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[Cost Related Medicaid Reimbursements to Nursing Homes in the State of Kansas (Code 106121)]. September 8, 1977. 5 pp.

Report to Gene Hyde, Acting Regional Administrator, Health Care Financing Administration; by David A. Hanna, Regional Manager, Field Operations Div.: Regional Office (Kansas City).

Issue Area: Health Programs: Health Providers (1202); Health Programs: Reimbursement Policies and Utilization Controls (1208).
Contact: Field Operations Div.: Regional Office (Kansas City).
Budget Function: Health: Nursing Homes (557); Miscellaneous: Financial Management and Information Systems (1002).

A survey was conducted of State of Kansas controls and procedures used to reimburse nursing homes for services provided patients under the Medicaid program. The investigators analyzed: the State's method of establishing reimbursement rates, selected program providers' cost reports which the State used to establish these rates, and four program providers' records to verify the propriety of selected costs included in the reports. Findings/Conclusions: The State was not effectively identifying and following up on questionable or unallowable provider costs. As a result, some providers were reimbursed at rates higher than justified on the basis of their allowable incurred costs, and the State's reimbursement ceilings were raised because these unallowable costs were included in the cost base the State used to set rate ceilings. Moreover, the State had erroneously raised the reimbursement ceilings even further by including in the cost base estimated operating costs for new facilities and facilities under new ownership. In fiscal years 1975 and 1976, about $700,000 should have been disallowed either during desk audits or followup field audits, and other costs were identified which appeared improper but passed through desk audit unchallenged. A recomputation of fiscal year 1977 reimbursement ceilings using the State's reimbursement formula and fiscal year 1976 reported costs but excluding the proposed budgets showed possible excessive payments of $800,000 to intermediate care facilities. Recommendations: The Acting Regional Administrator should monitor the State's progress in correcting the deficiencies cited and recover the Federal portion of the overpayments found by the State in its followup reviews. (Author/SW)

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UNITED STATES GENERAL ACCOUNTING OFFICE
REGIONAL OFFICE
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September 8, 1977

Mr. Gene Hyde
Acting Regional Administrator
Health Care Financing Administration
Department of Health, Education and
Welfare
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Hyde:

We have surveyed State of Kansas controls and procedures used to reimburse nursing homes for services provided patients under the Medicaid program. We analyzed the State's method of establishing reimbursement rates; reviewed selected program providers' cost reports which the State used to establish these rates; and examined four program providers' records to verify the propriety of selected costs included in the reports.

The examination showed the State was not effectively identifying and following up on questionable or unallowable provider costs. As a result, some providers were reimbursed at rates higher than justified on the basis of their allowable incurred costs and the State's reimbursement ceilings were raised because these unallowable costs were included in the cost base the State used to set rate ceilings. Moreover, the State had erroneously raised the reimbursement ceilings even further by including in the cost base estimated operating costs for new facilities and facilities under new ownership.

State officials advised us they will take action to correct these deficiencies. Details follow.

NEED FOR MORE THOROUGH REVIEW
OF COST REPORTS TO PRECLUDE
EXCESSIVE PAYMENT RATES

From examination of selected administrative and property costs included in provider cost reports submitted during fiscal years 1975 and 1976, we identified about $700,000 that should have been disallowed either during desk audits or follow-up field audits and other costs which appeared improper but passed through desk audit unchallenged. In the desk audit function, which is the first step in the State's cost-related rate setting process, the desk auditor allows or disallows costs

at face value or based upon additional information he may request. He may also initiate follow-up by field auditors to verify the accuracy and allowability of claimed costs.

Once passed by desk audit, however, costs are included in the calculations of the individual provider payment rates and the Statewide ceiling rates. If subsequent field audit shows that costs should have been disallowed, the individual provider's payment rate is adjusted, but adjustments are not made to the Statewide ceilings. Thus, unallowable costs not detected during the desk audits can result in increased payment rates to all providers whose costs exceed the Statewide ceilings. Specific cases of unallowable costs are discussed below.

Case I

In its fiscal year 1975 financial report submitted to the State, a provider reported $828,121 in loans for a nursing home building and equipment. Interest on these loans totaled $71,773. The cost of the building and equipment recorded on the financial report was $447,133. The desk auditor had not questioned the necessity for the excessive loans reported. We visited the provider and found that the existing mortgages on the home actually totaled $453,121 and the fiscal year 1975 interest expense actually incurred amounted to only $41,056. The provider advised us that the additional reported loans and interest were clerical errors. As a result, the cost base for computing the provider's reimbursement rate was erroneously increased $30,717.

Case II

In fiscal year 1976, a provider reported amortization costs of $100,000 on the cost of a "covenant not to compete." In addition, $26,929 of the reported interest expense was applicable to the covenant. The desk auditor did not disallow these costs, nor did he disallow $4,500 in amortization costs and $27,000 in related interest expense reported the previous fiscal year. Based on our inquiry, State officials had field auditors visit the provider and subsequently disallowed the amortization costs and interest expense associated with the covenant. As a result, the provider's daily patient rate was reduced 60 cents. The provider has agreed to refund the overpayments resulting from the covenant costs.

Case III

A multi-home provider (parent corporation) leases a nursing home to each of eight wholly-owned subsidiaries. This was known to the desk auditor. The subsidiaries reported lease payments

of about $1.3 million in fiscal years 1975 and 1976. The desk auditor allowed these costs without determining what costs were actually allowable for reimbursement. The HEW-Medicare manual (HIM-15) states that lease costs between related organizations will be limited to the costs of ownership. Our examination of parent corporation records showed that the annual property costs (depreciation and interest expense) incurred were about $232,000 less than the subsidiaries lease payments to the parent.

Case IV

In July and August 1975, a multi-home provider made loans totaling $448,500 to nine wholly-owned subsidiaries. In fiscal year 1976, the subsidiaries reported to the State loan interest costs of about $25,900. Interest on these type loans are considered in HIM-15 as investments of capital. The desk auditor did not question these interest costs even though similar costs previously reported by this same provider were disallowed.

Following are other costs providers reported which appeared improper to us but were not questioned during desk audit. Although further review may show that some of these costs are proper and reasonable, follow-up was warranted to determine their allowability.

—Two providers reported loans totaling $312,112 and $289,669 more than their respective buildings and equipment costs.

—Three providers claimed interest costs on loans from owners, stockholders or related organizations. Interest on these loans totaled about $21,000.

—A provider reported insurance costs of $30,980 for his 64-bed intermediate care facility. The average insurance cost for 100-bed intermediate care facilities participating in the Kansas program was about $6,400.

—A provider reported legal and accounting fees of $20,144 for a 50-bed intermediate care facility. The average legal and accounting fees for 100-bed intermediate care facilities participating in the Kansas program was about $2,800.

—Two providers reported depreciation costs which appeared to be on leased facilities.

—One provider reported using the double-declining balance method of depreciation even though State regulations require use of the straight line method.

—Eight other providers used the straight line method of depreciation but depreciated their facilities over 20 years or less. The desk auditor said 30 years was the minimum acceptable.

State Comments

State officials generally agreed with the above facts. They advised us that they would look into each case cited and take corrective action. A State official also told us that they had recently entered into a contract with a local accounting firm to design an automated system to review provider cost reports and identify those costs which should be disallowed or further reviewed by the State. An official in the accounting firm told us that the firm would develop a program in which data from financial reports would be put into a computer system and the various cost elements would be measured against established norms or standards.

Recommendations

We recommend that you monitor the State's progress in correcting the deficiencies cited and recover the Federal portion of the overpayments found by the State in its follow-up reviews.

INCREASED CEILINGS ON REIMBURSEMENT RATES

The fiscal year 1977 Medicaid payments for intermediate care in 220 facilities in Kansas increased about $800,000 because proposed budget estimates for 32 new facilities or facilities under new owners were included in the State's computations of cost reimbursement ceilings. Although we did not determine the dollar impact on skilled nursing services, the State also included budget estimates in its calculations of those reimbursement ceilings.

A State official said that budget estimates were included in the calculation of cost reimbursement ceilings because it was believed there would not be very many of them and they would be comparable to the adjusted actual costs of existing facilities. However, daily patient rates for those who submitted proposed budgets during fiscal year 1976 were mostly in the upper 25 percent of all homes in the State. Additionally, some of the providers had significantly overestimated their costs and had included estimates for such things as management fees, home offices, and interest where no costs were incurred.

Because of the questionable nature of many of the items in the proposed budgets, we recomputed the fiscal year 1977 Statewide reimbursement ceilings using the State's reimbursement formula and fiscal year 1976 reported costs but leaving out the proposed budgets. The effect of using the proposed budgets in the computation of the different ceilings on daily rates is depicted below:

Cost Center	State	GAO	Difference
Administration	$ 2.50	$ 2.46	$.04
Property	3.64	3.32	.32
Room and Board	4.08	4.08	-0-
Health Care	4.99	4.92	.07
Total Costs	$14.84	$14.24	$.60

Applying the lower ceiling rates to fiscal year 1977 estimated patient days shows possible excessive payments of $800,000 to intermediate care facilities.

State Comments

A State official said he had become concerned with the increased number of proposed budgets being submitted and with over-estimation of costs in the proposed budgets, but was not aware of the significant impact this data could have in increasing ceiling rates. He advised us that proposed budgets had been excluded in the fiscal year 1978 rate setting process.

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We shall appreciate being advised of actions taken on our recommendations. We would be glad to discuss this report with you or your staff.

Sincerely yours,

David A. Hanna
Regional Manager