HEALTH CARE FOR THE DEVELOPMENTALLY DISABLED AND MENTALLY RETARDED

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Issue Statement

North Carolina continues to increase the number of Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) while most states are decreasing their use of ICF/MR beds, instead aggressively implementing home-and community-based service as an alternative to ICFs/MR.

The purpose of this paper is to examine the factors that have contributed to North Carolina's:

- Continued reliance on ICF/MR services as a preferred mode of service delivery
- Higher costs of care for these facilities relative to other states' costs
- Underutilization of home- and community-based services, specifically as it relates to individuals with more challenging medical and behavioral needs.

Several options presented in this paper provide the state with options to control the size and expenditures of this program by expanding home- and community-based services.

Background

Prior to 1972, most states provided services to individuals with mental retardation in large congregate care institutions, often owned and operated by the state. These institutions varied in size from 300 to 1,000 beds. In many states, these facilities were over 100 years old with decaying infrastructures.

Concern over the conditions of these facilities and the treatment of the residents in these institutions prompted federal intervention. In 1972, the Department of Health and Human Services (HHS) allowed states to include a new optional service in their Medicaid Plan, Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). States could capture federal Medicaid revenue for services provided in these facilities that were previously funded by state revenues only. To receive Medicaid dollars for these facilities, states were required to comply with various regulations and license these facilities.

States quickly included the option in their state plans. Every state, with the exception of Arizona, developed ICFs/MR. By 1977, over 149,000 individuals nationwide were residing in ICFs/MR.

To meet federal standards, states expended more revenue for these facilities. Between 1977 and 1982, total expenditure for these facilities increased by 295 percent. As concerns over these expenditures grew, and as families advocated for community services, states began funding small community-based ICFs/MR with 16 beds or less. These small facilities were

less costly than large state ICFs/MR, provided care in a more normative, home-like setting, and were closer to the residents' families.

Most states, including North Carolina, developed smaller community-based ICFs/MR to downsize state-operated facilities and to serve individuals who were in the community who needed residential services. Between 1982 and 1988, 157,000 individuals were served nationwide in small community-based ICFs/MR. Since 1988, the development of smaller community-based ICFs/MR has decreased dramatically, due to the development of other Medicaid funded community-based services. (These services will be discussed later in this issue paper). As Exhibit 1 illustrates, the nationwide ICF/MR population has decreased by 1.5 percent since 1987.

This overall decrease is due to a simultaneous:

- Decrease of approximately 11,000 individuals (12 percent) in state-operated ICFs/MR between 1987 and 1990 from 91,000 to 80,000 individuals.

- Increase of approximately 8,500 (12 percent) individuals in private ICFs/MR between 1987 and 1990 from 58,000 to 66,900.

Despite this national trend, private ICFs/MR continue to be developed in North Carolina. Between 1987 and 1990, the number of individuals served in private ICFs/MR increased by 226 percent from 698 to 2,282.

State Facility Phasedown

In addition to phasing down community ICF/MR development, most states have aggressively downsized state-operated ICFs/MR. Between 1977 and 1988, the number of individuals residing in state-operated ICFs/MR decreased from 149,000 to 91,000. Most states have been successful in downsizing state facilities due to their aggressive development of community programs and restrictive admission policies for individuals seeking admission to these facilities. Some states are under court order to deinstitutionalize state-operated ICFs/MR and allow no new admissions, due to poor conditions in their facilities. Other states have voluntarily developed admission policies which allow access only in emergent situations.

North Carolina has followed the national trend to downsize its state-operated ICFs/MR. Between 1977 and 1991, the state-operated ICF/MR census decreased from 3,800 to 2,525 individuals. However, the state-operated ICF/MR census has remained relatively constant over the last few years, with annual decreases from 3 to 5 percent. This is attributed to an increase in the number of admissions and a decrease in the number of discharges.

EXHIBIT 1

ICF/MR MEDICAID POPULATION: 1987-1990

State	1987	1988	1989	1990	Percent Change 1987-1990
North Carolina	3,245	3,439	3,687	4,000	23.3%
Alabama	1,374	1,369	1,362	1,354	(1.5%)
Florida	3,419	3,365	3,401	3,247	(5.0%)
Georgia	1,765	1,743	1,765	1,758	(0.4%)
Kentucky	1,268	1,300	1,259	1,259	(0.7%)
Mississippi	1,628	1,640	1,681	1,905	17.0%
South Carolina	2,900	2,974	3,254	3,397	17.1%
Tennessee	2,538	2,347	2,254	2,269	(11.6%)
Total Region IV	1,8138	18,177	18,663	19,189	5.8%
Nation	149,413	145,408	147,767	146,931	(1.5%)

Source: HCFA 2082 reports

ICF/MR Rates

Each state develops its own reimbursement methodology to reimburse ICF/MR providers. The reimbursement methodology may be based on the:

- Size of the facility. The reimbursement methodology may take into account differences in cost due to economies of scales for a facility serving 16 versus 100 individuals.

- Difference in level of care needed by individuals residing in these facilities. In some states, facilities are paid higher rates of reimbursement for more medically and behaviorally involved/individuals.

- Historical cost. In some states, facilities will have their rates increased annually based on the previous year's costs of the facility. This methodology is often used for state-operated facilities.

- Annual increases in flat rates. In this case, every provider throughout the state receives the same rate. Rates are adjusted annually based on market basket inflation factors.

This variance in rate methodology has led to difference in rates paid to ICF/MR providers. Although FY92 data was not readily available for each state's ICF/MR rates, several states with private ICFs/MR and similar number of ICF/MR beds were contacted to obtain this data. Exhibit 2 provides a comparison of other states daily rates. Of the states surveyed, North Carolina has the highest community ICF/MR rates. The higher rates may be due to:

- The current methodology, which reimburses providers on facility-specific basis adjusted for inflation annually rather than a flat prospective rate.

- Inadequate review of proposed capital expenditures during the Certificate of Need process.

- Relatively more stringent licensure requirements related to minimum staffing requirements and physical plant requirements.

The North Carolina General Assembly recognizes the significant impact of ICF/MR reimbursement on the State budget. For this reason, the Department of Human Resources is mandated to study ICF/MR reimbursement and report to the 1993 General Assembly.

EXHIBIT 2
COMPARISON OF PER DIEM RATES FOR COMMUNITY ICFs/MR

State	Average Per Diem
Idaho	$160
Indiana	$108
Kansas	$130
Minnesota	$109
Illinois	$80
Pennsylvania	$157
North Carolina	$172
Oklahoma	$58

Source: KPMG Peat Marwick state survey 9/15/92

Home- and Community-based Services

In 1982, HHS allowed states to receive federal Medicaid reimbursement for home-and community-based services (HCBS) for the mentally retarded and developmentally disabled. States requesting these funds were required to submit applications (Waivers) to the Health Care Financing Authority (HCFA) to:

- Restrict access to services to individuals currently residing in ICFs/MR or at risk of being placed in an ICF/MR to home- and community-based services.

- Require states to demonstrate that the average cost of home- and community-based care would be equal to or less than the average cost of care in an ICF/MR.

Thirty-eight states applied for a HCBS Waiver and are receiving Medicaid funding for these services. Nationwide, participation in the HCBS Waiver has increased dramatically from 200 individuals in 1982, to 69,000 in 1992.

North Carolina offers home- and community-based services under its Medicaid State plan. This program, the Community Alternative Access Program for persons with Mental Retardation (CAP/MR), serves 1,288 individuals.

States have used their HCBS Waiver to deinstitutionalize their state and private ICFs/MR and to keep individuals in their own or families' homes. Initially, most states targeted HCBS to individuals residing in these facilities who had fewer limitations on activities of daily living and therefore requiring less staff resources, and required less resources. These individuals require a moderate scope of HCBS services, including:

- Respite care
- Personal care
- Habilitation and training services
- Day Service
- Routine medical care

As deinstitutionalization occurred, the case mix of ICFs/MR changed, serving more medically and behaviorally involved individuals. The initial scope of HCBS offered under the waiver was not adequate to meet these individual needs. In an effort to continue deinstitutionalization efforts, some states have amended their HCBS Waivers to include services that respond to these individuals' needs. Additional services states include under their Waivers are:

- Behavioral respite
- Behavioral intervention
- Adaptive equipment

North Carolina provides an array of services similar to those provided by most other states, including:

- Case management
- Homemaker
- Personal care
- Recreational therapy
- Adult day health
- Personal habilitation
- Respite care
- Ancillary services

The State has not amended its Waiver to include services for persons who are more medically or behavioral involved.

In an effort to control HCBS costs, HCFA allows states to set cost limits that are below the average costs of ICF/MR services. Most states use the ICF/MR average cost as their cost ceiling for HCB services. North Carolina does limit or "cap" services for CAP/MR recipients below the average cost of ICF/MR services. In FY92, expenditures for CAP/MR services per individual were limited to $12,000 annually, significantly below the average North Carolina ICF/MR annual cost of $61,000.

Findings

Finding 1: ICFs/MR continue to be developed in North Carolina, even though most states have decreased the number of individuals residing in ICFs/MR.

Between 1987 and 1990, the number of individuals residing in private and State-operated ICFs/MR increased from 3,245 to 4,000, a 23 percent increase. Nationwide, the ICF/MR census decreased from 149,143 to 146,931 individuals, a decrease of 1.5 percent. Five of the seven states in the Health Care Financing Administration Region IV decreased their ICF/MR populations. Most states that have decreased this population have aggressively implemented an HCBS system for residents previously residing in ICFs/MR.

In FY91, 434 more ICF/MR beds were added to the existing supply of beds in North Carolina; 140 were added in FY92, and another 160 beds are scheduled to be developed in FY93. This expansion continues, although DMH/DD/SAS has identified 236 persons who no longer need ICF/MR placement and only 90 additional individuals who will need ICF/MR level of care. In addition, a provider has requested approval from the State to convert a residential group home to an ICF/MR. This will increase daily costs from $66 to $172 per resident.

Finding 2: North Carolina rates for private ICFs/MR are ranked among the highest in the country.

North Carolina daily expenditures for an individual residing in an ICF/MR were $172. As Exhibit 2 indicates, North Carolina ICF/MR rates are higher than rates in six states surveyed in the study.

This higher rate may be due to several factors. Currently, North Carolina's ICF/MR reimbursement methodology is based on the historical cost of a facility. The reimbursement rate will increase based on costs incurred by the facility, regardless of whether this increase is consistent with increases in the market basket index for medical care, nursing facility care, or the general Consumer Price Index. Over the last five years, increases in the daily North Carolina ICF/MR rate have varied from 5 to 9 percent, slightly higher than market basket increase of 5 to 7 percent used for nursing facility rate increases.

Other states have controlled the average cost per individual by:

- Moving to a case-mix reimbursement system which more adequately reimburses providers based on resources needed to serve an individual.
- Limiting capital reimbursement.
- Limiting the annual inflation factor to no more than 3 to 5 percent.

Finding 3: North Carolina continues to admit a significant number of individuals to state-operated ICFs/MR, while most other states are moving to deinstitutionalize the mentally retarded.

Over the last 15 years, North Carolina has reduced its State-operated ICF/MR census from 3,800 to 2,525 individuals, a decrease of 33.6 percent. However, the census of residents in these facilities over the past few years is decreasing less rapidly than in prior years because the number of admissions is equal to or slightly less than the number of discharges. In FY92, 320 individuals were admitted into ICFs/MR, while only 400 were discharged, a cumulative decrease of 3 percent.

Other states have been more aggressive with their deinstitutionalization efforts of state-operated ICF/MR residents by implementing more restrictive admission policies, and by limiting admissions only to those individuals for whom intense community-based crisis intervention is not effective.

Recommendations

Recommendation 1: Limit the growth in the number of intermediate care facilities for persons with mental retardation by implementing a moratorium on the development of new ICF/MR beds.

Under this moratorium, providers could not obtain CON approval to develop new facilities or expand current facilities. Several states have effectively limited ICF/MR bed growth by placing a moratorium on CON approval for ICF/MR beds. North Carolina has utilized this approach in the past to effectively control expenditures for the ICF/MR program. The current development of 160 new beds will adequately meet the demand of the 90 individuals seeking ICF/MR level of care. To avoid a sudden surge in growth of new beds when the moratorium is lifted, the State should take steps to improve availability of home- and community-based services.

Implications:

- The number of individuals who may request State-operated ICF/MR services may increase if private ICF/MR and home- and community-based services are not available in a particular community.

- The number of beds that are available to the ICF/MR State-operated population (i.e., State ICFs/MR patients) will be decreased.

- There will be increased demand for other residential services and home- and community-based services.

- Stringent screening and assessment is needed to ensure appropriate utilization of HCBS.

Recommendation 2: Develop a prospective case-mix methodology for ICF/MR reimbursement.

The current Medicaid reimbursement policy bases payments on facility-specific costs. A different rate is established for each facility, according to its historical costs; rates are increased annually by an inflation factor. For this reason, Medicaid rates paid to ICFs/MR vary significantly across facilities. Average Medicaid rates per patient day are relatively high compared to the rest of the nation and are increasing at a rapid rate. Variation in rates may be due to several factors, including relative patient needs, capital layouts, area wage differences and relative efficiencies of operation.

While some facilities face higher costs due to more intense patient needs, others incur higher costs due to inefficient operation. For example, the State is unable to determine

whether ICFs/MR are appropriately and efficiently staffed given the characteristics of their residents. Because cost-based reimbursement methodologies do not address the relative needs of patients in establishing rates, the current system limits the State's ability to control costs by encouraging facilities to operate efficiently.

The Division of Medical Assistance is considering development of an alternative reimbursement methodology for ICF/MR services. The State should adopt a payment methodology which compensates facilities according to the needs of its residents. By incorporating a case-mix adjustment into reimbursement rates, facilities will receive payment sufficient to meet residents' staffing needs.

Other states have experienced significant cost savings after implementing case-mix based reimbursement systems. However, actual cost savings will depend upon the number and types of additional controls built into the system. In addition to cost savings, case-mix based reimbursement systems offer other advantages:

- Equitably distributes payments among providers according to the relative needs of their patients
- Encourages efficient provision of care
- Improves access for patients requiring more intense levels of care

As North Carolina revises its Medicaid payment methodology for operating costs, the State should also consider alternative reimbursement policies for capital-related costs. Because ICFs/MR are typically small structures (4-6 beds), capital costs are often a significant part of total costs.

The North Carolina Medicaid program currently reimburses capital-related costs on a facility-specific, cost basis. For this reason, great variation exists among facilities' average costs per bed. Additionally, the current system provides little incentive for facilities to control capital-related costs. The State should consider moving toward a capital reimbursement policy which standardizes payments across facilities, provides incentives for facilities to control capital costs, and ensures the appropriate amount of investment in the ICF/MR industry.

Implications:

- Cost-savings can be significant if a methodology is based on client need, and if facilities are peer grouped and cost ceilings are applied.
- A prospective capital reimbursement methodology may discourage investment in ICFs/MR.

- Reimbursement to facilities of will become more equitable, because the system will recognize cost differences associated with facility size and resident case-mix.

- Some additional resources may be necessary to maintain the system because case-mix systems require periodic patient assessments.

Recommendation 3: Transition inappropriately placed ICFs/MR residents to home- and community-based services.

DMH/DD/SAS should transition the 236 individuals inappropriately placed in ICF/MR settings to community-based services. Individuals transitioned to home- and community-based services will reduce expenditures for services provided to these individuals. These individuals will receive services in a more appropriate setting.

Implications:

- The move from ICF/MR settings to community-based settings will create excess capacity; these slots will likely be filled if stringent screening criteria are not applied.

- A prospective capital reimbursement system is needed to ensure that capital costs, which could be reallocated among remaining residents, are not reimbursed.

Cost Savings

Exhibits 3-5 (at the end of this section) provide cost savings projected over the next decade for each of the previous recommendations.

Cost savings on implementing a moratorium on ICF/MR development were based on the following assumptions:

- Continued growth of ICF/MR beds at FY92 levels of 160 beds/year.

- Increase in the ICF/MR per diem rate at seven percent annually. This represents the average annual increase in the ICF/MR per diem rate for FY87-FY92.

Initial cost savings would not occur in FY93 due to legislative changes required to change the state CON law. The first year savings were $2.4 million with a cumulate savings of $135.1 million over the next 10 years.

Savings estimates associated with developing a new reimbursement methodology for ICF/MR (Exhibit 4) were based on the following:

- Several states that have implemented a case-mix reimbursement methodology and reduced capital rates have experienced a decrease in rates of five percent.

- ICF/MR program costs, without modification of reimbursement will increase 7 percent annually.

- The current number of community ICF/MR beds will be maintained at approximately 4,000.

The initial year's cost savings for the state would be $1.4 million with a cumulative savings of $19.5 over the next ten years.

Exhibit 5 provides net savings to the state if 236 ICF/MR residents identified by DMH/DD/SAS as inappropriately placed were transitioned to community-based services. Net savings were based on the following assumptions:

- All 236 individuals in FY93 are transition to HCBS waiver.

- Increases the average cost per waiver recipient by seven percent annually.

- A prospective payment system for ICF/MR reimbursement should be in place so that excess capacity in ICFs/MR is not reimbursed.

- A moratorium is in place on new ICF/MR construction.

Initial year's savings would total $3.5 million. North Carolina can realize a cumulative savings of $49.3 million over the next ten years.

EXHIBIT 3

MORATORIUM ON ICFs/MR ($ MILLIONS)

Fiscal Year	93	94	95	96	97	98	99	0	1	2
Current Program	$88.6	$104.3	$121.2	$140.7	$162.3	$186.2	$212.6	$241.7	$273.4	$309.2
Implement Moratorium	--	$96.4	$107.0	$118.4	$130.5	$143.5	$152.3	$172.3	$188.2	$206.1
Cost Savings (State Share)	--	$2.4	$4.4	$6.9	$9.8	$13.2	$18.6	$21.5	$26.4	$31.9
Cumulative Savings		$2.4	$6.8	$13.7	$23.5	$36.7	$55.3	$76.8	$103.2	$135.7

Assumptions:

- Continued bed growth of 160 beds per year
- Increase in ICF/MR rate of 7 percent annually

EXHIBIT 4

DEVELOP NEW REIMBURSEMENT METHODOLOGY ($ MILLIONS)

Fiscal Year	93	94	95	96	97	98	99	0	1	2
Current Program	$91.2	$ 97.6	$103.9	$111.4	$119.3	$127.8	$136.8	$146.4	$157.0	$167.6
Proposed Program	$86.7	$92.7	$ 99.2	$106.0	$113.5	$121.5	$130.1	$138.9	$148.5	$159.3
Cost Savings (State Share)	$1.4	$1.5	$1.6	$1.65	$1.8	$1.9	$2.1	$2.3	$2.6	$2.8
Cumulative Savings	$1.4	$2.9	$4.5	$6.2	$7.9	$9.8	$11.9	$14.2	$16.9	$19.6

Assumptions:

- Developing new case-mix methodology and reduced capital rate will decrease rates by 5 percent
- ICF/MR costs will continue to increase 7 percent annually
- Maintains ICF/MR beds @ 4,000

EXHIBIT 5

APPROPRIATELY PLACE ICF/MR RESIDENT ($ MILLIONS)

Fiscal Year	93	94	95	96	97	98	99	0	1	2
Current Program	$14.4	$15.5	$16.5	$17.7	$18.9	$20.3	$21.7	$23.2	$24.8	$26.6
Proposed Program	$2.8	$3.0	$3.2	$3.5	$3.7	$3.9	$4.3	$4.5	$4.8	$5.2
Savings	$3.5	$3.8	$4.1	$4.4	$4.7	$5.0	$5.3	$5.7	$6.2	$6.6
Cumulative Savings	$3.5	$7.3	$11.4	$15.8	$20.5	$25.5	$30.8	$36.5	$42.7	$49.3

Assumptions:

- 236 persons would be moved from ICF/MR to HCBS services
- ICF/MR and HCBS services would increase seven percent annually