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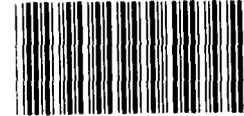
GAO

United States General Accounting Office
Report to the Secretary of Health and
Human Services

May 1986

MEDICAID

Methods for Setting Nursing Home Rates Should Be Improved



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**Human Resources Division
B-221534**

May 9, 1986

The Honorable Otis R. Bowen, M.D.
The Secretary of Health
and Human Services

Dear Mr. Secretary:

Because of the rapidly growing elderly population, nursing home care has become the nation's third largest health care expenditure (behind physicians and hospitals). As you know, almost 50 percent of nursing home expenditures come from Medicaid, a grant-in-aid program authorized by title XIX of the Social Security Act. Under Medicaid, the federal government pays 50-78 percent of costs incurred by states for medical services for persons unable to pay for their care. In fiscal year 1985, Medicaid paid an estimated \$12 billion to nursing homes, an increase of 255 percent over fiscal year 1975 payments.

Until 1980, states were required to pay for Medicaid nursing home care on a reasonable cost-related basis. Because of general concern that the requirements for cost-related payment systems were too restrictive and inflexible to enable the states to effectively contain Medicaid costs, the Congress, through enactment of the Omnibus Reconciliation Act of 1980, gave states more flexibility in designing their reimbursement systems. Specifically, the act replaced the requirement that nursing homes be paid on a reasonable cost-related basis with a requirement that states make assurances, satisfactory to the Secretary of Health and Human Services, that the rates were reasonable and adequate to meet the costs incurred by efficiently and economically operated nursing homes in providing quality care. The Department of Health and Human Services (HHS) published interim regulations to implement the law in September 1981 and final regulations in December 1983.

Many states have taken advantage of the increased flexibility and developed or revised prospective payment systems for nursing homes. Under prospective payment systems, nursing homes are paid a predetermined daily rate based on historical cost experience, irrespective of current costs, for each Medicaid patient. Such systems are designed to give nursing homes incentives to hold down their costs. A nursing home whose costs exceed the predetermined payment suffers a loss, but it makes a profit if its costs are less than the payment.

In developing nursing home prospective payment rates, states generally

- establish allowable nursing home costs for some base period using actual historical cost data,
- group the state's nursing homes into various subgroups to reflect differences in costs caused by such factors as location and level of care,
- establish a cost ceiling or reimbursement limit for homes in each group, and
- adjust the base-year costs for inflation since the base period.

As a result of the Omnibus Reconciliation Act of 1980, states are required to give assurances to HHS' Health Care Financing Administration (HCFA) that their payment rates are reasonable and adequate to meet the costs incurred by efficiently and economically operated nursing homes to provide care in conformity with applicable state and federal laws, regulations, and quality and safety standards. These assurances must be made at least annually and whenever a significant change is made in reimbursement methods. HCFA is responsible for determining whether there is an adequate basis for the assurances.

How effective have states been in establishing prospective payment systems that provide nursing homes an incentive to reduce costs without adversely affecting quality of care? To get an idea of this, we reviewed the prospective payment systems in seven states: Arkansas, Georgia, Illinois, Kentucky, Minnesota, South Carolina, and Texas. Our findings are summarized in this letter and detailed in appendix I. Our work was performed in accordance with generally accepted government auditing standards. Details on our objectives, scope, and methodology appear in appendix II.

In our review, we identified weaknesses in each phase of the rate-setting process described above. These weaknesses meant that HCFA lacked adequate assurances that the states' reimbursement rates were reasonable and adequate to meet the costs incurred by efficiently and economically operated nursing homes. Specifically,

- Allowable base costs were too high, resulting in increased reimbursements, because states had not always (1) established specific written criteria limiting allowable costs for such items as luxury automobiles, (2) used the results of audits to adjust base costs and nursing home rates, and (3) established limits on the allowances for increased costs resulting from the sale or lease of nursing homes that would discourage such sales and leases solely to maximize Medicaid reimbursements.
- None of the seven states had done adequate studies to insure that subgroupings reflected legitimate differences in the costs of operating an

efficient, economical nursing home (such as differences in costs in urban versus rural areas). This resulted in reimbursement rates that may not be adequate to insure quality care in some economically and efficiently run nursing homes, while giving other nursing homes in the subgroup unreasonable profits.

- Inflation indices used by some states did not accurately measure inflation within the nursing home industry.
- None of the seven states had done a study to insure that the cost ceilings they established would maximize nursing homes' incentives to contain costs without jeopardizing quality of care.

The Congress, through enactment of the Deficit Reduction Act of 1984, set new limits on Medicaid reimbursement for the costs associated with the sale of a nursing home (see p. 16). Effective implementation of the act should enable HCFA and the states to better control cost increases resulting from these transactions. As of February 1986, however, HHS had not published regulations implementing the act.

Although the Deficit Reduction Act does not specifically address lease arrangements, the conference report on the act indicates that the conferees expressed concern about the reasonableness of lease amounts. Our review confirmed the need for controls over lease arrangements.

Although HHS regulations require states to submit assurances to HCFA that their reimbursement rates are reasonable and adequate, HCFA has not established adequate guidelines to be followed by states in making assurances. Nor has HCFA adequately reviewed the basis for states' assurances. As a result, HCFA does not know whether the full potential of prospective payment systems to contain nursing home costs is being realized or whether reimbursement rates are adequate to assure Medicaid beneficiaries access to quality nursing home care.

We recommend that you direct the Administrator of HCFA to establish guidelines to be used by states in making assurances that their nursing home reimbursement rates are reasonable and adequate and use these guidelines to review the adequacy of states' assurances. The guidelines should, at a minimum, provide that states make assurances that they have

- established specific criteria defining allowable costs for such items as luxury automobiles and out-of-state travel,
- used the results of audited cost reports to compute reimbursement rates,

- used inflation indices that reasonably reflect increased costs in the nursing home industry,
- performed studies to ensure that the subgroupings used result in reasonable and adequate reimbursement for all nursing homes within the group,
- performed studies to ensure that the ceilings set on reimbursement rates are appropriate,
- performed studies to demonstrate an actual shortage of nursing home beds before allowing proprietary nursing homes a separate return on equity, and
- established adequate limits on the effects of sales and leases on property costs.

In addition, we recommend that you publish regulations to implement the provisions of the Deficit Reduction Act of 1984 relating to the effects of nursing home sales on allowable property costs and that you provide technical assistance to the states in developing or revising prospective payment systems.

In commenting on a draft of this report on February 10, 1986, HHS indicated that it believes existing HCFA guidance reflects congressional intent to increase the states' administrative and fiscal discretion to set payment rates. HHS also indicated that federal requirements should be kept to the minimum level necessary to assure proper accountability. But HHS said it would take into account our findings in its ongoing monitoring and oversight of state Medicaid operations.

We believe, however, that information discussed in this report shows that the guidelines we are recommending are needed to enable HCFA to properly perform its oversight responsibilities under the act. Existing HCFA guidance and monitoring have not been adequate to ensure proper accountability and compliance with the requirements in the statute and regulations that all nursing homes receive reasonable and adequate payments.

HHS is developing regulations to implement the provisions of the Deficit Reduction Act of 1984 relating to the effects of nursing home sales on allowable property costs. The agency also said that it is providing technical assistance to states developing case-mix reimbursement systems.

HHS comments and our evaluation are discussed in more detail on pages 30 to 33.

As you know, 31 U.S.C. 720 requires that the head of a federal agency 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 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 are sending copies of this report to the Director, Office of Management and Budget, and the Chairmen of the four above-mentioned committees, the Senate Committee on Finance, and the House Committee on Energy and Commerce, Subcommittee on Health and the Environment, as well as to other interested parties. We will make copies available to others upon request.

Sincerely yours,



Richard L. Fogel
Director

Contents

Letter		1
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Appendix I		8
Improvements Needed in Medicaid Methods for Setting Nursing Home Rates	Background	8
	Better Use of Audited Cost Data Could Save Millions	11
	More Specific Written Criteria for Allowable Costs Needed	14
	Deficit Reduction Act Strengthens Controls Over Property Costs	16
	Grouping Nursing Homes Helps Ensure Reasonable, Adequate Payments	19
	Cost Ceilings Can Affect Program Costs, Access, and Quality of Care	22
	Some Inflation Indices Do Not Reflect Nursing Home Cost Increases	24
	Including Return on Equity Increases Costs, Lessens Incentives	27
	Conclusions	29
	Recommendations	29
	Agency Comments and Our Evaluation	30

Appendix II		34
Objectives, Scope, and Methodology		

Appendix III		37
Controls on Allowable Property Costs From Sales and Leases: Summary of Seven States Reviewed by GAO	Arkansas	37
	Georgia	37
	Illinois	38
	Kentucky	39
	Minnesota	40
	South Carolina	41
	Texas	41

Appendix IV	43
Advance Comments	
From the Department	
of Health and Human	
Services	

Tables	
Table I.1: Results of Field Audits of Nursing Home Cost Reports in 1980	12
Table I.2: Use of Field-Audited Cost Data in Nursing Home Rate Setting	13
Table I.3: Effects of Audit Adjustment Factor on Nursing Home Payments	14
Table I.4: Peer Groupings of Nursing Homes	20
Table I.5: Methods for Establishing Reimbursement Limits	22
Table I.6: Nursing Home Payments in Arkansas at Selected Cost Ceilings (Fiscal Year 1983, Estimated)	24
Table I.7: Comparison of Indices Used to Adjust Base Costs for Inflation (1979-84)	26

Abbreviations

CPI	consumer price index
GNP	Gross National Product
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
ICF	intermediate care facility
SNF	skilled nursing facility

Improvements Needed in Medicaid Methods for Setting Nursing Home Rates

Background

Because of the rapidly growing elderly population, nursing home care has become the nation's third largest health care expenditure (behind physicians and hospitals). Nursing home expenditures increased from about \$500 million in 1960 to an estimated \$32 billion in 1984. According to a January 1985 report by the Urban Institute, the public share of nursing home expenditures rose from 28 to 55 percent between 1960 and 1982, while the nursing home population grew from 470,000 to 1.4 million.

Almost 90 percent of the public share of nursing home expenditures comes from Medicaid, a grant-in-aid program authorized by title XIX of the Social Security Act. Under Medicaid, the federal government pays from 50 to 78 percent of costs incurred by states for medical services for persons unable to afford their care. In fiscal year 1983, Medicaid spent over \$35 billion of which about \$10.3 billion was for nursing home care (\$5.7 billion was the federal share of nursing home costs). In fiscal year 1985, Medicaid paid an estimated \$12 billion to nursing homes, an increase of 255 percent over fiscal year 1975 payments.

Medicaid is administered at the federal level by HCFA within HHS. The role of HCFA and HHS in the program generally is to issue regulations and guidelines, review and approve state Medicaid plans for federal financial participation, and monitor the states' performance.

Two basic types of nursing homes are eligible to participate in Medicaid. One, referred to as skilled nursing facilities (SNFs), includes homes designed to care for patients whose need for professional nursing services is demonstrated and documented. All states must provide SNF care under their Medicaid programs.¹ Homes of the second type, referred to as intermediate care facilities (ICFs), care for patients who do not require the degree of care and treatment a hospital or SNF is designed to provide but, because of physical or mental condition, require supervision, protection, or assistance. ICF care is an optional service under the Medicaid law. It is offered under 50 of the 55 Medicaid programs.²

¹ Arizona was granted a waiver from this requirement under the authority of section 1115 of the Social Security Act and does not include nursing home services under its Medicaid program.

² ICF care is not covered by Arizona, Guam, the Virgin Islands, the Northern Mariana Islands, and Puerto Rico.

States' Flexibility in Designing Reimbursement Systems Increased

Initially, the Medicaid law did not include any specific requirements regarding the methods to be used to pay for nursing home services. States were permitted to develop their own payment methods, subject only to the general requirement that payments not exceed reasonable charges consistent with economy, efficiency, and quality of care.

States tried a variety of payment methods ranging from the retrospective, reasonable-cost reimbursement system used by Medicare³ to prospective rates based in some instances on state budgets or other factors not directly related to costs associated with providing nursing home care. Under a retrospective reimbursement system, nursing homes are reimbursed for the actual allowable costs they incur. Such systems entail after-the-fact reporting of historical costs with a settlement between the interim rates paid by Medicaid during the period and the actual allowable costs as evidenced by the homes' cost reports. Under prospective payment systems, rates are set in advance, and the nursing home may be permitted to keep all or part of the difference between the rate and actual costs. If the nursing home's costs are more than the prospective payments, it suffers a loss.

There are two primary types of prospective payment systems—class and facility-specific. Under a class-rate system, all nursing homes in the class receive the same rate, based on all homes' allowable costs for some base year and adjusted for inflation since the base year. Under a facility-specific rate system, each nursing home's prospective payment rate is based on its allowable per diem costs (up to some maximum), again adjusted for inflation.

The Congress was concerned that some nursing homes were being paid too much, while others were not being paid enough to support the quality of care needed by Medicaid patients. Through the Social Security Amendments of 1972, it required that, effective July 1, 1976, state Medicaid plans provide for payment for nursing home services on a reasonable cost-related basis in accordance with payment methods and standards developed by the states and approved by HCFA. HCFA implementing regulations, however, did not require states to be in compliance until January 1, 1978. The regulations also required that all nursing homes be audited by the states within 3 years and that 15 percent of all homes be audited each year thereafter.

³Medicare, the largest federal health financing program, provides health insurance to most people 65 or older and many disabled people.

Some states believed the act's requirement for cost-related payment systems was too restrictive and inflexible. Consequently, the Congress through the Omnibus Reconciliation Act of 1980 modified the cost-related reimbursement requirement. It provided that states pay for nursing home services by using rates the state found reasonable and adequate to meet the costs that had to be incurred by efficiently and economically operated facilities to provide care in conformity with applicable state and federal laws, regulations, and quality and safety standards. The Omnibus Reconciliation Act of 1980 also modified the audit requirements by providing that the state must provide for "periodic" audits of the financial and statistical records of participating providers. Such audits are performed to determine the nursing home's allowable costs for reimbursement purposes.

As a result of the Omnibus Reconciliation Act of 1980, states must provide assurances to HCFA that their payment rates are reasonable and adequate to meet the costs incurred by efficiently and economically operated nursing homes to provide care in conformity with applicable state and federal laws, regulations, and quality and safety standards. These assurances must be made at least annually and whenever reimbursement methods are significantly changed. HCFA is responsible for determining whether there is an adequate basis for the assurances.

HCFA's State Medicaid Manual requires that a state must

"... make a finding and satisfactorily assure the Secretary that it pays for nursing home care through rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards."

The manual does not require submission of studies or analyses supporting the "finding" and provides no guidance on what constitutes an acceptable basis for a "finding." According to HHS' implementing regulations, HCFA's acceptance of a state's assurance that its nursing home payment rates are reasonable and adequate is based on whether the state has made a "finding." As part of its annual assessment of state Medicaid programs, HCFA determines whether the states actually performed studies or analyses to support their "findings." HCFA does not review the technical merit of such studies or analyses.

States' Rate Setting Methods Vary

Increasingly, states have been moving toward some form of prospective payment system as a way to constrain the growth of nursing home costs. Although specific methods used to establish prospective payment rates vary, states generally

- establish allowable nursing home costs for a specified base period using actual cost data submitted by nursing homes on annual cost reports,
- assign the states' nursing homes to various subgroups (such as urban vs. rural, or SNF vs. ICF) to reflect differences in their operating costs,
- establish a maximum or "cap" on costs to be reimbursed so that inefficient or uneconomical nursing homes will not be "rewarded" for their high costs, and
- apply indices to the base-year costs to account for economic inflation since the base year.

Better Use of Audited Cost Data Could Save Millions

Accurate base-cost data are essential in setting prospective payment rates. In the seven states we reviewed, base costs made up from about 85 to 90 percent of the prospective payment rates.⁴ In addition, base costs are used in computing increases in the rates for inflation and in computing amounts allowed nursing homes as incentives for containing costs. However, most of the cost reports the seven states used in setting prospective payment rates were only desk reviewed, not field audited or reduced by some percentage based on the results of those cost reports that were audited. As a result, the costs used to set rates were overstated and payment rates inflated. By reducing the desk-reviewed only cost data by the average percentage difference between desk-reviewed costs and field-audited costs for those nursing homes audited, Medicaid could reduce its nursing home costs by millions of dollars.

Yearly nursing home cost reports are desk-reviewed by the states or their fiscal intermediaries for completeness and accuracy. In the seven states we studied, such examinations were limited to a review of the content of the cost reports and included comparative analyses of current and prior years' costs and application of any cost limits established by the state. Additional information on or clarification of reported costs was sometimes obtained, usually by telephone, from a nursing home. Unallowable costs identified through such desk reviews were disallowed.

⁴The remaining 10-15 percent of prospective payment rates include inflation adjustments, incentive payments, and return on equity payments.

**Appendix I
Improvements Needed in Medicaid Methods
for Setting Nursing Home Rates**

Although desk reviews generally result in reductions to a nursing home's reported costs, they do not include on-site verification of the costs against the nursing home's accounting records and other supporting evidence. As a result, each year a percentage of the cost reports is field-audited to identify additional unallowable costs. Field audits in the states we reviewed revealed significant unallowable costs not identified through desk reviews (see table I.1).

Table I.1: Results of Field Audits of Nursing Home Cost Reports in 1980^a

State	Percent of cost reports field-audited	Additional unallowable costs identified (percent)
Arkansas	15.0	2.3
Georgia	23.0	3.4 ^t
Illinois	21.0	3.1
Kentucky	75.0	1.9
Minnesota	27.0	0 ^o
South Carolina	100.0 ^c	2.4
Texas	11.3	1.5

^aExcept Arkansas, which is based on 1979 cost reports.

^tIncludes both desk-review and field-audit adjustments

^cState received a one-time 100-percent field audit of cost reports; reduced to 15 percent after December 1980.

^oReductions based on audited costs not available.

Although the states generally audited the minimum number of cost reports required by their state Medicaid plan, most of the costs used to compute prospective payment rates were desk-reviewed only. For example, Arkansas, South Carolina, and Minnesota did not complete their field audits in time to use the results in computing prospective payment rates and relied entirely on desk-reviewed costs.⁵ Only Kentucky had field-audited over 30 percent of the costs used, as table I.2 shows.

⁵The three states did retroactively adjust the rates of individual homes subsequently audited, but did not use the audit results to recompute new rate limits for nursing homes.

**Appendix I
Improvements Needed in Medicaid Methods
for Setting Nursing Home Rates**

Table I.2: Use of Field-Audited Costs in Nursing Home Rate Setting

State	Cost data used to establish rates		
	Total	Field-audited	Percent
Arkansas	\$126.1	\$ 0.0	0
Georgia	260.4	69.9	27
Illinois	698.1	180.1	26
Kentucky	152.8	106.2	69
Minnesota	490.2	0.0	0
South Carolina	103.8	0.0	0
Texas	515.8	71.1	14

Similarly, Mississippi used unaudited, unverified cost reports in computing nursing home rates, according to an August 1984 legislative report⁶ on the state's Medicaid program. Therefore, the state cannot assure that the computed rate ceilings are valid. The Mississippi Medicaid Commission lacks reasonable assurance that valid information is available for use in computing reimbursement limits, the report concludes. It notes that artificially inflated costs would increase the reimbursement rates and that, after a review of both desk-review and field-audit adjustments for 15 nursing homes, allowable costs were decreased by an additional \$585,000 (or 192 percent) over the desk-reviewed adjustments.

Despite their reliance on desk-reviewed cost reports, none of the seven states we reviewed nor Mississippi applied their field-audit reduction experience to costs subjected only to desk reviews. By contrast, California (not included in our detailed review) applies an audit adjustment factor to each nursing home's reported costs to account for the difference between reported and field-audited costs.

For example, California applied an audit adjustment factor⁷ (based on the results of calendar year 1981 field audits) to the cost reports used in setting the fiscal year 1984 prospective payment rates. According to a

⁶Joint Committee on Performance Evaluation and Expenditures Review, Report to the Mississippi Legislature on a Review of Selected Areas of Operation of the Mississippi Medicaid Program, Aug. 30, 1984, pp. 11 and 15.

⁷To establish the audit adjustment factor, California selected audited cost reports at random so that at least 15 percent of the state's nursing homes were included. The audit adjustment factor was then calculated as a simple average percentage difference between reported and audited costs. A factor was added for settled appeals of cost reports.

**Appendix I
Improvements Needed in Medicaid Methods
for Setting Nursing Home Rates**

California Medicaid official, the audit adjustment factor of approximately 4 percent reduced fiscal year 1984 Medicaid costs for nursing home care by about \$41 million.

The effect that applying an audit adjustment factor could have on other states' Medicaid nursing home payments can be approximated by using table I.3. The state's audit adjustment factor (calculated by determining the average additional percentage reduction to reported costs that occurs as a result of field audits) is matched to its nursing home payments for the applicable 12-month rate period.

Table I.3: Effects of Audit Adjustment Factor on Nursing Home Payments

(Figures in millions)

Annual nursing home payments	Savings from application of audit adjustment factor						
	1.0%	1.5%	2.0%	2.5%	3.0%	3.5%	4.0%
\$ 50	\$0.50	\$0.75	\$1.00	\$1.25	\$1.50	\$1.75	\$2.00
100	1.00	1.50	2.00	2.50	3.00	3.50	4.00
150	1.50	2.25	3.00	3.75	4.50	5.25	6.00
200	2.00	3.00	4.00	5.00	6.00	7.00	8.00
250	2.50	3.75	5.00	6.25	7.50	8.75	10.00
300	3.00	4.50	6.00	7.50	9.00	10.50	12.00
350	3.50	5.25	7.00	8.75	10.50	12.25	14.00
400	4.00	6.00	8.00	10.00	12.00	14.00	16.00
450	4.50	6.75	9.00	11.25	13.50	15.75	18.00
500	5.00	7.50	10.00	12.50	15.00	17.50	20.00
550	5.50	8.25	11.00	13.75	16.50	19.25	22.00
600	6.00	9.00	12.00	15.00	18.00	21.00	24.00
650	6.50	9.25	13.00	16.25	19.50	22.75	26.00
700	7.00	10.50	14.00	17.50	21.00	24.50	28.00

For example, Texas, by applying an audit adjustment factor of 1.5 percent (see table I.1) could have reduced its fiscal year 1982 nursing home payments (\$593.5 million) by about \$9 million.

More Specific Written Criteria for Allowable Costs Needed

Because nursing home prospective payment rates are still based largely on allowable prior-period costs, it is important that states have well-defined written criteria defining allowable and unallowable costs. However, the only criteria provided by some states we reviewed for such costs as vehicles, out-of-state travel, management fees, legal fees, and association dues were that they be reasonable and patient care-related. As a result, whether and to what extent such costs were allowable for reimbursement purposes was left to the judgment of the auditor and

subject to litigation. By clarifying and expanding their criteria, Medicaid agencies would make it clear to nursing home operators what costs were allowable and might thereby eliminate the reporting of some questionable costs. This would, in our opinion, improve the data base used for rate setting and reduce the number of challenges to disallowed costs.

The Omnibus Reconciliation Act of 1980 gave states flexibility in defining allowable costs without using Medicare principles of cost reimbursement. Neither HHS' implementing regulations nor the State Medicaid Manual provide guidance on allowable cost criteria. Three of the seven states we reviewed (Arkansas, Minnesota, and Texas) have developed their own allowable cost guidelines while the other four use a combination of their own guidelines and Medicare cost reimbursement principles.

The following examples illustrate the variation in the seven states' allowable cost criteria for vehicle costs and out-of-state travel:

Vehicle costs—Generally, Medicaid agencies' allowable cost guidelines provided for reimbursement of vehicle costs that were patient- or facility-related, but provided little or no guidance on the number and type of vehicles allowed. Only three states (Georgia, Arkansas, and Illinois) specified the number and price range of vehicles allowed. For example, Georgia allowed one vehicle for each 100 nursing home beds and set an upper limit (\$8,000 in 1983) for each vehicle.

By contrast, South Carolina provided little guidance on the type of vehicles allowed; it had allowed nursing homes to include the costs of such vehicles as Mercedes-Benz and Chevrolet Corvettes. Similarly, field auditors in Minnesota, which provided no guidance on types of vehicles allowed, found quite a few luxury cars during their audits. While such cars could be allowed based on the auditors' judgment, a Minnesota Medicaid official told us that the auditors generally disallowed them.

Out-of-state travel—The Texas Medicaid plan specifically stated that out-of-state travel would be allowed for seminars in the United States only if the curriculum were related to patient care. By contrast, Arkansas, Minnesota, and Illinois did not address out-of-state travel in their allowable cost guidelines.

In an October 1982 report,⁸ we suggested that the Texas Medicaid agency clarify and expand its written criteria on allowable and unallowable costs to make it clear to nursing home operators which costs are and are not allowable in cost reports. The revisions should include more specific language we said, as well as examples of the allowability and unallowability of frequently incurred costs, e.g., entertainment expenses or life insurance premiums. At that time, a state Medicaid official told us he wanted to keep the guidelines as brief as possible because of administrative requirements that would be involved in modifying the criteria.

Officials in several other states recognized the need for more specific written criteria on allowable costs. For example, Medicaid officials in Arkansas acknowledged that their Medicaid plan did not adequately address the treatment of allowable costs and said they planned to clarify and expand their guidelines. Similarly, an audit official in South Carolina said that the state's written criteria were vague and lacked specific standards for such items as vehicles, dues, and licenses.

In addition to leaving auditors confused, vague criteria can result in frequent appeals and legal challenges. For example, a Minnesota Medicaid official said that the staff's judgment of reasonableness of costs not specifically addressed in their written guidelines was often challenged or appealed by nursing homes. According to a Medicaid official, they were developing more specific guidelines.

State officials from Arkansas, Georgia, and Minnesota said that it would be helpful if HCFA provided technical assistance to states in establishing more specific guidelines on allowable costs.

Deficit Reduction Act Strengthens Controls Over Property Costs

The Congress, through enactment of the Deficit Reduction Act of 1984, set new limits on Medicare reimbursement for the costs associated with the sale of a nursing home. Congressional conferees also expressed concern about the reasonableness of lease amounts, although the act does not address lease arrangements. Our detailed review, completed before enactment of the Deficit Reduction Act, confirmed the need for limits on both sales and leases.

⁸ Audit of Medicaid Costs Reported to Autumn Hills Convalescent Centers, Inc., Houston, Texas (GAO/HRD-83-9, Oct. 14, 1982).

Sales of Nursing Homes Affected

Nursing home "trafficking" (the sale and resale of a home to maximize reimbursement) has been a longstanding problem in both the Medicare and Medicaid programs. Normally, when acquiring an operating nursing home, the new owner records the value of the acquired assets in its books at a higher amount than carried in the previous owner's books. This occurs because the purchaser usually pays more for the acquired nursing home than its depreciated book value. Therefore, depreciation expense, which is related to book value, increases even though the acquired assets themselves are not altered. Similarly, when a purchaser borrows funds to cover a substantial portion of the purchase price of an operating nursing home, additional interest costs are normally incurred. The higher depreciation and interest in turn increase the nursing homes' Medicaid payment rates.

To better control nursing home trafficking, the Congress set limits under the Deficit Reduction Act of 1984 for establishing an appropriate allowance for depreciation, interest on capital indebtedness, and, if applicable, return on equity for nursing home reimbursement under Medicare. The act provides that the valuation of the asset be the lesser of the allowable acquisition cost to the first owner of record (on or after the enactment of the law) or the acquisition cost to the new owner.

The limits established under the Deficit Reduction Act do not specifically apply to the Medicaid program. But the act requires that states make assurances to HCFA that their methods used to set Medicaid rates reasonably can be expected not to increase such payments, solely as a result of a change of ownership, in excess of the increase that would result from application of the Medicare provisions. The assurances were required for Medicaid rates effective on or after October 1, 1984.

Before enactment of the Deficit Reduction Act, all the states we reviewed had changed or were changing their systems for controlling the effects of sales on nursing home property costs. As we show in appendix III, their systems ranged from allowing no increase in the original or historical cost basis of the nursing home and related property to full recognition of increased costs based on the actual sales price or lease amount, subject only to whatever general payment limits apply. Changes states made in response to the Deficit Reduction Act are also shown.

Lease Transactions Not Addressed

Lease arrangements also can inflate Medicaid payment rates. The Deficit Reduction Act does not specifically address leases. Frequently an owner will lease a facility to another party who becomes the provider of nursing home care. The provider may then claim the cost of the lease to the extent this amount is reasonable. When the amount of the lease payment, a cost to the new provider, exceeds the owner's (lessor's) property costs, the allowable property costs and ultimately Medicaid nursing home reimbursement rates are increased. Some such leases are entered into solely to inflate property costs and increase Medicaid payment rates.

When nursing home lease transactions are conducted between parties related by common ownership or control, the related organization reimbursement principle should apply. This principle limits the costs allowed for reimbursement purposes to the lower of the costs of the selling (or leasing) organization or the price available in the marketplace.

As shown by the following examples, lease arrangements can significantly inflate property costs and thus Medicaid reimbursement rates.

Example 1—South Carolina had a consultant determine the validity and reasonableness of 12 selected lease transactions. The consultant reported to the state in May 1982 that 3 of the 12 were related-party transactions. Additionally, the consultant identified pertinent issues (i.e., unreasonable lease amounts, employees leasing from employers, employee salary arrangements) that indicated that four other leases might also be related-party transactions.

Our analysis of one of the three nonarm's length transactions identified by the consultant showed that the nursing home was leased to a company in which the owner's son had a 20-percent interest. The term of the lease was for 5 years with an option to renew for an additional 5 years. The transaction involved two leases, one for the building and one for the equipment. The building, with a book value of about \$318,000, was leased for about \$109,000 a year; the equipment, book value about \$109,000, for about \$56,000 a year. Thus, over the initial 5 years of the lease agreement—the renewal option provided for renegotiation of the rates—allowable nursing home property costs would be reported as about \$825,000, while the book value on the date of the lease totaled only about \$427,000.

Example 2—HHS' Office of the Inspector General⁹ found that the Arkansas Medicaid agency had allowed payments significantly in excess of costs for leases between related organizations. During the period July 1, 1978-June 30, 1981, excessive lease payments to 27 nursing homes resulted in Medicaid overpayments totaling about \$1.6 million, the Inspector General reported. The most common type of related-party lease arrangements occurred when the nursing home owners formed separate entities that were related through common ownership. Typically, the nursing home owner would form a new business and transfer, at no cost, the license and right to provide Medicaid nursing home services to the new business, while retaining the title to the facility (building and equipment) under the original business. The newly formed business—the new Medicaid provider—would then lease the facility from the original business. This general type of arrangement occurred in 22 of the 27 Arkansas nursing homes.

For example, a husband and wife who had owned and operated an Arkansas nursing home since its construction in the early 1960's, established a new corporation, wholly owned by the husband and wife and their two children, in August 1976 and transferred their license to do business as a Medicaid provider to the new corporation. The husband and wife retained ownership of the building and leased it to the new corporation—the Medicaid provider. Over \$163,000 in lease payments for use of the building were made during a 3-year period. During that time, they incurred costs for the building of about \$11,000, the owners' records showed. Because the lease payments (\$163,000) rather than the owners' costs (\$11,000) were included in the base costs used to set the prospective payment rate for the facility, base costs for the nursing home were inflated by about \$152,000 over the 3 years.

Grouping Nursing Homes Helps Ensure Reasonable, Adequate Payments

In setting reimbursement rates, states generally group nursing homes according to certain characteristics, such as level of care, number of beds, or geographic location, and set different prospective payment rates for each group. Such "peer grouping" is done because homes with different characteristics and patient mixes provide different kinds and intensities of services and incur different costs. Selection of appropriate peer groupings is essential to ensure that all nursing homes receive reasonable, adequate payments.

⁹"Review of Medicaid Reimbursement to Nursing Homes for Related Party Transactions for the period July 1, 1978, through June 30, 1981."

**Appendix I
Improvements Needed in Medicaid Methods
for Setting Nursing Home Rates**

Although each state we reviewed grouped nursing homes according to levels of care provided (i.e., skilled, intermediate, or both), and four states grouped them according to other factors (see table I.4), no state had analyzed nursing homes' characteristics to identify the most appropriate peer groupings. Our analysis of grouping methods used in Arkansas, Minnesota, and Georgia demonstrates differences that may occur in the cost to operate a nursing home based on the nursing home's patient mix, location, and size.

Table I.4: Peer Groupings of Nursing Homes

State	Number of peer groups	Factors used for groupings
Arkansas	6	Level of care (three classes each for SNF and ICF patients)
Georgia	7	Level of care and bed size for four different cost centers
Illinois	^a	Geriatric/specialized nursing; geographic location
Kentucky	2	Level of care
Minnesota	12	Level of care; profit/nonprofit; geographic location
South Carolina	9	Level of care (SNF, ICF, dual); bed size for nonproperty cost centers
Texas	3	Level of care (one class for SNF and two for ICF patients)

^aIllinois sets separate rates for each home based on such factors as patient mix and geographic location.

Because there are differences in nursing home costs, depending on the level of care required by the homes' patients, groupings by level of care are appropriate. However, grouping all SNFs or ICFs together and establishing a single rate may penalize homes that have a concentration of heavy-care patients and result in payments that are inadequate to cover their costs. Conversely, the single rate may encourage nursing homes to admit primarily light-care patients in order to obtain higher profits. The use of a single SNF or ICF rate gives nursing homes incentives to admit only the least resource-demanding patients.

Similarly, the use of a single rate for "dual" nursing homes accepting both SNF and ICF patients gives such homes an incentive to accept primarily less-costly ICF patients. For example, some of the "dual" nursing homes in Georgia have over 80-percent ICF patients. As a result, such homes may make higher profits, while nursing homes that accept more SNF patients may not receive payments adequate to recover their allowable costs.

To overcome such problems, Arkansas established three groups within each level of care, according to the level of impairment of patients served. An Arkansas nursing home would then allocate allowable costs among the three categories according to its number of patients in each category and total the costs by the actual patient days reported for each level of care. In fiscal year 1983, this resulted in daily reimbursement rates of \$33.11, \$27.52, and \$25.59 for the three SNF levels, respectively.

Beyond the level-of-care groupings, we believe that states should determine whether other factors, such as geographic location or the size of the nursing home, have a significant effect on nursing home costs that would warrant establishment of additional peer groupings, e.g.:

Minnesota grouped nursing homes within each level of care by geographic location, establishing separate reimbursement rates for nursing homes in urban and rural areas. According to a Minnesota Medicaid official, this was done to provide equitable treatment of homes in urban areas that pay higher nursing salaries because of union contracts and greater competition for nursing care personnel. Minnesota's maximum 1982 SNF reimbursement rates were 29 percent higher for nursing homes in urban areas than for those in rural areas (\$64.35 vs. \$50.00). Our computation of the average rates actually paid SNF homes in urban vs. rural areas showed about the same percentage difference. Clearly, had the state not grouped by geographic location, homes in rural areas would have received higher profits at the expense of urban homes, which might not have received payments adequate to enable them to recover their allowable costs.

Georgia grouped homes within each level of care based on the number of beds in the facility, setting separate rates for nursing homes with 50 or fewer beds, 51 to 100 beds, and over 100 beds. These groupings were used to set limits for four cost centers.¹⁰ Within each cost center, the costs to operate nursing homes with 50 or fewer beds were substantially higher than for larger facilities. For example, ICFS with 50 or fewer beds had costs¹¹ for housekeeping and operations about 22 percent higher than homes with 51 to 100 beds, and about 24 percent higher than homes with over 100 beds. However, our analysis showed insignificant differences in the costs to operate nursing homes with 51 to 100 beds

¹⁰The four cost centers were: routine and special services, dietary, housekeeping and operations, and administrative and general.

¹¹For computing reimbursement rates effective January 1-December 31, 1981.

and those with over 100 beds, with the exception of differences in administrative and general costs.

Cost Ceilings Can Affect Program Costs, Access, and Quality of Care

After establishing peer groups of nursing homes, states set ceilings on the per diem costs they will pay nursing homes in each peer group. The ceiling chosen is important because it affects the nursing homes' incentives to contain costs, willingness to accept Medicaid patients, and ability to provide quality care. A lower ceiling increases nursing homes' incentives to operate economically and efficiently. But too low a ceiling may adversely affect access to and quality of care by forcing nursing homes to either deny admission to Medicaid patients or reduce essential services to Medicaid patients to stay within reimbursement limits. On the other hand, too high a ceiling results in most nursing homes being reimbursed for the actual costs they incur, providing little incentive to contain costs. None of the seven states we reviewed had performed a study to identify cost ceilings that would maximize nursing homes' incentives to contain costs without jeopardizing access to and quality of care.

All seven states we reviewed used maximum limits in establishing their prospective payment amounts (see table I.5). Four (Georgia, Arkansas, Texas, and Illinois) used to varying degrees a percentile technique in establishing these limits.

Table I.5: Methods for Establishing Reimbursement Limits

State, by type of system	Reimbursement limits	Comments
Class system:		
Arkansas	80th percentile of allowable costs of all nursing homes within peer group.	Because of funding problems, percentile limits for 1981 rates were based on 1979 costs.
Texas	60th percentile of all major cost centers. Payment rate for all homes within peer group set at sum of 60th percentile costs.	Texas officials said they selected 60th percentile because HCFA had approved Louisiana's system using 60th percentile.
Facility-specific system:		
Georgia	75th percentile of allowable nursing, dietary, administrative, housekeeping, and maintenance costs.	No documentation of how percentiles were selected. State officials said percentiles represent upper limits for reasonable cost.
	90th percentile of allowable property costs.	Between January 1980 and May 1981, nursing homes were allowed the lower of the depreciated replacement costs (if supported by appraisal) or actual costs submitted.

**Appendix I
Improvements Needed in Medicaid Methods
for Setting Nursing Home Rates**

State, by type of system	Reimbursement limits	Comments
Facility-specific system:		
Illinois	<p>Nursing component limited to</p> <p>—median value per "point" for specialized homes (under point system, nursing cost is calculated by point counts established through review of patients' charts).</p> <p>—regionalized costs for assessed patient needs for geriatric homes.</p> <p>150 percent of target rate for capital. Target rate based on median of capital costs of all facilities in peer group and net of property taxes.</p> <p>60th percentile of allowable support costs except that</p> <p>—homes qualifying for quality incentive payments may increase their support rate up to 104 percent of the 60th percentile.</p> <p>—specialized homes, such as facilities for mentally retarded, may be reimbursed up to 152.8 percent of the 60th percentile, depending on type of care provided.</p>	<p>Support costs reimbursed at 50th percentile through rate year 1981.</p> <p>New limits established through negotiation with health care groups.</p>
Kentucky	<p>110 percent of computed median of all homes for SNFs and ICFs.</p> <p>165 percent of 110 percent of median of SNFs (excluding cost of hospital-based SNFs) for hospital-based homes.</p> <p>Homes entering Medicaid program on or after April 1, 1981, limited to</p> <p>—lower of actual cost or 125 percent of median per diem costs for nursing and dietary.</p> <p>—105 percent of the median per diem costs for property and all other costs.</p>	<p>No documentation of how limits were selected. State officials believe limits are reasonable.</p>
Minnesota	<p>125 percent of the average costs for all homes within peer group.</p>	<p>No documentation of how limits were selected. Limits based on availability of funds.</p>
South Carolina	<p>Arithmetic mean of allowable nonproperty costs plus 8 percent "quality assurance" factor.</p> <p>Nursing homes whose allowable costs are less than maximum limit in any of four cost centers may receive an "efficiency incentive" equal to 50 percent of difference, not to exceed 7.5 percent of maximum.</p>	<p>Based on evaluation of other states' systems; no evaluation of cost of operating an efficient, economical nursing home.</p>

Under this technique, states array nursing homes' allowable per diem costs in ascending order for each home within the peer group. The state then selects for each peer group the home located at the predetermined percentile. The per diem costs of that home then serve as the payment rate (in the case of class-rate systems) or the rate ceiling (in case of facility-specific systems). The following example illustrates the effect

**Appendix I
Improvements Needed in Medicaid Methods
for Setting Nursing Home Rates**

that selection of different percentile limits can have on a state's nursing home payments.

In fiscal year 1982, Arkansas adopted a class-rate system and began paying all nursing homes within each of six classes the per diem amount of the home located at the 80th percentile of the inflation-adjusted costs of all nursing homes within the class. Homes with per diem costs below the payment rate were allowed to retain the difference as profit. As shown by table I.6, had Arkansas selected the 60th rather than 80th percentile home, its 1983 Medicaid nursing home costs would have been reduced by about 5.1 percent, or \$7.4 million. On the other hand, if Arkansas had reimbursed all nursing homes based on the per diem costs of the highest cost home, its nursing home costs would have increased by 172 percent, or about \$261.7 million.

Table I.6: Nursing Home Payments in Arkansas at Selected Cost Ceilings (Fiscal Year 1983, Estimated)

(Dollars in thousands)	
Percentile ceilings	Estimated payments
50th	\$142,572
60th	145,208
70th	147,716
80th ^a	152,622
90th	166,962
100th	414,353

^aPercentile ceiling used.

Some Inflation Indices Do Not Reflect Nursing Home Cost Increases

After establishing the costs to run an efficiently and economically operated nursing home during the base period, states adjust these costs for inflation during the 12- to 18-month period between the base and the rate years. Selection of an appropriate index is important, according to a March 1983 report by the National Governors' Association,¹² because 50 to 60 percent of increased expenditures in nursing homes is due to inflation. However, most states were not using inflation indices that accurately reflected the increased costs experienced by nursing homes. If an inflation index is too high, it increases nursing homes' profits; if too low, their profits will decrease and the rates may be inadequate to ensure Medicaid beneficiaries access to quality care.

¹²Nursing Homes, Hospitals, and Medicaid: Reimbursement Policy Adjustments, 1981-1982, National Governors' Association Center for Policy Research.

CPI Used by 27 States

According to the National Governors' Association report, 27 states were using the consumer price index (CPI) even though it did not accurately measure increased costs in the nursing home industry. The CPI is a historical measure of inflation for a market basket of consumer goods that includes current mortgage interest rates (although these affect only a few nursing homes), only consumer products, and a fixed weighted distribution of goods and services. These characteristics have made the CPI a less desirable index than two other inflation indices that the Governors' Association believed more accurately reflected inflation in the nursing home industry:

- The Gross National Product (GNP) Deflator, which includes changes in prices in government and investor and producer goods in addition to consumer goods, and uses increases in rent rather than mortgage rates.
- The HCFA Nursing Home Input Price Index, which was specifically designed to measure cost increases in the market basket of goods and services purchased by nursing homes. It is derived from detailed analysis by the Bureau of Labor Statistics of more than 15 percent of the nation's nursing homes.

In addition to the 27 states that used the CPI (15 used it exclusively), the report stated, 19 states used composite indices designed by the state (which might or might not include a CPI component); three (Alabama, Rhode Island, and Wisconsin) used the HCFA index; and one (Connecticut) used the GNP Deflator. Another report, by the National Conference of State Legislatures,¹³ showed that as of July 1984 the same three states still used the HCFA index, but a second state (Tennessee) had begun using the GNP Deflator in a demonstration project.

States that used the CPI rather than the GNP Deflator or HCFA index during 1979 and 1980 paid nursing homes at a rate higher than the rate those states had determined to be adequate to meet the costs of an economically and efficiently operated nursing home in the base period, as table I.7 shows. However, with the decrease in the rate of inflation in consumer products since 1981, use of the CPI during 1982 and 1983 may have resulted in reimbursement rates that were inadequate to ensure Medicaid beneficiaries access to quality care.

¹³State Efforts at Health Care Cost Containment, September 1984.

**Appendix I
Improvements Needed in Medicaid Methods
for Setting Nursing Home Rates**

**Table I.7: Comparison of Indices Used
to Adjust Base Costs for Inflation
(1979-84)**

Year	Inflation indices		
	CPI	GNP deflators	HCFA index
	1979	11.3	8.7
1980	13.5	9.2	9.9
1981	10.4	9.7	10.0
1982	6.1	6.0	8.4
1983	3.2	3.9	5.8
1984	4.3	3.8	4.8

Two of the seven states (South Carolina and Kentucky) we reviewed were using the CPI but changed to more appropriate inflation indices. Before 1982, South Carolina used the CPI to adjust base year costs. In a February 1982 report, however, the state's Legislative Audit Council estimated that the state could have saved about \$2.3 million in 1981 had it used an index that properly reflected price changes experienced by South Carolina's nursing home industry. The estimated savings were based on the difference between the CPI rate and what the state's Division of Research and Statistical Services computed as being the 1981 rate of increase in costs for nursing home goods and services in South Carolina. In February 1982, the state began using the Division's inflation index instead of the CPI.

Kentucky also used the CPI to adjust base year costs until January 1983, when it changed to an index based on changes in nursing home costs. According to a state official, Kentucky began using the CPI when reimbursement policies were more lenient as an enticement to nursing homes to enter the Medicaid program. The state's analysis of the effect of changing from the CPI-based inflation factor to the index based on nursing home costs showed that the Medicaid program saved about \$1.7 million during the 7-month period from December 1982 through June 1983.

**Budget-Based Adjustments
Do Not Ensure Adequate
Rates**

Two states we reviewed, Arkansas and Georgia, limited inflation adjustments because of state Medicaid budgets. This resulted in reimbursements at rates below what the state had previously determined were needed for an efficiently and economically operated nursing home to provide quality care.

Arkansas based both its 1982 and 1983 inflation indices on the state's budget situation. In setting 1982 rates, it limited the inflation index applied to 1981 base costs to 4.1 percent, although the HCFA Nursing Home Input Price Index showed that increased costs in the nursing home industry averaged 10.0 percent. The following year, the state allowed 6 percent over the 1982 rates for inflation, while the HCFA index showed costs up an additional 8.4 percent over 1981. This use of budget-based inflation indices in 1982 and 1983 resulted in 1983 per diem rates about 8.1 percent too low to reflect the rates the state had previously determined were reasonable and adequate to meet costs incurred by an economically and efficiently operated nursing home. As a result, Arkansas nursing homes had an incentive to either cut services or admit only those Medicaid patients requiring the least costly care.

In Georgia in November 1981, the legislature reduced 1982 Medicaid program funds by \$67 million, of which \$24 million were for nursing homes. The Medicaid agency reacted to the reduction by reducing the existing nursing home inflation factor of 12.6 percent to a budget-based 4.5 percent and eliminating the inflation rate adjustment scheduled for 1982. The state reinstated the 12.6-percent inflation index in April 1982 after the legislature restored sufficient funds to the Medicaid budget. In April 1983, the Medicaid agency added 4.9 percent to the 1982 rates to reflect an increase in the Medicaid appropriation. Georgia's 1983 nursing home rates were set at 17.5 percent above 1980 base costs. Use of the HCFA Nursing Home Input Price Index to adjust the 1980 base costs would have resulted in an overall increase of 31 percent. As with Arkansas, nursing homes in Georgia were reimbursed at a level below that which the state had determined was adequate to meet the costs of an efficiently and economically operated nursing home.

Including Return on Equity Increases Costs, Lessens Incentives

A specific amount for a return on equity was included in the prospective payment rates for proprietary nursing homes in five states (Georgia, Kentucky, South Carolina, Minnesota, and Illinois) of the seven reviewed, even though there was no demonstrated need for such payments.

As an incentive to alleviate demonstrated shortages of nursing home services, Medicaid permits states to allow proprietary nursing homes a return on equity capital invested and used in providing patient care. Equity capital refers to the provider's investment in plant, property, and equipment related to patient care plus net working capital—funds necessary for day-to-day operation of patient care activities.

States that include a return on equity in the nursing home payments use either the Medicare rate of return or a state-designated rate. Until April 1983, Medicare's rate of return on equity capital was equal to 1-1/2 times the rate earned on funds invested by Medicare's Hospital Insurance Trust Fund. After April 1983, the rate was reduced to equal the Trust Fund rate. The March 1983 report by the National Governors' Association showed that 28 of the 46 states responding to its questionnaire included a return on equity capital in their nursing home payment rates—13 at the Medicare rate and 15 at a state-designated rate.

Historically, proprietary nursing homes have financed capital expenditures through funds invested by owners in expectation of earning a return on their investment. Therefore, the return is needed to avoid withdrawal of capital and attract capital for needed expansion. At issue is not the need to allow proprietary nursing homes a return on their investment, but the way that allowance should be provided. Specifically, should a separate return on equity capital be provided in addition to the prospective payment rate, or should proprietary nursing homes obtain their return exclusively from their ability to provide services at a profit under the prospective payment rates?

Including a separate return on equity capital increases Medicaid costs. But the increased costs may be justified in some cases to encourage investment where there are demonstrated shortages of nursing home beds. The effect of a separate return on equity capital on a state's Medicaid costs will depend on such factors as the number of investor-owned nursing homes in the state, the rate of return allowed, and the prospective payment rates.

Except for Minnesota, each of the five states that included a separate return on equity capital in their facility-specific prospective payments also included specific amounts for incentive profits if homes kept their costs below maximum cost limits. We determined the total return on capital added to prospective payments in four of the five states¹⁴ during calendar year 1981.¹⁵ The four states paid almost \$32 million to proprietary homes in addition to the prospective payments and incentive profits.

¹⁴Sufficient data were not available to determine total return on equity payments in Illinois.

¹⁵Except Kentucky, which was for the period July 1981-June 1982.

Although states are allowed to include a return on equity in their nursing home payments to alleviate demonstrated shortages of nursing home beds, none of the five states paying a separate return on equity were doing so based on a needs assessment demonstrating such shortages. In fact, based on discussions with state Medicaid officials in the five states, and our review of related reports and other documents, none of the states appeared to be experiencing a shortage of nursing home beds.

Two of the seven states, Texas and Arkansas, did not provide for payment of a separate return on equity capital. Officials from these states said that they believed their prospective payment systems provided adequate opportunities for profit based on the owners' ability to provide nursing home services at a cost below the established prospective payment rate. Texas' analysis of 1980 cost reports showed that 80 percent of the state's proprietary nursing homes reported a profit. Arkansas officials said that the state would reconsider including a separate return on equity in nursing home payments in the future if it were needed to attract growth in the nursing home industry.

Conclusions

Although the Omnibus Reconciliation Act of 1980 gave states more flexibility in designing their nursing home reimbursement systems, HCFA remains responsible for ensuring that the payment methods developed by the states result in all nursing homes receiving reimbursement that is reasonable and adequate to meet the costs incurred by an efficient and economical nursing home in providing quality care. However, HCFA has neither established adequate guidelines to be followed by states in making assurances that their payment rates meet these standards nor has it adequately reviewed the basis for the assurances made. As a result, HCFA and the states do not know whether the full potential of prospective payment systems to contain nursing home costs is being realized or reimbursement rates are adequate to assure Medicaid beneficiaries access to quality care.

Recommendations

We recommend that the Secretary of Health and Human Services direct the Administrator of HCFA to (1) establish guidelines to be used by states in making assurances that their nursing home reimbursement rates are reasonable and adequate and (2) use these guidelines to review the adequacy of states' assurances. The guidelines should, at a minimum, provide that states make assurances that they have

- established specific criteria defining allowable costs for such items as luxury automobiles and out-of-state travel,
- used the results of audited cost reports to compute reimbursement rates,
- used inflation indices that reasonably reflect increased costs in the nursing home industry,
- performed studies to ensure that the subgroupings used result in reasonable and adequate reimbursement for all nursing homes within the group,
- performed studies to ensure that the ceilings set on reimbursement rates are appropriate,
- performed studies to demonstrate an actual shortage of nursing home beds before allowing proprietary nursing homes a separate return on equity, and
- established adequate limits on the effects of sales and leases on allowable property costs.

In addition, we recommend that the Secretary publish regulations to implement the provisions of the Deficit Reduction Act of 1984 relating to the effects of nursing home sales on allowable property costs and direct the Administrator of HCFA to provide technical assistance to the states in developing prospective payment systems.

Agency Comments and Our Evaluation

In its February 10, 1986, comments on a draft of our report, HHS said that it believed that existing guidance provided in its State Medicaid Manual reflected congressional intent to increase the states' administrative and fiscal discretion in setting payment rates. According to HHS, this is done by keeping federal requirements to the minimum level necessary to assure proper accountability. This role has been consistently upheld by the courts, HHS said. Early litigation under the Omnibus Reconciliation Act of 1980, HHS noted, focused heavily on whether the Secretary was required to provide detailed criteria in order to implement the statute as, according to HHS, we suggest is the case. HHS said that no court has found that such detailed criteria are the responsibility of the Secretary.

HHS further noted that the State Medicaid Manual indicates that HCFA's review, as influenced by congressional intent, is not directed to reviewing or accepting a state's payment methods and standards from a technical standpoint. According to HHS, HCFA's approval of a state plan amendment does not indicate that it believes that the payment methods and standards are the best means of establishing payment rates. Rather,

according to HHS, the approval indicates that the state had complied with the requirements in the statute and regulations.

Finally, HHS noted, the State Medicaid Manual provides a checklist showing the regulatory citation and applicable requirements to use in reviewing a state plan amendment. According to HHS, the first element of the checklist provides that the state has found that the rates are reasonable and adequate.

According to HHS, it uses the State Medicaid Manual instructions to (1) evaluate the acceptability of a state's assurances that its nursing home reimbursement rates are reasonable and adequate, (2) determine the approvability of each state plan amendment, and (3) "look behind" and monitor the actual performance and compliance of the states with the reasonable and adequate nursing home reimbursement rate standard. HHS said that, in view of our findings and recommendations, it will consider determining what additional steps might be taken in HCFA's ongoing monitoring and oversight of nursing home reimbursement.

We are not suggesting that HHS must publish guidelines such as those we are recommending to properly implement the statute. However, we believe the information discussed in this report shows that the guidelines we recommend are needed to enable HCFA to properly perform its oversight responsibilities under the act. We agree with HHS that federal regulatory and other requirements should, consistent with congressional intent, be kept to the minimum level necessary to ensure proper accountability. But existing HCFA guidance and monitoring have been inadequate to ensure both proper accountability and compliance with the requirements in the statute and regulations that all nursing homes receive reasonable and adequate reimbursement.

We agree with HHS that the states, not HHS, are responsible for establishing specific criteria to define what is meant by such phrases as "efficiently and economically operated facilities" and for establishing specific payment methods or standards. We recommend, not that HHS define such phrases or prescribe specific payment methods or standards, but that HHS, to maintain proper accountability, determine whether states have established criteria to define such phrases and developed payment methods and standards based on studies or analyses supporting the reasonableness and adequacy of the resulting rates.

The State Medicaid Manual instructions to which HHS refers require that each state

**Appendix I
Improvements Needed in Medicaid Methods
for Setting Nursing Home Rates**

“... make a finding and satisfactorily assure the Secretary that it pays for ... long term care facility services through rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.”

HCFA's acceptance of a state's assurance is based on whether the state “has made a finding that the payment rates are reasonable and adequate” (48 F.R. 56046, Dec. 19, 1983). However, the manual provides no further guidance on what constitutes an acceptable basis for a finding that nursing home payment rates are reasonable and adequate.

As emphasized in the conference report on the Omnibus Reconciliation Act of 1980, the Secretary of HHS retains final authority to review the rates and disapprove them if they do not meet the requirements of the statute. The conferees further noted their intent that a state not develop rates solely on the basis of budgetary appropriations and indicated that the Secretary is not expected to approve a rate lower than the applicable legal requirement would mandate. HCFA's acceptance of a state's assurance based on whether a “finding” has been made does not, in our opinion, provide an adequate basis for determining (as HHS acknowledges HCFA is responsible for doing) whether the state has complied with the requirements in the statute and regulations. In a 1982 decision, a U.S. district court in California found that the state had obtained HHS approval of a 6-percent cap on increases in inpatient hospital rates based on defective assurances that the rates were reasonable and adequate. Although the court concluded that HHS did not act improperly in accepting California's assurances, it concluded that the finding made by the state that the proposed rates were reasonable and adequate to pay the necessary costs of efficiently and economically operated hospitals did not satisfy the requirements of the HHS regulations and other pertinent federal law. The court enjoined the adoption of the 6-percent cap until the state made a fair finding as to the reasonableness and adequacy of the resulting rates.

As discussed on pages 26 and 27, two of the seven states we reviewed had similarly limited inflation adjustments to their nursing home rates because of state Medicaid budgets. In both cases, HHS accepted the states' findings and assurances that their rates were reasonable and adequate. Requiring states to make assurances, as we recommended, that they use inflation indices that reasonably reflect increased costs in the nursing home industry could help ensure that there is an adequate basis for a state's finding and that its rates are reasonable and adequate.

Furthermore, HCFA evaluates assurances to determine whether the state provides for periodic audits but does not require the state to provide assurance that the results of those audits are used to compute reimbursement rates. As discussed on pages 11 to 14, none of the seven states reviewed were effectively using field audits to adjust reimbursement rates.

In summary, we suggest, not that HCFA prescribe payment methods and standards, but that it have assurances that the states have performed adequate studies or analyses to support the payment methods and standards they have developed.

HHS said it has developed regulations to implement the provisions of the Deficit Reduction Act of 1984 relating to the effects of nursing home sales on allowable property costs and that draft regulations are presently under review. According to HHS, the regulations were delayed awaiting anticipated legislative modifications included in the recently enacted Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272).

With respect to our recommendation that it provide technical assistance to states in developing prospective payment systems, HHS said that HCFA is currently working with New York and Texas to develop case-mix reimbursement systems and that Massachusetts has expressed interest in developing such a system.

While we encourage such cooperative efforts to develop case-mix reimbursement systems, we believe HCFA also should provide technical assistance on the fundamental decisions states must make in developing or revising prospective payment systems. Such decisions include selection of inflation indices, establishment of peer groupings, and selection of cost ceilings.

Objectives, Scope, and Methodology

Our objectives were to evaluate and compare various features of state systems of prospective payment for nursing homes under Medicaid by assessing strengths and weaknesses of the systems. Specifically, we wanted to determine whether states

- used appropriate methods for establishing base costs, peer groupings, inflation adjustments, and payment caps;
- used equitable and effective controls and limits over payment of property costs;
- had effective audit systems and guidelines for determining allowable costs; and
- had adequate information on the best rate-setting and auditing practices.

We focused our review on prospective payment systems because states are increasingly turning to prospective payment to contain costs.

Our review was conducted at HCFA central office in Baltimore; at HCFA regional offices in Atlanta, Chicago, and Dallas; and at the state Medicaid agencies of Arkansas, Georgia, Illinois, Kentucky, Minnesota, South Carolina, and Texas. We selected these states so that our review would include (1) relatively large and small Medicaid nursing home programs, (2) both facility-specific and class-rate payment systems, (3) varied geographical locations, and (4) systems paying for nursing home care based on an assessment of individual patient needs at each nursing home (Illinois). Thus, we believe the results of our review are indicative of states' prospective nursing home payment systems nationwide.

In each state visited, to determine the effectiveness of its system for establishing prospective rates, we interviewed Medicaid program officials, including rate setting, licensing and certification, and auditing officials. Also, we examined state payment policies, rate-setting methodologies and standards, and supporting cost report audit systems.

For each state, we examined prospective rates for the first complete rate period after October 1, 1980, the effective date of the Omnibus Reconciliation Act of 1980. Because of significant changes in the rate setting methodologies, we examined additional rate periods for Arkansas, Illinois, and Texas. We examined Arkansas' July 1, 1980-June 30, 1981, rate period for computing facility-specific nursing home rates because these rates were used to compute the state's first class rates when it changed to a class rate system for the period July 1, 1981-June 30, 1982. For Illinois, we reviewed 1982 as well as 1981 rates because the state

changed the methodology for computing each of the three components of its rate (nursing, support, and capital) after litigation and negotiations with health care groups. For Texas, we also reviewed the rate period beginning in calendar year 1982, because the state eliminated the return on equity capital for nursing homes on December 1, 1981.

The focus of our review was on the rate-setting methods the seven states used, not the appropriateness of individual payment rates. Significant changes made to the rate-setting methods in the seven states subsequent to completion of our detailed audit work have, to the extent possible, been reflected in the report. We did not, however, attempt to evaluate the case-mix reimbursement system recently developed by Minnesota.

For the selected rate periods, we evaluated (1) the nursing home peer grouping schemes used, (2) techniques for computing maximum rate and cost limits and their application, (3) inflation indices used to measure economic growth, and (4) methods for paying a specific return on investment not related to cost efficiency.

We held discussions with state officials and obtained information on the volume of sales, leases, and related-party transactions for the rate periods we reviewed and for previous periods to the extent available. Our purpose was to determine the effect of the costs of these transactions on rates. We also obtained and evaluated data on the approaches taken by the seven states to lessen the impact of these transactions on rates.

We evaluated each state's provisions in its Medicaid plan for auditing provider cost reports and how well the audit system supported the payment system. For the periods we reviewed, we determined the number of cost reports audited and used by each state in setting the rates and the extent to which audit cost-reduction experience was applied to unaudited cost reports used to set rates. Additionally, through discussion with state officials and reviews of audit results, we determined the extent to which (1) audits were conducted for a specific period but never used for computing rates, (2) audit findings were not traced to prior-period unaudited cost reports, and (3) audit results were not analyzed to identify and correct system weaknesses.

For each state, we held discussions with state officials and determined whether the state had developed its own guidelines for determining allowable costs for use in computing rates; used a combination of its

own guidelines and Medicare principles of cost reimbursement; or used the Medicare principles of cost reimbursement entirely. We examined selected provider cost reports and related audits for selected items of costs to determine the adequacy of the states' guidelines for determining allowable costs for use in computing rates. We also reviewed HHS Inspector General and state legislative audits that contained data on the adequacy of the states' guidelines for determining allowable costs.

At the HCFA central and regional offices, we interviewed officials involved in the review and approval process for states' Medicaid plan amendments and state assurances on rates and periodic cost report audits. We also reviewed HCFA's regulations and records to determine the adequacy of HCFA's reviews. Additionally, we obtained information on HCFA's annual assessments of states' Medicaid programs and its guidelines for making the assessments.

We also obtained and reviewed a nationwide study on state Medicaid nursing home payment systems reported in March 1983 by the National Governors' Association Center for Policy Research. In addition, we obtained and considered various HCFA study reports on nursing home payment systems. Finally, we obtained and used recent evaluation reports by consultants, management firms, and state legislative committee staffs on specific state payment systems.

Our work was performed in accordance with generally accepted government auditing standards.

Controls on Allowable Property Costs From Sales and Leases: Summary of Seven States Reviewed by GAO

Arkansas

Controls at Time of Review	Arkansas recognized the full selling price as the property cost basis for allowing depreciation and placed no restrictions or ceilings on lease amounts allowed.
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GAO Comments	Theoretically, nursing homes that increase their property costs through sale or lease transactions and whose total per diem costs remain either below or above the 80th percentile level have no impact upon the rates paid. This is because all homes are paid the rate of the home at the 80th percentile. If a sale or lease transaction results in a different home being placed at the 80th percentile, however, all homes within that class would be paid the higher rate. Accordingly, sales and leases could cause some increase in the class rates from year to year.
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Changes Resulting From Deficit Reduction Act	Arkansas amended its cost reports to reflect the restrictions imposed by the Deficit Reduction Act, but the revised cost reports have not been used in setting rates. Rates are still based on cost reports submitted for 1979, adjusted each year for inflation.
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GAO Comments	Because the state has a class rate and that rate is no longer directly linked to nursing home cost reports, HCFA has accepted the state's assurance that its rate setting methods will not result in an increase in nursing home rates in excess of that which would result under the Medicare provisions.
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Georgia

Controls at Time of Review	Georgia allowed increased costs resulting from sales and leases up to the 90th percentile of property costs for all homes. Prior to May 1981, a nursing home's property and related portion of the rate could exceed the 90th percentile when depreciated replacement costs plus the estimated value of the land exceeded the limit.
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GAO Comments

Our detailed review of 2 of the 24 sales during the 4-year period January 1979-March 1983 showed that the system had little impact on controlling increased costs resulting from the two sales. A Georgia Medicaid official said that the 44 nursing homes leased during the 3-year period January 1980-December 1982 resulted in additional annual costs to the Medicaid program of about \$2 million.

**Changes Resulting From
Deficit Reduction Act**

Georgia implemented a new property payment system in June 1983, before enactment of the Deficit Reduction Act. Under the new system, building and building equipment costs are allowed based on the estimated original construction cost (plus 8 percent for miscellaneous costs) for the facility, limited to a maximum of 300 square feet per bed and a 40-year life. Amounts allowed annually for the building and building equipment will be based on no less than 50 percent of the original construction floor described above. Major and minor movable-equipment costs are allowed at current replacement costs limited to \$1,600 a bed. Motor vehicle costs are subject to a maximum dollar amount for each 100 beds. No further changes have been made since enactment of the Deficit Reduction Act.

GAO Comments

Georgia's new system is an improvement but may have only limited effectiveness in eliminating increased property costs because (1) the acquisition cost will be updated each year and (2) the allowable cost for building and building equipment will never be based on less than 50 percent of the estimated original construction costs. HCFA, as of September 15, 1985, had not accepted the state's assurance that its system would meet the restrictions of the Deficit Reduction Act.

Illinois

Controls at Time of Review

Illinois established a "fair rental value" system in September 1981. Computation of the fair rental value included the sum of the undepreciated construction cost of the building times a construction index, the undepreciated cost of equipment and vehicles plus inflation, and a working capital allowance equivalent to 2 months' nursing and support cost plus inflation multiplied by a rate of return on investment. The amount obtained divided by annual patient days was the fair rental value.

GAO Comments

The effectiveness of the system depended heavily on the amount of the working capital allowance and return on investment paid the owner. To illustrate, homes with a fair rental value equal to or less than the maximum limit would receive the fair rental value. For example, one nursing home's capital per diem rate for 1982 was \$2.41 (\$2.32 fair rental value plus \$0.09 property taxes) or about 39 percent higher than its actual property cost of \$1.73. In such cases, the Illinois fair rental value system may give nursing homes substantially higher profits.

**Changes Resulting From
Deficit Reduction Act**

Illinois amended the state plan to provide that, for any change of ownership after July 18, 1984, the cost basis of an asset be the lesser of the allowable acquisition cost of such asset of the first owner of record on or after July 18, 1984, or the acquisition cost of such asset to the new owner. Expenditures attributable to the negotiation or settlement of the sale or purchase of any capital asset (including legal fees, accounting and administrative costs, travel costs, and the cost of feasibility studies) were not considered to be allowable costs.

GAO Comments

HCFA accepted the state's assurance for fiscal year 1985 because the prospective rates were based on asset costs before implementation of the changes. However, HCFA asked that the state plan be clarified to eliminate certain ambiguities before assurances are submitted for fiscal year 1986.

Kentucky

Controls at Time of Review

Kentucky allowed only a graduated proportion of the gain on the sale of a nursing home to be considered in determining the new owner's cost basis where the seller had owned the facility for less than 12-1/2 years. In such cases, the gain to be added to the seller's depreciation cost basis was limited to two-thirds of one percent for each month the seller owned the nursing home. For nursing homes owned by the seller for 12-1/2 years or more, the entire gain was added to the seller's depreciated cost basis to determine the new owner's depreciable cost basis.

Other payment provisions also limited a portion of the increased property costs resulting from sale and lease transactions that could be reimbursed. Specifically,

- the overall maximum per diem rates for ICF and SNF nursing homes were limited to 110 percent of the median facility costs for each class of homes; and
- for homes entering the Medicaid program after April 1981, the property payments were limited to 105 percent of the median property costs for all homes within the class.

The allowable lease costs are limited to the owner's (lessor's) historical costs.

GAO Comments

Under this procedure, a nursing home could be sold three times over a 40-year life with the full gain on each sale being included in the new owner's cost basis for depreciation.

**Changes Resulting From
Deficit Reduction Act**

Kentucky advised HCFA that its controls were stricter than the requirements of the Deficit Reduction Act and that no changes were being made based on the act.

GAO Comments

HCFA has accepted the state's assurance.

Minnesota

Controls at Time of Review

In May 1983, the Minnesota state legislature

- froze the number of nursing home beds and facilities and related property costs at the then current levels with no recognition of increased costs due to sales and
- required the state Medicaid agency to establish procedures to (1) recapture excess depreciation upon sale of a nursing home and (2) pay nursing homes an amount for property equal to an amount that a renter might expect to pay for the existing buildings and equipment.

GAO Comments

At the time of our review, the state's new restrictions had not been in place long enough for us to assess their effectiveness.

Changes Resulting From Deficit Reduction Act	No changes have been made in response to the Deficit Reduction Act.
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GAO Comments	HCFA has accepted Minnesota's assurances that its renter value system will not increase the rates more than under Medicare policy.
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South Carolina

Controls at Time of Review	Since December 15, 1981, the allowable cost resulting from sale or lease transactions has been limited to the historical cost of ownership.
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GAO Comments	South Carolina has been working on a new nursing home payment system, but as of December 1985 the system had not been implemented because of legal actions by the state's nursing home association.
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Changes Resulting From Deficit Reduction Act	South Carolina plans to continue to limit sales and lease transactions to the historical costs of ownership until HCFA issues guidance for implementing the provisions of the Deficit Reduction Act.
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GAO Comments	HCFA has not yet accepted South Carolina's assurance for fiscal year 1985 rates.
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Texas

Controls at Time of Review	Texas recognizes the full selling price as the property cost basis for allowing depreciation and has placed no restrictions or ceilings on lease payments.
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GAO Comments	Theoretically, nursing homes that increase their property costs through sale or lease transactions and whose total per diem costs remain either below or above the 60th percentile level have no impact upon the rates paid. This is because Texas has a class-rate system and all nursing
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**Appendix III
Controls on Allowable Property Costs From
Sales and Leases: Summary of Seven States
Reviewed by GAO**

homes are paid the rate of the home at the 60th percentile. However, if a sale or lease transaction results in a different home being placed at the 60th percentile, all homes within that class would be paid the higher rate. Accordingly, sales and leases could cause some increase in the class rates from year to year.

**Changes Resulting From
Deficit Reduction Act**

No changes have been made to the state Medicaid plan based on the Deficit Reduction Act.

GAO Comments

Texas will be moving to a new reimbursement system during the next year.

Advance Comments From the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

FEB 10 1986

Mr. Richard L. Fogel
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for the Department's comments on your draft report, "Medicaid Payments: Nursing Home Rate Setting Methods Should Be Improved." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "R. P. Kusserow".

Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report,
"Medicaid Payments: Nursing Home Rate
Setting Methods Should Be Improved"

Overview

GAO conducted this review to determine how effective States have been in establishing prospective payment systems that provide nursing homes an incentive to reduce their costs without adversely affecting the quality of care. To do this, GAO reviewed prospective payment systems in seven States. That review identified weaknesses in each phase of the rate setting process. As a result, GAO believes that the Health Care Financing Administration (HCFA) does not have adequate assurances that the States' nursing home reimbursement rates were reasonable and adequate to meet the costs incurred by efficiently and economically operated nursing homes in providing quality care.

More specifically, GAO found that: allowable base costs were too high, resulting in increased nursing home reimbursements; none of the States had performed adequate studies to ensure that subgroupings reflected legitimate differences in the costs to operate an efficient, economical nursing home resulting in questionable reimbursement rates; inflation indices used by some States did not accurately measure inflation within the nursing home industry; and, none of the seven States had performed a study to ensure that the cost ceilings they established would maximize nursing homes' incentives to contain costs without jeopardizing quality of care.

In addition, GAO's review confirmed the need for controls over lease arrangements citing the conference report of the Deficit Reduction Act of 1984 (DEFRA) where the conferees expressed concern about the reasonableness of lease amounts.

GAO Recommendation

That the Secretary direct the Administrator of HCFA to (1) establish guidelines to be used by States in making assurances that their nursing home reimbursement rates are reasonable and adequate; and,

Department Comment

Subsequent to issuing final regulations on December 19, 1983, implementing section 962 of the Omnibus Reconciliation Act of 1980 and section 2173 of the Omnibus Reconciliation Act of 1981, we issued manual instructions (sections 6000-6006 of Part 6 of the State Medicaid Manual). These instructions provide guidance regarding the Federal implementation of section 1902(a)(13)(A) of the Social Security Act, and the final regulations at 42 CFR 447.250ff.

In substance, the instructions reflect congressional intent to increase the State's administrative and fiscal discretion to set payment rates by keeping the Federal regulatory and other requirements to a minimum level necessary to assure proper accountability. We would also note that such role has been consistently upheld by the

Page 2

courts. For example, early litigation under the Boren amendment, in particular, focused heavily on whether the Secretary was required to provide detailed criteria in order to properly implement the statute (as GAO suggests is the case), yet no court has found that such detailed criteria are the responsibility of the Secretary. Further, we indicate in the manual that HCFA's review, as influenced by congressional intent, is not directed to reviewing or accepting a State's payment methods and standards (State plan) from a technical standpoint; nor does HCFA's approval of a State plan amendment indicate that we believe that the payment methods and standards are the best means of establishing payment rates. Instead, HCFA's approval of a State plan amendment indicates that the State has complied with the requirements in the statute and regulations.

In fact, section 6305 of the State Medicaid Manual provides a checklist showing the regulatory citation and applicable requirements to use in reviewing a State plan amendment. The first element of the checklist provides that the State has found that the rates are reasonable and adequate. This instructional material was made available to the States and has been used in developing many individual plan amendments.

GAO Recommendation

(2) use these guidelines to review the adequacy of States' assurances. These guidelines should, at a minimum, require that States make assurances that they have:

- established specific criteria defining allowable costs for such items as luxury automobiles and out-of-State travel;
- used the results of audited cost reports to compute reimbursement rates;
- used inflation indices that reasonably reflect increased costs in the nursing home industry;
- performed studies to ensure that the subgroupings used result in reasonable and adequate reimbursement for all nursing homes within the group;
- performed studies to ensure that the ceilings set on reimbursement rates are appropriate;
- performed studies to demonstrate an actual shortage of nursing home beds before allowing proprietary nursing homes a separate return on equity; and,
- established adequate limits on the effects of sales and leases on allowable property costs.

Department Comment

As noted in response to the previous recommendation, the manual instructions also include the criteria HCFA uses to evaluate the acceptability of a State's assurances that its nursing home reimbursement rates are reasonable and adequate. The guidance is used by HCFA in determining the approvability of each plan amendment.

Page 3

The instructions are also used by certain HCFA operational components as an assessment program to "look behind" and monitor the actual performance and compliance of the States with the reasonable and adequate nursing home reimbursement rate standard. In that regard, and in view of GAO's findings and recommendations, we will consider determining what additional steps might be taken in HCFA's ongoing monitoring and oversight of Medicaid State plan operation and administration for nursing home reimbursement.

GAO Recommendation

That the Secretary publish regulations to implement the provisions of the Deficit Reduction Act of 1984 relating to the effects of nursing home sales on allowable property costs and direct the Administrator of HCFA to provide technical assistance to the States in developing prospective payment systems.

Department Comment

Draft proposed regulations have been developed and are presently under review which would implement section 2314 of DEFRA of 1984. However, the regulations were delayed awaiting anticipated legislative modifications included in the proposed Reconciliation Act of 1985. With respect to providing technical assistance to the States in developing prospective payment systems, we would note that HCFA is currently working with New York and Texas to develop case-mix reimbursement systems based on patient grouping methodologies such as the Resource Utilization Groups developed by Yale University. In addition, the State of Massachusetts has also expressed an interest in developing such a system.

Technical Comments

Now on p. 9.

In the first paragraph on page 10, the report erroneously states that under a prospective payment system providers may keep all or part of the difference between the rate and the provider's costs. While States may permit providers to retain varying amounts between a rate cap and a provider's actual costs, States are also free to limit providers to no more than their costs up to the reimbursement cap.

Now on p. 10.

On page 11, the report clearly implies that States were acting under an impression fostered by the Secretary that States were to use, under Medicaid reasonable cost-related reimbursement, the same methods and standards used under the Medicare program. In fact, through both rulemaking and litigation, the Department could not have been any clearer that it believed States ought to move away from the "inherently inflationary" reimbursement principles used in the Medicare program.

Now on p. 10.

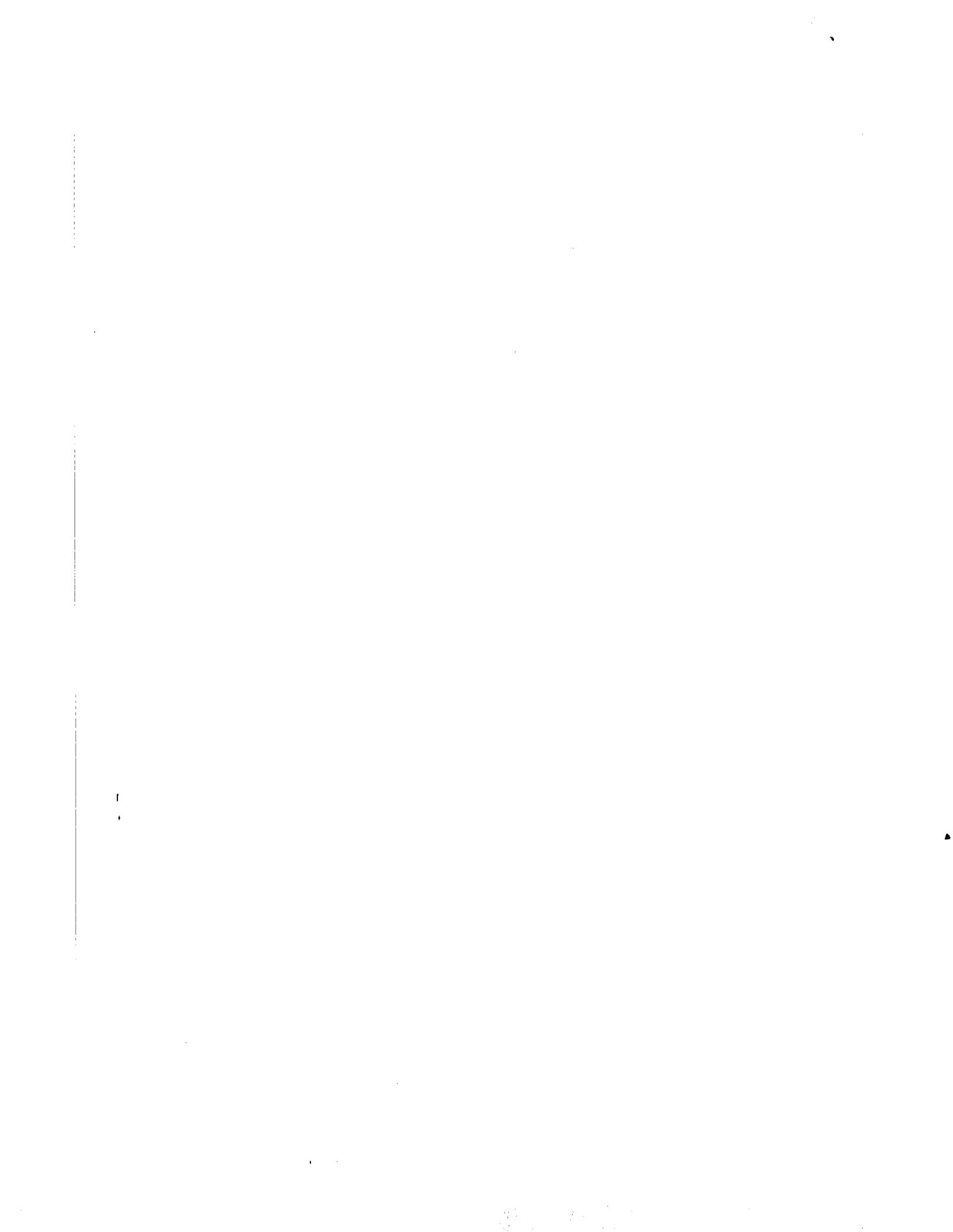
On page 11, the report states that prior to the Omnibus Reconciliation Act of 1980 States were required to seek HCFA's approval before making significant changes in nursing home reimbursement. While States were required to seek such prior approval for hospital reimbursement plans, there was never an analogous requirement for nursing home reimbursement plans. The only limitation that States faced in the case of such plans was that they could not be effective earlier than the first day of the quarter in which they were submitted in approvable form. (45 C.F.R. Section 201.3(g)).

**Appendix IV
Advance Comments From the Department of
Health and Human Services**

Page 4

On page 38, the report speaks to "HHS regulations" that specify the manner by which States may set a return on equity for nursing home providers. There are no such regulations, however, that speak even generally to a return on equity for providers, much less the methodologies from which States may choose in setting such payments.

Now on p. 31.



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