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Report to the Chairman, Subcommittee on Regulation, Business Opportunity, and Technology, Committee on Small Business, House of Representatives

August 1994

FINANCIAL MANAGEMENT

Oversight of Small Facilities for the Mentally Retarded and Developmentally Disabled

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GAO

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The Honorable Ron Wyden
Chairman, Subcommittee on Regulation,
Business Opportunity, and Technology
Committee on Small Business
House of Representatives

Dear Mr. Chairman:

This report responds to your request that we provide baseline information on federal and state financial and program oversight of facilities providing residential and other Medicaid funded services to people with mental retardation and developmental disabilities (MR/DD). As agreed with your office, we focused our review on small (15 beds or fewer) private and nonprofit intermediate care facilities for the mentally retarded and developmentally disabled (ICFs/MR) and facilities providing residential and other services under a Medicaid Home and Community Based Service Waiver (the Medicaid waiver program).

We judgmentally chose three states (Colorado, Michigan, and New York) to provide diversity in terms of geographic dispersion and program size. Specifically, we identified (1) federal and state requirements for financial and program oversight and (2) whether the three states we visited complied with those requirements. We also identified federal and state mechanisms for investigating fraud and abuse and obtained examples of what officials in the three states we visited felt were best practices for preventing financial fraud and ensuring quality care.

Results in Brief

While federal requirements for financial oversight of MR/DD service providers are general in nature, the three states we reviewed required most providers to have financial audits by an outside agency. To provide program oversight, cognizant federal and state agencies utilize quality assurance inspections of ICFs/MR and of facilities providing residential and other services under the Medicaid waiver program. These inspections are required by federal and/or state regulations. Our review, and the most recent Department of Health and Human Services (HHS) examinations of the three states we visited, found that these inspections were being performed as required. However, we found instances in which more attention could be given to follow-up procedures to ensure that deficiencies are corrected.

Instances of possible fraud and abuse in ICFs/MR and Medicaid waiver program facilities in the states we visited are investigated only when cognizant federal or state officials receive an allegation or referral. While our survey of Medicaid Fraud Control Units in 41 states[1] having such units did not identify any fraudulent schemes occurring on a national scale, the units reported several types of fraudulent or abusive activity that were common to many states. These included facility operators using related party, or "non-arms length," transactions to inflate charges and to bill for services not provided. Providers found guilty of fraud or other program abuses can be excluded from receiving Medicaid funds by the HHS Office of Inspector General (OIG). The HHS-OIG maintains and distributes a nationwide database, based on input from federal, state, and local officials, of the excluded providers.

Officials in the three states we visited identified several program features that they believed helped ensure financial and program integrity. For example, in Colorado, individuals and entities providing services to people with MR/DD must do so at a predetermined reimbursement rate, thereby reducing the opportunity for inflated billings.

Background

Medicaid is a state-operated program financed with federal and state (and sometimes local) funds. It is administered under the oversight of the Health Care Financing Administration (HCFA) within HHS. Each state manages its Medicaid program through a designated single state Medicaid agency, usually the state human services department responsible for welfare and social service programs. The basic Medicaid program responsibilities of that state agency include eligibility determination, provider certification, claims processing, review and inspection of facilities providing care, and maintenance of the program's integrity and administration.

States have broad discretion in carrying out these responsibilities and administering the program. However, the details on how each state will run its program are contained in a contract with the federal government called a "Medicaid State Plan." This arrangement permits the level of services provided and reimbursement methodology to vary from state to state, but it also helps to ensure that each state follows broad federal requirements covering such things as the minimum service levels, retention of records, and disclosure of ownership interests.

[1]Subsequent to our survey, a 42nd state (Missouri) established a Medicaid Fraud Control Unit.

Needs of the MR/DD population are addressed through a number of Medicaid funded facilities and services included in Medicaid State Plans. One of the most common facilities is the ICF/MR, which can house from several to hundreds of residents. Under Medicaid regulations, ICFs/MR are required to provide, or arrange for, a full range of medical and habilitative services based on the needs of the residents. To provide a more home-like setting, new ICFs/MR tend to be small facilities of 15 beds or fewer.

In addition, since 1981, states have used the Medicaid Home and Community Based Service Waiver program to treat the MR/DD population. Under this program, commonly referred to as the Medicaid waiver program, individuals who would be eligible for ICFs/MR can live at home or in other community residences. The Medicaid program funds needed medical and health services for these individuals but does not cover room and board. This deviation from Medicaid State Plans is permitted under a waiver agreement that must be approved by HCFA.

Two of the three states we visited (Colorado and Michigan) contract with community boards to administer their MR/DD programs. Colorado has 20 Community Centered Boards, and Michigan 55 Community Mental Health Boards. The boards, in turn, are responsible for contracting with service providers and, in Colorado, may also operate facilities. In New York, MR/DD facilities are operated by nonprofit organizations. New York has decentralized some financial and program oversight through the use of 19 District Developmental Service Offices, which are staffed by state government employees. Table 1 provides demographic data on the MR/DD population for fiscal year 1993 for the three states we visited.

Table 1: Demographic and Financial Information for MR/DD Population in States Surveyed for Fiscal Year 1993

	Colorado	Michigan	New York
Individuals			
Total receiving residential services (includes residents in state-operated and large ICFs/MR)	3,343	8,780	22,089
Private or nonprofit ICFs/MR of 15 beds or less	0	2,835	6,794
Private or nonprofit community residences of 15 beds or less	1,177[a]	2,533	710
Facilities			
Total facilities (includes state-operated and large ICFs/MR)	207	1,700	3,237
Private or nonprofit ICFs/MR of 15 beds or less	0	472	722
Private or nonprofit community residences of 15 beds or less	170	522	135
Expenditures (in millions)			
Total for all programs	$108[b]	$627	$2,974
Private or nonprofit ICFs/MR of 15 beds or less	$0	$160	$2,319
Private or nonprofit community residences of 15 beds or less	$61[b]	$105	$76

Source: Unaudited information provided by the states.

[a]Figure does not include people in alternative personal care settings.

[b]Colorado was not able to provide expenditure data as of September 30, 1993. Expenditures represent amounts allocated by the state for its fiscal year, July 1, 1993, through June 30, 1994.

Scope and Methodology

To obtain information on financial oversight requirements, we reviewed federal and three states' regulations on, and instructions for, financial requirements for facilities and operators of facilities for the MR/DD. We also obtained financial information on each state. We interviewed key HHS, HCFA, and state personnel to determine how they use financial information and audit reports.

To assess whether the three states were performing required financial oversight, we selected random samples of 177 private or nonprofit ICFs/MR and facilities that included residents participating in the Medicaid waiver

program (59 in each state). We did not verify the completeness of the lists the states provided and from which we selected our sample facilities. In some cases, an audit covered more than one facility. Of the 177 facilities in our sample, 132 were covered by an independent financial audit requirement. Most of the remaining 45 facilities were not required to have an independent financial audit but were required to have a cost report audited by the state. For these facilities, we obtained and reviewed the most recent independent financial audit or cost report covering the facility.

To identify program oversight requirements applicable to MR/DD facilities, we reviewed federal and state regulations and instructions. We interviewed key HHS, HCFA, and state personnel to determine how they ensure that facilities adhere to program oversight requirements.

To assess whether the three states were performing required program oversight, we reviewed the most recent certification or recertification inspection for each of the 177 facilities in our sample. In addition, we reviewed state files to determine whether deficiencies noted during an inspection were corrected. Because Colorado did not have private or nonprofit ICFs/MR of 15 beds or fewer, we did not examine that state's inspection process for these facilities. For New York facilities serving people in the Medicaid waiver program, we only reviewed initial certifications because the statewide waiver program began less than a year before we started our review.

To identify federal and state mechanisms for investigating fraud and abuse, we met with federal and state auditors responsible for investigating Medicaid fraud and asked if they were aware of any schemes that are used to bill for unnecessary or unperformed services. We surveyed the 41 state Medicaid Fraud Control Units existing at the time of our survey to determine whether there were any patterns of fraud in programs for people with MR/DD.

To identify best practices that ensure financial and program integrity, we asked officials in the three states we visited what practices in their states they considered to be the most beneficial. We compared the best practices identified by these officials with deficiencies identified by the Medicaid Fraud Control Units to determine whether they might prevent or reduce fraud and abuse.

We performed our work from October 1993 through July 1994 in accordance with generally accepted government auditing standards. We discussed the results of our work with HHS and state program officials and have incorporated their comments where appropriate.

Financial Oversight Requirements

Federal regulations specify broad requirements that the states must meet regarding setting payment rates and conducting financial oversight of MR/DD facilities. The specific requirements for a state are those set by the state and included in the state's HCFA approved State Medicaid Plan or Medicaid Home and Community Based Service Waiver. States specify the type of financial reports to be submitted by MR/DD facilities and whether the facilities must obtain financial audits. All three states we reviewed required cost reports and, for most providers, independent financial audits.

The following sections summarize the results of our review of federal and state financial oversight requirements and the states' compliance with them. Appendix I presents comparative information on the requirements.

Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled

While ICFs/MR are jointly funded by states and the federal government, the states have primary responsibility for financial oversight. Federal Medicaid law and regulations require states to describe the rate-setting methods used for ICFs/MR in their Medicaid State Plans but do not specify any single method. As a result, states employ a variety of rate-setting methods. HCFA's reviews of rate-setting procedures focus on ensuring that the procedures are consistent with methods presented in the approved state plan. The staff of HHS-OIG, which has the authority to perform financial audits of ICFs/MR, told us they would only do so on an exception basis.

Home and Community Based Service Waivers

Under the Medicaid Home and Community Based Service Waiver program, Medicaid funding can be used for program services, such as physical therapy, but not for room and board. States develop their own methods for calculating reimbursements to be made to operators of facilities providing residential and other services to waiver recipients. Audits of reimbursements to ICFs/MR or to facilities providing residential and other services under the Medicaid waiver program are made at the states' discretion. The HHS-OIG has the authority to perform financial audits, but, again, staff from that office told us they would only do so on an exception basis.

State Reporting Requirements

All three states that we visited required providers to annually prepare and submit financial reports. In Colorado, operators of each residential facility were required to submit annual cost reports to the state. Cost reports for facilities operated by Community Centered Boards are to be submitted as supplemental information with a board's annual financial statements. State officials said they use the cost reports to monitor facilities' revenues and expenses, negotiate rate changes, and support requests for state appropriations.

In Colorado, Community Centered Boards and other operators of residential facilities are also required to have an independent financial statement audit annually. The state is to ensure that audits of Community Centered Boards are performed. The boards are responsible for ensuring that audits of non-board operated facilities are completed. While officials for the state MR/DD agency told us that they do not have sufficient staff to determine whether the boards are overseeing compliance with this requirement, our sample did not identify any required audits that were not completed or underway.

Michigan requires annual cost reports and uses these reports to reconcile service providers' and Community Mental Health Boards' actual costs to budgeted costs. These reconciliations, called cost settlements, are used to determine if the provider was paid too much or was due additional money from the state. Service providers that contract directly with the state are audited by an audit group internal to the MR/DD agency. Other providers in Michigan are required to have an independent financial audit.

In New York, MR/DD facilities submit annual consolidated financial reports to the state. These reports are used by the state for special studies, the appeals process (when applicable), and rate-setting. While the reports are not audited, a small state-run MR/DD audit group performs limited scope financial reviews of facilities at its discretion. According to its director, the group did not have sufficient resources to conduct a full scope financial audit of all providers in the state. Also, organizations with revenues and financial assistance in excess of $25,000 must file an annual financial report with the state. Those with revenues and financial support in excess of $75,000 must have an independent financial audit. This requirement is not targeted to MR/DD facilities, but it is a general New York state requirement for most nonprofit groups. According to state officials, the results of these audits are rarely used as a tool for fiscal monitoring even though they are filed in a central state location.

Compliance With Financial Audit Requirement

We examined 64 independent financial audit reports covering 122 of the 132 facilities in our sample required to have a financial audit. Nine of the 10 remaining facilities were not audited because they had recently opened, changed owners, or just come under the audit requirement. The cognizant Community Centered Board had not requested an audit of the remaining facility, but an audit of this facility was being performed at the time of our review. All of the audit reports we reviewed contained unqualified opinions on the entities' financial statements. We did not evaluate the quality of the audits performed for the 122 facilities.

Program Oversight Requirements

While financial oversight, including establishing requirements for financial reporting and audit, are left primarily to the states, the federal government has very specific quality-of-care requirements. For ICFs/MR, these requirements range from areas such as the level of staffing at a facility to the dietary needs of the residents. For waiver facilities, states develop program requirements subject to federal review and approval.

Because Medicaid pays only for the habilitation or program services these facilities provide, states set policies related to room and board and other protective services. For the three states we visited, these policies included requirements for annual inspection and certification (or re-certification) of facilities and following up on deficiencies found by state inspectors. Follow-up activity would depend on the nature of the deficiency, but might consist of ensuring that a facility filed a corrective action plan for deficiencies noted during the inspection or re-inspection of the facility.

The following sections summarize the results of our review of federal and state program oversight requirements and the states' compliance with them. Appendix II provides comparative information on these requirements.

Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled

Federal regulations specify 489 separate standards for quality of care at ICFs/MR. These standards focus on staff performance but also address facility specifications and health and safety measures. Regulations also require the states to annually inspect the facilities and certify their compliance with the standards. These annual inspections are a primary means for ensuring that the facilities provide quality care.

The 489 standards are organized into eight conditions of participation:

- governing body and management,
- client protection,
- facility staffing,
- active treatment services,
- client behavior and facility practices,
- health care services,
- physical environment, and
- dietetic services.

According to federal regulations, an ICF/MR must substantially comply with the specifications of all eight conditions of participation to stay certified and continue to receive Medicaid reimbursement. However, a facility will generally not lose its certification if some of the standards are not met, as long as the facility submits an acceptable plan for correcting the deficiencies and client health and safety are not in jeopardy. HHS regional office staff annually evaluate each state's operations, including the certification process. If HHS determines that a facility should not be certified, the facility's participation in Medicaid can be terminated. The most recent HHS examinations of the three states we reviewed found that the states were doing an acceptable certification job.

Home and Community Based Service Waivers

Federal quality of care standards for the waiver program are less definitive than those for the ICF/MR program. In the absence of detailed federal standards, states establish their own standards, which must be included in their waiver applications. Federal regulations require that state standards provide assurances that "necessary safeguards have been taken to protect the health and welfare of waiver clients." These safeguards must also include standards for all types of providers that furnish services under the waiver, as well as standards for the facilities where Medicaid waiver program participants reside. HCFA reviews the states' standards as part of the waiver application approval process. In addition, states are required to ensure that these standards, as well as any state licensing or certification requirements, are met and are to report annually to HCFA on compliance.

States are also required to commission an independent assessment of their waiver programs and submit the results to HHS regional office staff for evaluation. HHS reviews waiver programs less frequently than ICFs/MR—3 years after inception for new programs and every 5 years thereafter. According to HCFA officials, HCFA regional offices also review these programs, on an exception basis, when problems have been reported.

State Compliance With Program Requirements

According to all 177 certification or recertification reports on annual inspections of ICFs/MR and facilities providing services under the Medicaid waiver program that we reviewed, the facilities had been inspected within prescribed time limits. However, we found that necessary follow-up procedures to help ensure that deficiencies identified during the inspections were corrected were not always performed. Of 177 facilities in our sample, state inspectors found deficiencies at 167. For these 167, we found that, in 15 instances, required state follow-up procedures were not performed. State officials informed us that they would follow up on these cases and that appropriate action would be taken. Appendix III lists the most common deficiencies disclosed by state inspectors for the facilities in our sample.

Fraud Investigation

Federal officials with responsibility for investigating and tracking fraud in the Medicaid program include HHS-OIG investigators and the HHS-OIG Sanctions Group. A total of 42 states have Medicaid Fraud Control Units, which are the primary offices for investigating fraud. Responsibility for fraud investigation rests with the state Medicaid agency in the remaining 8 states. State audit offices can also investigate fraud.

Office of Inspector General

HHS' Inspector General has broad authority to investigate fraud and abuse in Medicare, Medicaid, and other HHS programs. In the Medicaid area, HHS-OIG audits have focused on reviewing state agencies' implementation of and compliance with state Medicaid plan provisions. Since ICFs/MR and facilities providing services under a Medicaid waiver are relatively small, the HHS-OIG has not routinely performed extensive reviews of these facilities. However, the HHS-OIG told us that, at a state's request, it will assist in investigating suspected large-scale or multistate fraud involving these facilities.

Also, the HHS-OIG's Sanctions Group can exclude from Medicaid programs those health care providers, individuals, and businesses committing fraud or other program abuses. The Sanctions Group does not initiate exclusion actions or perform its own investigations of fraud or abuse. Rather, its determinations are based on evidence provided by state Medicaid Fraud Control Units; federal, state, and local prosecutors; state licensing boards; and others. Under the exclusion provisions, a sanctioned provider (individual or entity) is prohibited from receiving Medicaid funds. The Sanctions Group maintains a nationwide list of providers that have been excluded from receiving Medicaid funds (and funds from other programs

under its jurisdiction) and provides (1) a new list to state human services departments, state licensing boards, insurance carriers, and other interested parties twice a year and (2) updates to the listing monthly.

State Medicaid Fraud Control Units

Colorado, Michigan, and New York are among 42 states[2] that have certified Medicaid Fraud Control Units (MFCU). The fraud units are staffed by the states, but about 75 percent of the funding for the units is federal. These units investigate and prosecute allegations of wrongdoing in Medicaid funded programs, including those for people with MR/DD. Investigations are normally performed only when a complaint is filed or allegations are referred to the fraud unit for investigation. A primary source of referrals to MFCUs are program integrity units within the single state Medicaid agencies.

Our survey of the 41 state Medicaid Fraud Control Units existing at the time of our review did not identify any fraudulent schemes occurring on a national scale related to facilities for people with MR/DD. However, the units reported several types of fraudulent or abusive activity common to many states, including

- use of related party transactions to overstate costs,
- inflation of cost reports,
- billing for services not rendered, and
- theft of patient funds.

Table 2 summarizes the cases fraud units investigated from October 1990 through September 1993 at ICFs/MR or other group homes for people with MR/DD in the three states we visited.

[2]See footnote 1.

Table 2: Fraud Cases Identified in Three States From October 1990 Through September 1993

State	Type of case(s) identified[a]	Referral source	Action/result
Colorado	The Colorado MFCU reported one case involving inflated billings for medical supplies.	Information developed in another investigation.	Referred to HHS.
Michigan	The Michigan MFCU reported that it had investigated and prosecuted two cases of patient abuse and one case of embezzlement. The MFCU received approximately 60 complaints during this time period. Most were closed shortly after receipt and referred to the appropriate state agency or law enforcement officials.	Family referral and information developed in another investigation.	Two cases resulted in convictions, one case was awaiting trial.
New York	The New York MFCU reported that it had investigated and prosecuted several cases involving rigging of bids on construction of ICF/MR facilities; related party transactions; inflated/bogus billings; and theft of patient funds.	Informants; referral from HHS surveillance unit.	Several convictions, several trials pending, one civil settlement.

[a]Type of case identified does not include instances reported by MFCUs where the charge was dismissed or the plaintiff was found not guilty. Pending cases were included.

Generally, MFCUs report all cases in which they have obtained an indictment and conviction to the National Association of Attorneys General, Medicaid Fraud Counsel. The association acts as a clearinghouse on Medicaid fraud and publishes the results of fraud unit investigations in a newsletter. The newsletter is distributed to all fraud units and other interested parties 10 times a year and provides a forum for the fraud units to discuss common areas of concern. Appendix IV lists the 42 MFCUs.

State Audit Agencies

In Colorado, Michigan, and New York, state auditor offices are authorized to perform financial and program audits of facilities and services for people with MR/DD. However, state audit officials told us that these audits are generally done only when complaints or referrals are received. According to one official at the Michigan Auditor General's Office, some of the issues they have reviewed include improper handling of patient's money, excessive transportation costs, lease-purchase decisions made by Community Mental Health Boards, and how administrative costs compare with contract requirements.

Best Practices

At our request, state officials in the three states we visited identified several program features as "best practices" that they believed helped to prevent fraud and ensure quality care. These practices included cost containment features such as fixed reimbursement rates, program oversight by case managers and state oversight agencies, and limitations on the number of facilities that a provider can operate. A description of best practices identified by officials in these states is provided in appendix V.

As agreed with your office, unless you publicly announce its contents earlier, we will not distribute this report for 30 days. At that time, we will send copies to the Secretary of Health and Human Services; state program officials in Colorado, Michigan, and New York; the Director of the Office of Management and Budget; the Chairmen and Ranking Minority Members of the cognizant appropriations and oversight committees; and other interested parties.

If you have any questions concerning this report, please call me at (202) 512-3406. Appendix VI lists major contributors to this report.

Sincerely yours,

George H. Stalcup
Associate Director
Financial Integrity Issues

Contents

Letter	1
Appendix I Financial Reporting and Audit Requirements for ICFs/MR and Facilities Providing Waiver Services	16
Appendix II Quality Assurance Requirements for ICFs/MR and Facilities Providing Waiver Services	17
Appendix III Common Deficiencies Noted by State Inspectors at Facilities in Our Sample	19
Appendix IV List of Medicaid Fraud Control Units	20

Appendix V
Best Practices Identified by State Officials to Prevent Fraud and Ensure Quality Care 23

Appendix VI
Major Contributors to This Report 25

Tables

Table 1: Demographic and Financial Information for MR/DD Population in States Surveyed for Fiscal Year 1993 4
Table 2: Fraud Cases Identified in Three States From October 1990 Through September 1993 12

Abbreviations

HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
ICFs/MR	intermediate care facilities for the mentally retarded and developmentally disabled
MFCU	Medicaid Fraud Control Unit
MR/DD	mental retardation and developmental disabilities
OIG	Office of Inspector General

Financial Reporting and Audit Requirements for ICFs/MR and Facilities Providing Waiver Services

Oversight requirement	Federal	Colorado	Michigan	New York
Reporting	HCFA approves state plans. States develop their own financial reporting requirements for ICFs/MR within the broad federal requirements. There are no specific financial reporting requirements for waiver facilities. Federal regulations apply to aggregated data reported by the states to HCFA.	An annual cost report must be prepared and submitted for each residential facility. These reports are used to monitor revenues and expenses, negotiate rate changes, and support requests for state appropriations.	Each agency that contracts to provide services to the state must submit and have approved a budgeted annual cost report. These reports are used as the basis for a final cost settlement at the end of the year.	Each provider of services must submit a consolidated financial report annually. Reports are used for special studies, the appeals process, if applicable, and rate setting development.
Audit	The HHS Inspector General has the authority to conduct fiscal audits, but this is rarely done. No specific requirements are placed on the states for financial audits of ICFs/MR and facilities providing services under a Medicaid waiver. In general, because MR/DD facilities are considered service vendors rather than subrecipients of federal funds, Medicaid funds paid by states to these providers are not subject to the Single Audit Act requirements.	There is no state agency internal audit group, but most providers are required to have an independent financial audit. The controller for the MR/DD agency in Colorado told us that instead of having an internal audit group, the agency relies on its quality assurance group to identify key issues.	Providers that contract directly with the state are audited by an internal audit group. Others are required to have an independent financial audit.	A small internal audit group, consisting of 5 auditors, performs limited scope financial audits on an exception basis. Also, all nonprofit organizations with annual revenues and financial assistance in excess of $75,000 are subject to the general state requirement for individual financial audit.

Quality Assurance Requirements for ICFs/MR and Facilities Providing Waiver Services

	Federal	Colorado	Michigan	New York
ICFs/MR	Medicaid statutes require facilities to meet eight conditions of participation. The focus is heavily directed toward ensuring that active treatment to clients is provided. States must certify annually that each facility is complying with the conditions of participation. Facilities not complying are subject to decertification but can remain open if they submit and then carry out an acceptable plan of correction for deficiencies noted. Federal law also requires states to establish advocacy groups to monitor programs for people with MR/DD.	Colorado did not have private or nonprofit ICFs/MR of 15 beds or less.	The state plan has designated the Department of Mental Health as responsible for determining, through inspection, whether facilities meet federal requirements. Michigan Protection and Advocacy assists the developmentally disabled and mentally ill in gaining access to services and protecting their civil rights.	The state plan has designated the Office of Mental Retardation and Developmental Disabilities as responsible for determining, through inspection, whether facilities meet federal requirements. The Commission on Quality of Care for the Mentally Disabled investigates unnatural or unusual deaths, provides advocacy services, responds to complaints, and conducts program and cost-effectiveness studies to both improve service delivery and ensure that the quality of care provided is of a uniform, high quality.

(continued)

	Federal	Colorado	Michigan	New York
Waiver services	States are to provide assurances that necessary safeguards have been taken to protect the health and welfare of people with MR/DD. Program regulations do not define safeguards or how they are to be developed; however, states must include standards for all types of providers that furnish services under the waiver, as well as standards for the facilities where Medicaid waiver program participants reside. In addition, states are required to ensure that these standards, as well as any state licensure or certification requirements, are met and are to report annually on compliance. HCFA reviews and approves the states' standards as part of the waiver application process. Federal law also requires states to establish advocacy groups to monitor programs for people with MR/DD.	The state plan has designated survey agencies, the Department of Health, and the Division for Developmental Disabilities as responsible for determining, through inspection, whether facilities meet state requirements. The Legal Center, an advocacy organization, provides legal and other services to persons with disabilities. Each of the Community Centered Boards is required to have a Human Rights Committee, which has oversight responsibilities for MR/DD programs and individuals. These committees are composed of persons with developmental disabilities, family members, and program participants. Committees oversee program participants on psychotropic medications and restrictive behavioral mechanisms, and review allegations of abuse and neglect.	The state uses the same quality assurance standards that it uses for ICFs/MR. Michigan Protection and Advocacy assists the developmentally disabled and mentally ill in gaining access to services and protecting their civil rights. Also, the Association of Retarded Citizens has a residential monitoring program funded by the state. Association representatives visit community residences for the purpose of observing the conditions of the homes and their residents.	The state requires, through annual certification, that facilities where waiver clients live meet physical plant and protective oversight requirements. There is no program review included in the certification process. Individual case managers are responsible for overseeing the program services, such as assessing the recipient's level of care and ensuring care is provided. The Commission on Quality of Care for the Mentally Disabled investigates unnatural or unusual deaths, provides advocacy services, responds to complaints, and conducts program and cost-effectiveness studies to both improve service delivery and to ensure that the quality of care provided is of a uniform, high quality.

Common Deficiencies Noted by State Inspectors at Facilities in Our Sample

Colorado

Waiver Facilities (59 Facilities)	• Uncleanliness and poor furnishings and equipment (37 facilities) • Misuse of psychotropic medications, such as missing authorizations (21 facilities) • Operators not fully complying with fire safety standards (21 facilities) • Buildings and structures poorly maintained (19 facilities)

Michigan

ICFs/MR (27 Facilities)	• Programs conducted for some residents without the informed consent of the client, parents, or legal guardian (7 facilities) • Evacuation drills not held as frequently as required, and emergency and disaster plans not evaluated for effectiveness (6 facilities)
Waiver Facilities (32 Facilities)	• Complete individual program plans not in place for all clients (21 facilities) • Adequate physician services not in place (7 facilities) • Adequate professional program services not in place to ensure that client's individual program plans were implemented (7 facilities)

New York

ICFs/MR (49 Facilities)	• Some clients not receiving continuous active treatment, as required (18 facilities) • Programs conducted for some residents without the informed consent of the client, parents, or legal guardian (17 facilities) • Clients' active treatment not integrated, coordinated and monitored by a qualified mental retardation professional (16 facilities)
Waiver Facilities (10 Facilities)	• No quality of care deficiencies noted—all inspections we examined were for initial certifications performed prior to residents' occupancy

List of Medicaid Fraud Control Units

ALABAMA

Director, MFCU
Office of the Attorney General
11 South Union Street
Montgomery, AL 36130
(205) 270-7780

ALASKA

Director, MFCU
Department of Law
1031 W. 4th, Suite 200
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(907) 276-3550

ARIZONA

Director, AHCCCS Fraud Unit
Office of the Attorney General
1275 West Washington
Phoenix, AZ 85007
(602) 542-3881

ARKANSAS

Director, MFCU
Office of the Attorney General
323 Center Street
Little Rock, AR 72201
(501) 682-7760

CALIFORNIA

Chief, Bureau of
Medi-Cal Fraud
Office of the Attorney General
1515 K Street, South Rm 400
Palm Iron Bld
Sacramento, CA 94244-4256
(916) 324-5186

COLORADO

Director, MFCU
Criminal Enforcement Section
Office of the Attorney General
1525 Sherman Street, 5th Fl
Denver, CO 80203
(303) 866-5431

CONNECTICUT

Director, MFCU
340 Quinnipiac Street
Wallingford, CT 06492
(203) 265-7821

DELAWARE

Director, MFCU
820 N. French Street, 8th Fl
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FLORIDA

Director, MFCU
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The Capital
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(904) 487-1963

HAWAII

Director, Medicaid
Investigations Division
425 Queen Street
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ILLINOIS

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INDIANA

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IOWA

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Best Practices Identified by State Officials to Prevent Fraud and Ensure Quality Care

Colorado

Uniform Reporting and Financial Audit Requirements	A central agency, the Division for Developmental Disabilities, established uniform reporting and financial audit requirements for all Community Centered Boards and other service providers. By having standard financial reporting and accounting procedures and definitions, the state is able to compare and evaluate the cost of services provided across the state.
Fixed Reimbursement Rates	Individuals and entities providing services to people with MR/DD must do so at a predetermined reimbursement rate, reducing the opportunity to inflate billings.
Human Rights Committees	Each of the 20 regional-based Community Centered Boards providing services to people with MR/DD must have a human rights committee composed of individuals who are not employed by or involved with the boards. These committees oversee program participants on psychotropic medications and restrictive behavioral mechanisms, and review allegations of abuse and neglect.
Case Management Oversight	Each program participant in Colorado has a case manager who works for one of the Community Centered Boards. These case managers are in continual contact with participants as well as third party providers to ensure that the participants are receiving proper care and services.

Michigan

Providers Do Not Own ICFs/MR	Officials believe the opportunity for providers to benefit from related party transactions is reduced in Michigan because the state leases all ICFs/MR as well as most facilities providing residential services to people receiving services under a Medicaid waiver. The provider agrees with the state to provide services at the leased site. Since providers do not own the facilities, it is also easier to replace providers that fail to perform satisfactorily. Instead of having to move the residents, the state can bring in a new provider to furnish services at the same site.

Providers Can Operate a Limited Number of Facilities	By not allowing a provider to operate more than 12 facilities, the state limits its exposure to any one provider if a problem arises.

New York

Review of Real Property Lease Agreements	The state reviews all real property leases entered into by providers of services to the MR/DD to ensure the existence of an arm's length relationship between the parties to the lease, lessening the opportunity for abuse through related party transactions.
Commission on Quality of Care for the Mentally Disabled	The state has an independent watchdog group called the State Commission on the Quality of Care for the Mentally Disabled. The Commission's functions include investigating unnatural or unusual deaths, providing advocacy services, responding to complaints, and conducting program and cost effectiveness studies to both improve service delivery and ensure that the care provided is of a uniform, high quality.
Not-for-profit Groups	State officials believe that because all facilities are run by established not-for-profit groups, such as United Cerebral Palsy, Catholic Charities, and the Association for Retarded Citizens, there is less chance of fraud and abuse.

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