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Release

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Report to Sen. Frank Church, Chairman, Senate Special Committee on Aging: Long-term Care Subcommittee; by Elmer B. Staats, Comptroller General.

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Techniques used by nursing home operators to inflate Medicaid costs and reimbursements were studied in New York, Florida, Massachusetts, and Virginia. The purpose of the study was to determine the adequacy of HEW and State systems to control and deflect such costs and the progress made by HEW in implementing State reimbursement on a cost-related basis. Findings/Conclusions: The most common types of costs which should have been disallowed were: nonpatient care revenues, costs not related to patient care, undocumented expenses, costs of capital items expensed rather than capitalized, and capital items both expensed and capitalized. Of more than \$300 million in total costs submitted by nursing homes, States disallowed about \$9 million or three percent. Field audits were productive in identifying costs that should be disallowed, but the States varied substantially in their field audit efforts. Law enforcement officials in New York and Massachusetts used field audits to obtain evidence for convictions of nursing home operators for fraudulent claims. The cost of State field audits will be justified if overpayments can be prevented or recouped. Recommendations: The Social and Rehabilitation Service should assess periodically whether each state identifies and reports promptly overpayments to nursing homes and should deny Federal participation in overpayments when States do not establish an effective recoument program promptly. (RRS)

00503

**REPORT TO THE SUBCOMMITTEE
ON LONG-TERM CARE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE**

**BY THE COMPTROLLER GENERAL
OF THE UNITED STATES**

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by the Office of Congressional Relations.**

**State Audits To Identify
Medicaid Overpayments
To Nursing Homes**

RELEASED
3/4/77

**Social and Rehabilitation Service
Department of Health, Education, and Welfare**

This report identifies the most prevalent types of excessive costs which have been identified and disallowed in audits of skilled nursing facilities in four States. It discusses HEW's efforts to implement section 249 of Public Law 92-603, which requires the States, beginning July 1, 1976, to reimburse nursing homes on a cost-related basis. Some States need to increase their audit effort to meet existing requirements and increase their efforts to recover overpayments identified in audits.



COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(3)

The Honorable Frank Church
Chairman, Subcommittee on Long-Term Care
Special Committee on Aging
United States Senate

Dear Mr. Chairman:

This report is in response to the Subcommittee's request for information about the methods and techniques used by nursing homes to inflate Medicaid costs and reimbursements.

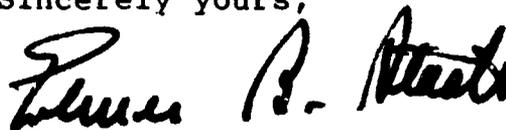
This information is based on analysis of the costs disallowed in 340 desk and field audits made by the States of New York, Massachusetts, Florida, and Virginia and in our audits of 12 skilled nursing facilities in the four States.

The report also addresses the Department of Health, Education, and Welfare's actions to implement section 249 of Public Law 92-603, which requires States, beginning July 1, 1976, to reimburse skilled and intermediate nursing facilities on a cost-related basis.

Our review was made pursuant to the Subcommittee's request of December 19, 1974. As requested, we have not provided HEW, the States, or the selected nursing facilities an opportunity to review and formally comment on our report. However, we have discussed our findings with HEW representatives and communicated our findings to the States and facilities involved.

This report contains recommendations to the Secretary of HEW. 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 the actions taken on our recommendations to the House and Senate Committees on Government Operations not later than 60 days after the date of the report and 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. We will be in touch with your office in the near future to arrange for release of the report so that the requirements of section 236 can be set in motion.

Sincerely yours,

A handwritten signature in black ink, appearing to read "James A. Stacks". The signature is written in a cursive, slightly slanted style.

Comptroller General
of the United States

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ABBREVIATIONS

CFA	Certified Public Accountant
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
ICF	intermediate care facility
SNF	skilled nursing facility
SRS	Social and Rehabilitation Service

COMPTROLLER GENERAL'S
REPORT TO THE SUBCOMMITTEE
ON LONG-TERM CARE
SENATE SPECIAL COMMITTEE
ON AGING

STATE AUDITS TO IDENTIFY MEDICAID
OVERPAYMENTS TO NURSING HOMES
Social and Rehabilitation Service
Department of Health, Education,
and Welfare

D I G E S T

Nursing homes submit reports of their costs for each year to agencies of their respective States. These reports are used to determine how much these homes will be reimbursed by Medicaid. The objectives of this review were to obtain information on

- the types of inflated or unallowable costs being identified by audits,
- the adequacy of HEW and State systems and controls to detect such costs, and
- the progress being made by HEW in implementing section 249 of Public Law 92-603, requiring that payments under Medicaid for nursing home services be made on a reasonable cost-related basis effective July 1, 1976.

UNALLOWED COSTS IDENTIFIED

The most prevalent unallowable costs identified by State and GAO audits involved:

- Nursing homes failing to offset certain costs with related income. For example, a county-owned nursing home in New York failed to report \$166,000 in income from Medicare for in-house physician services to Medicaid patients but claimed the full cost of the physicians' salaries as a reimbursable Medicaid expense. (See p. 15.)
- Costs not related to patient care. At one profit-making nursing home in Florida, for example, State auditors disallowed costs for luxury automobiles and travel expenses. (See p. 17.)

--Massachusetts' policy was to field audit all nursing homes each year, but the State had a 2-year backlog. (See p. 24.)

--New York had completed field audits of only 98 of 540 skilled nursing facilities since the State Medicaid program began in May 1966. The State limited its field audits to for-profit skilled nursing homes. (See p. 24.)

In addition, law enforcement officials in Massachusetts and New York had used field audits to get several convictions of nursing home operators for fraudulently claiming costs to the Medicaid program. (See pp. 24 and 25.)

On July 1, 1976, HEW issued regulations requiring all States to field audit all nursing homes over a 3-year period unless the State already has an acceptable field audit program. (See p. 23.)

The cost of State field audits will be justified if the States can prevent overpayments and recoup overpayments identified. Only Virginia appeared to have an effective program for recovering overpayments. (See p. 28.)

Massachusetts and New York had \$13.6 million in overpayments outstanding and problems in recovering it. (See pp. 26 and 28.) Florida had no recoupment program, had never recovered any payment from a nursing home for any reason, yet claimed it could recoup overpayments. (See p. 26.)

HEW should direct its Social and Rehabilitation Service to

--assess periodically whether each State identifies and reports promptly overpayments to nursing homes, as required, and

--deny Federal participation in overpayments when States do not establish an effective recoupment program promptly.

IMPLEMENTING THE LAW

Although Public Law 92-603 was enacted on October 30, 1972, HEW did not issue final regulations until July 1, 1976, and permits States to delay full implementation until as late as January 1, 1978. (See p. 30.)

The implementation of section 249 undoubtedly will cause some States and the Federal Government to spend more money on nursing home services. However, the regulations contain features--such as authorizing reimbursement limitations and requiring field audits--that could enable the States to reduce the financial burden of changing reimbursement systems.

CHAPTER 1

INTRODUCTION

On December 19, 1974, the Chairman, Subcommittee on Long-Term Care, Senate Special Committee on Aging, asked us to identify techniques used by nursing home operators in New York to inflate Medicaid costs and reimbursements. He was joined in this request by 14 New York Representatives and four Representatives-elect. The Subcommittee later agreed that we should expand our review to include the States of Florida, Massachusetts, and Virginia.

THE MEDICAID PROGRAM

Medicaid--authorized by title XIX of the Social Security Act, as amended--is a grant-in-aid program under which the Federal Government pays part of the costs incurred by States in providing medical services to persons unable to pay for such care. The Federal Government pays from 50 to 78 percent of the costs incurred by States in providing medical services under the Medicaid program. The Social Security Act requires that State Medicaid programs provide skilled nursing home services. About 7,100 skilled nursing facilities (SNFs) participate in the Medicaid program, and about 4,000 of the SNFs also participate in Medicare. ^{1/} In fiscal year 1976 the Federal share of Medicaid payments to SNFs was estimated at \$1.5 billion, 20.3 percent of the total estimated Federal share of Medicaid payments to all providers of services.

At the Federal level the Medicaid program is administered by the Social and Rehabilitation Service (SRS), within the Department of Health, Education, and Welfare (HEW). States have primary responsibility for initiating and administering their Medicaid programs.

^{1/}Medicare, authorized by title XVIII of the Social Security Act, is the Federal health insurance program for the aged and disabled. Part A of Medicare provides hospital insurance and also covers certain post-hospital care in SNFs or in a patient's home.

Basis for reimbursing
SNFs under Medicaid

Until July 1976, Federal regulations (45 CFR 250.30 (b)(3)(ii)) stated that payment under Medicaid for SNF services shall be "customary charges which are reasonable." These regulations also stated that the Medicaid payment rate should not exceed the Medicare payment rate. The two general methods of establishing reimbursement rates were on a cost-related or fixed-fee basis. When rates were on a cost-related basis, the regulations provided for "appropriate audits."

Section 249 of Public Law 92-603, enacted October 30, 1972, requires that effective July 1, 1976, SNFs in all States be reimbursed on a cost-related basis.

Types of audits of SNF costs

Depending on the State reimbursement system, the SNFs submitted their actual costs, generally for a previous year, to the State agency or its fiscal agent. These submissions were generally referred to as cost reports and were used to determine the amount of reimbursement.

State audits or reviews of cost reports consist of either desk audits or field audits. Desk audits consist of an examination of the cost reports and any related documents at the State's office or that of its fiscal agent. In such an examination, the reviewer looks for obvious mathematical errors or other discrepancies, compares the costs submitted with previous years' costs, checks the costs reported against any State ceilings or limitations, and attempts to identify and eliminate any obvious unallowable or excessive costs. Unresolved questions may be answered by telephone. On the other hand, field audits--which may be in addition to the desk audit--consist of visits to the SNF and include examinations in varying detail of the institution's accounting records and supporting documents such as payrolls and invoices.

SCOPE OF REVIEW

The objectives of our review were to obtain information on

--the types of inflated or unallowable costs being identified by audits,

--the adequacy of HEW and State systems and controls to detect such costs, and

--the progress being made by HEW in implementing section 249 of Public Law 92-603.

Our review included work at HEW headquarters in Washington, D.C., and HEW regional offices in Atlanta, Boston, Philadelphia, and New York. We visited State agencies in Florida, Massachusetts, New York, and Virginia, where we reviewed and analyzed selected reports of desk and/or field audits of SNF cost reports.

In analyzing the various State desk and field audits, we did not attempt to evaluate the reasonableness of any particular disallowance except to note inconsistencies. We visited a total of 12 SNFs in these four States, and at each facility we audited selected costs reported on the latest Medicaid cost report submitted to the State for reimbursement purposes. These SNFs included proprietary, private nonprofit, and public facilities.

CHAPTER 2
IMPACT OF STATE AUDITS
AND CEILINGS IN CONTROLLING
NURSING HOME COSTS

In the four States we reviewed, the methods for identifying and disallowing inflated costs claimed by skilled nursing facilities consisted of (1) desk and/or field audits of cost reports and (2) limitations or ceilings on total reimbursable costs or on specific categories of expense. In the 340 State desk and field audits we analyzed, the States disallowed about \$9 million as erroneously claimed, about 3 percent of the \$305 million in total costs submitted by SNFs for reimbursement by Medicaid.

An additional \$7.3 million in costs, about 2.4 percent of the costs claimed or submitted by SNFs, were not allowed because of the application of the States' ceilings. The State audits also increased the costs allowable to SNFs by about \$2.3 million primarily through identifying understated costs during the State field audits.

For the 12 SNF cost reports we reviewed involving submitted costs of about \$35 million, we identified an additional \$385,000 in erroneously claimed costs that should have been disallowed by the State and an additional \$379,000 which was or should have been disallowed because the costs exceeded the applicable ceilings. Some of these 12 SNF cost reports had not been field audited by the State prior to our review, but all had been desk audited. Our findings of erroneously claimed costs do not duplicate findings from any other audit. A State-by-State summary of these various audits is included as appendix I of this report.

The most prevalent types of disallowances identified by State audits and our audits involved

- the failure of SNFs to offset certain costs with related income, such as interest expense not offset by interest income;
- costs not related to patient care, such as personal expenses of SNF operators and public relations and advertising expenses; and

--unsupported or "paper" costs primarily involving "non-arm's-length" transactions between entities related by ownership or control.

STATE SYSTEMS FOR LIMITING PAYMENTS
OF COSTS TO SNFs AND IDENTIFYING
UNALLOWABLE COSTS

The methods used by the four States to limit costs reimbursed to SNFs ranged from a rather elaborate system used by New York, including ceilings on individual items such as administrative salaries and property expenses, to a modified version of the traditional Medicare reimbursement system used by Virginia, which paid SNFs on the basis of estimated costs and later made retrospective cost determinations through desk or field audits in accordance with the Medicare reimbursement principles 1/ subject to an overall maximum daily reimbursement rate.

Florida

As of January 1975, there were 254 SNFs participating in the Florida Medicaid program. The upper limit of reimbursement that any SNF could receive under the Florida program is the lowest of three rates: a predetermined maximum fixed rate established by State law, the reasonable patient care cost for each SNF, or usual and customary charges to the public. The State maximum rate for fiscal year 1975 was \$550 per patient per month. Approximately two-thirds of Florida's SNFs received the State maximum rate in January 1975.

Each SNF was required to submit a cost report for the most recent fiscal year. Total allowable costs were to be consistent with the principles of reimbursement as established for Medicare. As of January 1975, Florida SNFs reported average monthly costs per patient ranging from a low of \$453 to a high of \$848.

1/Medicare reimbursement principles consist of essentially three features. First are the rules pertaining to the allowability of specific costs. Second are the procedures for cost finding, which is the process of allocating overhead costs among the routine and ancillary care activities of an institution. And third are the rules for cost apportionment, which is the process of dividing the routine and ancillary costs between Medicare and non-Medicare patients. States are free to adopt some or all of the Medicare principles for their Medicaid reimbursement systems for SNFs.

In the Florida rate-setting process, the State Medicaid agency received the cost reports from the SNFs, made desk audits of the costs submitted, and, after making any corrections, adjusted the monthly per-patient cost upward by 9 percent to arrive at the reasonable cost of patient care. Under the Florida system, these rates were prospective and were not subject to retrospective adjustment on the basis of actual experience. According to a Florida official, the reason for the 9-percent adjustment was that Florida law requires that payment for obligations incurred in a fiscal year must be made not later than 6 months after the close of that year. Since it would be difficult to make retroactive adjustments that promptly, the 9-percent adjustment was given instead of any retroactive adjustment.

SNFs in Florida were not routinely subject to a field audit. However, they could be audited at the discretion of the State Medicaid agency. We examined State desk audits and field audits which identified approximately \$4.2 million of erroneous costs or costs over ceilings reported by the SNFs. The field audits covered fiscal years 1972 and 1973, while the 25 desk audits generally covered cost reports submitted by SNFs for fiscal year 1974. The 25 desk-audited cost reports showed total operating expenses of \$18.3 million, and the State disallowed \$2.8 million, about 15 percent for 23 nursing homes with over 90 percent disallowed as over State ceilings.

As previously stated, Florida did not routinely make field audits of SNFs, and the State, at the time of our visit, had issued no audit reports on SNF costs since the inception of its Medicaid program in January 1970. However, as of August 1975, the State had in various stages of completion 23 field audits of nursing facilities. We analyzed the results of 10 of these audits. The State auditors had identified about \$1.4 million in unallowable costs or costs over ceilings, which was about 19 percent of the \$7.3 million in total costs submitted by the SNFs.

Because of the State ceilings, however, the unallowable expenses directly affected the payment rates for only 5 of the 10 SNFs. The daily payment rates after audit were excessive by amounts ranging from \$1.30 to \$4.74 and resulted in estimated overpayments of about \$682,000 which, at the time of our field visit, had not been recovered.

We visited three Florida SNFs to review the costs they submitted for 1974. All three had been desk audited but not

field audited by the State. Our field review showed that the three SNFs had overstated their costs by about \$363,000, 13 percent of their total reported costs of \$2.8 million. One of the facilities had submitted costs we considered excessive by about \$34,200, such as:

- \$18,600 of proprietor's compensation costs above the State's ceilings. For the 12-month period ended November 30, 1974, owner's compensation totaled \$36,000. On the basis of a schedule of allowable owner's compensation supplied to us by the State Medicaid agency, we believe the total compensation should have been \$17,400.
- \$8,000 of income not offset against expenses, including discounts on milk purchases, income from vending machines, pay telephones, patient laundry services, sales of drugs, and private contributions to the care of specific patients.
- \$800 for expenses applicable to another SNF.
- \$3,500 for unsupported costs including travel, long distance telephone calls, and promotion expenses.
- \$3,300 for yellow pages advertising, overstatement of interest expense, and miscellaneous expenses.

A second SNF which we audited submitted excessive costs of \$24,600 because of excess proprietor's compensation costs (\$17,400); income from such sources as pay telephone, patient laundry services, and discounts on milk purchases not being offset against expenses (\$6,400); and other expenses (\$800). The third SNF had overstated its costs by about \$303,000 but was not excessively reimbursed because its reported costs were far above the State's upper limit for reimbursement; it thus was paid the lower maximum monthly rate. (See pp. 18 to 20.)

Massachusetts

As of March 1975, Massachusetts had 237 SNFs participating in the Medicaid program. In Massachusetts SNFs were paid under a retrospective cost reimbursement system under which interim rates based on estimated costs were subject to adjustment after a State field audit of each SNF's actual costs.

The interim rate was established midway through the year in which the rate applied, on the basis of costs incurred two years before. For example, the 1975 interim rates were established using regulations issued in June 1975 and were based on 1973 costs with an inflation factor of 10 percent added to the variable costs (net operating costs exclusive of interest and depreciation).

The State made desk audits of the reports submitted by the SNFs and adjusted the costs to the extent required by the State's applicable regulations. These adjustments include State limitations on administrative and nursing salary expenses. The adjusted total cost was then divided by each SNF's total number of patient days and an inflation factor added to arrive at the interim rate for the current year. In addition, Massachusetts limited payment for total allowable variable operating costs to 110 percent of the "weighted average cost" of all facilities in the State providing the same level of care.

Until the interim rate had been established, SNFs were reimbursed at the previous year's interim daily rate. If the new rate was higher than the previous year's interim rate, the State paid the SNF the difference between the two interim rates for those patient days incurred between January 1 and the date the new interim rate went into effect. Until April 1976, however, if the new interim rate was lower, the State had no procedures to recover the overpayment other than applying the overpayment to outstanding underpayments. (See pp. 26 to 28.)

The final reimbursement amount was generally determined at least a year or more after the year to which it applied. This determination was based on State field audits of the financial records maintained by the SNFs, using regulations which the State issued annually.

As of August 1975, Massachusetts had made field audits of the actual costs incurred by a number of SNFs for calendar year 1973. We reviewed the adjustments made to the costs reported by 26 SNFs for which final rates had been established and noted that the State had not allowed \$3.9 million, about 20 percent of the costs submitted, and had identified about \$1.1 million of understated costs. Examples of such disallowed costs are on page 13.

We field audited adjusted cost reports for three additional SNFs that had been previously audited by the State and

identified additional overstated costs of \$41,000 for two of these SNFs. This amount included \$18,600 for a nun's donated services which was included in nursing salaries. The nun told us she was the SNF's assistant administrator in 1973. A State official told us the nun's salary should have been included in the administration and policy planning category of expenses. If this had been done, the value of her donated services would have been disallowed because the SNF's administrative salaries exceeded the State's limitation for the administrative function.

New York

There are approximately 540 SNFs participating in the Medicaid program in New York. The State cost reimbursement system was essentially prospective in that the rates were based on a projection of allowable historical costs reported by each facility. Each SNF was required to prepare uniform cost reports annually as the basis for the rate computation. The rate computation formula began with total reported operating costs for a base year that was to be used in arriving at the reimbursement rate for the second year after the base year (i.e., costs incurred in 1973 were used in setting the 1975 rate). From this total, costs were reduced by subtracting real property, movable equipment, and automobile costs, which were used later in the computation. Administrators' salaries, including assistant administrators' and relatives' salaries, were subject to limitations both in total and by individual. Costs in excess of these limitations were subtracted by the State from total operating costs. All non-allowable costs identified by State reviewers, such as advertising and food for visitors, were also subtracted by the State from total operating costs.

Two rates were established for each facility to represent the relationship of costs to patient care. The first rate represented costs of administrative, housekeeping, and dietary services, while the second represented the cost of routine nursing care. Rates were computed from the data provided by each SNF and subsequently compared with those established for its respective peer grouping. SNF peer groups are based on size of facility, type of ownership, and geographical location. The ceiling for administrative, dietary, and housekeeping services for each SNF was 110 percent of its group average. Similarly, the ceiling for total allowable costs (excluding property, therapy, drugs, and return on equity) was 115 percent of the group average. Costs above these ceilings were not allowed for rate-setting purposes.

New York had a complicated system for calculating reimbursement rates for real property costs. 1/ Depending on whether the SNF was proprietary and whether the facility was owned by the operator or leased under an arm's-length or non-arm's-length rental agreement, different rules and rates would apply. Generally, if the SNF was owned by the operator, an ownership cost (depreciation, insurance, interest, and a return on equity) would be allowed. If the facility was leased in an arm's-length transaction, the SNF would be reimbursed on the basis of the actual rent or a State "maximum" rent, whichever was less. If the facility was leased from a related party, the SNF would be reimbursed on the basis of the ownership cost of the related party or a State "imputed" rental rate, whichever was greater. The allowable real property cost was then calculated as a per diem rate. Per diem rates were also established for movable equipment costs and auto expenses after ceilings were applied to each. After the various rates had been established, the State added, as appropriate, an inflation factor, an incentive allowance factor, and a profit factor to arrive at the composite or total rate for the following year. However, this rate was subject to revision based on exceptions taken in any field audit performed later by the State.

We analyzed the desk audits for 62 SNFs located in the New York City metropolitan area and noted that of the \$112.7 million in costs reported by the SNFs for 1973, the State disallowed \$3.1 million, of which \$2.1 million (about 2 percent of the costs submitted) was disallowed through the application of the various State ceilings. In addition, the State reviewers determined that these facilities understated costs by about \$392,000.

Our analysis of the 210 completed field audits of 98 SNFs showed that of costs totaling about \$146 million submitted by SNFs, the State auditors disallowed about \$4.8 million (including costs over ceilings), about 3 percent of the amounts claimed. The average field audit disallowance amounted to about \$22,800 per report. In addition, the State field audits determined that these facilities had understated costs by \$693,000.

1/Several State review commissions have criticized the system on the grounds that the States maximum and imputed rental schedules were arbitrary and unsupported and that the system was subject to manipulation and permitted excessive "cash flow" profits.

We made field audits at one proprietary SNF, one voluntary SNF, and one public SNF in the New York City metropolitan area. All three had been desk audited, but none had been field audited by the State. Of the \$27.9 million in costs reported by the three SNFs, we identified \$359,000, about 1 percent, which should have been disallowed. The major problems identified were that about \$166,000 in Medicare Part B reimbursements for in-house physicians' services were in effect paid twice (by Medicare and Medicaid); \$64,000 for capital equipment purchases was simultaneously expensed and depreciated; and \$54,000 in interest income was not offset by the State in computing the SNFs' real property cost rate. We reported these findings to the State with the recommendation that overpayments be recovered.

Virginia

There are 35 SNFs in Virginia participating in the Medicaid program. During the 11 months from July 1, 1974, through May 31, 1975, Virginia paid about \$4.5 million for SNF care, of which the Federal share was 62 percent. Effective July 1, 1975, the Federal share has been 58 percent.

Virginia paid SNFs on a retrospective cost basis using a modified version of Medicare principles and standards in that the State allowed a growth and development factor, while Medicare did not. ^{1/} During the year, SNFs were reimbursed at an interim rate. Within 90 days after a SNF's fiscal year ends, it must submit a cost report to the State Medicaid agency. The State makes a desk audit of the cost report, reconciles the differences with the provider, and prepares a preliminary cost settlement for the year. After the completion of any field audits, final adjustments are made. If no field audit is made within three years, the preliminary cost settlement automatically becomes final. Also, reimbursement rates for SNFs in Virginia were limited to 150 percent of the State's average per diem cost. In fiscal year 1975 the ceiling was \$40.58.

^{1/}In July 1975 the HEW Audit Agency issued a report which in part recommended that the State discontinue payment of the growth and development factor on the grounds that the factor was not based on reasonable cost standards. According to a State official, effective April 1976 the State stopped paying the growth and development factor.

We examined seven cost reports submitted by SNFs during fiscal year 1974 to determine the extent of the State's desk audit disallowances. The seven cost reports showed a total of \$1,833,000 submitted as the basis for Medicaid reimbursements. During the desk review the State determined that these seven SNFs had a net overstatement of costs of about \$39,000, primarily as a result of misstating patient days and underreporting payments for patient care from other sources. The State then added a growth and development factor of \$87,000 ^{1/} and applied the State ceiling to reduce the claimed amounts by \$168,000, making the total allowable reimbursable costs of the seven SNFs \$1,713,000.

Virginia did not use State employees to field audit SNFs. Instead, the State either received the Medicare audit report or when necessary contracted with Certified Public Accountant (CPA) firms to make field audits. A State official told us his goal was to field audit SNFs with significant amounts of Medicaid utilization at least once every 3 years. We audited three SNFs in Virginia, and of \$773,000 claimed for Medicaid reimbursement, we found only minor discrepancies. All three SNFs had been desk audited by the State and field audited by Medicare prior to our review.

SUMMARY OF AUDITED COSTS WHICH WERE
OR SHOULD HAVE BEEN DISALLOWED

The \$9.3 million of costs which were either disallowed or should have been disallowed by the States as erroneously claimed was compiled by analyzing 340 desk and field audits made by the four States and our field audits of 12 SNF cost reports. Erroneously claimed costs amounted to about 3 percent of the \$340 million in total costs submitted. However, we noted that only 56 audits (16 percent of the audits) accounted for \$6.5 million (68 percent) of the erroneously claimed costs. For these 56 audits, most of which were field audits, the erroneously claimed costs identified were about 5.6 percent of the costs claimed. Overall, the erroneously claimed costs disallowed by State field audits--excluding the application of ceilings--were about 4.5 percent of costs claimed. Most of the disallowances made by the States were based on provisions of the Medicare Provider Reimbursement Manual, which interprets Medicare cost reimbursement principles. The most common types of disallowances were:

^{1/}According to a State official, the State stopped allowing the growth and development factor, effective in April 1976.

- Nonpatient care revenues, such as income from beauty shops, vending machines, and investments not offset against related expenses. If the nonpatient care revenues are not offset against expenses before cost-based reimbursement rates are calculated, the facility could be paid twice--once as income and again as a Medicaid reimbursement for the cost of the activity that produced the income.
- Costs not related to patient care, such as advertising in the yellow pages, expenses for luxury automobiles, and vacation trips.
- Expenses not documented, such as "paper" tax and interest charges and nonexistent invoices. In the case of "paper" charges, no actual payments were made by the facility and the transactions often involved one SNF and another entity closely related to the facility through ownership or control.
- Costs of capital items being expensed rather than being capitalized. These capital items are such items as wheelchairs, kitchen equipment, and permanent improvements in a building.
- Costs of capital items being both capitalized and expensed. This results in reimbursing the facility twice during the useful life of the item.

The types of disallowances above were identified in proprietary, private nonprofit, and public SNFs.

Following are examples of unallowable costs identified by State and GAO audits.

Public facility in Massachusetts

This tax exempt municipally owned facility reported costs of \$1.1 million for 1973. The State field audit of this facility resulted in disallowances of \$223,000, 20 percent of the costs submitted. The adjustments were as follows.

Interest expense

In 1971, Massachusetts enacted legislation allowing the establishment of an authority to oversee, maintain, and operate this municipal facility. On January 1, 1972, the authority assumed operation of the facility. The municipality

transferred all assets to the authority under an agreement that the authority would pay the city \$345,000 in principal only in annual payments of \$15,000 for 23 years. However, interest expense was claimed for this transaction on the basis of a loan repayment schedule calling for combined interest and principal payments at \$15,000 annually for 23 years. The interest expense for this and other transactions was disallowed because the State felt they were not arm's-length transactions and did not represent a bona fide expense of the facility. The total disallowed interest expense was about \$16,000.

Real estate taxes

Real estate taxes for 1973 were reported at \$123,000. This was based on an assessed value of the SNF at \$1 million with a tax rate of \$1.23 per thousand. Thus, a "paper" tax bill was received by the SNF from the city for \$123,000. The agreement transferring the SNF from the city to the authority stated that the property tax payment was actually in lieu of taxes and was payable to the city only to the extent that the claimed property tax payment was actually reimbursed by the State. The \$123,000 claim was disallowed by the State auditors.

Other city expenses

The city charged \$31,900 to the facility for the city departments of auditor, treasurer, purchasing, and legal services as well as the salary for an employee hired through the Emergency Employment Act. The State auditors disallowed the entire amount because the departments had not done any identifiable work for the facility and the employee's salary had already been paid with Federal funds under the Emergency Employment Act.

Duplicate administrator's expenses

The facility charged \$14,400 for the administrator's salary and related benefits which were included on the cost report twice.

Other disallowances

The State auditors made several other disallowances to arrive at the total of \$223,000. These other disallowances included

- \$4,000 for pension costs of a retired person and an allocation from the city for services rendered to the facility;
- \$9,000 for physician salaries because such costs were not eligible for reimbursement under the applicable State guidelines;
- \$5,000 for repair expenses which should have been capitalized; and
- \$2,000 for legal services defined by State regulations as not related to the rate appeal process.

Public facility in New York

This county-owned facility submitted calendar year 1973 costs of \$14.2 million. These costs were accepted by the State without field audit as the basis for the establishment of the 1975 reimbursement rate. On the basis of our audit, we determined that the costs were overstated by \$250,000, about 2 percent of the \$14.2 million costs submitted. The overstatements resulted from the following.

Capital equipment

The facility purchased capital equipment for about \$64,000 during the year. The purchase was charged as a direct expense and simultaneously capitalized on the SNF's Medicaid cost report, but not on its Medicare cost report. This practice would result in the facility being reimbursed twice over the useful life of the equipment. The practice of charging equipment purchases as a direct expense while simultaneously capitalizing such purchases for Medicaid reimbursement purposes has been in effect since 1969, and has resulted in a total overstatement in equipment costs amounting to about \$340,000 as of December 31, 1974.

Reimbursement from Part B of Medicare

In calendar year 1973, the facility received Medicare Part B reimbursements amounting to about \$166,000 for in-house physician services provided to patients who were covered by Medicare Part B and by either Medicare Part A or Medicaid. Although this arrangement was properly handled by the SNF in making the cost settlement under Medicare Part A by deducting physicians' salaries applicable to professional services to patients from the costs claimed, neither the payments nor the

related costs were deducted in submitting the costs for determining Medicaid reimbursement. Because Medicare Part B and Medicaid covered the same patient days, in effect, this resulted in the SNF being paid twice (by Medicare Part B and Medicaid) for such services. The facility had failed to deduct the Part B reimbursement since 1969; one SNF official estimated that from 1969 through 1973 about \$704,000 in Medicare Part B payments had not been deducted in calculating Medicaid reimbursement rates.

Patients' clothing and incidentals

The facility made purchases of patients' clothing totaling about \$15,800 during the year.

Purchases should be made using patients' funds and, therefore, not be a cost to the program. The facility has included such purchases in its cost reports since calendar year 1969.

Income from other resources

During 1973, the facility earned revenue of about \$1,300 from vending machines and other miscellaneous sources. This income was not offset against operating expenses as required by the State. The facility had failed to offset such miscellaneous income since calendar year 1969.

Proprietary facility in New York

This privately owned facility reported costs for 1970 at \$3.2 million. The State made a field audit of the cost report and disallowed about \$130,000, 4 percent. Among the unallowable items were

- \$33,000 of interest income not offset against interest expense;
- \$9,800 of transportation expense for luxury automobiles considered by the State criteria as beyond the needs of the facility;
- \$36,800 of capital expenditures charged as an operating expense;
- \$6,500 of salaries paid to relatives through the related management company and deemed excessive by the State auditors;

- \$7,600 for public relations expense;
- \$5,100 for advertising expense;
- \$7,900 erroneously included in office expense actually spent for entertainment charges, unsubstantiated "salaries" paid through petty cash, and public relations expense;
- \$4,900 in barber and beautician services, for which patients were also charged; and
- \$5,500 in land costs charged to repairs and maintenance.

Proprietary facility in Florida

This private facility reported costs of \$407,000 for the year ended December 31, 1973. Florida auditors disallowed costs of \$79,000, 19 percent of the total reported. Among the items disallowed were the following:

- \$32,700 in owner's compensation, because it was in excess of the Medicare guidelines.
- \$23,600 in income from the sale of medical supplies that should have been offset against the medical supply expense.
- \$6,100 of interest, because it was paid to stockholders.
- \$6,700 for Cadillac automobile and boat expenses and depreciation not related to patient care.
- \$3,000 in equipment rental income which should have been offset against related expenses.
- \$1,600 income on drugs which exceeded expenses.
- \$1,600 in consultant and director's fees.
- \$3,700 for other items such as personal travel and entertainment expenses, telephone expenses related to the SNF Comptroller's home phone, auto tires not related to patient care, and income from incidental oxygen sales not offset against expenses.

COSTS DISALLOWED BY THE STATES
BECAUSE OF STATE CEILINGS

Field and desk audits made by the four States and our audits disallowed an additional \$7.6 million in SNF costs, about 2.2 percent of the costs reported, because the amounts were over the States' (either total or individual) ceilings.

In addition to providing overall limits on reimbursable costs, States' ceilings can also be an effective means for not reimbursing costs which are otherwise unallowable. We noted, for example, that excessive or unallowable costs for one SNF which we reviewed in Florida were not reimbursed as a result of the application of a ceiling.

This 220-bed privately owned facility reported total 1974 costs of \$1,625,000. During our audit, we concluded that \$303,000 of its reported costs were either excessive or questionable. Following are the items of costs which we believe should have been disallowed. Each of these items was discussed with a State auditor who generally agreed with our conclusion of unallowability or income that should have been offset against expenses.

Proprietor's compensation costs

This SNF had an agreement with a related management firm to provide the facility with management services for a fee of \$131,000 for 1974. The main duty of the management firm was to administer the facility. Based on guidelines furnished us by State auditors, we calculated that the allowable administrator's compensation should have been \$34,000, and therefore we considered \$97,000 of the management fee unallowable. An additional \$4,700 in costs included in the cost report was disallowed because it was listed as administrator's salary.

Interest expense

The SNF reported interest expense (including late charges) of \$92,900 on notes payable. Our review of this item disclosed that the interest was for loans from a related organization. Discussions with an executive of the management firm disclosed that, although the interest was listed as a cost to the facility, the interest had never been paid and was in fact a paper transaction only. Also, the Medicare Provider Reimbursement Manual provides that interest paid on money borrowed from related organizations is not allowable.

Contributions

Contributions of \$26,700 were made by family or friends, apparently on behalf of specific patients. The Florida Medicaid Nursing Home Manual provides that contributions made on behalf of specific patients will be considered as available income to meet the patients' cost of care unless the contributor signs a statement that the contribution is not intended to supplement expenses relative to a particular patient. Such statements could not be provided by the nursing home for 46 of the 53 individual contributors. No adjustment was made to the Medicaid cost report by the facility for these contributions. Therefore, we offset these contributions against the cost report and reduced the allowable cost by the \$26,700.

Miscellaneous income

The facility had miscellaneous income for the year of \$33,400, which should have been offset against expenses. This income was made up of

- \$19,500 for unclaimed patients' deposits treated by the facility as miscellaneous income. We could not ascertain what these patients' deposits were for;
- \$13,000 from the pharmacy located in the facility;
- \$700 charged patients for laundry, barber, and beauty services; and
- \$200 for television rental.

Other unallowable expenses

The facility reported an additional \$48,700 in Medicaid costs which were unallowable. This amount included items such as

- \$11,000 in overstated medical supplies due to a posting error;
- \$8,200 insurance expense included twice in the cost report;
- \$5,000 paid a firm to supervise the preparation of financial statements, which was unnecessary since the facility paid a local CPA to prepare the statements; and

--\$2,500 in fines levied by the State for noncompliance with staffing standards and other violations.

Misreporting of patient days

On its cost report, the facility reported total patient days of 61,764. During our review, we determined patient days to be 62,397, or 633 more than the facility reported. Reporting fewer days than are actually incurred raises the claimed per diem reimbursement rate.

Total effect of inflated costs

The inflated costs affected the reported daily patient cost by \$5.59, as follows:

	Cost reported for 12-month period ended <u>December 1974</u>	<u>Our estimate</u>	<u>Difference</u>
Total expenses	\$1,625,420	\$1,322,106	\$303,314
Patient days	61,764	62,397	633
Cost per patient day	26.32	21.19	5.13
Add 9-percent allowance <u>1/</u>	28.69	23.10	5.59

Therefore, the unallowable costs plus the errors in reporting patient days could have caused the SNF to have been overreimbursed by \$5.59 per Medicaid patient day for 1975. However, because of the State ceiling, the SNF was actually paid \$18.08 per day until June 1975 and \$19.72 after that time, whereas the amount the facility would have been entitled to in the absence of the ceiling would have been \$23.10 a day.

CONCLUSIONS

Two States, Massachusetts and Virginia, used retrospective cost-based systems and two others, Florida and New York, used prospective systems. All four States had provisions for ceilings which had some effect in preventing

1/The 9-percent allowance is explained on page 6.

excessive reimbursement. Under any system, however, the largest disallowances, in terms of actual dollars and as a percentage of costs submitted, resulted from field audits. Also, field audits seemed to be productive regardless of whether the SNF was private nonprofit, for profit, or a public facility. In general, we identified smaller amounts of unallowable costs in previously field audited nursing homes in Virginia and Massachusetts than in Florida and New York where field audits had not been performed.

CHAPTER 3

EXTENT OF FIELD AUDITS

AND PROBLEMS IN RECOVERING

OVERPAYMENTS TO SNFs

HEW regulations require the States to assure that appropriate audits are made of records whenever reimbursement is based on costs of providing care or services. However, prior to July 1, 1976, HEW had not issued guidelines defining the required frequency of State audits or standards for making such audits. Accordingly, each of the States we reviewed, although reimbursing SNFs on the basis of cost, varied substantially in their field audit efforts. At the time of our visits:

- Florida had not issued any field audit reports on SNFs since the inception of the Florida Medicaid program on January 1, 1970. After our field visit, Florida did issue reports on 23 SNFs.
- Massachusetts' program provided for field auditing all SNFs each year; however, there was about a 2-year backlog in completing such audits.
- New York had audited only 98 of the 540 SNFs in the State participating in the Medicaid program since the inception of the New York Medicaid program in May 1966.
- Virginia either purchased audit reports from the Medicare intermediary or contracted with a certified public accounting firm to make selective audits of SNFs.

In addition, two of the four States reviewed had problems with collecting overpayments made to SNFs, and Florida had not taken action to collect overpayments. As of June 1976, Massachusetts had about \$11.5 million in overpayments to SNFs and intermediate care facilities (ICFs) outstanding for the period 1968 to mid-1973. New York estimated overpayments to SNFs at \$3.2 million based on State audits, but had recovered only \$1.1 million.

HEW GUIDANCE ON THE FREQUENCY OF AUDITS

Until July 1, 1976, Federal regulations required States to assure appropriate audit of records whenever reimbursement is cost-based without specifying the number or frequency of audits. No distinction was made between field and desk audits.

On July 1, 1976, HEW issued regulations to implement section 249 of Public Law 92-603, which requires that, effective July 1, 1976, payments under Medicaid for SNF services be made on a reasonable cost-related basis. One provision of the regulations requires that all facilities (both ICFs and SNFs) be field audited over a 3-year period beginning no later than January 1, 1978. 1/ Thereafter, in each year a minimum of 15 percent of all facilities in each State must be field audited--5 percent selected on a random sample basis and the remainder selected on the basis of exceptional provider profiles. The regulations require some States to substantially increase their audit capabilities. The status of the four States' field audit capability at the time of our visits was as follows:

Florida

Although the Medicaid program began in Florida in January 1970, as of July 31, 1975, the State had not issued any field audit reports of nursing home costs. However, at that time the State auditors had in process audits of 23 of the 261 nursing facilities in Florida. 2/ Most of these audits were of cost reports submitted for fiscal years 1972 and 1973.

1/A State that can demonstrate that it has in effect a continuing audit program under which it has completed field audits of all SNFs and ICFs in the State during the preceding 3-year period may be exempt from the requirement to field audit all nursing facilities no later than January 1, 1981.

2/The HEW Audit Agency contracted with a CPA firm to perform field audits in six nursing facilities in Florida. The results of these field audits were given to the State by HEW in October 1973. We did not include these audit reports in our review because the State field audited these same facilities for the same fiscal years as part of the 23 audits noted above.

A State official told us the State Medicaid agency had requested the audits because of large amounts paid to a particular SNF or because of indications of overpayments. State health department officials indicated to us that they did not have sufficient staff to make periodic audits of each nursing home. In May 1975, the State Medicaid audit staff consisted of 22 auditors for the entire program, including SNFs. In May 1976, a Florida official informed us that the State had issued its reports on the 23 SNFs.

Massachusetts

Massachusetts, which had 237 SNFs participating in the Medicaid program, determined final cost reimbursement amounts after field audits at each SNF. The State had 14 auditors to make field audits of SNFs, of whom 9 were State employees and 5 were under contract from Blue Cross-Blue Shield. As of June 1976, a State official estimated the backlog of field audits at about 2 years.

As recently as June 1976, the State had not provided its auditors with written procedures or guidelines for making field audits other than the State's annual regulations governing the determination of payment rates.

In June 1976, an official of the Massachusetts Bureau of Welfare Auditing told us that the Bureau had been concerned for a number of months with the specific causes of overpayments to nursing homes. The Bureau is generally concerned with fraud activities of providers, recipients, and State employees for all State welfare programs. As of June 1976, the Bureau had obtained conviction of a nursing home operator and indictment of another for manipulation of their cost reports. In the former case, the operator had manipulated the reported equity for the purpose of claiming extra reimbursement for return on equity and in the latter case patient days were misreported. The Bureau official expected several more indictments during the summer of 1976.

New York

As of July 11, 1975, the State had made 210 field audits in 98 of the 510 SNFs participating in the Medicaid program and was making 142 audits at an additional 58 SNFs. The 352 audits covered primarily cost reports submitted for calendar years 1969-71 and were only for proprietary SNFs. Both private nonprofit and public SNFs were excluded because of the limited staff available for such audits. Until

December 1974, the maximum number of State auditors assigned provider reimbursement activities never exceeded 16. However, as of May 1976, the staff had increased to 153 auditors according to a State official who told us that the State intends to audit all SNFs at least once a year.

In addition to the audits of SNFs routinely performed by the State, a special series of audits was made at selected SNFs and ICFs by the audit staff of the Special State Prosecutor for Health and Social Services. On January 10, 1975, the Governor of New York appointed a Deputy Attorney General to act as Special Prosecutor. In January 1976, the Special Prosecutor released his first annual report, "Investigation into Allegations of Criminality in the Nursing Home Industry in the State of New York." The investigation covered three areas of concern--patient abuse, fraud, and political influence.

In his January 1976 report, the Special Prosecutor reported the filing of 12 felony indictments for fraud and larceny of over \$3.4 million. Four convictions had been obtained. The Special Prosecutor's own audit staff had completed 13 audits which identified Medicaid overcharges of \$3.7 million and had in process 27 additional audits which had identified an additional \$8 million in overcharges. Total costs submitted by all 40 nursing homes were estimated by the Special Prosecutor's staff to be "roughly \$200 million." This means that, with less than half the audits finished, a minimum of 6 percent of submitted costs represented overcharges.

Virginia

Virginia has 35 SNFs participating in the Medicaid program, of which 34 also participate in Medicare. Virginia did not use its audit staff to make field audits of SNFs. Instead, the audit staff was used on hospitals and ICFs which represented the bulk of Medicaid payments. For SNFs which provide services to both Medicaid and Medicare, the State purchased the audit reports which it believed would be useful from Blue Cross, a Medicare intermediary. Otherwise, we were told, the State would contract with a CPA firm to make selective audits of SNFs. During fiscal year 1974,

Virginia's audit effort on SNFs consisted of purchasing 9 audit reports from Blue Cross. 1/

PROBLEMS WITH COLLECTING
OVERPAYMENTS FROM SNFs

There are no uniform Federal requirements for State recovery systems. 2/ We believe, however, that the cost effectiveness of any State provider audit program depends to a large extent on the State's capability to actually recover overpayments identified during audits. Two of the four States that we reviewed had problems collecting overpayments from SNFs; only one appeared to have an effective collection program, while another had no collection program at all.

Florida

According to a State official, Florida has never recovered any payments from SNFs for any reason. The official told us, however, that the State could recover any overpayments that were found to have been made in connection with its recent field audits of 23 nursing facilities.

Massachusetts

In June and July 1971, the HEW Audit Agency reported that nursing homes in Massachusetts were overpaid \$915,000 and recoveries had not been made. These overpayments occurred because the State failed to make retroactive adjustments for 1969 when the 1969 interim per diem rates were lower than the 1968 interim rates. These nursing homes were paid at the 1968 interim rates until the 1969 interim rates were established. SRS offset a subsequent State claim for Federal financial participation by the Federal share of the \$915,000 (\$457,000) as a result of the two 1971 reports.

1/The HEW Audit Agency field audited six Virginia nursing facilities (one SNF and five ICFs) and turned the results over to the State in July 1975. Because the findings pertained primarily to ICFs, we did not include these audit reports in our analysis of disallowances.

2/Under the regulations issued July 1, 1976, States are required to account for overpayments identified through State audits on the quarterly Statement of Expenditures submitted to SRS. This accounting must occur no later than the second quarter following the quarter in which the overpayment is found.

In February 1974, the HEW Audit Agency issued another report on the Massachusetts Medicaid program which pointed out that

- the State had not recovered from the nursing homes the \$915,000 in overpayments cited in the 1971 reports even though SRS had recovered the Federal share from the State,
- overpayments continued to be made without recoveries, and
- SNFs and ICFs had been overpaid by at least an additional \$1.9 million for 1970 and 1971.

The report went on to recommend that the State either credit the Federal account for the Federal share of the \$1.9 million (\$950,000) or develop on a timely basis a systematic plan to recoup overpayments.

The State chose the option of establishing a recovery system. An SRS official told us that after several months SRS started procedures to recover the Federal share of the \$1.9 million from the State because of the State's failure to make satisfactory progress in establishing an effective system. State appeals to SRS delayed SRS's attempted recovery. Collections and offsets made by the State reduced the outstanding balance to \$405,000 by March 1976. In August 1976 an SRS official told us that he was recommending that SRS stop further actions to recover the Federal share of this balance. Both State and SRS officials told us that the State's recovery system was not satisfactory, but they all believed that progress was being made.

In May 1975, a Massachusetts official estimated that \$11.5 million was outstanding which had been overpaid to 340 SNFs and ICFs from 1968 to mid-1973. The State did not know how much it had actually overpaid facilities since mid-1973 because its automated accounting system for retroactive adjustments was programed only to handle underpayments. SRS had not required the State to change its automated accounting system to tabulate overpayments made to SNFs.

In June 1976, another Massachusetts official told us that although some part of the \$11.5 million overpayments estimated in May 1975 had been recovered, additional overpayments to nursing homes identified by the State auditors after May 1975 would probably make the outstanding

overpayments around \$11.5 million as of June 1976. However, he could not supply us with any data to support this estimate. He also noted that since "final" rates are subject to appeal, not all of them can be considered final. Pending appeals of final rates go back as far as 1970. In June 1976, another official told us that there were about 1,600 pending appeals of both interim and final rates. Appeals of interim rates are normally dropped when the final rate is established, although the final rate is, of course, subject to appeal. Also, until April 1976, the State did not have a systematic procedure for recovering overpayments after they were identified.

New York

New York did not have an effective program for recovery of overpayments made to SNFs. In July 1975, a New York State official estimated that the State was entitled to recover about \$3.2 million as a result of rate adjustments based on State audits of SNF costs. Actual recoupments, however, have amounted to only about \$1.1 million, about 34 percent of the estimated total due the State. The Federal share of this amount outstanding is 50 percent. In May 1976 a State official told us the State Medicaid agency was developing repayment schedules so that outstanding overpayments could be recovered, but these repayment schedules had not been finalized at that time.

Virginia

Virginia uses Medicare policies for recovering Medicaid overpayments to SNFs. Upon determination that money is owed to the State, the provider is notified and requested to make repayment. If repayment or acceptable agreement for repayment is not reached within 120 days, the State gives the provider 30 days' notice that current interim payments will be stopped. Acceptable repayment arrangements include a reduction in the interim rate, full repayment, installment repayments, or offsets against the following year's cost settlement. At the time of our visit in July 1975, no SNFs owed the State because of outstanding overpayments.

CONCLUSIONS

Federal regulations require that States assure appropriate audit of records whenever reimbursement is based on costs of providing care or services. All of the States we reviewed were reimbursing SNFs on either a prospective or

retrospective cost basis, yet each State varied in its audit effort from no completed audit reports in Florida to a requirement in Massachusetts that all SNFs be audited prior to the annual retrospective final settlement. However, HEW issued regulations on July 1, 1976, that will require many States to increase their audit efforts.

Also, Massachusetts and New York were having difficulties collecting overpayments made to SNFs, and Florida had not taken action to identify or collect overpayments. Only Virginia, which has a small SNF program and which has adopted Medicare's procedures for systematically identifying and recovering overpayments to SNFs, seemed to have an effective program.

RECOMMENDATIONS

In order to better assure that overpayments made to SNFs and ICFs are either recovered or offset against current payments, we recommend that the Secretary direct the Administrator of SRS to

- periodically assess States' actions to comply with the recently issued regulations requiring States to identify and report overpayments to SNFs and ICFs on a timely basis and
- deny Federal participation in overpayments when States do not establish effective recovery programs on a timely basis.

CHAPTER 4
PROGRESS IN
IMPLEMENTING A NATIONWIDE CONVERSION
TO COST-RELATED REIMBURSEMENT SYSTEMS

HEW has been slow in issuing regulations requiring States to reimburse SNFs on a reasonable cost-related basis by July 1, 1976. HEW did not issue final regulations until July 1, 1976. The regulations permit States to delay implementation until January 1, 1978, 18 months after the statutory effective date. HEW estimates that the additional cost to the Medicaid program for SNF services, as a result of implementing the proposed regulations, will be about \$117 million in payments to SNFs for the first full year of implementation.

HEW PROGRESS IN ISSUING REGULATIONS

Section 249 of Public Law 92-603, enacted October 30, 1972, requires that, effective July 1, 1976, payments under Medicaid for SNF services be made on a reasonable cost-related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary.

SRS issued its first proposed regulations to implement section 249 in March 1975. The preliminary draft regulations were distributed at the State Medicaid directors meeting held on March 24-26, 1975, to the State directors in attendance and to representatives from HEW regional offices. In addition, copies were mailed to those States not represented at the meeting.

The draft regulations initially proposed by SRS met opposition from within HEW as well as from the States. The Office of the Deputy Assistant Secretary for Planning and Evaluation/Health commented that the draft regulations were too permissive and lacked clear Federal guidance regarding the type of cost-based payment systems that would be acceptable within the statutory requirement that they be "reasonable cost-related." By letter dated June 27, 1975, the Office made a series of specific suggestions for strengthening the proposed regulations, including recommendations relating to cost features, reimbursement policy, and specified minimum audit priorities and frequency. Some States opposed the

reasonable cost-related feature of the conversion mandate because they expected increases in program costs.

HEW formally issued proposed regulations to implement section 249 on April 13, 1976, and final regulations on July 1, 1976.

Among the provisions included in the final regulations are these:

- The Medicare reasonable cost reimbursement formula may be used. State systems following Medicare principles of reimbursement would have automatic HEW approval.
- Rates of payment may be determined prospectively or retrospectively.
- Reimbursement rates within a State may be determined on a class basis.
- State reimbursement rates for routine services must include payment for regular room and board, nursing services, special diets, minor medical and surgical supplies, and the use of equipment and facilities.
- States may establish reasonable ceiling limitations based on costs for the efficient delivery of service. Limits on costs must be established at levels adequate to permit adherence to health and safety standards for participation in Medicaid.
- Field audits must be performed at all SNFs and ICFs over a 3-year period beginning not later than January 1, 1978, unless the State already has an acceptable field audit program.
- Medicare audit standards are recommended, but each State may develop its own audit standards which are consistent with standards approved by the American Institute of Certified Public Accountants.

Until the final regulations were published, it was not possible to identify what changes, if any, needed to be made in each State's reimbursement system. As noted above, the States may delay full implementation until January 1, 1978. In the preamble to the final regulations, HEW acknowledged that its delay in publishing regulations made it impossible

for many States to comply with the July 1, 1976, effective date for implementation of section 249. We agree that many States will require a period of time to make changes in their reimbursement systems. It seems clear to us that the Congress was aware that a period of time was needed to make changes in State reimbursement systems when it provided from October 1972 until July 1976 to bring about implementation.

COST OF IMPLEMENTING
COST-RELATED REIMBURSEMENT
SYSTEMS

In September 1975, SRS requested its regional offices to obtain from each State a financial impact statement so that SRS could prepare an inflationary impact statement for implementing the changes required by section 249. Based on these statements, ^{1/} SRS estimated that the additional costs to the States and the Federal Government for SNF services would be about \$117 million, approximately 4 percent of total payments to SNFs nationwide. The estimated increase includes \$44.8 million for Ohio, which did not submit a financial impact statement, and \$17 million for Illinois, which stated it could not estimate the impact of the proposed regulations. SRS made estimates for both States based on a comparison of the then-current average reimbursement rate in Ohio and Illinois to the average rates paid in adjacent States.

Pennsylvania reported that the conversion would cost the State an increased \$35.6 million for SNF care. However, an HEW General Counsel memorandum pointed out that Pennsylvania's reimbursement procedures for SNFs might not be in accordance with the existing Federal regulations because the State paid publicly owned facilities on a different basis than it paid privately owned facilities for similar SNF services. Public SNFs were paid on the basis of reasonable costs and private SNFs were paid a flat rate. An SRS official stated that if Pennsylvania was not in compliance with Federal regulations

^{1/}The estimates were based on the assumption that all cost related reimbursement systems would be fully implemented as of July 1, 1976, and the time period for which increased costs were to be estimated was July 1, 1976, to June 30, 1977. The assumption turned out to be unrealistic as a predictor of when full implementation would take place, but it did serve to eliminate any obvious bias in the estimate due to differing perceptions of when implementation could take place.

and had to pay all SNFs on a reasonable cost basis as it paid public SNFs, there would be a substantial reduction in the estimated increased costs for the section 249 conversion. The SRS official also stated that it is unlikely Pennsylvania would want to meet the equal payment requirement by paying public SNFs a flat rate for SNF care because all costs above the flat rate would then be borne by the State without Federal financial participation.

In addition, there are a number of features in the July 1976 regulations that we believe could help to hold down the costs of SNF care, such as authorizing ceilings and requiring field audits.

CONCLUSIONS

Although Public Law 92-603 was enacted on October 30, 1972, HEW did not issue final regulations for the implementation of section 249 until July 1, 1976. Until the regulations were issued it was not possible to identify the changes, if any, to be made in State reimbursement systems. Consequently, some States were not able to implement the changes by July 1, 1976, as mandated by the law.

The implementation of section 249 undoubtedly will cause some States and the Federal Government to spend more money on SNF and ICF services. However, we believe that the regulations contain features such as authorizing reimbursement ceilings and requiring field audits that could enable the States to minimize the financial impact of changing to a reasonable cost-related system of reimbursement.

SCHEDULE OF COSTS ERRONEOUSLY CLAIMED BY SNFS,
COSTS OVER STATES' CEILINGS, AND UNDERSTATED COSTS

<u>State</u>	<u>Type of audit</u>	<u>Number of audits</u>	<u>Total costs submitted</u>	<u>Costs erroneously claimed</u>	<u>Costs over State ceilings</u>	<u>Total costs disallowed</u>	<u>Understatement of costs</u>
<u>Florida</u>	Desk audits	25	\$ 18,301,720	\$ 160,889	\$2,646,142	\$ 2,807,031	\$ -
	Field audits	10	7,285,639	1,226,376	155,790	1,382,166	-
	GAO audits	3	2,759,036	40,946	321,907	362,853	-
<u>Massachusetts</u>	Field audits	26	19,172,470	2,461,644	1,475,540	3,937,184	1,065,079
	GAO audits	3	3,481,611	22,202	18,686	40,888	-
<u>New York</u>	Desk audits	62	112,705,512	963,641	2,095,518	3,059,159	392,218
	Field audits	210	145,922,754	4,075,302	710,333	4,785,635	692,570
	GAO audits	3	27,938,547	320,265	38,259	358,524	-
<u>Virginia</u>	Desk audits	7	1,832,706	68,183	167,575	235,758	116,390
	GAO audits	3	773,070	1,577	-	1,577	-
	<u>Total</u>	<u>352</u>	<u>\$340,173,065</u>	<u>\$9,341,025</u>	<u>\$7,629,750</u>	<u>\$16,970,775</u>	<u>\$2,266,257</u>

PRINCIPAL HEW OFFICIALS
RESPONSIBLE FOR THE ADMINISTRATION OF
ACTIVITIES DISCUSSED IN THIS REPORT

	<u>Tenure of office</u>	
	<u>From</u>	<u>To</u>
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
David Mathews	Aug. 1975	Present
Caspar W. Weinberger	Feb. 1973	Aug. 1975
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
Robert Fulton	June 1976	Present
Don I. Wortman (acting)	Jan. 1976	June 1976
John A. Svahn (acting)	June 1975	Jan. 1976
James S. Dwight, Jr.	June 1973	June 1975
Francis D. DeGeorge (acting)	May 1973	June 1973
Philip J. Rutledge (acting)	Feb. 1973	May 1973
John D. Twiname	Mar. 1970	Feb. 1973
Mary E. Switzer	Aug. 1967	Mar. 1970
COMMISSIONER, MEDICAL SERVICES ADMINISTRATION:		
M. Keith Weikel	July 1974	Present
Howard N. Newman	Feb. 1970	July 1974
Thomas Laughlin, Jr. (acting)	Aug. 1969	Feb. 1970
Francis L. Land	Nov. 1966	Aug. 1969

OTHER NURSING-HOME-RELATED REPORTSISSUED SINCE 1972

<u>Report title</u>	<u>Number</u>	<u>Date issued</u>
Federal Fire Safety Requirements Do Not Insure Life Safety In Nursing Home Fires	B-164031(3)	6- 3-76
Improvements Needed In Medicaid Program Management Including Investigations Of Suspected Fraud and Abuse	MWD-75-74	4-14-75
Improvements Needed in the Managing and Monitoring of Patients' Funds Maintained by Skilled Nursing Facilities and Intermediate Care Facilities	MWD-76-102	3-18-76
VA Community Nursing Home Program	MWD-76-97	3- 8-76
Error in Veterans Administration's Calculation of Community Nursing Home Rates in Medical District 5	MWD-76-50	10-24-75
Increased Compliance Needed with Nursing Home Health and Sanitary Standards	MWD-76-8	8-18-75
Many Medicare and Medicaid Nursing Homes Do Not Meet Federal Fire Safety Requirements	MWD-75-46	3-18-75
Need to More Consistently Reimburse Health Facilities Under Medicare and Medicaid	B-164031(4)	8-16-74
Better Use of Outpatient Services and Nursing Care Bed Facilities Could Improve Health Care Delivery to Veterans	B-167656	4-11-73
Problems in Providing Guidance to States in Establishing Rates of Payment for Nursing Home Care Under the Medicaid Program	B-164031(3)	4-19-72
Summary of Reviews of Planning, Construction, and Use of Medical Facilities at Selected Locations	B-167956	3- 7-72