MINUTES

MONTANA HOUSE OF REPRESENTATIVES
51st LEGISLATURE - REGULAR SESSION

SUBCOMMITTEE ON INSTITUTIONS

Call to Order: By Rep. William Menahan, on January 30, 1989, at 8:00 a.m.

ROLL CALL

Members Present: All

Members Excused: None

Members Absent: None

Staff Present: Taryn Purdy, Associate Fiscal Analyst

Announcements/Discussion: EXECUTIVE ACTION -SUPPLEMENTALS

Discussion on Medicaid - Dept. of Health

Taryn Purdy discussed the supplemental for the Montana Developmental Center and the request for $294,669 to continue funding of 15.0 direct care positions added in fiscal 1988. HB301, which is the supplemental bill, includes an amount of $200,000 for the Montana Developmental Center. If the committee wishes to approve the $294,669 it will require an amendment to HB301 in the Appropriations Committee.

Ms. Purdy answered a question about the $200,000 raised by Sen. Aklestad. The $200,000 was originally estimated by the Dept. as far as what their needs would be. The $294,669 is a revised estimate after HB301 had been written. Sen. Aklestad then asked what the difference was between the $200,000 and the $130,109 as the cost as outlined on Page D-49 of the LFA current level. Ms. Purdy explained the $130,000 was the amount expended in fiscal 1988, when the positions were added midway through the year. This will be funding for the entire year.

Curt Chisholm, Director of Dept. of Institutions, also gave some comments regarding the request for supplemental figures. They had to determine what the needs were to certify.

Tape 1A 78

Sen. Bengtson moved to accept the $294,669 supplemental. Sen. Aklestad asked what the total FTE level was in the 1985 budget. Mr. Chisholm stated the authorized FTE level was 441 in 1985. In fiscal 1983 they were authorized 485 positions. The client load was 202.9 in 1985, 201.87 in 1986, and 202.41 in 1987. Sen. Bengtson stated that if the additional habilitation aides are put on there is not much choice. Question was called and motion carried.

Tape 1A 111

DEPARTMENT OF HEALTH DISCUSSION

Ms. Purdy stated the Department of Health was present to give their views on Medicaid. Rep. Menahan stated the committee would address the certification at Boulder problem and why the Institution is under more inspection than the day care facility.

Dale Talliaferro, Div. Administrator for Health Services, Jackie McKnight, Bureau Chief for Licensing and Certification and Linda Sandman, Surveyor, were present from the Dept. of Health to answer questions.

Ms. McKnight asked Rep. Menahan about his question concerning why there are more stringent rules for the Institution at Boulder than there would be at Westmont. She explained that Westmont is certified as a home health agency and surveyed under different conditions of participation. Rep. Menahan referred to her report concerning mealtime and clients watching TV while others were being fed and that some were not being attended to and he cited the same situations at other facilities. He questioned the reasoning.

Tape 1A 190

Ms. Sandman stated she did not recall a deficiency related to mealtime programing as some of the current active treatment occurring at Boulder as related to mealtime programing has improved. Sen. Bengtson asked if the surveying has become more sophisticated and in their training for inspection of Medicaid certification what sorts

of things are expected of them by the Federal guidelines. Also is it objective or is there a lot of subjectivity, and what do they look for in a Medicaid waiver facility such as a group home. Ms. McKnight stated they do not look at group homes. They are handled under the community based waiver and their surveillance is through the Dept. of SRS, DD Division. She could not respond to comparisons between ICFMRs and the group homes. Ms. Sandman addressed the training question. Two surveyors, including herself, have received federal training for surveying facilities like Boulder. She stated there has been a great deal of national attention focused on intermediate care facilities. Congress became very concerned when they saw federal Medicaid money going into institutions and still found clients in conditions that left a lot to be desired. New regulations focused very heavily on active treatment. She stated one of the problems at Boulder is that it has been a custodial care institution. It was originally designed to serve a large number of clients. As the regulations have focused more on active treatment it is a dilemma. It is a philosophical shift moving away from custodial care, which focuses on just feeding people and keeping them clean, to providing meaningful activities and training to allow the clients to be as independent as they are able. Sen. Bengtson asked if the structure and facility at Boulder lends itself to custodial care, making active treatment more difficult, and are other states having as much trouble getting certified. Ms. Sandman said yes to both questions.

Tape 1A 276

Rep. Menahan asked about the 100% turnover in their training staff in the group homes. In talking to people at Boulder he stated they have a more stabilized staff and he has looked at both situations. The group homes might have more training for kitchen or housekeeping.

Sen. Aklestad stated he wanted an example as to how the federal government mandates differ in 1987 and 1988 compared to 1985. How is the inspection different and do they have a set criteria or form to go by, or is it just personal reflections.

Ms McKnight stated the difference not only in ICFMRs but in long term care facilities is they are looking at outcome care now. Prior to that time they were looking at staffing and the various services and determining if the care could be given, rather than assessing it by the treatment the patient was receiving. Sen. Aklestad asked if

there was a specific rule that could be shown him that would illustrate that change. Ms. Sandman stated the shift has been, rather than looking at the facility's ability to provide care, is resident focused and outcome oriented. They have protocol to look at a sampling of residents, as at Boulder. They track the residents and look at their records and follow them through a day and look at what kind of training they are receiving and interaction between staff and residents. Therefore, the regulations aren't different but rather the way they arrive at conclusions. Sen. Aklestad asked if there is a set form or criteria to help draw those conclusions. Ms. Sandman stated that under the new regulations they do not have a check list similar to that used under the prior survey. They now have Appendage J and a copy can be supplied to the Senator.

Sen. Aklestad asked what was used before Oct. 3 when Appendage J was put into operation. The way in which they look at active treatment is not any different.

Tape 1A 403

Sen. Aklestad asked how many inspectors go to the Boulder facility and how many times. Ms. McKnight responded that the survey is annual. They have fire safety, social worker, QMRP, dietician, one or two nurses, land survey and a pharmacist. Sen. Aklestad then asked about the areas Boulder did not meet compliance and how many inspectors were involved. Ms. McKnight stated there were 10 standards not met. Sen. Aklestad asked how many inspectors were involved to make a determination on those 10 standards. All of the surveyors do some observation, then get together as a group and reach their determinations. Sen. Aklestad asked if each team member signs off on the determination the others make. Ms. Sandman stated their report is written as a team and she is not aware of any deficiency ever being written that was not a reflection of team consensus and agreement.

Sen. Aklestad asked what they were expecting of the Boulder facility, how many hours of actual treatment they were mandating that they provide, and whether this mandate is directed from the federal government. Ms. Sandman stated the old regulations had specific requirements, such as clients could not be idle or unengaged for three continuous hours. The new guidelines have gotten away from some of those specific kinds of references. The whole outcome really implies an aggressive, continuous kind of process, which does not mean clients would need to be in an educational setting all day. It implies that there is competent staff interaction occurring with clients, that

clients are being taught to do things, that they are being treated in a manner that is respectful and dignified.

Rep. Menahan asked if they make recommendations to include FTE levels. He stated the committee realizes the facility is out of compliance and would like to know how to get back in.

Tape 1A 516

Rep. Peterson asked about the judgments in guidelines. She felt they were very subjective and wonder if the inspections differ from person to person. Mr. Talliaferro stated one of the changes that has occurred is it becomes harder to specify how much treatment has to be decided for each individual. Some require more than others. It is his impression as they read the reports that there is lack of staff.

Tape 1A 551

Sen. Aklestad asked if under the federal mandates each and every patient will improve in one or more areas in one inspection to another. Mr. Taliaferro stated they are not to judge that. They would go back to the assessment of the individual. Every client is different and every potential is different. All they can look for is if the program is appropriate. They ask the professionals if this client has reached his developmental limit.

Tape 1B 452

Sen. Aklestad asked if there is a time frame for an appeal. Mr. Talliaferro stated the facility is on appeal status now and certification has to be resolved within 120 days.

Rep. Peterson mentioned the long range planning committee is doing some extensive plans for remodeling. She asked if any of the remodeling resolves some of the problems. Rep. Menahan stated it would not. Mr. Chisholm referred to the issue and stated the reason for the remodel was to bring the cottage area up to institutional code compliance.

Sen. Bengtson asked Cris Volinkaty, lobbyist for the developmentally disabled in the state of Montana, both

providers and consumers, how the group homes can be certified with Medicaid. She stated community homes also follow accreditation standard. The difference is that group homes are not in a hospital setting and not an ICMFR, so they have a little more leeway. As far as active treatment goes they are under the same guidelines.

Tape 2A 71

Chairman Menahan thanked the department for appearing before the committee and answering questions.

ADJOURNMENT

Adjournment At: 10:00 a.m.

Rep. Wm Menahan

REP. WILLIAM MENAHAN, Chairman

WM/ms

2524.min

Exhibit 1
1-30-89

DEPARTMENT OF INSTITUTIONS
SUPPLEMENTAL REQUESTS
FY89

| | |
|---|---|
| MONTANA DEVELOPMENTAL CENTER to fund 15 additional people<br>GENERAL FUND | $294,669 |
| MONTANA STATE HOSPITAL motion proposed<br>CANTEEN ACCOUNT | $ 42,076 |
| MONTANA STATE PRISON<br>CANTEEN ACCOUNT | $181,616 |
| CENTRAL OFFICE MEDICAL<br>GENERAL FUND | $ 48,360 |

Exhibit 2

BUDGET STATUS REPORT

PROGRAM 47 CORRECTIONS MEDICAL — DECEMBER 1988

| RESPONSIBILITY CENTER: | PREVIOUS FY BUDGET | CURRENT FY BUDGET | CURRENT BIENNIUM BUDGET | SBAS YTD BIENNIUM | PROJECTION BIENNIUM | SURPLUS (DEFICIT) |
|---|---|---|---|---|---|---|
| SWAN RIVER FOREST CAMP | $16,044 | $16,044 | $32,088 | $25,131 | $32,929 | ($841) |
| MEN'S CORRECTIONS | $4,452 | $4,452 | $8,904 | $15,884 | $19,513 | ($10,609) |
| WOMEN'S CORRECTIONS | $44,325 | $44,325 | $88,650 | $93,457 | $127,028 | ($38,378) |
| MONTANA STATE PRISON | $793,345 | $772,725 | $1,566,070 | $1,035,863 | $1,564,603 | $1,467 |
| TOTAL | $858,166 | $837,546 | $1,695,712 | $1,170,334 | $1,744,072 | ($48,360) |

Jan. 30, 1989

# DISCUSSION PAPER - ACTIVE TREATMENT

"Active treatment" for residents of intermediate care facilities for the mentally retarded or persons with related conditions (ICFs/MR) is a concept of some vintage but a focus of only recent attention. This attention has largely been generated by the recent state of federal "look-behind" surveys of three Medicaid-funded ICFs/MR in Utah, which greatly reinforced the actions of the state survey agency in this arena. However, since "Active treatment" is a requirement for federal financial participation (FFP) in the Medicaid reimbursement of each ICF/MR resident's cost of care, immediate attention was galvanized by the federal survey finding that active treatment is not being delivered in any of the three facilities surveyed. In theory, this finding could jeopardize the roughly seventy two (72) percent federal share of the cost of care in these facilities if the federal agency chose to withhold FFP due to the lack of active treatment. In addition, the state survey agency recently found that the Utah State Training School (USTS) did not comply with the active treatment requirement, nor did other private ICFs/MR surveyed in August, 1985. Thus, since June, 1985, a total of four private facilities and USTS have been found to be out of compliance on this issue. These facilities represent approximately two-thirds of the residents in the total ICF/MR system. Furthermore, the state survey agency privately estimates that only two Utah facilities, representing only about five percent of the ICF/MR residents, are likely to meet current federal interpretations of the active treatment requirement. Potentially ninety five (95) percent of the federal share of this program - about $18 million - could therefore be in jeopardy.

## HISTORY

Active treatment was first required by the 1971 Amendment to the Social Security Act, which made federal Medicaid funding available for the care of mentally retarded/developmentally disabled (MR/DD) persons residing in public and private long-term care facilities. The cost of this care was previously a state responsibility.

To prevent the use of federal funds to provide only basic custodial care Congress limited FFP to only those residents who received "active treatment" to improve their functioning.

However, the concept of "active treatment" was not defined until 1974 with the publication of federal Medicaid regulations which specified its major component parts. The federal standards for Medicaid certification of ICFs/MR also appeared in 1974, and echoed the "active treatment" requirement with many stringent standards concerning the provision of a variety of professional services to ICF/MR residents.

The State of Utah entered the ICF/MR program in 1977, when USTS was certified for Medicaid participation. There are now ten private facilities (623 total beds) and one public institution (750 total beds) in the program.

In general, neither the federal nor state agencies have been notably aggressive in the past concerning the enforcement of the active treatment requirements per se. Rather, the survey focus tended to be on compliance with the extensive facility certification standards, on the assumption that active treatment would automatically be met if there were not substantial problems noted in meeting those standards. In fact, the state survey agency in July, 1984, did write survey deficiencies on active treatment in several buildings at USTS, but found that the federal "look-behind" survey of USTS in January, 1985 minimized these issues and did not find deficiencies in active treatment. While some other federal regional survey agencies did write active treatment deficiencies during this time, the Region VIII office serving Utah was perhaps less aggressive on this issue than was the state agency.

Developments at the federal level in 1983 and onward have radically altered federal enforcement of the active treatment requirement. Certain complaints to Congress about conditions in ICFs/MR resulted in attention focused on this issue by the Senate Subcommittee chaired by Senator Lowell Weicker (R., Conn.). In response to this pressure, the federal Department of Health and Human Services doubled the frequency of its federal surveys of ICFs/MR between January 1984 and June, 1984. More than half were found to have serious deficiencies, including deficiencies in the provision of active treatment. The subcommittee felt that more independent direct federal surveys of ICFs/MR were needed to spot and push for correction of problems. Consequently, more than fifty new specialized federal surveyor positions were created and assigned to the various federal Regional Offices. (The Region VIII office serving Utah did not fill this special surveyor position until May, 1985). The number of direct federal surveys increased dramatically. Prior to 1984, about twenty per year were performed; since July, 1984 over 280 have been done, a 1400 percent increase in little over a year.

Concurrently, the federal interpretation of the active treatment requirement was tested at the departmental-appeal level. A federal "look-behind" survey was performed at the Southbury State Training School in Connecticut after state surveyors had already cited the facility for lack of active treatment. The federal survey focused on 29 residents (approximately ten percent sample of the facility) and found that 27 residents were not receiving active treatment. The federal office took action to regain the FFP paid to the state for the care of these residents. The State of Connecticut formally appealed this decision to the federal departmental Grant Appeals Board. The Board upheld the finding and the right of the federal government to recover FFP, with the result that Connecticut had to repay $2,303,360 to the federal government. The decision was not taken to court.

## STATE RELATIONSHIP TO FEDERAL AGENCY

The State of Utah is essentially in a contractual relationship with the federal government to administer the Medicaid program in the state. The state, through the state Department of Health, contracts with the federal government, though the federal Department of Health and Human Services. In return for federal government's provision of federal Medicaid funds, the state must agree to perform a variety of administrative and quality control duties mandated by the Social Security Act, as amended in Sections 1864 and 1874 of the Act. The state agency must certify to the federal agency whether or not Medicaid providers/suppliers within the state are complying with all applicable definitions and requirements of the Act and of its implementing regulations. This certification of compliance is based on state agency on-site surveys of each provider/supplier. Deficiencies in compliance cited by the state agency must be addressed by the provider/supplier with an acceptable plan of correction, to be implemented within an acceptable time frame. The state agency then monitors actual implementation of correction through follow-up surveys. Failure by a provider/supplier to correct cited deficiencies may result in the state agency decertifying that provider/supplier from the Medicaid program, which prevents them from receiving Medicaid funds for their services.

The federal agency, through its regional offices, monitors the state agency's performance of its contractual certification and survey duties. On form of monitoring state agency performance may be the direct federal survey of providers/suppliers previously surveyed and certified by the state agency. This form of monitoring is known as the federal "look-behind" survey, and it is specifically cited in the federal-state contract as the primary method used in federal evaluation of state agency performance. Deficiencies cited in state agency performance must be addressed by an acceptable plan of correction, and failure to comply could result in federal termination of the contract, with consequent loss of federal Medicaid dollars to the state.

In addition, the federal agency has the right to seek recoupment of FFP directly from providers/suppliers if their direct surveys reveal that FFP was inappropriately used. (e.g. - if active treatment was paid for by FFP, but not delivered). The authority of the federal agency to take such action was specifically upheld by the departmental Grant Appeals Board decision in the Southbury case mentioned earlier. Since the state agency contracts for services with the providers/suppliers, the state would have to pay the federal government any amount of FFP disallowed.

## REVIEW OF 1985 DIRECT FEDERAL SURVEYS IN UTAH

In June and July of 1985, three direct federal surveys of privately-owned ICFs/MR were performed in Utah by staff from the federal Region VIII office located in Denver, Colorado. All three facilities were cited for failure to provide active treatment.

The most frequently cited component parts of this generic finding of "no active treatment" are generally around professional services and specialized training programs. These major areas were criticized regarding both quality and quantity of service delivered relative to observed client needs for service. A third major area had to do with direct care (non-professional) staff, who were cited for lack of training and skills to implement programs for residents, and for inadequate supervision of residents.

In their exit interviews, the federal surveyors strongly suggested that the facility needed more professional and direct-care staff. The facilities have responded by stating that the current reimbursement rate is inadequate to pay for these increased costs, and have requested a 50 percent increase in the reimbursement rate.

## STATE AGENCY PERSPECTIVE ON FEDERAL FINDINGS

In general, the state survey agency agrees with the general slant of the current federal interpretation of active treatment, but disagrees with its timing and methods.

The state agency strongly supports the principles of active treatment for the ICF/MR residents. Well before the federal surveys in this state, the state agency had put into rulemaking new state rules which are consistent with the emerging federal emphasis on active treatment. Plans were made to train state agency staff and providers on the more stringent standards emerging at the state and federal levels.

However, little was in place before the onset of the federal surveys. Within a few weeks of filling the specialized surveyor position, the federal regional survey team did two surveys within two weeks, and three within five weeks. This virtual blitzkrieg approach was without notice to the state agency, without training to either state agency or to providers on the more stringent standards to be used, and applied standards which were much more strict than those previously used by the regional office to judge the presence or absence of active treatment. These tactics created much confusion, anxiety and resistance among providers, factors which had hitherto not generally been present. The working relationship between the state agency and providers was marred by this situation.

CONCLUSION

# ...RVEYOR TRAINING PROGRAM

J.Kurzer and D.O'Connell

## Introduction

As superintendents throughout the country are aware, the federal government has begun an intensive "look behind" survey of ICF/MR facilities to ascertain the extent to which retarded citizens are receiving active treatment in quality-life enriching environments. Authorization has been received to hire 59 additional federal surveyors in the regional offices to conduct these surveys in a timely fashion. Surveyors have already visited several facilities throughout the country and more will be surveyed in the ensuing months.

It is the plan of the federal government to personally survey all ICF/MR facilities in excess of 300 residents, while inspecting 40 percent of the facilities with between 15 and 299 residents, and 20 percent under 15 persons. A larger sample may be drawn in states where systemic problems are identified.

A recent training program was held for the federal inspectors to outline the elements to be considered in conducting "look behind" surveys. At the request of the National Association of Superintendents of Public Residential Facilities for the Mentally Retarded, (NASPRFMR) two representatives of our Association were allowed to attend this initial training. The report which follows reflects their observations.

## The Survey Process

"Client centered" and "active treatment imperative" was the charge federal surveyors received at the initial training program held in Baltimore, MD, March 12-14. Couched in the newly distributed "Protocol for Conducting Direct Federal Surveys of Intermediate Care Facilities for the Mentally Retarded" and (a must reading for all superintendents) a tag-by-tag approach to ICF/MR regulations, faculty provided in-depth presentations focusing on a "wholistic" and "humanistic" approach toward serving mentally retarded persons in the nation's ICF/MRs.

The faculty was spearheaded by Wayne Smith, PhD, Senior Program Analyst at Health Standards and Quality Bureau in Baltimore; and Eugene Clark, ACSW, QMRP, Regional Coordinator for ICF/MR Programs, Atlanta. Other faculty included Stephen Edlestein, JD, discussing legal implications related to the survey process and David Lawson, PhD, Director, Northern Virginia Training Center, addressing the provider perspective.

The two representatives present from NASPRFMR were favorably impressed with focus, content, and commitment which prevailed throughout the training sessions. While none of the content was strikingly new or different, several themes were recurrent and should be carefully considered as part of any facility's review of services in light of full or improved compliance with ICF/MR regulations.

Active treatment, based on the premise of growth and development of all human beings in a predictable and sequential fashion, must exist for each person and was presented in terms of statutory and regulatory expectations. Lifted from the Protocol, emphasis was placed upon the three prominent components including:

1. The annual staffing to reevaluate the client's medical, social, and psychological needs. This must include review of the individual's progress toward meeting the plan objectives and the appropriateness of the plan of care;

The setting forth of measurable goals or objectives stated in terms of desirable behavior and the prescription of an integrated program of activities, experiences, or therapies necessary for the individual to reach those goals or objectives; and

3. The regular participation in professionally designed and supervised activities, experiences, or therapies in accordance with the plan of care.

In accomplishing this major task, surveyors were urged to seek "functional" evaluations—those which, regardless of professional discipline, provide information as to what the client can do and identifies needs across his/her developmental and behavioral spectrum of skills. In his presentation, Smith urged facilities, through the evaluation process, to elicit information concerning client performance of those skills fundamental or common to his daily existence. This must be accomplished on the basis of assessment of client performance in a formal setting, against criteria, by competently trained personnel. Good functional assessment leads to objective setting and, in turn, the objectives are "reasonable" and "attainable," stressed Smith.

Competent staff, staff training, and a transdisciplinary philosophy were admitted biases often repeated and illustrated to trainees. Smith stressed the availability of knowledge in the field and a concern of its absence from certain environments. "We know too much to tolerate lack of knowledge transfer to caregivers." Professional staff must share their knowledge and skills with each other and with all levels of staff. Staff training by competent personnel, who are present in learning and living environments will result in a client centered and client oriented focus. This will enable a client's needs to be met throughout the day in a consistent and knowledgeable fashion by all personnel responsible for his care and treatment.

In order to ascertain the presence of active treatment, facilities will be informed of the importance of observation throughout the waking hours of its clients' day and interaction with staff throughout the survey process. Paper aspects such as policies and procedures, various reports, etc, will receive less attention; however, client related documentation will continue to play an important role as essential indicators of active treatment. Policies, procedures, life safety reports and actions may rise in prominence based on questions or concerns observed through the survey process.

For the many ICF/MRs, whose clients are involved in a day program off-grounds which are sponsored by other agencies, it was stressed that the responsibility for the necessary linkages and communication in order to integrate and assess the client's progress rests with the ICF/MR.

In the discussion of implementation of active treatment, several expectancies were stressed. Upon the basis of looking at and for content, surveyors will expect others (staff persons) to know, implement and reinforce portions of the client's program throughout the client's day and in other parts of the facility. "Communication training cannot only exist in a speech therapy session in order for a retarded person to learn," serves as an example of this thrust. They will look for 5 to 7 objectives and go from place to place to see that these are being implemented both within training time frame and otherwise, as appropriate. Surveyors were challenged to see and find "that what is going on is content rich to meet the developmental needs of the individual clients." In addition, they will seek "how effectively the facility is organized to attack client problems from many different directions and being successful whenever possible."

Participants were clearly instructed to conduct a "client based, outcome oriented" survey. The true test of active treatment lies in the growth, development, and progress of the retarded person.

For more information, call or write:

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VISITOR'S REGISTER

_____ SUBCOMMITTEE

AGENCY(S) _____ DATE 1-30-89

DEPARTMENT _____

| NAME | REPRESENTING | SUP-PORT | OP-POSE |
|---|---|---|---|
| Virginia Kenyon | Board of Visitors | X | |
| | | | |
| Linda Sandman | Survey, Dep. of Health | | |
| Dale Tallia Ferro | Adm. ~~Chief~~ Health Serv. Div. | | |
| Jackie McKnight | Bureau Chief Dept. of Health | | |
| Bill Opitz | Dept. Dir. | | |
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IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT.
IF YOU HAVE WRITTEN COMMENTS, PLEASE GIVE A COPY TO THE SECRETARY.

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