



Converting Community Residences  
into Intermediate Care Facilities  
for the Mentally Retarded:  
Some Cautionary Notes

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A REPORT BY THE NEW YORK STATE COMMISSION  
ON QUALITY OF CARE FOR THE MENTALLY DISABLED

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## Acknowledgements

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Thanks are also extended to the Office of Mental Retardation and Developmental Disabilities and the Division of the Budget for their cooperation in the preparation of the report. Special thanks are extended to Robert Norris and Barbara Hawes of the Office of Mental Retardation and Developmental Disabilities and to Alex Rollo of the Division of the Budget for their assistance and thoughtful commentary on issues related to the appropriateness of the conversion of community residences to ICF-MRs.

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## PREFACE

The New York Mental Hygiene Law (MHL) requires this Commission, in part, to:

Review the cost effect of mental hygiene programs and procedures provided for by law with particular attention to efficiency, effectiveness, and economy in the management, supervision, and delivery of such programs. Such review may include but is not limited to: (i) determining reasons for rising costs and possible means of controlling them; (ii) analyzing and comparing expenditures in mental hygiene to determine the factors associated with variations in costs; and (iii) analyzing and comparing achievements in selected samples to determine the factors associated with variations in program success and their relationship to mental hygiene costs. (Section 45.07 MHL)

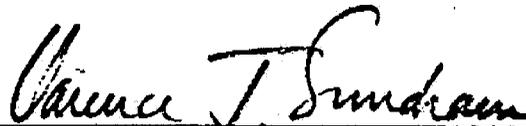
In conjunction with this responsibility, the Commission has conducted a study of the program initiative of the Office of Mental Retardation and Developmental Disabilities to convert a majority of New York City's community residences for the developmentally disabled to Medicaid-reimbursable intermediate care facilities for the mentally retarded (ICF-MRs).

Proposed to resolve the longstanding difficulty the State has encountered in financing community residences primarily through State appropriations, the conversion of community residences to ICF-MRs will allow the State to shift 50 percent of the costs of these programs to the federal government. While recognizing the urgent need for the State to bring federal fiscal participation into the

community residence program, the Commission was concerned whether this avenue for accessing federal funds would provide a long-term solution to the fiscal problems facing community residences. In addition, the Commission was concerned whether the conversion of community residences to ICF-MRs would affect the widely acknowledged success of these programs in providing quality residential care for the developmentally disabled.

Based on these concerns, the Commission has conducted a study and analysis of the long-range fiscal and programmatic appropriateness of the conversion proposal. This paper presents the findings and conclusions of this study.

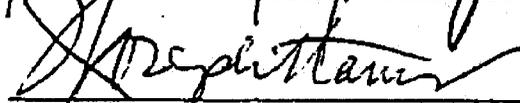
It is hoped that this paper will assist decision-makers in all affected sectors--the Office of Mental Retardation and Developmental Disabilities, the voluntary sector, the Division of the Budget, and the Legislature--in taking whatever steps are necessary to preserve and improve the quality of a community residential program for the developmentally disabled that is nationally recognized as highly successful.



CLARENCE J. SONDRAM, Chairman



MILDRED B. SHAPIRO, Commissioner



I. JOSEPH HARRIS, Commissioner

## EXECUTIVE SUMMARY

In recent years, the State's financing of small group homes or community residences for the developmentally disabled has been beset with problems. Recognized as one of the State's most successful long-term residential care alternatives for the developmentally disabled, many community residences, particularly in the New York City area, have from the start required supplemental State aid in excess of that provided in the standard Section 41.33 community residence contract. In the New York City area, for example, the average cost per client in a community residence is \$19,800 annually or 99 percent in excess of the typical community residence contract of \$9,960 provided pursuant to Section 41.33.

In order to finance those community residences requiring State aid in excess of that provided by the basic Section 41.33 contract, the Office of Mental Retardation and Developmental Disabilities (OMRDD) has provided supplemental State aid contracts through other legislative appropriations, primarily purchase of service (POS) and Chapter 620 monies. Many community residences, particularly in the New York City area, have come to rely on these supplemental contracts for over half of their operating expenses.

Long recognized by OMRDD, the Division of the Budget, and the voluntary agencies, as an inappropriate and unstable funding arrangement, the continued large-scale supplementation of community residences' basic Section 41.33 contract through POS and Chapter 620 monies became a virtual impossibility last year. In the 1979-80 fiscal year, the Legislature and the Division of the Budget respectively, placed restrictions on the utilization of POS and Chapter 620 allocations for the long-term financing of community residences. As a result of these restrictions the OMRDD was faced with either closing many community residences requiring substantial State aid in excess of that allowed by the Section 41.33 contract or seeking an alternative funding mechanism for these programs.

Conversion of these community residences to community-based intermediate care facilities for the mentally retarded (ICF-MRs) was seen by the OMRDD as the only solution to the above fiscal dilemma. Designated as a federal health care modality, ICF-MRs have access to the Medicaid funding stream which provides 50 percent federal fiscal participation, significant reductions in the State's financial share as well as a single source funding mechanism for these programs.

While recognizing the immediacy and seriousness of the fiscal situation confronting these community residences and that conversion of these residences to ICF-MRs may provide

immediate fiscal relief, the Commission on Quality of Care for the Mentally Disabled was concerned about the long-term fiscal and programmatic implications of the conversion plan. Based on this concern, as well as requests from several voluntary agencies sponsoring community residences slated for conversion to ICF-MRs, the Commission conducted a study and analysis of the long-term appropriateness of the proposed conversion plan. This paper presents the findings and conclusions of this study.

The Commission's study focused on one general fiscal issue and three related programmatic issues pertaining to the long-range appropriateness of the proposed conversion of these community residences to ICF-MRs:

1. *The ultimate cost-effectiveness of community residential programs for the developmentally disabled in view of the costs emanating from conversion of community residences to ICF-MRs;*
2. *The appropriateness of ICF-MR level of care relative to the needs of clients in community residences converting to ICF-MRs;*
3. *The long-range capability of community-based ICF-MRs to provide homelike, residential care for individuals with developmental disabilities; and*
4. *The long-term programmatic consequences of converting a majority of the traditional community residences in the New York City area to ICF-MRs.*

The Commission's analysis of these issues was based on interviews conducted with senior representatives of voluntary agencies sponsoring 28 of the 54 community residences in the New York City area slated for conversion, as well as representatives of the County Service Group of OMRDD in New York City, the Central Office of OMRDD, and the Division of the Budget. Commission staff also undertook a detailed comparative analysis of the State and federal regulations governing ICF-MRs and the State regulations governing community residences.

In the conduct of this study, the seriousness of the immediate fiscal dilemma of many community residences and the difficulty that OMRDD faced in seeking its speedy solution were clearly identified. Specifically, it became apparent that, in large part, the fiscal problems besetting these community residences derive from the failure of the federal government to provide adequate fiscal assistance to programs like New York State's community residences.

Although federal statutes and federal court decisions mandate that states provide care for the developmentally disabled in the least restrictive setting appropriate to their needs, the provision of substantial federal fiscal assistance only to ICF-MRs and not to programs similar to the community residence creates a disincentive for states who may have difficulty establishing and maintaining costly

community residences despite the fact that these latter programs may be the least restrictive appropriate residential setting for many developmentally disabled persons.

While the Commission's study found that there are clear and present benefits of conversion (i.e., access to the more stable Medicaid funding stream, increased federal financial participation, and consequent immediate State fiscal savings), there are also potential fiscal and programmatic problems which may emerge in the future and indicate the need for caution. They are:

1. *The overall cost escalation of 45 to 70 percent resulting from conversion of community residences to ICF-MRs represents a dramatic increase in the budgets of these already costly residences. While State savings should nevertheless be realized in the short-term, these increased costs indicate the need for fiscal vigilance in the State's continuing efforts to contain long-term residential costs for the disabled and elderly.*
2. *The increased Medicaid bill for local governments resulting from conversion of community residences to ICF-MRs places additional financial burdens on New York City and other localities which can ill afford it. This reinforces the need for cost containment as well as other mechanisms to reduce or eliminate the fiscal impact of this program upon localities.*
3. *To avoid the danger of clients being inappropriately placed in a care modality that is potentially more restrictive and more service intensive than they require, there should be a careful assessment of clients' needs in converting community residences to ICF-MR level of care. Such careful planning is*

consistent with State policy mandating that mentally disabled individuals should be placed in the least restrictive residential environment appropriate for their needs.

4. While the capability of existing community residences to provide homelike, noninstitutional environments has been demonstrated, the ICF-MR program, with its emphasis on intensive services at the residence, needs to be monitored to ensure that it can be implemented without significantly restricting the homelike environment; and
5. The conversion of the majority of the traditional community residences for developmentally disabled individuals in the New York City area into ICF-MRs may limit the State's capability to provide a range of residential alternatives appropriate to the diverse needs of this population. This concern ought to be addressed by OMRDD both in the process of implementation of the conversion plan as well as in future planning for community residential programs for the developmentally disabled.

While these conclusions indicate to the Commission that conversion of existing community residences to ICF-MRs may lead to long-range fiscal and programmatic problems, they do not indicate that limited-bed ICF-MRs should not be established or that all residences slated for conversion to ICF-MRs should not convert. Rather, the Commission's study confirms the important role of the limited-bed ICF-MR for severely impaired developmentally disabled individuals whose disabilities and health-related needs preclude their placement in any other form of community residential care. The Commission also recognizes that some clients in the community residences slated for conversion are probably in need of ICF-MR level of care. We therefore support the priority being given to the development of the small, community-based ICF-MR.

The Commission, however, cautions against a conversion of virtually all community residences in the New York City area to ICF-MRs. Believing that such a conversion will contribute to escalating residential care costs for the developmentally disabled and may lead to the placement of some persons who are inappropriate for ICF-MR level of care, as well as to curtailing the long-term capability of the State to provide quality and appropriate residential care for these individuals, the Commission recommends conservative evaluation of each community residence converting to ICF-MR.

In recommending that OMRDD proceed with caution in converting community residences to ICF-MRs, the Commission recognizes that at the present time conversion of community residences to ICF-MRs is the only means of bringing substantial federal fiscal aid to these residential programs. As such, the Commission believes that the conversion of residences to ICF-MRs should be pursued with care to minimize adverse fiscal and programmatic effects.

The Commission also believes there is a need for OMRDD, over the long term, to seek greater utilization of other, admittedly less substantial, avenues for federal aid to community residences which are not appropriate for conversion. These include greater use of personal care providers

(financed by Medicaid) and CETA trainees as staff in community residences and the more aggressive seeking of HUD subsidies for the residences' leasing costs. The Commission also recommends that OMRDD initiate negotiations with the Health Care Financing Administration within HHS (U.S. Department of Health and Human Services, formerly HEW) to provide for waivers and other necessary accommodations in the federal ICF-MR regulations which will enhance the flexibility of the ICF-MR care modality to more appropriately meet the variable residential and treatment needs of New York State's developmentally disabled citizens.

In conjunction with these recommendations, the Commission also believes that any lasting solution of the fiscal problems facing the community residence program must comprehensively address and revise the current mechanism for providing State fiscal assistance to these programs. In the course of the Commission's study, it was apparent that the current amalgamation of State funding streams flowing to these programs makes it difficult to account for the costs of these programs and may be contributing to an inequitable distribution of State funds among programs.

Specifically, the Commission on Quality of Care for the Mentally Disabled recommends that:

1. *The OMRDD should, whenever possible, avoid inappropriate levels of care for the clients affected by the conversion; ensure the ultimate cost-effectiveness of the converted programs; and seek within the ICF/MR modality a full range of alternative services from more restrictive to less restrictive settings, appropriate to individual needs.*
2. *In accord with this cautious approach each community residence slated for conversion should be carefully reviewed:*
  - ° *to ascertain that the existing operating costs of the community residence appropriately reflect the services provided to clients and that the additional costs incurred by conversion to an ICF-MR will provide improvement of the existing program for clients; and*
  - ° *to analyze the impact of the conversion of the community residence on the range of residential care alternatives appropriate for the developmentally disabled individuals in the locality.*
3. *The State Legislature and the Division of the Budget should, as an interim measure, permit the continuation of the use of purchase of service and Chapter 520 monies to finance community residences where conversion is not appropriate. This interim measure should remain in effect until comprehensive revisions can be made in funding for community-based residential programs.*
4. *The OMRDD should carefully monitor those community residence programs converting to ICF-MRs to evaluate the programmatic and fiscal effects of the conversion. This deliberate monitoring process, which should continue for at least three years following conversion, should be focused on two broad*

objectives: (1) to assess the immediate and long-term impact of the converted ICF-MRs on State and local governments' costs; and (2) to assess the appropriateness of the converted ICF-MRs to address the residents' needs and to provide a residential setting which is the least restrictive possible in accordance with their needs.

5. At the same time, the State Legislature, the Division of the Budget, and the Office of Mental Retardation and Developmental Disabilities should develop a sophisticated system of determining the real costs of care in community residences so that State funding of these programs may be more equitable than in the past.
6. Based on the data derived from this cost finding system, the statutorily provided formula for State assistance to community residences (Section 41.33 MHL) should be revised to reflect the real costs of operating such residences in different geographical regions of the State for clients of different functional levels and care needs.

Special attention in this revision process should be directed toward:

- providing a single source of State fiscal assistance to community residences;
- developing an on-going monitoring mechanism to guarantee the cost-effectiveness of community residences' operations;
- providing State fiscal incentives for community residence providers to obtain federal and other non-State financial aid for their programs, other than their clients' SSI payments; and
- including a provision in the statute requiring OMRDD to clearly show in its Executive Budget request all State fiscal assistance, including monies from allocations outside of Section 41.33 of the Mental Hygiene Law, used for the support of the community residence program.

In addition to the above recommendations, the Commission also believes that certain other long-term efforts should be initiated by the Office of Mental Retardation and Developmental Disabilities to pursue other avenues for increasing federal aid to community residential alternatives for the developmentally disabled wherever appropriate. While these efforts will not provide an immediate remedy to the fiscal problems facing community residences, they may contribute to a meaningful long-term resolution. These efforts include:

1. *The Office of Mental Retardation and Developmental Disabilities, together with voluntary agencies, should pursue additional avenues to bring federal fiscal participation into the State's community residence program, without the risk of altering the family-like, group home residential model of the community residences.*

*Sources of existing federal financial assistance which appear to be consistent with these criteria include:*

- o *increased utilization of personal care providers, financed by Medicaid, in community residences, particularly for 621 eligible clients. The use of personal care providers as staff to a residence allows significant federal fiscal sharing through Medicaid funds without affecting the generally programmatic guidelines of the community residence or substantially increasing existing care costs.*
- o *increased utilization of federal Housing and Urban Development (HUD) funds for rent subsidies by community residences. Currently few community residences, particularly in the downstate region, take advantage of these HUD subsidies which could relieve the State of a significant portion of the leasing costs of these residences.*

- o increased utilization of CETA trainees and other federally funded employee trainee programs in community residences.

Expansion of these trainee programs in community residences would reduce the State's staffing costs for these programs, as well as augment the number of trained paraprofessionals in community care of the developmentally disabled.

2. The OMRDD should actively negotiate with the Health Care Financing Administration within HHS for waivers and other accommodations in the federal ICF-MR regulations which would permit greater flexibility in utilizing the ICF-MR for developmentally disabled clients who require a supervised, supportive, rehabilitative residential environment, but who do not require active treatment on a regular basis in the residential setting. Such waivers or other accommodations would permit New York State to incorporate in its continuum of residential care alternatives a lower level of ICF-MR care which would allow the State to more appropriately serve the majority of developmentally disabled clients in need of congregate residential care in the community. As a result of such efforts the additional costs incurred by compliance with existing ICF-MR regulations would be reduced, and the potential of creating unnecessarily service intensive and restrictive residential settings for clients would be lessened.
3. New York State should, in conjunction with the above effort, work with the Federal Housing and Urban Development Agency to consider the possibility of HUD setting aside funds for states to allocate for housing specifically for persons with mental disabilities. At the present time, intense competition for Section 8 HUD rent subsidy funds and Section 202 HUD mortgage funds by other groups often severely limits their utilization by individuals with mental disabilities. By providing a set-aside fund for the mentally disabled administered by the states, HUD would be fostering the development of much needed housing for this population and, at the same time, would be providing financial assistance to states endeavoring to establish such housing.

## CHAPTER I

### Overview of the Problem

Since the late 1960's, New York State has increasingly relied on small group homes as a community residential alternative to institutional care for individuals with developmental disabilities. These group homes, or community residence programs, have become a mainstay of the State's deinstitutionalization efforts and a broad policy objective of providing developmentally disabled individuals with residential care in the least restrictive environment according to their needs. Affirming its commitment to the community residence program, the State Legislature in 1972 enacted what is now Section 41.33 of the Mental Hygiene Law providing State aid to private and public agencies sponsoring community residences.

Viewed as providing a homelike, noninstitutional environment for residents, and an effective means of transitioning clients out of institutions, as well as preventing unnecessary institutionalization, the community residence program has been acclaimed as among the State's most successful care modalities. As a result of this success and the concerted effort of the Office of Mental Retardation and Developmental Disabilities (OMRDD) and voluntary agencies in

the State, the community residence program for developmentally disabled persons has experienced tremendous expansion. Largely as a result of the Willowbrook Consent Judgment<sup>1</sup> signed by Governor Hugh L. Carey in 1975, the growth of this program has been most pronounced in the New York City metropolitan area where approximately 37 percent of the State's community residences for the developmentally disabled are located.

In recent years, however, latent problems in the State's financing mechanism for the community residence program, provided for in Section 41.33, became apparent. Many community residences, particularly in the New York City area, had from the start required State aid in excess of the maximum 50 percent of the total operating expenses allowed by Section 41.33. In the New York City area, for example, OMRDD estimates that the average per resident cost in these programs is \$19,800, or 99 percent in excess of the budget of a typical community residence financed under Section 41.33.<sup>2</sup>

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<sup>1</sup> The Willowbrook Consent Judgment (NYSARC v. Carey, U.S. District Court, E.D.N.Y.) requires in part, that members of the plaintiff class be placed in community residences of ten beds or less and that the census of Willowbrook Developmental Center (now Staten Island Developmental Center) be reduced to a maximum of 250 by March 31, 1981.

<sup>2</sup> The \$19,800 per capita average annual cost figure of New York City community residences represents OMRDD's stated cost of community residence care in New York City in May, 1979.

In order to finance these community residences requiring State aid in excess of that provided by Section 41.33, the OMRDD has provided supplemental contracts through other legislative appropriations, primarily purchase of service (POS) and 620<sup>3</sup> monies. Many community residences, particularly in the New York City area, have come to rely on these supplemental contracts for over half of their operating expenses.

Long recognized by the OMRDD and the Division of the Budget (DOB), as well as the voluntary agencies, as a cumbersome and unstable funding arrangement, the problems emanating from the deficiencies in Section 41.33 State aid formula for community residences came to the forefront this year when the Legislature and the Division of the Budget restricted the utilization of supplemental State aid, in excess of that provided by Section 41.33, to support community residences. This restriction was achieved through two measures.

First, the Legislature limited OMRDD's flexibility in using other Maintenance Undistributed allocations for purchase of service contracts to 10 percent above the legislative allocation for POS monies. Previously, since POS was

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<sup>3</sup> Chapter 620 of the Laws of 1974 which provides 100 percent State funding for mental hygiene services to certain long-term patients discharged from State institutions.

included under Maintenance Undistributed in the State Purposes budget, OMRDD was able to shift rather large amounts of monies from other unexpended Maintenance Undistributed allocations to POS. Last year, for example, OMRDD shifted from other Maintenance Undistributed items between \$2 and \$3 million to POS contracts to sustain community residences and other programs needing supplemental funding.

Secondly, the Division of the Budget put tighter controls on 620 funds which OMRDD directly administered. While most 620 monies are channeled through local governments, 620 funds going to community residences were directly allocated by OMRDD to specific voluntary agency providers. At one time, DOB allowed OMRDD considerable interchange between the general 620 funds, going through local governments, and direct 620 funds, going directly to community residences or other programs. In the 1979-80 budget year, however, DOB denied OMRDD's request to make up deficits in their direct 620 funds through utilization of unexpended general 620 funds.

As a result of these restrictions, the available POS and 620 funds to supplement costly community residence programs were greatly reduced and the OMRDD was faced with either closing many community residences requiring substantial State aid in excess of that allowed by Section 41.33, or seeking an alternative funding mechanism for these programs.

Conversion of these community residences to community-based intermediate care facilities for the mentally retarded (ICF-MRs) was seen by the Commissioner of OMRDD as the only solution to the above fiscal dilemma.<sup>4</sup> Designated as a federal health care modality, ICF-MRs have access to the Medicaid funding stream, which provides maximization of federal fiscal participation, significant reductions in the State's financial share, as well as a single source funding mechanism for these programs. As a result of conversion to ICF-MRs, the operating expenses of these programs, now assumed almost entirely by the State, will be shared 50 percent with the federal government. The State's expenditures for the converting residences are further reduced by the fact that counties in New York State assume 25 percent of the Medicaid expenses for all their residents, except those who had resided in a State institution for five or more years.<sup>5</sup> Finally, Medicaid, a federal entitlement program which does not require annual State legislative approval of funding for qualifying services, is seen as a more stable, simplified funding mechanism for these programs than the

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<sup>4</sup> A letter from Acting Commissioner James Introne of the Office of Mental Retardation and Developmental Disabilities, stating this position, is included in Appendix A.

<sup>5</sup> Chapter 621 of the Laws of 1974 (amended in 1975, 1977) provides that the State will assume all county Medicaid costs for these latter residents. Approximately 53 percent of the residents in the converting community residences are 621 eligible.

existing arrangement which requires agencies to juggle three funding sources, the basic Section 41.33 contract, POS contracts, and 620 contracts. While reducing State expenditures for support of the community residence programs, conversion into ICF-MRs will also make it possible to enrich the staffing and services available to clients.

However, if conversion of these community residences to ICF-MRs does seemingly resolve the immediate fiscal dilemma facing these programs, the conversion plan, as with any major new initiative, also presents its own problems. Among these problems are the overall cost escalation of between 47 and 71 percent required to bring converting residences in compliance with ICF-MR regulations and the new financial burden placed on local governments who for the first time will be required to share 25 percent of these costs. Recognizing that the conversion plan was being urged primarily as a solution to a fiscal problem, the Commission sought to ensure that this proposed solution would achieve the desired results.

The Commission was also concerned about the programmatic effects of the proposed conversion plan upon the long-term quality of care of residents. Specifically, the Commission was concerned about the implications of the conversion of the majority of the traditional community residences in the New York City area, the region of the State where the

program has been, perhaps, most successful. Another significant and related concern was whether the conversion to ICF-MRs, defined by federal regulations as a care modality for those individuals whose needs cannot be addressed "in other than an institutional setting," had the potential to contribute to the placement of individuals with developmental disabilities in inappropriate service intensive and restrictive environments. Such placement would be contrary to both State policy and the Willowbrook Consent Decree's requirement of placement of clients in the least restrictive environment consistent with their needs. If such potential were found to exist, appropriate care would have to be taken in the implementation of the conversion plan to avoid such a result.

#### Purpose of the Commission's Study

Concerned about these problems and their possible long-term implications for the quality of care, and the cost-effectiveness of the State provision of residential care services for individuals with developmental disabilities, the Commission on Quality of Care for the Mentally Disabled, in accord with its statutory responsibilities, has conducted a study of the programmatic and fiscal appropriateness of the conversion of these community residences to ICF-MRs.

In the conduct of this policy analysis study, the Commission has solicited information and advice from voluntary agencies operating community residences in the New York City area, the county service group of OMRDD in New York City, the Central Office of OMRDD, and the Division of the Budget. These meetings have highlighted the seriousness of the immediate fiscal dilemma of many community residences and the difficulty that the OMRDD faced in seeking its speedy solution.

This paper is not presented, therefore, as a critique of the OMRDD efforts; rather, it is intended to assist decisionmakers in taking whatever steps are necessary to preserve and improve the quality of a community-based residential program for the developmentally disabled that is nationally recognized as highly successful.

## CHAPTER II

### The Long Range Appropriateness of The Conversion Plan

Recognizing the immediacy and seriousness of the fiscal situation confronting the more costly community residences, particularly in the New York City area, the Commission believes that conversion of these residences to ICF-MRs may provide immediate fiscal relief for the State. Furthermore, interviews with senior representatives of voluntary agencies, operating approximately half of the community residences scheduled for conversion, indicate that most of these providers feel they can maintain the programmatic integrity of their community residences after conversion, although they will experience some difficulty in the process. As with any large scale shift in a major program, the process will not be easy and can be expected to present some problems. The Commission believes that by anticipating problems which may develop in the future, appropriate cautionary steps can be taken now to minimize any adverse consequences.

Among the issues that need to be carefully considered and addressed are:

1. The ultimate cost-effectiveness of the community residential program following conversion of community residences to ICF-MRs;
2. The appropriateness of ICF-MR level care to the needs of clients in community residences converting to ICF-MRs;

3. The long-range capability of community-based ICF-MRs, to continue to provide the type of homelike, noninstitutional residential care for individuals with developmental disabilities as they now receive in community residences; and
4. The long-term programmatic consequences of the conversion of the majority of the traditional community residences in the New York City area into ICF-MRs.

A. The ultimate cost-effectiveness of the conversion plan

The Office of Mental Retardation and Developmental Disabilities (OMRDD) has indicated, as stated above, that the primary rationale for converting existing community residences to ICF-MRs in the New York City area is financial. Conversion of these residences to ICF-MRs is being urged to provide access to the more stable and effective funding source of Medicaid for these programs; to maximize federal fiscal participation in these programs; and to reduce State fiscal participation in these programs while simultaneously enriching staffing and services available to the clients.

While recognizing both the financial dilemma which spurred OMRDD to pursue these fiscal objectives for its community residence program, as well as the importance of the objectives themselves, the Commission had serious concerns related to the appropriateness of the conversion plan to address the long-range problem of financing community residential care for the developmentally disabled.

More specifically, the Commission was concerned with the significantly greater costs of the ICF-MR's over community residences and the fiscal obligations of local governments which will have to contribute 25 percent of these ICF-MR costs.

The Office of Mental Retardation and Developmental Disabilities, in conjunction with the Division of the Budget, has developed six models of limited-bed ICF-MRs for implementation in the community. At the present time, the rate making methodology for these models would produce rates for the models which would approximately be 45-70 percent greater than the average rate for a community residence in the New York City area. The increased costs of the ICF-MRs can be attributed to many factors, including but not limited to:

1. The higher administrative costs of the ICF-MR which are necessary to comply with federal and State regulations;
2. The direct care staff ratios of the ICF-MRs which are often higher than those presently existing in the community residences;
3. The total care approach of the ICF-MR which may not presently be available in the community residence; and
4. The costs of the ICF-MR which include some costs related to recreation, transportation, and other auxiliary services not included in the community residence budget.

The overall increased costs of the ICF-MRs lessen considerably the attractiveness of their increased federal reimbursement. More clearly, the present rate making methodology

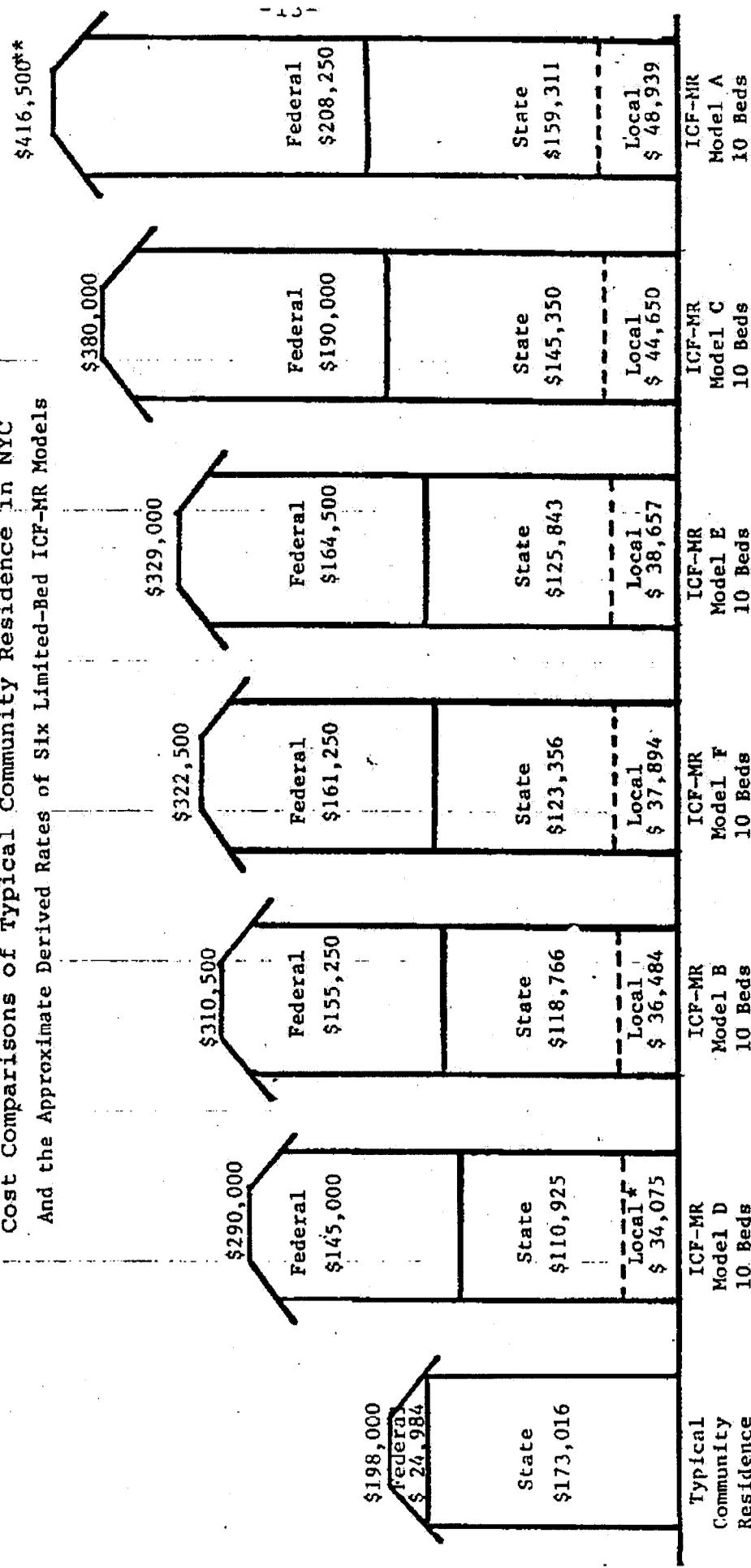
for the six alternative models of ICF-MRs, designed to accommodate the differentiating level of care needs of clients, would produce approximate derived per client annual rates of ICF-MRs ranging between \$29,000 and \$41,500. These rates would result in an increased per client cost of at least \$9,000 per year over the current average cost of care in community residences in the New York City area.

Approximate derived rates for the four least expensive models of ICF-MRs (ranging from \$29,000 to \$32,500 per client per year) would not include day programming costs. Clients in these models would continue to be served in day programs outside of the facility, as they are currently. These outside day program costs are estimated at \$7,800 annually per client. The day programming costs of clients in the most expensive models would be subsumed in their ICF-MR rates (approximate derived rates of \$38,000 and \$41,500 per client annually). Other medical services costs, such as medication, physician office visits, etc., currently billed directly to Medicaid through the client's personal Medicaid cards, would not be included in the rates for any of the six models.<sup>6</sup>

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<sup>6</sup> It should be pointed out that these approximate derived rates for the limited bed ICF-MR are considerably lower than the average developmental center ICF-MR reimbursement rate in the New York City/Long Island County Service Group. OMRDD indicates that in 1979-80 these reimbursement rates ranged from a low of \$100.80 per day per client at Suffolk Developmental Center to a high of \$163.80 per day per client at Bronx Developmental Center. Based on these figures, the average annual per diem reimbursement rate for the New York City/Long Island Developmental centers in 1979-80 was cited by OMRDD as \$46,611.

Figure 1  
 Cost Comparisons of Typical Community Residence in NYC  
 And the Approximate Derived Rates of Six Limited-Bed ICF-MR Models



\* Local share was calculated on the basis of 53 percent of the population being 621 eligible.  
 \*\* Includes the costs of day programming.

Based on approximate derived rates for the six proposed ICF-MR models, and making allowances to exclude day programming costs from those models which include them, figure 1 illustrates the resulting increase in community residential costs over present community residences due to conversion. Figure 1 also shows the differentiating distribution of costs of community residences and ICF-MRs to the Federal, State, and local governments.

This analysis, shown in Figure 1, while clearly indicating the dramatic rise in federal fiscal participation from 14 percent in a community residence to 50 percent in an ICF-MR, also shows how actual State savings are affected by overall increased costs, and the significance of new fiscal contributions expected of local governments as a result of conversions. Further analysis of the dollar cost savings to the State of the least costly ICF-MR model clarifies how this increased cost affects State savings and local government costs.

Relying on OMRDD's estimate that 47 percent of the clients in converting residences are not 621 eligible, this analysis indicates that conversion to the least costly ICF-MR model will result in State savings of approximately \$6,250 per client, or a 36 percent decrease, with local government's costs increasing \$3,410 per client. Thus, for every \$2 the

State saves as a result of conversion, local governments must spend an additional \$1.<sup>7</sup>

In short, while conversion of community residences to ICF-MRs eliminates significant costs from the State's budget, it simultaneously raises the overall costs and significantly increases the fiscal share of these programs for local governments.

The OMRDD, recognizing the financial burden conversion of community residences to ICF-MRs will place on local governments, has recommended that the State assume the local governments' share of the Medicaid bill for limited-bed ICF-MRs. OMRDD notes that there is currently no local share for the cost of care in State developmental centers, which are also ICF-MRs, in State-run community-based ICF-MRs, or in community-based ICF-MRs operated by voluntaries for Chapter 621 eligible clients. Maintaining that the limited-bed ICF-MRs, although operated largely by the voluntary sector, are actually public institutions, the OMRDD argues that this State assumption of local governments' costs in this instance is reasonable.

There are two drawbacks to this proposal. First, such State assumption of local governments' Medicaid costs for

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<sup>7</sup> Projecting the actual total increased costs to New York City as a result of the immediately pending conversion of 54 community residences to ICF-MRs is difficult since the OMRDD has not yet identified the ICF-MR models to which different community residences will convert. A conservative projection, based on the assumption that all residences will convert to the least costly ICF-MR model, however, indicates that New York City's Medicaid bill will increase by over \$2 million annually as a result of conversion.

the developmentally disabled may set a very costly precedent for the State's financing of residential and treatment services for all the mentally disabled or, for that matter, for all other Medicaid services.<sup>8</sup> Secondly, if the State were to assume these local governments' costs for the ICF-MRs, State savings attributed to conversion of a community residence to the least expensive ICF-MR model of 36 percent, stated above, will be reduced to 16 percent. (Table 1 shows in greater detail how State savings will be affected by assuming the local governments' Medicaid costs for these programs.)

It should be noted that the above cited State savings resulting from the conversion plan (36 or 16 percent, depending upon whether the State assumes the local governments' share) are calculated based on the assumption that all community residences will convert to the least costly ICF-MR model. In fact, all residences will not convert to this model. Indeed, this ICF-MR model is designed only for mildly to moderately retarded adults with daily living skill deficiencies. Children, as well as all more severely disabled clients, will be placed in more expensive ICF-MR models, and, as the cost of the ICF-MR model increases, State savings are further reduced. Thus, actual State

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<sup>8</sup> States have the authority to set their local governments' share of Medicaid costs. Currently these shares vary from 25 percent to 0 percent among states. In 38 states local governments do not share any Medicaid costs for their residents.

Table 1  
Analysis Of Change In Annual Costs And Federal, State And Local Shares  
In Annual Costs Incurred By The Conversion Of A Typical Community  
Residence To The Least Costly ICF-MR Model  
(Includes Factoring In Of 621 Eligibility)

	Typical 10 Bed Community Residence	Least Costly 10 Bed ICF-MR	Change in Costs	Percentage Change In Costs
Total Costs	\$ 198,000	\$290,000	+\$ 92,000	+ 46%
Federal Share	\$ 24,984	\$145,000	+\$120,016	+ 480%
State Share (Assuming Local Financial Participation)	\$ 173,016	\$110,925	-\$ 62,091	- 36%
Local Share (Assuming Financial Partici- pation)	-0-	\$ 34,075	+\$ 34,075	
State Share (Assuming <u>No Local Financial</u> Participation)	\$ 173,016	\$145,000	-\$ 28,016	- 16%

savings resulting from conversion will be less than those stated here.<sup>9</sup>

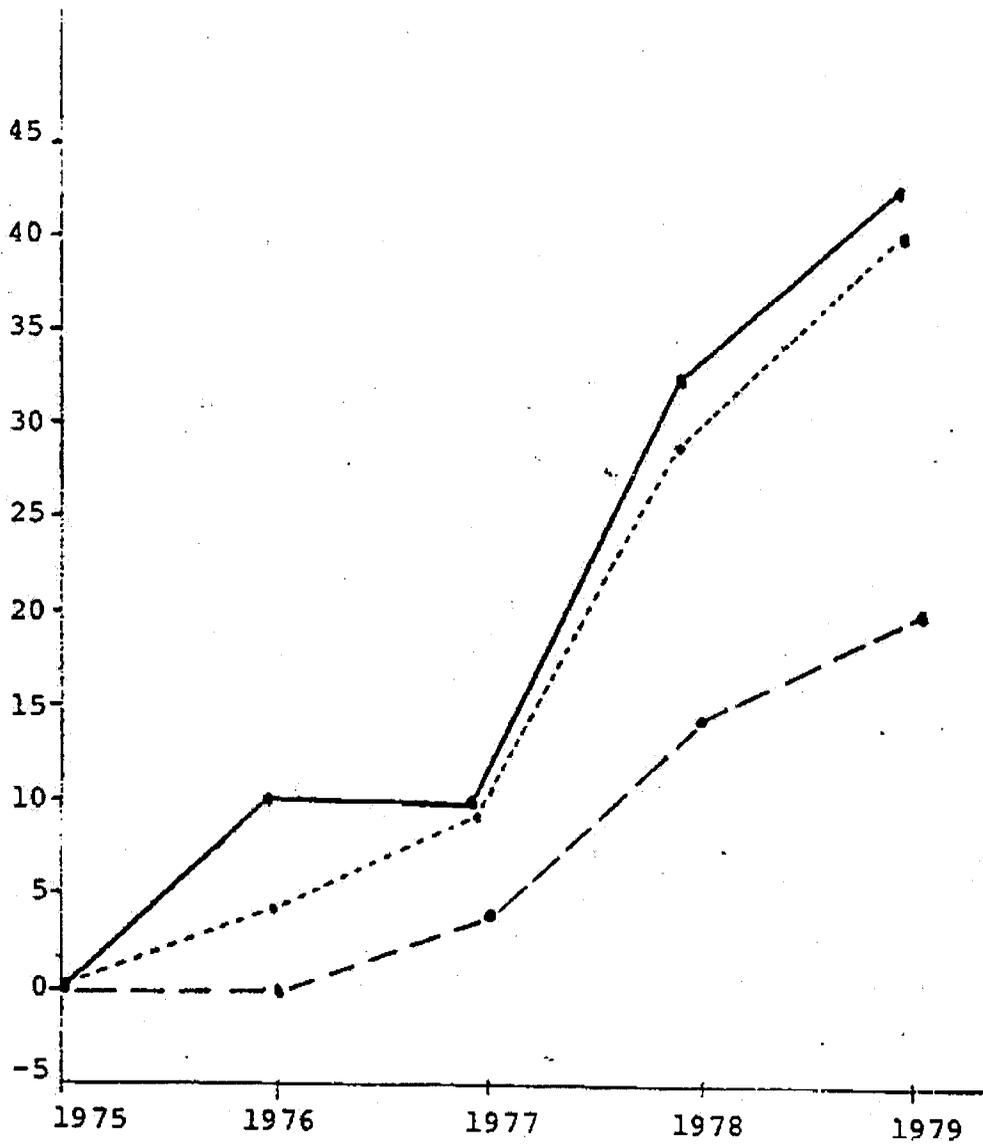
Other factors, including inflation and Medicaid audits, are likely to further erode State savings resulting from conversion. Medicaid reimbursable residential care alternatives historically have had higher inflation rates than residential care funded by other revenue sources. Figure 2 illustrates this trend showing the comparative rise in the State's average Medicaid rate for skilled nursing facilities (SNFs) and health-related facilities (HRFs) and the state/federal Supplemental Security Income (SSI) rate for congregate care from 1975-1979. This analysis indicates that while the Medicaid rates for SNFs and HRFs have increased 41 and 43 percent, respectively, the SSI rate for congregate care, often used as a base payment rate for adult homes and other domiciliary (non-medical) care facilities, has increased by only 20 percent over the same period. Furthermore, the State has assumed only 12 percent of the rise in the SSI rate, while the State and local governments have assumed 50 percent of the rise in Medicaid rates for SNFs

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<sup>9</sup>The possibility that actual State savings will be less than those stated in the report is confirmed by the actual Medicaid rates (effective through December 31, 1980) as reported by the OMRDD of the 68 community residences in the New York City area which have already converted to ICF-MRs. The average per diem client Medicaid rate at these facilities is \$90 or \$32,850 per capita annually. This average figure represents a 66 percent cost escalation over the average annual per capita cost of community residence care (\$19,800). Based on these rates, actual State savings derived from converting these residences to ICF-MRs are 27 percent if the State does not assume the local share, and only 5 percent if the State does in the future assume the local share.

Figure 2  
Percentage Increase In Reimbursement Rates  
For Residential Care Facilities Over  
The 1975 Base Year Rates

Percentage  
Increase



- Health Related Facilities (based on average Medicaid rates)
- Skilled Nursing Facilities (based on average Medicaid rates)
- - -●- - - Congregate Care Facilities Level II (based on SSI payment rate)

and HRFs. This low percentage of the State's share of the SSI rate increase derives from the fact that the increases in SSI rates have largely emanated from increases in the federal government's SSI payment, with limited increases in the State's contribution to the SSI payment. (A bar graph illustrating the annual per diem rate increases for SSI congregate care, HRFs and SNFs over the past five years is included in Appendix B.)

Finally, the inevitably forthcoming Medicaid audits of these to-be-established limited-bed ICF-MRs are also likely to cut State savings. State mental hygiene programs have fared poorly in the past in Medicaid audits.

A recent audit of five State-operated mental health outpatient facilities cited in the Office of the State Comptroller's Audit Report [NY-ST-5-79] found that over 75 percent of the Medicaid payments to these facilities were disallowed. Hopefully, voluntary providers of limited-bed ICF-MRs will fare better in Medicaid audits than the Office of Mental Health facilities cited in this report. However, as any provider will attest, disallowance of some payments is virtually a "given".

In summary, while the most salient fiscal benefit of conversion of community residences to ICF-MRs is the access it provides to the single funding stream of Medicaid for these programs and the concomitant federal participation, the cost escalation of these programs, incurred by compliance with ICF-MR regulations, points to the need for fiscal

vigilance in the State's continuing efforts to contain long-term residential costs for the disabled and elderly. If local governments are held accountable for their share of the Medicaid costs for the limited-bed ICF-MRs, a substantial additional fiscal burden is placed on localities already suffering from escalating Medicaid bills. And, if the State assumes the local share for these programs, State savings are reduced proportionately.

The overall escalation of costs incurred by the conversion of community residences to ICF-MRs also illustrates the reduced incentives for the State to contain the costs of Medicaid reimbursable residential care modalities. While currently the State budget directly bears the burden of each increased dollar in the community residence program, with conversion to Medicaid funding, the federal and local governments bear 75 percent of the cost. The State's incentive to hold down costs is thereby greatly reduced because the impact of increased costs is not felt as directly. Indeed the current costs can increase by nearly 75 percent without increasing State expenditures.

This reality is unsettling particularly in the Medicaid program where costs have historically been inadequately controlled. Attention to the long-term fiscal implications of this cost escalation is particularly merited at this time when federal concern over the rapidly expanding Medicaid budget is mounting and whispers of the possibility of a federal cap on Medicaid are becoming louder.

In conclusion, the Commission believes that the program of conversion of community residences to ICF-MRs as a long-range solution to the problem of financing community residential care for the developmentally disabled in the New York City area while immediately reducing State costs, has the potential for increasing the overall costs of such care unless a strong program of cost containment is put in place. With a program of cost containment, the impact of future increases in costs due to inflation may be held below the level the State would experience in the community residence program had there been no conversion to ICF-MRs.

In large part, these fiscal problems derive from the failure of the federal government to provide significant fiscal assistance to traditional community residences which provide homelike environments, while such assistance is available for the more structured, service intensive residential alternative of the ICF-MR. Thus, although federal statutes and federal court decisions provide the primary impetus for states to provide care for the developmentally disabled in the least restrictive setting appropriate to their needs, the federal funding system provides strong disincentives for states to develop programs like the traditional community residence which may be the least restrictive, as well as the most cost-effective, program alternative for many developmentally disabled clients.

In sum, this inconsistency of the incentives of the federal funding system with the federal government's stated

programmatic criteria for developmentally disabled individuals is a major cause for the fiscal problems confronting New York State's community residences and those future fiscal problems which will likely emanate from their conversion to ICF-MRs. And, as such, correction of this inconsistency represents the only viable long-term solution to these fiscal problems.

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Beyond the fiscal wisdom of the conversion plan, the Commission is concerned about the long-range effect on the day-to-day lives of clients and about its impact on the State's capability to provide appropriate care for the developmentally disabled. The following sections focus on three related issues addressing these programmatic concerns.

B. The appropriateness of ICF-MR level of care

Of primary concern to the Commission was whether the ICF-MR program is as appropriate or more appropriate to the needs of clients as their currently existing community residence programs. In exploring this concern, the Commission was aware that several other states have developed small limited-bed ICF-MRs using basically the same programmatic model as New York State's community residence program. In addition, a review of the federal ICF-MR regulations indicates that a significant proportion of the clients in converting community residences are eligible for ICF-MR care.

At the same time in our interviews, most representatives of voluntary agencies did not feel that the ICF-MR was programmatically necessary. Commission staff interviewed senior representatives of five voluntary agencies operating 28 of the 54 community residences slated for conversion. Four of the five voluntary providers indicated that they would choose not to convert a majority of all of their residences if given another option providing stable financing for existing community residences. Generally, these representatives felt that their clients were currently receiving their needed services through outside community agencies, and that provision of these services either in or through more direct linkage with the residence, as is required by ICF-MR regulations, may often result in an unnecessary duplication of services.

Since the time of these interviews, there has been softening in this position of representatives of voluntary agencies as a result of changes in the State's ICF-MR regulations and increased dialogue with State officials. There remains, however, considerable agreement among voluntary providers of community residences slated for conversion to ICF-MRs that the vast majority of their clients are served appropriately in their existing program, and, if given a stable financing source for these programs, they would not choose to change the program of these clients to the ICF-MR program.

In conclusion, it appears that the ICF-MR care modality can be appropriately utilized for clients similar to those

currently served in New York State's community residence programs. This is possible, however, only if the State maintains a flexible attitude toward the implementation of federal ICF-MR regulations and does not impose uniformity in programmatic services where they are not necessary. The voluntary agencies sponsoring community residences almost unanimously indicate that the greatest danger of converting these residences to ICF-MRs is the imposition of programmatic requirements which are not needed by their clients.

C. Capability of ICF-MRs to provide homelike non-institutional environments

Another issue, closely related to the appropriateness of ICF-MR care, which was of concern to the Commission was the capability of ICF-MRs to offer homelike, noninstitutional environments comparable to community residences. To examine this issue Commission staff comparatively analyzed the State regulations governing community residences and the State regulations for ICF-MRs. This comparative analysis sought to determine if there were significant differences in these regulations which may affect the day-to-day lives of clients in converting residences.

Commission staff also solicited the opinion of senior representatives of five voluntary agencies, operating 28 of the 54 residences slated for conversion, as to the capability of ICF-MRs to provide homelike, noninstitutional environments.

The Commission's review of the State regulations for ICF-MRs and community residences, as well as other related documents, indicates that both care modalities share a common goal of providing a residential environment that is the most normalizing possible. At the same time, this review indicated several important differences between the two forms of residential care.

The most significant difference was the ICF-MR's greater emphasis upon active treatment and professional intervention in the residential setting. While a community residence emerges primarily as a home which provides an environment supportive of personal growth, the ICF-MR, based on a medical, rehabilitative model, emerges as a comprehensive and intensive treatment-oriented residential setting.

More specifically, the Commission's comparison of the regulations for ICF-MRs and community residences indicated the following:

1. The ICF-MR regulations, as a whole, and in specific instances, reflect that this is a service intensive rehabilitative, medical care modality, while the regulations governing community residences clearly indicate that these programs are primarily residential homes and that habilitation or rehabilitation services should be provided by outside community agencies.

2. The ICF-MR regulations' references to required staff and staffing credentials demonstrate the intent of this care modality to provide comprehensive and professional intervention in the residential setting. Such requirements are minimized in the community residence regulations, where the fundamental role of staff supervision is to provide quality homelike care which enhances the resident's skills in daily living.
3. The ICF-MR regulations include far more extensive and comprehensive program planning requirements for clients than the community residence regulations. These stringent planning mandates of the ICF-MR are consistent with its intensive treatment orientation and involvement of professional staff.
4. The ICF-MR regulations for administrative record keeping and monitoring of resident care are significantly more stringent than those referenced in community residences' regulations. Among these more stringent standards are: a sophisticated central record system; record keeping on all aspects of a client's life, including recreational activities; dental care services, etc.; and a formal utilization review process.

Another significant and related difference between the regulations governing ICF-MRs and community residences is the greater detail and specificity in the ICF-MR regulations. In general, State regulations for community residences indicate an intention to create a homelike lifestyle which strives to develop the individual's skills in life maintenance with a minimum of enforced standardization of program or staff. Regulations for ICF-MRs, on the other hand, reflect the federal government's intention to establish a highly structured and carefully regulated uniform

rehabilitative, medical care modality. Overall, the regulations for ICF-MRs are much more stringent and comprehensive with regard to administrative, programmatic, and staff procedures than are those for community residences.

While these differences do suggest that conversion of community residences to ICF-MRs will alter the nature of the program, they do not necessarily imply that the resulting changes will affect the existing homelike, noninstitutional environment of converting residences.

To explore this latter issue more directly, Commission staff consulted with voluntary agencies sponsoring community residences slated for conversion to ICF-MRs. These interviews focused on two questions:

1. Will compliance with ICF-MR regulations cause significant changes/improvements in resident life? More specifically, will your residences become more restrictive, less homelike residential programs as a result of conversion?
2. Are the additional professional staff required by ICF-MR regulations necessary for your community residence? Will the addition of such staff improve the quality of care for residents?

As one might surmise, the responses of voluntary agency representatives to these questions varied. However, certain trends were also apparent in their responses.

For example, in response to our question regarding whether the service intensive orientation would change or improve the quality of care, one voluntary agency responded that they had been providing an ICF-MR-type program all along and that conversion will merely formalize, through regulation, this program. However, the remaining voluntary agencies were in agreement that conversion to ICF-MRs would mean program changes, and that they would have to be careful to ensure that these changes did not lead to more restrictive, less homelike environments.

Significantly, four of the five voluntary agency representatives felt that through careful and innovative planning they would be able to avoid this potential pitfall of creating more restrictive programs after converting their residences to ICF-MRs. The fifth agency representative stated unequivocally that the ICF-MRs would be more restrictive than the existing community residences. In his opinion, there is no way to make regulations, clearly intended by the federal government for an institutional model of care, operational in a normalizing fashion.

To our question on the necessity and benefits of the additional professional staff required by conversion to ICF-MRs, responses of the voluntary agencies' representatives were strikingly consistent.

Representatives agreed that their programs could benefit from some additional staff, but that all the staffing requirements of the ICF-MR were not needed. Most commonly cited as unnecessary were the nursing and physician services, while other staff, such as the speech and occupational therapists, were more often cited as beneficial additions.

Many agencies voiced concern about the inherent danger that the presence of a cadre of professional staff posed for maintaining a normalizing, homelike setting. All volunteers indicated that the challenge to operators was to incorporate the additional staff in a creative, non-imposing fashion. Incorporating additional staff into the fabric of the house, rather than in the traditional professional-client office visit, was seen as the conceptual solution to this problem. For example, the speech therapist, sharing mealtimes with residents, could observe communication patterns and opportunities for language development and then train staff to take advantage of these opportunities.

In summary, voluntary agencies' representatives agreed that not all additional staff required by the ICF-MR are necessary. Whether or not these additions of staff will improve care for clients, they warned, will depend on how well providers, together with the professional clinicians hired, can devise creative means to reshape the conventional professional-client relationship to fit it into the

fabric of a home. Thus, similarly to incorporating the service intensive orientation in a homelike setting, the incorporation of new staff will require sophisticated and innovative programming.

Conversion of existing community residences to ICF-MRs will require voluntary agency providers to delicately juggle the stringent, institutional-like regulations of the ICF-MR care modality with their concomitant goal of providing home-like environments. It remains to be seen whether, and how well, this "programmatic juggle" can be executed by providers.

D. Consequences of the conversion of the majority of the traditional community residences in the New York City area into ICF-MRs

Concern over whether the loss of 54 of the 81 voluntary operated community residences would create a missing link in the State's residential care alternatives for the developmentally disabled was another major issue related to long-term appropriateness of the conversion plan investigated by the Commission. To examine this issue, interviews were held with senior officials of the OMRDD and senior representatives of five voluntary agencies operating 28 of the 54 residences slated for conversion.

In meeting with officials of OMRDD, Commission staff learned that the immediate pending conversion of 54 community residences in the New York City area is only the first phase of the State's efforts to expand its utilization of the limited-bed ICF-MR for residential care of the developmentally disabled. Commissioner of the Office of Mental Retardation and Developmental Disabilities, James Introne, has indicated that by the close of 1980 there will be a total of 150 limited-bed ICF-MR programs in the New York City area, and 50 more upstate.

Officials at OMRDD further explain that the concentrated development of the ICF-MR in the New York City area reflects the intention to convert almost all traditional community residences<sup>10</sup> in this area to ICF-MRs. They clarified that this conversion effort means that traditional community residences, as they are known today in the New York City area, will be subsumed under the State's limited-bed ICF-MR program,

Maintaining that such an incorporation of the community residence program into the ICF-MR program reflects a broadening of the ICF-MR concept, rather than an elimination

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<sup>10</sup> The State currently operates two types of community residences for the developmentally disabled in the New York City area: the traditional group home with 24-hour staff and supervision and the supportive apartment which offers itinerant staff and supervision. In this paper, community residences refer to 81 traditional group homes in the New York City area.

of the group home concept, OMRDD officials insist that the conversion effort will not lead to a missing link in the State's capability to provide an appropriate range of residential alternatives for the developmentally disabled in the New York City area.

Commission staff interviews with voluntary agencies sponsoring a majority of the residences slated for conversion indicated, however, that these providers were considerably more uncertain than OMRDD that the conversion effort would not disrupt the continuum of care for their clients. The overwhelming majority of these providers felt their programs would change as a result of conversion to ICF-MRs. Citing the ICF-MR's service intensive orientation, higher staff ratios and administrative requirements, these providers feel that conversion reflects more than a "renaming" and incorporation of their programs into another residential program.

Instead, they perceive the ICF-MR as a higher level of care, which may or may not be appropriate for their clients, and they wonder where their clients will go when they become clearly ineligible for ICF-MR care. One voluntary agency representative citing this concern stated that her agency had rejected OMRDD's offer to convert more of their community residences to ICF-MRs because they felt without operating some community residences their clients have no

place to go as they gained the skills and independence to live in a less restrictive setting than the ICF-MR.

Another agency representative said: "With conversion of most community residences to ICF-MRs, clients living in ICF-MRs, accustomed to a service intensive and staff heavy environment, will have to take a giant leap to supportive apartment living. I don't think this is too realistic. Many clients benefit from the interim step of the traditional community residence."

Thus, while officials at OMRDD state that conversion will not affect the State's capability to provide a range of residential alternatives for the developmentally disabled, voluntary agencies sponsoring community residences are less certain. Citing the recognized strengths of the existing community residence program to serve this population, they are concerned about its abandonment in the New York City area.

Based on these conversations with voluntary agency providers, together with the other findings of its study, the Commission believes that both in the implementation of the ICF-MR conversion program and in long-range planning for community residential programs for the developmentally disabled, OMRDD should be sensitive to the need for preserving a graduated continuum of care for the developmentally disabled in the New York City area. The traditional community residence may well have an important place in this

continuum for those clients who no longer require the type of medical or rehabilitative services that the ICF-MR program was designed to provide.

E. Conclusions

In conclusion, the Commission's study finds that behind the short-term benefits of conversion--access to the Medicaid funding stream, increased federal financial participation, and State fiscal savings--lurk potentially serious fiscal and programmatic problems. Specifically, the Commission cites the following problems and contraindications for the State's continued pursuit of conversion to ICF-MRs as a resolution to the fiscal problem facing New York City's community residences:

1. The overall cost escalation of approximately 45 to 70 percent resulting from conversion of community residences to ICF-MRs represents a dramatic increase in the budgets of these already costly residences. While, State savings should nevertheless be realized in the short-term, these increased costs indicate the need for fiscal vigilance in the State's continuing efforts to contain long-term residential costs for the disabled and elderly.
2. The increased Medicaid bill for local governments resulting from conversion of community residences to ICF-MRs places additional financial burdens on New York City and other localities which can ill afford it. This reinforces the need for cost containment as well as other mechanisms to reduce or eliminate the fiscal impact of this program upon localities.

3. To avoid the danger of clients being inappropriately placed in a care modality that is potentially more restrictive and more service intensive than they require, there should be a careful assessment of clients' needs in converting community residences to ICF-MR level of care. Such careful planning is consistent with State policy mandating that mentally disabled individuals should be placed in the least restrictive residential environment appropriate for their needs.
4. While the capability of existing community residences to provide homelike, noninstitutional environments has been demonstrated, the ICF-MR program, with its emphasis on intensive services at the residence, needs to be monitored to ensure that it can be implemented without significantly restricting the homelike environment; and
5. The conversion of the majority of the traditional community residences for developmentally disabled individuals in the New York City area into ICF-MRs may limit the State's capability to provide a range of residential alternatives appropriate to the diverse needs of this population. This concern ought to be addressed by OMRDD both in the process of implementation of the conversion plan as well as in future planning for community residential programs for the developmentally disabled.

## CHAPTER III

### Recommendations

The Commission's study indicates that there are clear and immediate fiscal benefits to the State from the conversion to ICF-MRs. The programs will likely benefit both from the enriched staff and services available as well as from the stability in funding which thus far has been lacking. At the same time, the study points to the need for fiscal and programmatic oversight to assure that some foreseeable problems are avoided or minimized.

In implementing the conversion plan, there must be vigilance to assure:

1. The appropriateness of ICF-MR level of care for the clients' needs;
2. That the changes in the program and environment of the existing community residences are potentially beneficial to clients;
3. That increases in overall costs of care for clients in community residences converting to ICF-MRs are fully justified;
4. That the impact of the imposition upon local governments of new and locally-uncontrollable Medicaid costs resulting from the conversion is minimized;
5. The long-term availability of a variety of less restrictive environments in the New York City area for the care of developmentally disabled people.

The Commission, in the course of its study, has become aware of the wide variation in costs of community residences serving similar developmentally disabled populations. The fact that some community residences in the New York City area are operating with less than \$1,000 per client annually of supplemental State aid in excess of their Section 41.33 contract, while others receive more than \$8,000 per client annually, cannot be readily explained.<sup>11</sup> These fluctuations in supplemental State fiscal assistance do not appear to be related to the functioning level of clients or any other apparent rationale.

These variations among the costs of similar programs, compounded by the amalgamation of monies from separately negotiated State contracts supporting these programs, indicate the importance of a more equitable funding mechanism for the State's community residences. The existing funding system for these programs has led to confusion among voluntary agencies, the Division of the Budget, and the Legislature as to the actual costs of these programs and to the

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<sup>11</sup> These cost figures derive from an OMRDD interdepartmental correspondence from Jill Comins of the New York City/Long Island County Service Group to Susan Swift, Associate Commissioner of OMRDD. The correspondence, entitled "Procedures Used in Relating 1979-80 Budget and Contracts to ICF-MR Prototypes," related brief program descriptions, budget and income figures for 16 community residences in the New York City area. A Commission internal memo interpreting the data of this correspondence is included in Appendix C of this report.

appropriateness of the varying allocations of State monies among programs.

There is a pressing need for the State to reevaluate the current financing of community residences and to develop a more rational funding mechanism for these programs which allows the State to better assess the cost-effectiveness of these programs and to distribute available State fiscal assistance more equitably among programs.

In the 1980 Legislative Session, Chapter 809 of the Mental Hygiene Law was passed which establishes a fee for service system in lieu of the current reimbursement mechanism for community residences. This bill requires the Commissioner of the Office of Mental Retardation and Developmental Disabilities to establish fee schedules for services and standards for services and, in addition, imposes restrictions on participation in the fee for service system during the first fiscal year. Due to the recency of this legislation, it is not possible to ascertain its impact on the funding of community residences or its potential to provide a better assessment of the cost-effectiveness of these programs; however, it does attest to the Office of Mental Retardation and Developmental Disabilities' recognition of the need to provide a more rational funding mechanism for community residences to promote their cost-effectiveness.

Specifically, the Commission on Quality of Care for the Mentally Disabled offers the following recommendations:

1. The OMRDD should avoid, whenever possible, inappropriate levels of care for the clients affected by the conversion; ensure the ultimate cost-effectiveness of the converted programs; and seek within the ICF-MR modality a full range of alternative services from more restrictive to less restrictive settings, appropriate to individual needs.
2. In accord with this cautious approach, each community residence slated for conversion should be carefully reviewed:
  - to ascertain that the existing operating costs of the community residence appropriately reflect the services provided to clients and that the additional costs incurred by conversion to an ICF-MR will provide needed improvement of the existing program for clients; and
  - to analyze the impact of the conversion of the community residence on the range of residential care alternatives appropriate for the developmentally disabled individuals in the locality.
3. The State Legislature and the Division of the Budget should, as an interim measure, permit the continuation of the use of purchase of service and Chapter 620 monies to finance community residences where conversion is not appropriate. This interim measure should remain in effect until comprehensive revisions can be made in funding for community-based residential programs.
4. The OMRDD should carefully monitor those community residence programs converting to ICF-MRs to evaluate the programmatic and fiscal effects of the conversion. This deliberate monitoring process, which should continue for at least three years following conversion, should be focused on two broad objectives: (1) to assess the immediate and long-term impact of the converted ICF-MRs on State and local governments' costs; and (2) to assess the appropriateness of the converted ICF-MRs to address the residents' needs and to provide a residential setting which is the least restrictive possible in accordance with their needs.

5. At the same time, the State Legislature, the Division of the Budget, and the Office of Mental Retardation and Developmental Disabilities should develop a sophisticated system of determining the real costs of care in community residences so that State funding of these programs may be more equitable than in the past.
6. Based on the data derived from this cost-finding system, the statutorily provided formula for State assistance to community residence (Section 41.33 MHL) should be revised to reflect the real costs of operating such residences in different geographical regions of the State for clients of different functional levels and care needs.

Special attention in this revision process should be directed toward:

- providing a single source of State fiscal assistance to community residences;
- developing an on-going monitoring mechanism to guarantee the cost-effectiveness of community residence operations;
- providing State fiscal incentives for community residence providers to obtain federal and other non-State financial aid for their programs, other than their clients' SSI payments; and
- including a provision in the statute requiring OMRDD to clearly show in its Executive Budget Request all State fiscal assistance, including monies from allocations outside of Section 41.33 of the Mental Hygiene Law, used for the support of the community residence program.

In addition to the above recommendations, the Commission also believes that certain additional long-term efforts should be initiated by the Office of Mental Retardation and Developmental Disabilities to pursue other avenues for increasing federal aid to community residential alternatives for the developmentally disabled wherever appropriate.

While these efforts will not provide an immediate remedy to the fiscal problems facing community residences, they may contribute to a meaningful long-term resolution. These efforts include:

1. The Office of Mental Retardation and Developmental Disabilities, together with voluntary agencies, should pursue other avenues to bring federal fiscal participation into the State's community residence program, without altering the family-like, group home residential model of the community residence.

Sources of existing federal financial assistance which appear to be consistent with these criteria include:

- increased utilization of personal care providers, financed by Medicaid, in community residences, particularly for 621 eligible clients. The use of personal care providers as staff to a residence allows significant federal fiscal sharing through Medicaid funds without affecting the generally programmatic guidelines of the community residence or substantially increasing existing care costs.
- increased utilization of federal Housing and Urban Development (HUD) funds for rent subsidies by community residences. Currently few community residences, particularly in the downstate region, take advantage of these HUD subsidies which could relieve the State of a significant portion of the leasing costs of these residences.
- increased utilization of CETA trainees and other federally funded employee trainee programs in community residences.

Expansion of these trainee programs in community residences would reduce the State's staffing costs for these programs, as well as augment the number of trained paraprofessionals in community care of the developmentally disabled.

2. The OMRDD should actively negotiate with the Health Care Financing Administration within HHS for waivers and other accommodations in the federal ICF-MR regulations which would permit greater flexibility in utilizing the ICF-MR for developmentally disabled clients who require a supervised, supportive, rehabilitative, residential environment, but who do not require active treatment on a regular basis in the residential setting. Such waivers or other accommodations would permit New York State to incorporate in its continuum of residential care alternatives a lower level of ICF-MR care which would allow the State to more appropriately serve the majority of developmentally disabled clients in need of congregate residential care in the community. As a result of such efforts the additional costs incurred by compliance with existing ICF-MR regulations would be reduced, and the potential of creating unnecessarily service intensive and restrictive residential settings for clients would be lessened.
3. New York State should, in conjunction with the above effort, work with the Federal Housing and Urban Development Agency to consider the possibility of HUD setting aside funds for states to allocate for housing specifically for persons with mental disabilities. At the present time, intense competition for Section 8 HUD rent subsidy funds and Section 202 HUD mortgage funds by other groups often severely limits their utilization by individuals with mental disabilities. By providing a set-aside fund for the mentally disabled administered by the states, HUD would be fostering the development of much needed housing for this population and, at the same time, would be providing financial assistance to states endeavoring to establish such housing.

A P P E N D I X E S



APPENDIX A

James E. Introne  
Acting Commissioner

STATE OF NEW YORK  
OFFICE OF MENTAL RETARDATION AND  
DEVELOPMENTAL DISABILITIES  
44 HOLLAND AVENUE  
ALBANY, NEW YORK 12220

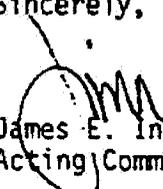
September 28, 1979

Mr. Clarence J. Sundram  
Chairman  
Commission on Quality of Care  
for the Mentally Disabled  
99 Washington Avenue  
Albany, New York 12210

Dear Clarence:

The Office of Mental Retardation and Developmental Disabilities' success in converting community residences to ICF/MR's is vital to the maintenance and continued development of a network of community service. Current funding arrangements offer no viable alternatives. Given the importance of this effort, I would like to meet with you to discuss how we can be most responsive to your inquiries.

Sincerely,

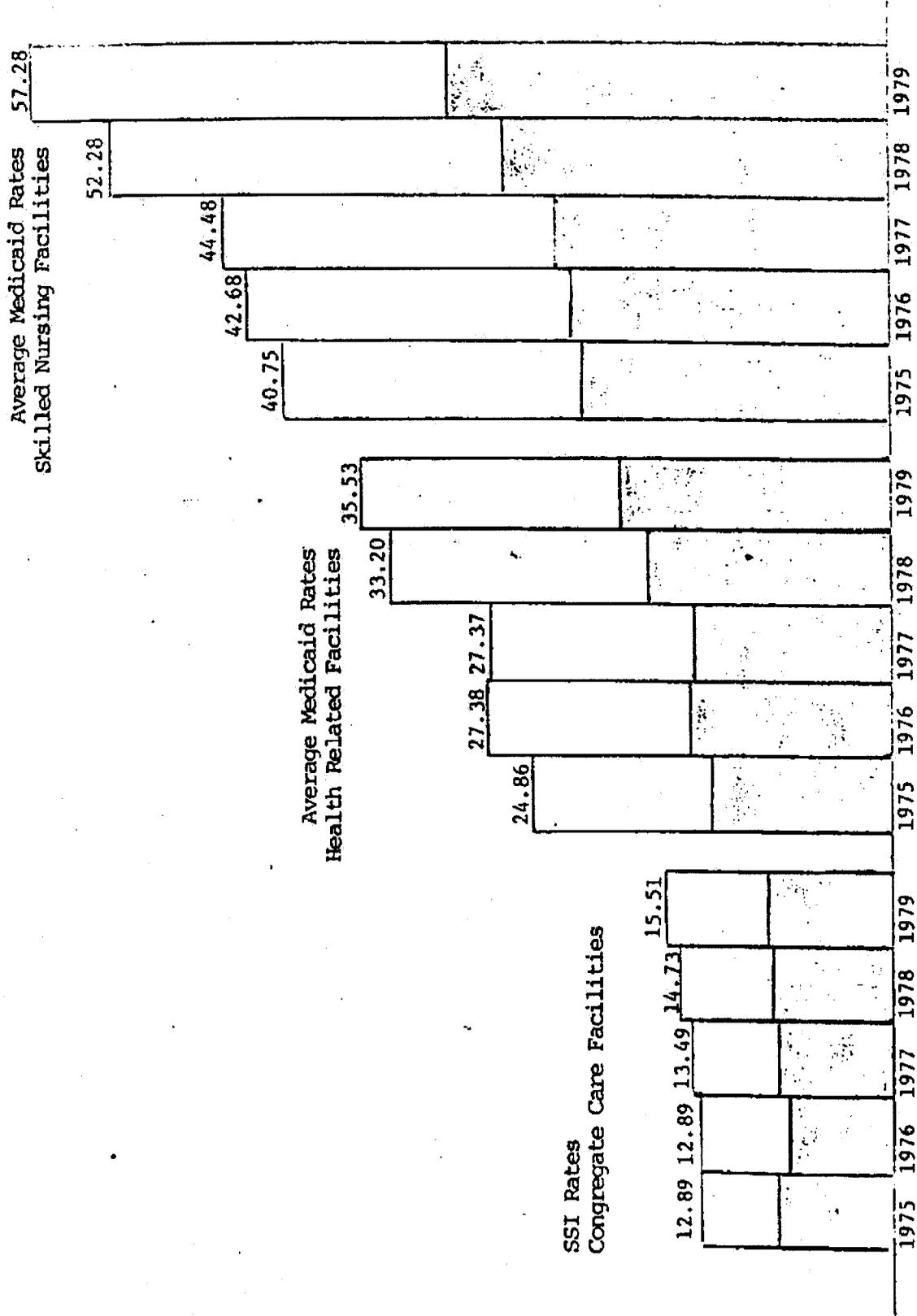
  
James E. Introne  
Acting Commissioner

JEI/ak

cc: Kevin Travis

Appendix B

Appendix B: Comparison of Per Diem Reimbursement Rates  
For Residential Care



Shaded Areas Indicate Non-Federal Share

Appendix C

Part 1: Memorandum

From: Jill Comins  
To: Sue Swift  
Entitled: Procedures used in relating 1979-80  
budget and contracts to ICF-MR  
prototypes

Part 2: Commission analysis of above memorandum  
Entitled: Brief Analysis of the Sources of  
Income and Budgets of Twelve  
Community Residences in New York City

Brief Analysis of the Sources of Income  
and Budgets of Twelve Community  
Residences in New York City

Introduction

In response to our inquiries on ICF-MRs, Susan Swift of the OMRDD forwarded to the Commission a memorandum on the procedures used in relating 1979-80 budgets and contracts to ICF-MR prototypes. The memorandum indicates that where the six ICF-MR models (A through F) leave off, four community residence models (G through J) begin; thereby completing, in 10 residential models, the continuum of community residential alternatives.

The community residence models are described below:

- Model G -- (specialized community residence) Mild to moderately retarded children/adults requiring special habilitative residential programming (some programs may include ICF-MR eligible clients, but they do not form a large enough part of the residential population to merit ICF-MR conversion or certification) with outside day programming.
- Model H -- higher functioning children/adults (i.e., mild to borderline retarded) requiring minimal formal residential programming with the residents participating in outside day programming workshops and/or gainful employment.
- Model I -- transitional housing on the grounds of developmental centers. Clients display a full range of functional levels, residing for a short period of time until appropriate placement is available in the community.
- Model J -- (supportive living program) high functioning clients living independently in their own apartments with minimal staff supervision. Programming includes sheltered workshop or gainful employment.

In addition to general descriptions of the Models, the memorandum included brief program descriptions, statements of source of income and budgets for 16 community residences. Twelve of these residences were "Model G" residences. The fact that the program descriptions of these residences included brief descriptions of the functioning levels of the clients being served made the grouping of homes serving analogous populations relatively easy.

With the grouping of residences serving analogous populations possible, a number of comparisons were likewise possible. Tables 1 through 4 illustrate the various sources and levels of income for the four groups of residences. Table 5 illustrates various cost trends such as: the cost of Personal Services (PS) in relation to the cost of Other Than Personal Services (OTPS); salaries per client; and fringe benefits. Finally, Table 6 illustrates the varying reliance of residences on supplemental funds (POS and 620).

### Findings

#### 1. Excess Income

Income, according to the memorandum, flows from four sources: SSI, the State matching grant, POS, and 620. The budgets of the residences cited in the memorandum included the costs of PS, fringe benefits, and OTPS. Since the memorandum did not offer total income figures but indicated the amount of income derived from each source for each residence, it was possible to calculate

the total income per residence.

Upon comparing these totals to the total budgeted costs of each house, it was found that in ten cases income exceeded cost. The excess income ranged from \$1, in the case of Residence #8 to over \$6,000 in Residences #9 and #11.

## 2. Similar Populations - Dissimilar Income

Line 4 of Tables 1 through 4 offers an analysis of each residence's income per client. In certain cases, as illustrated in Table 1, residences serving similar populations have similar per client levels of income. As can be seen in the case of these two residences serving mildly retarded adults, the per client incomes are very similar. This, however, is not a consistent pattern. In Table 2 one sees a difference of over \$4,000 in the income per client in two residences serving severely and moderately retarded adults. Similarly, as illustrated in Table 3, the income per client in three residences serving moderately and mildly retarded adults ranges from a low of \$10,534 to a high of \$11,781; a difference of over \$1,200.

## 3. Reliance on Supplemental Funds

Section 41.33 establishes a funding mechanism which allows the State to pay up to 50 percent of a community residence's cost of operation. The other 50 percent must come from other sources. In the residences analyzed, the agencies relied on the clients' SSI benefits as the first source of income and as the

50 percent of the cost of operation. In turn, this was matched dollar for dollar by the State.

Unless an agency can come up with other sources of funds (i.e., voluntary contributions), and relies solely on clients' SSI benefits, the basic community residence funding formula will never exceed SSI plus the State match. Assuming the State matches the total SSI benefit (less that part which is designated as the client's personal allowance), this formula translates into \$9,960 a year per client.

In the residences analyzed, the funds available through this formula (referred to in Tables 1 through 4 as 41.33 income) were supplemented by 620 or POS funds.

Referring to lines 1, 2 and 3 of Tables 1 through 4, one finds differing combinations of 41.33 funds and supplemental funds in the total income of residences. For example, in Table 2 it can be seen that four residences serving similar populations rely on supplemental funds to varying degrees. In one residence supplemental funds account for 50 percent of the total income; in another, 34 percent; in a third, 29 percent; and finally in another only 7 percent.

There appears to be no clear pattern for such a distribution of funds. Although agencies differ in their levels of 41.33 income (line 5 of Tables 1-4),<sup>1</sup> these differences hardly justify

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<sup>1</sup>It should be noted that clients may not receive the full SSI benefit of \$465.00 a month due to disallowances for earned or unearned income. In such cases the State matching grant is reduced and, as a result, the total 41.33 income is less than the \$9,960 which is the maximum given the right circumstances.

the differences in their levels of supplemental funds (line 6). In Table 3, for example, it can be seen that the 41.33 income for Residences #4 and #10 is slightly less than the \$9,960 per client which is the maximum, yet the difference in their supplemental funds per client is over \$1,100. Residence #2 as illustrated in this table, receives \$4,125 per client in supplemental funds, \$3,419 more than Residence #4 and \$2,303 more than Residence #10 despite the fact that it receives only \$2,173 and \$1,929 less than these respective agencies in 41.33 funds.

The absence of a pattern in the distribution of supplemental funds is also evidenced in Table 2, line 6. Here can be seen four agencies serving similar populations which receive per client supplemental funds ranging from \$706 to \$7,368.

The reliance on supplemental funds and the lack of a pattern in that reliance are illustrated in Table 6. As evidenced in this table, it appears as though supplemental funds have little bearing on the degree of clients' disabilities. Take, for example, Residences #11, #6 and #8. As seen in Table 6, they rank second, third and last respectively in their reliance on supplemental funds. Yet, as illustrated on the next page, the program descriptions of these three residences are strikingly similar.

Program Descriptions  
(Source: NYC/LI County Service Group)

Residence #11

The clients currently residing at Residence #11 are moderate-severely retarded who require supervision and assistance in the basic areas of ADL and socialization. Some of the clients are being evaluated for their capability to move to a less restrictive setting.

Residence #6

This program currently serves clients who are moderate-severely retarded adults who require supervision and assistance in achieving their maximum potential in independent living, ADL and socialization skills.

Residence #8

This program currently serves moderately-severely retarded adults who require supervision and assistance in attaining their full potential in ADL and socialization skills.

In summary, upon analysis, one finds no observable pattern in the distribution of supplemental funds for community residences.

4. The Role of Purchase of Service Funds

POS funds, according to the Executive Budget, are intended as start-up funds or as transitional funds to support the costs of services until these services can be financed by more permanent

funding sources.<sup>2</sup> The analysis of the twelve community residences for which data were available seems to indicate a discrepancy between the intent and actual use of POS funds. More than \$324,000 of POS funds were made available to these residences, yet most of the residences have been in existence for over two years. In fact, Residence #11, which has been in operation since 1972, received approximately 23 percent of the POS funds distributed amongst the 12 residences.

It appears, based on the analysis, that POS has become a permanent rather than temporary funding source.

#### 5. Various Anomalies

The absence of a discernible pattern in the financing of community residences also appears in the way residences intend to expend their income. Table 5 offers various comparisons of elements of the budgets of the twelve community residences included in the analysis.

Take, for example, the ratio of personal service costs to other than personal service costs. In this table it can be seen that the costs for personal services ranges from 51 percent of a residence's total budget to 73 percent. To a certain degree, the functioning level of clients probably plays a role in this wide range. For example, Residence #12, in line D-3 of Table 5, has the highest percentage of personal costs; however, this house serves non-

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<sup>2</sup>State of New York Executive Budget 1979-80, page 439

ambulatory individuals who are severely, moderately and mildly retarded. One would assume that with such a wide range of multiple disabilities, the need for personal services is great. However, when one compares residences serving similar populations with a single disability, it is difficult to make assumptions regarding the percentage differences among their personal costs.

In lines A-1 through A-4 it can be seen that, although four residences serve a similar clientele, their personal service costs range from 53 percent of their total cost to 71 percent.

Similarly, total salaries per client share the same wide range of discrepancy. Column 2 of Table 5 translates personal service costs into more concrete terms -- total salaries per client. Again, the first grouping of residences (those serving severely and moderately retarded adults) indicates an almost \$4,000 difference in the total salaries per client.

Finally, the next two columns of Table 5 offer some insights into the personnel practices of the different residences. As can be seen, salaries for managers or supervisors of the residences range from \$9,630 to \$16,000. Fringe benefits also have a wide range -- 10 percent to 22 percent. Although it should be recognized and appreciated that each of the agencies operating these residences are corporate structures responsible to their boards of directors and, as such, the OMRDD can exert little influence over their personnel practices, it appears that some staff are either being grossly overpaid or grossly underpaid.

TABLE: 1

Analysis of Income for Community Residences  
Serving Mildly Retarded Adults

	Residence #3 15 Clients	Residence #14 12 Clients
1) Total Income	\$175,623	\$143,098
2) 41.33 Income/Percentage of Total	\$134,032/76%	\$111,976/78%
3) Supplemental Income/Percentage of Income	\$ 41,591/24%	\$ 31,122/22%
4) Total Income per Client	\$ 11,708	\$ 11,925
5) 41.33 Income per Client	\$ 8,935	\$ 9,331
6) Supplemental Income per Client	\$ 2,773	\$ 2,594
a) POS Total	\$ 27,727	\$ 18,155
b) POS Eligible Clients	10	7
c) POS per Client	\$ 2,773	\$ 2,594
d) 620 Total	\$ 13,864	\$ 12,967
e) 620 Eligible Clients	5	5
f) 620 per Client	\$ 2,773	\$ 2,593

TABLE: 2

Analysis of Income for Community Residences  
Serving a Mixed Population of Severely  
And Moderately Retarded Adults

	Residence #6 10 Clients	Residence #8 8 Clients	Residence #9* 15 Clients	Residence #11 10 Clients
1) Total Income	\$141,772	\$84,272	\$186,198	\$147,492
2) 41.33 Income/Percentage of Total	\$ 94,425/66%	\$78,622/93%	\$132,158/71%	\$ 73,680/50%
3) Supplemental Income/Percentage of Total	\$ 47,347/34%	\$ 5,650/7%	\$ 54,040/29%	\$ 73,682/50%
4) Total Income per Client	\$ 14,177	\$10,534	\$ 12,413	\$ 14,749
5) 41.33 Income per Client	\$ 9,442	\$ 9,828	\$ 8,811	\$ 7,368
6) Supplemental Income per Client	\$ 4,735	\$ 706	\$ 3,602	\$ 7,368
a) POS Total	\$ 18,939	\$ 2,825	\$ 39,629	\$ 73,812
b) POS Eligible Clients	4	4	9	10
c) POS per Client	\$ 4,735	\$ 706	\$ 4,403	\$ 7,381
d) 620 Total	\$ 28,408	\$ 2,825	\$ 14,411	-0-
e) 620 Eligible Clients	6	4	6	-0-
f) 620 per Client	\$ 4,735	\$ 706	\$ 2,402	-0-

Residence #9 also serves some mildly retarded adults among its 15 residents.

TABLE: 3

Analysis of Income for Community Residences  
Serving a Mixed Population of Moderately  
And Mildly Retarded Adults

	Residence #2 15 Clients	Residence #4 12 Clients	Residence #10 9 Clients
1) Total Income	\$176,710	\$126,408	\$102,655
2) 41.33 Income/Percentage of Total	\$114,830/65%	\$117,934/93%	\$ 86,260/84%
3) Supplemental Income/Percentage of Total	\$ 61,880/35%	\$ 8,474/7%	\$ 16,395/16%
4) Total Income per Client	\$ 11,781	\$ 10,534	\$ 11,406
5) 41.33 Income per Client	\$ 7,655	\$ 9,828	\$ 9,584
6) Supplemental Income per Client	\$ 4,125	\$ 706	\$ 1,822
a) POS Total	\$ 41,253	\$ 7,768	\$ 9,108
b) POS Eligible Clients	10	11	5
c) POS per Client	\$ 4,125	\$ 706	\$ 1,822
d) 620 Total	\$ 20,627	\$ 706	\$ 7,287
e) 620 Eligible Clients	5	1	4
f) 620 per Client	\$ 4,125	\$ 706	\$ 1,822

TABLE: 4

Analysis of Income for Community Residences  
Serving Adults with Varying Degrees  
of Retardation

	Residence #1 27 Clients Borderline-Mild	Residence #7 19 Clients Borderline-Moderate	Residence #12 9 Clients Borderline-Severe
1) Total Income	?	\$223,001	\$158,568
2) 41.33 Income/Percentage of Total	?	\$173,640/78%	\$ 82,208/52%
3) Supplemental Income/Percentage of Total	?	\$ 49,361/22%	\$ 76,360/48%
4) Total Income per Client	?	\$ 11,737	\$ 17,618
5) 41.33 Income per Client	?	\$ 9,139	\$ 9,134
6) Supplemental Income per Client	?	\$ 2,598	\$ 8,484
a) POS Total	\$11,926	\$ 38,969	\$ 33,938
b) POS Eligible Clients	27	15	4
c) POS per Client	\$ 442	\$ 2,598	\$ 8,485
d) 620 Total	?	\$ 10,392	\$ 42,422
e) 620 Eligible Clients	?	4	5
f) 620 per Client	?	\$ 2,598	\$ 8,484

10MRDD error precludes gathering reliable data.

Table 5  
Various Analyses

	PS/OTPS <sub>1</sub> Ratio	Total Salaries Per Client	Manager Salary	Fringe Benefits
Residences Serving Severely and Moderately Retarded Adults (Clients)				
1) Residence #6 (10)	71/29	\$ 9,259	\$ 12,000	13%
2) Residence #8 (8)	53/47	5,272	9,630	10%
3) Residence #9 (15)	57/43	6,530	14,830	17%
4) Residence #11 (10)	68/32	8,622	15,266	17%
Residences Serving Moderately and Mildly Retarded Adults				
1) Residence #2 (15)	52/48	5,475	16,000	19%
2) Residence #4 (12)	51/49	4,951	9,630	10%
3) Residence #10 (9)	61/39	6,529	10,233	12%
Residences Serving Mildly Retarded Adults				
1) Residence #3 (15)	53/47	5,511	16,000	19%
2) Residence #14 (12)	61/39	6,673	13,500	14%
Residences Serving Adults With Varying Degrees of Retardation				
1) Residence #1 (27)	59/41	2,834	11,000	20%
2) Residence #7 (19)	42/58	2,598	16,000	19%
3) Residence #12 (9)	73/26	8,484	?	22%

Excluding Fringe Benefits

Table 6

Ranking Of Residences By Reliance On  
Per Client Supplemental Funding

Rank	Residence	Supplemental Funds Per Client	Degree of Clients' Disability
1	#12	\$ 8,484	Borderline to Severe Non-ambulatory
2	#11	7,368	Moderate and Severe
3	# 6	4,735	Moderate and Severe
4	# 2	4,125	Mild and Moderate
5	# 9	3,602	Mild, Moderate and Severe
6	# 3	2,773	Mild
7	# 7	2,598	Borderline to Moderate
8	#14	2,594	Mild
9	#10	1,822	Mild and Moderate
10	# 4	706	Mild and Moderate
11	# 8	706	Moderate and Severe

**STATE OF NEW YORK**  
**OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES**

44 Holland Avenue · Albany · New York · 12229

**JAMES E. INTRONE**  
Commissioner

July 10, 1980

Mr. Clarence J. Sundram  
 Chairman  
 State of New York Commission on  
 Quality of Care for the Mentally Disabled  
 99 Washington Avenue  
 Albany, NY 12210

Dear Mr. Sundram:

Thank you for the opportunity to review the confidential draft report entitled Converting Community Residences into Intermediate Care Facilities for the Mentally Retarded: Some Cautionary Notes. I appreciate your support of the State's initiative to increase the utilization of Federal funds in the development of community based programs for the mentally retarded and developmentally disabled. I also recognize the need to maintain those costs within firmly established cost ceilings that provide appropriate levels of program to our clientel. The existing ICF/MR models developed in concert with the Division of the Budget are an initial step in that direction. I anticipate that as we gain more experience with the ICF/MR community program, our levels of anticipation in terms of program output and program cost will become more refined.

We, too, are concerned about the long-term fiscal and programmatic implications of the conversion plan. We agree with your assessment that there are "clear and present benefits of conversion" and have commented on your cautionary notes as follows:

1. The overall cost escalation resulting from conversion of community residences to ICF/MR status could total 47 to 71 percent if ICF/MR program rates are set at the maximum allowable by the Division of the Budget. Actually, average budgeted costs should be compared and more specifically, it would be more appropriate to compare average actual costs rather than budgets. We will have the opportunity to do this as we cost audit individual ICF/MR programs.
2. We are concerned about the fiscal impact of the conversion efforts on local governments. Legislation is needed to relieve local government from their share of such costs.



Being retarded never stopped anyone from being a good neighbor.

Mr. Clarence J. Sundram

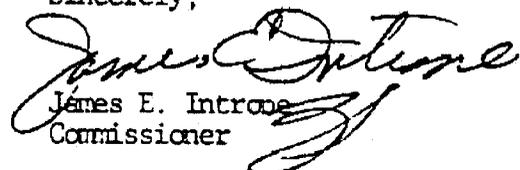
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July 10, 1980

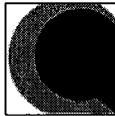
3. We are very sensitive to the less restrictive issue. However, we are faced with the fact that many community residences cannot support the level of service required by their clientel under a 41.33 contract. Such providers require other supplementation as you are aware. The six(6) ICF/MR models that have been developed in concert with the Division of the Budget provide graduations of more intensive program for more intensive need. The 41.33 funding formula does not allow such flexibility. The 41.36 amendment to the Mental Hygiene Law will provide a certain amount of flexibility. We will have to develop experience in implementing this new section of the law to determine if least restrictive and less costly are necessarily synonymous. Client need will have to be the determining factor in arriving at any placement decisions.
4. The small community based ICF/MR residences and apartments being converted and developed in the State are virtually indistinguishable in terms of environment and setting from the typical community residences serving more handicapped clientel. What is mandated by the ICF/MR program is the provision of services and documentation of such services required by each client plus policy and procedures requirements that should be part of every program serving our clientel.
5. The 41.36 amendment reflects our commitment to the maintenance of a continuum of residential alternatives that everyone can afford - the voluntary providers as well as State government. Where individual level of need indicates a more structured program is required that program will be provided. Where less structure is required, that will also be available.
6. It is anticipated that the application of the utilization review requirements of the ICF/MR program will make it difficult to maintain individuals in an inappropriate setting while fiscal audit requirements will identify cost increases that could curtail our long term capability to provide quality residential care. We are proceeding with caution in the development of all residential alternatives and will continue to pursue other avenues for Federal aid for a variety of programs.

I suggest that those sections of your paper dealing with community residences take into account the potential impact of the 41.36 amendment. Your staff should be congratulated for the extensive amount of work put into this report.

Sincerely,

  
James E. Introne  
Commissioner

The New York State Commission on Quality of Care and Advocacy for Persons with Disabilities is an independent, New York State government agency charged with improving the quality of life for New Yorkers with disabilities, protecting their rights, and advocating for change.



New York State  
Commission on Quality of Care and Advocacy  
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