REPORT

PREPARED BY THE

HORACEK REVIEW COMMITTEE

FOR THE

U. S. DEPARTMENT OF JUSTICE

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PREFACE

The following report to the U.S. Department of Justice is titled: Analysis of the Nebraska Mental Retardation Panel's Plan of Implementation and the Amended Alternate Plan of Implementation as Recommended by Charles Thone, Governor of Nebraska, In Connection with Horacek and the United States v. Thone (D. Neb.). The report was prepared by a Review Committee appointed by the Department of Justice comprised of the following individuals:

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INTRODUCTION

Background

This report of the Review Committee, convened by the U.S. Department of Justice in connection with Horacek and the United States v. Thone (D. Neb.), is based on study of the following list of principal documents:

1. Consent Decree, October 31, 1975;
2. The Nebraska Mental Retardation Panel's Plan of Implementation, Sections I, II, and III, undated;
3. The Nebraska Mental Retardation Panel's Report of the Task Force on Manpower Development, January 16, 1979;
4. The Nebraska Mental Retardation Panel's Report on Costs, December 11, 1978;
5. The Amended Alternate Plan of Implementation as Recommended by Charles Thone, Governor of Nebraska, June 28, 1979;
6. Objections of United States to Governor's Proposed Alternate Plan of Implementation, July 18, 1979;
7. Three Year Plan of the Nebraska Mental Retardation Regions, draft composite report on individual regional plans, December, 1979.

Members of the Review Committee met twice to discuss the strengths and weaknesses of the Nebraska Mental Retardation Panel's Plan of Implementation and the Amended Alternate Plan of Implementation as Recommended by Charles Thone, Governor of Nebraska. At these meetings on November 14, 1979, and January 29, 1980, and based on numerous telephone conversations, the Review Committee reached agreement about what steps to recommend to the several parties with an interest in resolving the issues that impede implementation of the Consent Decree entered on October 31, 1975.

The chapters of this report generally follow the organization of the Nebraska Mental Retardation Panel's Plan of Implementation and the defendants' Amended Alternate Plan, wherever possible. Exceptions occur when topics of the aforementioned plans can be discussed more coherently together or certain topics that are considered essential to the formulation of an adequate plan of implementation are found entirely lacking in both the Panel's and the defendants' plans.

Each chapter of this report first sets forth what the Review Committee considers to be the content of a minimally acceptable plan of implementation in conection with a given topic and then: (a) critiques the defendants' Amended Alternate Plan; (b) offers suggestions, where applicable, for improvements of the Panel's Plan of Implementation (which the Review Committee found more closely approximating a minimally acceptable plan than the defendants' Amended Alternate Plan); and (c) presents the Review Committee's recommendations on how all parties to the Consent Decree ought to proceed to correct planning deficiencies.

The Review Committee adopted as its standard for a minimally acceptable plan of implementation what is considered the standard of prudent management in the public contracting environment. Government agencies usually require bidders on contract requests for proposals (RFPs) to demonstrate concretely in their proposals that they (1) understand the objectives of the procurement; (2) can specify the tasks that must be accomplished in order to meet the objectives according to a predetermined standard of quality, (3) can identify the kinds and mix of personnel that

must be recruited and assigned to each of the tasks to be accomplished, and (4) know how to organize and schedule resources to meet the objectives within the alloted time frame and budget constraint. The Review Committee has adopted this standard of public accountability because the Horacek Consent Decree represents a binding commitment and obligation on all parties to effectuate each of its provisions.

The Review Committee, in adopting this standard of prudent management, was mindful of the history of the Horacek action and the slight progress that has been made since the parties to the action entered into the Consent Decree on October 31, 1975. The Review Committee is of the opinion that broad statements of good intentions accompanied by vaguely outlined specifications of tasks, scheduling, and required resources are not conducive to the accomplishment of the objectives set forth in the Consent Decree.

The Review Committee believes that all parties to the Consent Decree need a concrete plan of implementation susceptible to public accountability. All parties should be able to ascertain at any point in time how implementation is progressing in connection with specific tasks and their scheduled accomplishment. To the extent that implementation is not progressing according to plan or schedule, who and what are impeding implementation should be readily discernible. An outline of the recommended contents of a plan of implementation, devised by the Review Committee, is included in Appendix 4 of this report.

Major Findings and Recommendations

General Findings

- The defendants' Amended Alternate Plan, in its current form, does not constitute a minimally acceptable plan of implementation pursuant to the Consent Decree because it is heavily qualified and evasive, lacks any affirmative commitment to resource development, and includes no specific timetable for action;

- By failing to adopt the community-based strategy embodied in the Panel's plan, the defendants commit themselves to a course of action that will ultimately be more expensive than the alternative;

- The Nebraska Mental Retardation Panel's Plan of Implementation, with some exceptions, includes most of the major ingredients that should comprise a minimally acceptable plan of implementation, including client assessments, manpower plans, and a comprehensive resource development strategy.

Specific Findings

- The defendants' plan is vaguely worded and therefore is not susceptible to public monitoring and accountability;

- The defendants' plan affirms principles of the Panel's plan but includes no assurances that concrete actions will be taken to carry them out;

- The defendants make no commitment to secure resources to support the development of community-based services;

- The defendants' "foundation principles" do not meet minimally acceptable standards for an implementation plan;

- In its current form, the defendants' plan is laced with loopholes that will conceivably support future rationalizations for inaction;

- The defendants have failed to specify a state-wide program plan for class members as a whole;

- Although the Panel has completed an assessment of class members for planning purposes, the defendants propose to conduct yet another assessment which will ultimately delay implementation and result in wasteful and duplicative use of resources available to the state of Nebraska;

- The defendants' plan focuses on multiple constraints to implementation and nowhere puts forth an affirmative plan for overcoming such obstacles;

- Interpretations of existing data on client characteristics in the defendants' plan are ambiguous and require further clarification;

- The defendants' plan for BSDC construction and renovation needs could justify indefinite infusion of capital funds into the institution without commitment to developing community-based alternatives;

- The defendants' plan includes no assurance that the state will provide support to CBMRs and generic agencies to assure the availability of services to class members;

- The defendants' plan makes no mention of the steps that must be taken to coordinate services for school-age class members in local school districts;

- The defendants' plan makes no provision for the return of school-age children to their normal or surrogate families;

- Neither the defendants' nor the Panel's plan speaks to the ways in which data from JET and IT evaluations will be integrated into a management information system necessary for intra-agency and inter-agency communication purposes;

- The defendants' plan includes no affirmative commitment to the development of resources for class members but rather makes placement of class members contingent on resource availability;

- The defendants' plan includes no provision for re-evaluation once class members have been placed in the community;

- The defendants' quality assurance discussion does not place sufficient weight on quality of life issues;

- No provision is made in either the defendants' or the Panel's plan regarding the funding required to secure external accreditation or the use to which accreditation reviews will be put;

- Neither plan contains an outline of a long-range evaluation of the deinstitutionalization activity contemplated in the Consent Decree;

- The Panel's manpower plan is thoughtful and responsive but is rejected by the defendants;

- Neither plan contains an adequate financial plan for the implementation of the Consent Decree;

- By failing to adopt the community-based strategy in the Panel's plan, the defendants risk unnecessary increases in state spending.

Specific Recommendations

- The implementation plan should include concrete objectives, task assignments, timetables, and projected resources necessary to carry out the activities in the Consent Decree;

- The final plan should include the statement of principles and goals proposed in the Panel's plan;

- The plan should identify gaps in services and should propose a strategy for developing resources to fill them;

- The plan should include a timetable for movement of BSDC residents, pursuant to the Consent Decree, and a commensurate strategy for resource development;

- Existing regional plans for resource identification and development should be included in the implementation plan;

- The final plan should draw together all relevant data from regional plans and integrate them into financial projections showing the average costs of maintaining individuals in both the institution and the community;

- Repairs and renovations at BSDC should not be made beyond the level absolutely necessary to meet the certification and accreditation requirements for a residential population of 250 persons;

- The plan should include the steps necessary to generate community resources and to upgrade the capabilities of the CBMRs and generic agencies to provide services to the class members;

- Clarification should be sought regarding what actions will be taken by the state to assure development of the necessary school programs for class members, and the creation of positive incentives for placement of school-age class members in normal or surrogate families where feasible;

- The plan should include the design of an integrated communication and management information system encompassing client flow, quality assurance, program development, and accountability information;

- The state should utilize information in the regional plans for resource development in advance of resident movement out of BSDC rather than making placement of class members contingent on resource availability;

- The plan should spell out how client transfers will take place, who is responsible at each juncture, time frames for movement, and necessary steps to be taken;

- The plan should include provision for re-evaluation of class members from 30 to 90 days after community placement;

- The parties should reach an agreement regarding the tools to be used for external accreditation and the use to which accreditation results will be put;

- Parties to the litigation should explore existing deinstitutionalization evaluation schemes in order to develop appropriate long-range evaluation procedures;

- The plan should include a comprehensive manpower training and development scheme;

- The state should develop a plan that specifies the fiscal impact of client movement; necessary changes in state laws; plans and policies needed to generate revenues; and alternative state and federal funding sources that can be utilized to implement the Consent Decree;

- The state should re-evaluate its general Medicaid Plan, and its Plan of Compliance for BSDC in particular, in light of the imperatives of the Consent Decree and changing federal policy.

CHAPTER 1

OVERALL STATEMENT OF GOALS AND FOUNDATION PRINCIPLES

In this chapter, the Review Committee sets forth in detail what, in view of the Consent Decree, a minimally acceptable plan of implementation should contain concerning a delineation of overall philosophy and specification of major goals and concrete objectives. The Review Committee then describes and critiques what the defendants did in comparison with the Nebraska Mental Retardation Panel, and offers its recommendations on how the parties to the Consent Decree should proceed in overcoming deficiencies in this area.

The Review Committee notes that the Consent Decree clearly articulates the following principles:

- Mentally retarded persons have the same constitutional rights as all other citizens;
- Mentally retarded persons have federal constitutional rights to adequate care and habilitation on an individual basis, directed to maximum opportunity to achieve normal living and coping with their environment;
- Mentally retarded persons have a right to be free from harm, and are entitled, as members of the class, to receive treatment designed to prevent regression;
- Members of the class have a right to receive adequate care and habilitation and to live free from harm in the setting which is least restrictive of their personal liberty (Par. 3a and b; Par. 4c and d).

The Review Committee, therefore, would expect a minimally acceptable plan of implementation to encompass, first, an overall statement of philosophy, expressing the plan's goal of securing the rights of individual class members in terms of the

Consent Decree and other major federal statutory protections including:

- Section 504 of the Rehabilitation Act of 1973 as amended (P.L. 93-112);
- Developmentally Disabled Assistance and Bill of Rights Act, as amended (P.L. 95-602);
- Education for All Handicapped Children Act (P.L. 94-142).

Second, the plan should stipulate that the major goals designed to assure these rights are:

- Improving care and achieving habilitation as well as adopting procedures for assuring client protection and well-being;
- Providing adequate environmental conditions with emphasis on resident privacy and dignity;
- Effectively using existing community-based programs and developing additional community-based programs in accordance with individually identified need;
- Involving clients, advocates, and parents and guardians (where appropriate) in decision-making.

Third, the plan should translate the goals into concrete objectives, including:

- Reducing the resident population at Beatrice State Developmenal Center (BSDC) in conformity with the provisions of the Consent Decree;
- Closing Hastings and Lincoln Regional Center units for the mentally retarded;
- Improving care and habilitation;
- Providing safe, sanitary, and normalizing environmental conditions;
- Developing and implementing procedures for protecting clients from abuse and neglect;
- Evaluating each class member's need and the readiness of the community programs to receive the class member;

- Assessing the effectiveness of the institutional and community-based programs in meeting individual class members' needs;

- Developing the capacity of the institutional and community-based programs to increase movement of class members into the community;

- Setting staff quantity and professional standards of performance in all residential facilities;

- Applying the aforementioned staff quantity and professional standards and instituting commensurate recruitment policies;

- Assessing the relevancy of staff training programs and providing the necessary training and supervision to all direct service workers;

- Securing accreditation of all facilities and programs;

- Implementing actual movement of individual class members into the community;

- Monitoring and overseeing the progress of class members after community placement and providing any additionally needed services;

- Developing appropriate local case management and an independent advocacy system to serve the specific needs of class members;

- Developing a visible and effective Consumer Advisory Board, as required by the Consent Decree;

- Complying with the terms of the Consent Decree in regard to the specified roles of the Nebraska Mental Retardation Panel and the defendants.

The defendants' Amended Alternate Plan only affirms the principles of the Consent Decree as goals to be sought, not as outcomes to be assured, and makes implementation contingent on the least restrictive alternatives becoming "reasonably available" without any clear commitment to make them available. Further, the defendants submit that the least restrictive

alternative may, in some instances, consist of continuing placement at BSDC or a similar public or private institution (p. 2). The Consent Decree, as far as the Review Committee can ascertain, makes no provision for transferring BSDC residents to other institutions.

The defendants' Amended Alternate Plan makes the right to adequate care and habilitation in an environment least restrictive of personal liberty contingent on the ability of the state of Nebraska to furnish the necessary resources (p. 12A) without any clear commitment to secure them. The defendants promise to undertake development of service systems capable of meeting each class member's individual habilitation requirements only insofar as reasonably possible (p. 52). Continuity of programs, comprehensiveness of programing, and meeting the special needs of individual class members are all reduced to contingencies dependent on reasonable possibilities of attainment and the availability of funds without commitment to obtain them, even though these goals are described as "foundation principles" in the Amended Alternate Plan (pp. 49-55).

These heavily conditioned statements of goals and principles, as well as the tone of the discussion at points, suggest the defendants' resistance to unqualified acceptance of the requirements of the Consent Decree, unless reinterpreted to permit the defendants to proceed as they see fit toward goals that they have redefined. The defendants' Amended Alternate Plan even suggests the impossibility of implementation in face of "the shortage of special medical, educational and related professional

services in the more rural areas ... notwithstanding the amounts of money available" (p. 3). In point of fact, the Nebraska Mental Retardation Panel has shown that shortage of special services in rural areas is not an issue. Two-thirds of the persons at BSDC reside in the Lincoln-Omaha area, and most of those from rural areas come from counties which have physicians or some form of regional health care coverage. What is more, the Panel has documented that the vast majority of BSDC residents have only routine medical needs.

Instead of stating unqualified commitment to an overall philosophy commensurate with the thrust of the Consent Decree and translating its principles into concrete objectives, as we would expect a minimally acceptable plan to do, the defendants set forth heavily conditioned "foundation principles," which suggest, in advance of any attempt to implement the Consent Decree, that the defendants are anticipating their own likelihood of failure.

Under the circumstances, the Review Committee must reject the defendants' overall statement of goals and foundation principles because they do not meet any of the known minimally acceptable standards for a plan of implementation. We must conclude that the defendants' "foundation principles" fail as a commitment to the agreements and obligations embodied in the Consent Decree. Whatever specific tasks and timetables are proposed by the defendants, they could--based on the conditional language in the defendants' statement--be dismissed at a later date because of the unavailability of funds or a host of intervening obstacles. The defendants have built into their plan

a series of loopholes that will provide numerous excuses for inaction in the future. The defendants' Amended Alternate Plan, in effect, undercuts the attempt of the Nebraska Mental Retardation Panel to articulate a set of goals, concrete objectives, and operational strategies embodying the principles of the Consent Decree which are susceptible to monitoring and enforcement.

The Review Committee, therefore, recommends that all parties adopt, as the point of departure for implementing the Consent Decree, the Nebraska Mental Retardation Panel's statement of overall goals and principles, together with their translation into specific service development guidelines. We further recommend that the parties to the Consent Decree amplify the Panel's statement in those places where gaps occur in relation to the elements which the Review Committee has identified as necessary in a minimally acceptable plan of implementation.

CHAPTER 2

SERVICE NEEDS OF PEOPLE AT BSDC, THE REGIONAL CENTERS, AND OF SCHOOL-AGE CHILDREN, GUIDELINES FOR MEETING SERVICE NEEDS, DEVELOPMENT OF COMMUNITY-BASED ALTERNATIVES, PROGRAM DESIGN ISSUES

In this chapter, the Review Committee indicates what a minimally acceptable plan of implementation should contain--again in greater detail than afforded by the outline in Appendix 4--if the provisions of the Consent Decree are to be met in a predictable and timely manner. Against this standard, the Review Committee then compares the Nebraska Mental Retardation Panel's Plan of Implementation and the defendants' Amended Alternative Plan and assesses the extent to which they meet the standard. The Review committee also states its concerns about matters which, if permitted to continue without correction, seem likely to obstruct implementation of the provisions of the Consent Decree, along with recommendations for their correction.

The Review Committee would expect a minimally acceptable plan of implementation to:

- Set guidelines for meeting service needs;
- Set forth a comprehensive program design to meet the multiple needs of all class members;
- Detail a systematic strategy to accomplish the ends of the plan;
- Include the entities responsible for particular activities;
- Include the timetables anticipated for accomplishment of each activity or task.

Because of the complexities entailed in any deinstitutionalization effort of the scope of Horacek, the Review Committee considers proper formulation of a transitional strategy particularly critical. It is within such a strategy that the state must address the diverse set of steps that must be taken in order to achieve the goals of the overall plan of implementation.

Comprehensive Assessment

A minimally acceptable plan of implementation should provide--at least in the aggregate--for a comprehensive assessment of individual service needs and incorporate the following types of information on which development of programs and services can be based in advance of the placement of specific individuals:

- Client residency or origins;
- Age and sex;
- Self-care functioning level;
- Medical needs;
- Behavioral adaptation/maladaptation;
- Type of residential and day program indicated for each client, based on the above five items, including client supportive service needs;
- Educational program needs, as defined by P.L. 94-142;
- Client eligibility for entitlements to relevant federal and state income maintenance, health, housing, social services, and vocational training and other educational programs.

Program Planning For The Class As A Whole

Based on the aggregation of service needs profiles developed from the aforementiond information, a minimally acceptable plan of implementation should lay out a state-wide program plan for

the class members as a whole. It should specify a timetable that establishes the rates of program development and movement of clients into the least restrictive environments commensurate with their service needs. The resultant state-wide plan should include:

1. Definition of the comprehensive service base (i.e., a composite resulting from analysis of client service needs and the programs/resources that currently exist);

2. Definition of the need for new program development, arising from the shortfall of programs/resources in relation to the comprehensive service base, as just defined; (New program development should be specified by physical location, type of physical plant and facilities, kind of service program, and resource requirements including personnel and funding.)

3. Analysis of any constraints to development of new programs, along with the actions required for their removal (e.g., how to obtain funding to meet the public school program needs where no appropriate program exists in the district of residency); (Where the defendants and/or regions are dependent on the voluntary cooperation of other sources of authority or funding, this dependency should be indicated together with the steps necessary to secure cooperation.)

4. Details concerning startup requirements, including site finding, securing of necessary zoning clearances, construction/renovation, advance hiring of staff and their training, meeting required accreditation and other standards, and the amount of seed money necessary to assure program readiness before actual placement of clients.

In relation to these elements of a minimally acceptable plan of implementation, the Review Committee finds the defendants' Amended Alternate Plan inadequate as to content and detail. The discussions concerning the service needs of people at BSDC, the needs of school-age children, guidelines for meeting service needs, development of community-based alternatives, and program

design issues are overly generalized and lacking in specificity. The discussions are further enunciations of principles rather than specifications of concrete performances within predetermined constraints of time and budget.

Nebraska Mental Retardation Panel's Approach

The Nebraska Mental Retardation Panel's Plan of Implementation, in contrast, has completed definition of the comprehensive service base (No. 1, above), partially completed the definition of the needs for new program development (No. 2), and identified several of the constraints to program development (No. 3) relating to public school accommodations, funding, and facility construction. The Panel has not as yet identified the actions required to remove constraints involving voluntary cooperation of other sources of authority, nor has it provided the necessary details concerning program startup requirements (No. 4).

The Review Committee, while wishing for greater specificity in places, could discern in the Panel's Plan of Implementation, both identification of the major necessary steps and the Panel's unqualified commitment to see actual movement of class members into community-based alternatives. The Panel asserted its belief that each community-based mental retardation (CBMR) program, and by implication every CBMR region, had the capability to develop the number and types of programs to meet the needs of the plaintiff class. The Panel promised to work closely with the CBMR regions between November 1978 and July 1979, to design specific programs and services for the class, and to use the

regional plans detailing client assessment and placement projections, program services, manpower requirements, and so forth, as the basis for future implementation efforts.

The Review Committee has reviewed a draft composite report on the individual regional plans as well as the specific plan of Region V. It is our considered judgment that these regional plans should be officially incorporated into the plan of implementation deemed acceptable to the plaintiff class and the United States. All areas of substance to effectuate implementation of the Consent Decree are found within the individual regional plans, with the possible exception of the need to clarify how high a priority is accorded by each plan to serving the class members. It is the Review Committee's opinion that one of the remaining questions regarding implementation of the Consent Decree is whether the state of Nebraska is committed to the support of the regional plans.

Last, consideration should be given by the Panel to rapid development of adequate emergency services in the community so as to eliminate further need for emergency admissions of class members to state institutions. In this regard, Panel definition of what constitutes an "emergency" and the "due process" procedures that will be applied when emergencies arise would strengthen its Plan of Implementation. The Review Committee is keenly aware of how easily the temporary solution in an emergency can become the final solution.

The Defendants' Approach

The defendants' Amended Alternate Plan interjects, as previously noted, numerous conditions on the commitment of the state of Nebraska's resources to the pursuit of the Panel's general outline of how to proceed to meet the terms of the Consent Decree. Indeed, the defendants' proposals in some instances argue against the validity of the Panel's suggested approach to implementation, or against the conclusions which the Panel draws from its assessment of the data it has collected on the class members and their circumstances.

For example, the defendants' Amended Alternate Plan promises that community-based mental retardation services--as soon as resources become available and as soon as reasonably possible--will be provided to class members, as revealed by the Joint Evaluation Team (JET) evaluation process (p. 5). This in effect denies the validity, for planning purposes, of the Panel's analyses of the CBMR Regions' overall resource requirements to accommodate class members. A personal evaluation of each class member has already been conducted which is adequate for general program planning purposes. The Panel's plan indicates that these evaluations were personal and that, based on interdisciplinary team records, it had conducted the kind of analysis necessary for projecting a service program development profile needed by each region to accommodate and plan for the service needs of the class as a whole. The Review Committee believes that a minimally acceptable implementation plan should provide details about the administrative mechanisms which the defendant would put into

place to assure quick transfer of class members from BSDC, requisite startup of needed community-based alternatives to accommodate them, and adequate, ongoing funding to support the effort.

Instead, the defendants promise to begin de novo a personal evaluation by the JET of each class member within 180 days of adoption by the Court of the Amended Plan and its standards. The Review Committee notes and agrees with the Objections of United States to Governor's Proposed Alternate Plan of Implementation in this regard. To accept the defendants' position of making no determination whatsoever about any class member until future JET evaluations take place is to disregard the substantial efforts of the Panel to determine how many might be placed into community-based alternatives and is tantamount to taking the position that planning for the class members must be done over again.

Service Needs of People Now at BSDC

The defendants accept the Consent Decree's specification of a residual population at BSDC only as a "speculative guideline," and proceed to condition their ultimate decision on what number will constitute a final residual population on a range of factors external to the premises of the Consent Decree. The defendants repeatedly mention the 66 individuals who have opted out of the class, implying that such individuals form another group beyond the 250 residual population who should remain at BSDC. No data are presented to support this supposition.

The defendants are apprehensive about "plans to create institutional-type programs at the local level as part of a chain

of progression toward a less restrictive environment," and thereby suggest that the Panel's recommendations are invalid. Again, no concrete data are presented to support the supposition. It is the responsibility of each client's interdisciplinary team, as prescribed by the Consent Decree, to assure that placement is made into the least restrictive and appropriate alternative in the community.

The guidelines in the Amended Alternate Plan for meeting the service needs of persons at BSDC everywhere mention the difficulties in meeting the performance mandates of the Consent Decree, but nowhere offer suggestions for overcoming these problems. Missing are concrete, positive suggestions about how to remove constraints by changing legislation, regulations and policies, developing improved technical assistance mechanisms, and the like. Further there is no discussion about the relative priority which the defendants give to implementation of the Consent Decree in the overall scheme of things. There is nowhere implied that implementation has any "special" character or affirmative action attached to it. The Review Committee believes that a minimally acceptable plan of implementation should state priorities, recognize constraints to accomplishment, and set forth the steps that may be necessary to overcome any and all impediments to successful implementation. It seems imperative that all parties to the Consent Decree cooperate in finding ways to remove identifiable constraints to implementation.

The defendants exclude 66 residents at BSDC from consideration for placement in a community-based alternative because such

residents or their guardians have opted out of the plaintiff class. The Review Committee believes that this is too hasty a conclusion, since it begs the question of the best interests of the 66 residents and exercise of "due process" to determine what are their best interests.

The defendants' overview discussion of overall needs of the residents at BSDC and the Regional Centers is ambiguous. The defendants' assertion that 21 persons (as opposed to 10 in the Panel's projections) are likely to have high medical needs (based on data showing that 100 persons required 25 or more days of acute care hospitalization in the past fiscal year) cannot be evaluated without knowledge of: (1) what sort of treatment constitutes "acute care hospitalization" within BSDC, and (2) whether the 100 compared to the 21 residents defined as having "high medical needs" received "acute care hospitalization" (by whatever definition) continuously or episodically and, if episodically, with what frequency. The defendants' assertions also do not take into account:

- Residents who may permanently reside in the infirmary unit, whom the defendants may consider to be acutely hospitalized;
- Medical problems commonly arising among institutional populations which lead to hospitalization;
- Increased hospitalization due to neglect and maltreatment.

The Review Committee believes that it will be to the interest of all parties to eliminate ambiguities and misunderstandings about what interpretation should be placed on the data which have already been collected by the Nebraska Mental Retar-

dation Panel. This can be accomplished in the course of implementing the Consent Decree without further delays. The Review Committee recommends that the parties draw together the data underlying the table describing the levels of need for support by region (Amended Alternate Plan, p. 17) and those contained in the tables (p. 98ff) and use them to estimate the average costs of maintaining a comprehensive system of services in each region compared with the average costs of maintaining a dual system of both community-based services and the BSDC and Regional Centers.

Without this kind of analysis concerning the average costs of maintaining a known mix of clients, the benefits which they would obtain from placement in alternative settings, and the time frame within which the benefits and the costs would accrue, discussions about "cost-effectiveness," "cost efficiency," and "prudent management," are essentially meaningless. So are promises to do the "cost-effective" or "cost-efficient" thing. In any event, the defendants' disagreement with a "constitutional right" requiring "every phase of every service to be available in every region notwithstanding the number of clients to be served, the cost of establishing and maintaining the program and the reasonable availability of professional personnel" (p. 18) has no basis. The Panel did not argue for this, nor is it implied by the Consent Decree.

The defendants discuss a general guideline for evaluating BSDC construction and renovation needs. This guideline, unfortunately, could justify the infusion of capital funds into

possible, throughout the State" (p. 21). If the defendants' views prevail, the exact number of BSDC residents will depend to a considerable extent on the defendants' administration of a fresh round of JET and IT evaluations, not on the Nebraska Mental Retardation Panel's overall assessment of the needs of the plaintiff class. What is more, the defendants' disclaimer that endorsement of a particular construction or renovation pattern does not constitute a recommendation that such a pattern be adopted on any long-term basis (pp. 22-23) runs counter to their ubiquitous qualification "subject to prudent management."

The Review Committee is chary of promises to undertake construction/renovation projects in institutions in process of deinstitutionalization. It understands too well the drive of managers in the name of "prudence" trying to extend the usable life of plant and equipment as long as possible. Only when reduced productivity reflected in a fall off of sales occurs in the competitive marketplace, or is anticipated to occur, does industry decide to upgrade plant and equipment or switch to more modern technology. But the state of Nebraska is not like competitive industry. It does not operate in any kind of competitive market for mental retardation services. Instead, the state is a monopolist and has no reason, except for Court pressure and/or the moral outrage of its citizens, to do anything different than what it has been doing for years for the plaintiff class. Accordingly, the Review Committee recommends that utmost circumspection be employed in permitting the defendant to spend for repairs and renovations beyond the level absolutely necessary

to meet the certification and accreditation requirements for the residual population of 250 residents at BSDC.

Community-Based Alternatives

The defendants' commitment to provide community-based programs for mentally retarded persons with severe emotional disorders and/or acute medical needs on a priority basis is qualified by the dictates of whatever financial plan is adopted by the state and by prudent management and economic feasibility. This triple qualification suggests to the Review Committee that the challenge of serving this group of BSDC residents in community-based alternatives will, in the end, receive low priority without close supervision by the Nebraska Mental Retardation Panel and the Court. Nowhere do the defendants identify the criteria and persons responsible for rendering judgments about financing, prudent management, and economic feasibility.

The Review Committee is convinced, after careful analysis, that the costs of not acting on the Nebraska Mental Retardation Panel's plan will exceed the costs of implementing the plan. The Panel's plan pursues a course of action which, by taking fullest advantage of federally-supported programs, will not only minimize net costs to Nebraska's state and local governments but also permit the plaintiff class to realize the benefits of living in the least restrictive care alternatives.

The defendants recommend that services available through generic agencies not be duplicated by the CBMR regions, but rather be assisted by CBMR regions to insure their capability of

serving mentally retarded persons. The defendants' Amended Alternate Plan, however, contains no content that affirmatively identifies any specific steps that the state of Nebraska will take to assure that either the CBMR or generic agencies actually develop the required program capability. If the challenge to programing in community-based alternatives is going to be greatest in relation to persons with severe emotional disorders and/or acute medical needs, the Amended Alternate Plan should describe what affirmative action the state of Nebraska would undertake to meet the challenge. This oversight, in conjunction with the many conditions which the defendants place on performance, indicates the need for clarification of what the defendants actually intend to do to upgrade the capabilities of the CBMR regions and the generic agencies to serve the more severely handicapped mentally retarded in community-based alternatives.

Services for School-Age Children

The defendants recommend that priority be placed on securing services for children and adolescents and that certain things be accomplished. Missing from the Amended Alternate Plan, however, are what actions and steps the defendants will take to coordinate the development of the necessary school programs. There is mention of the Governor's Placement Review Committee that will assume responsibility for recommending placement of BSDC residents into school districts, and so forth. But no mention is made about how this body will relate to, or share power with, the Joint Evaluation Teams (JET) or Interdisciplinary Teams (IT)

charged with assesing the needs of school-age children. The Review Committee recommends that clarification be obtained on what actions and steps the defendants intend to take to assure development of the necessary school programs for school-age class members.

The defendants' Amended Alternate Plan makes no provision for the return of children to their natural families or to surrogate families. This omission bears heavily on the development of appropriate educational services within the school districts. A minimally acceptable plan of implementation should specify strategies which indicate necessary actions and time frames for assuring that the school districts actually undertake development of appropriate educational services for school-age class members whose return to the school districts is planned.

The Amended Alternate Plan promises to undertake comprehensive examination of existing policies, laws and regulations that create "unreasonable" disincentives toward serving children at home and in local schools. The defendants acknowledge the Nebraska Mental Retardation Panel's examples of such disincentives, but show reluctance to grant their unqualified existence, referring to "such disincentives, if any," in their recommendation. There is no indication of who will undertake this study or within what time frame. The Review Committee recommends that the Nebraska Mental Retardation Panel's assessment of the disincentives to movement of school-age childen back into their school districts be accepted by all parties. Further, the defendants should make a positive commitment to remove such

distincentives through concrete actions within a specific time frame. One specific action that is within the realm of immediate possibility is to reallocate, with each child returned to his or her school district, a commensurate share of federal and state matching funds under P.L. 89-313 and Title XIX of the Social Security Act now being spent on education services within BSDC and the Regional Centers.

CHAPTER 3

INDIVIDUAL PLACEMENT, QUALITY ASSURANCE, PROGRAM EVALUATION

In this chapter, the process of individual assessment, quality assurance, and program evaluation as proposed by the Nebraska Mental Retardation Panel and the defendants are reviewed. The Review Committee believes that a minimally acceptable plan of implementation should stress the vital relationship between the processes of individual assessment and placement, quality assurance of the programs into which individuals are placed, and feedback to the Court and public at large of the benefits and costs of compliance with the Consent Decree.

A minimally acceptable plan of implementation should include design of an integrated communication system which permits coordination of the flow of client movement from BSDC and any planned movement from the Regional Centers into community-based alternatives and between community placement settings. The communication system should be related to projected program development in terms of:

- Anticipated number of client transfers;
- An overall time frame as well as accompanying benchmarks for deinstitutionalizing BSDC and for any planned movement from the Regional Centers;
- Anticipated movement among community-based settings.

The plan of implementation should also specify the design of a screening process for client selection, preparation, and the

setting of priorities for transfer of residents from BSDC and, for that matter, from any other institutional environments into the regional CBMR programs. This is ~~especially~~ critical because many clients will be at different stages of movement at the same time and because Regions V and VI face the influx of large numbers.

To sustain the aforementioned activities, the plan of implementation should further outline the design of a management information system capable of:

- Translating the results of client screening and program development profiles into monthly, bi-monthly, or quarterly placement projections of specifically named individuals;
- Tracking the actual execution of the various placement and case management responsibilities by personnel within the BSDC and CBMR program units throughout the state;
- Scheduling and documenting the results of quality assurance program reviews, as well as monitoring compliance with any required corrective actions that may be ordered both in the institution and in any of the programs serving class members;
- Documenting the contents of individualized programs for individual class members resulting from JET and IT reviews and their periodic revision, as well as certification that all precribed services are being rendered according to plan;
- Monitoring the functioning of advocates both in terms of initial assignments and their on-going performance;
- Tracking client progress and outcomes.

Finally a minimally acceptable plan of implementation should specify a long-range evaluation strategy that will assure periodic reports to the Court and other interested parties which

makes known:

- Agreed on evaluative criteria and procedures;
- Areas of compliance and non-compliance;
- Client progress;
- Comprehensiveness and adequacy of the services provided;
- Utilization of funding sources (federal, state, and local);
- Barriers to implementation and strategies for overcoming them;
- Plans for upgrading deficiencies, including projected manpower and financial resource requirements for doing so.

Both the Nebraska Mental Retardation Panel's Plan of Implementation and the defendants' Amended Alternate Plan make provision for joint evaluation and placement evaluations of class members by team effort, followed by continued re-evaluation of individuals by an interdisciplinary team as the basis for subsequent decisions concerning programing and placement, as well as for quality safeguards, systems review, and human rights monitoring. No explicit mention is made, however, of how the considerable data base, which will accumulate as the result of these activities, will be managed and used to coordinate actions throughout Nebraska.

To be sure, three types of evaluation processes, involving the Joint Commission on the Accreditation of Hospitals Accreditation Council on Facilities for the Mentally Retarded (JCAH/AC/MR-DD), self-administered agency reviews, state agency reviews, and consumer monitoring of human rights, are proposed. But unless these evaluation processes and the uses that will be

made of the information which they generate are carefully planned for in advance with the view to coordination of effort and management of the information to assure discharge of assumed responsibilities and promised performances, there is potential for considerable duplication, confusion, and waste. The Review Committee, therefore, recommends that the final plan of implementation which is adopted detail the steps, assigned responsibilities, and time frame for development of an integrated communication/management information system capable of sustaining client flow and movement, program development, quality assurance, and accountability reporting.

The Review Committee's more specific concerns about certain features of the defendants' Amended Alternate Plan in relation to these issues follow in the succeeding paragraphs.

Joint Evaluation and Placement Process

The Review Committee considers it inadvisable, as proposed in Amended Alternate Plan, to establish a mechanistic voting procedure within the JET or IT. The purpose of the JET and IT deliberations is to develop a picture of client needs based on the perceptions of both professionals and family members. If formal voting is instituted, the consensus building process would be impeded and unnecessary polarization fostered. Further, it seems highly inappropriate to make final decisions of the JET appealable to the state district court, as the defendants propose, given the jurisdiction of the federal court over the plaintiff class, and the Panel's responsibility pursuant to the Consent Decree to exercise full authority over placement

decisions. Finally, some form of hearing could surely be made the next step in the appeals process rather than making the court the first resort.

The defendants' proposed transition process matches clients to services that will be concurrently developed. The Review Committee believes that each CBMR region of Nebraska, within its recently formulated regional plan, has already assessed the number of class members who are to be transferred for placement therein. The defendants should be utilizing this information in advance to plan and implement the needed community programs rather than qualifying its commitment by making final approval for placement contingent on the availability of quality treatment and habilitation services in the community. This means getting on with the job of developing quality services, not waiting for others to make them available.

The actual matching of individuals with services and programs should be the primary responsibility of the region. The contribution of institutional staff should, of course, be sought in identifying the types of appropriate programs and services that are needed. Certification that the appropriate residential and day programs, together with supportive services, are available should occur within 30 days prior to actual placement. The Review Committee, therefore, recommends that the minimally acceptable plan of implementation adopted by the parties to the Consent Decree identify how transition will actually take place, who is to assume responsibility for carrying out whatever steps are entailed, and the time frame for doing so.

In addition, the Amended Alternate Plan establishes no standards for re-evaluation of individuals and programs. It would be inappropriate to allow an individual to be placed in either an institution or a community-based alternative for a year before undertaking re-evaluation. Better practice would permit only 30 to 90 days after initial placement to elapse for the first re-evaluation. After that, annual evaluations are appropriate.

Quality Assurance

The Amended Alternate Plan fails to specify what actions will be taken and by whom on the basis of the information gathered by the several proposed quality control systems. And while quality of life issues are to be addressed, a survey instrument must await July 1, 1980 before completion. The Review Committee does not consider these provisions of the Amended Alternate Plan to be sufficiently responsive. The Consent Decree itself identifies the quality of life issues that must be reviewed. What is needed is the designation of who will be held responsible for getting on with the job and within what time frame. The defendants' proposed procedure and time frame represents only a conditional commitment to produce a survey instrument to address quality of life issues, and suggests that no such issues may be found on the basis of a random sampling of consumers and direct service providers.

Both the Panel's Plan of Implementation and the defendants' Amended Alternate Plan propose using the JCAH/AC/MR-DD to conduct external program evaluations. This body ceased to exist in July,

1979. Although a new body is in process of development, for the time being Nebraska will have to find some interim alternative means of obtaining external evaluation of its mental retardation programs. Further, neither the Panel nor the defendants address the issue of who shall be responsible for paying for the accreditation surveys. Some advance provision should be made in view of the substantial sums that are involved. The Review Committee, therefore, recommends that the parties to the Consent Decree reach early agreement on the types of external evaluations they wish to have conducted as well as the uses to which these evaluations will be put.

Last, the Review Committee is concerned that the defendants' commitment to accreditation and quality safeguards may not be real. Making accreditation contingent on available financing and personnel availability suggests less than full commitment to external program evaluation. The Amended Alternate Plan, as just mentioned, does not budget for external program reviews nor does it, in general, specify how often the evaluation procedures will be applied, including the conduct of fiscal and management audits. The Review Committee recommends that such details be included in the minimally acceptable plan of implementation adopted by the parties to the Consent Decree.

Long-Range Evaluation Strategy

Since neither the Panel nor the defendants presented an outline for a long-range evaluation strategy, the Review Committee will confine itself to urging all parties to the Consent Decree to adopt such a strategy in order to avoid useless

and wasteful duplication of effort. We recommend that the parties review the types of information systems that have either already been developed or are in process of development in other places. There may be merit in at least adopting the logic, if not the actual system, that was developed to support deinstitutionalization efforts in Virginia.* An information system to evaluate the implementation of the court order in Halderman v. Pennhurst State School and Hospital (CA No. 74-1345; E.D. Pa. 3/17/78) is being constructed with the assistance of a federal contract. The procedures being employed by the Willowbrook Panel in NYARC and Parisi v. Carey (CA No. 72-356/357; E.D. N.Y.) may also provide useful ideas.

*The SID Reports: Executive Summary. Washington, DC: PROJECT SHARE, 1975. Available NTIS, PB-255 352-359, and SHARE, SHR-405, 722-728 and SHR-0000729-0000730.

CHAPTER 4

MANPOWER AND FINANCIAL RESOURCES

Manpower Issues

The Review Committee notes that the Amended Alternate Plan of the defendants apparently rejects the Nebraska Mental Retardation Panel's recommendations for development of a state-wide manpower model and its implementation. We have reviewed the Panel's Report of the Task Force on Manpower Development and find it a thoughtful approach to meeting the manpower needs of Nebraska in support of mental retardation service programs. Our only criticisms relate to the Panel's failure to provide cost estimates for the proposed undertaking and to offer details concerning in-service training programs directed to existing staff and future recruits. We recommend, therefore, that the parties to the Consent Decree clarify these matters as soon as possible in the implementation process.

Financing Issues

Neither the Nebraska Mental Retardation Panel nor the defendants offered a financial plan meeting minimally acceptable standards for such a plan, despite the fact that the materials for fashioning an acceptable plan were available in the Panel's background documents and in state of Nebraska memoranda. The Review Committee, therefore, undertook to draw up four simplified, yet detailed, alternate financial plans to show what could be expected as the result of inaction compared to a range of alternative courses of action.

Our analysis in summary, shows that the state of Nebraska, by not implementing a community-oriented program of the form called for by the Nebraska Mental Retardation Panel, is losing large amounts of money in federal reimbursements which could have been used to carry out the Consent Decree. Comparison of a "no-change" strategy (essentially projecting the costs of the current system into the future) with a strategy much like that proposed by the Panel indicates that the Panel's strategy will save the state of Nebraska and its localities more than $70 million between now and July 1, 1984. Even if the state moves to system change at the local level (emphasizing at that level Medicaid and other federal sources of reimbursement) but lowers bed occupancy at BSDC to only 472, as proposed in the state capital construction plan, the state would lose more than $45 million between now and July 1, 1984 in comparison with what could be achieved under the Panel's plan.

Under the circumstances, it seems clear to the Review Committee that adoption of a detailed, multi-year, community-oriented development plan to serve the needs of Nebraska's mentally retarded citizens (which reduces BSDC to the level specified by the Consent Decree of 250 well-staffed beds) would be fiscally superior to either the current state strategy or the one proposed in the current state construction plan.

Before proceeding with its analysis, the Review Committee wishes to indicate what should be contained in a minimally acceptable financial plan directed to implementation of the Consent Decree. Such a plan should include a clear statement of

the primary events which will generate predictable financial effects (i.e., the transfers of patients out of BSDC into community-based alternatives and the movement of new patients out of the population at risk into the institution or into the community-based alternatives), in terms of:

- How many transfers;
- How many of each kind (e.g., severe or profound, mobile or ambulatory, with or without behavior problems, etc.);
- Into what kinds of programs and services;
- In what areas of the state;
- Over what period of time.

The plan should also clearly state the intermediate effects (and their scheduled production) which will generate the predictable financial effects, including:

- Remodeling or construction in the institution and its costs;
- Staffing changes in the institution and their costs;
- New construction and new personnel training and recruitment needed for community-based alternatives and their costs;
- Effects of timing (i.e., inflation) on costs.

The financial plan should describe what changes are needed in the system, if any, to generate the revenues necessary to underwrite the expenditures required by the primary events and intermediate effects, including:

- Changes in the state's Medicaid Plan;
- Changes in uses of Social Security Disability Insurance or Supplemental Security Income revenues, and Section 110 Vocational Rehabilitation funds;

- Changes in state-local cost-sharing arrangements and tax levies;

- Changes needed in state categorical funding directed to providing an even flow of incentives toward achievement of desired goals (e.g., financing such that, the more normalized the placement setting, the less cost to each and every level of government and the better the possibility of support in the natural family);

- A description of alternative approaches to achieve the deinstitutionalization goals, together with multi-year budgets and details concerning estimated final gross costs, projected revenues by source, and the net costs of each of the alternative approaches. (For individual components of the care continuum, e.g., small community-based ICF-MRs, sheltered apartments, etc., there should be a detailed financing model encompassing the needed supply of each level of care.)

Neither of the plans developed by the Nebraska Mental Retardation Panel and the defendants meet the aforementioned criteria of a minimally acceptable financial plan. Both plans seemed content with general statements of intent. The Panel's plan is somewhat more specific in its recommendations than that of the defendants. The defendants' plan pledges general acceptance of the Panel's plan, but always with an escape clause hinging on the availability of funds and prudent business management.

Noteworthy is the omission from both plans of other materials which were available and on which the elements of a financial plan could be based.*

Using the materials that were omitted from the Panel's and the defendant's plans, the Review Committee developed a sample set of alternatives for financing mental retardation deinstitutionalization in the state of Nebraska. The examples are somewhat oversimplified insofar as they do not include detail on such important elements as construction costs, changing state-federal financing formulas, and the like. However, the examples do provide an exploration of defensible financial estimates that demonstrate the cost differences among the alternatives. They show that the state of Nebraska has been putting far more of its own money into the maintenance and growth of the current system than would have been necessary had it moved aggressively into a deinstitutionalization and community-based alternative strategy of the kind defined by the Consent Decree.

*These materials are found in the Panel's Report on Costs, December 11, 1978 and in a state DPI memorandum included as an appendix to the Nebraska Mental Retardation Panel's Facilities Report. In the first-mentioned document, the Panel used materials supplied by the state OMR to elaborate a four-year projected financing plan for BSDC, based on a multi-year plan for transferring people out of BSDC to meet the Consent Decree's bed occupancy goal of 250 by fiscal year 1982-1983. The second document, within the context of a capital construction report, proposes a different goal. The state of Nebraska proposes, as part of its compliance strategy for Title XIX funding of BSDC, to remodel BSDC over a four-year period to house a population of 472 persons. While the latter proposal does not meet the Court's 250-bed prescription, it does at least provide the minimum ingredients for elaborating a financial plan, when taken together with historic information on institutional and community-based alternative costs.

Costs of Pursuing the Alternative Strategies

We have attempted to follow Nebraska data closely in developing four hypothetical strategies and their fiscal consequences, so that we obtain a fairly realistic projection for Nebraska of gross costs, federal revenues, and the net costs of each alternative strategy.

The four alternative hypothetical strategies that we have selected are:

1. Do nothing. This means permitting the system to continue as it has been over the past six years. The analysis here is limited to a study of cost trends, especially state and local costs, on the assumption that things will continue for the next five years in roughly the same way that it has been moving over the last six. It assumes, for example, that the state will hold onto its Medicaid reimbursement for BSDC, but will not increase Medicaid reimbursements for community-based alternatives.

2. Follow the "Panel Plan." Here, the state is assumed to take action to move all but 250 residents out of BSDC in the next five years, and 200 new patients per year will come out of the population at risk to occupy places in the community-based alternatives. It is also assumed that Medicaid financing will continue for all residents remaining at BSDC in any year and will be extended into community-based alternatives.

3. Follow the "Defendants' Plan"--Version I. This approach assumes that 228 persons will move into the community over the next five years, leaving a residual population at BSDC of 472 persons. All other assumptions of the "Panel Plan" concerning financing are also maintained.

4. Follow the "Defendants' Plan"--Version II. This approach assumes the same resident movement as Version I, but assumes that all community development and financing are the same as in the "Panel Plan" and the "Defendant's Plan"--Version I, except that because the Medicaid Plan of Compliance is not met, Medicaid financing ceases for BSDC, effective July 1, 1980.

The results of our analysis of the fiscal effects of each of these alternative strategies are dramatic. Doing exactly what it

has been doing is by far the most expensive way for the state of Nebraska to proceed. In gross costs, it will cost only a few million dollars more per year than the other alternatives. However, because of the lack of Medicaid and other federal reimbursements to support a growing CBMR system, state and local costs (most of which would be borne by the state--see Table 2, which demonstrates that state net costs for MR-DD over the past six years have quadrupled, while local net costs have grown by less than 60 percent) can be expected to reach $171.321 million over the next five fiscal years. This course of action will prove to be 19 to 75 percent more expensive than the other alternatives, depending on which of the other alternatives is being compared.

The "Panel Plan," because it relies most heavily on community-based alternatives and least on BSDC, and makes maximum use of federal sources of support, has the smallest net costs to Nebraska taxpayers over the next five years--about $97 million (see Table 1). Because very little extra could be done in 1979-1980 to transfer people into federally supported community-based alternatives, lesser amounts of federal reimbursements were assumed for that year. In 1980-1981, with full movement into deinstitutionalization, the net cost to state and local governments of Nebraska is expected to decline to 70 percent of the high-year cost of $19.4 million in 1978-1979. While costs increase to $26.6 million in 1983-1984, it should be noted that, in "inflation-corrected" terms (see Table 10.D, column 1), the "Panel Plan" would assure that the net cost of the

MR-DD system to the state and local governments of Nebraska would stay below the 1978-1979 level for a considerable number of years into the future.

The "Defendants' Plan"--Version I, or our modeling of it, would cost about $3 million more than the "Panel Plan" over the five year period, simply because it would depend more heavily on the higher-cost BSDC.

The "Defendants' Plan"--Version II, aside from the "no change" alternative, is the most expensive of the alternative strategies. It will be about 50 percent more expensive, net, to the state and local governments of Nebraska than the "Panel Plan" over the next five years (about $143 million). What happens to net state and local expenditures when no Medicaid reimbursement is available for BSDC is the critical assumption for this alternative. The assumption is that all beds at BSDC would lose their Medicaid reimbursement, under the further assumption no beds at BSDC are now unconditionally certified or certifiable. The resultant loss of Medicaid reimbursement for BSDC would cost the state of Nebraska about $43 million over the five year period.

Table 1 presents the estimates for each of the four alternatives. Appendix 1 is a note on costs and their projection. Table 2 sets forth historical trends for state and local net costs for Nebraska MR-DD services. Table 3 presents the basis for a "no system change" projection of state and local costs for Nebraska MR-DD services. Table 4 gives the basis for assuming increases in BSDC costs, 1979-1983. Appendix 2 and

tables 5 to 10 provide calculations for the alternative strategies on the basis of their underlying assumptions. And Appendix 3 provides a final set of notes concerning assumptions, including technical notes.

Financial Issues Relating to BSDC

Issues of gross costs, revenues, and net costs were discussed above. But there are several major points to be made that highlight the relative contribution of BSDC to these costs of caring for Nebraska's mentally retarded citizens. First, the historic rate of cost escalation for BSDC has been high--about 18.5 percent annually per resident. This historic rate of cost increase is expected to continue because of the proposed staff-resident ratios that have been projected (see OMR data underlying the Nebraska Mental Retardation Panel's Report on Costs, December 11, 1978). This historic rate of cost increase has not been as high for CBMR programs.

Second, the net cost of serving the MR-DD population of the state of Nebraska that falls on state and local governments is a function of several factors: (a) the total number of persons for whom the public sector assumes responsibility; (b) the relative proportions who are served in BSDC and in the community-based alternatives; and (c) the ability of the state to obtain federal funding for a share of the cost burden of BSDC and the community-based alternatives.

Given that the number of persons for whom the public treasury will have to pay is predictable (i.e., an average increase of 200 persons annually) and something of a constant,

the most important factor determining net costs is the ability of the state of Nebraska to gain access to available federal funding for the community-based alternatives. After this, the next most important factor is the ability of the state of Nebraska to find federal financing for BSDC. Federal policy has been moving increasingly over the past 10 years toward funding smaller community-based facilities for mentally retarded people.

The situation of BSDC with respect to compliance with Medicaid regulations is somewhat problematic. In order to meet Medicaid standards, the state submitted a Plan of Compliance to the U.S. Department of Health, Education, and Welfare in January 1978. Staffing and construction changes that were to be made (assuming the need to make improvements to accommodate a census of 833 residents) have not been carried out, partially because of the Court's refusal to permit construction which would violate the terms of the Consent Decree. At present, planning for BSDC's future is tending toward the Nebraska Mental Retardation Panel's approach. However, despite the ostensibly close agreement on design for average capacity at BSDC, disagreement exists over the amount of maximum capacity that should be allowed. The state of Nebraska, apparently, wants to plan for a maximum capacity of 472 persons, while the Panel recommends a maximum of 250 residents in conformity with the Consent Decree.

The Plan of Compliance submitted by the state of Nebraska to the U.S. Department of Health, Education, and Welfare may be of questionable validity, given the constraints placed on the state by the Consent Decree. Meanwhile, the state continues to draw

federal Medicaid financing for a portion of the costs of maintaining BSDC. The Review Committee recommends that the state of Nebraska reconsider its Plan of Compliance and the impossiblity of meeting its terms in face of the Consent Decree. It makes sense for all of the parties concerned to reformulate the Plan of Compliance such that it is directed toward meeting the goals of the Consent Decree and the tendencies of regulations undergoing periodic revision by the U.S. Department of Health, Education, and Welfare. In a word, it is possible for the state to have a valid Plan of Compliance, but only if it is in harmony with the thrust of the Consent Decree and federal policy promoting care in the least restrictive alternatives.

Models for proceeding in this way are found in a number of places. New York and Michigan, for example, have negotiated Plans of Compliance which involve: (a) scheduled reduction of bed occupancy; (b) scheduled improvement of staffing for the remaining beds; and (c) scheduled remodeling of the remaining beds. Insofar as the U.S. Department of Health, Education, and Welfare continues to allow Medicaid payments for beds being used on an interim basis under the Plan of Compliance, those beds not scheduled for improvement or permanent use are receiving--at least on a temporary basis--a Medicaid bonus payment.

The Review Committee, therefore, recommends that the state of Nebraska re-evaluate its Plan of Compliance with the U.S. Department of Health, Education, and Welfare in light of the Consent Decree and the thrust of federal policy change. Acting on this recommendation will buy the state of Nebraska both the

time and resources needed to minimize the long-term net costs to the state and local governments. Proceeding in this fashion is consistent with economic rationality and, in the opinion of the Review Committee, the essence of prudent management.

Re-evaluating financing provisions to promote implementation of the Consent Decree will require skillful and competent attention over a long period of time by representatives of many state and local government agencies. It will, however, result in significant and long-lasting benefits to the mentally retarded citizens of the state of Nebraska.

APPENDIX 1: A Note on Costs and Their Projection

In making the above comparisons, we have depended heavily on net costs to the state and local governments. If we look only at gross costs, there are some differences between alternatives, but they are relatively small. However, when federal revenues are taken into consideration, then the differences between alternatives are magnified. In all but Tables 1 and 10, we have looked at Title XIX only. In Table 10, in order to have a full view of federal revenues, we included the approximately $6.5 million per year of Title XX which are now going to CBMR programs.

In order to estimate net costs to the state and to the local governments, we took the historic trend, averaged it (at 18.5% per year) and applied it to the succeeding four years (see Table 3). What is notable here (as shown in Table 2) is the very quick rise in the cost burden assumed by the state over the past years, when non-federal, non-local costs for BSDC and state appropriations for CBMR programs are looked at together. At the same time, the county and school board shares of the costs have remained almost stable for CBMR programs and have declined for BSDC. What is clear from these data, and the estimates for the approaches taken by the Panel and by the defendants under its Plan-I, is that the state and local governments are paying far more than need be.

In order to estimate BSDC costs, we took the historic trend,

averaged it (at 22% per case average annual increase) and applied it to the final four years of the series. The results are not far off from the estimates in the Nebraska Mental Retardation Panel's Report on Costs based on OMR data.

In making all other cost projections, we have assumed an inflation rate of 14%, based upon experience with community facilities in other states (see especially Table 6).

Table 1

Net State and Local Costs in Nebraska
MR-DD Under Four Alternatives

1978-79 through 1983-84
($ Millions)

Year	Alternatives (1) No System Change	(2) Panel Plan	(3) Defendants' Plan I	(4) Defendants' Plan II
1978-79	19.352	19.352	19.352	19.352
1979-80	23.712	18.302	18.302	18.302
1980-81	28.099	13.552	13.592	22.774
1981-82	33.297	17.352	17.692	27.350
1982-83	39.457	21.534	22.496	33.904
1983-84	46.756	26.661	28.405	40.586
Total Cost 1978-79 Through 1983-84	171.321	97.401	100.481	142.916

Table 2

Historical Trends in State and Local
Net Costs for Nebraska MR-DD*

	State Costs			Local Costs		
	BSDC	CBMR	Total	BSDC	CBMR	Total
1973-74	2.883	1.745	4.628	1.245	2.770	4.015
1974-75	2.723	2.533	5.256	1.123	4.380	5.503
1975-76	3.144	2.827	5.971	1.084	5.478	5.562
1976-77	4.076	4.658	8.734	1.000	4.887	5.887
1977-78	5.465	6.826	12.291	.885	4.779	5.664
1978-79	4.943	8.191	13.134	.830	5.814	6.644
1979-80	7.494	9.264	17.022	.777	5.913	6.690

*For BSDC and CBMR programs only. Hastings, Lincoln and Central Office figures not included.

Table 3

Basis for a "No System Change" Projection* of State and Local Costs in Nebraska MR-DD**

Historical Trend and Projections
($ Millions)

		Percent Change Over Previous Year	
1973-74	8.643		
1974-75	10.759	24	
1975-76	11.533	7	
1976-77	14.621	27	
1977-78	17.955	23	Average Annual Increase: 18.5%
1978-79	19.352	8	
1979-80	23.712	23	
1980-81	28.099		
1981-82	33.297		
1982-83	39.457		
1983-84	46.756		

* 1973-74 through 1978-79: Actual costs
1979-80: Budgeted costs
1980-81: Projected costs, assuming annual 18.5% increase in each year, over previous year
**BSDC and CBMR program net costs to both state and local governments

Table 4

BSDC Annual Cost Assumption Basis

	Cost per Patient	Percent Increase per Year per patient	
1973	6,009	20	
1974	7,229	28	
1975	9,279	22	
1976	11,358	9	22% per case average annual increase
1977	12,383	26	
1978	15,593	25	
1979	19,542		
1980	23,841		
1981	29,086		
1982	35,485		
1983	43,292		

APPENDIX 2: Calculation Tables for the Alternatives

For each of the alternatives other than the "no change" alternative, the following method was used:

1. A set number of transfers into the community was assumed, from BSDC, for each year. Assuming uniform movement across the year, the average for the year was assumed to be the number in the category (BSDC, ICF/MRs, etc.) at midyear. No new admissions were assumed for BSDC, nor any deaths. (See Table 5.)

2. The transfers out of BSDC were not assumed to be in any specific category (e.g., ICF/MR, non-medical supervised living, home care). The only assumptions made were that their care cost would be almost double, on the average, the average cost of care of "old" CBMR cases and new accessions to CBMR programs out of the community. (See Table 5.)

3. All CBMR cases were assumed to be in a 25:25:50 split between ICF/MR, non-medical supervised living, and independent living and home care support, respectively. All new accessions from the community (a net annual amount of 200, coming in uniformly across the year) were assumed to have the same proportions. (See Table 5.)

4. With the numbers set for each category of care, for each alternative (Panel Plan and Defendants' Plan), the projected annual costs were developed (See Table 6), using historic costs and trends, when possible, to define a percentage increase in per patient annual costs.

5. The numbers of clients in each category, in each year, were multiplied by the costs in each category, in each year, thus generating gross costs in each category (the first subtable in Tables 7, 8, and 9).

6. Revenue assumptions on reimbursements from Title XIX and other sources were applied to the gross costs in every year and category, in Tables 7, 8, and 9. The assumptions: BSDC-57% return; BSDC community transfers-57%; ICF/MR-57%; Non-medical supervised living-75%; IL, home care and other-35%. The results are in the revenue subtables of Tables 7, 8, and 9.

7. Net costs. For each of Tables 7, 8, and 9, revenues for each year and alternative were subtracted from gross costs. The result was a net cost amount for each alternative and year.

8. A summary comparison of operating costs could now be made of each of the three fully-costed alternatives (Panel Plan, Defendants' Plan-I, Defendants' Plan-II), in Table 10. The gross costs were summed from Tables 8, 9, and 10, across patient categories to arrive at a gross cost for each alternative in each year (Table 10. A). The same operation was carried out for revenues, but Title XX revenues ($6.5 million per year) were added on, for each alternative and year (Table 10.B). The result was Table 10.C, Net State and Local Costs. In order to put the annual costs in perspective, they were corrected for inflation, using a deflator assumption of 10% annual general inflation, for each year considered, and putting the costs in terms of 1978-79 dollars (Table 10.D).

9. For the "no change" alternative, a simple historic cost trend assumption was applied to state and local costs in 1979-80. The 18.5% historic average annual rate of increase in MR-DD state and local costs was applied to state and local costs, thus generating the "no system change" net state and local costs column (Column 1 in Table 1). This provided a basis for comparing a "do nothing different" (from what is now being done) strategy with the other strategies. It is assumed that the gross cost of this strategy would be greater than the gross cost of the next most costly strategy (because of the greater reliance upon the more expensive BSDC beds), but no calculation of that cost was made. It was also assumed (probably unrealistically) that federal Title XIX dollars would continue to be available for BSDC in this alternative -- so that the state and local net cost estimate for this alternative is probably somewhat low.

Table 5

Numbers of Clients in Each Category at Midyear, 1979-80 through 1984-84

	1979-80	1980-81	1981-82	1982-83	1983-84
A. BSDC Patients					
1) Panel Plan	710	620	475	325	250
2) Defendants' Plan	710	644	557	492	472
B. CBMR Cases					
1) Transfers from BSDC (cumulative)					
a) Panel's Plan	18	108	253	403	478
b) Defendants' Plan	18	84	171	236	256
2) ICF/MR	625	675	725	775	825
3) Non-Med. Supr'd Living	625	675	725	775	825
4) IL, Home Care Support, and Other	1250	1350	1450	1550	1650
Total CBMR Cases					
1) Panel Plan	2518	2808	3153	3503	3778
2) Defendants' Plan	2518	2784	3071	3336	3556

Table 6

Projected Annual Unit Costs for Each Significant
Client Subgroup, 1979-1984
(mid-year averages)

	1979-80	1980-81	1981-82	1982-83	1983-84
BSDC[1]	20,438	24,934	30,420	37,112	45,277
BSDC Transfers into community[2, 3]	16,000	18,240	20,794	23,704	27,023
"Old" Community[2] Cases & New Accessions from Community					
a) ICF/MR	14,000	15,960	18,194	20,742	23,645
b) Non-Medical Supr'd. Living	10,000	11,400	12,996	14,815	16,890
c) Independent Living and Home Care Support	6,000	6,840	7,798	8,889	10,134

1 Assumes historic 22% per year per patient increase
2 Assumes 14% per year per patient increase
3 Assumes higher average cost for current and future transfers from BSDC to community

Table 7

BSDC Costs

Gross Costs ($ Millions)

	Panel Plan	Defendants' Plan
1979-80	14.511	14.511
1980-81	15.459	16.057
1981-82	14.450	16.944
1982-83	12.061	18.259
1983-84	11.319	21.371

Revenues from Title XIX and other sources

	Panel's Plan	Defendants' Plan with deficiency waiver	Defendants' Plan without deficiency waiver
1979-80	8.271	8.271	8.271
1980-81	8.812	9.152	-----
1981-82	8.237	9.658	-----
1982-83	6.875	10.408	-----
1983-84	6.452	12.181	-----

Net Costs

	Panel's Plan	Defendants' Plan with deficiency waiver	Defendants' Plan without deficiency waiver
1979-80	6.240	6.240	6.240
1980-81	6.647	6.905	16.057
1981-82	6.213	7.286	16.944
1982-83	5.186	7.851	18.259
1983-84	4.857	9.190	21.371

Table 8

BSDC Transfers Into Community Costs

Gross Costs ($ Millions)

	Panel Plan	Defendants' Plan
1979-80	.144	.144
1980-81	1.970	1.532
1981-82	5.261	3.556
1982-83	9.553	5.594
1983-84	12.917	6.918

	Revenues from Title XIX		Net Costs		
	Panel Plan	Defendants' Plan		Panel Plan	Defendants' Plan
1979-80	.082	.082	1979-80	.062	.062
1980-81	1.123	.873	1980-81	.847	.659
1981-82	2.999	2.027	1981-82	2.262	1.529
1982-83	5.445	3.189	1982-83	4.108	2.405
1983-84	7.363	3.943	1983-84	5.554	2.975

Table 9

CBMR Costs ("Old Cases") and New Accessions Out of the Community

Gross Costs

	ICF/MR (57)	Non-Medical (75)	IL and Other (35)	Total
1979-80	8.750	6.250	7.500	22.500
1980-81	10.773	7.695	9.234	27.702
1981-82	13.191	9.422	11.307	33.920
1982-83	16.075	11.482	13.780	41.337
1983-84	19.507	13.934	16.721	50.162

	Revenues from Title XIX				Net Costs				
	ICF/MR	Non-Medical	IL & Other	Total		ICF/MR	Non-Medical	IL & Other	Total
1979-80	2.000	1.000	1.000	4.000	1979-80	6.750	5.250	6.500	18.500
1980-81	6.141	5.771	3.232	15.144	1980-81	4.632	1.924	6.002	12.558
1981-82	7.519	7.067	3.957	18.543	1981-82	5.672	2.355	7.350	15.377
1982-83	9.163	8.612	4.822	22.597	1982-83	6.912	2.870	8.958	18.740
1983-84	11.119	10.451	5.852	27.422	1983-84	8.388	3.483	10.869	22.740

Table 10

Comparison of Operating Costs of Three Plans: (1) Panel Plan; (2) Defendants' Plan with Deficiency Waiver from DHEW; (3) Defendants' Plan Without Deficiency Waiver, 1979-80 through 1983-84

A. Gross Costs ($ Millions)

	(1)	(2)	(3)
1978-79	33.700	33.700	33.700
1979-80	37.155	37.155	37.155
1980-81	45.131	45.291	45.291
1981-82	53.631	54.420	54.420
1982-83	62.951	65.190	65.190
1983-84	74.398	78.451	78.451

B. Federal Revenues (Title XIX and XX)

	(1)	(2)	(3)
1978-79	14.348	14.348	14.348
1979-80	18.853	18.853	18.853
1980-81	31.579	31.669	22.517
1981-82	36.279	36.728	27.070
1982-83	41.417	42.694	32.286
1983-84	47.737	50.046	37.865

C. Net State and Local Costs

	(1)	(2)	(3)
1978-79	19.352	19.352	19.352
1979-80	18.302	18.302	18.302
1980-81	13.552	13.592	22.774
1981-82	17.352	17.692	27.350
1982-83	21.534	22.496	32.904
1983-84	26.661	28.405	40.586

D. Inflation-Corrected Net State and Local Costs*

	(1)	(2)	(3)
1978-79	19.352	19.352	19.352
1979-80	16.638	16.638	16.638
1980-81	11.200	11.233	18.821
1981-82	13.037	13.292	20.548
1982-83	14.586	15.366	22.475
1983-84	16.549	17.632	25.193

*Assumes 10% annual general inflation from 1979-80 through 1983-84

APPENDIX 3: Assumptions and Technical Notes

1. Costs of current community ICF/MR, Hasting, Lincoln, and Central Office were not included in calculations.

2. Rates of cost increase assumed were:

   a. BSDC: 22% per year per patient
   b. All Other: 14% per year per patient or client
   c. General Inflation: 10% per year

3. Actual vs. Projected. Actual data were used for 1978-79 and previous years. Appropriation data were used for 1979-80, except for last quarter of FY 79-80, where a "slow start" assumption was used for new community revenues.

4. Revenue tables involve Title XIX reimbursements only, except for Tables 1 and 10, which involve Title XIX and Title XX reimbursements.

5. Construction and remodeling costs for BSDC were not included in calculations; construction costs for new community facilities were not included. (It should be noted, however, that under a bond issue/sale-leaseback model, with projected reimbursements, they are essentially self-financing.)

6. Reimbursement levels

   a. BSDC: 57% Title XIX reimbursement was assumed for all costs.
   b. BSDC transfers: 57% Title XIX reimbursement was assumed for all transfers from BSDC into community.
   c. ICF/MR in community: 57% Title XIX reimbursement was assumed for both residential and associated programs and services (e.g., workshop, day activity centers, transport).
   d. Non-medical supervised living facilities: 75% federal sharing was assumed from Title XIX for staff, HUD Sec. 8, SSI, and Food Stamps.
   e. Independent living, home care, and other: 35% return of total cost from Title XIX was assumed.

7. Assumed Medicaid reimbursement for BSDC and community Medicaid funding were as follows:

	Alternative			
	No Change	Panel	Defendants' Plan I	Defendants' Plan II
Medicaid Reimbursement at BSDC	Yes	Yes New Waiver	Yes Current Waiver	No
Medicaid Reimbursement For Community Services	No	Yes	Yes	Yes

8. Assumed Community Services Usage: Approximately one-fourth of all CBMR cases would receive services through ICF/MR at a 1979-80 price of $14,000 per patient per year; one-fourth would receive services in non-medical supervised living facilities, at a 1979-80 price of $10,000 per year; and one-half would receive care at a 1979-80 price of $6,000 per year, in independent living, home care, and related services. A last category -- transfers from BSDC to the community -- would receive care at an average cost of $16,000 per year in 1979-80, given their lower average functioning level. The partitioning of the first three categories is done in proportion, and at prices, that when averaged, equal the average projected 1979-80 per-case cost for the entire CBMR system for that year -- $9,000.

APPENDIX 4: Outline of Implementation Plan

To guide its examination of the Nebraska Mental Retardation Panel's and the defendents' plans, the Review Committee developed an outline of the premises and tasks which should comprise a minimally acceptable plan of implementation responsive to the provisions of the Consent Decree. We believe that such a plan should encompass the topics, if not the ordering of the following outline of required premises and tasks:

I. OVERALL PHILOSOPHY AND LEGAL BASIS FOR ACTION

A. Consent Decree Principles

1. Mentally retarded persons have the same constitutional rights as all other citizens;

2. Mentally retarded persons have constitutional rights to adequate care and habilitation on an individualized basis, directed to maximum opportunity to achieve normal living and coping with their environment;

3. Mentally retarded persons have a right to be free from harm, and are entitled to receive treatment designed to prevent regression;

4. Mentally retarded persons have a right to live free from harm in the setting which is least restrictive of their personal liberty consonant with their capability;

B. Federal Statutory Rights

1. Section 504 of the Rehabilitation Act of 1973, as amended (P.L. 93-112);

2. Developmentally Disabled Assistance and Bill of Rights Act (P.L. 94-103);

3. Education for All Handicapped Children Act (P.L. 94-142).

C. Translation of Principles and Legal Rights into Concrete Objectives and Outcomes:

1. Improve care and habilitation by developing procedures for assuring client safety, protection and well-being;

2. Improve environmental conditions with emphasis on resident privacy and dignity;

3. Make effective use of existing community-based programs and develop additional community-based programs to meet the needs of each class member;

4. Involve clients, advocates, and parents and guardians (where appropriate) in decision-making;

5. Reduce the resident population at Beatrice State Developmental Center (BSDC) to the number specified in the Consent Decree;

6. Close Hastings and Lincoln Regional Center MR units;

7. Evaluate each class member's need and readiness for community programs and follow each class member's progress over time;

8. Assess the adequacy of the institutional and community-based programs and make improvements when needed;

9. Secure accreditation of all facilities and programs;

10. Develop a Consumer Advisory Board.

II. DETERMINATION OF PROGRAM REQUIREMENTS

A. Assess the Individual Service Needs and Client Characteristics of Each Class Member

B. Ascertain the Comprehensive Service Base Needs by Aggregrating the Individual Service Needs (See II A above) by Type of Service Needed and by Type of Clients

C. Identify Existing Service Resources and Capabilities

D. Identify Gaps Between Service Needs (See II B above) and Service Resources (See II C above) by Type of Service and by Type of Client

E. Identify Organizational and Administrative Resources for Remedying Existing Service Gaps, Constraints, and Inadequacy of Existing Services

F. Develop Cost Estimates Necessary to Fill Services Gaps and Identify Funding Sources to be Used in Filling Service Gaps

G. Identify and Specify Manpower Requirements Needed to Operate Program (Including Redeployment of State Employees, as Well as Redeployment of Personnel Within the Institution to Correspond with Outward Movement of Residents and Employees)

III. DEVELOPMENT OF A TRANSITIONAL STRATEGY

A. Delineate Specific Role Responsibilities and Tasks of Principal Agents and Agencies

B. Develop Time Lines

C. Identify Start-up/Seed Money for Initiation of Services

D. Specify Auditing, Evaluation, and Monitoring Tasks and Responsibilities

E. Specify Ombudsman/Advocacy Entity for Class Members

F. Identify Assistance for Generic Service Providers (at Regional Level)

G. Delineate Physical Program Location and Match with Existing Resource Availability

H. Specify Training Programs (Timing, Auspices, Content, Students)

I. Specify Relative Funding Responsibilities and Level of Effort

J. State Implications of Educational Plans and Identify Sources of Funding

IV. DEVELOP STRATEGY FOR PROCESSING INDIVIDUAL CLIENTS

A. Match Individual Assessments with Existing Resources -- What is Required with What is Available -- to Ascertain if and When the Client can be Moved

B. Specify Transfer Rules, Timing, Authorization, etc. (e.g., JET Process Results as Trigger for Placement Through Appointment of Case Manager)

C. Specify Monitoring and Oversight Function Once the

Individual is Placed (e.g., Case Manager Following and Reporting)

V. FORMULATION OF LONG-RANGE EVALUATION STRATEGY

A. Ascertain Areas of Compliance and Non-compliance

B. Specify Expected Client Outcomes

C. Identify Funding Sources to be Utilized

D. Capture Costs/Benefits of the Program

E. Describe Adequacy of the Service Continuum

IV. DEVELOPMENT OF PLAN FOR BEATRICE STATE DEVELOPMENTAL CENTER AND REGIONAL CENTERS

A. Identify Transitional Programing Needs

B. Project Residual and Fluid Population

C. Develop Transitional Staffing Requirements

D. Specify Resident Protections Needed

E. Delineate Construction/Modification/Closure Projections and Timing

F. Specify Strategy to be Used for Shifting Institutional Resources (Dollars and Personnel) to the Community

G. Develop Educational Plans and Identify Sources of Funding

VII. DEVELOPMENT OF AN OVERALL FINANCIAL PLAN

A. Estimate Fiscal Impact of Desired Program Changes (e.g., Reallocation of Institutional Educational Funding)

B. Develop Multi-year Projections Based on Client Movement Targets

C. Integrate Budgets for Transition to Community

D. List Expenditures and Revenues for Total System (by Source)

E. Derive Net Cost Comparisons for Alternate Strategies (Status Quo v. Reform)

F. Reorganize Incentive/Disincentive Funding Effects (e.g., Funding for Support in Natural Family)

G. Develop Financing Models for Individual Components of the Comprehensive Continuum (e.g., ICF/MR, Sheltered Apartment, etc.).