
26.	$1.5 million	Nebraska	Results of Medicaid Management Information System
27.	$1.3 million	Nebraska	Fee schedule
28.	$1.1 million	Missouri	Eliminated adult dentures
29.	$1 million	Alabama	Drug copayment of 50¢
30.	$1 million	Nebraska	Trauma investigations
31.	No amount given, but "$4 recovered for every $1 spent"	Nebraska	Third party liability section

Three of the top four actual money savers (in absolute dollars) in Table 6.1 were administrative attempts to detect and control unintentional error. In addition to the actual savings reported above, a number of states have implemented cost-containment changes and report that although it is too soon to be certain of the exact amount of resulting savings, they are willing to project annual state savings based on experience to date. Table 6.2 presents the rank order of those projections which were $1 million or more. The 25 cost-containment efforts listed on Table 6.2 represent the following six general categories:

Response Category	Number of times it appears in Table 6.2
Alter eligibility	2
Alter services	10
Reduce state payment	10
Limit eligible providers	1
Control fraud and error	1
Reduce overhead	1

Tables 6.1 and 6.2 reveal that most (77%) of the cost-containment efforts which have thus far yielded, or are expected to yield, annual state savings of at least $1 million are attempts to either alter services (types, levels, or usage) or reduce state payment for existing services. However, among these efforts which have saved $1 million or more, three of the top four most successful money saving efforts (ranked by dollars saved annually) have been neither efforts to alter services nor reduce state payment: they have been administrative attempts to control fraud and error.

Using the results of this survey, we selected for further brief examination a few additional cost-containment efforts, including those which other states found to be most effective, and those which seemed most applicable for Minnesota.

We discuss first those efforts currently implemented in Minnesota and then analyze the cost and other impacts of several other alternatives. To repeat, because of severe time constraints, our analyses of these alternatives were necessarily general rather than as detailed as we would have preferred. Despite the brevity however, we believe that our recommendations are sound.

TABLE 6.2
PROJECTED ANNUAL DOLLAR SAVINGS
OF $1 MILLION OR MORE

	Projected annual state savings	State	Cost-containment effort
1.	$57 million	California	Establishing on-site review of inpatient hospital days
2.	$38 million	New York	Limiting rates for acute and long term facilities
3.	$30 million	California	Limiting hospital rate increases
4.	$16 million	California	Reducing number of emergency days not subject to prior authorization from 8 to 3
5.	$15 million	New Jersey	Calculating nursing home per diems
6.	$8.9 million	New York	Limiting surgery and pre-operative and hospital stays
7.	$7.5 million	New York	Freezing clinic rates
8.	$7.2 million	Maryland	Limiting dental services
9. & 10.	$7 million	New York	Altering eligibility criteria and limiting provider facilities
11.	$5.5 million	California	County administration of Medicaid
12.	$5 million	Washington	Screening nursing home patients
13.	$5 million	Illinois	Auditing providers
14.	$3.7 million	California	Simplifying eligibility determination
15.	$3.5 million	Mississippi	Drug copayment of 50¢
16.	$3 million	New York	On-site review teams in certain hospitals
17.	$3 million	Georgia	Drug copayment of 50¢
18.	$2 million	Georgia	Hospital copayment of $25

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continued

	Projected annual state savings	State	Cost-containment effort
19.	$1.8 million	Maryland	Limit hospital inpatient services
20.	$1.7 million	Maryland	Limit over the counter drugs
21.	$1.7 million	California	Drug utilization review unit
22.	$1.6 million	Maryland	50¢ copayment on legend drugs
23.	$1.4 million	Maryland	Limit vision services
24.	$1 million	Georgia	$2 copayment on outpatient services
25.	$1 million	Nebraska	Limit nursing home reimbursement

B. Medicaid Cost-Containment in Minnesota

This section discusses several proposals which are claimed, at least theoretically, to have Medicaid-cost savings effects. These proposals were abstracted from the survey of 50 states just discussed, literature, and personal communications. They are:

1. Third Party Benefits Recovery
2. Surveillance and Utilization Review (SUR)
3. Prior Authorizations/Second Surgical Opinions
4. Centralized Payments
5. Quality Assurance and Review
6. Professional Standards and Review Organizations (PSROs)
7. Health Maintenance Organization (HMOs)
8. Altering Eligibility Criteria
9. Reducing Covered Services
10. Limiting Service Amounts
11. Cost-Sharing
12. Hospital Rate Regulation

Minnesota has already implemented, in some form, the proposals which attempt to reduce fraud or error by better administrative control (1 through 4). Minnesota has also undertaken the required outside reviews (5 and 6) and has some experience with HMOs (7). However, it has not implemented proposals which attempt to contain costs by altering services or reducing state payment for services. Minnesota currently has no hospital rate regulation.

1. Third Party Benefits Recovery

Medicaid is, by law, the payer of last resort. Thus it is intended to cover eligible expenses only after all other potential insurance coverages, including Medicare, have been exhausted. Yet in Minnesota and other states it has been commonly accepted that all other insurance coverages of Medicaid recipients have not been exhausted: Medicaid has been paying for services which could have been billed to other insurance carriers.

Generally, the reason for the above-described situation is that health insurance is a complex, technical, and confusing field. To discover and pursue other insurance coverages of MA recipients can be a time consuming process. To facilitate recovery of MA recipients' other insurance coverages, a Third Party Benefits Recovery Unit was created in January, 1976. In calendar year 1976 it is estimated that this unit itself will recover $0.8 million at a cost of $0.3 million. The unit will assist in recovering another $5.5 million, for a total third party recovery effort of $6.3 million.

Instances in which other insurance may exist and where the assistance of the Third Party Benefits Recovery Unit is needed to recover the payment include the following.

- Some Medicaid recipients may not know that they have other coverages or may not think it important and thus will not report these other coverages to the provider. The provider will bill Medicaid, not knowing other coverage exists. For example, a working recipient may have employment coverage; a person recently terminated from a job may have extended benefits; a caretaker parent may have an ex-spouse required to insure the children; a person disabled while covered may be eligible for extended coverage of private insurance.

- The provider may be unable to get an assignment of benefits from the policy holder. For example, a father required to provide coverage for his AFDC children may be unwilling or unable to sign the required forms. An assignment of benefits allows the insurance carrier to directly pay the provider; without an assignment of benefits, the carrier directly pays the policy-holder, who then is expected to pay the provider, but sometimes does not. Without an assignment of benefits, a provider will bill Medicaid rather than a private carrier. Enabling legislation passed last session permits the Medicaid Program to pursue recovery from a private carrier without an assignment of benefits.

- Some providers prefer not to bill an insurance company directly. Billing Medicaid is easier and perhaps more reliable than billing recipients and expecting them to pay the bill and then collect from the insurance company.

- A recipient may be trying to defraud Medicaid and other insurance carriers by having the provider bill Medicaid and trying to individually collect again on the same bill directly, from another insurance carrier.

Presently, Minnesota and other states find third party benefits recovery to be a substantial dollar-saver in the Medicaid Program. However, it is not clear how much additional potential third party benefits recovery has: Given the characteristics of the Medicaid population -- aged, disabled, and other poor families -- one would expect a limited potential. Thus, doubling the state's present investment in third party recoveries may not double present returns. However, it would appear that there is additional potential in Minnesota. Given the uncertainties, a slow expansion of this effort, while monitoring results, would be the best policy.

2. Surveillance and Utilization Review (SUR)

Department of Public Welfare's Surveillance and Utilization Review (SUR) Division attempts to detect and correct misuse of the Medicaid Program by providers and recipients. A Surveillance and Utilization Review System[1] (SURS), part of the Medicaid Management Information System, is the basic information source for SUR Division activities.[2] SURS can aggregate and disaggregate data on Medicaid services along a variety of recipient and provider profiles, identifying those providing or utilizing unusually large amounts of services. Those identified can subsequently be investigated by SUR Division staff. Complaints, tips and county welfare departments are additional sources of information used by the SUR Division.

> With one year's experience the Division has been able to determine that although fraud and abuse certainly exist among Minnesota Medical Assistance providers, the extent of this activity is hopefully not as extensive as it is in the larger, more populated states. The fraud that has been identified is similar in nature to that seen in other states but is notably lacking in the volume of 'Medicaid mills' and independent laboratories. As the Division adds personnel, improves its computer identification system, and gains experience in corrective action, this picture may change. At this point it would appear that there may be more problems with overutilization than with actual fraudulent practice among the medical vendors in the State of Minnesota.[3]

During the 22 months of its operation (January, 1975 to October, 1976), the SUR Division has recovered $20,000 on

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[1]Also called a Subsystem.

[2]Inter-office memo from Thomas Gaylord, Director, SUR Division, November 2, 1976.

[3]Ibid.

its own, $30,000 working with Department of Public Welfare auditors and, in cooperation with Department of Public Welfare auditors and the Attorney General's office, has asked for return of $342,000 in overpayments. To date, the SUR Division has obtained 22 indictments for fraudulent activity, resulting in 11 convictions, one acquittal, four dismissals, and six pending cases.[4] When misuse is determined to result from unintentional error, repayment is requested and training in correct practices is provided.

Overutilization of services by recipients, cited earlier as possibly the greater "misuse" problem, is difficult to effectively and equitably address. SUR identifies one form of overutilization, the recipients who are 'heavy users' of Medicaid services, for example: the hypochondriac bouncing from one provider to another, the drug abuser using one or more physicians to supply numerous prescription drugs, or someone seemingly out to just rip-off Medicaid. Not all heavy users are overutilizing services; some are simply very sick people. Since SURS (and other sources) can identify heavy users and investigation can determine abusers, it is possible to aim corrective action at only these people. This is more reasonable than designing restrictive Medicaid program rules, directed at the few abusers but potentially adversely affecting the many non-abusers. Abusers could be required to obtain prior authorization for all services or their free choice of provider could be limited. An experimental 'restriction program,' beginning in Hennepin County, will determine if prior authorization and limitation of free choice can be effective in controlling abusers.

Another type of overutilization, perhaps the most prevalent form, would probably not be discovered by SURS. It includes persons seeking treatment for illnesses not commonly believed to require professional medical care (such as colds, sore throats, viruses, and other minor maladies with no complications). In addition, some elective surgery is clearly unnecessary, undertaken only because 'the doctor told me to do it' or 'with Medicaid I can have it done for free now.' However, other elective surgery, while not necessary to live, clearly improves the health status of an individual. Thus, whether elective surgery represents overutilization can be a question of values. While it is relatively simple to speak in general about overutilization and agree that it does exist, it is difficult to apply the concept to specific cases, e.g., judging that Person A did not need all the medical services delivered for a given condition while Person B did.

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[4] Ibid.

The problem of overutilization is complicated by the fact that physicians and other medical professionals may be the cause. Physicians may over-prescribe for a number of reasons: out of fear of a malpractice suit (better safe than sorry); out of a desire to meet the psychological needs of patients (it will make the patient feel better and won't do any harm); out of a desire for money -- many claim that there is an oversupply of some professionals, for example surgeons, and that much unneeded surgery is undertaken to keep surgeons gainfully employed; or for some other reason. SURs will systematically identify only professionals who blatantly over-provide services to large numbers of Medicaid recipients.

Overutilization is not limited to Medicaid and thus, it is difficult to address solely within the context of the Medicaid program. There may be no short-run solution and the long-run solution may be education of providers and consumers: professionals need standards and incentives to not over-prescribe and consumers need to have medical care de-mystified.

To date, much SUR activity has been devoted to making MMIS an effective tool for detecting heavy or other suspicious utilization patterns by consumers or over-provision of service by providers. So far, only a modest amount of provider fraud has been uncovered. Recipient overutilization is not a simple problem to address; SUR activities will probably be able to effectively detect and investigate only heavy utilization and heavy provision of services. Once SUR activities have been fully operational for a year, a study of the program's cost-effectiveness might be warranted.

SURS aggregates information in ways which could be useful to planners, managers, policy-makers and others. Unfortunately, some of the information on this system is not yet clean, or complete. Further, the system was designed for a single purpose, SUR activities, and consequently, some information is not recorded in ways useful for other purposes. Once the basic system is operational, attention ought be given to modifying or expanding the system to meet the information needs of others.

Such an effort might be part of an overall effort to review MMIS; its SURS, MARS (Medical and Administrative Review Subsystem), and Nursing Home Subsystems; and other information sources on the Medicaid Program for duplications, contradictions and possible improvements in records management.

3. Prior Authorization/Second Surgical Opinions

Prior Authorization

Prior authorization is required for Medicaid services which are very expensive, of questionable medical value, or easily abused by providers or recipients. Examples of some of the kinds of services requiring prior authorization are:

- Hospital care of marginal medical necessity;
- Services aimed at weight reduction;
- More than ten hours of psychiatric care per year;
- Contact lenses or more than one pair of glasses within a 12 month period;
- Dental surgery or hospitalization for dental care (except in emergencies);
- Orthodontics; and
- Gold teeth/root canals/periodontics.

Minnesota has not chosen to require prior authorization of normal hospital stays or physican visits. When required, prior authorization is given by the local welfare department.

California found prior authorization to have more effect in reducing both utilization and costs than did recipient cost sharing.[5]

Our 50 state survey shows California is now performing on-site review of hospital care which, in effect prior authorizes all non-emergency care. California believes this will result in substantial cost-savings. New York is conducting a similar program in a few hospitals. California is also requiring prior authorization on emergency hospital care of more than three days.

Prior authorization has appeal to program administrators. However, it is difficult to operationalize. Few agreed-upon standards exist which can be used to determine 'needed' and 'unneeded' care. Thus, enforcement can be a problem and can challenge the professional ethics of physicians. Further, review such as California is doing duplicates some of the activity of Professional Standards Review Organizations (PSROs). The difference is that prior

[5]Carl Hopkins, et. al., "Cost Sharing and Prior Authorization Effects on Medicaid Services in California. "Parts I and II. Medical Care Vol. XIII Numbers 7 and 8.

authorization is prospective review and PSROs are retrospective review.

Because of the potential administrative problems of prior authorization, we do not advocate expanding it without a careful review of expected benefits, costs and problems. Review should be directed at specific Medicaid services. Two services that we believe warrant careful review right now are LTC and surgery.

Long Term Care for the Elderly

Eligibility for Medicaid-reimbursed LTC for elderly persons requires a physician-completed form stating the elderly person's need for a specific level of nursing home care. Physicians are not reimbursed for this procedure and it has been claimed that they do a less than thorough job as a result, in some cases merely signing the forms already completed by nursing home personnel. Even when an examination is undertaken, the physician may not have the knowledge of existing community alternatives which might make institutionalization unnecessary. In other cases, the elderly person is already settled in a nursing home, having been admitted as a private-pay patient. Is the physician to make the elderly person leave and find alternative living arrangements? In short, it is relatively easy for elderly persons to receive Medicaid-supported nursing home care without objective determination of the need for the services.

In FY 1975, $88.8 million or 35% of Minnesota's total Medicaid expenditures were for nursing home care for 26,204 elderly persons. If the same trends hold true, the FY 1976[6] figure will have risen to $150 million. One way to contain these rising costs is to keep people out of nursing homes. A thorough pre-placement evaluation, assessing need for care and community alternatives, might assist in this effort. Ideally, evaluation would include non-Medicaid nursing home applicants, as many persons entering nursing homes as private pay patients end up on Medicaid once their financial resources are exhausted. Assessment could be done by a team having knowledge of medical needs and community resources. Such a program would require financial investment, paying those doing the assessment. However, it may well be worthwhile in the long run. We believe the idea merits further development and perhaps a pilot program.

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[6] In FY 1975, about 80% of the cost of all SNF and ICF care was for elderly persons. FY 1976 breakdowns of SNF and ICF care by client group are not yet available. However, a total of $185.2 million was spent on SNFs and ICFs; 80% of that is nearly $150 million.

Second Surgical Opinions

Recent research has indicated that much unnecessary surgery is being undertaken in the United States:

- A recent study of national surgical patterns found that differences between localities could not be "justified on any conceptual basis or be rationalized by demonstrable differences in outcome, morbidity, or mortality " (page 34), but rather were explained by availability of beds, availability **and concentration** of surgical manpower, geographic location and financial arrangement.[7]

- A 1974 study found 24% of all recommended surgical procedures were not confirmed by a consultant giving a second surgical opinion.[8]

- Experience with a New York union health insurance program instituting a second surgical opinion requirement showed that 29% of the recommended procedures were not confirmed by a second consultant.[9]

- It might also be mentioned that problems exist with the quality of surgery. A recent study sponsored by the American College of Surgery and the American Surgical Association found that of a sample of surgical deaths, 35% were preventable.[10]

Many private insurers are beginning to institute and monitor a second surgical opinion program with regard to overall costs and effects on quality of care. New York's Medicaid program has begun a second surgical opinion program."[11]

In FY 1976, Minnesota's Medicaid program paid about $6.2 million to physicians for surgical services.[12] In addition, some portion of inpatient hospital, laboratory, x-ray, and drug expenses are attributable to surgery. If these expenses could be reduced by one quarter, a second surgical opinion program might be worth its costs. We believe it is worth pursuing further.

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[7]DHEW, Forward Plan for Health FY 1978-82, Public Health Service, 8/76.

[8]Eugene McCarthy and Geraldine Widmer. "Effects of Surgery by Consultants on Recommended Elective Surgical Procedures," NEJM, December 19, 1974.

[9]Forward Plan for Health, page 35.

[10]Surgery in the US: A Summary Report of Surgical Services for the US, 1975.

[11]Forward Plan for Health. Page 35.

[12]From MMIS, Provider Class Profiles - all physicians.

4. Centralized Payments

The United States Department of Health, Education, and Welfare has strongly recommended that states adopt a Medicaid Management Information System which has as its primary function the centralization and computerization of Medicaid payments. As an incentive, it has offered to pay up to 90% of the costs of installation.

Minnesota began in late 1972 to centralize Medicaid claims processing at the recommendation of a LEAP task force.[13] Over the next 2½ years an MMIS system was installed, which handles centralized billings.

The dollar savings of centralized payments are not specifiable. However, most agree that such savings do exist.

5. Quality Assurance and Review

Title XIX of the Social Security Act requires that all Medicaid recipients of long term residential care (LTC) be reviewed annually to determine the quality and appropriateness of their LTC placement. The review must be done on-site by a medical review team. For Medicaid recipients of SNF and mental hospital care, the review required is the Periodic Medical Review conducted by a registered nurse, social worker, and physician team. For Medicaid recipients of ICF (including ICF/MR) care, the review required is the Independent Medical Review conducted by a registered nurse and social worker team.

In Minnesota, the two reviews have been combined into one program, Quality Assurance and Review (QA&R) conducted by the Department of Health. QA&R "... is a patient oriented "Output" or "Outcome" type program focusing on the specific needs of each patient, the treatment being given, and recommendations for changes in level of care and for strengthening components of the treatment program."

In 1975, QA&R reviewed 27,687 Medicaid LTC recipients. Of these, 2,167 (8%) were recommended for a change in level of care. Slightly more than half of the 2,167 were recommended for movement to a less intense level of care, one-third to a more intense level of care, and the rest to a similar level of care. QA&R staff estimated that implementing its recommendations could have an estimated cost-savings of $1.3 million annually.[14]

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[13]John Anderson and Paul Farseth, "Issues in Implementing the Model Medicaid Management Information System," April 20, 1976.

[14]Our calculations in Chapter V.C. used more recent cost data, thus the savings estimates differ.

Unfortunately, a QA&R follow-up revealed that fewer than one-third of its recommendations were implemented.

Of those Medicaid LTC recipients recommended for a change in level of care, only 48 were not thought to need residential care. Yet an analysis by QA&R staff of its data revealed that 949 persons had no medical or nursing reason for institutionalization: Nine stringent criteria were used to identify such cases,[15] so the number can be considered a conservative estimate. Most of the 949 individuals were elderly (88%) and nursing home residents (95%). QA&R did not recommend discharge for most of these people because no suitable community alternative existed.

Poor elderly persons not requiring medical or nursing care may nevertheless be in a nursing homes because of the nature of the system of care available to them. An elderly person totally dependent on SSI will have a monthly income of $167 for housing, food, transportation and personal needs. The problems of surviving on this income are obvious -- even if housing costs are partially subsidized by some other program. The same person opting to live in a nursing home will receive housing, food, other residential and nursing care worth about $400 to $700 per month in addition to a $25 per month SSI grant for personal needs. In a nursing home, a poor elderly person does not have to worry about having sufficient money to eat, pay the heating bill, and so on. The financial attractiveness of the nursing home to elderly persons and their families is obvious.

The problem just discussed is systemic: As long as a poor elderly person can receive care costing $250 to $500 per month more by choosing nursing home care over independent living, people not needing nursing home care will continue to be there and we can expect Medicaid's expenditures for LTC to continue to be unnecessarily high.

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[15]According to the 1975 Quality Assurance and Review Report:

> In order to identify and characterize this portion of the long term care population a computer program was developed to select Medicaid residents with the following characteristics:
>
> 1. Length of stay less than 24 months.
> 2. Relative living within 20 miles.
> 3. No unstable medical conditions.
> 4. No disability in Mental, Emotional/Behavioral or Bowel and Bladder functioning.
> 5. Less than 10 total disability points - this means no more than disability in one or two of the other ADL's.
> 6. No injections or special nursing treatments.
> 7. General condition static or improving.
> 8. Mental Retardation, if present, must not be severe or profound.
> 9. Mental Illness, if present, must not be severe or very severe and there must be no special psychiatric behavioral problems.

Medicaid requirements for QA&R are not well-defined. States are required to do the review, but not required to report or implement the results. Minnesota has set up a comprehensive and fairly expensive review mechanism with QA&R, but with limited impact on care or costs. LTC facilities need not follow QA&R recommendations regarding changes in level of care or the quality of care for an individual. In many cases, a change in level of care would be appropriate but is not even recommended because in the team's judgement, suitable alternatives do not exist.

Issues which need further consideration include:

- Should LTC facilities be required to implement QA&R recommendations regarding changes in quality of care and level of care?
- How can the State encourage less-expensive alternatives to LTC, so that people not needing LTC placement do not seek it?
- Can the QA&R data base be made more general and used as an information system on individuals in LTC for managers and policy makers? This might require collecting different data and/or expanding to survey non-Medicaid LTC recipients.

6. Professional Standards Review Organizations

Professional Standards Review Organizations (PSROs) were enacted as part of the Social Security Amendments of 1972 (Title XI, Part B). PSROs are associations of physicians organized to review institutional and professional services provided under Medicare and Medicaid. The organization is to monitor both cost and quality of care. Review is external to the institution as contrasted with Utilization Review, which is internal institutional review.

PSROs must review hospital and other institutional care; optionally they may review ambulatory care. Currently, the focus is on review of short-term hospital care.[16] Methods employed by PSROs include:[17]

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[16]DHEW, Forward Plan for Health, FY 78-82. Page 63.

[17]Ibid. Page 63.

Concurrent review, examining need for admission and continued hospital stay. PSROs need to establish standards for this task. Then unneeded stays can be identified and handled.

Medical care evaluation studies examining medical and administrative aspects of care and aiming at correcting unacceptable practices when identified.

Profile analyses retrospectively reviewing aggregate data of community patterns of medical care.

Assuring the quality of care and, at the same time, lowering costs may not be compatible goals for one organization. Today, the quality of care aspect is emphasized as the PSRO's primary goal.[18] However, many believe PSROs were originally 'sold' primarily as a medical care cost-containment approach.

The effects of PSROs on cost and quality of care have not yet been determined; PSROs are still new and have had limited funding. DHEW believes the PSRO system should become operational in the period FY 1978-82.[19] Some preliminary evidence of the experience of four PSROs shows a 20% decrease in length of hospital stay.[20]

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[18] Ibid. Page 35.

[19] Ibid. Page 35.

[20] Ibid. Page 35.

7. Health Maintenance Organizations

Health Maintenance Organizations (HMOs) have emerged in the 1970's as an alternative form for ensuring and delivering comprehensive medical services. Proponents claim that ideally, HMOs have incentives to reduce the costs and improve the quality of medical care with minimal regulation.

HMOs have the distinction of generating political support among conservatives and liberals. Federal policy supporting HMOs was first advocated by President Nixon in 1971. Yet subsequent federal legislation, The HMO Act of 1973, was passed with liberal support (including the Senate bill's architect, Senator Edward Kennedy).

Key elements of HMOs include:

- prepayment for comprehensive medical coverage. People (or employers) pay a fixed monthly charge which will cover services defined by the HMO, usually including physician charges, inpatient and outpatient hospital care, home health care, and other services. The monthly charge is fixed and not linked to the amount of services delivered. This eliminates one incentive for providers to over-prescribe.

- service to a fixed population. People voluntarily enroll as members of the HMO, agreeing to obtain all its medical services from authorized providers, usually a group of physicians and one hospital.

- vertical integration of the HMO. All covered primary medical care and many specialist services, along with needed ancillary services are provided the member. When provided in a group practice setting, the member has a single medical record. This is thought to improve quality --- a provider can see a complete history and peer review occurs by sharing the record. Further, it is difficult for a member to be unnecessarily overutilizing services.

HMOs generally seek members among employer groups. While Medicaid and Medicare recipients are another potential group of members, many HMOs do not wish to enroll the poor who are believed to be sicker and more expensive to serve. To do so results in higher rates, thus making it more difficult to attract employer groups. However, to qualify for federal assistance under the HMO Act, an HMO must enroll "medically underserved groups."

Other states promoting HMOs for Medicaid recipients as a cost-containment strategy show mixed results: SRS, the federal administrator of Medicaid, believes "the ultimate cost-effectiveness of HMO-type providers has not been fully determined."[21] In SRS's opinion, the most definitive experiment to date was a 3 year demonstration/evaluation in the District of Columbia which showed HMOs saved an average of 21% over fee-for-service.[22] These savings are similar to those reported by the Group Health Cooperative of Puget Sound for its Medicaid enrollees.

In 1972, California began extensively utilizing HMOs as a cost-savings measure. By 1974, California had over 200,000 enrollees in 50 HMO plans.[23] Recently, the experiment was termed a "colossal failure."[24] Loose controls allowed many abuses: store-front HMOs opened in welfare neighborhoods, enrolling mostly Medi-Cal eligibles; providers and operators drew exorbitant salaries and poor quality of care was delivered.

Minnesota has limited experience using HMOs for Medicaid recipients: presently the Medicaid Program has three contracts with HMO providers and is in the process of negotiating two more.[25] Only one of the existing contracts, enrolling 200-300 Ramsey County Medicaid recipients, is in the Twin Cities area, though both of the contracts in negotiation will be for Hennepin County Medicaid recipients. AFDC recipients usually form the pool of eligibles, since most HMOs will not enroll aged or disabled persons.[26]

Minnesota's limited experience shows the cost of care for Medicaid recipients to drop between 20-25% after enrollment in an HMO. If these figures were to continue to hold true,

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[21] DHEW, History of the Rising Costs of the Medicare and Medicaid Programs and Attempts to Control These Costs: 1966-1975, Report to the Human Resources Task Force, House Committee on the Budget, by the Comptroller General, Feb. 11, 1976. p. 24.

[22] Ibid. p. 25.

[23] James Hester and Elliot Sussman, "Medicaid Prepayment: Concept and Implementation," Milbank Memorial Fund Quarterly, Fall, 1974. p. 416.

[24] Janice Prindle, "New York's $3 Billion Medicaid Boondoggle" Empire State Report, July, 1976. p. 211-237. Quote p. 233.

[25] Information supplied by Medical Assistance Division, DPW.

[26] One of the existing HMO contracts with Community Health Center in Two Harbors will enroll Medicaid recipients over age 65.

the state could save around $10 million annually by enrolling all 150,000 AFDC eligibles in HMOs. However, this is not possible:

- Few HMOs exist outside the Twin Cities area in which outstate recipients could enroll.

- Even in the Twin Cities area, the availability of HMOs is limited. To avoid experiences such as California's, Medicaid Program contracts with HMOs allow no more than 20% of the HMO enrollees to be Medicaid recipients. Thus not all Twin Cities Medicaid recipients could potentially enroll in an HMO.

- Free choice of provider is guaranteed by the Medicaid program. Even if enough HMOs existed, many Medicaid recipients would undoubtedly choose not to participate in an HMO.

Experience to date indicates HMOs, effectively controlled, as in Minnesota, can contain costs. However, given the limited availability of HMOs, widespread use for Medicaid recipients is not possible at the present time.

8. Alter Eligibility

State Medicaid programs must offer services to all AFDC and SSI eligibles.[27] This is translated into two groups of eligibles: those actually receiving assistance and those eligible for assistance but not receiving a cash grant. The latter case includes persons in an LTC residential placement where Medicaid is paying 50% or more of the LTC costs: SSI-eligibles continue to receive a $25 monthly personal expenses allowance, but neither AFDC nor SSI continues to pay its full monthly cash grant.

States may elect, as Minnesota has done, to provide Medicaid to medically needy persons: elderly persons, disabled persons, and families whose income is not more than 100% above the maximum allowable for the categorical program (AFDC or SSI). States may also elect, as Minnesota has done, to provide Medicaid coverage to needy children, including children under state guardianship. Since coverage of the medically needy and needy children is optional, Minnesota could elect to reduce or eliminate Medicaid coverage for these groups.

In FY 1975, approximately 59,000 persons or one-fourth of all Minnesota Medicaid recipients were classified as medically needy. Of this group, 25,911 were elderly, 7,594 were blind or disabled, 4,204 were members of families with dependent children, and 21,410 were needy children. These people accounted for $103.4 million or about 40% of Minnesota FY 1975 MA expenditures. Of this amount, $72.3 million were expended on the elderly, $19.9 million on the blind or disabled, $1.2 million on families and $9.8 million on needy children.

Since 99% of the expenditures for the medically needy goes to classically dependent groups (the old, disabled, blind, and needy children), it is likely that public funds would be supporting some of the medical needs of these people, with or without Medicaid. It is probably to the State's advantage that the federal government share in the medical costs of these people.

We would not recommend reducing or eliminating coverage for the medically needy.

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[27] In 16 states, including Minnesota, all those transferred to SSI from OAA, AB OR AD are automatically eligible for Medicaid but new SSI recipients must meet the January 1972 program standards.

9. Reduce Types of Services Covered

All state Medicaid programs are required to provide basic mandatory services, including inpatient and outpatient hospital services, laboratory and x-ray services, SNF care, physician services, home health care, family planning services and early and periodic screening, diagnosis, and treatment (EPSDT) for children under 21 in AFDC families. States may provide numerous optional services, including ICF care, dental care, drugs, eyeglasses and medical care provided by licensed non-physician professionals. Both mandatory and optional service costs are shared by the federal government. Minnesota is one of four states (New York, Illinois, and Wisconsin are the other three) offering the full range of optional services. In Minnesota, roughly half of the FY 1976 expenditures were for required services and half for optional services.

The largest single expenditure category in the Minnesota Medicaid program in FY 1976 was ICF care, an optional service added to Minnesota's MA program in 1972: ICF care accounted for $118.3 million or 36.8% of all MA expenditures. About half of this was for care of MRs in SHs or community ICF-MRs and about half went to care for elderly and disabled residents of nursing homes.

Other optional services individually accounting for more than 1% of FY 1976 expenditures include drugs ($16.4 million or 5.1%), dental care ($8.4 million or 2.6%), and SH care for some MIs and CDs ($5.5 million or 1.7%).

Whether Minnesota should have begun funding ICF care, particularily for MRs, with Medicaid program funds is still debated by those contending it is wrong to use a medical program to fund residential care in a non-medical setting. Whether this argument has validity or not, it has little practical relevance. The decision was made and a system of care has developed around the decision. The state has invested considerable moneys in remodeling SHs so that they would be eligible for Medicaid reimbursement. There seems no turning back now and no alternative funding source. (See Chapter V, Section E for discussion of alternative funding sources for residential care of the mentally retarded).

Eliminating Medicaid coverage for elderly persons receiving ICF care in nursing homes, would mean they would probably either move to SNF care (a more expensive level of care) or be funded, in ICF care, by another public program (which may be all state- and county/local - funded). Thus it does not seem feasible to suggest eliminating coverage of ICF care.

Elimination of other optional services also appears to be infeasible:

- during a sample time period,[28] 40% of the drug prescriptions went to Medicaid recipients in LTC who have no or very limited amounts of liquid assets. Thus, if Medicaid would not pay for drugs for these people, it is likely another public funding source would have to be found.

- dental care is necessary for good health. Further, it can be a preventative health measure and as such could prevent later, higher medical costs.

- eliminating coverage for SH care would simply mean that the state would pay the whole care bill. Using Medicaid, federal and county governments share the costs.

Optional services account for nearly half of the State's Medicaid costs. Yet, for the reasons discussed above, we would not recommend eliminating any at this time.

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[28]April/May/June 1976. Information from Department of Public Welfare.

10. Limit Service Amounts

Some states have begun placing limits on services, e.g., only 30 days of hospital care per year, only 2 physician visits per month will be paid by Medicaid, or only 2 drug prescriptions per month will be paid by Medicaid. While this approach has definite cost saving advantages, these advantages may be outweighed by the hardships it places on poor people - specifically those chronically and/or catastrophically ill. For example:

- If a child in an AFDC family is severely burned and requires 60 days of hospitalization when the state Medicaid maximum is 30 days, who will pay for the other 30 days? Will the hospital have to absorb the loss, passing it along to other paying customers? Will another public assistance program need to step in? Would a severely ill child need to be moved to a general hospital (where other public money would be paying for the other 30 days)? Clearly someone will pay.

- If a poor elderly person in a nursing home requires eight prescriptions per month when only two are allowed, who will pay? Will the nursing home put it on their bill? Will the elderly person not get needed drugs and thus suffer impaired health and perhaps unnecessary death?

Many other examples could be given to illustrate that it makes little sense for Medicaid, the payer of last resort, to set arbitrary limits on its coverage for people having no other possible source of payment. Some states utilizing such limits do allow services over the maximum, but only with special authorization. In such a case, the approach ensures only that people using the service really need it. Minnesota has other mechanisms (e.g., SURs, PSROs), better tailored to individual circumstances, to insure that over-utilization by recipients and delivery of unnecessary care by providers is contained. Thus, we see no merit in placing limits on Medicaid services.

11. Cost-Sharing

Cost-sharing mechanisms have long been a part of private health insurance programs. The present Medicare program uses many cost-sharing mechanisms. However, cost-sharing in the Medicaid program has been resisted as contrary to the program's intent. It is argued that it makes little sense to set up a program whose intent is to facilitate access to the medical care system by poor people and, at the same time, institute barriers to discourage utilization.

However, faced with sky-rocketing costs, budgetary crunches and beliefs that Medicaid recipients may be overutilizing 'free' services, many states have begun instituting cost-sharing. Cost-sharing generally takes the form of a co-payment or deductible. Enrollment fees or premiums are another cost-sharing technique. The Medicaid program does not allow states to charge categorically needy recipients enrollment fees, although medically needy recipients may be charged an income-related fee. States cannot require either co-payments or deductibles for required (mandatory) program services (e.g., hospital care, physician services, SNF care) from categorically needy recipients, although they may require nominal payments from medically needy recipients. States may charge nominal payments for non-mandatory services (e.g., drugs, dental care, ICF care) from both the categorically and medically needy. HEW considers a 'nominal' payment to be 50¢ for all services costing less than $10.[29]

Two cost-savings effects can be anticipated by premiums, co-payments or deductibles:

- A reduction in demand, since as price rises, demand is expected to decrease.
- A reduction in cost per unit of service, since the recipient will pay a portion of the overall cost.

One cost increase can be anticipated:

- An increase in administrative costs, particularly if a cost-sharing plan requires separating the categorically from the medically needy.

Other states and Canadian provinces have experience with cost-sharing. Generally a deductible frequently referred to as a co-payment has been instituted.[30]

- In January 1972, California began requiring some Medicaid ("Medi-Cal") recipients to pay 50¢ each for the first two prescriptions filled each month and $1 each for the first two physician visits. 30% of all Medi-

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[29]Requiring cost-sharing from the categorically needy on required services or other changes to the above are possible but require an HEW waiver.

[30]Deductibles are frequently referred to as co-payments. Technically, when a fixed percentage is paid by the recipient (e.g. 20% of cost) it is a co-payment; when a fixed dollar amount is paid (e.g., $1.00), generally on the first dollar coverages, it is a deductible.

Cal recipients were designated as co-payers. The program assumed that overutilization of medical services by Medi-Cal recipients was a major cause of program cost increases and cost-sharing could control this. An evaluation of the cost-sharing revealed minimal reduction in utilization overall. A possible explanation offered by the study was that Medi-Cal recipients did not understand the cost-sharing program. Those most affected were the chronically ill. Prior authorization, implemented at the same time, had a larger cost-savings effect. California stopped cost-sharing after 18 months.[31]

- In 1968, the province of Saskatchewan, as part of its medical insurance plan, instituted a 'utilization' fee of $1.50 for each physician office visit and $2.00 for all other physician visits. A study showed the utilization fee resulted in an 18% reduction in service utilization by the poor in 1968. The study could not determine whether the decline was due to a reduction in needed or unneeded services. However, it concluded "co-payment introduces a barrier to services which may be difficult to justify within the framework of public medical insurance " (p.141). The utilization fee was discontinued in 1971.[32]

- In June 1975, Alabama began requiring that recipients pay 50¢ on each non-mandatory drug prescription (excluding birth control pills which are part of the required family planning program). The co-pay program's rationale was to reduce 'overutilization' of drugs. As a result, utilization and costs of drugs have declined. As of 1/76, monthly claims had declined 15% and monthly costs declined $130,000 from 5/75. (This may underestimate actual reduction because the baseline is a summer month which normally has a lower utilization than winter.)[33]

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[31]Carl Hopkins, Milton Roemer, Donald Procter, Foline Gartside, James Lobitz, Gerald Gardner and Marc Moser, "Cost-Sharing and Prior Authorization Effects on Medicaid Services in California: Part I. The Beneficiaries' Reactions" and "Part II. The Provider's Reactions," Medical Care, Vol XIII, No.7 and No.8, p.582-594 and 643-647.

[32]R.G. Beck, "The Effects of Co-Payment on the Poor," Journal of Human Resources, Vol IX, No.1, p.129-142.

[33]Linda B. Jenkins, "Co-Pay in the Alabama Medicaid Program," Alabama Journal of Pharmacy, Nov. 1975, p.19-21. Also Linda Jenkins, "Update on Co-Pay in the Alabama Medicaid Program."

The NASBO questionaire (see Section A of this Chapter) shows that many states have begun, have planned, or are thinking of 'co-payments' on prescription drugs. It is an optional service and one frequently charged with overutilization and abuse.

Potential Savings of Drug Co-Payments in Minnesota

In FY 1976, the Minnesota Medicaid program paid $16,212,585 for 2,812,433 drug prescriptions. This is an average cost of $5.76 per prescription. If, in FY 1976, Minnesota had required a 50¢ co-payment on each drug prescription it might have saved up to $2.9 million dollars. The following details three possible savings levels:

- If we assume the co-payment would reduce utilization 10%, and 50¢ would be paid by the recipient for each prescription, then $2.9 million could have been saved in FY 1976.[34,35]

- If we assume a 5%reduction in utilization with 50¢ being paid on each prescription by the recipient, then $2.1 million could have been saved.

- If we assume no reduction in utilization, but 50¢ per prescription paid by recipients, $1.4 million would have been saved.

These estimates assume no change in the average cost per prescription resulting from either changes in the size of each prescription or the kinds of drugs foregone as a result of instituting co-payments.

The projected savings, $1.4 to $2.9 million dollars, represents less than 1% of the overall FY 1976 Medicaid expenditures. Actual savings would be further reduced by the inability of some recipients to pay the co-payment: during a sample time period,[36] 40% of all drug prescriptions were for MA recipients in LTC. If Medicaid pays more than 50% of the LTC costs, the maximum income the person will have from SSI is a $25 per month personal allowance. If these people could not meet the 50¢ deductible out of their personal allowance, it would be hidden in the LTC cost and Medicaid would still pay the full cost of the prescriptions or the Medicaid administrative structure would have to dis-

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[34]We assume utilization reduction would be less than Alabama because Minnesota has higher welfare payments to families, the elderly, blind and disabled than Alabama. Thus, the marginal value of a welfare dollar is less in Minnesota.

[35]Actually, savings would be slightly less since the 50¢ could not be applied for birth control pills for the categorically needy.

[36]April/May/June 1976. Information from MMIS.

tinguish those able to co-pay from those not able to co-pay.

In summary, instituting cost-sharing on drugs might not save substantial amounts. The costs of administration may even outweigh savings. The rationale for cost-sharing, most states say, is to reduce overutilization, not to save substantial amounts of money. In Minnesota, drug overutilization and abuse is suspected, but is not viewed by most as a widespread problem. SURS should be able to detect and deal with some of the drug overutilization. Thus we would not recommend cost-sharing on drugs at this time.

Other Cost-Sharing Possibilities

Cost-sharing on dental services, another optional Medicaid service, is not recommended since Minnesota already prior-authorizes certain expensive dental services that might be overutilized and presumably prevents overutilization.[37]

Cost-sharing on mandatory services is not recommended because of the anticipated difficulty in separating the categorically from the medically needy (providers would need to know whom to charge and whom not to charge). Further, it may not be possible for the medically needy to pay any required cost-sharing.[38]

Since it is not clear that Minnesota Medicaid recipients do overutilize services, nor that cost-sharing would reduce overutilization, nor that any savings would result, we do not recommend implementing cost-sharing at this time.

12. Hospital Rate Regulation

For the last few years, inflation in the health care industry has been greater than inflation in the overall economy. In 1975, while general inflation was 7.7%, it was 10.3% in health care.[39] Hospital care had the largest degree of inflation, 13%, which is most significant because hospital care accounts for 40% of total health care expenditures. Data compiled by the American Hospital Association shows revenue per patient day, another indicator of increased

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[37]Recall, California found prior authorization more effective than cost-sharing.

[38]The medically needy, who could be required to participate in cost-sharing on required services, comprise about a quarter of all FY 1975 Medicaid recipients. Of this group, 36% are children under 21 not in a family group (generally wards of the state - 2/3 are in ICF/MRs), 48% are elderly, 9% are blind or disabled, and 7% are children or adults in poor families.

[39]Executive Office of the President, Council on Wage and Price Stability, Staff Report, The Problem of Rising Health Care Costs, April 1976.

expenditures for hospital care, increased an average of 18.4% for hospitals in 1975.[40]

Analysts generally concur that hospitals have no incentive for efficiency. Cost increases are simply passed along to third party payers (92% of hospital costs are borne by third party payers),[41] who pass costs along to employers and taxpayers.

Traditionally, public policy has been to regulate industries, like hospitals, which have no incentives for efficiency. To date, much piece-meal legislation, generally regulating construction of hospitals, has been implemented. However, this has had little effect on hospitals; "...despite the hundreds of regulatory laws and thousands of regulations, hospitals basically continue to go their own way, constantly criticized, scrutinized, sometimes harassed by public officials, but rarely called to account for or forced to assume responsibility for violation of some regulations."[42]

Today some analysts are beginning to approach regulation of hospitals slightly differently. Hospitals are being thought of as public utilities requiring, among other things, rate regulation.[43] By 1975, three states had established independent commissions to regulate health facilities under a public utility concept,[44] even though "to date there is no conclusive quantitative evidence that rate review systems do in fact contain costs."[45] One of the reasons no evidence exists may be because there is a "paucity of research across the entire field of health care regulation ...(there is no)

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[40]Ibid. Page 4.

[41]DHEW - Public Health Service, Forward Plan for Health FY 1978-82, August 1976, p.28.

[42]Anne Somers, "Regulation of Hospitals," Annals, Vol 400 (March 1972), p.77.

[43]A.J.G. Priest, "Possible Adaptation of Public Utility Concepts in the Health Care Field," Law and Contemporary Problems, Vol 35, (Autumn 1970), p.839-848.

[44]Gary Clarke, Health Programs in the States: A Survey, Center for State Legislative Research and Service, Rutgers University, March 1975.

[45]Lewin and Associates, Inc., An Analysis of State and Regional Health Regulations, Wash. D.C., 1975, p.13.

single, comprehensive empirical evaluation of any regulatory mechanism."[46] Thus, while the public utility concept has intuitive appeal to many people, its effectiveness has not been tested or proven.

In 1976, the Minnesota State Legislature passed the Hospital Administration Act of 1976 under which authority the Department of Health has begun creating a structure to review hospital rates. Once a review structure is operating, rate regulation could be tested and, if effective in containing costs, a rate setting structure could be implemented state-wide. The Medicaid program should consider participating in an experimental program if one occurs.

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[46] P. O'Donoghue, Evidence About the Effects of Health Care Regulation: An Evaluation and Synthesis of Policy Relevant Literature, Spectrum Research Inc., Denver, 1974.

GLOSSARY

ADAPTIVE BEHAVIOR SCALE (ABS)	A scale designed to measure the functioning level of MRs for purposes of behavioral assessment.
AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)	A federal-state program which provides cash payments to low income families with dependent children. Persons in AFDC families are automatically eligible for medicaid.
ALLOWABLE COST CATEGORIES	Items or categories of a facility's costs which are reimbursable under a payment formula. Medicare and Medicaid reimburse facilities on the basis of certain costs, but do not allow reimbursement for all costs.
BOARDING CARE HOME (BCH)	An MDH licensure category for health facilities. Care provided in BCHs is less intensive than skilled nursing or hospital care but care above room and board is provided. ICFs and ICF/MRs can be licensed by the state as BCHs.
CBF	See COMMUNITY BASED FACILITY.
CD	Chemically dependent, including alcohol and drug abusers.
CATEGORICALLY NEEDY (or CATEGORICALLY ELIGIBLE)	Economically needy persons who are eligible to receive public assistance. As used in Medicaid, this means a person who is aged, blind, disabled or AFDC eligible, and who meets specified income and resources requirements. In general, categorically needy individuals are persons receiving cash assistance under the AFDC or SSI programs. A state may cover additional specified groups (Minnesota covers needy children), as categorically needy.
CATEGORICALLY RELATED	Those persons who have sufficiently low income to receive cash assistance as an aged, blind or disabled person, or as an AFDC family member; but who do not receive such cash assistance, usually because they live in an institution, nursing home, etc. In Minnesota these persons are Medicaid-eligible.

CENTRALIZED DISBURSEMENT	In Minnesota, all Medicaid services are paid for through a statewide centralized computer system (rather than payment being made by individual counties).
CERTIFICATION	The process of determining facility compliance to federal regulations in order to certify the facility as eligible to provide skilled or intermediate care and to receive Medicaid reimbursement. MDH performs certification review in Minnesota.
COMMUNITY BASED FACILITIES (CBFs)	In our report we use this term to refer solely to Medicaid funded residential facilities for the mentally retarded which are located in the community.
COST SHARING	A provision of a health insurance policy or Medicaid which requires covered individuals to pay some portion of covered medical expenses. Several forms of cost-sharing are used: deductibles, coinsurance and copayments. Cost-sharing mechanisms are used to control the utilization of covered services, and to reduce costs of services.
DD	See DEVELOPMENTAL DISABILITY.
DPW	Minnesota's Department of Public Welfare.
DHEW	The federal Department of Health, Education and Welfare.
DAY ACTIVITY CENTER	A non-residential facility offering programs intended to develop the abilities of mentally retarded persons residing in the community. DACs provide counseling and training designed to increase independence, improve physical condition, social

DAY ACTIVITY CENTER (DAC) (continued)	behavior and academic skills. Funding of DACs is local, often at least partially funded through TITLE XX dollars. (State hospitals provide similar day activity programs. However, these SH programs are not funded in the same manner and are thus not DACs).
DEINSTITUTIONALIZATION (DI)	In our report we use the term DI to refer to moving MRs out of state hospitals and the elderly out of nursing homes. This stems from a more general definition of DI. DI is the act of: 1) moving a person from a higher to a lower level of care; 2) preventing admissions to state institutions; and 3) preventing inappropriate placement in higher levels of care by seeking the least restrictive level of care that will offer the necessary services.
DEDUCTIBLE	The amount a covered individual must pay before an insurer will assume liability for the remaining cost of covered services. Deductibles may be either fixed dollar amounts or the value of specified services and are usually tied to some reference period, e.g., $100 per calendar year, or spell of illness.
DEVELOPMENTAL DISABILITY	A handicapping disability of developmental origin attributable to mental retardation, epilepsy, cerebral palsy or other related neurological conditions.
EMR	Educable mentally retarded (See MR).
EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT PROGRAM (EPSDT)	Medicaid requires that screening programs be provided by states for recipients of M.A. who are under 21. The purpose is to diagnose medical and developmental problems at early stages and treat them before they become more serious.

EPSDT--continued	These EPSDT programs must also have an active outreach component to inform eligible persons, actively bring them in to care and, if necessary, assist them in obtaining appropriate treatment.
FMAP	Federal Medical Assistance Percentage.
FRAUD	Intentional misrepresentation by either providers or consumers to obtain services, obtain payment for services, or claim program eligibility. Fraud is illegal and carries a penalty when it is proven.
HEALTH MAINTENANCE ORGANIZATIONS (HMOs)	HMOs are organized systems for providing health care in a geographic area. HMOs provide agreed-upon sets of basic and supplemental health maintenance and treatment services to voluntarily enrolled groups of persons. The HMO is reimbursed for services through a predetermined, fixed, periodic prepayment made by or on behalf of each person or family unit enrolled in the HMO without regard to the amounts of actual services provided.
HOME HEALTH CARE	A range of services (medical and other) provided in the home which enable individuals to remain in or return to their own homes rather than live in any residential facility or institution. Medicare and Medicaid cover some home health services, particularly medically related services, within specific requirements.
ICF, ICF/MR, ICF-I, ICF-II	See INTERMEDIATE CARE FACILITY.
IPP	Individual Program Planning.
IPR	See PROFESSIONAL MEDICAL REVIEW.
INSTITUTION	Technically, this term could refer to any facility providing care/services to the elderly or disabled. However, for purposes of our report, we use this term to refer to state hospitals when analyzing care of MRs and nursing homes when analyzing care of the elderly.

INTERMEDIATE CARE FACILITY (ICF)	An institution reimbursed by Medicaid which is licensed by the state and certified by the federal government, to provide health-related care and services to individuals who do not require the degree of care which a hospital or skilled nursing facility is designed to provide, but who require care above the level of room and board which can be made available to them only through institutional facilities. An ICF/MR is an ICF which cares solely or particularly for the mentally retarded. ICF coverage is an optional service under Medicaid. Minnesota covers ICF/MR care and recognizes two levels of general ICF care for purposes of reimbursement; ICF-I and ICF-II. ICFs may be facilities or parts of facilities.
JOINT COMMISSION FOR THE ACCREDITATION OF HOSPITALS (JCAH)	An independent review organization which accredits hospitals, state hospitals, nursing homes, etc., on the basis of compliance to JCAH standards. JCAH review is voluntary on the part of facilities and a fee is charged for the review.
LEVEL OF CARE	For purposes of our report, we use the federal categorizations of level of care in Medicaid residential facilities: skilled nursing care and intermediate care. In addition, we use the state divisions (for purposes of reimbursement) of intermediate care into level I and II. See ICF and SNF for further definition.
LICENSURE	The process of determining compliance with state standards in order to operate as a facility (Nursing Home, Boarding Care Home, Supervised Living Facility) or to provide certain programs (e.g., Rule 34 program rule for MR residential facilities). MDH licenses facilities for the type of care provided; DPW licenses facilities for the type of program offered.

LONG TERM CARE (LTC)	We use the term LTC to refer only to long term residential care provided in facilities such as nursing homes, residential facilities for the retarded, and state hospitals.
M.A.	Medical Assistance (See MEDICAID).
MDH	Minnesota Department of Health.
MDPS	See MINNESOTA DEVELOPMENTAL PROGRAMMING SYSTEM.
MI	Mentally ill persons, mental illness.
MR	Mentally retarded persons, mental retardation. Mental retardation is subaverage general intellectual functioning originating in the developmental period. There are four levels of retardation generally defined in terms of I.Q. scores (i.e., Mildly retarded = 52-67 on the Stanford-Binet I.Q. test; moderately retarded = 36-51; severely retarded = 20-35; profoundly retarded = below 20. For purposes of special education, the retarded are divided into the educable (EMR) and the trainable (TMR). EMRs are generally considered to be mildly and moderately retarded, TMRs generally the severely retarded and possibly the profoundly retarded.
MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)	A computer based information system intended to provide necessary Medicaid program information for cost reporting, problem identification, etc.
MANAGEMENT AND ADMINISTRATIVE REPORTING SYSTEM (MARS)	A subsystem of MMIS, Minneota's MARS is based on the model system developed by DHEW for the Medicaid program.
MEDICAID (TITLE XIX OF THE SOCIAL SECURITY ACT; MEDICAL ASSISTANCE:; M.A.)	A federally-aided, state-operated and -administered program, to provide medical benefits to certain low-income persons within rules and regulations set by DHEW. Persons receiving AFDC or SSI payments, others who meet financial need requirements, and those in "special need" categories are Medicaid-eligible. Under broad federal guidelines, the states have options as to what

MEDICAID--continued

services are provided, who is eligible, rates of provider payments, etc. Every state's Medicaid program must cover at least the following services for at least everyone receiving federally-supported financial assistance: inpatient hospital care; outpatient hospital services; other laboratory and x-ray services; skilled nursing facility services and home health services for individuals 21 and older; EPSDT for individuals under 21; family planning; and physician services. Optional services include: prescribed drugs; clinic services; dental services; eyeglasses; private duty nursing; skilled nursing facility services; prosthetic devices; physical therapy and related services; other diagnostics, preventive and rehabilitation services; optometrist services; podiatrist services; chiropractor services; care for persons 65 or older in institutions for mental diseases; and care for patients 65 or older in tuberculosis institutions. Minnesota covers all optional services.
(In our report, we use the term Medical Assistance or M.A. only in reference to the Title XIX Medicaid program.)

MEDICALLY NEEDY

In the Medicaid program, persons who have enough income and resources to pay for their basic living expenses (and thus do not need welfare) but not enough to pay medical expenses. There is an income standard, i.e., income cannot exceed 133% of the maximum amount paid to a similar sized AFDC family. In order to be eligible, as medically needy, people must be either aged, blind, disabled, or members of AFDC families. They receive Medicaid benefits if their income is below the eligibility standard, but do not receive an SSI or AFDC grant, after deducting medical expenses (see SPEND DOWN). Minnesota provides this optional Medicaid coverage to the medically needy.

MEDICARE (TITLE XVIII OF THE SOCIAL SECURITY ACT)	A federal health insurance program for people aged 65 and over, for persons eligible for social security disability payments for over two years, and for certain workers and their dependents who need kidney transplantation or dialysis, without regard to income. Money from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting expenses incurred by those eligible. Medicare has two separate but coordinated programs: hospital insurance (part A) and supplementary medical insurance (Part B). Part A Medicare pays for most medical, hospital, and skilled nursing care. Part B insurance can be purchased, covering physician visits, supplies, drugs, etc.
MINNESOTA DEVELOPMENTAL PROGRAMMING SYSTEM (MDPS)	A system designed to measure the functioning level of MRs for purposes of behavioral assessment and individual program planning.
MINNESOTA SUPPLEMENTAL ASSISTANCE (MSA)	The state supplement paid to SSI recipients and also, currently, to some individuals who receive no other cash assistance.
NHs	See NURSING HOMES.
NON-LTC	Non-long term care. We use non-LTC to refer to care provided outside of the Medicaid LTC system. This can include general hospital care or any care not provided in SHs, NHs, or CBFs.
NORMALIZATION	A principle relating to the care of the mentally retarded which holds that MRs should have an existence which adheres as much as possible to the norms and patterns of mainstream society. The rationale is that MRs should not be deprived of a normal lifestyle due to their disability and that providing a more normal lifestyle encourages and foster growth and development of potential.

NURSING HOMES (NHs)	Generally, a wide range of institutions, other than hospitals, which provide various levels of maintenance and personal or nursing care to persons unable to care for themselves and who may have health problems. Nursing homes include skilled nursing facilities and intermediate care facilities and can provide both levels of care in separate parts of one facility. NH is also an MDH licensure category for health facilities.
PSRO	See PROFESSIONAL STANDARDS REVIEW ORGANIZATION.
PRIMARY PAYER	Payer obligated to pay prior to any liability of other, secondary payers. Under current law, Medicare is a primary payer with respect to Medicaid. For a person eligible under both programs, Medicaid pays only for services not covered under Medicare, or after Medicare benefits are exhausted.
PRIOR AUTHORIZATION	Requirement that a provider, in order to receive reimbursement, must justify the need for delivering a service to a patient before actually providing the service.
PROFESSIONAL MEDICAL REVIEW	External peer review required by Medicaid to assure the quality of care, quantity of care, and the appropriate level of care for recipients in Medicaid long term care facilities. In Minnesota this has been combined with the Independent Professional Review of ICFs (IPR) to form the Quality Assurance and Review (QA&R) conducted by MDH.
PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSROs)	Independent, physician-sponsored organizations which provide comprehensive and ongoing review of services provided under the Medicare, Medicaid and Maternal and Child Health programs. The purpose of this review is to determine the medical necessity of services, the quality of services, and the appropriateness of the setting for the services.

PROSPECTIVE RATE SETTING	A mechanism to determine Medicaid reimbursement rates for residential care. DPW uses this mechanism through Rule 49 for nursing homes and Rule 52 for community ICF/MRs. A rate is established based on historical costs.
PROSPECTIVE REIMBURSEMENT	The method of payment to Minnesota's Medicaid eligible nursing homes and community ICF/MRs. A per diem rate for the next year is established based on historical costs.
PROVIDERS (VENDORS)	An individual or institution which gives medical care. Institutional providers can be hospitals, skilled nursing facilities, home health agencies, etc. Individual providers include individuals who practice independently of institutional providers, e.g., physicians, dentist, nurses, etc. Providers receive cost-related reimbursement under Medicare and Medicaid. The provider (or vendor) must be properly enrolled in the program, and must submit an invoice for the services provided in order to receive reimbursement.
QUALITY ASSURANCE AND REVIEW (QA&R)	See PERIODIC MEDICAL REVIEW.
REASONABLE COSTS	The actual amount permitted for reimbursement under Medicare and Medicaid. Reasonable costs are those actually incurred in delivering health services, excluding any part of such costs found to be unnecessary for the efficient delivery of needed health services.
RETROSPECTIVE REIMBURSEMENT	This is payment to providers for costs or charges actually incurred in a previous time period. This is the method of payment used under Medicare and Medicaid non-LTC providers, e.g., individual doctors, nurses, etc.
RULE 34	A DPW rule governing the programs offered in residential facilities for the mentally retarded. Facilities that are found to be in compliance with Rule 34 requirements receive Rule 34 program licenses which are necessary for their operation in Minnesota.

RULE 49	A DPW prospective rate setting rule governing Medicaid prospective reimbursement of nursing homes. Each nursing home submits cost reports according to the specific requirement of the rule.
RULE 52	A DPW prospective rate setting rule governing Medicaid prospective reimbursement of community residential facilities for the retarded. Each facility submits cost reports according to the specific requirements of the rule.
SLFs	See SUPERVISED LIVING FACILITY.
SNFs	See SKILLED NURSING FACILITY.
SSI	See SUPPLEMENTAL SECURITY INCOME.
SHELTERED WORKSHOPS	Community based facilities that provide productive work for handicapped persons (including MRs) unable to find work in the private market. Sheltered employment experience and supportive services (e.g., vocational counseling, job placement, etc.) are provided by Sheltered Workshops. Participants earn money for their work.
SKILLED NURSING FACILITY (SNF)	An institution reimbursed under Medicaid and Medicare programs which is licensed by the state and certified by the federal government, to provide health-related care and services to individuals who need a high level of nursing or rehabilitative services. An SNF must offer 24-hour nursing care and must employ at least one R.N. on a full-time basis.
SUPERVISED LIVING FACILITY (SLF)	An MDH licensure category for health facilities. SLFs provide an intermediate level of care in a supervised living environment. Most ICF/MRs are licensed by the state as SLFs.
SPEND DOWN	A method for establishing eligibility for Medicaid by reducing gross income through incurring medical expenses until net income (after medical expenses) becomes low enough to make one eligible for the program. The individual, in effect, spends income down to the eligibility

SPEND DOWN--continued	standard by paying for medical care until bills become high enough in relation to income to allow qualification. Thus, an aged, blind or disabled person, or an AFDC family member whose income is higher than eligibility standards but whose medical expenses are high, can become Medicaid eligible as a medically needy recipient by spending down income on medical care.
STATE HOSPITALS (SHs)	Large, multi-purpose residential facilities that provide a full range of services to MRs, MIs, and CDs.
STATEWIDE ACCOUNTING SYSTEM (S.W.A.)	All state hospital expenditures are paid and reported through this accounting mechanism used by DPW and all other state departments.
SUPPLEMENTAL SECURITY INCOME (SSI)	A federal-state program which makes cash payments to the low-income aged, blind and disabled. The federal payments are made through the Social Security Administration. Minnesota has a supplemental SSI program (MSA). In Minnesota, SSI recipients converted from OA, AB, AD and OADSI are automatically eligible for Medicaid. New SSI recipients (since Jan. 1, 1974) become Medicaid-eligible if they meet the January, 1972 standards which include a spend-down provision.
SURVEILLANCE AND UTILIZATION REVIEW SYSTEM (SURS)	This system provides computerized review of claims (invoices), and sifts out both vendors and recipients of services who provide or receive unusual amounts of services; these cases can then be investigated for possible improper use of the M.A. program. Minnesota's SURS system is based on the model system developed by DHEW and is a subsystem of MMIS.
THIRD-PARTY PAYER	Any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients (e.g., Blue Cross and Shield, commercial insurance companies, Medicare, and Medicaid).

TMR	Trainable mentally retarded. (See MR)
UTILIZATION REVIEW (UR)	Internal peer review, required by Title XIX, within each long term care facility, used as a quality control mechanizm. The necessity, appropriateness and efficiency of the use of medical services, procedures and facilities are evaluated by a utilization review committee, PSRO, peer review group, or public agency.
VENDOR	See PROVIDER

APPENDIX A: ADDITIONAL INFORMATION on PUBLIC FUNDING SOURCES FOR THE ELDERLY in NURSING HOMES

Medicare/Medicaid

The elderly in Minnesota qualifying as medically needy must first reach a spend-down of $750 on all liquid assets before the facility's charges are collected from Medicaid.[1] If the patient is in an SNF, he/she can receive Medicare for the first 100 days of institutionalization. Any gaps in these funding mechanisms are most likely bridged with individual or family resources.

Social Security

Persons undergoing the spend-down process while receiving Social Security income are allowed to retain $25 per month for clothing and personal needs. The remainder of the income, within the legal maxima for the family, must be attributed to the maintenance needs of the legal dependents (e.g., when one spouse is living home, the other is in a nursing home). Any excess income, after the personal allowance and the dependency allowance is subtracted, is to be applied to the institutional charges.

SSI

SSI is a federal cash grant program to the aged, blind and disabled. In general, these funds are not available to institutionalized persons, with the rationale that other programs are available for this population. However, a small SSI grant is available for institutionalized persons, including the poor elderly residing in nursing homes. For an individual in a public institution where Medicaid is paying 50 percent or more of the cost of care, a $25 monthly personal spending allowance is provided through SSI. A resident of a non-public institution without income and for whom Medicaid is providing less than half of the monthly charge, could be eligible for SSI payments up a maximum monthly amount of $167.80, depending on other funding resources.

If an individual resides with a related person, the SSI allotment is reduced by one third of what it would have been under independent living conditions. This disincentive for the aged to live with relatives has contributed to the growth of a for-profit boarding home industry.[2] About 60 boarding care homes in Minnesota are licensed, but not certified because of a failure

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[1] DPW MA Program Manual, April 1, 1976. p. IV-G-5.

[2] "The Role of Nursing Homes in Caring for Discharged Mental Patients (and the Birth of a For-Profit Boarding Home Industry)", Senate subcommittee, March 1976.

to meet ICF regulations. These are financed primarily through the SSI income of the residents.[3]

Veterans Administration

The specialized target population (veterans and veteran's dependents) of this agency is able to receive total nursing home benefits during the determined coverage period. Only after the expiration of this period would Medicaid, Medicare or other funding sources be tapped.

[3] Carol Hirschfeld, 9/27/76.

APPENDIX B: FEDERAL REGULATIONS GOVERNING PERSONNEL QUALIFICATIONS FOR HEALTH FACILITIES

This appendix contains the federal regulations listing qualifications for certain health related employees of nursing homes and other federally regulated health facilities, as referred to in Chapter II D3 (Table 2.17 footnotes).[1]

Subpart K—Conditions of Participation; Skilled Nursing Facilities

AUTHORITY: Secs. 1102, 1814, 1832, 1833, 1861, 1863, 1865, 1866, 1871, 49 Stat. 647, as amended, 79 Stat. 294, as amended, 79 Stat. 313-327, as amended, 79 Stat. 331 (42 U.S.C. 1302, 1395f, 1395k, 1395l, 1395x, 1395z, 1395bb, 1395cc, 1395hh)

SOURCE: 39 FR 2240, Jan. 17, 1974, unless otherwise noted.

§ 405.1101 Definitions.

As used in this subpart, the following definitions apply:

(a) *Administrator of skilled nursing facility.* A person who:

(1) Is licensed as required by State law; or

(2) If the State does not have a Medicaid program, and has no licensure requirement, is a high school graduate (or equivalent), has completed courses in administration or management approved by the appropriate State agency, and has 3 years of supervisory management experience in a skilled nursing facility or related health program; or

(3) If the administrator of a hospital in which there is a hospital-based distinct-part skilled nursing facility, in a State that does not license skilled nursing facility administrators, meets the requirements of § 405.1021(f).

(b) *Approved drugs and biologicals.* Only such drugs and biologicals as are:

(1) In the case of Medicare:

(i) Included (or approved for inclusion) in the United States Pharmacopoeia, National Formulary, or United States Homeopathic Pharmacopoeia; or

(ii) Included (or approved for inclusion) in AMA Drug Evaluations or Accepted Dental Therapeutics, except for any drugs and biologicals unfavorably evaluated therein; or

(iii) Not included (nor approved for inclusion) in the compendia listed in paragraphs (b)(1)(i) and (b)(1)(ii) of this section, may be considered approved if such drugs:

(A) Were furnished to the patient during his prior hospitalization, and

(B) Were approved for use during a prior hospitalization by the hospital's pharmacy and drug therapeutics committee (or equivalent), and

(C) Are required for the continuing treatment of the patient in the facility.

(2) In the case of Medicaid, those drugs approved by the State Title XIX agency.

(c) *Charge nurse.* A person who is:

(1) Licensed by the State in which practicing as a:

(i) Registered nurse; or

(ii) Practical (vocational) nurse who:

(A) Is a graduate of a State-approved school of practical (vocational) nursing; or

(B) Has 2 years of appropriate experience following licensure by waiver as a practical (vocational) nurse, and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, or on a State licensure examination which the Secretary finds at least equivalent to the proficiency examination, except that such determinations of proficiency shall not apply with respect to persons initially licensed by a State or seeking initial qualifications as a practical (vocational) nurse after December 31, 1977; and

(2) Is experienced in nursing service administration and supervision and, in areas such as rehabilitative or geriatric nursing, or acquires such preparation through formal staff development programs.

In the case of skilled nursing facility services in an institution for the mentally retarded or in an institution for those with mental diseases, or a distinct part thereof, a person licensed in another category of health care discipline who has special training in the care of such patients may serve as charge nurse provided that such person is licensed in such category by the State following completion of a course of training which included at least the number of classroom and practice hours in all the nursing subjects included in the program of a State-approved school of practical (vocational) nursing, as evidenced by a report on comparison of the courses in the respective curricula to the State agency by the agency(ies) of the State responsible for the licensure of such personnel. (An institution primarily engaged in the care of the mentally retarded or in the treatment of mental diseases cannot qualify as a participating skilled nursing facility under Medicare.)

(d) *Controlled drugs.* Drugs listed as being subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970 (Pub. L. 91-513) as set forth in 21 CFR Part 308.

[1] From the Code of Federal Regulations "Title 20--Employees' Benefits", § 405.1101.

(e) *Dietetic service supervisor.* A person who:

(1) Is a qualified dietitian; or

(2) Is a graduate of a dietetic technician or dietetic assistant training program, corresponding or classroom, approved by the American Dietetic Association; or

(3) Is a graduate of a State-approved course that provided 90 or more hours of classroom instruction in food service supervision and has experience as a supervisor in a health care institution with consultation from a dietitian; or

(4) Has training and experience in food service supervision and management in a military service equivalent in content to the program in paragraph (e)(2) or (e)(3) of this section.

(f) *Dietitian (qualified consultant).* A person who:

(1) Is eligible for registration by the American Dietetic Association under its requirements in effect on January 17, 1974; or

(2) Has a baccalaureate degree with major studies in food and nutrition, dietetics, or food service management, has 1 year of supervisory experience in the dietetic service of a health care institution, and participates annually in continuing dietetic education.

(g) *Director of nursing services.* A registered nurse who is licensed by the State in which practicing, and has 1 year of additional education or experience in nursing service administration, as well as additional education or experience in such areas as rehabilitative or geriatric nursing, and participates annually in continuing nursing education.

(h) *Drug administration.* An act in which a single dose of a prescribed drug or biological is given to a patient by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper patient, and promptly recording the time and dose given.

(i) *Drug dispensing.* An act entailing the interpretation of an order for a drug or biological and, pursuant to that order, the proper selection, measuring, labeling, packaging, and issuance of the drug or biological for a patient or for a service unit of the facility.

(j) *Existing buildings.* For purposes of ANSI Standard No. A117.1 and minimum patient room size (see § 405.1134 (c) and (e)) in skilled nursing facilities or parts thereof whose construction plans are approved and stamped by the appropriate State agency responsible therefore before the date these regulations become effective.

(k) *Licensed nursing personnel.* Registered nurses or practical (vocational) nurses licensed by the State in which practicing.

(l) *Medical record practitioner (qualified consultant).* A person who:

(1) Is eligible for certification as a registered record administrator (RRA), or an accredited record technician (ART), by the American Medical Record Association under its requirements in effect on the publication of this provision; or

(2) Is a graduate of a school of medical record science that is accredited jointly by the Council on Medical Education of the American Medical Association and the American Medical Record Association.

(m) *Occupational therapist (qualified consultant).* A person who:

(1) Is a graduate of an occupational therapy curriculum accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association; or

(2) Is eligible for certification by the American Occupational Therapy Association under its requirements in effect on the publication of this provision; or

(3) Has 2 years of appropriate experience as an occupational therapist, and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, except that such determinations of proficiency shall not apply with respect to persons initially licensed by a State or seeking initial qualifications as an occupational therapist after December 31, 1977.

(n) *Occupational therapy assistant.* A person who:

(1) Is eligible for certification as a certified occupational therapy assistant (COTA) by the American Occupational Therapy Association under its requirements in effect on the publication of this provision; or

(2) Has 2 years of appropriate experience as an occupational therapy assistant, and has achieved a satisfactory

grade on a proficiency examination approved by the Secretary, except that such determination of proficiency shall not apply with respect to persons initially licensed by a State or seeking initial qualification as an occupational therapy assistant after December 31, 1977.

(o) *Patient activities coordinator (qualified consultant)*. A person who:

(1) Is a qualified therapeutic recreation specialist; or

(2) Has 2 years of experience in a social or recreational program within the last 5 years, 1 year of which was full-time in a patient activities program in a health care setting; or

(3) Is a qualified occupational therapist or occupational therapy assistant.

(p) *Pharmacist*. A person who:

(1) Is licensed as a pharmacist by the State in which practicing, and

(2) Has training or experience in the specialized functions of institutional pharmacy, such as residencies in hospital pharmacy, seminars on institutional pharmacy, and related training programs.

(q) *Physical therapist (qualified consultant)*. A person who is licensed as a physical therapist by the State in which practicing, and

(1) Has graduated from a physical therapy curriculum approved by the American Physical Therapy Association, or by the Council on Medical Education and Hospitals of the American Medical Association, or jointly by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association; or

(2) Prior to January 1, 1966, was admitted to membership by the American Physical Therapy Association, or was admitted to registration by the American Registry of Physical Therapists, or has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education; or

(3) Has 2 years of appropriate experience as a physical therapist, and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, except that such determinations of proficiency shall not apply with respect to persons initially licensed by a State or seeking qualification as a physical therapist after December 31, 1977; or

(4) Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring physicians; or

(5) If trained outside the United States, was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy, meets the requirements for membership in a member organization of the World Confederation for Physical Therapy, has 1 year of experience under the supervision of an active member of the American Physical Therapy Association, and has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

(r) *Physical therapist assistant*. A person who is licensed as a physical therapist assistant, if applicable, by the State in which practicing, and

(1) Has graduated from a 2-year college-level program approved by the American Physical Therapy Association; or

(2) Has 2 years of appropriate experience as a physical therapist assistant, and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, except that such determinations of proficiency shall not apply with respect to persons initially licensed by a State or seeking initial qualification as a physical therapist assistant after December 31, 1977.

(s) *Social worker (qualified consultant)*. A person who is licensed, if applicable, by the State in which practicing, is a graduate of a school of social work accredited or approved by the Council on Social Work Education, and has 1 year of social work experience in a health care setting.

(t) *Speech pathologist or audiologist (qualified consultant)*. A person who is licensed, if applicable, by the State in which practicing, and

(1) Is eligible for a certificate of clinical competence in the appropriate area (speech pathology or audiology) granted by the American Speech and Hearing Association under its requirements in effect on the publication of this provision; or

(2) Meets the educational requirements for certification, and is in the process of accumulating the supervised experience required for certification.

(u) *Supervision*. Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his sphere of competence, with initial direction and periodic inspection of the actual act of accomplishing the function or activity. Unless otherwise stated in regulations, the supervisor must be on the premises if the person does not meet assistant-level qualifications specified in these definitions.

(v) *Therapeutic recreation specialist (qualified consultant)*. A person who is licensed or registered, if applicable, by the State in which practicing, and is eligible for registration as a therapeutic recreation specialist by the National Therapeutic Recreation Society (Branch of National Recreation and Park Association) under its requirements in effect on publication of this provision.

[39 FR 2240, Jan. 17, 1974, as amended at 39 FR 35775, Oct. 3, 1974]

APPENDIX C: MINNESOTA MEDICAID LONG TERM CARE for MIs.

The long term care system for MIs is ambiguous at best. There is no secure source of funding for community residential facilities that care for MIs. Medicaid coverage is limited primarily to persons under 21 and over 65 in psychiatric settings. This lack of secure funding has created an ill-developed and poorly regulated MI LTC system. No one is entirely sure of the number of MI community facilities, although it is estimated that there are 160 currently in Minnesota.[1] DPW's Rule 36 governing programming in MI facilities has not yet been enforced; of the estimated 160 MI LTC facilities, only 4 or 5 have received Rule 36 licenses.[2] The facilities known to exist are unevenly distributed and vary greatly in quality.[3] A survey of MI community facilities in Hennepin and Anoka counties found that MI residential facilities are neither expected nor able to provide more than custodial care.[4] While the administrators of such facilities may wish to provide servces in addition to custodial care, they are hampered by the lack of funding available to MI community residential facilities for both construction and operation. Administrators can also be hampered by a lack of knowledge of other community resources in an ill-defined system.

All of these difficulties encountered as we studied MI LTC rendered a discussion of the total system beyond the scope of a 6-month project. However, we were able to obtain information from the MDH Quality Assurance and Review (QA&R) survey of 1975 on those MIs who are receiving Medicaid funded care. All Medicaid recipients in Medicaid funded LTC facilities who had an MI diagnosis are described. Some of the persons with MI diagnosis also are elderly, physically ill or handicapped and/or mentally retarded. Thus the MI population described is not a discrete category of persons but rather represents all Medicaid long term care recipients who have had an MI diagnosis. Of the total Minnesota Medicaid population in LTC facilities, 6856 or 24.8% were diagnosed by the QA&R Program as having psychiatric conditions relating to mental illness.

Long term residential care necessitated by psychiatric conditions is automatically covered for Medicaid eligibles under 21 years of age or those 65 years and older. For all other persons,

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[1] Interview with David Van Wyk, DPW Licensing Division, July 17,1976.

[2] Ibid.

[3] Office Memorandum from David Van Wyk to James Hiniker, Deputy Commissioner, DPW. July 10, 1974. p. 3.

[4] Community Health and Welfare Council. Mental Health Aftercare Services. Minneapolis, March, 1976. p. 43.

LTC[5] required by psychiatric disabilities is covered only if the person is SSI-eligible (has been disabled for two or more years due to the psychiatric condition) and Medicaid-eligible (can spend down to the categorically needy level). Psychiatric care for those SSI/Medicaid eligibles between 21 and 65 years is not covered in state hospitals.[6] These Medicaid coverage restrictions affect the characteristics of LTC Medicaid recipients with diagnoses relating to mental illness. Table 1 shows that most MIs are under 20 years of age,[7] 65 years or older, or mentally retarded. Because the amount of overlap cannot be determined from this data alone (e.g., 65+ and mentally retarded), it is impossible to discern the exact number of persons 20 to 64 years and not mentally retarded; we estimate that it would be between 1050 and 1275 residents.

Placement of MIs

Table 2 shows that 90% of Medicaid LTC recipients with an MI diagnosis are in nursing homes, primarily in SNF and ICF-Is. About 5.8% of those with an MI diagnosis are living in ICF/MRs, 3.3% in state hospitals, and 2.5% in community facilities. The balance (4.8%) are found in the state hospitals' "psych" level of care.

Prior MI HIstory

70% of the MI Medicaid LTC recipients discussed here had histories of mental illness prior to this residential placement. 44% had previously been in a mental hospital.

MI Diagnoses

Table 3 shows the MI diagnoses for Medicaid LTC recipients with an MI addendum.[8] Organic Brain Syndrome (OBS), sometimes called a "garbage can diagnosis"[9] is the most common. The OBS diagnosis is most common in the SNF and ICF-I levels of nursing home care. Schizophrenia, the second most common diagnosis, is more likely found in ICF-II, community ICF/MR and state hospital residents.

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[5] Psychiatric care in acute hospitals is covered for Medicaid eligibles.

[6] Unless the person is mentally retarded.

[7] 20, rather than 21 years, is used because that is how the QA&R data report it.

[8] The QA&R program added the "MI Addendum" after beginning the 1975 survey. It collects additional items of interest for those with an MI diagnosis. It was completed on 5064 of 6856 Medicaid LTC residents with a MI diagnosis.

[9] Ibid.

TABLE 1
Medicaid Recipients with an MI Diagnosis by Type of Facility and Level of Care

Facility and Level of Care	% < 20[1]	% ≥ 65	% MR[2]	N
Nursing Homes				
SNF	-	90	2	2655
ICF-I	-	81	3	2924
ICF-II	-	41	5	538
Community ICF/MR	4	6	82	174
State Hospital				
ICF/MR	12	1	100	229
Psych	6	81	8	328

[1]Categories are 0-19 years and 20-44 years. Cannot distinguish in latter category those 20 years old.

[2]It is possible a person could be MR and >65 or MR and < 21 years.

TABLE 2
Residential Placement of Medicaid LTC Recipients with an MI Diagnosis

Facility and Level of Care	N	% of Total
Nursing Homes	6117	89.2%
SNF	2655	38.7
ICF-1	2924	42.6
ICF-II	538	7.8
Community ICF/MR	174	2.5
State Hospital	564	8.2
ICF/MR	229	3.3
Psych	328	4.8
Other	7	.1
All Facilities	6856	100

TABLE 3
MI Diagnoses for Medicaid LTC Recipients

Facilities and Level of Care	N	Percent with Each Diagnosis[1]					
		OBS	SCHIZOPHRENIA	DEPRESSION	PARANOID PSYCHOSIS	CHEMICAL DEPENDENCY	OTHER
Nursing	1	62	27	6	2	2	6
SNF	2406	78	15	5	1	1	6
ICF-I	1678	52	36	8	2	3	6
ICF-II	281	23	61	9	3	4	4
Community ICF/MR	174	16	63	8	3	1	10
State Hospital	555	29	47	6	1	3	19
ICF/MR	229	13	44	6	2	-	37
Psych	326	39	49	7	1	6	6
All Facilities	5064	59	29	6	2	2	7

[1]Percentages may total more than 100% due to multiple MI diagnoses.

Table 4
Special Psychiatric Problems of MIs

Facility and Level and Care	N	Percent with Each Problem[1] None	Assault Staff	Assault Patients	Suicidal	Elopement	Disruptive	Other	Total
Nursing Homes									
SNF	2406	56	9	5	1	3	20	18	100
ICF-I	1678	67	6	5	1	2	14	15	100
ICF-II	281	60	3	4	1	2	14	23	100
Community ICF/MR	158	64	3	3	1	1	15	19	100
State Hospital	541	28	19	21	3	7	38	23	100
ICF/MR	215	15	23	31	3	4	45	31	100
Psych	326	36	16	14	3	9	33	18	100
All Facilities	5064	57	9	7	1	3	19	18	100

[1]Percentages may total more than 100% due to multiple problems.

TABLE 5
MIs in Medicaid-Supported LTC:
Treatment Received

Facility and Level of Care	Percent with Each Type of Treatment				
	None	Drug	EST[1]	Psycho Social	Other
Nursing homes	31	63	-	17	-
SNF	32	60	-	19	-
ICF-I	33	62	-	10	-
ICF-II	18	80	-	37	-
Community ICF/MR	18	76	-	13	1
State-Hospital	19	72	2	30	2
ICF/MR	10	82	-	31	2
Psych	25	64	3	30	2
All Facilities	30	64	-	18	-

[1]EST=Electro-Shock Therapy.

Table 4 details the special psychiatric problems of persons with an MI Addendum by facility and level of care. The majority, 57%, had no special psychiatric problems. Those patients in state hospitals are more likely to have behavioral problems.

Nature of MI Condition

45% of MIs were diagnosed as having a chronic-stable condition, 20% were diagnosed chronic-degenerative, and 7% chronic-recurrent. Another 27% had indeterminate conditions. Only 3% were considered to have acute conditions.

22% of MIs were judged to have severe or very severe conditions. However, only 6% were judged to be improving, with the balance having static or declining conditions.

Treatment of MIs

For MIs with an MI Addendum, only 39% have a psychiatric evaluation in their record. For those with an evaluation, an average of 51 months has elapsed since the evaluation.

Table 5 shows the treatment that MIs in Medicaid-supported LTC currently receive in their residential placement. Nearly one-third get no treatment. For most of those getting treatment, it consists of drug administration. Fewer than one-fifth receive any psycho-social counseling. This varies by facility and level of care: those in ICF-IIs and state hospitals are more likely to be receiving counseling. The figures reported may be misleading, however: a person could be getting counseling outside the residential facility but the relative frequency of this is not known.

QA&R data on Medicaid long term care recipients with an MI diagnosis reflect the Medicaid coverage limitations for MI care. Most of the Medicaid MIs are under 20 years or over 65 years of age or are also mentally retarded. Most live in nursing homes, primarily SNFs and ICF-Is. Relatively few live in state hospitals or are between 65 and 21. Treatment of MIs in Medicaid supported facilities is drug oriented.

This is the most detailed information available on Medicaid MIs. It is essentially the only statewide information on the MI system of care. MIs who are not Medicaid funded receive care in a care system about which little is known. Clearly, before irreversible decisions are made about DI of MIs, much more must be known about the system of care available and about the planning needs necessarily preceding DI action.

APPENDIX D: REVIEW of RELEVANT LITERATURE on COSTS of LONG TERM CARE for the MENTALLY RETARDED

Appendix D summarizes two recent publications that discuss the interrelationships among economics, DI, and MR. The two works are: Ronald Conley, The Economics of Mental Retardation, Johns Hopkins University Press, Baltimore, 1973; and Tadashi Mayeda and Francine Wai, The Cost of Long Term Developmental Disabilities Care, Prepared for the Office of the Assistant Secretary for Planning and Evaluation, DHEW. Undertaken at the University of California, Los Angeles - Neuropsychiatric Institute, Research Group at Pacific State Hospital, Pomona, California, July 1975.

SUMMARY OF Ronald W. Conley: The Economics of Mental Retardation

The Reasons for Institutionalization

Conley, a proponent of small, community-based residential facilities for the mentally retarded, identifies four major reasons why mentally retarded individuals are "institutionalized" (i.e., placed in a residential care setting).

The first reason is the "difficulty of providing adequate care in the home" (p. 88). He notes that "severity of retardation alone would probably be sufficient ultimately to cause the institutionalization of almost all the profoundly retarded, most of the severely retarded, and many of the moderately retarded" (p. 88). Conley defines the profoundly retarded as having IQ's of less than 25, the severely and moderately retarded as having IQ's of 25-50, and the mildly retarded as having IQ's of 51-70. Conley estimates the numbers of individuals in each of these three groups for 1970, and the numbers in residential care or "institutional" settings. His estimates are found in Table D. 1.

As the above table, shows, the more severe the retardation, the more likely that the retarded individual is in a residential care setting.

Conley also cites other reasons for institutionalization of the mentally retarded: (1) illegal and/or immoral behavior, (2) the unavailability of community developmental services and the lack of adequate community-based residential alternatives to residential placement in a large public institution, and (3) the concomitant existence

TABLE D.1

Number of MRs by Severity, 1970

Severity of MR	Number	Number in Residential Care	% of Severity Group in Residential Care
Profoundly Retarded	200,000	65,000	33%
Moderately and Severely Retarded	490,000	130,000	25%
Mildly Retarded	5,310,000	75,000	1.5%
Total	6,000,000	270,000	4.5%

TABLE D.2

Total program costs of caring for the MR

Residential care	$1.6 billion
Special Education	$1.5 billion
Regular Education	$ .7 billion
Other Programs	$ .5 billion
Income transfers	$ .4 billion
Total	$4.7 billion

of MR with physical and psychiatric handicaps.

Total Costs of Care for the Mentally Retarded

Nationally, the total program costs of caring for the mentally retarded are estimated by Conley, in a related article,[1] for 1970 (p. 22) and are shown in Table D. 2.

The figure from Table D. 2, of $4.7 billion, does not include the costs, which are undoubtedly considerable, of providing medical care to the mentally retarded.

Conley also estimates that $4.8 billion was lost to the economy in 1970 because of excessive unemployment among those mentally retarded who are capable of working in the private sector (p. 23 of article.) He also summarizes the findings of other studies relating to employment of the retarded. These findings (p. 24 of article) reveal that in 1970: 87% of mildly retarded males are employed at a given time; and that earnings of the mildly retarded are high, slightly in excess of 85 percent of the population norm; but that below IQ 40, employment is infrequent. Conley does not attempt to estimate the aggregate or disposable income of the mentally retarded or the multiplier effects this income has on the U.S. economy. He does estimate the value of all capital utilized in residential care to be $3.2 billion in 1968, assuming the average cost of construction per bed was $15,000 (p. 103 of book). "Capital" here denotes buildings, equipment, and land utilized in residential care settings.

Important Economic Issues Concerning Mental Retardation and Institutionalization

One controversy revolves around the question of the "economies of scale" found in large institutions. Economies of scale occur when average cost per unit of output declines over a given range of output in a significant fashion. Conley addresses this issue directly in his book: he studied this issue empirically by examining per patient costs for 139 institutions which were residential care settings for the mentally retarded. Of these 139 institutions (the smallest contained 69 residents), 107 had resident populations of over 500 individuals. Conley found that "per patient cost declined rapidly as institution size increased" (r=-.69, N=139). When Conley restricted the sample to those institutions with 500 or more residents the results were "less pronounced" (r=-.31, N=107) (p. 354). He concludes that "economies of scale decline rapidly after institution size reaches 500 residents and are of minor importance for institutions over 1,000 residents." (p. 356).

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[1] Ronald W. Conley; "Economics and Mental Retardation", Social and Rehabilitation Record, USDHEW, Vol. 1, No. 10, Vol. 1974, page 22.

We can conclude that state hospitals do have "economies of scale," which are not characteristic of community-based residential facilities, in certain areas such as the purchase of food and equipment. (However, it should also be noted that if, as in Minnesota, state hospital populations continue to decline, then even these limited "economies of scale" may be severely jeopardized and state hospital per diem rates will increase substantially. It should also be noted that state hospitals are not now taking full advantage of existing "economies of scale" in view of reported underutilization of some existing physical plants.)

Conley explores what he believes to be the economic advantages of small (e.g., less than forty residents) residential facilities for the mentally retarded. To Conley, small facilities, if properly developed, may be less costly to operate and will produce more benefits than the present large residential institutions (p. 356). His rationale for this assertion is found on pages 356-8:

1) Small, community-based residential facilities for the mentally retarded can actually obtain certain services at a cost equal to or less than large institutions. Many large institutions are self-contained entities that provide their own essential services whereas small, community-based residential facilities can utilize essential services provided by the local community. Therefore, even though the small community-based residential facilities do not inherently retain the "economies of scale" that large institutions have, they can purchase the same services (heat, water, power, etc.) at similar or lower unit cost levels.

2) Small community-based residential facilities can be specialized in the provision of developmental services, providing no unnecessary developmental services for any given retarded individual. This is a situation much different from a large residential facility where a broad range of services must be offered to meet the needs of a highly diverse clientele.

3) Conley believes that there are additional benefits to be gained from small, community-based residential facilities: the retarded individual can remain closer to his/her home and relatives, and will be able to find employment in the local community through either sheltered or regular employment.

Unfortunately Conley presents no empirical data regarding detailed cost comparisons between large institutions and small community based residential facilities to support

his beliefs. He also neglects to describe the characteristics of each of these facility types (e.g., clientele served) in a detailed manner.

The Demand for Community-Based Facilities

Conley notes that "there is a tremendous potential demand for community-based sheltered living accommodations among noninstitutionalized adult retardates" (p. 359), but that this demand function would be difficult to estimate precisely. However, he does attempt a gross estimate of potential demand for the nation as a whole. He estimates that there are 180,000 adult retardates with IQ's between 25 and 50 (severe and moderate levels of retardation) and 2.5 million with IQ's between 50 and 70 (mild retardation) living in community settings. He then assumes that 25% of those with IQ's between 25 and 40, 50% of those with IQ's between 40 and 49, and 5% of those with IQ's between 50 and 70 would move into community-based residential facilities if available. Therefore, over 195,000 adult retardates would probably move into community-based residential facilities if available. (This estimate does not include retarded children.)

An Optimal Program of Residential Living for the Mentally Retarded

Conley believes that an optimal program for the mentally retarded consists of five elements (pp. 358-9):

1) A wide range of alternatives;

2) Small residential facilities located in the community and dispersed throughout a state equitably so as not to place undue financial strain on local governments. (In the case of Minnesota's Medical Assistance Program, this would be the county level);

3) Community-based facilities integrated with other services offered in the community;

4) Placement never regarded as permanent, but rather there should be constant reevaluation of the appropriateness of the placement; and

5) Community acceptance.

SUMMARY OF MAYEDA AND WAI: THE COST of LONG TERM DEVELOPMENTAL DISABILITIES

Introduction

Mayeda and Wai's study was an attempt to determine the costs and utilization levels of an individual receiving care in state run institutions (SHs), compared with costs and utilization levels of an individual receiving care in community residential facilities. The study took place from June 1974 - June 1975 with cost and client

characteristics data collected on 4,268 MRs in five SHs in California, Florida, and Washington and community facilities in Florida and southern California.

Findings

One of the major findings of the study was that the cost of delivering the full range of services does not differ significantly between SHs and community facilities (p. 4). In the study, the cost differences seemed significant at first, with an average of $6,247 for 6 months of SH care and an average of only $638 for 6 months of community care. However, the cost of community care approached that of institutional care when costs were adjusted to include all costs of care. This adjustment entailed adding the costs of non-residential services provided by other care givers (e.g., independent doctors or nurses, other agencies) to MRs living in a community residential facility. The comparison between the adjusted community costs and the SHs then revealed little cost difference for providing similar services in the two settings.

In order to arrive at the above finding, and to validly compare costs, the Mayeda study developed a cost model. They hypothesized that the cost of providing programs to individuals was a function of many factors (e.g., age, severity of retardation, etc.). Several influences modifying the applicability of the model became quickly apparent. One of the major modifying factors was the difference found between the administrative structure of SHs and community systems of care and the effect of this difference on costs.

The administrative difference between the two systems was characterized as the difference between a "unified" system vs. a "coordinated" system. In the unified system (SH system) there is a single point of control, a single point of entry into the system (thus only one set of eligibility requirements), and a known fiscal perimeter. The coordinated community system, however, contains multiple points of control, many entry points into the system (thus different and even conflicting eligibility requirements may exist), and an ill-defined or unknown fiscal perimeter. In the SH system, demand dominates but in the community system the providers, or supply, dominates. The effect of these differences is to compromise direct cost comparisons. (pp. 6,18).

The decentralized community system requires much inter-agency coordination. The lack of a viable coordination effort in the community creates a different service utilization pattern where individuals may not receive all the services that they might have received in an SH. In SHs, provision of needed services is coordinated

and centralized. The different utilization patterns lead to apparent lower costs for the residential community facilities, since not all of the SH services may be offered.

The utilization differences are complicated by the reimbursement and eligibility requirements of funding sources, i.e., Medicaid and SSI. The eligibility requirements and reimbursement system serve to obscure the flow of dollars and services in the community since there are many points of entry into the community system, and many separate payments to service providers. Utilization of the more highly reimbursed out-of-the home placements is encouraged by the financial incentives and eligibility requirements, while movement to more independent environments (which tend to be less highly reimbursed) is discouraged (pp. 3, 14-17).

Another effect of different administrative structures on utilization, that the study found, was a uniform pattern of services provided to SH residents. This pattern in SHs is not dependent on age group or level of retardation. The pattern of utilization of services for community facility residents varies widely and is dependent on age and retardation level (p. 38). The service pattern in the community was hard to pinpoint, since many service givers were involved. Often a lack of communication between the various service givers rendered an exact assessment of what services were received virtually impossible (pp. 85,86).

After adjusting costs to reflect some of the SH-community administrative and utilization differences, the study concluded that the true costs of community facilities and SHs were not significantly different. The study found that there was only one actual cost savings that can be attached to different service modes, occurring when liberal support is provided to enable the MR to remain at home (pp. 7,8). The study concluded that parents represent an untapped resource in MR care, as their capabilities of caring for MRs, regardless of age or level of retardation, are ". . . well beyond that which has been expected " (pp. 7,8). Thus, in-home placement and special professional services were found to be more cost effective than out-of-home placements.

Another general cost finding reported by the study was that costs are related to severity of condition. Costs were found to be the lowest for the borderline retarded and increasing for each group with the highest for the profoundly retarded. This relationship was more pronounced for community facilities than for SHs, but evident in both settings.

Summary

The Mayeda and Wai study found that cost savings in

long term disabilities care are actually present only for in-home placement. Also apparent were the many differences between the systems of SH and community care, and the difficulty this creates in attempting valid cost comparisons. Also complicating the cost estimating efforts are the problems occurring as a result of accounting procedures that do not use the individual as a base, and as a result of non-uniform cost categorization, etc. These problems make computation of total costs of caring for MRs to counties and other government units difficult, and thus, many costs are hidden, and unavailable at the individual level.

Appendix E: Cost Estimates of Programs for the Chemically Dependent

In a June report of a study[1] done by the Chemical Dependency (CD) program division of DPW, an attempt is made to compare the costs of various kinds of CD programs: subacute detoxification, halfway houses, residential primary treatment, and extended care programs. Their study indicates that extreme caution is necessary in interpreting the variations in cost figures for the various programs, as the program's environment (hospital vs non-hospital), modality (or type of services provided), and location (rural vs urban) all can affect the costs. The population served, special program needs, and administration can also affect costs.

In this appendix we present a short summary of their findings. Some specific findings for each of the four types of CD programs are also listed in Table E. 1.

- Subacute Detoxification: Costs of these programs depend on the size of the unit, whether the unit is located in a hospital or not, and the utilization of the unit. Utilization can vary on an urban-rural basis; so can transportation and other costs. In general, larger units cost more, units with low utilization rates cost more, hospital units cost more, and units in rural areas cost more.

- Halfway Houses: Halfway house costs vary with the size of the house, the type of house (mansion vs small house), the amount of services provided, who the services are provided to, and utilization. In general, larger houses cost more, those providing more services cost more, and those who serve youth or minority groups cost more. Metropolitan halfway houses are generally larger, providing more services and thus more staff. Utilization in the metro area is greater with more opportunities for employment.

- Residential Primary Treatment Programs: These program costs vary by what is included in the per diem (some do not include medical services), and whether or not they are located in a hospital. Those programs located in hospitals are of generally higher cost, primarily because of the share of hospital overhead the program must pay.

- Extended Care Programs: These programs cost about the same in state hospitals as in residential facilities. Those offering special programming to minority populations, chronic population, or to adolescents would have

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[1] Chemical Dependency Program Division, DPW. Problems with Developing Compatible Figures and Comparing Costs of Chemical Dependency Programs. June 1, 1976.

different costs.

Table E. 1 presents the estimates of the costs of the CD programs as well as the source of funding for each. This table summarizes further the specific findings of the CD division study.

TABLE E.1

CHEMICAL DEPENDENCY FUNDING[1]

Program	Average Per Diem Cost	Range of Per Diem Costs	Average Stay	Source Of Funds	Formula FY 77	Utilization Rate
RESIDENTIAL:						
Halfway House	$17.00/Day	$7.00-35.00/Day	6 months	State Grant Fees, Title XX, GIA, etc.	30% of total 70% of total	77% (FY77)
Detox	$45.00/Day	$29-59/Day	3 Days	State Grant Other County Fees	75% 25%	78% (FY77)
PRIMARY TREATMENT:						
Hospital	$67.00/Day	$50-106.00/Day	30 Days	Insurance Title XIX General Asst. Medical	Varies	N/A
PRIMARY TREATMENT:						
Non-Hospital	$45.00/Day	$25.08-65.71/Day	30 Days	NIDA-410 Insurance Title XX Fees	Varies	N/A
STATE HOSPITAL:	$41.00/Day	$26-60/Day	30 Days	State	100%	95% (FY76)
NON-RESIDENTIAL:						
Counselor & Coordinator MHC	$ 5.60/Hour		N/A	State Grant Title XX-Fed.	up to 50% 75% of elig. clients (counseling) 100% of coordination	N/A
Counseling & Aftercare SS						

1 **Source:** CD Program Division, DPW

N/A= Not Available

Appendix F: Further Description of Minnesota Nursing Homes

In chapter IV D we presented our findings on Minnesota Nursing Homes. We gathered data from information contained in the Cost Analysis and Field Audits section of DPW's Bureau of Support Services and from MDH licensing reports. We described the Nursing Homes in terms of: level of care (SNF, ICF-I, and ICF-II); levels of care within facilities (SNF, ICF-I, and ICF-II levels of care in single level of care facilities, total of the mixed level facilities. Sometimes Total Mixed is divided into SNF units in mixed level facilities, ICF-I mixed and ICF-II mixed); ownership (proprietary, governmental, and non-proprietary); region; size; and occupancy rate. After these descriptions we compared facilities on costs, deficiencies issued during certification, and staffing patterns. (See chapter IV D for these descriptions and comparisons). In the chapter, we confined our descriptions to one variable at a time. In this appendix we present some further descriptions by using more than one variable at a time, e.g., describing nursing homes both in terms of size and the units of level of care within the facilities.

Units by Facility Size

In Chapter IV D we found a relationship between size and level of care. In general, the SNF level of care had a larger average size than did the ICF-I level of care, with the ICF-II level of care having the smallest average size. Further examining this relationship, we look at the difference between a particular level of care offered in a multiple level of care and a single level facility. Table F.1 shows a slight tendency for levels of care in single level facilities to be larger than levels in multiple level facilities.

Ownership and Size by Level of Care

We found, in Chapter IV D, 172 proprietary nursing homes, 174 non-proprietary nursing homes and 68 governmental, with average sizes of 73 beds, 74 beds, and 66 beds, respectively. Table F.2 refines this further, showing the ownership and average size of each level of care.

Ownership by Occupancy Rate

We found that Minnesota Nursing Homes averaged 92.1% occupancy rate, overall. To further describe NHs, Table F.3 shows the average occupancy rates of NHs by type of ownership: governmental, proprietary, or non-proprietary. Table F.3 shows that governmental units have the highest average occupancy rates except in SNF units in single

TABLE F.1
600 Minnesota Nursing Home Units
in Multiple and Single Level
Facilities by Size

	NH UNITS					
#Beds	SNF Mixed[1]	SNF Single[1]	ICF-I Mixed	ICF-I Single	ICF-II Mixed	ICF-II Single
<60	46%	30%	72%	45%	80%	80%
60-100	12%	42%	22%	42%	11%	70%
>100	22%	28%	6%	13%	9%	13%
TOTALS	100%	100%	100%	100%	100%	100%

[1] Mixed categories refer to levels of care found in a multiple level facility, single categories to levels of care in single level facilities.

TABLE F.2
414 Minnesota Nursing Homes: Level of Care by Ownership and Size

NHs	Ownership	N	Average # of Beds
SNF SINGLE	G	23	54
	P	34	108
	NP	31	85
	TOTAL	88	86
ICF-I SINGLE	G	28	77
	P	59	67
	NP	46	67
	TOTAL	133	69
ICF-II SINGLE	G	1	32
	P	19	23
	NP	10	72
	TOTAL	30	46
TOTAL MIXED[1]	G	17	112
	P	62	133
	NP	84	122
	TOTAL	163	125

[1] Total Mixed refers to all levels of care found in multiple level facilities.

TABLE F.3
Minnesota Nursing Homes: Occupancy Rates by Ownership

Ownership	Nursing Home							
	SNF SINGLE		ICF-I SINGLE		ICF-II SINGLE		TOTAL MIXED	
	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
G	95%	23	93%	28	99%	1	96%	17
P	94%	34	92%	59	87%	19	92%	62
NP	96%	31	92%	46	91%	10	92%	84

level facilities, where NP units average higher occupancy rates. Proprietary homes have the lowest occupancy rates in all categories except units in multiple level facilities.

Region by Occupancy and Level of Care

Table F.4 shows the occupancy rates of the different level of care units in each region. From the table we see further description of the variation in occupancy rates of Minnesota NHs.

TABLE F.4
Minnesota Nursing Homes: Occupancy Rate of Nursing Homes by Region

	Occupancy Rate of Nursing Homes							
	SNF SINGLE		ICF-I SINGLE		ICF-II SINGLE		TOTAL MIXED	
Region	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N	$\bar{X}$	N
1	95	5	96	8	70	3	91	6
2	99	2	93	5	92	1		
3	94	11	97	9	93	1	97	11
4	97	3	94	11	94	1	94	15
5	98	1	97	8	99	1	97	6
6	97	3	95	14	91	1	96	9
7	95	16	94	5	92	2	96	9
8	97	5	94	16			92	9
9	97	4	95	16	97	1	92	10
10	93	16	79	9	99	2	96	22
11	94	20	88	31	88	15	89	66
Total	95	88	92	132	88	29	92	163

APPENDIX G: TITLE XX SERVICES[1]

1. Adoption Service: Secure for children, who are without legally responsible parents, social and legal family memberships through: home selections; placement and post-placement supervision; studies on petitions referred by the courts; and evaluation of prospective adoptive homes in cooperation with authorized out-of-state and international adoption agencies.

2. Chore Service: Arrange and/or provide for the performance of routine housekeeping tasks, the performance of minor household repairs, shopping, lawn care and snow shoveling.

3. Counseling Service for Families and Individuals: Utilization of a professional helping relationship to enable individuals and families to deal with and to resolve whatever intra and/or interpersonal relationship problem or stress is encountered by them.

4. Day Care Service (Adults): Personal care during the day (for less than 24 hours) in a protective setting approved by the state or local agency providing companionship, educational, recreational, and developmental activities as well as integral but subordinate medical services. Subgroups:

    1) Regular Day Care;
    2) Day Activity Center for Mentally Retarded.

5. Day Care Service (Children): Personal care during the day (for less than 24 hours) in the child's own home or in a nurturing and protective setting to substitute for or supplement the child rearing provided by the child's parents; as well as integral but subordinate medical services. Subgroups:

    1) Regular Day Care;
    2) Day Activity Center for Mentally Retarded.

6. Educational Assistance Service: Arrange and provide education and training unrelated to employment, most appropriate to the individual's abilities -- including special educational assistance to the blind, deaf, and other disability groups, and individuals with school adjustment problems.

7. Employability Service: Arrange and provide for assistance to persons obtaining, maintaining and improving employment through the use of vocational counseling, employability testing, college and vocational training, job finding assistance, and special employment services for individuals who are handicapped because of some social, economic, or mental/physical health condition.

8. Family Planning Service: Arrange for and provide social, educational, and medical services (including sterilization) and supplies to enable individuals to determine family size or prevent unplanned pregnancies.

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[1]This list from: State of Minnesota. DPW. FINAL PLAN TITLE XX. pp. 5-5b.

9. Foster Care Service (Adults): Arrange and provide for the care and supervision in a 24-hour per day family setting for adults unable to live independently as well as integral but subordinate medical in the form of preplacement physical examinations and annual medical re-evaluation.

10. Foster Care Service (Children): Arrange and provide care in a 24-hour per day family setting and counseling services to the child, the foster parents, and the natural (or legal) parents as well as integral but subordinate medical in the form of preplacement physical examinations and annual medical reevaluation.

11. Health Service: Arrange and facilitate access to and use of health resources including mental health resources. Subgroups:

    1) General and Mental;
    2) Deinstitutionalization.

12. Home Delivered and Congregate Meals Service: Arrange and provide meals to individuals who are without means or ability to adequately prepare or plan their own meals.

13. Homemaking Service: Provision of surrogate care in the absence of disability of the caretaker, providing for the personal care of ill or disabled individuals as well as instruction on more effective methods of home management, the development and maintenance of self-care and social skills.

14. Housing Service: Services to help individuals obtain, maintain, and improve housing, and/or to modify existing housing.

15. Information and Referral Service: Provide information to individuals seeking knowledge of community resources and to assist individuals in making contact with a resource that can respond to their need or problem.

16. Legal Service: Arrange and provide for assistance in resolving non-criminal legal matters and the protection of legal rights.

17. Money Management Service: Arrange and provide assistance in developing effective budgets and managing indebtedness.

18. Protection Service (Adults): Determine need for protective intervention and help correct hazardous living conditions or situations of an individual who is unable to protect or care for himself, providing emergency care for individuals in need of subacute detoxification, including integral but subordinate medical, room and board, and also providing the necessary planning and supervision pursuant to a court order. Subgroups:

    1) Protection;
    2) Subacute Detoxification;
    3) Mental Retardation Guardianship.

19. Protection Service (Children): Determine need for protective intervention and respond to instances and substantiate the evidence of neglect, abuse, or exploitation of a child; helping families recognize the causes thereof and a strengthening of parental ability to provide acceptable care; providing integral but subordinate medical, room and board and remedial services; when necessary, bringing the situation to the attention of the appropriate court or law enforcement agencies, and furnishing relevant data; arrange or provide legal representation or an advocate for the child; and providing the necessary planning and supervision pursuant to a court order.

20. Residential Treatment Service: Arrange and provide a therapeutic experience including an interrelated set of activities within a controlled 24-hour per day live-in setting, including integral but subordinate medical and remedial care and integral but subordinate room and board, as well as preplacement medical examinations and medical reevaluation. Subgroups:

    1) Emotionally Disturbed Children;
    2) Primary Treatment/Extended Rehabilitation - Chemical Dependency;
    3) Half-way House - Chemical Dependency and Mentally Ill;
    4) Correctional - Children;
    5) Mentally Retarded Children and Adults.

21. Social and Recreational Service: Arrange and provide social, recreational and camping programs and activities for individual and family well being.

22. Transportation Service: Arrange and provide travel and escort to and from community resources and facilities.

APPENDIX H
PRELIMINARY TABULATION OF 50-STATE SURVEY SPONSORED BY THE NATIONAL ASSOCIATION OF STATE BUDGET OFFICERS (NASBO)

Appendix H contains the preliminary tabulation of the results of the 50-state survey highlighted in Chapter VI A. Included in this Appendix are a summary of findings, tabulation of responses, and a copy of the survey form.

I. INTRODUCTION AND SUMMARY

A. Introduction

This preliminary report, prepared for the National Association of State Budget Officers (NASBO) Committee on Systems, Techniques, and Data, is a tabulation of responses to a survey (see Attachment A) which NASBO mailed to the states and the District of Columbia in Spring 1976. The report is intended to give the Committee an indication of the quantity and nature of responses received.

The survey questionnaire was designed by the State of Minnesota's Department of Administration, Management Services Division, as part of their current study of Medicaid cost-containment. Purpose of the survey was to identify cost-containment efforts already undertaken or being considered by the states in the face of escalating Medicaid program costs. The Minnesota staff intends to use the survey responses in their analysis leading to recommendations for cost-containment actions to be taken in Minnesota.

Thirty-six responses were received, as follows: Alabama, Alaska, Arkansas, California, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, and Wyoming.

No attempt has been made to evaluate survey responses; a number of states included evaluative comments or advice based on their experiences, and these comments are quoted in the report.

In order to place recent and proposed cost-containment efforts in proper perspective, it is necessary to understand both the extent to which the various states emphasized cost-containment in their original Medicaid programs and how much they are spending on Medicaid. Descriptions of the states' basic Medicaid programs and data on Medicaid expenditures are being obtained from the Medical Services Administration, USDHEW, and were intended to be analyzed in conjunction with the survey results. This information came too late to be included in this report.

An executive summary, highlighting some of the more interesting findings, precedes the detailed presentation of survey responses. A short glossary of acronyms used in the survey responses is contained in Attachment B.

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The presentation of survey responses is organized according to a simple economic framework which divides cost-containment approaches into those which are intended to influence consumer demand, those intended to influence producer supply, and those intended to create administrative efficiency.

B. Summary

Table 1 summarizes the questionnaire responses (grouped as indicated in the left-hand column) by the categories in our economic framework ("Impacts on Consumer Demand," "Impacts on Producers' Supply," "Efficient Medicaid Administration," and "Other"). Headings across the top of the table divide the responses in each category by current status: "Proposed but Rejected," "Being Considered," "Implemented but Later Withdrawn," and "Being Implemented at the Present Time." Those which are "Being Implemented at the Present Time" are further grouped by whether or not dollars have been saved, and whether it is even possible to estimate dollars saved.

Of the 445 cost-containment changes mentioned by survey respondents, 290 (65%) were attempts to impact consumer demand, 15 (3%) were attempts to impact producers' supply, 138 (31%) were attempts to administer Medicaid more efficiently, and 2 (less than 1%) were "other." Of the total of 445, 35 (8%) had been proposed but rejected, 128 (29%) were under consideration, 10 (2%) had been implemented but later withdrawn, and 272 (61%) were being implemented at the present time.

Of the 272 cost-containment changes which were being implemented at the present time, 170 (62%) were attempts to impact consumer demand, 6 (2%) were attempts to impact producers' supply, and 96 (35%) were either attempts to make Medicaid administration more efficient or "other." Of the 272, it was not possible to estimate dollars saved for 127 (47%); no savings at all had resulted from 4 (1%) of the changes; savings were being realized but it was too soon to make a precise estimate in 71 (26%) of the cases; and amount of actual annual savings was known in 70 (26%) of the cases.

The 290 reported attempts to alter consumer demand for Medicaid services fell into three categories: altering eligibility criteria (23, or 8%), altering services covered (158 or 54%), or reducing state payment for covered services (109 or 37%). Eleven actual changes in eligibility criteria were reported; for 3 of these it was not possible to estimate savings, for 6 of them savings had resulted but amount could not yet be determined, and for 2 of them actual savings had resulted.

TABLE 1. SUMMARY OF RESPONSES FROM 35 STATES AND D.C., MEDICAID COST-CONTAINMENT QUESTIONNAIRE

Response Category	Status of cost-containment changes							Total
	Proposed but rejected	Being considered	Implemented but later withdrawn	Implemented at the present time				
				Not Possible to estimate savings	No savings	Too soon to be sure, but estimated savings	Actual savings	
A. Impact Consumer Demand	(Number of changes mentioned by States)							
1. Alter eligibility								
a. Categorical	3	3	0	2	0	2	1	11
b. Medically needy	3	3	0	1	0	4	1	12
								23
2. Alter services								
a. Types	7	3	3	6	1	7	10	37
b. Levels	5	10	3	12	0	21	13	64
c. Control use	0	12	0	4	0	2	0	18
d. Minimize level used								
(1) Acute care	0	4	0	2	0	1	2	9
(2) Long term care	2	5	0	15	1	4	3	30
								158
3. Reduce state payment								
a. Copayment	2	10	4	3	0	7	5	31
b. Deductible	0	1	0	1	0	0	0	2
c. Rate limits	6	6	0	9	0	5	9	35
d. Maximums per patient	0	0	0	2	0	0	2	4
e. Reimbursement formula	1	24	0	4	0	4	4	37
								109
Total: Group A	29	81	10	61	2	57	50	290

TABLE 1 - CONTINUED

Response Category	Status of cost-containment changes							Total
	Proposed but rejected	Being considered	Implemented but later withdrawn	Implemented at the present time				
				Not possible to estimate savings	No savings	Too soon to be sure, but estimated savings	Actual savings	
B. Impact Producers Supply								
1. Limit eligible providers	0	5	0	3	0	2	0	10
2. Limit provider earnings	0	4	0	1	0	0	0	5
Total: Group B	0	9	0	4	0	2	0	15
C. Efficient Medicaid Administration								
1. Control systems								
a. Fraud detection	2	15	0	28	0	9	2	56
b. Error detection	1	11	0	20	1	1	13	47
								103
2. Reduce overhead								
a. Centralized payments	0	0	0	0	1	0	1	2
b. Cheaper claims processing	0	4	0	2	0	0	0	6
c. Contracts with private insurer	0	4	0	7	0	1	3	15
d. Other contracts	0	2	0	2	0	0	0	4
e. Other	3	0	0	1	0	0	0	4
								31
3. Bulk buying	0	2	0	0	0	1	1	4
								4
Total: Group C	6	38	0	60	2	12	20	138
D. Other	0	0	0	2	0	0	0	2
Total: Group D	0	0	0	2	0	0	0	2
TOTAL	35	128	10	127	4	71	70	445

Seventy reported changes had been made in either type or level of services covered by Medicaid: for 18 of them, no savings estimate was possible; for 1, there had been no savings; for 28 it was too soon to tell exactly how much was being saved; and for 23, actual savings were reported.

Thirty-four implemented changes were reported to control utilization or to minimize level of service used: for 21 of these, no savings estimate could be made; for 1, no savings had resulted; for 7, it was too soon to make an estimate; for 5, actual savings were reported.

Fifty-five reported changes had been implemented to reduce amounts of state payment: for 19 of these, no savings estimate could be made; for 16, it was too soon to make an estimate; and for 20, actual savings were reported.

There were 15 attempts to alter producers' supply of Medicaid - reimbursed services. Of these, 6 attempts had actually been implemented; for 4 of these, no savings estimate was possible; for 2, it was too soon to report the actual amount saved.

There were 138 reported attempts to administer Medicaid more efficiently. Of these, 94 had actually been implemented: for 60 of them, it was not possible to estimate savings; for 2, no savings had resulted; for 12, it was too soon to know the actual savings; and for 20, actual savings were reported.

Table 2 displays actual annual state dollar savings of $1 million or more which survey respondents reported had resulted from specific Medicaid cost-containment efforts. These results are rank ordered by reported amount of state dollar savings per year. As Table 2 indicates, all of the cost-containment efforts which resulted in savings of $1 million or more were either attempts to control consumer demand or administer Medicaid more efficiently; none were results of efforts to impact producer supply of Medicaid services. The 31 cost-containment efforts listed in Table 2 represent only four general categories, as follows:

TABLE 2. ACTUAL ANNUAL STATE DOLLAR SAVINGS OF $1 MILLION OR MORE

	Amount saved state per year	State	Cost-containment effort	Response category
1.	$35 million	Virginia	Editing provider files for duplicate billing and recipient files for service limitations	C1
2.	$34.8 million	New Jersey	Third party benefits recovery	C1
3.	$22.6 million	Florida	Reduction of allowable optometrist rates	A3
4.	$12-15 million	New York	Fraud investigations and prosecutions	C1
5.	$14 million	New Jersey	Reducing provider fees by 10%	A3
6.	$11.2 million	Virginia	Limiting inpatient days to 14.	A2
7.	$10 million	Washington	Controlling hospital rates	A3
8.	$4.5 million	Minnesota	Third party benefits recovery	C1
9.	$4.3 million	Virginia	Eliminating the "growth and development" factor for nursing homes	A3
10.	$4 million	New Jersey	Allowing only half the normal inflationary increase in nursing home per diems	A3
11.	$3.4 million	Florida	Establishing a flat, all-inclusive rate for physician visits	A3
12.	$3.3 million	Virginia	Eliminating coverage for non-legend drugs	A2
13.	$3 million	Florida	Placing a cap of $20/month per recipient	A3
14.	$3 million	Virginia	Changing fiscal agents	C2
15.	$3 million	Florida	Reducing coverage of prosthetic devices with required services	A2
16.	$2.85 million	Oregon	Level of care planning for long term care	A2

TABLE 2 - CONTINUED

	Amount saved state per year	State	Cost-containment effort	Response category
17.	$2.5 million	Nebraska	Field nurses review placement of nursing homes patients	A2
18.	$2.4 million	Florida	Reduce annual hospital out-patient services	A2
19.	$2.1 million	Virginia	Drug co-payment	A3
20.	$2 million	New York	Control and decertification of beds	A2
21.	$2 million	Georgia	Reduced adult dental services	A2
22.	$1.9 million	Virginia	Limit dental services	A2
23.	$1.6 million	Florida	Reduced inpatient hospital days from 45/yr. to 30/yr.	A2
24.	$1.5 million	Washington	Curtail elective surgery	A2
25.	$1.5 million	New Jersey	Drug copayment of 25¢	A3
26.	$1.5 million	Nebraska	Results of Medicaid Management Information System	C1
27.	$1.3 million	Nebraska	Fee schedule	A3
28.	$1.1 million	Missouri	Eliminated adult dentures	A2
29.	$1 million	Alabama	Drug copayment of 50¢	A3
30.	$1 million	Nebraska	Trauma investigations	C1
31.	No amount given, but "$4 recovered for every $1 spent"	Nebraska	Third party liability section	C1

Response Category	Number of times it appears in Table 2
Alter services	12
Reduce state payment	11
Control fraud and error	7
Reduce overhead	1

Three of the top four actual money savers (in absolute dollars) in Table 2 were administrative attempts to detect and control unintentional error.

In addition to the actual savings just discussed, a number of states have implemented cost-containment changes but report that although it is too soon to be certain of the exact amount of resulting savings, they are willing to estimate annual state savings based on experience to date. Table 3 presents the rank order of those estimates which were $1 million or more. The 25 cost-containment efforts listed on Table 3 represent the following six general categories:

Response Category	Number of times it appears in Table 3
Alter eligibility	2
Alter services	10
Reduce state payment	10
Limit eligible providers	1
Control fraud and error	1
Reduce overhead	1

TABLE 3. ESTIMATED ANNUAL DOLLAR SAVINGS OF $1 MILLION OR MORE

	Amount saved state per year	State	Cost-containment effort	Response category
1.	$57 million	California	Establishing on-site review of inpatient hospital days	A2
2.	$38 million	New York	Limiting rates for acute and long term facilities	A3
3.	$30 million	California	Limiting hospital rate increases	A3
4.	$16 million	California	Reducing number of emergency days not subject to prior authorization from 8 to 3	A2
5.	$15 million	New Jersey	Calculating nursing home per diems	A3
6.	$8.9 million	New York	Limiting surgery and pre-operative and hospital stays	A2
7.	$7.5 million	New York	Freezing clinic rates	A3
8.	$7.2 million	Maryland	Limiting dental services	A2
9. & 10.	$7 million	New York	Altering eligibility criteria and limiting provider facilities	A1, B1
11.	$5.5 million	California	County administration of Medicaid	C2
12.	$5 million	Washington	Screening nursing home patients	A2
13.	$5 million	Illinois	Auditing providers	C1
14.	$3.7 million	California	Simplifying eligibility determination	A1
15.	$3.5 million	Mississippi	Drug copayment of 50¢	A3
16.	$3 million	New York	On-site review teams in certain hospitals	A2
17.	$3 million	Georgia	Drug copayment of 50¢	A3
18.	$2 million	Georgia	Hospital copayment of $25	A3

TABLE 3 - CONTINUED

	Amount saved state per year	State	Cost-containment effort	Response category
19.	$1.8 million	Maryland	Limit hospital inpatient services	A2
20.	$1.7 million	Maryland	Limit over the counter drugs	A2
21.	$1.7 million	California	Drug utilization review unit	A2
22.	$1.6 million	Maryland	50¢ copayment on legend drugs	A3
23.	$1.4 million	Maryland	Limit vision services	A2
24.	$1 million	Georgia	$2 copayment on outpatient services	A3
25.	$1 million	Nebraska	Limit nursing home reimbursement	A3

Tables 2 and 3 reveal that most (77%) of the cost-containment efforts which have thus far yielded, or are expected to yield, annual state savings of at least $1 million are attempts to either alter services (types, levels, or usage) or reduce state payment for existing services. However, among these efforts which have saved $1 million or more, three of the top four most successful money saving efforts (ranked by dollars saved annually) have been neither efforts to alter services nor reduce state payment: they have been administrative attempts to control fraud and error.

II. COST-CONTAINMENT APPROACHES INVOLVING CHANGES IN THE MEDICAID PROGRAM

A. Approaches which primarily impact on the consumer's demand for Medicaid services.

1. Approaches which alter criteria for Medicaid eligibility.

a. Approaches which alter categorical eligibility.

Alabama's state agency is considering a proposal to reduce the amount of personal resources allowable for eligibility in medical institutions from $336 to $189, thus rendering 3,200 persons presently in nursing homes ineligible for Medicaid and saving an estimated $320,000 annually in state dollars.

California began, in July 1976, to treat those refused categorical grants as medically needy. Nominal state dollar savings are anticipated as a result. The proposal, which began in the agency and required state legislation and HEW waiver, is part of a major simplification package for medically needy and non-categorically needy Medicaid eligibles.

California also implemented, at Legislative mandate in July 1976, a cost-containment plan involving county administration of Medicaid which is expected to save $5.5 million in state dollars annually. Counties will determine Medicaid eligibility and will be held to performance standards in efficiency of caseload management, etc.

In Georgia, both the state agency and the Governor rejected a proposal to make nursing home patient coverage optional, because too many patients would have been forced out of existing nursing homes.

Hawaii's state agency rejected a proposal to apply SSI criteria for aged, blind and disabled because although it would have resulted in lower administrative cost, service costs would have been higher.

Mississippi responded that it is a "209-B" state, i.e., it does not use SSI determination of Medicaid eligibility but rather chose to return to more restrictive eligibility criteria. This, they say has resulted in their maintaining a virtually constant Medicaid roll,"in contrast to an approximate 24% increase in national Medicaid rolls."

Nevada's legislature rejected a proposed "300% rule of institutionalized adults" which would have saved the

state an estimated $1.3 million annually.

New York's legislature authorized the agency to begin, on May 14, 1976, denying Medicaid reimbursement unless a client who appears eligible for Medicare applies for Medicare. This is expected to save the state $7 million annually, in conjunction with several other related changes (discussed later) also implemented at the same time. (Comment: "Problem is that eligibility determination may be delayed; benefit is that it forces use of third party insurance and preserves Medicaid as a payor of last resort.")

Ohio is currently considering a number of proposals as a result of (1) a 50-state survey which its Legislative Budget Office undertook this spring and (2) a survey of its state employees. One proposal under consideration would have the state pay private carriers such as Blue Cross to continue coverage of laid-off employees or others who would become eligible for Medicaid. Another proposal being considered is to increase efforts to reduce the AFDC error rate, thus reducing Medicaid costs by reducing the number of ineligible recipients.

Oregon, in July 1975, eliminated Medicaid for spouses of disabled recipients where the spouse is not needed in the home to care for the recipients. Oregon's legislature mandated this change in the state plan, and state savings amount to about $15,000 per year.

Texas reports that in June 1976 its state agency decided on a Cap of $390, to remain for Fiscal Years 77, 78, and 79; amount of resulting state dollar savings is not possible to calculate.

b. Approaches which alter eligibility of the medically needy.

Arkansas's state agency and legislature are considering a proposal to discontinue the medically needy program as of July 1, 1977, thus saving an estimated $250,000 in state dollars per year.

California's legislature authorized a simplification of the eligibility determination process for the medically needy, and the elimination of some differences between AFDC-MN and ABD-MN eligibility criteria. An estimated $3.7 million in state dollars will be saved per year. (Comment: "HEW waiver was needed. The proposal began in the agency and required state legislation.")

District of Columbia's agency is considering a proposal to eliminate the medically needy from Medicaid coverage, at an estimated annual saving to the District of 25%;

the Legislative Branch does not favor such a change, however.

Hawaii's state agency rejected a proposal to eliminate the medically needy from Medicaid coverage. (Comment: "It increases State's operating costs for public medical institutions.")

Iowa's legislature eliminated medically needy coverage in February 1969; not possible to calculate resulting annual state dollar savings.

Kansas is revising the eligibility standard for the medically needy for FY 1977; this move is part of a cost-containment effort which includes a drug copayment of 50¢. The total package is expected to save $1,236,000 state dollars annually. Kansas increased the number of months that the medically needy client's average income must meet income standards from one to six, as of May 1, 1976; result of this change is expected to be annual savings of $250,000 in state funds.

Kentucky's Mainstream Project, initiated by the Governor in July 1969, reduced the number of medically needy recipients by 14,500 individuals formally covered under the consolidated employment program. Actual yearly savings in state dollars totals about $680,000. ("Savings estimate is based on constant number of recipients/ utilization rate. Inflation was the only factor considered in revising 1969 dollars.")

Louisiana's state agency was considering a change in medically needy eligibility in June 1976; not possible to estimate probable savings.

Maryland's state agency rejected a proposal to alter medically needy eligibility because it would not have produced savings quickly enough to balance a $3.2 million budget deficit in FY 1976.

New York's denial (discussed above) of Medicaid reimbursement unless a client who appears eligible for Medicare applies for Medicare (expected to save $7 millions in state dollars annually) applies to the medically needy as well as to the categorically eligible.

Virginia's state agency rejected a proposal to alter the medically needy category.

2. Approaches which alter services covered.

a. Approaches which alter types of services covered.

Alabama's agency discontinued Medicaid payment for beds held in nursing homes as of October 1975; no savings estimate possible. Alabama's agency also discontinued payment for telephone consultations as of January 1976; no savings estimate possible.

District of Columbia's agency eliminated over the counter drugs from Medicaid reimbursement, with estimated annual savings of 2%; this move was subsequently rescinded, however.

Florida's Governor ordered reduced coverage of prosthetic devices with required services as of January 1975; actual savings in state dollars per year is $3,000,000.

Georgia's Governor reduced adult dental and adult optometric services in March 1975; actual savings have been $2,000,000/year from the dental coverage reduction and $50,000/year from the optometric coverage reduction. (Comments: "There is considerable lag time before these savings can be achieved.")

Hawaii excluded chiropractic services and others of experimental nature as of 1/1/66. (Comment: "No known impact on other programs.")

Illinois's state agency has rejected proposals to eliminate chiropractors/podiatrists, OTL items, visiting nurses, and appliances from Medicaid coverage.

Iowa's state agency proposed elimination of non-mandatory services on April 20, 1976; estimated annual state savings would be $3,500,000.

Louisiana's state agency has rejected proposals to eliminate inpatient psychiatric hospital services and Intermediate Care Facility services. Louisiana is considering limiting category of drugs, thus saving an estimated $7,000,000/year.

Maryland's state agency, as of January 1976, no longer covers OTC drugs (excluding insulin and syringes, and family planning products); expected state savings total $1,677,614/year. In January 1976, Maryland also began including drugs for nursing home patients in the per diem; no savings of state dollars expected.

Nevada's state agency reduced psychological services covered by Medicaid in May 1976; expected state savings will be $6,000/year. Nevada also reduced intermediate care coverage for the mentally retarded, as of June 1976; expected state savings will be $80,000/year. (Comment: "Fiscal strain will be shifted to State Division of Mental Health and Retardation.") Nevada also reduced coverage in a mental institution for those age 65 and over, as of June 1976; expected savings to the state will be $210,000. (Comment: "Individuals will continue to be served.")

New Hampshire, in July 1975, eliminated all dental services

for recipients 21 and over except to treat acute pain or infection, actually saving $400,000/year. New Hanpshire also eliminated payments for multivitamins as of July 1975, saving $60,000 per year.

New Jersey, as of January 1976, eliminated adult dental and vision services, podiatry, chiropractic and psychological services, medical supplies and prosthetics. However, these service reductions were rescinded in March 1976, following passage by the legislature of supplemental appropriations.

New York's legislature, in May 1976, authorized the agency to limit surgery to emergencies, certain non-emergency surgery, and surgery authorized by second opinions. Expected annual savings in state dollars will be $8.9 million, when considered in conjunction with pre-operative and length of stay limits discussed later. (Comment: "Problems: Potential conflict with PSRO prerogatives; could restrict hospital revenues. Benefits: Reduces malpractice suits and unnecessary care.") New York's legislature also authorized the agency to deny reimbursement for non-prescription drugs with exceptions, as of April 1976. Expected state savings will be $700,000/year , in conjunction with a restriction on dispensing fees discussed later. (Comments: "Problems: Could reduce pharmacists' participation in Medicaid program. Benefits: Reduces program overutilization.") New York's legislature rejected an agency proposal to eliminate certain optional services. (Comment: "Our objective was to reduce non-essential services.")

North Carolina, between 1971 and 1973 did not allow dental and chiropractor services for medically needy; in 1973 these services were reinstated under a prior approval program.

Ohio is considering a proposal to limit availability of over-the-counter drugs. Purpose of this proposal is to cut down the use of non-prescription drugs.

Oregon reports that at one time or another, elimination of most optional services has been considered, but then rejected, by the state agency.

Rhode Island's state agency has rejected proposals to eliminate the following services for the medically needy only: pharmacy, dental, podiatry, optometry, and ambulance.

South Carolina reports that "elimination of types of services has been considered, but not on a serious basis due to anticipated political reaction."

South Dakota's Governor proposed, and the legislature approved, elimination of physical therapy, speech therapy and oxygen from reimbursement under Nursing Home Care, saving an estimated $136,000 in state funds per year, beginning July 1976.

Texas's state agency eliminated mental hospital coverage on July 1, 1975; state annual savings are not possible to estimate.

Virginia's state agency reduced dental services in January 1975, with annual state savings of $1,900,000; eliminated non-legend drugs in January 1975, with annual state savings of $3,300,000; reduced medical supplies (except for "life-sustaining" equipment) in January 1975, with annual state savings of $800,000; and eliminated the "Growth and Development Factor" for nursing homes in March 1975, with annual savings of $4,300,000.

Wyoming comments that the "only non-required care covered is adult optometric, the cost of which is, and intermediate care which was more costly to State with no Federal match."

Washington's state agency curtailed elective surgery, eye refractions, eyeglasses, and prosthetic devices in July 1966; not possible to estimate savings. In May 1967 Washington eliminated physiotherapy treatment; no savings estimate possible. In May 1971, Washington limited services for federally-aided indigents to acute and emergent conditions, resulting in approximately a 30% reduction in the Medically Needy Program. In March 1975, Washington curtailed all elective surgery, saving $1.5 million in state dollars annually.

b. Approaches which alter levels of services covered.

Alabama reduced the number of Medicaid-covered hospital days from 30 to 20 in June 1975, saving $160,000 in state dollars/year. Alabama reduced hospital extensions to 10 days in January 1976; not possible to calculate annual state dollar savings. Alabama limited physician visits to one per month for chronic, stable illness in November 1975; no savings estimate possible. Alabama also, in October 1975, reduced amount for personal needs retained by long term care patients from $45 to $25; savings to the state are about $490,000/year.

Arkansas, in January 1976, limited prescription drugs to 3 per month; annual state savings are $700,000. Arkansas discontinued granting hospital extensions beyond a 26 day limit in October 1975; annual state savings are $500,000.

California, in December 1975,reduced the number of emergency days not subject to authorization from 8 to 3, expecting to save the state $16,000,000/year. (Comment: "Initial

provider dissatisfaction. Discovered 8-day period not subject to review was being abused.")

Florida reduced the number of covered inpatient hospital days per year from 45 to 30 in January 1975; found annual savings to the state to be $825,504, based on first 6 months.

Georgia's state agency, in August 1975, limited physician visits to one per month; estimated savings to state will be $100,000/year. (Comment: "Considerable discretion must still be left with the physician.") Georgia also, in July 1975, limited outpatient visits to one per month; expected savings to state will be $100,000/year. (Comment: "Considerable discretion must still be left with the physician.")

Hawaii's state agency rejected a proposal to reduce the number of hospital days. (Comment: "Utilization controls are much more effective and with less negative impact on recipients and providers.)

Illinois' state agency implemented a concurrent review of hospital stays in 1973; not possible to calculate state savings. Illinois also requires prior approval for some services; not possible to calculate savings.

Iowa's state agency, in April 1976, proposed: reducing coverage of dental prosthetics, expecting to save the state $214,350/year; reducing optician services, expecting to save the state $10,119/year; reducing optometrist services, expecting to save the state $37,217/year; limiting days in hospital for psychiatric care, expecting to save the state $150,000/year, and reducing reserve bed days in nursing homes, with expected savings to the state of $128,610/year.

Louisiana, in July 1975, limited number of physician visits and limited type of drugs available; no estimates of state savings are possible.

In January 1976, Maryland's state agency implemented the following in order to reduce Medicaid spending quickly: limited dental services for those 21 and over to emergency care, hoping to save the state $7,217,990/year; limited hospital inpatient days to only medically necessary days, as determined by PSRO, to save the state an estimated $1,837,986/year; limited medical equipment as under Medicare, with expected state savings of $38,640/year; required preauthorization for ambulance transportation to and from hospital outpatient departments, expecting to save the state $194,880/year; limited podiatry services to diagnostic and surgical procedures,

except for diabetes and vascular conditions where routine foot care is still covered, to save the state about $186,667/year; and limited eyeglasses and examinations to one per year for those under 21 and once every two years for those 21 and over unless preauthorized because of medical necessity, plus eliminating repair and replacement of eyeglasses, expecting to save the state $1,430,042/year.

Mississippi limits dental services for adults to treatment of acute medical or surgical conditions and emergency dental extractions.

Missouri initially did not limit number of inpatient hospital days paid, but in July 1970 a limit of 14 days was established by the state agency and then changed (when funding situation improved) to 21 days per admission in July 1972; no estimate of state savings is possible. Missouri eliminated dentures for adults in July 1970; estimated savings in state funds is $1,125,000/year.

Nevada's state agency restricted audiological services to EPSDT cases only in May 1976, expecting to save the state $28,000/year. In addition, in May 1976 Nevada imposed the following limitations which, combined, are expected to save the state $900,000/year: limited refractions to one every 36 months, limited chiropractic services to hospital emergency only, limited dental services to emergency only, limited podiatry services to emergency only, limited physician visits to two per month, limited drugs to three prescriptions per month, placed inpatient limits on therapy the same as the Medicare limits, limited outpatient therapy to $100/year, and limited inpatient hospital admissions to those involving certain specified conditions only.

New Jersey's state agency rejected a proposal to limit the number of hospital days. New Jersey in January 1976 eliminated non-legend drugs; this action was rescinded in March 1976 following passage of supplemental appropriations by the legislature. In July 1975 New Jersey limited the increase in nursing home per diems to one half the normal inflationary increase, saving the state $4 million/year. In January 1970 New Jersey implemented a change whereby initial hospital stay was approved based on diagnosis, extension was approved only with documentation; estimate of state savings was not possible to calculate.

New York's legislature authorized the state agency to limit pre-operative stays to one day with exceptions, beginning in May 1976; anticipated state savings are included in the $8.9 million discussed earlier. (Comments: "Problems: Administrative difficulties in authorizing exceptions; potential PSRO conflict. Benefits: Reduces overutilization.") Also in May 1976, New York's

legislature authorized limiting hospital stays to maximums of 20 days with exceptions; anticipated state savings are included in the $8.9 million discussed earlier. (Comments are same as above.) New York's legislature, in July 1976, authorized establishment of on-site review teams in certain hospitals; anticipated state savings are $3 million/year. (Comments: "Problems: Potential PSRO conflict; potential lack of hospital cooperation. Benefits: Facilitates cost containment achievement; establishes a state presence in certain hospitals for monitoring purposes.") New York's Governor authorized an ongoing monitoring of patterns of hospital utilization through computerized reporting; state savings not possible to calculate. (Comments: "Problems: Possible untimely and inaccurate data; difficult to overcome obstacles to corrective action. Benefits: Enables state check on utilization based on norms of care.")

North Carolina's state agency, in January 1975, required that for each acute hospital admission, maximum length of stay be established according to diagnosis. The provider is reimbursed up to the maximum days certified. Monetary impact on the state has not been determined. (Comment: "There have been no reported problems.")

Ohio is considering a proposal to limit hospital inpatient days to 60 per year without prior authorization. Ohio currently allows 90 days per spell of illness, with a maximum of 245 days per year. This proposal would be an attempt to reduce unnecessary utilization. Another proposal under consideration by Ohio is to allow a maximum of only 2 to 4 physician visits per month without prior authorization or certification; this proposal is designed to cut expenses by cutting down on unnecessary visits. Ohio is also considering a proposal to reduce maximum allowable quantities for prescriptions; at the present time certain drugs, particularly antibiotics, are prescribed in quantities that exceed what is normally prescribed for private sector patients. This proposal would establish reduced maximum allowable quantities for prescription drugs. Ohio is also considering a proposal to limit the number of replacement sets of glasses and/or eye exams per year per recipient, to provide better controls against overutilization of vision care services.

Oregon's state agency rejected a proposal to reduce non-Medicheck dental services.

Pennsylvania's state agency, in July 1976, limited over-the counter drugs; no estimate is possible yet of state savings.

South Carolina's state agency proposed in February 1976

changes which would reduce state Medicaid spending by about $5 million/year by the following changes in its Medicaid State Plan: reduce inpatient hospital days from 40 to 20 per fiscal year; limit outpatient hospital and physician visits to a total of two visits per month; limit lab and x-ray services to those related to the two patient visits per month; limit skilled nursing facility services to 180 days per year; require copayment of $1/visit for optometrists, for non-EPSDT services; limit of two chiropractic visits per month, plus a $.50 copayment per visit except for EPSDT services; limit of two podiatrist visits per month, with a $2 copayment per visit except for EPSDT services; limit to two visits per month for outpatient psychiatric clinics and mental health centers, with $3 copayment per visit, except for EPSDT services; various limits on dental services including $1 copayment per visit, except for EPSDT services; copayment of $.50 per drug prescription except for EPSDT services; limits on therapy; copayment of $1 per item of medical equipment for non-EPSDT services; limit to 20 days per year for inpatient psychiatric hospital services for individuals under age 22; limit to 180 days per year for skilled nursing facility services for patients under age 21, including those with joint eligibility for Medicare and Medicaid.

South Dakota, on July 1, 1976, implemented the following in an attempt to save an estimated $66,105 in state funds per year: reduced podiatric services from 4 to 2 treatments/month for acute cases and from 12 to 6/year for chronic cases; reduced optometric and optical services from unlimited to one refraction and one pair of eyeglasses every four years; reduced chiropractic services from unlimited to one treatment per month. (All three of these services require prior authorization.) In July 1975, South Dakota began restricting payment, entirely or in part, for the following categories of drugs, thus saving about $215,000 per year or about 30% of the dollars expended in the previous full coverage drug program: for tranquilizers and anti-depressants, payment is restricted on 21 items; expensive brand name antibiotics are restricted unless prescribed for urinary infections; payment is allowed for six low-cost generic items including pencillin, ampicillin, and tetracycline; payment is restricted on Darvon and similar items but payment is allowed for low cost generic equivalent product; items for external application - lotions, ointments, shampoos, suppositories, gargles, and throat tablets; blood tonics; items for cough control; nasal decongestants; diabetic syringes, needles, and urine test items; over the counter items such as vitamins, laxatives, antacids and pain compounds (also excluded from payment are items not requiring a prescription even though they are normally purchased in that manner); products taken

for appetite control; foods and food supplement items.

Tennessee's state agency had proposed the following limitations in anticipation of a budget deficit in 1975-76: reduction on inpatient hospital days from 20 to 14/year, and reduction of outpatient visits from 30 to 24 per year; however, the legislature provided supplemental funds in lieu of the proposed reductions.

Texas reduced mental hospital stays to 30 days in July 1975; no estimate of state savings is possible.

Virginia limited inpatient days to 14 per year (which can be extended to 21 days where medically indicated) in January 1975; expected state savings of $11,200,000 per year. Virginia also administratively reduced travel aid in January 1975; expected state savings of $800,000 annually.

Washington, in July 1969, reduced the number of non-emergent physician visits from 4 to 3/month; this was done with concurrence of the Governor based on fiscal circumstances at the time. Then, in November 1969, the number of non-emergent physician visits was limited to 1/month, extended care patients to 2/month; no estimate of state savings is possible. A proposal to reduce length of hospital stays was rejected by the Washington legislature.

Wyoming comments as follows: "We, at one time, had a limit on number of physician visits, which was administratively impractical. We also limited hospital days to 14, which merely passed the cost on the county or the hospital who had to cover with no Federal match. Both of these limits were removed for the reasons stated."

c. Approaches requiring second surgical opinions and other prior authorization requirements.

California established, in September 1975, on-site review of inpatient days, estimated to save the state $57,000,000/year. (Comment: "Initial mixed reaction from providers - obviated chance of retroactive denials.")

Mississippi requires prior authorization based on a medical evaluation for all nursing home admissions.

New Jersey made prior authorization for certain services optional in January 1970; not possible to calculate annual state savings.

New York has had ongoing prior authorization for transportation and other services; no cost estimate possible. (Comment: "Problem: Entirely subject to county control without state pre-audit.")

Ohio is considering the following proposals:

- pre-authorization for those recipients who use an unusually high amount of services for minor ailments; these recipients would be allowed only to use non-emergency services by prior authorization through the county;

- on-site utilization review by stationing a UR team at high-volume hospitals to do pre-admission review and monitor each patient's treatment and length of stay;

- pre-admission certification for all elective in-patient care;

- require second opinions for elective surgery;

- not allow hospitals to be used for routine medical care: caseworkers could help patient to obtain a medical practitioner rather than using hospital for outpatient treatment except in emergencies;

- reinstate prior authorization requirements for nursing home placements: these were in effect from July 1969 to July 1974 but have since been discontinued;

- prohibit payments to physicians associated with care provided during hospital stays for which Medicaid will not reimburse the hospital;

- prior authorization and plan of treatment for psychiatric and psychological patients who are not hospitalized;

- eliminate use of Darvon and mild therapeutic tranquilizers without prior authorization (these commonly prescribed drugs account for 12% of Medicaid drug expenditures in Ohio);

- require pre-and post-authorization for optional services in order to control and constrain the utilization of optional services;

- tighten controls on use of durable goods: through prior authorization based on a plan of treatment, disallowance of unlimited or ongoing prescriptions for some supplies and oxygen, and denial of all prior authorization requests when Medicare denies them; and

- require prior authorization of non-emergency transportation services at the county level.

Washington, in October 1974, deleted psychotropic drugs from its drug formulary, saving an estimated $708,000 in state funds per year. In January 1969, with the concurrence of the Governor based on fiscal circumstances at the time, Washington required that elective surgery have prior approval from the state office and that acute/emergent surgery have prior approval from local office, and that the Medically needy would receive only acute/emergent care; no estimates of state savings are possible.

d. Approaches involving specification of minimum-cost treatment consistent with quality of care, for each diagnosis. (This category of approach could also have supply impacts.)

(1) Specifying the least expensive services for acute care.

Georgia, on August 1, 1975, implemented the Prudent Buyer Concept; amounts of state dollars saved are not possible to calculate.

Idaho, on July 1, 1975, eliminated coverage for expensive materials used in dental services, e.g., gold - ceramics; expected savings in state funds are $250,000/year (Comment: "We do not expect any real problem - Dental Association has concurred with this restriction.")

Iowa implemented a plan to encourage use of the lowest cost drug product in July 1976; expected state savings of $150,000/year.

Mississippi limits reimbursement for prescription drugs by formulary and by maximum allowable cost on listings by generic name wherever drugs are available from multiple manufacturers.

Missouri, in 1969, instituted a double pricing system for drugs to encourage use of acceptable generic drugs; no estimate of savings is possible.

Ohio is considering the following proposals:

- repeal of anti-substitution laws, thus allowing pharmacists to substitute generic equivalents for brand name drugs and saving about $3 million annually;

- limitations on lab payments: payment only for profiles since when batteries of tests are done they can be performed by profile on automated equipment but if the same tests are done by hand without the automated equipment, the cost can be three times as much.

The maximum to be allowed would be based on profile charges only;

- Allow operating room reimbursement for outpatient procedures; the purpose would be to reduce the frequency of inpatient hospitalization by encouraging greater usage of outpatient surgical procedures; and

- stronger utilization review of lab and X-ray services; procedures would be developed to assure that services rendered are appropriate to the diagnosis and/or condition of the patient.

Oregon's legislature mandated payment for ambulance services only if medically necessary, as of July 1975; the state has saved $110,000/year. (Comment: "Ambulance providers have protested. No major problems.")

South Dakota has placed limits on drug payments as discussed above under Section IIA2b.

Wyoming initiated the practice, as of July 1967, of having medical necessity for physican services reviewed by a committee of the State Medical Society; state savings have been about $20,000/year.

(2) Specifying the least expensive form of long-term residential care.

District of Columbia is considering conversion of some acute hospital beds to ICF beds, in a demonstration project funded by DHEW; no estimate of District savings is possible.

Georgia began its Nursing Home Alternatives project on July 1, 1976; estimated state savings will be $150,000/year. (Comment: "DHEW waiver authority will be used to cover foster care and the alternatives to institutionalization.") Georgia established utilization review for SNF's in July 1974; state savings are not possible to estimate. (Comment: "UR team carefully examines all SNF's for potential to downgrade.")

Hawaii proposed, but SRS rejected, ICF reimbursement to SNF for patients requiring less than skilled care. (Comment: "Would result in considerable Medicaid savings. SRS claims such a reduction is contrary to Federal regulation.") Hawaii

implemented, in 1966, the use of home health services instead of institutional services. (Comment: "Physicians show preference to institutional care over home health services.") Hawaii, in 1972, specified use of ICF over SNF when medically indicated. (Comment: "ICF beds are insufficient in the State.")

Iowa's state agency considered but rejected the use of custodial homes. In July 1976, Iowa's state agency proposed payment at the custodial rate for persons in ICFs; annual savings would be about $500,000/year.

Kentucky implemented its Utilization Control Program in 1973; it ensures proper placement of institutional patients. No savings estimate is possible.

Missouri, in 1969, began requiring that nursing home level-of-care certification be made by an agency physician instead of by the recipient's or institution's physician; savings estimate not possible.

Nebraska, in January 1973, began having field nurses review all nursing home patients in a timely manner to place at the appropriate level; annual savings to the state are estimated at $2,500,000. (Comment: "Department has experienced problems with community and clients in attempting to make changes to either more or less restrictive care; reluctance on part of aged clients to make any change in living arrangements.") Nebraska initiated its surveillance/utilization review team in July 1972; no estimate of state savings is possible.

New Hampshire, as per HEW instructions, began to follow Medicare guidelines for skilled care under Medicaid in November 1975; state savings are about $100,000/year.

New Jersey implemented level of care reviews in January 1970; no estimate of state savings is possible. In January 1973, New Jersey began its ICF program; again, no estimate of state savings is possible.

New York has had ongoing development of long-term care assessment methods, and demonstration and testing of the community-based approach; no estimate of state savings is possible. (Comment: "Problems: Certain amount of community resistance; difficult to evaluate; lack of effective patient

placement system after treatment assessment is made. Benefit: Encourages more appropriate utilization.") New York has also had an ongoing expansion of its home health program (excluding proprietary home health providers); no estimate of state savings is possible. (Comments: "Problems: Requires initial cash outlays with only potential long-term savings; difficult to control because of uncoordinated home health care delivery system at local level. Benefit: Effective means of preventive and convalescent care.")

North Carolina, in March 1974, began reviewing applicants and patients in long term care facilities to ensure appropriate placement; no estimate of state savings is possible.

Ohio is considering the following proposals:

- to enforce level of care determination on the grounds that existing federal regulations allow a reduction in payments for Medicaid patients in a skill level that is too high;

- establish a Nursing Home Peer Review Council, to review conditions of payments for nursing home services and to assist the agency in other areas of program development; and

- develop alternatives to nursing homes.

Oregon, in July 1969, implemented level of care planning in congregate care facilities on State's definition of Skilled and Semi-skilled ICF level of care; actual state savings are about $2.85 million per year. (Comment: "Been well accepted by providers.")

Pennsylvania, in 1972, instituted pre-discharge utilization review for inpatient hospital care; no estimate of state savings is possible.

Rhode Island initiated, in January 1975, utilization review prior to PSRO operation; no estimate of state savings is possible. (Comment: "Management of hospital utilization improved as indicated by decreased length of stay.")

South Dakota, on July 1, 1976, moved 400 cases from SNF care to ICF care; state savings are estimated to be $140,000/year. South Dakota also, on July 1,1976, moved 30 cases from nursing homes to in-home care and prevented nursing home admissions of 120 persons; state savings per year are estimated at $105,000.

Texas reports the following changes: Home Health project was initiated in January 1974; two levels of ICF in nursing homes since 1967; ICF/MR since October 1974; Utilization Review in hospitals since 1967; Utilization Review in Nursing Homes by MAU's since February 1970; Utilization Review in Nursing Homes since 1976; no estimates of state savings are possible.

Washington began screening nursing patients, ICF vs. home care, in December 1975; expected state savings are $5 million/year.

Wyoming began, as per Federal requirement, SNF-ICF classification distinction in January 1967; no savings of state dollars. (Comment: "Since we attempt to pay cost in all facilities, it is doubtful if classification saves any money.")

3. Approaches involving changing amount of state payment for services.

a. Requiring copayment.

Alabama implemented a 50¢ copayment on drugs in June 1975; annual savings to the state are about $1,000,000.

California implemented a limited pilot copayment project for 18 months, starting in 1972. (Comment: "Not now considered to be politically acceptable.")

District of Columbia is considering the following copayments: $2 for eyeglasses, to save the District 4½%/year("primarily for deterrent effect re: abuses"); 50¢ for prescription drugs, to save the District 11%/year; $1 for physician services for medically needy, saving the District 8%/year ("primarily for deterrent effect re: abuses").

Georgia instituted a 50¢ copayment on drugs in August 1975; state savings are estimated to be about $3,000,000/yr. (Comment: "A simple administratively workable plan to significantly reduce cost. Drug copayment is extremely useful and easy to administer if done on a flat charge.") Georgia instituted an optional service copayment in August 1975 of from 50¢ to $3; savings to state are estimated to be about $50,000/yr. (Comment: "More psychological than dollar generating.") Georgia instituted a physician copayment of $1 on January 1, 1976; too soon to estimate state savings. (Comment: "Implemented with HEW waiver authority.") Georgia's hospital copayment of $25 was instituted on January 1, 1976; savings are estimated to be $2 million/yr. in state funds. (Comment: "Procedure Georgia is testing is probably too complicated due to numerous compromises in project.") Georgia also initiated an outpatient copayment of $2 on January 1, 1976; savings to state are estimated at $1 million/yr. Georgia began factoring physicians and druggists on December 1, 1975; no comment on results.

Hawaii's state agency rejected a copayment proposal. (Comment: "Financial impact on recipients regarded as too serious.")

Illinois rejected a drug copayment proposal. (Comment: "Anticipated excessive administrative costs.")

Iowa proposed, in July 1976, a copayment on drugs; estimate of annual state savings is $257,220.

Kansas began requiring a drug copayment of 50¢ per prescription paid by client on July 1, 1976; estimated state annual savings will be $986,000.

Louisiana is considering a copayment for drugs; anticipates annual savings of $2,700,000.

Maryland began a 50¢ copayment on all legend drugs as of January 1, 1976; estimated annual savings to state will be $1,626,030.

Mississippi implemented a 50¢ drug copayment for each drug prescription beginning 7/1/76; estimated annual saving for FY 1977 will be $3.5 million.

Nevada implemented a drug copayment plan on 5/10/76; estimated annual state savings will be $67,000.

New Jersey implemented a pharmacy co-pay of 25¢ per prescription in August 1975; estimated savings per year would be $1,500,000. (This action was rescinded in March 1976.)

North Carolina began a copayment program in 1973 for services and pharmaceutical items; not possible to calculate state savings.

Ohio is considering a proposal to require copayments of $.50 to $1.00 for prescriptions; purpose would be to reduce unnecessary prescriptions. Ohio is also considering a proposal to use copayments as a means to tighten controls on utilization in the dental program.

Oregon is considering a proposal to require copayments on outpatient and emergency room charges, physician services, and drug services. (Comment: "DHEW has said we cannot legally use copayment on Outpatient and Emergency room charges and physician services.")

South Carolina's state agency proposed the following in February, 1976: $1/visit copayment for optometrists services for non-EPSDT services, a 50¢ per visit copayment for chiropractic visits for non-EPSDT, a $2 copayment per visit for podiatrists services for non-EPSDT, a $3 copayment per visit for outpatient psychiatric clinics and mental health centers for non-EPSDT, a $1 per visit copayment for dental services for non-EPSDT, a 50¢ per prescription copayment for drugs for non-EPSDT, and a $1 per item copayment for medical equipment for non-EPSDT (all part of the estimated $5 million/yr. savings proposal discussed earlier.)

South Dakota implemented a 50¢ copayment on prescription drugs on July 1, 1976; estimated annual state savings will be $47,250. (Comment: "State Attorney General opinion was positive.")

Texas is considering a proposal for a copayment on non-mandatory services; would save $4 million/yr. in state funds. (Comments: "1. Administrative burden for provider; 2. Possible sales tax on copay.; and 3. Loss of federal funds on copay amount.")

Virginia began copayment for all legend prescriptions and refills in January 1975; estimated annual savings will be $2.1 million. Virginia also began requiring a copayment for eyeglasses in January 1975; estimated annual savings of $89,000.

Washington, in May 1974, imposed a monthly premium payment on medically needy families; this was terminated in September 1974 because not cost-effective. Washington also implemented a policy of limiting income exemptions for medical bills paid prior to application for assistance to bills paid 7 days prior, rather than 90 days. (Comment: "This was implemented, however Federal rules forced a return to the 90-day standard.")

b. Require a deductible.

Ohio is considering a proposal to establish deductible provisions for optional services; federal regulations allow a deductible or flat fee to be assessed Medicaid recipients for the use of optional services.

Washington, in May 1971, began requiring a deductible of $200/year for Medical Only program; no estimate of state savings is possible.

c. Place a fixed rate limit upon a service.

Alabama placed a $25 ceiling on home health care in October 1975; no estimate of state savings. (Comment: "Preventive measure.")

Alabama also placed a $21.50 ceiling on SNF care in January 1975; estimated annual savings to state of $600,000. Alabama placed a $19.35 ceiling on ICF care in January 1975; estimated annual state savings of $400,000.

District of Columbia is considering limiting reimbursement for emergency room treatment; no estimate of savings to the District.

District of Columbia is also considering a proposal in which reimbursement for laboratory fees would not exceed the rate established under the bid process; no estimate of District savings is possible. (Comment: "Bid rate would reflect cost of automated procedures.")

Florida's legislature mandated, on January 1, 1976, a flat rate, all inclusive, for physician visits in office, hospital, and nursing home. Actual savings to state based on 6 months experience have been $1,717,442. Also in January 1976, Florida's legislature mandated that optometric

services (refractions) be reduced to $15 per exam; actual savings to state in 6 months was $11,351. At the same time, Florida's legislature reduced the reimbursement rate for screening in the EPSDT program from $10 to $6.20; state savings in 6 months were $84,294.

Illinois' state agency is considering prospective reimbursement for inpatient facilities; no estimate is possible of savings to the state.

Iowa began, in July 1967, to reimburse physicians on a profile; no estimate of savings to state.

Mississippi has paid for physician services on a fee schedule adopted in 1970; these fees have not been increased since that time.

Nebraska has used fee schedules since the late 60's, to limit payment for certain services. In July 1974 Nebraska implemented a system of "usual and customary charges" with savings to the state of about $1.3 million in one year. (Comment: "Screening of costs which fall outside normal range and reduction of payment if additional cost is not justified.")

In April 1976, Nevada implemented lower reimbursement rates for drug vendors, expecting to save $22,000/yr. In May 1976, Nevada began reimbursement of outpatient hospital visits on the same cost per unit basis as physicians; they formerly used cost reimbursement; estimated state savings will be $95,000/yr.

New Jersey began calculation of nursing home per diems on July 1, 1976; estimated state annual savings will be $15 million. New Jersey, in August 1975, reduced provider fees 10%, to save the state $14 million annually. New Jersey had proposed, but a Federal Court rejected, limiting hospital increases in per diem rates.

New York's Governor and Legislature authorized, and the agency is to implement "ASAP" a limit on rates for hospitals, nursing homes, and ICFs for 1976; estimated state savings will be $38 million/yr. (Comments: "Problems: Could restrict facility revenues and possibly patient care. Benefits: Provides opportunity to reverse increasing facility costs; encourages efficient production of services.")

New York's agency is also mandated to freeze clinic rates at 1975 levels for 1976; estimated state savings will be $7.5 million/yr. (Comment: "Problems: Could restrict clinic revenues. Benefits: Provides opportunity to reverse increasing costs; encourages efficiency.")

Ohio is considering the following proposals:

- implement Maximum Allowable Cost (MAC)/Estimated Acquisition Cost (EAC) to take advantage of price differentials among brands of the same drug. HEW has established a Pharmaceutical Reimbursement Board to identify the lowest price at which a drug is widely and consistently available. This price, the MAC, becomes the reimbursement ceiling, and reimbursement would be made at or below the MAC;

- develop a customary clinic charge basis: federal regulations allow reimbursements on a customary clinic charge basis, either on an individual or a group facility basis. Given the staffing pattern in clinics, maximum limits established in this manner may be lower than those based on "pure" physician service costs;

- reduce payments for ambulance services by: reducing mileage allowance which is now 75¢ per mile beyond ten miles; discontinuing payment for mileage for each person hauled (example: if a van carries four wheelchair patients on same trip, mileage is paid for each of the patients and payment is 10 miles x 4 x 75¢ =); reducing amount of payment for water hauls from the full one-way payment which is $36; and

- penalize hospitals for excessive stays in order to encourage hospitals to discharge patients promptly be reducing reimbursement to 50% for any inpatient days in excess of the days certified as necessary for the patient.

Oregon, in January 1968, developed fixed fee schedules for chiropractor services whereas they had paid negotiated rates with each provider prior to this change; actual annual savings of $6,000. Oregon, in January 1974, developed fixed fee schedules for psychotherapy services; actual annual state savings of $6,000.

Pennsylvania is considering reduction of laboratory fees. As of August 1976, Pennsylvania's agency began applying the Maximum Allowable Cost/Extimated Acquisition Cost for drugs, as per Federal regulations. (Comment: "Anti-substitution laws hinder total implementation.") Pennsylvania is considering developing standards for hospital reimbursement; no estimate of state savings.

Rhode Island's state agency rejected proposals to freeze hospital outpatient charges at the 1/1/76 level and Skilled Nursing and Intermediate Care Facilities per diem reimbursement rates at the 1/1/76 level.

South Carolina has implemented a contract with Blue Cross - Blue Shield since July 1973 to act as fiscal intermediary for all Part B services; these services covered under Medicare are paid on a "usual and customary charge" basis; no estimate of state savings.

Tennessee's state agency and legislature had considered reducing ICF state maximum payment from $17 to $15/day, reducing pharmacy fee from $2.10 to $1.90, and reducing other providers reimbursement by 10%, all in order to head off an anticipated deficit in 1975-76; in lieu of these proposed reductions, the legislature granted supplemental funds.

Texas began reimbursing physicians at 95% in September 1975; no estimate of state savings.

Virginia, in July 1969, limited out-of-state providers to 81% of allowable charges; no estimate of state savings.

d. Place dollar maximums on care per individual.

Florida's legislature placed a limit of $312 per person per year for outpatient psychiatric care as of January 1, 1976; no estimate of state savings. Florida's legislature at the same time placed a cap of $125 on dental services for children: prior authorization beyond; no projection of state savings. Also, in January 1976, Florida's legislature reduced annual outpatient hospital services from $200/yr. to $50/yr.; estimate savings to state in first six months was $1,226,814. Florida's legislature reinstated a cap of $20 per month per recipient starting in June, 1975; estimated annual savings to state are $3 million plus.

e. Change the reimbursement formula. (This could also have supply impacts.)

Alabama's state agency is considering limiting physician payment for office visits to state-wide average plus one standard deviation; no estimate of savings.

California, in February 1976, implemented a cost-containment plan which affects the determination of reasonable cost for inpatient hospital services. Final settlements for the July 1975 through June 1976 period will be limited to a 10% increase over the average cost per patient day during the preceding twelve months. Hospital interim payments are limited to an 0.8% increase over the previous month payment. (0.8% compounded monthly is equivalent to 10% per year.) Estimated annual savings to state: $30 million. (Comment: "The cost containment plan was approved by USDHEW prior to adoption of state regulation. HEW approval was contingent upon development of an appeal procedure for hospitals experiencing extraordinary, but necessary, cost increases above 10% to apply for adjustment to the 10% limitation.")

District of Columbia is considering the establishment of a rate-setting commission for hospitals. (Comment: "Will require legislation.")

In Florida, the legislature mandated, as of January 1976, that current hospital inpatients costs be computed on the basis of last year's cost plus 6%, rather than 9% as in the past; no estimate available on state savings.

Idaho has imposed " no cost controls other than those required by law: maximum limit of 75%ile of 1975 fee schedule for physicians services."

Iowa's state agency proposed, in April 1976, a reduction in fees for all providers 15% across the board; estimate annual state savings would be $7 million. Iowa's agency also proposed, in July, 1976, to eliminate the 5% economic factor to nursing homes; estimated state savings would be $1,598,000.

Kansas has paid medical vendors on a given percentile since 1970. Kansas indicated that it is "already at 50 and 2 percentile on all vendors, except nursing homes at the 75th; savings are substantial but no estimate can be made since potential cost of full payment of all vendors cannot be determined using existing data."

Minnesota now reimburses at "usual and customary unless other Federal requirement, i.e., physicians not to exceed 75%ile of Title XVIII."

Missouri responds that "various reductions have been made during tight fiscal periods and lifted later. State law requires pro rata reductions in payments when funds are insufficient to make full payments." Missouri, in February 1976, limited reimbursement for inpatient hospital services to 75%ile of length of stay shown in professional activities study (PAC) unless otherwise authorized; no estimate of state savings.

Nebraska's agency and Governor planned to implement, in July 1976, a limit on nursing home cost reimbursement to median cost for type of facilities plus fee for services; estimated savings will be $1 million in state funds per year. (Comment: "Median limitation is part of proposed plan but may be modified as a result of unfavorable responses from nursing home administrators; plan has not been formalized.")

New York's legislature authorized implementation, in April 1976, of the elimination of dispensing fees for non-prescription drugs which are prescribed; estimated savings are part of the $700,000 package discussed earlier, which included denial of reimbursement for non-prescription drugs with some exceptions. (Comment: "Problems: Could inhibit pharmacists' participation in program. Benefits: Encourages efficient handling of drugs by pharmacists.") New York's state agency rejected a proposal to reduce reimbursement for research and education costs related to residents and interns. (Comment: "Objective was to eliminate reimbursement for care not related to patients.") New York's legislature has authorized an ongoing program (since 1969) of state prospective reimbursement; no estimate of cost savings. (Comment: "Objective is to control costs through application of cost-based reimbursement system. Received HEW waiver from Medicare cost-based requirements.")

Ohio is considering proposals to:

- compute hospital per diems on the basis of 95% occupancy;

- limit hospital outpatient charge to 65% of billed charges in order to reduce payments to hospitals by paying them at the same level clinics or physicians' offices would charge for the same service rather than on the basis of their actual costs;

- adopt a system of prospective reimbursement, to give hospitals a greater incentive to keep costs down by allowing them to keep part or all of any savings under the predetermined rate and requiring them to absorb all or part of any losses above the predetermined rate;

- place an upper limit on reasonable cost rate. Currently there is no upper limit or ceiling on the rates payable to hospitals under the reasonable cost formula; it is argued that by establishing an upper ceiling (such as the 90th%ile) hospital payments could be reduced;

- assume full Medicare coverage for Skilled Nursing Facility patients eligible for Medicare; the purpose of this proposal would be to give nursing homes a greater incentive to use Medicare funding where available by not automatically paying for services covered by Medicare with Medicaid monies;

- pro-rate reductions in nursing home payments;

- ceilings on reasonable cost care for SNFs ($26/day) and for ICFs ($22/day);

- pay lesser of fixed rate or actual cost for plant operating costs; under H.B. 155, nursing homes are reimbursed at a flat rate for depreciation, etc., even though actual costs for some nursing homes may be less than the flat rate. The purpose of this proposal would be to reduce or eliminate payments above actual costs;

- adopt a system of prospective reimbursement for SNFs and ICFs;

- adopt provisions of PL 92-603: H.B. 155 froze hospital reimbursement to the Medicare reimbursement formula prior to the Social Security Amendments of 1972; removal of this language from H.B. 155 would make Medicaid reimbursement consistent with the current Medicare formula;

- use the Medicare rate for specific localities: current physician reimbursement has been established at a state-wide level of 75% of usual charges. However, cost savings could be realized if the agency were to implement federal regulations permitting the use of the median of the previous year's charge as computed for specific localities rather than on a statewide basis;

- use different charges on multiple visits: PL 92-603 indicates that there should be a considerable difference between the amount reimbursed when a physician visits a nursing home to see a single patient and that paid when several patients in the same nursing home are seen on the same visit; current reimbursement procedures do not recognize this;

- reduce reimbursement to physicians by 50% for services rendered in outpatient settings: this would take into account the physician's free use of hospital facilities;

- better controls over payments to physicians, including better control to eliminate allowing payment for hospital visits when fees should be part of surgery fee, not reimbursing for certain services which are available free of charge (e.g., VD lab tests are all done by the State at no charge), not reimbursing separately for physician and outpatient hospital visits when these are already supposed to be included in an all-inclusive billing for obstetrical care, not reimbursing for the all-inclusive obstetrical care if the physician only delivered the baby without any previous visits, allowing only a one-time fee for newborn care: a fee for routine newborn exams and care after delivery should be a total fee and not be paid each time pediatrician sees baby, and not allowing a physician to bill for services of an unlicensed physical therapist;

- reimburse pharmacy chains on the same basis as outpatient hospital. Since large pharmacy chains are able to buy bulk drugs at as much as 41% less than the Average Wholesale Price, adoption of this proposal would reduce drug costs by between $.8 and 1 million per year;

- establish a negative formulary: this proposal would set price ceilings at a rate of 25% greater than the average cost of all available comparable drugs for each accepted therapeutic category; any prescription drug would then be compensated for up to the maximum amount allowable per therapeutic category;

- reduce professional dispensing fee: pharmacists are currently reimbursed $2 per prescription; this proposal would reduce this fee to $1.50 per prescription;

- place some sort of limitations on clinic payments: due to the ability to refer patients from one provider type to another within the clinic, it gives the provider-owner of the clinic a distinct financial leverage; one suggestion would be to pay clinics on a cost basis; another suggestion would be to require a certain portion of all practices to be private pay in order to act as a control for comparison purposes, since private pay utilization of services and third pay patients should be basically the same;

- capitation method for payment of pharmacy services and physicians' services in nursing homes: at the present time, neither pharmacy services nor physicians' care are included in the calculation of the per diem nursing home reimbursement levels. By placing these two types of services to nursing home patients outside the per diem calculations, with its internal system of edits, little or no control can be exercised over these costs. However, if the nursing home reimbursement rate were to be all-inclusive, the agency could better check any excessive utilization of drugs or physicians' visits; and

- reduce incentive for physicians to bill separately for outpatient clinic services: at the present time, a physician who provides professional services in a hospital outpatient clinic or emergency room and does not receive compensation from the hospital may bill separately for these services. Yet, because the physician's reimbursement rate includes administrative overhead, this separate reimbursement for services performed outside the physician's office should be reduced by 50% of the amount recognized for physicians rendering similar services in their own offices. In this way Medicaid would not be paying overhead expenses twice.

Oregon's legislature ordered, in July 1975, payment for emergency and outpatient room charges at same percent of public billing as physicians: at 75%ile. Previously, they had paid reasonable audited costs. Estimated annual savings: $80,000. (Comments: "Providers have protested. Procedural disaster since have "co-mingled" payment systems, i.e., part reasonable audit cost, balance at percent of public billing.")

Rhode Island implemented in October 1974 the prospective reimbursement for hospital services; estimate yearly savings for Medicaid program of $516,000. (This estimate is based on a calendar year increase of 17% nationally, as reported by Journal of AHA, but only a 14.3% increase in Rhode Island between 10/74 and 10/75.)

South Dakota, following Federal regulation, limited physicians' charges to 75%ile of 1973 charges; no estimate of cost savings. South Dakota's Governor proposed, and legislature accepted, limits on nursing home costs starting in July 1976 as follows: maximum allowable costs were limited to 110% of the state average on nursing salaries and supplies, kitchen salaries and raw food, laundry services, and total recognized per diem; maximum administrator's salary ranging from $15,000 to $20,000 depending on size of facility and experience of administrator; assistant administrator salary limited to 75% of the administrator and disallowed in facilities with less than 75 beds; management fees limited to $15 per bed per month less administrative salaries, excluding the administrator, and no management fee allowed unless the facility is part of a chain operation with an established home or central office; travel in excess of $2,000 must be substantiated; building depreciation can be straight line only with masonry buildings at 3% of cost and frame buildings at 4% of cost; furniture and equipment depreciation limited to 10% of cost; automobile and special equipment depreciation limited to 20% of cost and all special equipment must be approved by the department; rent paid to a related person or organization is disallowed and only actual ownership costs are to be reported; growth and improvement is to be calculated on net equity at a rate equal to the average real estate loan market in South Dakota for the previous year (approximately 9%), and profit facilities are to receive 100% of the rate, with non-profit receiving 50% with a minimum of 3% return; minimum occupancy to be used in calculating per diem is 90%; optional cost services, such as physical, speech, and occupational therapy and oxygen are to be eliminated from cost statement. It is estimated that these measures will save $264,000 in state dollars per year.

Washington, in 1973, established a State Hospital Commission which instituted prospective rate setting and budgeting systems. As of October 1975, Washington hospitals had changed to an entirely new chart of accounts and accounting system, adopted a completely new and extremely complex and detailed budgeting system, carried out a budgeting and rate setting process, many for the first time, submitted for the first time a budget and rate request, and explained and justified their budget and related requests to a public agency. Since October 1975, the Commission has completed review and taken action on 90 budgets and related rates: original requests totaled $524 million; the Commission approved rate-setting revenues of about $514 million, some $10 million less than requested. To date, none of the hospitals has appealed the Commission's decisions. A side benefit is the data which has been made available to improve management of the hospitals in Washington.

Washington's report on its Commission comments; "Continuation of retrospective cost reimbursement payment systems is counter-productive to the cost-containment emphasis of the Commission... to meet this problem, the Commission has proposed to the Social Security Administration an experimental prospective reimbursement project, to include Medicare, Medicaid, WC, and Blue Cross."

Wyoming, in July 1970, limited hospital inpatient reimbursement to length of stay based on 75%ile of area prevailing by diagnosis; actual state savings are $100,000/year.

B. Approaches which primarily impact on the producer's supply of Medicaid services.

1. Approaches which limit eligible providers.
California is considering contracting out provision of services to groups of providers; no estimate on cost savings.

District of Columbia has never considered limiting eligible providers; comment: "Might conflict with 45 CFR 249.10, freedom of choice."

Hawaii, in January 1966, excluded chiropractors. (Comment: "Services available through other participating providers of professional services.")

Nebraska, in July 1973, implemented a "lock-in" whereby recipients are locked in on physician and pharmacy"to eliminate shopping around"; no estimate of state savings.

New York's legislature authorized the state agency to implement, on May 14, 1976, a limitation by which Medicaid reimburses only those facilities which have applied for Medicare. (Projected savings are included in the estimated $7 million annually discussed earlier.) (Comments: "Problems: None significant. Benefits: Assists in collecting third party coverage, forces similar standards for Medicaid and Medicare, and makes providers more cost conscious.") New York has under consideration a proposal to centralize clinical laboratories; no estimate of cost savings. (Comments: "Problems: Causes legal challenges. Benefits: Encourages efficient production of services, reduces provider abuse.") New York has had ongoing the practice of prohibiting creation of unnecessary beds and eliminating unnecessary beds through certificate of need process, decertification of beds, and continuation of underutilization penalties; estimated annual savings are $2 million. (Comments: "Problems: Lengthy decertification process; possible conflict between State and the new Health Systems Agencies; restricts facility revenues. Benefits: Encourages appropriate distribution of beds and efficient utilization of existing beds.")

Ohio is considering a proposal to limit psychological services to clinics, rather than eliminating these services entirely, on the grounds that use of mental health clinics may result in less expensive provision of service. Ohio is also considering a limit concerning Medicare crossover: only allow payment to providers who accept payment on assignment basis. Some providers collect the coinsurance and deductible from recipient; Medicare pays their portion. The claim is passed on to the state agency and the coinsurance and deductible is paid again. Regulations clearly state that no providers are to collect monies from the patient. Ohio is considering a proposal to tighten conditions of participation for clinics, thus eliminating ambiguity concerning whether a facility is a clinic or not.

Washington's practice of putting drugs on a bid basis, begun in October 1974, resulted in all contractors except in one county withdrawing from the bidding, thus reducing the list of providers.

2. Approaches which limit the amount of money a provider can collect.

District of Columbia is considering a proposal to limit the number of physician services; no estimate of District savings.

Minnesota is considering limiting psychiatric services to 10 visits without prior authorization; no estimate on savings.

New York has had an ongoing policy of limiting numbers of visits to certain providers; no estimate of savings. (Comments: "Problems: Difficult to control number of visits; difficult to monitor without a centralized claims payment system.")

Ohio is considering a proposal to place stricter limits on allowable physician visits per family by establishing a maximum payment to a physician who sees more than one member of a family on the same day, thus eliminating the situation in which Medicaid is billed for physician services to all family members when the services were neither requested by the recipient nor adequately completed by the physician. Ohio is also considering a proposal to limit licensed therapists to Medicare benefit limits: with Medicare, the independent therapist is limited to $100/yr/patient, and the Medicare patient is limited to a total of 200 therapy visits each year.

C. Approaches which primarily impact on the Medicaid program's Administration.

1. Install better control systems.

a. Install better control systems aimed at fraud detection.

Alabama comments: "Costs very low already; have increased costs somewhat to monitor program more effectively." MMIS was implemented in October 1976; annual audit of all nursing homes began in January 1976 and is expected to save $125,000/year; Alabama increased personnel in its Integrity Section in June 1976 but there is no estimate on potential savings to state.

Arkansas implemented its control system in July 1975; estimates savings to state of $500,000/yr.

California implemented a Drug Utilization Review Unit to perform onsite review of pharmacies, starting in December 1975; estimated annual savings is $1,750,000. (Comment: "San Jose pharmacist convicted of 10 counts of felony fraud.")

District of Columbia is considering a S/UR process and MAQC to identify those suspected of Medicaid fraud; no estimate of savings.

Georgia implemented its provider fraud detection system in July 1975; no estimate of savings. Georgia implemented its recipient fraud detection system in July 1976; no estimate of savings.

Hawaii implemented in 1971 its systems of surveillance of potential abusers and prosecution for fraud, which "provides a profile and payment record review to identify actual and potential abusers." Since 1966 Hawaii has conducted fraud investigation and prosecuted recipients, hoping to "deter others when publicized by local papers."

Illinois has implemented computer profiling to detect provider fraud; no estimate of savings. Illinois also conducts audit and investigation of providers; estimates savings of $5,000,000 in FY 76-78. (Comments: "Estimated savings will decrease to approximately $2.0 million per year by FY 79.)

Idaho's MMIS, implemented in June 1976, has brought "repercussion from providers, recipients, etc."

Iowa began computer-generated and manually created profiles of providers and recipients in July 1970; in saving unknown amounts per year. Iowa proposed a "Form agreement" in July 1976, projected to save some state dollars. Iowa has conducted regular audits of hospitals and nursing homes since July 1973; annual state savings are about $290,000. Iowa's use of case

data system with built-in safeguards for detection of errors, implemented in October 1975, has helped reduce administrative misuse; savings are not yet known.

Kansas is requesting, in its budget request in September 1976, a system to detect Medicaid fraud; estimated savings are not possible to calculate. Kansas has a fraud detection unit in each office which is programmed to detect intentional fraud.

Kentucky implemented a "lock-in" program in January 1971, which identified up to 434 recipient over-utilizers and "locked" them to specific limitations; savings not known but "evaluation is underway to determine cost savings."

Louisiana implemented its fraud detection system in January 1975; no savings estimates are possible.

Maryland's agency rejected a proposal to implement a fraud detection system in FY 76, since it would only result in long-term savings, not in the immediate savings needed by the state to balance the FY 76 budget.

Minnesota's SURS system provides a device to detect fraud by providers, recipients, and administrators.

Mississippi comments that: "Since the beginning of the program in Mississippi, a computerized Surveillance and Utilization Reporting System has been in operation. This system provides, on an exception basis, profiles on providers and recipients. Exceptional profiles are used by the Utilization Review Unit in auditing and investigations of overuse and possible fraudulent activities by providers and recipients."

Missouri proposed, but its legislature rejected, the formation of a small (5 investigator) investigative staff to verify delivery of service and look into other program abuse. (Comment: "Appropriation not received for recommended investigative staff exclusively for Medicaid. Legislature did appropriate funds for department-level staff to investigate abuse in all state health, welfare and offender programs, but resources to be devoted to Medicaid have not been determined.")

Nebraska, since May 1972, has "assigned specific staff to investigate potentially fraudulent situations." No savings estimate possible.

Nevada comments that "concentrated efforts in eligibility quality control and utilization review are being made. However, no estimate of savings can be attached to the additional activity in this area."

New Jersey began fraud detection activities in January 1970; no estimate of savings.

New York has had ongoing the offices of Special Prosecutor for Long-Term Care, Welfare Inspector General, and various other auditing units; estimated annual savings are $12 - 15 million. (Comments: "Problems: Legal case-building is very difficult; difficult to coordinate between Federal, State and local levels. Benefits: Preserves integrity of program; provides major deterrent effect.")

North Carolina has reviewed provider records and recipient profiles since the beginning of its Medicaid program. Suspected over-utilization has been investigated.

Ohio is considering the following proposals:

- inform recipients of payments made to providers on their behalf. It is hoped that recipients could thus assist in detecting fraud on the part of providers;

- have recipients sign for billed services, possibly helping eliminating billing for services not rendered;

- limit the use of direct entry or institute better controls so providers will not be paid more than usual and customary;

- tighten provisions for reimbursement of vision care services by establishing a special travel code to nursing homes allowing payment for each patient seen at the same home (should allow only one travel charge when more than one patient is examined), and eliminating paying for optometry codes as well as an office call in a clinic or physician's office;

- tighten provisions for reimbursement of dental services by building in computer edit for policy restrictions, by discontinuing allowing payment for dental exam as well as service rendered, and by ensuring that dental providers are not using palliative treatment code for services not covered by the program;

- suspend recipients who are flagrant abusers or place them on probation, followed by a suspension of health services for a required period;

- a "get tough" policy to terminate the most flagrant offenders, including issuing provider numbers only after verification of licensure and a determination that the provider has not exhibited patterns of overutilization;

- more specific policies on use of Medicaid services, in order to keep down abuse. Ohio's Auditor to date has had findings amounting to approximately $900,000 against individual providers but only about one third of this has been collected due to weak or unclear policy;

- develop a coupon or stamp system for recipients, to prevent "doctor shopping" and other abuses of services;

- closer coordination with counties, to involve the county caseworkers toward the aim of identifying, correcting, and controlling program misuse and abuse;

- curb loaning of Medicaid card by providing a picture of the recipients on an ID card along with the Medicaid card. Make it responsibility of provider to adequately identify recipient;

- require recipient to sign for services received: change billing form so recipient would have to sign as having received services; and

- control general physical exams: during pre-audit by Auditor, it appeared that some patients were getting general physical exams without any ailment.

Oregon increased thoroughness of congregate care reasonable cost audit in January 1976 by increasing its audit staff; no estimate of resulting savings. Oregon also began formal surveillance review activities in March 1976; estimated annual savings are $5,000. (Comment: "Added staff of 2.") In July 1975, Oregon began including medical assistance payments in recipient reimbursements due to ineligibility; no savings estimates yet. (Comment: "Handled by Fraud Investigation Unit.")

Pennsylvania created a Fraud and Abuse Unit in July 1976; no estimate of savings yet.

Rhode Island, in May 1976, complied with Federal regulations and notified all Medicaid providers of the penalties to be imposed in cases of provider fraud; no estimates of savings.

South Carolina implemented a Department Fraud Section in November 1975; savings are "insignificant at present but should bring considerable savings as it develops."

Tennessee built into its original Medicaid program the following: claims and provider audit, "lock-in" of recipients to one physician and one pharmacy, and field audit to detect administrative fraud.

Texas reports the following efforts to reduce fraud: audit of division hospitals starting in 1967 (no savings estimate); Investigation Division begun in 1974 (no savings estimate yet); Audit Division for Nursing Homes begun in 1972 (estimated annual savings of $100,000), and computer reference, edits and cross files of recipients begun in 1970 (no savings estimates).

Virginia organized Program Compliance Unit in November 1975; estimated annual savings of $100,000. Also in November 1975, Virginia increased detection activities concerning recipients; no estimate of savings yet.

Washington implemented Quality Control on Medically Needy program eligibility in July 1975; no estimate of savings yet. In July 1976, Washington implemented a mechanized utilization review to reduce or eliminate duplicate payments; estimated annual savings of $600,000.

Wyoming has had fraud detection procedures in place since January 1967; no estimates of savings are available. (Comment: "No cases for prosecution have been found.")

b. Install better control systems aimed at detecting unintentional error.

Arkansas estimates that its control system aimed at prevention of accidental error, in place since January 1970, saves about $100,000/year. In July 1975, Arkansas implemented an approved Medicaid Management Information System (MMIS) which is saving an estimated $200,000/year.

California's legislature decided, starting January 1974, to contract administration of SSI/SSP Medicaid eligibles to SSA; no savings of state dollars resulted. (Comment: "SDX problems and loss of dollars due to slow discontinuance of grant upon entering LTC offset small initial Medicaid savings.")

District of Columbia began, in 1970, performing post-audit reviews; no estimate of savings. The District is considering developing a management information system and is reviewing other states' prepaid plans; no estimate of possible savings.

Florida's legislature mandated in January 1976 that when patients are reclassified from skilled nursing care to intermediate, that skilled payments can continue for a period not to exceed 30 days; estimated savings in first 6 months were $196,365.

Georgia increased its efforts to obtain third party payments starting in September 1975; no estimate of savings yet. Georgia's MMIS and SUR became operational in July 1976. (Comment: "This offers the best long range potential for correcting errors and improving information.")

Hawaii began identification of 3rd party resources in January 1971. (Comment: "Medicaid I.D. card identifies 3rd party resource for provider to collect from it first.") Hawaii also relies on recipients to declare income and 3rd party resources. (Comment: "Not correct often; requires verification to substantiate accuracy of information disclosed.")

Idaho's MMIS (implemented in June 1976) is expected to reduce unintentional errors.

Illinois' MMIS is to be phased in during 1977; no estimate of savings.

Iowa implemented monthly I.D. cards with resource codes in October 1975 to help prevent unintentional errors by providers. Iowa in July 1976 proposed the assignment of third party resources to the department; no estimate of expected savings. Iowa's case data system (implemented in October 1975) and MMIS (to be proposed in January 1977) are expected to reduce error rates.

Kansas was to begin converting to MMIS starting July 1, 1976.

Kentucky's MMIS was to be implemented in July 1976. (Comment: "The system provides improved mechanized reporting and numerous cross-matching of data to control payments, eligibility, etc.")

Louisiana implemented its controls to reduce unintentional errors in January 1975; its MMIS is to be implemented in July 1977.

Minnesota's Benefits Recovery Program, implemented by legislative mandate, is saving an estimated $4.5 million per year. The program has identified additional insurance coverage held by Medicaid recipients and has made providers more aware of 3rd party benefits.

Missouri, since 1969, has restricted recipients to certain providers when recipient's over-utilization is detected. (Comment: "Dollar savings are impossible to calculate, but in a sample of affected recipients, utilization was reduced by 50%.") Missouri began internal planning for an MMIS in July 1974; FY 1977 appropriations for an improved data processing system include funds for MMIS. (Comment: "The system being developed will be especially useful in detecting and controlling overutilization and abuse and in controlling eligibility by date, instead of by month.") In April 1975 Missouri began a tape exchange with Medicare carriers for verifying Medicare premiums and copayments; no savings estimate available. In May 1976, Missouri implemented a suspense and automatic rejection file for improper claims or claims with errors. (Comment: "Computerized printing of suspense and rejection notices is expected to reduce correspondence costs and encourage accurate billing.") In January 1976 Missouri began a vendor training program "expected to reduce administrative costs and encourage vendors to check client eligibility more closely."

Nebraska's "trauma investigation" program, begun in January 1974, saves $1,000,000/year. Nebraska implemented, in July 1974, a systematic effort to increase 3rd party payments, with $270,000 savings estimated per year. Nebraska's legislators have approved funding for a MMIS, and have requested information about resulting savings "but do not take a very active role in agency policy because they are only in session a few months a year." The MMIS was to be fully operational as of July 1976 but has been partially operational for several years.

New Hampshire's MMIS was implemented in March 1975; no savings estimate yet.

New Jersey is considering a MMIS. New Jersey's effort to reduce unintentional error or oversight, including efforts to obtain 3rd party payments, began in 1970; actual savings of about $34,800,000 per year have resulted.

New York has had an ongoing extensive audit capability, detailed client information requirements, and use of collection agencies for third party payments. (Comments: "Problems: Difficult to coordinate between Federal, State and local levels; difficult to determine third party liability without a centralized payment system; lack of local aggressiveness. Benefits: Ensures appropriate internal agency management because a politically autonomous and independent audit agency exists.")

North Carolina established an audit unit to increase 3rd party reimbursements in 1973; no savings estimate is available. North Carolina's MMIS was introduced in June, 1975, under a private contractor.

Ohio is considering the following proposals:

- improve audit capability of Bureau of Fiscal Review to allow more on-site audits and provide faster recovery of funds. Cost would be $1.2 million for 58 additional staff but savings would be about $9 million annually;

- turn over on-site auditing function to State Auditor; to maximize Federal matching funds, this would have to be done via contract between the state agency and the Auditor's office;

- implement a program to recover Medicaid expenses from appropriate third party sources, in order to make sure all available sources of payment for which the recipient may be eligible, such as Medicare, are used first. Cost would be about $56,000 per year; savings would be about $444,000 per year;

- greater effort to ensure that Medicaid reimbursement is not greater than Medicare. State agency should verify, through Medicare intermediary, charges allowed for each provider and limit the Medicaid payment accordingly. The treatment codes are not entirely compatible at this time. Regulations state that Medicaid is <u>not</u> to pay more than Medicare;

- establish effective desk review procedures: to date, not one of the state agency's desk reviews examined by the Auditor has been found to be entirely correct. Constant changes are being made in policies and procedures and a codified set of instructions must be made available to each welfare department employee performing these desk reviews;

- implement a turn around document for invoicing purposes to make nursing homes more accountable and responsible for starting and discontinuing payments for patients entering or leaving nursing homes;

- better education of recipients on proper use of services; and

- develop on-line CRT system for county welfare departments, making Medicaid and AFDC eligibility as well as G.R. eligibility information readily accessible. At present, counties do not play a significant role in the Medicaid program. With better information to deal with, the counties could help educate and inform recipients regarding their individual Medicaid costs.

Oregon, in July 1975, added staff, increased training and agency emphasis, and increased filing of accident liens, etc., in order to increase efforts to obtain 3rd party resources. Estimated annual savings are about $100,000.

Pennsylvania is to develop its Medicaid MMIS by July 1977.

Rhode Island, in 1975, implemented a certification by recipients of their health insurance status, for purposes of increasing 3rd party payments; no savings estimate is possible. Rhode Island is considering a proposal to monitor actual vs. budgeted revenue in relationship to expenses to prevent over or under payment during a fiscal year. (Comment: " $550,000 potential overpayment avoided.")

South Carolina implemented a department 3rd party liability section in July 1973; through March 1976, $375,752 had been saved. (Comment: "The Department has collected $4 for every $1 spent.")

Texas has been using computer cross reference and edits since 1970.

Virginia implemented three efforts in May 1974 which in combination are calculated to reduce program expenditures by $35,000,000 per year; this does not include an undetermined dollar savings from the deterrent effect of the efforts. These three efforts are: combination edits and duplicate billing edits for providers, and service limitation edits for recipients. In addition, increased efforts for 3rd party collections began in May 1974 and are saving an estimated $300,000/year.

Washington began quality control on Medically needy program eligibility in July 1975; no savings estimate. In July 1976 Washington began a mechanized utilization review with reduction or elimination of duplicate payments; estimated savings of $600,000/yr.

Wyoming had previously considered an MMIS but rejected it as too costly. (Comment: "Study now being conducted to determine possible cost-benefit.")

2. Reduce administrative overhead.

a. Reduce overhead by use of centralized payments.

Minnesota has a centralized payment system; no savings to the state.

New Hampshire implemented an in-house computerization of Medicaid provider payments under their MMIS in November 1973; savings are estimated at about $550,000/yr.

New York's legislature has authorized an ongoing effort to develop computer claims payment and management information system. (Comment: "Objective is to provide centralized state control over claims payments and effective use of management information; New York City, however, poses unique problems.") New York's state agency has an ongoing consortium of providers, payors, PSRO's, and the State to develop uniform accounting, billing, and other mutually agreed upon program changes. (Comment: "Objective is to arrive at mutually agreed upon data needs and procedures.")

b. Reduce cost of claims processing.

Ohio is considering proposals to:

- simplify hospital billing procedures in order to save administrative expenses which hospitals have to pass on to the Medicaid program;

- reduce abuse of transportation services by making the mechanism for bus or cab authorization less time-consuming; and

- require providers to enter identification coding on Medicaid claims: this is now being done through contract with a private firm. Cost: none; savings: $38,000/yr.

Oregon is considering a proposal to accept computer tape billings from providers of physician services. Annual savings in data entry costs would be about $50,000.

South Dakota computerized claims processing in July 1975; no estimate of savings yet.

Texas is revamping the Medical Claims Section of Fiscal, starting in July 1976; no estimate of savings yet.

c. Contract with a private insurer.

California now has a state-county task force evaluating alternatives to the present fee-for-service Medicaid system.

District of Columbia increased number of HMO's in 1972; no cost savings estimates.

Florida contracted out the Prescribed Medicine Program in July 1974; savings have been about $429,340 over two years.

Hawaii in 1970 began a prepaid contract with an HMO. (Comment: "Eliminates claims processing costs. Provides additional benefits of health education and preventive care.")

Iowa has proposed use of HMOs, "but so far none have applied."

Minnesota has several HMO contracts; no estimate of savings.

New York has had an ongoing effort to develop HMOs and other prepaid health plans. (Comment: "Problems: Lack of clear state definition of HMOs; difficulty in setting capitation rates; limited available Federal and State funds for development. Benefits: Potential long-range savings; potential higher quality of primary care.")

Ohio is considering a proposal to use a private intermediary; it has been suggested that the Department could contract with a private company, such as an insurance company, to administer the Medicaid program. Ohio is considering a proposal to contract with HMO's to cover Medicaid recipients: purpose would be to reduce costs by greater emphasis on prevention and control of utilization.

Oregon implemented a fixed price capitation agreement with a HMO in September 1975; estimated annual savings are $200,000. (Comment: "Capitation rates are less than actual experience through private providers. 8,200 AFDC clients enrolled.")

Pennsylvania implemented insurance coverage for drugs in February 1975; savings estimate not possible yet.

Rhode Island implemented a HMO contract for family groups in 1972; no savings of state dollars resulted.

South Carolina, in July 1973, contracted with Blue Cross - Blue Shield as Fiscal Agency for Part B services; savings not known.

Tennessee, in 1969, began the use of fiscal agents: Equitable Life Assurance for physicians, lab and x-ray claims and Blue Cross - Blue Shield for other claims; no estimate of savings.

Virginia changed fiscal agents in July 1972; savings of about $3,000,000/yr.

Washington in July 1973 increased HMO enrollment; estimated savings of $300,000/year. (Comment: "Actual enrollment increases not as great as expected.")

d. Use of other contracts.

Ohio is considering the following proposals:

- contract for provision of medical supplies: the Department might utilize contracts for medical supplies and equipment, thereby assuring increased monitoring capabilities; and

- contract with SSA for Medicaid eligibility determination. Purpose of this proposal would be to free staff time for other purposes, especially on the county level.

Tennessee implemented an in-house ICF in May 1972; no estimate of savings.

Wyoming, in August 1973, deleted a dental plan contract for dental services; no estimate of savings.

e. Other.

Hawaii, in 1966, began an effort to control personnel requirement by limiting applications (medically needy) to persons currently in need of health care. (Comment: "Reduces the high cost of maintaining eligibility for non-users of services under Medicaid. SRS claims such a practice is contrary to Federal regulation.")

Ohio is considering a proposal to hire an outside consultant to review Medicaid management and make recommendations to improve its operation.

Iowa's Legislature implemented a study of Medicaid in April 1976.

Minnesota is proposing revision of its Medicaid Rule 47; no savings of state dollars are expected although it is basically a cost-containment effort.

Ohio is considering a proposal to require legislative approval of its Medicaid plan; this would give the legislature greater authority in its oversight function.

3. Use bulk buying for eyeglasses, drugs, or laboratory.

Ohio is considering proposals to:

- have the state purchase durable medical equipment for use by successive recipients; and
- have the state provide bus tickets to counties, thus reducing abuse of transportation services.

Washington began purchase of drugs on a bid basis in October 1974, saving $75,000/year. (Comment: "All contractors except in one county have withdrawn.") In July 1975, Washington began purchase of eyeglasses on a bid basis; estimate savings of $78,000/year.

D. Other

New York is continuing to expand EPSDT as a preventive health program; no cost saving estimate possible. (Comment: "Problems: Requires initial cash outlay for only potential savings; administratively cumbersome due to Federal requirements. Benefits: Helps to detect and prevent potentially very costly institutional care; provides continuous periodic family-oriented medical care.")

Texas began a recipient health information project in March 1976.

III. "CAN YOU PROVIDE ANY ADVICE TO OTHER STATES?"

Alabama: "Each state has differing structures and problems. Would hesitate to offer advice on a blanket basis."

Alaska: "We have found no method, simple or otherwise, to "contain" Medicaid costs largely because this state has almost exclusively the mandated services and our hospitals and nursing homes are reimbursed on the basis of "reasonable costs" as opposed to flat state determined rates applicable across the state."

Arkansas: "An accepted Medicaid Management Information System is essential to the operation of an efficient and effective Medicaid Program."

Idaho: "Need more federal technical and legal help and support to address the volumes of regulations and activities produced daily."

Kentucky: "Work closely with Advisory Committee when developing new program entry so that any pre-authorization procedures or visit limitations are consistent with quality health care."

Nevada: "Not yet, our cost control efforts are too recently instituted for us to have had the opportunity."

New Hampshire: "We believe we have effected significant cost containment by the implementation of our Medicaid Management Information System."

New Jersey: "Good data is essential to administration for evaluation. Also, adequate staff to use data, to stay abreast of changes, to evaluate and initiate changes. Annual Cost Study and Biannual Audit of Nursing facilities. Pre-Admission Testing. Explanation of benefits."

New York: "Our recently-enacted Medicaid Cost Containment bill (copy was attached to questionnaire) (Chapter 76 of the Laws of 1976) may be a useful guide to other states. Of special note is section 12 which provides the Budget Director with power to consider the State's economic conditions in judging the acceptability of hospital rates certified as reasonably related to cost. This power, if used, is expected to be challenged in the courts. In attempting to contain Medicaid costs, we would advise other states to ensure that adequate financial and beneficiary records are maintained, especially in the optional services area where interest groups are very strong. In New York there is currently an investigation being conducted regarding the possibility of such interest groups or persons inappropriately influencing legislative decision-making."

Oregon: "If you enter an agreement with an HMO, have them provide or sub-contract to provide all services "covered" under your Medicaid program. Otherwise there will be confusion to all parties involved."

South Carolina: "Advise close scrutinizing of eligibility rolls, establish controls to insure payment to eligibles only. The computerization of eligibility criteria, and Medicaid-Medicare profile system in conjunction with a Medicaid Management Information system would be of great use in minimizing costs. The development of a strong fraud section will prove its value as well."

Tennessee: "Continuous monitoring and surveillance by a capable and aggressive staff; provide limitations for services and reimbursement."

Virginia: "The advice that we could give is cited in the "Assessment"*which specifies performance in the critical program elements and addresses certain exemplary practices which could be used by other states."

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* See p. 58 for reference.

IV. " HAVE YOU DONE ANY EVALUATIONS, FORMAL OR INFORMAL, OF THE EFFECTS OF A PARTICULAR COST CONTROL EFFORT OR OF THE MEDICAID PROGRAM IN GENERAL? IF SO, PLEASE SUMMARIZE OR CITE REFERENCE."

Iowa: "Continuous evaluation of effects of utilization review. This evaluation has shown an average recovery of Medicaid dollars of $45,000 to $50,000 per month. Also, a special study of psychiatric care. This study has shown that a three day limitation for inpatient hospital psychiatric care would save $150,000 annually."

Kentucky:" 'Lock in' program evaluation is currently in progress to determine the overall effects of limiting services to certain recipients identified as overutilizing program benefits."

Nebraska: "Not much evaluative information available because data has only recently been computerized and in many cases is not complete or detailed enough to provide useful comparisons. Difficult to separate changes in cost which result from program variations and those which result from increased costs for and increased utilization of services. The Management and Data division has compared amounts of third party payments and payment amounts disallowed or reduced in FY 74 with corresponding amounts for FY 1975 (after MMIS had been initiated which generated daily and weekly reports and allowed systematic review of claims). The resulting cost avoidance savings for FY 1975 amounted to $1,570,000."

New York: "An evaluation is underway of a recently-initiated Medicaid prepaid plan, the Rochester Health Network, to identify numbers and types of enrollees, "leakage", ease of enrollment, quality of service, etc. Home health care is being explored as an alternative to long-term institutional care through a demonstration project in one of the state's localities; some initial difficulties have arisen, especially with community voluntary agencies, but evaluation of the project should be possible during late 1976."

North Carolina: "An analysis of the North Carolina prepaid Medicaid program was completed in May 1976. The report concluded that the implementation of the contract with Health Application Systems was hampered by insufficient analysis and planning. Also, the contract failed to properly link the contractor's profits with their performance. Factors over which the contractor has no control, such as eligibility determination, could have serious implications relative to profit and loss. The contract so heavily favored the State that it was probably unrealistic."

Oregon: "Reducing payment to hospitals for outpatient and emergency room charges has had no impact on utilization of these services by welfare clients."

Virginia: "MSA/SRS/DHEW performed A Management Assessment of the Virginia Medicaid Program, November 1975. (Should be available from HEW.)

Attachment A

THE NATIONAL ASSOCIATION OF STATE BUDGET OFFICERS

P.O. BOX 11910 IRON WORKS PIKE, LEXINGTON, KENTUCKY 40511 606-252-2291

May 4, 1976

To: State Budget Office Contacts

From: George A. Bell, Executive Director

Re: Medicaid cost - containment survey

The NASBO Systems, Techniques and Data Committee is conducting a survey on methods used to reduce or curb the growth of costs in medicaid programs.

The purpose of the survey is to assist those states contemplating Medicaid cost-containment efforts by systematically describing the Medicaid cost-containment ideas and efforts of other states. The survey report will attempt to: (1) identify many possible alternatives, (2) estimate the potential for reducing costs assiciated with each alternative, and (3) evaluate the alternative in terms of feasibility and impacts on other-than-cost factors. The results of the survey would be further analyzed in conjunction with demographic variables and information about state program characteristics (information already available from other sources).

The information to be obtained from the survey would include: (1) efforts to contain Medicaid costs which have been or are about to be proposed and/or tried; (2) information, insofar as it is available, on the resulting cost savings and other impacts; and (3) hopefully, information on problems, political acceptability, etc., regarding the alternative efforts identified. To the extent possible, please include information on all cost containment actions taken after your Medicaid program was begun.

Some budget officers may wish to ask the state medicaid director to complete this questionnaire. The program management staff of the Minnesota Department of Administration will analyze the responses and prepare a report, which will be distributed to all budget offices. To assist the Minnesota staff in maintaining its schedule, we ask that responses be sent to us by May 24. We look forward to receiving your responses quickly.

This is one of two new surveys being initiated by NASBO at this time. Please see the revised research schedule enclosed.

LHL

MEDICAID COST-CONTAINMENT SURVEY

Instructions

Column 1 Identify and describe any changes or proposed changes aimed at cost-containment in the Medicaid program in your State. Please include only those changes or efforts designed to control or reduce Medicaid expenditures, not expansions of the programs. Be specific on type and extent of cutback and, where appropriate, the methods used to achieve it.

Several broad categories or types of possible cost-containment changes are suggested; your State may have considered or implemented changes in any or all categories suggested. Feel free to include changes or proposed changes that do not appear to fit into any one category.

Include only cost-containment changes proposed or implemented after your State had already initiated its Medicaid program.

Columns 2 & 3 For each change or proposed change that you have listed in Column 1, answer all the questions in either Column 2 or Column 3, whichever applies. To shorten the responses, use the codes indicated in the columns. For example, in Column 2 write: 1 for "never considered;" 2a for "proposed but rejected by state agency," etc.

In Column 3 there are similar codes indicated for each of the three subcolumns.

For date, use month and year if possible, otherwise year; for example a response "already proposed in March 1976" would be written: 3, 3/76.

For "how," use numbers only.

For "savings," answers for codes 1 and 4 also ask estimate of annual dollar savings. For example, to report actual saving of 4 million dollars, write 4; $4,000,000.

Column 4 Include any other comments you have about the proposal, such as HEW opinion, trade off effect on other state and local programs, whether legislation was required, etc.

Additional comments Please comment on the two questions following the chart, on page 6.

Attach additional pages for answers, if needed.

We realize that this asks for a lot of information. Your time and effort in responding will be greatly appreciated. Results of the survey will be forwarded to you, providing what is hoped will be useful ideas and information to consider if your State plans any further cost-control changes in your Medicaid program.

Please complete and return by May 24 to:

George A. Bell, Executive Director
National Association of State Budget Officers
P. O. Box 11910 - Lexington, Kentucky 40511

State_____ Respondent _____ Date_____

MEDICAID COST-CONTAINMENT SURVEY

1 General categories of medicaid cost-controls	2 "Not Active" (indicate either "1" or "2" 1. Never considered or 2. Proposed, but rejected by: (indicate either "a", "b", or "c" & reason): a.State agency b.Governor c.Legislature	3 "Active Proposal" (proposed, to be proposed, or already accepted, or already implemented) Indicate status & date: 1.Under consideration 2.To be proposed on____ 3.Already proposed on____ 4.To be implemented on____ 5.Already implemented on____	How? Indicate either "1","2", or "3" 1.Agency (administrative decision 2.Governor 3.Legislature	Estimated annual State dollar savings (indicate either "1","2","3", or "4" 1.Too soon to tell but we estimate $_____ 2.Not possible to calculate 3.No savings of State dollars 4.We are actually saving about $_____ State dollars per year.	4 Comments on other possible or known impacts or problems, such as effect on other state & local programs, legislation required, HEW opinion, etc.
A.Alter eligibility criteria of: a.categorically eligible (specify)					
b.Medically needy (specify)					

1 Categories (continued)	2 "Not Active"	3 "Active Proposals" status & date	How?	Savings	4 Impacts, Problems, etc.
3. Reduce Medicaid Services 1. Reduce types of services covered (specify)					
2. Reduce levels of services covered: a. Reduce amount of a given service (e.g., No. of hospital days, etc.) (specify)					
b. Reduce amount of state payment for a given service (e.g., require co-payment, etc.) (specify)					

1 Categories (continued)	2 "Not Active"	3 "Active Proposals" status & date	How?	Savings	4 Impacts, Problems, etc.
C. Limit providers participating in Medicaid: 1. Limit who can be reimbursed (e.g., manpower contracts) (specify)					
2. Limit services or dollars per eligible provider (specify)					
D. Changes to ensure that client need is being adequately met as inexpensively as possible: 1. Encourage use of the lowest cost type of service that will meet the client's need (e.g., hospital vs SNF vs ICF vs in-home care, etc.) (specify how)					

1 Categories (continued)	2 "Not Active"	3 "Active Proposals" status & date	How?	Savings	4 Impacts, Problems, etc.
D -(cont.) 2.Encourage efficient provision of a service (e.g.,, limit reimbursement to a given %ile of the range of provider charges for a service, etc.) (specify how)					
E. Reduce misuse of Medicaid: 1.Detect and prosecute intentional fraud: (specify how) a.by providers					
b.by recipients					
c.by Administrators					

1 Categories (continued)	2 "Not Active"	3 "Active Proposals" status & date	How?	Savings	4 Impacts, Problems, etc.
E - (cont) 2. Reduce accidental unintentional errors or oversight (e.g., increase efforts to obtain 3rd party payments; obtain adequate information etc.) (specify how) a. by providers					
b. by recipients					
c. by administrators					
F. Reduce state administrative costs or change administrative procedures (e.g., computerization; contract out administration of all or part of Medicaid). (specify)					

1 Categories (continued)	2 "Not Active"	3 "Active Proposals" status & date	How?	Savings	4 Impacts, Problems, etc.
G. Other (e.g., use of HMO's; purchase of private insurance coverage of M.A. medical services; attempts to influence medical care costs in general; etc.) (specify)					

Can you provide any advice to other States?

Have you done any evaluations (formal or informal) of the effects of a particular cost-control effort, or of the Medicaid program in general? If so, please summarize or cite reference.

Attachment B

Glossary of Acronyms used by Survey Respondents

ABD-MN	Aid to the Blind and Disabled-Medically Needy
AFDC	Aid to Families with Dependent Children
AFDC-MN	Aid to Families with Dependent Children - Medically Needy
AHA	American Hospital Association
CFR	Code of Federal Regulations
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
GR	General Relief
HEW	U.S. Department of Health, Education, and Welfare
HMO	Health Maintenance Organization
ICF	Intermediate Care Facility
ICF/MR	Intermediate Care Facility for Mentally Retarded
LTC	Long Term Care
MAQC	Medical Assistance Quality Control
MMIS	Medicaid Management Information System
NASBO	National Association of State Budget Officers
PSRO	Professional Standards Review Organization
SNF	Skilled Nursing Facility
SRS	Social and Rehabilitation Service, USDHEW
SSA	Social Security Administration, USDHEW
SSI	Supplemental Security Income
SUR, SURS	Surveillance and Utilization Review System
Title XVIII	The Medicare Program, as defined by the Social Security Act
Title XIX	The Medicaid Program, defined by the Social Security Act
UR	Utilization Review
USDHEW	U.S. Department of Health, Education and Welfare
WC	Workmen's Compensation