

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICAID PAYMENTS TO INSTITUTIONS  
FOR PEOPLE WITH MENTAL  
RETARDATION**



JUNE 1993    OEI-04-91-01010

# EXECUTIVE SUMMARY

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## PURPOSE

To determine the extent and causes of variation among States in per resident Medicaid reimbursement rates for large intermediate care facilities for people with mental retardation.

## BACKGROUND

"Intermediate Care Facilities for the Mentally Retarded" (ICF/MRs) are Medicaid funded State or privately-run facilities for people with mental retardation or other developmental disabilities. Large ICF/MRs are those with over 15 beds and are traditionally referred to as institutions. Seventy percent of all residents of large ICF/MRs are in State-run facilities.

To be certified to receive Medicaid reimbursement, ICF/MRs must annually meet 489 Federal standards. The standards require that ICF/MRs provide 24-hour health care and continuous individualized training for residents. Federal Medicaid rules for reimbursing States for ICF/MRs are not clearly defined. Each State, therefore, defines the rules independently.

The preferred treatment setting for people with mental retardation has shifted from large ICF/MRs to community-based care. Yet, in 1991 estimated Medicaid spending (including State and Federal shares) for large ICF/MRs reached \$6.7 billion for approximately 110,000 residents. The average annual Medicaid reimbursement to large ICF/MRs was \$61,000 per resident. Eight percent of Medicaid dollars are spent on 0.4 percent of Medicaid recipients who still reside in large ICF/MRs.

We analyzed factors which affect per resident Medicaid reimbursement rates for large ICF/MRs in a stratified random sample of 22 States.

## FINDINGS

*Medicaid reimbursement rates for large ICF/MRs are more than five times greater in some States than in others*

The average annual per resident Medicaid reimbursement for large ICF/MRs ranged among States from \$27,000 to \$158,000 in 1991.

*State policies account for variation in ICF/MR Medicaid reimbursement rates among States, rather than quality of service, facility characteristics, or resident demographics*

The significant factors which cause some States to pay higher rates than others are State rate-setting methods, high wages paid to State employees, higher staff-to-resident

ratios, and newer facilities. States with lower reimbursement rates generally had included, in their rate-setting methodology, caps on costs or efficiency incentives to control costs.

Wide variation in reimbursement rates is not due to differences in quality or level of service at facilities, as measured by ICF/MR certification standards. Facility characteristics, such as occupancy and size, and resident demographics, such as level of retardation, also did not account for the differences in rates among States.

*Lack of effective controls results in excessive spending*

Overstaffing and exorbitant spending for buildings and grounds occur at ICF/MRs in some States because Medicaid reimbursements are not effectively controlled.

**RECOMMENDATIONS**

*HCFA should take action to reduce excessive spending of Medicaid funds for ICF/MRs.*

HCFA can accomplish this objective in several ways, including one or more of the following.

HCFA can take administrative action to control ICF/MR reimbursement under current authorities. HCFA can encourage States to adopt cost controls, strengthen Federal rate-setting guidelines and provide technical assistance to States to help them adopt effective controls.

HCFA can seek legislation to control ICF/MR reimbursement. Legislative options include mandatory cost controls, a Federal per capita limit, a flat per capita payment, a case-mix reimbursement, and a national ceiling for ICF/MR reimbursements.

HCFA can seek comprehensive legislation to restructure Medicaid reimbursement for both ICF/MR and Home and Community-based waiver services for developmentally disabled people. Restructuring could include global budgeting, block grants, and financial incentives.

We expect considerable savings to the Medicaid program depending on what option HCFA pursues. For example, we estimate that \$683 million in Federal and State Medicaid funds could have been saved in 1991 by only capping costs.

**AGENCY COMMENTS**

The Assistant Secretary for Planning and Evaluation (ASPE) and HCFA commented on the report. ASPE concurred with the recommendations. While HCFA did not dispute our findings, they did not concur with the recommendations because they considered that the Medicaid statute and regulations allow them little discretion in imposing additional controls to curb ICF/MR payments. Further, HCFA stated that

any legislative changes should be considered within the framework of national health care reform, which is still being developed.

We continue to believe that HCFA should take action to control ICF/MR reimbursement. We have documented excessive Medicaid spending. Prudent management of Federal resources for ICF/MRs is important and will continue to be so under upcoming health care reform. Therefore, controls over unnecessary Medicaid spending should not be delayed. As we recommended, HCFA certainly can encourage States to adopt effective cost controls, can strengthen rate-setting guidelines, and can develop legislative proposals to control payments for ICF/MRs.

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# INTRODUCTION

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## PURPOSE

To determine the extent and causes of variation among States in per resident Medicaid reimbursement rates for large intermediate care facilities for people with mental retardation.

## BACKGROUND

### *What is an ICF/MR*

"Intermediate care facilities for the mentally retarded" (ICF/MRs) are State and privately-run facilities for people with mental retardation. The Health Care Financing Administration (HCFA) recognizes two categories of ICF/MR facilities. Those with 4 to 15 beds may be located in community settings and are generally referred to as small ICF/MRs. Large ICF/MRs are those with over 15 beds. Across States, large ICF/MRs average 160 residents per facility and are traditionally referred to as institutions. State-run ICF/MRs are generally much larger than private ICF/MRs. Seventy percent of all residents of large ICF/MRs are in State-run facilities.

Both State-run and private ICF/MRs must demonstrate annually that they meet Medicaid's conditions of participation. There are 8 conditions or categories of rules encompassing 489 standards that facilities must meet to be certified. The standards require that ICF/MRs provide 24-hour health care and continuous, individualized training programs for their residents. States conduct annual surveys to assure the requirements are met and are required to inform HCFA of any deficiencies.

### *Who is served in ICF/MRs*

People with mental retardation and related conditions are served in ICF/MRs. Medicaid guidelines refer to mental retardation as significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. Persons with related conditions have severe, chronic disability that is attributable to cerebral palsy, epilepsy, autism, or any other condition closely related to mental retardation; is manifested before a person reaches age 22; is likely to continue indefinitely; and results in substantial functional limitations in at least three of six major life activities. The six activities are self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. The terms mental retardation or related conditions and developmental disabilities are generally used interchangeably. Over 90 percent of people with developmental disabilities who are receiving services are mentally retarded.

### *How are ICF/MRs funded*

In 1971, the Medicaid program was amended to provide Federal reimbursement to States for caring for people with mental retardation living in institutions. Previously, these institutions were financed solely by State, local and private funding. Over half of the States applied to participate the first year. All States now have Federally-funded, certified ICF/MRs.

In 1980, via the Boren amendments, Congress made significant changes in the provisions for Medicaid reimbursement of long-term care facilities, including ICF/MRs. The amendments direct States to pay all long-term care facilities on the basis of rates which States assure are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities...". Congressional intent behind the amendments was to give States more flexibility in developing rates, but not to allow them to develop rates solely on the basis of State appropriations.<sup>1</sup>

Federal Medicaid rules for reimbursing States for ICF/MRs are not tailored specifically to ICF/MR operations and are not clearly defined. Federal regulations do not precisely define "reasonable costs" or "efficiently and economically operated facility." Each State, therefore, is allowed to define these terms independently.

The Federal regulations which address allowable costs and upper payment limits require States to assure that the estimated average payment for ICF/MRs does not exceed, in the aggregate, the amount that can "reasonably" be estimated would have been paid for the same services under Medicare principles of reimbursement. The Medicare law and guidelines specify that reimbursement must be based on the "reasonable cost" of services covered under the program and must be related to patient care. Although ICF/MRs are not reimbursed under the Medicare program, States are required to apply the Medicare principles and assure HCFA that they are only reimbursing providers for "reasonable costs" incurred in providing care.

### *What are the trends in serving people with developmental disabilities*

The preferred setting for treating people with developmental disabilities has shifted from institutional to community-based care. A number of studies have shown that clients with developmental disabilities make better progress toward independent functioning in community rather than in institutional settings.<sup>2</sup> Accordingly, the Federal goal for people with developmental disabilities is to enable independence, productivity and community integration.<sup>3</sup> This goal was most recently reiterated in the Developmental Disabilities Assistance and Bill of Rights Act of 1990. Since the ICF/MR program began 20 years ago, institutions have not only improved conditions in their facilities, but have discharged many residents who could live in a less restrictive community setting. Appendix A gives a bibliography of relevant studies.

In 1981, Medicaid was amended to permit waivers for home and community-based (HCB) services. Under HCB waivers, States may provide services in a community

setting for persons who would otherwise be treated in an ICF/MR, if the average Medicaid cost per person is the same or less. Reimbursement for HCB care is cost-based, as it is for ICF/MRs. However, HCFA limits the number of people that States may serve under HCB waivers. Incentives in the current reimbursement system are in conflict with the Federal goal of community integration.

*What are the present expenditures for large ICF/MRs*

Despite the policy shift toward community-based treatment, most Federal Medicaid funds for people with developmental disabilities continue to be spent on large ICF/MRs. In 1991, States' average annual expenditure in large ICF/MRs was ...

**\$61,000 per resident**

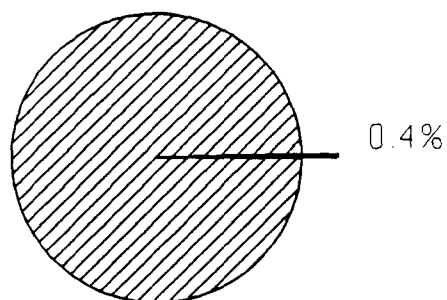
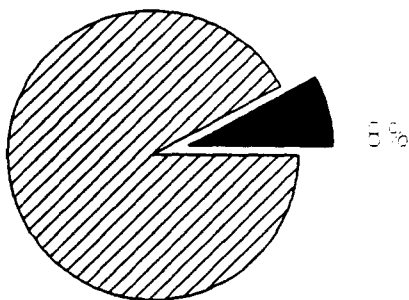
Further, ICF/MR expenditures have been one of the fastest growing elements of the Medicaid program. Total Medicaid expenditures for large ICF/MRs have more than doubled over the last decade. Over the same period, the population in those institutions has steadily declined -- reduced by 28 percent in the State-run facilities alone. In 1991<sup>4</sup>, estimated Medicaid expenditures (including State and Federal shares) for both State-run and private, large ICF/MRs reached ...

**\$6.7 Billion for 110,000 Residents**

The chart below<sup>5</sup> illustrates the disproportionate share of Medicaid dollars spent on people with developmental disabilities who still reside in large ICF/MRs.

**8% of Total Medicaid Dollars**

**0.4% of Total Medicaid Recipients**





## METHODOLOGY

We examined factors which affect per resident reimbursement rates for large ICF/MRs in 22 States. We originally selected 24 States through stratified random sampling, but dropped 2 that did not respond to our survey.

We surveyed Medicaid agencies in each of our sample States to obtain current (1) Medicaid reimbursement rates for each large ICF/MR, (2) rate-setting methods, and (3) ICF/MR expenditures, including average wage, percent of State central office overhead costs allocated to an ICF/MR, and capital expenditures. We obtained resident and facility characteristics from HCFA's On-line Survey and Certification Reporting System (OSCAR).

To determine the extent of reimbursement rate variation among States, we compared the average facility per diem rates as reported to us by State Medicaid agencies.

To determine causes of variation among States in reimbursement rates, we performed a stepwise regression analysis using only State-run facilities. We examined 24 factors or independent variables pertaining to (1) facility characteristics, (2) resident demographics, and (3) State reimbursement policies. We used the SAS (Statistical Analysis System) software program to perform the stepwise regression.

We completed site visits to 15 ICF/MR facilities in 7 States. In each State we selected at least one State-run and one privately-run large ICF/MR, where available, to determine how ICF/MRs are using Medicaid dollars. We interviewed staff at State Medicaid agencies and State Developmental Disabilities agencies. Appendix B gives a detailed description of the methodology.

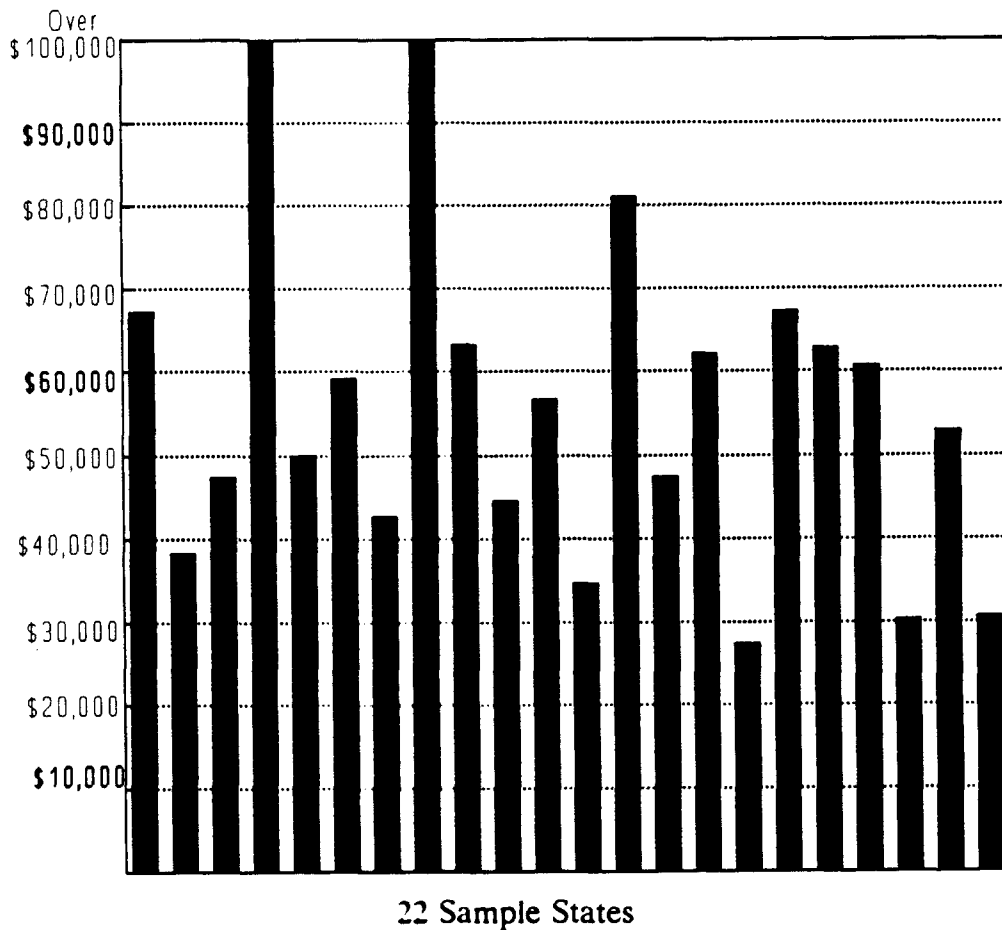
Our review was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

# FINDINGS

## MEDICAID REIMBURSEMENT RATES FOR LARGE ICF/MRS ARE MORE THAN FIVE TIMES GREATER IN SOME STATES THAN IN OTHERS

Average Medicaid reimbursement in 1991 for large ICF/MRs ranged among States from \$27,000 to \$158,000 per resident. In 1991, the average reimbursement for all large ICF/MRs was \$61,000 per resident. The following chart illustrates widely varying State average annual per resident reimbursement rates for both private and State-run large ICF/MRs combined.

Annual Per Resident Reimbursement Rate  
By State, 1991



## **STATE POLICIES ACCOUNT FOR VARIATION IN ICF/MR MEDICAID REIMBURSEMENT RATES AMONG STATES, RATHER THAN QUALITY OF SERVICE, FACILITY CHARACTERISTICS OR RESIDENT DEMOGRAPHICS**

We examined characteristics of ICF/MR facilities and their residents, such as size of facility and severity of disability, because we expected these factors to significantly affect ICF/MR reimbursement rates. Further, in general discussions, we were frequently told that variation in rates was due to differences in quality or level of service. We found that State reimbursement policies caused most of the variation, however, not quality of care or facility and resident characteristics.

### **State Policies Account for Most Variation in ICF/MR Medicaid Reimbursement Rates Among States**

The most significant causes of variation in ICF/MR Medicaid reimbursement rates were rate-setting methods, wages, and staff-to-resident ratio. The age of a facility also caused significant variation in reimbursement rates. Based on our regression analysis, these factors explain 75 percent of the variation in reimbursement rates. These factors are controllable by States.

#### *Rate-setting Methods*

Federal Medicaid law and regulations require States to describe the rate-setting method in their Medicaid State Plans, but do not specify what that method will be. Not surprisingly, States employ widely different methodologies. Our analysis showed that State reimbursement rate policies accounted for variation in rates. States with the lower rates

- apply limits or caps on costs in calculating reimbursement rates,
- give efficiency incentives to encourage cost control,
- do not reimburse based on a minimum occupancy, and
- have a lower proportion of State central office overhead costs allocated to individual ICF/MR budgets.

States that use caps may apply them to specific cost centers (e.g., maintenance, dietary, routine services) or to aggregate costs. Frequently, a cost center cap is set by (a) ranking all the ICF/MRs based on their reported costs in that cost center, and (b) selecting a level for the cap. For example, one State caps the cost centers for administration, room, and board at 110 percent of the median costs of all large ICF/MRs in the State.

In addition, some States give facilities an incentive to keep costs down. For example, facilities were allowed to keep a portion of the difference between their actual costs

and the allowed amount under specific caps. The amount of the efficiency incentive ranged from 10 to 75 percent.

Some States reimburse facilities based only on actual patient days. Other States base reimbursements on a minimum occupancy, generally 80 or 90 percent of capacity, if actual patient days are less. States that do not use a minimum occupancy adjustment have lower reimbursement rates.

States allocate a portion of State-level administrative costs to the ICF/MRs. The percent of reimbursement for State administrative costs ranged from less than 1 to 12 percent. Those States with a smaller proportion of State administrative costs allocated to ICF/MR facilities had lower reimbursement rates.

### *Wages*

The wage level of ICF/MR employees was a very influential factor affecting reimbursement rates. The lower the wages, the lower the reimbursement rates. The large State-run ICF/MRs we examined are staffed with State government employees; therefore, the wage levels are determined by the State rather than the facility. Average annual wage, including fringe benefits, for direct care workers at State-run large ICF/MRs ranged from \$14,000 for the State with the lowest average reimbursement rate to \$47,000 for the State with the highest rate.

### *Staff-to-Resident Ratio*

A major expense for ICF/MRs is their staff. The number of staff each facility employs and how much they are paid strongly influences what a facility's reimbursement rate will be. Our analysis confirmed that ICF/MRs with lower staff-to-resident ratios have lower rates. In one of the States with high reimbursement rates the staff-to-resident ratio was three to one, while in a State with a lower rate the ratio was one to one.

### *Facility Age*

The final factor that our regression analysis showed had a statistically significant influence on reimbursement rates was age of the facility. We used the date each facility was certified to participate in the ICF/MR program as a proxy for age. The older its certification date, the lower its rate. This may be due to the way States reimburse ICF/MRs for capital costs. For example, in one State, capital costs for its newer facilities resulted in higher reimbursement rates.

## **Wide Differences in ICF/MR Reimbursement Rates Are Not Due to Quality of Service, Facility Characteristics, or Resident Demographics**

We included characteristics of ICF/MR facilities and their residents, such as size of facility and severity of disability, in our regression analysis because these factors could affect

ICF/MR reimbursement rates. Such variables, however, were not statistically significant; that is, they did not account for the wide differences in reimbursement rates among States.

### *Quality and Level of Service*

Quality and level of service as measured by ICF/MR certification standards did not cause wide variation in reimbursement rates. All facilities in our sample had passed their most recent annual surveys and been certified as having met the Federal operating and program standards. The 489 standards by which ICF/MRs are evaluated are the only measure of quality used to authorize or deny payment of Medicaid funds. Although it is difficult to measure quality, HCFA's quality of care standards require that each (1) resident receive continuous active treatment according to a detailed, individualized training plan, aimed at increasing independence, and (2) facility meet specified management, staffing, treatment, client rights, health, diet, and safety requirements. Since 1988, Federal guidance has directed State surveyors of ICF/MRs to focus on implementation of the active treatment requirement.

Our regression analysis showed that level and quality of service, as measured by ICF/MR certification standards, did not significantly affect reimbursement rates. Further, our on-site visits to 15 ICF/MRs in 7 States confirmed this finding. We observed little difference in quality and level of care in facilities with the highest rates and those with the lowest.

### *Facility Characteristics*

Our regression analysis showed that the following facility characteristics of the ICF/MRs were not significant in explaining the wide variation in reimbursement rates.

- size, as measured by number of residents
- percent of employees in direct care
- number of discrete living units
- occupancy rate (number of beds divided by number of residents)
- percent of all beds in a facility that are ICF/MR-certified

### *Resident Demographics*

For each ICF/MR, we included in our regression analysis the percent of residents

- with profound retardation,
- over age 65,
- under age 22,
- who are blind or deaf,
- who are nonambulatory,
- attending off-campus day programs, and
- using medication to control behavior.

None of these resident characteristics had a statistically significant effect on the wide variation among States in reimbursement rates. For example, differences among States in the proportion of residents who are nonambulatory or profoundly retarded did not account for the wide variation in reimbursement rates.

Appendix C contains details of the results of the regression analysis.

## **LACK OF EFFECTIVE CONTROLS RESULTS IN EXCESSIVE SPENDING**

Although some States have established effective controls and have lower reimbursement rates, in other States ICF/MR reimbursement rates may have exceeded a level necessary to provide required care. In the 15 ICF/MRs we visited, the prevailing attitude is that funding is not a problem. In an era when most Medicaid providers are being cut back and States are faced with budget shortfalls, virtually all ICF/MR administrators said they have sufficient funds. As one State administrator commented, any request for funds is rubber stamped, even if it is excessive.

States place fewer controls, in particular, on their State-run large ICF/MRs than on their other Medicaid providers. For example, all States apply limits or caps on costs when setting reimbursement rates for their nursing homes and 78 percent of States cap costs for their private ICF/MRs. Yet, only a third of the States use such cost control methods when setting reimbursement rates for their State-run ICF/MRs. Across States, the average, annual, per resident reimbursement for State-run large ICF/MRs (\$77,000) is almost double the average for large private ICF/MRs (\$42,000). Furthermore, in the privately-owned ICF/MRs we visited, cost controls had not forced cuts in services; rather, they had forced the ICF/MRs to operate more efficiently.

In some of the 15 facilities we visited, we observed the products of uncontrolled, excessive reimbursements, notably in staffing and buildings and grounds. In one State that has a high reimbursement rate, a State program official said that they were spending dollars on staff and buildings with no attendant improvement in quality of care.

### **Staffing**

In some facilities with higher-than-average reimbursement rates, the average staff-to-resident ratio is 50 percent higher than the national average. Further, our analysis of annual Medicaid survey data shows that the more employees per resident a facility has, the lower the percent of staff there are in direct care. For example, in one high-cost facility, an administrator commented that their four-fold increase in recordkeeping staff had not increased resident care.

In the States we visited, those with the highest reimbursement rate not only hire more staff, but hire professionals with advanced degrees to do the same jobs that are being done effectively by skilled staff without formal degrees in States with lower rates. Some States, for example, use volunteer foster grandparents while others employ full-

time degreed professionals to supervise residents when they are not engaged in formal training routines.

Extra staff does not necessarily improve resident outcomes. Outcomes are less affected by numbers of staff, than how they are deployed. Our analysis shows virtually no correlation between staff to resident ratios and the number of deficiencies on annual certification surveys. At one ICF/MR, we were told that correction of most certification deficiencies requires better management of staff, not added staff. The administrator at another ICF/MR commented that if staff do everything for residents, prepare food, do laundry, etc., as is done in large institutions, residents do not have the opportunity to develop independent living skills.

### **Buildings And Grounds**

As shown by the following illustrations, Medicaid funds are used to help maintain large and sometimes exorbitant ICF/MR buildings and campuses.

- Two of the 15 ICF/MRs we visited maintain what they called hospitals on campus. The hospitals were fully staffed with physicians and nurses, yet surgery and inpatient care are obtained at nearby community hospitals.
- Another ICF/MR that was slated to close in 3 years is building a \$7.2 million food service building.
- At another ICF/MR major renovations to dormitory buildings are underway despite plans for closure in a few years.
- Many ICF/MRs maintain hundreds of acres of grounds which in some cases are used for recreational activities by the neighboring community, more than by the ICF/MR residents.

# RECOMMENDATIONS

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## HCFA SHOULD TAKE ACTION TO REDUCE EXCESSIVE SPENDING OF MEDICAID FUNDS FOR ICF/MRs.

HCFA can accomplish this objective in several ways, including one or more of the following.

*HCFA can take administrative action to control ICF/MR reimbursement under current authorities.* Conceivably, administrative controls can forestall a need for legislative action. However, HCFA should take administrative actions in the interim even if it chooses to develop legislative proposals. Following are examples of specific administrative actions.

**Administrative Cost Controls:** Encourage States to adopt effective cost controls for ICF/MRs. HCFA can do so by: strengthening Federal rate-setting guidelines, such as those on upper payment limits; periodically producing a compendium of cost containment mechanisms successfully used by States to control ICF/MR expenditures; and providing technical assistance to State Medicaid agencies to help them adopt methods used by other States with effective controls.

*HCFA can seek legislation to control ICF/MR reimbursement.* Following are several examples of legislative options.

**Mandatory Cost Controls:** Require States to implement effective cost control mechanisms in their ICF/MR rate-setting methodology as a condition for receiving Federal financing. The legislation could specify the kinds of controls, such as caps on costs, or efficiency incentives.

**Federal Per Capita Limit:** Limit Federal financial participation for each resident of an ICF/MR. The Federal government would match State payments up to a maximum amount per resident. State expenditures beyond that amount would not be eligible for Federal matching payments.

**Flat Per Capita Payment:** Set a specific Federal per capita payment amount for residents of ICF/MRs. States would receive a flat amount for each resident of an ICF/MR regardless of how much States spend. In addition to helping control Federal expenditures, this would allow States to budget for Federal funds based on their institutionalized developmentally disabled population.

**Case-mix Reimbursement:** Develop a reimbursement system for residents of ICF/MRs based on the functioning level of the residents and the level of care provided to them. Specific payment amounts would be based on a facility's case mix of residents and the programs being provided for them. This option



would refine the typical State reimbursement methodology which reimburses facilities at the same rate per resident regardless of residents' needs or level of care being provided.

**National Ceiling for ICF/MR Reimbursements:** Cap total Federal reimbursements for ICF/MR services. States would be allocated a specific amount under the cap regardless of any State program changes.

*HCFA can seek comprehensive legislation to restructure Medicaid reimbursement for both ICF/MR and Home and Community-based (HCB) waiver services for developmentally disabled people.* Restructuring would combine institutional and community-based Medicaid expenditures under one authority and remove the current reimbursement incentive that favors institutional over community spending. HCFA could expand one or more of the ICF/MR-specific options listed above to include community-based care or select one of the following broad legislative options.

**Global Budgeting for Developmentally Disabled Recipients of Medicaid Services:** Combine all Federal ICF/MR and HCB waiver funding under one authority. To compute the amount of Federal funds each State would receive, HCFA could negotiate a dollar cap with the States.

**Block Grants:** Provide a grant to each State for operating institutional and community-based programs for its developmentally disabled citizens. This option offers States flexibility; however, the legislation should assure that Federal program requirements continue to be enforced.

**Financial Incentives:** Offer States financial incentives to move residents out of institutions and into lower cost community-based care. An incentive system is consistent with existing Federal program policy preferences for community-based care. The program would be structured to ensure that savings from more cost efficient operations exceed the amount of incentives offered.

The above options are not intended to be an all inclusive list for reducing excessive spending for ICF/MRs. However, we estimate considerable savings to the Medicaid program from implementing one or more of the suggested options. To illustrate, we estimate that \$683 million in Federal and State Medicaid funds could have been saved in 1991 by implementing only the cost control method of capping costs. Potential savings from implementing other options would depend on how the options are implemented. For example, if a Federal per capita limit for ICF/MRs were set at no more than the current average annual reimbursement rate of \$61,000, we estimate \$565 million in Federal and State Medicaid funds could have been saved in our sampled States in 1991. Appendix D shows how we estimated savings.

## AGENCY COMMENTS

We circulated the draft report for comment to the Administrator of the Health Care Financing Administration (HCFA), the Assistant Secretary for Planning and Evaluation (ASPE), and the Assistant Secretary for Management and Budget (ASMB). Appendix E shows the full text of the comments provided by ASPE and HCFA. ASMB did not comment on the report.

The ASPE concurred with our recommendations but expressed concern that they could appear to some readers of the report as an unfounded attempt to reduce total spending on behalf of people with mental retardation. To clarify, our recommendations are targeted to reduce only excessive spending which we found does not affect the quality of care for residents of ICF/MRs. In response to ASPE's technical comments, we made changes to clarify our information where necessary.

The HCFA did not dispute our report findings but did not concur with our recommendations. They stated that the Medicaid statute and regulations allow little discretion in imposing additional administrative controls to curb ICF/MR payments and that legislation would be needed to implement the other options we recommended. Further, HCFA stated that any legislative changes should only be considered as part of the Administration's national health care reform, which is still under development.

We continue to believe HCFA should take action to control reimbursement and ensure that Medicaid payments for ICF/MRs are reasonable. We have documented unnecessary Medicaid spending at ICF/MRs. HCFA certainly can encourage States to adopt effective cost controls for ICF/MRs, can strengthen rate-setting guidelines, and can develop specific legislative proposals and submit them for Departmental review. We believe prudent management of Federal resources for ICF/MRs is important and will continue to be so under the Administration's upcoming national health care reform. Therefore, controls over unnecessary Medicaid spending should not be delayed, particularly during this period of financial crisis for the Medicaid program.

## ENDNOTES

1. House Report No. 96-1479 (p. 154) on H.R. 7765, the "Omnibus Reconciliation Act of 1980," Section 962 of P.L. 96-499.
2. See Bibliography for exact citations of studies conducted by Conroy, and Bradley; Nerney, Conley, and Nisbet; and Moscovitch. These are just a few of the studies on this issue. Many more are cited in the report by Robert Helms, Assistant Secretary for Planning and Evaluation.
3. In the 1990 reauthorization of the Developmental Disabilities Assistance and Bill of Rights Act, one of the stated purposes of the law is, "to enable [persons with developmental disabilities] to achieve their maximum potential through increased independence, productivity, and integration into the community." 42 U.S.C., section 6000, (b)(1).
4. To estimate total 1991 Medicaid expenditures, we multiplied the average reimbursement per resident, obtained from our State survey, by the number of residents in ICF/MRs over 15 beds. The latest available data for residents in facilities over 15 beds is 1990 -- 110,548. The resident data was obtained from the Recurring Data Set Project of the Center for Residential Services and Community Living, University of Minnesota, K.C. Lakin. We reduced the 1990 figure and used 110,000 as an estimate for 1991, a conservative reduction of 0.5 percent.
5. To calculate the percentage of total Medicaid dollars and recipients attributable to large ICF/MRs, we referred to HCFA's Form 2082 which reports the total vendor payments and total recipients for all Medicaid for Fiscal Year 1991. We then divided the expenditure and recipient figures we use in the report for large ICF/MRs (\$6.7 billion and 110,000, respectively) by the Medicaid totals from the HCFA Form 2082.

# APPENDIX A

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# APPENDIX B

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## METHODOLOGY

### *Sample Selection*

Our population included 48 States and the District of Columbia. Wyoming and Arizona were excluded because they participated in the ICF/MR program for only part of the 1981 to 1990 period we used for stratification.

For a regression analysis, we stratified States by percent change in number of residents of all large ICF/MRs (over 15 beds) between 1982 and 1990. We placed each of the 48 States and the District of Columbia in one of three strata.

- 1) Large decrease in residents (26% - 78%)
- 2) Moderate decrease in residents (1% - 25%)
- 3) Increase in residents

By stratifying and then randomly choosing States from each strata, we assured that our sample included States that are pursuing different policies regarding the size of their institutions. The amount of decrease in institutional residents reflects differing State policies on downsizing institutions and increasing community-based care. We obtained the number of residents in ICF/MRs from the Recurring Data Set Project of the Center for Residential Services and Community Living, University of Minnesota, K. Charlie Lakin.

We then selected 24 States through random sampling. Within these States, we included all large ICF/MRs.

Two States did not respond to our survey questionnaire, reducing the sample from 24 States and 399 large ICF/MRs to 22 States and 380 large ICF/MRs. Of the large ICF/MRs in the sample, 117 were State-run and 263 were private.

For site visits, we arrayed the 22 sampled States according to percent change in (1) number of residents between 1982 and 1990, and (2) expenditures for large ICF/MRs between 1981 and 1988 (latest available data). We placed the States in two strata based on change in expenditures. We obtained the expenditure data from a study done by the University Affiliated Program, University of Illinois at Chicago, Dave Braddock, et.al., 1989.

The following matrix illustrates the 6 categories (cells) our bracketing created and the number of sampled 22 States in each cell.

SAMPLING MATRIX				
		% CHANGE IN ICF/MR RESIDENTS		
		Large Decrease	Moderate Decrease	Increase
% CHANGE IN TOTAL ICF/MR EXPENDITURES	Smaller Increase	4	3	2
	Larger Increase	4	5	4

For our site visits, we then randomly selected one State from each cell, a total of six States. We selected States this way to assure that we visited States that represent wide differences in expenditure and resident trends. In addition we visited one State to test our data collection instruments, for a total of seven States selected for site visits.

#### *Data Collection*

We collected data from the following four sources.

- 1) The On-line Survey, Certification and Reporting System (OSCAR) maintained by HCFA
- 2) A mail survey of State Medicaid agencies
- 3) Interviews with State officials in seven States
- 4) Site visits to 15 large ICF/MRs

The OSCAR database contains detailed information on ICF/MRs. These data are updated at least once a year when a facility is surveyed for Medicaid recertification. We compiled a database, using dBase III+, consisting of variables from the OSCAR file for all the facilities in our 22 sample States. The variables identified the facilities, including whether they were private or State-run, and described the residents and the facilities. We also used existing OSCAR data to create new variables, such as staff-to-resident ratio.

We compiled a second database from the results of a State survey. We asked each State Medicaid agency to answer questions concerning (1) reimbursement rate for each facility for State Fiscal Year 1991, (2) how States set reimbursement rates for both State-run and private ICF/MRs, (3) average wage for direct care workers at State-run and private ICF/MRs, and (4) percent of reimbursement for capital, administration, and State central office overhead allocated to ICF/MRs. When

needed for clarification, we requested that States also send supporting documents describing their rate-setting methodologies.

Finally, we visited seven States and, using structured guides, interviewed Developmental Disabilities program staff, and, in most cases, State Medicaid agency staff involved in setting ICF/MR rates. We also visited at least one State-run and one private ICF/MR, where available, in each State, toured the facility, and interviewed staff.

### *Data Analysis*

To determine the extent of variation in reimbursement rates, we computed each State's average rate and compared those across States. We used analysis of variance to confirm that there was significant variation in rates among States.

To determine causes for variation in rates, we completed a regression analysis. We constructed and tested a model consisting of 24 independent variables to determine which variables affect the reimbursement rate (dependent variable).

The independent variables are listed below by three categories. Following each variable, in parentheses, is an abbreviated title that we used for our regression analysis described in Appendix C.

#### Facility Characteristics

- 1) Size, measured by number of residents (Size)
- 2) Number of discrete living units (# Units)
- 3) Occupancy rate -- number beds divided by number residents -- (Occup.)
- 4) Percent of all beds in a facility that are ICF/MR certified (%ICF/MR)
- 5) Age of facility -- date began participation in the ICF/MR program -- (Part.date)
- 6) Percent of employees working in direct resident care (%DirCare)
- 7) Total number of deficiencies on the facility's last annual Medicaid certification survey (Defics.)
- 8) Total staff-to-resident ratio (Stff:Res)

#### Resident Characteristics

##### Percent of residents

- 1) with profound retardation (%ProRtrd)
- 2) over age 65 (%Over 65)
- 3) under age 22 (%Under 22)
- 4) who are blind or deaf (%Bld/Deaf)
- 5) who are nonambulatory (%Nonambu)
- 6) attending off-campus day programs (%DayProgs)
- 7) using medication to control behavior (%onDrugs)



## State Reimbursement Policy Factors

- 1) Limits or caps on allowable costs (Caps)
- 2) Efficiency incentive (Incentive)
- 3) Minimum occupancy adjustment (OccAdjmt)
- 4) Amount of cost of living adjustment (COLA)
- 5) Percentage of total reimbursement for capital expenditures (Capital)
- 6) Percentage of total reimbursement for administration (Admin.)
- 7) Percentage of total reimbursement for State, central office overhead allocated to the ICF/MRs (Overhead)
- 8) Average wage of direct care staff (Wage)
- 9) Per capita State spending for all services -- total direct general expenditures for the State divided by total residents, based on data obtained from the U.S. Bureau of the Census, Government Finances, Series GF, No. 5, annual -- (PerCapSp.)

Our regression analysis included only State-run facilities. We did not complete a regression analysis of the private ICF/MRs because many States were unable to provide data on wages, proportion of reimbursement for capital, administration and central office costs.

We did not validate the OSCAR database prior to our analysis.

We used a linear regression analysis to determine which of the above variables significantly affected Medicaid expenditures for ICF/MRs. This method uses the data from the independent variables to explain variation of the dependent variable. Linear regression fits a straight line to the data using the method of least squares. Below is the equation for the general model.

$$Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \dots + \beta_k X_k + e$$

In this equation, Y, the dependent variable, is the per diem reimbursement rate. The X's, the independent variables, are the variables listed above that we included in the model (the facility and resident characteristics, and State reimbursement policy factors). The Betas are values calculated as a result of the regression and show the influence of each factor on the reimbursement rate. The Beta values are reported in Appendix C under Parameter Estimate. The epsilon represents the residuals, the difference between the observed and the predicted values according to the model.

# APPENDIX C

## REGRESSION RESULTS

We used SAS (Statistical Analysis System) software for the regression analysis. The SAS program eliminates all data for an observation with missing values. We did not receive complete information for 20 State-run facilities. Therefore, the regression model was computed using 97 of 117 selected State-run ICF/MRs.

The following table shows the overall regression results of our full model, i.e., with all 24 variables. It includes the estimate, standard error, t-value for all variables and the significance level (probability  $> |t|$ ). The t-value for each variable tests for the effect of each independent variable on the dependent variable. The last column gives the probability of the t-value. The t-values and the associated probabilities (probability  $> |t|$ ) test the hypothesis that the parameter is actually zero and answers the question: If the true slope and intercept were zero, what would the probability be of obtaining, by chance alone, a value as large or larger than the one actually obtained?

STATE FACILITIES FULL MODEL

Variable	Parameter Estimate	Standard Error	t-Value	Probability $>  t $
Intercept	-141.94	151.25	-0.938	0.3511
Caps	-32.69	20.58	-1.589	0.1165
COLA	3.11	2.64	1.177	0.2429
Incentive	-76.82	25.07	-3.064	0.0031
OccAdjmt	110.35	27.56	4.004	0.0001
Wage	.003	.0009	3.166	0.0023
Capital	-2.08	3.93	-0.529	0.5983
Overhead	3.60	4.16	0.867	0.3889
Admin.	-1.84	1.20	-1.536	0.1288
Part.date	2.86	1.63	1.751	0.0843
PerCapSp.	.003	0.02	0.136	0.8920
Defics.	0.57	0.32	1.778	0.0797
Size	-0.01	0.03	-0.423	0.6737
# Units	-0.62	0.68	-0.909	0.3665
Occup.	-0.04	0.08	-0.444	0.6581
%ICF/MR	0.57	1.45	0.391	0.6971
%Bld/Deaf	1.74	68.51	0.025	0.9798
%DayProgs	-21.18	34.52	-0.614	0.5414
%onDrugs	-14.82	35.82	-0.414	0.6802
%ProRtrd	-17.53	26.14	-0.670	0.5048
Stff:Res	30.04	10.34	2.904	0.0049
%DirCare	-2.76	29.13	-0.095	0.9248
%Undr22	-30.71	38.70	-0.794	0.4300
%Over65	1.60	54.12	0.030	0.9765
%Nonambu	14.23	16.17	0.880	0.3817

The R-square term indicates the percentage of the variation explained by the model. The R-squared value and adjusted R-squared values of .80 and .73, respectively, indicate that 73 percent of the variation in per resident reimbursement rate in State-run facilities is explained by the full model.

***Reduced model***

Next, we performed a stepwise regression in order to find the model which explains the greatest amount of the variation in the dependent variable with the fewest number of independent variables. Most variables that were statistically significant in the full model were also significant in the stepwise regression. However, in the regression model building process, the statistical significance of the independent variables may change in the reduced model. The following table shows the results of the stepwise regression. As shown in this table, all eight independent variables in our reduced model were statistically significant at the .01 level. We examined the residuals and found that they were normally distributed.

Of the 24 independent variables, only the following 8 variables were statistically significant. These 8 variables explain 75 percent of the variation in the dependent variable. The regression model produced an R-square of .77 and an adjusted R-square of .75.

STATE FACILITIES REDUCED MODEL

Variable	Parameter Estimate	Standard Error	t value	Probability >  t
Intercept	-198.19	122.10	-1.62	.1081
Caps	-33.16	13.20	-2.51	.0138
Incentive	-88.59	19.95	-4.44	.0001
OccAdjmt	145.89	17.69	8.25	.0001
Wage	0.0026	0.0006	4.28	.0001
Overhead	7.70	2.54	3.04	.0031
Admin.	-3.01	0.87	-3.47	.0008
Part.date	3.55	1.40	2.54	.0129
Stff:Res.	26.05	6.95	3.75	.0003

# APPENDIX D

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## SAVINGS CALCULATION

### COST CONTROLS

1. From our sample, we determined that **73 percent** of residents in State-run ICF/MRs are in States where the rate-setting methodology does not include caps on costs.
2. Based on data from the Recurring Data Set Project, there were **77,281 residents** in all State-run large ICF/MRs in 1990.
3. **77,281 residents x 73 percent = 56,415 residents** are in State-run large ICF/MRs in States without caps.
4. The regression results showed that, controlling for all other variables in our model, States that applied caps in their rate-setting methodologies had significantly lower per diem rates. The cumulative effect of caps over time was a reduction in the per diem rate of **\$33.16 per resident on average, or \$12,103 per year per resident.**
5. If all States that did not cap allowable costs in 1991 had implemented caps at the same time intervals as those with caps, then the Medicaid savings, Federal and State shares combined, in 1991 would have been **\$683 million** (56,415 residents x \$12,103 per resident).

### FEDERAL PER CAPITA LIMIT

1. From our sample, we listed the average annual reimbursement per resident in large State-run ICF/MRs in 1991 for each of the 22 sampled States.
2. We selected the overall average annual rate of reimbursement for all large ICF/MRs, \$61,000, as the per capita limit. HCFA may select other ways of determining a per capita limit.
3. We subtracted the per capita limit from each State's 1991 average annual reimbursement for large State-run ICF/MRs to determine the amount each State exceeded the limit. States with average per capita reimbursement below the limit would not have been subject to the limit; therefore, they were not included in this calculation.
4. We then multiplied the amount each State exceeded the limit by the number of ICF/MR residents in the State and determined the savings would have been **\$565 million** in 1991.

# APPENDIX E

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## AGENCY COMMENTS

1993 FEB -6 PM 4:32

FEB 5 1993

TO: Bryan B. Mitchell  
Principal Deputy Inspector General

FROM: Acting Assistant Secretary for Planning and Evaluation

SUBJECT: OIG Draft Report: "Medicaid Payments to Institutions  
for Mentally Retarded People," OEI-04-91-01010 --  
CONCUR WITH COMMENTS

I am pleased to have the opportunity to comment on your recently completed study "Medicaid Payments to Institutions for Mentally Retarded People." Your staff has worked closely with ASPE in the design of this study and I hope that we will be able to continue such collaborative efforts in the future.

I would also like to commend your staff for taking on such a methodologically complex task. The findings are very important and we appreciate their good work.

#### COMMENTS

##### Primary Comment

In our original discussions with your staff, we proposed that you analyze the extent and causes of variations in the costs of large ICFs/MR and compare them to the costs of serving people with mental retardation in community-based residential settings funded under the Medicaid waiver program. Because the focus of the actual study was limited to large ICFs/MR, the policy implications tend to focus on strategies for limiting the cost of these types of facilities. Yet, as you point out in the report, large state institutions are becoming anachronistic as a way of providing services to people with mental retardation and there is widespread agreement that small community-based residential arrangements are superior settings for virtually everyone regardless of their level of disability.

In addition, recommending that HCFA take action to reduce ICF/MR spending could appear to some readers of the report as an unfounded attempt to reduce spending on behalf of a population that receives a relatively small percentage of total Medicaid spending. That is, while ICF/MR per capita expenditures are high, and while ICF/MR costs are several times higher than community MR/DD Medicaid costs, spending on behalf of other

populations far exceeds MR/DD spending. I do not believe the intent of this report was to reduce total federal spending on behalf of people with mental retardation.

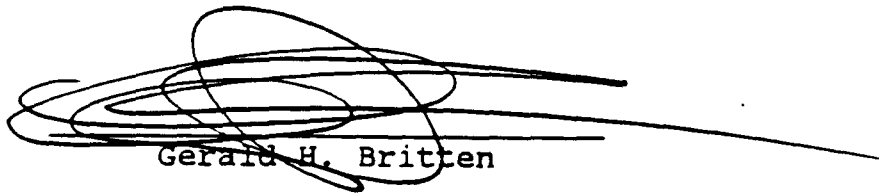
I think the report would be strengthened if it straightforwardly acknowledged right up front some of these issues and dilemmas. For example, it should point out that there is widespread agreement in the MR/DD field that people with mental retardation are better off in community settings rather than in institutions. It should also point out that in spite of some steps such as the waiver program and the new Community Supported Living Arrangements program in Medicaid, Medicaid expenditures go overwhelmingly to support large scale institutions. It should also acknowledge that the scope of this report had to be limited to a study of institutions although it would have been desirable to do the comparisons with community settings originally contemplated. Finally the report should state that although the findings of the study largely focus on short term ways to control reimbursement to large institutions, comprehensive reform of federal MR/DD policy is required to align it with what we know about the best way to provide services to people with mental retardation. The report should also acknowledge the fact that the evolution of ICF/MR policy has resulted in some perverse incentives for state officials to over-rely on ICF/MR reimbursements in order to buy flexibility on the community side of the equation.

#### Other Comments

1. It would be useful to include statistics comparing the proportion of total Medicaid dollars spent on large ICFs/MR and on community residential settings. Such comparisons could be drawn using the work of Charlie Lakin and Dave Braddock. The report should also compare the number of people residing in large ICFs/MR with the number of persons receiving community based MR/DD services.
2. "People First" language should be used throughout the report, consistent with efforts by Congress and the Administration to use such language. In particular, the report should refer to "people with mental retardation" rather than "the mentally retarded," or "mentally retarded people."
3. In explaining "Who is Served in ICF/MRs" in the Introduction, the authors use definition of "developmental disability" contained in the Developmental Disabilities and Bill of Rights Act. Since Title XIX defines ICF/MR eligibility in terms of people with "mental retardation and related conditions," and Medicaid guidelines define that phrase, it would be more clear to explain "who is served in ICF/MRs" in terms of ICF/MR eligibility guidelines.

4. In the section on "Trends," it is confusing to say that federal program policy encourages treatment in community settings. It is much more accurate to say that the federal DD Act goals for people with mental retardation which promote productivity, independence and community integration are in conflict with federal financing policy under the Medicaid program which continues to be biased in favor of institutional care (as you explain when you talk about limits on the number of people served under the HCB waivers).
5. In the section on "Methodology," it is not clear whether you interviewed staff of State MR/DD agencies, developmental disability councils or both.
6. Regarding "Quality and Level of Service," the point should be made that compliance with the ICF/MR standards ensures only a minimal level of quality. It is very difficult to measure quality of life and service outcomes, even in the relatively controlled environment of an institution.

If you have questions or concerns, please contact Mary Harahan, Acting Deputy Assistant Secretary for Family, Community and Long-Term Care Policy at 690-6443.



Gerald H. Britten

cc: William Toby, Jr.  
Acting Administrator  
Health Care Financing Administration

Elizabeth M. James  
Acting Assistant Secretary for  
Management and Budget



**Memorandum**

APR 26 1993

Date *William Toby, Jr.*  
From William Toby, Jr.  
Acting Administrator

Subject Office of Inspector General (OIG) Draft Report: "Medicaid Payments for Institutions for Mentally Retarded People" OEI-04-91-01010

To Bryan B. Mitchell  
Principal Deputy Inspector General

We have reviewed the above-referenced draft report which attempts to determine the extent and causes of variation among States in per resident Medicaid reimbursement rates for large intermediate care facilities for the mentally retarded (ICFs/MR).

OIG found that Medicaid reimbursement rates for large ICFs/MR are more than five times greater in some States than in others. State policies, rather than quality of service, facility characteristics, or resident demographics, account for variation in ICF/MR Medicaid reimbursement rates among States. As a result of the findings, OIG recommends that the Health Care Financing Administration (HCFA) take action to reduce excessive spending of Medicaid funds for ICFs/MR.

We must nonconcur with the recommendation. Medicaid's statutory provisions allow States to establish their own payment systems. This flexibility allows for the variation among States in their payment rates, methods, and standards used in determining these rates.

States are free, within two constraints, to establish their methods and standards for determining ICF/MR rates. The minimum limit is that the rate paid must be, as required by section 1902(a)(13)(A) of the Social Security Act, reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities. The maximum limit is that aggregate payments may not exceed the amount that would have been paid using the Medicare principles of reimbursement. The State must provide an assurance to the Secretary that its rates are consistent with the upper limit requirements at 42 CFR 447.272. The regulation also requires States to provide this assurance for State-operated facilities.

**Page 2 - Principal Deputy Inspector General**

**Therefore, the statute and implementing regulations that govern Medicaid payments to ICFs/MR, allow HCFA little discretion in imposing additional administrative controls to curb ICF/MR payments. Legislative action would be necessary to implement the mandatory cost controls contained in the recommendation. Furthermore, any new legislation should be considered within the national health care reform framework being developed by the new administration.**

**Thank you for the opportunity to review and comment on this draft report. Please advise us if you agree with our position on the report's recommendation at your earliest convenience.**

Health and Human Services

OFFICE OF  
DIRECTOR GENERAL

AND PAYMENT TO INSTITUTIONS  
FOR PEOPLE WITH MENTAL  
RETARDATION

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This report was prepared in the Atlanta regional office under the direction of Jesse J. Flowers, Regional Inspector General and Christopher Koehler, Deputy Regional Inspector General.  
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