DOCUMENT RESUME

03148 - [A2353466]

[Review of Systems Used by Georgia and Tennessee in 1975 and 1976 to Assure that the Care Received by Medicaid Patients in Intermediate Care Facilities Was Proper]. HRD-77-129; B-164031(3). August 16, 1977. 17 pp.

Report to Secretary, Department of Health, Education, and Welfare; by James D. Martin (for Gregory J. Ahart, Director, Human Resources Div.).

Issue Area: Health Programs: Compliance With Financing Laws and Regulations (1207); Health Programs: Quality Care and its Assurance (1213); Health Programs: Efficiency and Effectiveness of Grantees and Contractors in Providing Treatment Services (1215).
Contact: Human Resources Div.
Budget Function: Health: Health Care Services (551); Health: Nursing Homes (557).
Organization Concerned: Health Care Financing Administration.
Congressional Relevance: House Committee on Interstate and Foreign Commerce; Senate Committee on Finance.
Authority: Social Security Amendments of 1971 (42 U.S.C. 1396d). 45 C.F.R. 250.24.

A review of the systems used by Georgia and Tennessee in 1975 and 1976 to assure that the care received by Medicaid patients in intermediate care facilities was appropriate indicated that the State systems were not functioning properly. Findings/Conclusions: Medicaid payments were being made for intermediate care facilities patients even though required written evaluations and plans of care were missing or incomplete. Without such evaluations and plans of care, facilities could not have adequately treated these patients, and the special needs of mentally retarded patients could not have been identified and met. Federal regulations provided that payments should not have been authorized for such patients unless their condition was independently evaluated and a written plan of care was developed. State surveys did not identify many deficiencies in the care provided to intermediate care facility patients. Recommendations: To better assure that intermediate care facilities provide proper care to Medicaid patients, the Secretary of Health, Education, and Welfare should direct the Administrator of the Health Care Financing Administration to: require the States to stop authorizing reimbursements for patients in these facilities who do not have written plans of care and evaluations of their needs; assist States to improve their surveys of intermediate care facilities; and use the results of State surveys and independent professional reviews in coordination with additional validation surveys to better evaluate State activities and assist them in improving their intermediate care facilities programs. (SC)

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

AUG 16 1977

B-164031(3)

The Honorable
The Secretary of Health,
Education, and Welfare

Dear Mr. Secretary:

We reviewed the systems used by Georgia and Tennessee in 1975 and 1976 to assure that the care received by Medicaid patients in Intermediate Care Facilities (ICFs) was proper. ICFs provide a level of care less than skilled nursing facility care, but greater than custodial care. We also reviewed (1) State survey reports, obtained from HEW's Atlanta regional office, on ICFs for seven States in Region IV and (2) HEW reports on 49 validation surveys, completed by April 1976, in six regions.

Our fieldwork was completed before HEW's March 1977 reorganization which established the Health Care Financing Administration (HCFA) to administer Medicare, Medicaid, and the standards, provider certification, and the professional standard review organization programs. As a result, most of the headquarters and regional office organizational components mentioned in this report have been merged into HCFA and may not now exist. To avoid confusion, we call these organizations by their pre-HCFA names.

Our review showed that:

--Payments were made to ICFs even though the required patient evaluation reports and plans of care were missing or incomplete.

--State inspections of ICFs' compliance with HEW standards reported less than half the deficiencies reported by HEW validation surveys or by independent professional reviews and about half the deficiencies noted during GAO visits.

--Independent professional reviews of ICF patients were not always made annually as required.

--HEW surveyors and State independent professional review teams determined that many ICF patients had received inadequate care.

--HEW's monitoring efforts to assure States effectively administer their ICF programs varied widely among regional offices. For example, as of early 1976, in 4 regions covering about 2,800 facilities in 20 States and jurisdictions, only 15 ICFs had received HEW validation surveys. In contrast, one regional office had surveyed 124 of the 1,100 ICFs in its 6 States.

--Special ICFs serving mentally retarded patients (ICF-MRs) 1/ were not adequately meeting the needs of their patients.

Although we did not analyze the underlying causes of these problems in detail, information provided by the States and HEW indicated that many of these deficiencies were attributable to shortages of qualified State surveyors, independent reviewers, and HEW monitoring personnel.

The HEW and State reports also indicated that reported deficiencies may not have been corrected. In some cases, successive surveys or independent professional reviews of ICFs showed that previously identified problems had not been corrected.

BACKGROUND

The 1971 amendments to the Social Security Act (42 U.S.C. 1396d) authorized payments for services provided in ICFs effective January 1, 1972. Nearly $8.2 billion in Federal and State funds have been spent for such services through fiscal year 1976. In contrast to about $1.2 billion spent in fiscal year 1973, the first full year for which ICF services were covered, about $2.8 billion was spent in fiscal year 1976.

So that patients in ICFs would receive appropriate care, HEW established regulations and procedures which required that:

1/ An ICF-MR facility is supposed to meet special Federal requirements for serving mentally retarded patients.

--Before payment for services can be authorized by the States, a comprehensive evaluation must be made of a patient's medical and other needs and an individual plan of care must be developed.

--Before an agreement to participate in Medicaid is completed or payment is made for providing ICF services, the facility must be certified and periodically recertified as meeting all Federal and State standards and requirements or have submitted a plan of corrective action. (The facility certification and recertification process must include a State survey (onsite inspection) by qualified staff at least annually.)

--At least annually each patient must be given an independent professional review by a team composed of a physician or registered nurse and other health and social service personnel to determine their need for the care and services provided by the facility.

--Through periodic onsite validation surveys or other Federal reviews and by using information in State certification records or other reports, HEW should monitor the States' processes and procedures for certifying and recertifying ICFs for participation in Medicaid.

WRITTEN PATIENT EVALUATIONS AND PLANS OF CARE WERE MISSING OR INCOMPLETE

Federal regulations (45 CFR 250.24) require that before payment can be authorized, (1) a review covering physical, emotional, social, and cognitive factors must be made for each patient to determine their need for the care and services provided by the facility, and (2) appropriate individual plans of care must be prepared. Each individual must receive a comprehensive medical and social evaluation, including diagnoses, summaries of present medical and social findings, medical and social family history, mental and physical capacity, prognoses, range of service needs, and amounts of care required. Where appropriate, a psychological evaluation must also be made.

Federal and State surveys and independent professional reviews showed that evaluation reports were either missing or

or incomplete in many facilities. Some facilities had no records of patients' physical examinations or medical histories. The lack of proper evaluations precluded developing adequate plans for medications, treatments, diets, and other services.

HEW validation surveys covering 49 facilities in 18 States showed that 26 facilities, 53 percent, lacked complete reports of patient preadmission evaluations and 36 of 49 facilities, 73 percent, lacked complete plans of care. For example, HEW surveyors determined that medical and social admission data was inadequate or missing and that medical records did not justify the diagnosis and treatment.

Our analysis of 341 State survey reports in Region IV showed deficient admission data in patients' records at 57 facilities.

In Tennessee, independent professional reviews at 23 facilities showed that the preadmission evaluation reports included as part of Tennessee's Preadmission Plan of Treatment, were not available in 188, or about 11.5 percent, of 1,635 patients records reviewed.

We also examined reports of visits made by nurses 1/ at 64 other facilities in Tennessee covering 1,782 patient records. These nursing surveys showed that evaluation reports were not available in 12 percent of the records and that records of physical examinations and medical histories were not available in 34 percent of the records.

The independent professional reviews and nursing surveys conducted primarily in 1975 covered 3,417 patient records at 87 facilities. Their reports showed no patient evaluations in 405 of the records at 44 facilities. We reviewed the reports for 91 selected patients with no record of evaluation at 6 of the 44 ICFs and found that 64 patients, 70 percent, had been in the facility at least 1 year.

1/ In Tennessee nursing visits were made to meet the requirements for both State surveys and independent professional reviews. The visits did not meet the requirements for independent professional reviews. (See p. 9.)

Tennessee's independent professional reviews and nursing surveys showed that adequate plans of care had not been developed for almost half of the patient records reviewed--1,676 of 3,417. We reviewed the reports for 173 patients with no plans of care at 7 ICFs and noted that 128, 74 percent, had been residents in the facilities for over 1 year.

Similar observations were made in Georgia. We analyzed State survey and independent professional review reports for 39 facilities in Georgia. The analyses showed that 13 facilities, or 33 percent, did not have complete records of patient preadmission evaluations as of the latest inspection made at the time of our fieldwork. Another review of 40 selected Georgia State survey reports showed that in 18 facilities, or 45 percent, most patients did not have adequate plans of care. The reports showed that many plans were missing or deficient in all areas--activities, social services, and medical-health.

In 1976, Tennessee introduced a new preadmission evaluation form. It was to be used as a basis for denying reimbursement if it was either missing from the ICF files or inadequate. In May 1977 one official said some claims had been denied, but no data was readily available on the amount or number of ICFs involved. Georgia officials stated that in the future they planned to recover payments made to ICFs if patient evaluations or plans of care were missing or inadequate.

STATE SURVEYS DID NOT REPORT NUMEROUS DEFICIENCIES

States are required to survey or inspect each facility at least annually to assure that ICFs comply with Federal and State standards, which include patient care requirements. State surveys showed deficiencies in meeting patient care standards at many ICFs; however, HEW validation surveys, State independent professional reviews, and our visits to ICFs in Georgia and Tennessee uncovered many deficiencies that the State surveys had not reported.

We recognize conditions may not have been exactly the same, due to the passage of time between surveys; however, some HEW validation surveys were made within 1 or 2 months of the State surveys. Officials in Georgia and Tennessee advised us that shortages of qualified surveyors had adversely affected State survey efforts.

We analyzed 49 HEW validation survey reports involving 18 States and determined that 38 of the reports included comparative analyses by HEW of previous State surveys. The State surveyors had not reported 372, or 53 percent, of 706 deficiencies identified by HEW at the 38 facilities. HEW surveys identified numerous deficiencies involving the lack of adequate plans of care, lack of adequate qualified facility staff, and inadequate patient services, which should have been identified during the State surveys, but were not.

HEW identified 446 deficiencies in patient services, including pharmaceutical, dietetic, rehabilitative, social, and other services. State surveyors had reported only about 50 percent of these deficiencies.

We compared State survey reports with independent professional review reports for 30 ICFs in Georgia. Between April 1974 and January 1976, 35 State surveys and 38 independent professional reviews were made at these facilities. During the reviews, 286 deficiencies were reported, 134 of which were duplicated. 1/ Independent professional reviewers reported 233 deficiencies, including 154 that were not reported by State surveyors. State surveyors reported 55 deficiencies, all of which were reported by independent reviewers.

In cases where State surveys were made first, independent reviewers reported substantially more deficiencies than State surveyors. In cases where independent reviews were done first, the reviewers also reported more deficiencies than the State surveyors.

We recognize conditions may have changed and State surveyors may have reported fewer deficiencies than independent reviewers because corrections had been made by the facility. However, if this was the reason surveyors reported fewer deficiencies, then the independent reviewers should also have reported fewer deficiencies when the surveys were made first. Since this was not the case, the difference may have been attributable to the State surveyors failing to report all deficiencies.

1/ The same deficiencies were reported either by a State surveyor and an independent reviewer or during a followup visit.

The following table illustrates the differences in the number of deficiencies reported.

	Number of inspections		Deficiencies reported		
	State surveys	Independent reviews	State surveys	Independent reviews	Difference
State survey first:					
Original inspections	16	16	13	88	75
Followup inspections	2	2	0	15	15
Independent professional review first:					
Original inspections	14	14	40	84	44
Followup inspections					
by State and reviewer	3	3	2	23	21
by reviewer only	(a)	3	(a)	23	23
Total	35	38	55	233	b/ 178

a/No second State survey.

b/Includes 24 duplicate deficiencies identified in the original and followup visits by independent reviewers.

GAO visits to ICFs

We accompanied State surveyors on inspections to five ICFs in Georgia and Tennessee--three general ICFs and two special ICF-MRs. All facilities had been previously inspected by State surveyors--four within 6 months of our visits.

During our visits, the surveyors identified 222 deficiencies, of which 118, or 53 percent, had been reported in the

previous survey. 1/ The following table shows the total number of deficiencies identified during our visits and the related deficiencies reported on previous surveys.

	Reported deficiencies			
	Previous survey	GAO visit	Differences	Percent reported by the State
General ICFs:				
Facility A	0	25	25	0
Facility B	2	41	39	5
Facility C	10	13	3	77
ICFs-Mentally Retarded:				
Facility D	64	77	13	84
Facility E	42	66	24	63
Total	118	222	104	53

As the table indicates, State surveyors during our visits generally identified many more deficiencies than had been identified in previous surveys. These variations could be due either to differences in State survey teams or in their application of criteria. There was some evidence of corrective action by the facilities. For example, a Georgia State official told us 2 months after our visit that facility C was now in compliance with Federal standards. We did not make a followup visit to verify the corrective actions. Other facilities also showed progress. The four facilities with previously identified deficiencies had developed plans for corrective action after the initial State survey and had made some progress in implementing their plans, though they were not in full compliance during our visits and we found many additional deficiencies.

INADEQUATE INDEPENDENT PROFESSIONAL REVIEWS

Federal regulations (45 CFR 250.24) require that States provide an independent professional review of each ICF patient at least annually, and more frequently if necessary.

1/In some cases, the State had identified deficiencies in earlier inspections which were not identified during our visits.

The review team must include a registered nurse or a physician (or a consulting physician) and other appropriate health and social service personnel. In the case of institutions for the mentally retarded, the team must include someone knowledgeable about the problems and needs of the mentally retarded.

Many patients were not reviewed annually as required by Federal regulations. Some reviews were incomplete because the necessary professionals were not included on the teams, such as social service personnel.

In Tennessee, independent professional reviews were made at only 23 of the State's 222 1/ ICFs in 1975 because, State officials told us, of insufficient staff. They said that there was only one social worker employed by the Medicaid office.

The State Medicaid director said professional reviews were not made of each ICF patient because the Medicaid department had not increased its staff due to a State hiring freeze.

Some Tennessee ICFs were not reviewed by either an independent professional review team or by a team of nurses in 1975. However, in addition to the 23 ICFs reviewed by independent reviewers, 163 other facilities were reviewed by teams of nurses. Although these reviews did not qualify as independent professional reviews because they did not include the professionals from other disciplines, such as the social service personnel required by Federal regulations, at least some effort was made to evaluate patients in these ICFs. In May 1977, Tennessee officials told us that the Medicaid office had increased its staff and independent review teams included social service personnel and other professionals.

In contrast with Tennessee, the Georgia State Medicaid agency contracted with a medical care foundation for fiscal years 1975 and 1976 to perform semiannual professional reviews of about 21,000 patients, about 13,000 of whom were ICF patients. According to a foundation official, the foundation had 10 teams, each comprised of a physician, registered nurse, and a social wo[illegible].

1/Between January and November 1975, 22 of these facilities stopped participating in Medicaid while 5 began.

Other States have problems similar to Tennessee's. During a previous GAO review of the States' deinstitutionalization process,1/ we reported that, as of July 1975, Massachusetts had made independent professional reviews in only 3 of approximately 600 ICFs because of staffing limitations. Oregon reviews included only a 25-percent sample of patients rather than all patients as required by Federal regulations. Also, officials in these States and Nebraska stated that review teams for ICFs serving mentally retarded patients did not include mental health or retardation professionals.

We discussed the lack of independent professional reviews and the lack of plans of care with the Director of the Division of Utilization Control of the Medical Services Administration as potential violations of section 1903(g) of the Social Security Act. Among other things, section 1903(g) requires a one-third reduction of the Federal Medicaid assistance percentages of the costs of inpatient care at an ICF beyond 60 days in a fiscal year if a State did not make a satisfactory showing to the Secretary that (1) it provided for an independent professional review of each ICF patient and (2) ICF services were furnished under a plan of care established by a physician. Section 1903(g) also requires HEW to validate the State showings that they were in compliance with that section.

These matters were included in our March 1, 1977, report to the Chairman, Subcommittee on Oversight and Investigation, House Committee on Interstate and Foreign Commerce, on compliance with section 1903(g).

NEED FOR MORE EFFECTIVE HEW ACTION TO IDENTIFY AND CORRECT PROBLEMS

HEW Region IV had not effectively used data from State survey and independent professional review reports to assure that ICF patients received adequate care. In addition, HEW monitoring through onsite surveys varied among regions and in some cases was very limited. HEW officials recognized the need for better monitoring and had taken some steps to improve it.

1/"Returning the Mentally Disabled to the Community: Government Needs to do More" (HRD-76-152, Jan. 7, 1977).

Discussions with officials of HEW's Atlanta regional office, including the Regional Director, Office of Long-Term Care Standards Enforcement, showed that little use had been made of the information in State survey reports. Officials said they depended on State surveys to identify deficiencies in ICFs and sometimes regional staff accompanied State surveyors on visits to ICFs. They said that the regional office did not receive copies of State survey reports, but that plans had been made to get copies of State survey reports in the future.

HEW has initiated action to make better use of State survey reports. HEW officials told us that a nationwide computerized management information system was being developed as a management tool for administering the certification and recertification of Medicaid providers, including ICFs. When fully operational, data from State surveys of ICFs would be put into a computer at HEW headquarters, and printouts showing relevant information, such as deficiencies and facilities not complying with Federal and State standards, would be sent to regional offices and State agencies for use in administering the ICF program. According to the Associate Director, Office of Long-Term Care, the system was not fully operational as of March 1977 due to a lack of qualified staff and proper equipment in the regional offices. However, the system had been partially implemented--some ICF data had been fed into the computer and some feedback had been sent to the regions.

In March 1976, the Associate Regional Commissioner for Medical Services in the Atlanta regional office told us he had not monitored independent professional review reports and could not require States to submit copies of the reports to him. In fact, he said the region had no reports showing that the reviews had been made. He agreed the reports contain useful information but said he did not have enough staff to read, analyze, and follow up on the reports.

The Associate Director, Office of Long-Term Care in HEW headquarters, told us in May 1977 that HEW had no uniform system for using data from independent professional review reports to monitor State certification and recertification of ICFs and that there were no immediate plans for developing such a system. He further stated that in order to computerize information from independent professional review reports, HEW would have to require States to submit standardized reports.

HEW has initiated action to obtain more information about independent professional reviews. Under new procedures, effective the quarter ended June 30, 1976, HEW required States to submit quarterly showings of compliance with section 1903(g), including listings of independent professional reviews made at ICFs. However, HEW did not require copies of the review reports. In the Federal Register on January 18, 1977, HEW declared its intention to publish proposed revised regulations implementing the quarterly showings requirement. HEW stated it was considering requiring the States to be able to provide even more detailed information on independent professional review results, including the composition of review teams, findings for individual patients, and actions taken on any team's recommendations. As of May 1977, the proposed regulations had not been published.

HEW procedures required the Office of Long-Term Care Standards Enforcement to make timely and effective validation surveys of selected facilities to insure that Federal standards were met. To ascertain the extent of HEW's efforts, we requested information on validation surveys from all HEW regional offices. We also obtained copies of 49 survey reports from 6 regions for our analysis of ICF problems.

Our analysis of the information from the regions showed that the HEW efforts varied greatly. For example, the Boston regional office reported surveying 124 of about 1,100 ICFs in its 6 States. The Kansas City, Philadelphia, San Francisco, and Atlanta offices, combined, reported surveying only 15 of about 2,800 ICFs in their jurisdictions, which included 19 States and the District of Columbia. The effort in these regions may have been inadequate if measured against the goals of the Office of Long-Term Care. According to officials in that office, visits should have been made to about 10 percent of the ICFs each year. However, the 10-percent goal applied to all visits, including visits to check complaints against ICFs. According to one official, when these visits were considered, most regions came close to meeting the goal. He also said the efforts differed among regions due to variations in staffing and the scopes of their surveys.

INADEQUATE PATIENT CARE

State surveys, HEW surveys, and independent professional reviews have identified many cases of inadequate patient care being provided by ICFs.

HEW surveys of 49 ICFs conducted during 1974, 1975, and 1976 showed that 21, 43 percent, had provided nursing services, medication, or food in an unsafe or unacceptable manner. About 39 percent had not provided the diets specified by physicians' orders and 37 percent had made numerous medication errors. Moreover, the HEW reports show that 10 facilities had not provided patients with necessary social services, specialized activities, or assistance with daily living activities.

The State survey reports on ICFs in Region IV identified deficiencies in meeting most Federal standards, many of which related to patient care. We reviewed the State survey reports that HEW had on hand for seven of the eight States 1/ in that region as of January 1976. The reports showed that 71 of the 338 facilities for which reports were available, or 21 percent, did not meet certain aspects of patient needs for ICF care. This represented from 6 to 47 percent of the facilities reviewed in each of seven States as shown below.

State	Number of facilities Reviewed	Deficient (note a)	Percent deficient
Alabama	47	11	23
Florida	21	6	29
Georgia	51	10	20
Kentucky	48	9	19
North Carolina	51	12	24
South Carolina	38	18	47
Tennessee	82	5	6
Total	338	71	21

a/Failed to meet patient care standards.

These deficiencies indicated patients were sometimes receiving only custodial care--and sometimes very poor care. However, the situation in some ICFs may have been worse than shown in State survey reports because, as previously discussed, many deficiencies were either not identified or not reported.

1/We did not include information from reports on Mississippi because only three were available in the HEW files.

We reviewed 70 independent professional review reports for general ICFs in Georgia and determined that 15 reports, 21 percent, identified deficiencies in patient care. Some examples follow.

Facility 1

"The quality of care * * * continues to be poor. It continues to be obvious that only the very basic custodial care is given to the patients."

"The staff did not appear knowledgeable about the patients * * *."

Facility 2

"The quality of care at this facility is primarily custodial, and specific needs are not met. The care is not felt to be individualized."

"It appears that the recreational and social needs of the residents are either being minimally met or not met at all."

"The rehabilitative services at this facility are nil."

Facility 3

"Treatments are inadequate for many of the patients' problems."

"The on-site review team physician found 4 cases of patients in need of immediate care."

Facility 4

"This * * *facility is providing fair quality care. The problem areas that need some attention are staffing, rehabilitation, and sanitation."

"It appears that this facility is providing minimal social and recreational care, and does not seem to be meeting the needs of most of the residents."

MENTALLY DISABLED PATIENTS NEED BETTER CARE

We reported to the Congress in January 1977, (see p. 10) that many mentally retarded and mentally ill patients had been transferred from State institutions to skilled nursing facilities and ICFs as part of a national effort to deinstitutionalize these patients and provide care in community facilities. Funding available under the Medicaid program, coupled with a lack of alternatives, had heavily influenced the placement of the mentally disabled into skilled facilities and ICFs. In many instances, persons were transferred without adequate plans of care, and the skilled facilities and ICFs were not prepared to meet the special needs of the mentally disabled.

Both general ICFs and ICF-MRs were required to identify and meet the needs of patients who were accepted. Federal and State controls previously discussed also governed the care and treatment of mentally retarded patients in general ICFs and ICF-MRs. ICFs had to provide active treatment--defined as regular participation, in accordance with an individual plan of care, in professionally developed and supervised activities, experiences, or therapies.

Weaknesses in Federal and State controls over patient care also affect the care and treatment of mentally disabled patients. Specifically, many patients lacked adequate written records of their plans of care and comprehensive evaluations, including psychological evaluations. Some ICFs were not meeting patients' needs.

Our January 7, 1977, report pointed out that many mentally disabled persons had been placed in skilled facilities and ICFs without provision for needed services in Massachusetts, Maryland, Michigan, Nebraska, and Oregon and the same situation had been identified by others in other States. We reported that, although in some cases special efforts had been made to meet the needs of mentally disabled patients, many of these persons were receiving only custodial care and some had been placed in substandard facilities inappropriate to their needs. Our current review identified these problems in Georgia and Tennessee.

CONCLUSIONS

State systems designed to assure that patients received adequate care in ICFs were not functioning properly. Medicaid payments were being made for ICF patients even though required written evaluations and plans of care were missing or incomplete. Without such evaluations and plans of care, facilities could not have adequately treated ICF patients and the special needs of mentally retarded patients could not have been identified and met. Federal regulations provided that payments should not have been authorized for ICF patients unless their condition was independently evaluated and a written plan of care was developed.

State surveys of ICFs did not identify many deficiencies in the care provided to ICF patients which were identified by independent professional reviews, HEW surveys, and our limited review. Independent professional reviews had not been made with either the required frequency or staff.

HEW should use the survey reports and independent professional review reports to identify trends and weaknesses in State programs. HEW should consider computerizing the results of independent professional reviews as it is doing with State survey reports. In addition, HEW needs to perform more validation surveys of ICFs.

RECOMMENDATIONS

To better assure that ICFs provide proper care to Medicaid patients, we recommend that the Secretary of HEW direct the Administrator of the Health Care Financing Administration to

--require the States to stop authorizing reimbursements for ICF patients who do not have written plans of care and evaluations of their needs;

--assist States to improve their surveys of ICFs; and

--use the results of State surveys and independent professional reviews in coordination with additional validation surveys to better evaluate State activities and assist them in improving their ICF programs.

As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report. In addition, we are sending copies of the report to the Senate Committee on Finance and the House Committee on Interstate and Foreign Commerce and to the Director of the Office of Management and Budget.

We will be pleased to discuss this report with you or your representatives.

Sincerely yours,

James D. Martin for

Gregory J. Ahart
Director