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HUMAN RESOURCES
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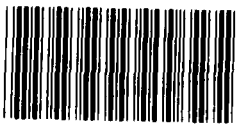

The Honorable Richard S. Schweiker
The Secretary of Health and Human Services

Dear Mr. Secretary:

Subject: Need to Establish Standards That Must Be Met Before Intermediate Care Facilities for the Mentally Retarded Can Obtain Medicaid Reimbursement (HRD-82-57)

We recently looked at the growth of small, community-based intermediate care facilities for the mentally retarded (ICFs/MR). States in certain circumstances can temporarily waive compliance with Federal ICF/MR standards and can certify for Medicaid reimbursement ICFs/MR which do not meet all the standards. With few exceptions, the 150 ICFs/MR having 15 clients or fewer initially certified by New York State had major deficiencies. Health Care Financing Administration (HCFA) Region II officials found that, when the State recertified these facilities, 67 still had major deficiencies, according to HCFA.

HCFA is attempting to recover about $7 million of Federal Medicaid funds which it believes were inappropriately provided to the 67 facilities since their initial certification. So that Federal funds will be disbursed only to New York ICFs/MR, which meet program standards for adequate care, HCFA Region II and New York State officials have agreed that in the future ICFs/MR will not receive State Medicaid certification unless they meet at least 13 specific standards. (See enc. I.)

The HCFA Region II agreement with New York State represents an attempt to assure that ICFs/MR meet basic and essential requirements. However, since HCFA has the responsibility for assuring that all States apply appropriate certification standards, we believe HCFA should establish which of the current 116 ICF/MR standards cannot be waived and must be met before any State can certify facilities as eligible for Medicaid reimbursement. Such guidance would assist States in certifying new facilities and HCFA regional offices in reviewing the adequacy of State certification programs.

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OBJECTIVES, SCOPE, AND METHODOLOGY

We initiated our review of small ICFs/MR because of concerns about the growing numbers of such facilities being certified for participation in Medicaid and rapidly rising associated Federal costs. While only a few States now have an ICF/MR program which supports small facilities, other States are also considering the establishment of such facilities as a method for upgrading health and rehabilitative services for the mentally retarded.

Our examination was conducted primarily in New York State because it has the largest number of small ICFs/MR and has also converted a significant number of group homes to ICF/MR status. We reviewed Federal and State laws, regulations, and data and interviewed State officials, representatives of public interest groups, and officials of organizations which operate nine small ICFs/MR in New York. We also made observations, interviewed officials, and reviewed records at two ICFs/MR.

Work was also performed at the Department of Health and Human Services (HHS), Washington, D.C.; HCFA Region II offices in New York City; and HCFA headquarters in Baltimore, Maryland. Additional interviews were held with officials of two other HCFA regional offices and officials from Minnesota and Texas. Our work was performed in accordance with GAO's current "Standards for Audit of Governmental Organizations, Programs, Activities, and Functions."

BACKGROUND ON ICFs/MR

The ICF/MR benefit was added to Medicaid (title XIX) as part of the 1971 amendments (Public Law 92-223) to the Social Security Act. Medicaid funds are now the largest single source of Federal aid for State mental retardation programs. HHS reported that Federal and State governments spent $1.3 billion for ICF/MR services in fiscal year 1978 and estimates that $2.7 billion was spent in fiscal year 1981.

One reason the Congress authorized the use of Medicaid funds for ICFs/MR was to encourage States to improve the quality of care for the mentally retarded by requiring active programs of health-related treatment or rehabilitation in such facilities. Currently, there are over 500 ICFs/MR with more than 15 clients. About one-half are State operated. States were also authorized to use Medicaid funds for small facilities serving 15 or fewer clients. Almost 600 small facilities have been established, primarily in New York, Minnesota, and Texas. Together, large and small ICFs/MR were serving almost 117,000 Medicaid recipients as of June 1981.

ICFs/MR WHICH DID NOT MEET STANDARDS FOR ADEQUATE CARE WERE CERTIFIED

Section 1905 of the Social Security Act authorizes Medicaid payments for services in an ICF/MR if (1) its primary purpose is to provide health or rehabilitative services for mentally retarded individuals, (2) it meets standards prescribed by HHS, and (3) individuals in the facility are receiving active treatment.

HHS regulations (42 CFR 442, subpart G) establish about 116 individual standards which ICFs/MR must meet including standards related to health, safety, and adequate care. Active treatment is considered to be part of adequate care in an ICF/MR. HHS regulations require that to provide such treatment an interdisciplinary team, consisting of individuals representative of the professions or service areas that are relevant in each particular case, must

--evaluate each resident's needs,

--plan an individualized habilitation program to meet each resident's needs, and

--periodically review how each resident responds to his or her program and revise it accordingly.

By law, HHS delegates to State survey agencies the responsibility for determining whether ICFs/MR meet program requirements. During a State survey a facility must undergo a review based on the 116 standards. ICFs/MR that comply with these requirements are certified as eligible for Medicaid reimbursement. Facilities can be initially certified even though they have some deficiencies as long as:

> "* * * the facilities' deficiencies, individually or in combination, do not jeopardize the patient's health and safety, nor seriously limit the facility's capacity to give adequate care." [42 CFR 442.105(a)]

ICFs/MR certified with deficiencies must have a corrective action plan, and the State survey agency is generally responsible for followup within 12 months to assure that corrective action is taken. Federal financial participation may be denied for services provided by an ICF/MR if HCFA determines that a State survey agency failed to apply the applicable certification standards. However, the regulations do not define which services, if deficient, would limit a facility's capacity to give adequate care.

In July 1981, HCFA Region II provided New York State with the results of its analysis of the State's certification and recertification reviews of small ICFs/MR. In his July 22, 1981, letter, the Region II Associate Regional Administrator, Division of Health Standards and Quality, said that the analysis measured, in part, compliance of 150 facilities with three "basic and essential" regulatory requirements related to active treatment which Region II considered prerequisite to the proper certification of an ICF/MR operation. They were:

--The ICF/MR must have available to direct care staff in each living unit, a specific evaluation and program plan for each resident, and these plans must be reviewed by the interdisciplinary team at least monthly.

--The ICF/MR must provide professional and special programs and services beyond custodial care based on residents' needs.

--The ICF/MR must (1) have written training and habilitation objectives for each resident and (2) provide evidence of services designed to meet those objectives.

The Associate Administrator said that, "Any one of these being not met would render a facility incapable of providing needed services in an acceptable manner."

The analysis showed that, with few exceptions, the 150 New York facilities were initially certified with deficiencies in at least one of the three critical requirements. Sixty-seven of these facilities continued to have deficiencies in at least one of these areas after recertification a year later. Furthermore, each of the 67 was also deficient in "a considerable number of other operational aspects."

The Associate Regional Administrator's letter said:

"It is not uncommon that an initial survey will find deficiencies and that a provider is accepted in the program with a responsible plan of correction. When such surveys are conducted on a pre-opening basis, the deficiencies usually have no immediate impact on patients or residents; however when those deficiencies are found on subsequent surveys, they may have a direct and potentially harmful affect on the facility's population. Moreover, requisite services are not being provided and the justification for any form of Federal reimbursement ceases to exist."

To be recertified, a facility is required by regulation to have corrected satisfactorily all deficiencies, demonstrated "substantial progress" in correcting deficiencies, or shown that a lack of progress was not the facility's fault. HHS regulations allow termination of provider agreements by State certification agencies based on recurring deficiencies. The regulations, however, do not define when a facility's capacity to give adequate care is seriously limited or provide adequate guidance as to when a State should deny initial certification because a facility is considered to be not capable of providing active treatment. HHS regulations (42 CFR 442.30(a) and (b)), however, permit the Administrator of HCFA to deny Federal financial participation after initial certification if a State fails to apply "applicable certification standards." Region II officials believe they must wait for deficiencies to appear at recertification before they can attempt to recoup Medicaid funds they believe have been inappropriately spent.

Region II is taking action to recover about $7 million in Federal funds paid to the 67 New York State facilities. These funds are for the time periods the facilities had the same deficiencies identified in the initial certification which were uncorrected when recertified. Although a New York State official agreed with Region II's assessment of the 67 facilities, he said that differences exist between the State and Region II computations of the amount of Medicaid funds that should be repaid and the procedure to effect repayment.

While performing its analysis of survey certifications and recertifications, Region II agreed with New York State on criteria for future initial certification surveys. The agreement sets forth, in full or in part, 13 of the 116 ICF/MR standards (see enc. I) which New York State and Region II officials agreed must be met in order to certify that ICFs/MR meet the adequate care criteria for Medicaid eligibility.

We also contacted Regions V and VI officials to get their views on the need to designate which of the 116 ICF/MR standards must be met before facility certification. They expressed concern over the lack of such guidance because of the growth in States' ICF/MR programs and the recent cutback in funding provided to State agencies performing the survey reviews. These officials could not provide us with any examples of certifications being denied facilities for deficiencies related to the adequate care criteria.

CONCLUSIONS AND RECOMMENDATION

HHS regulations allow small ICFs/MR to be initially certified with some deficiencies provided that they do not jeopardize the client's health and safety or seriously limit the facility's capacity to give adequate care. About 116 individual standards apply to ICFs/MR and while some are more directly related to the ability of a facility to provide adequate care than others, the regulations do not indicate which would constitute unacceptable deficiencies if not met at initial certification.

A recently negotiated agreement between HCFA Region II and New York represents an attempt to deal with this issue in one State. Because HCFA has the responsibility for assuring that all States apply appropriate certification standards, we believe there is a need for guidance on which of the ICF/MR standards must be met before a facility can be certified as eligible for Medicaid reimbursement. Such guidance would help to assure that (1) clients in all States receive adequate care, (2) Medicaid funds are appropriately spent, and (3) HCFA regional offices have guidelines for reviewing State certification programs.

We recommend that you direct the Administrator of HCFA to establish which ICF/MR standards cannot be waived and must be met before a State can certify a facility as eligible for Medicaid reimbursement.

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As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

Copies of this report are being sent to the appropriate congressional committees and the Director, Office of Management and Budget.

Sincerely yours,

Gregory J. Ahart
Director

Enclosure

STANDARDS WHICH MUST BE MET FOR ICF/MR CERTIFICATION BY AGREEMENT BETWEEN HCFA REGION II AND NEW YORK STATE

(42 CFR 442 references in parenthesis)

1. Admission with Comprehensive Evaluation. (442.418(a) and (b)(1))

2. Evaluation and Program Plans for Each Resident: Available and Reviewed Monthly. (442.434)

3. Training in Health, Hygiene, and Grooming. (442.443(a))

4. Provision of Services and Programs Each Resident Needs. (442.454)

5. Training and Habilitation Plan Requirements. (442.463(c), (d) and (e)(1))

6. Fulfillment of Resident's Food and Nutritional Needs. (442.473(a))

7. Formal Arrangement for Qualified Medical Care. (442.476(a) and (b))

8. Provision of Nursing Services. (442.478)

9. Appropriate Utilization and Administration of Medications. (442.485)

10. Storage of Medications. (442.485)

11. Resident Record Requirements. (442.499(a))

12. Availability of Records in Resident Living Areas. (442.503(b) and (c))

13. Evacuation Drill Requirements. (442.506(b))