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STATEMENT OF

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BEFORE THE SENATE SPECIAL COMMITTEE ON AGING

ON

ISSUES ASSOCIATED WITH

PROSPECTIVE PAYMENT SYSTEMS

FOR NURSING HOME CARE

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Mr. Chairman and Members of the Committee, we are pleased to be here today to discuss certain features of the prospective payment systems developed by various State Medicaid programs to pay nursing homes, particularly the system developed by the State of Texas and discussed in our October 14, 1982, report entitled "Audit of Medicaid Costs Reported by Autumn Hills Convalescent Centers, Inc., Houston, Texas."

My testimony today will focus on four issues. First, in contrast to the Federal Medicare program which continues to reimburse skilled nursing facilities (SNFs) retrospectively based on actual allowable incurred costs, about 36 States have adopted some form of prospective system, in which the payment rates for a particular period are set in advance based on costs incurred during a prior period. Because in 1982 Congress mandated that the Department of Health and Human Services develop legislative proposals to provide for reimbursing SNFs prospectively under Medicare, and because Medicaid is the dominant governmental payer for nursing home care, we believe that these existing State systems should be seriously looked at when developing the Federal Medicare system.

Second, under the system developed in Texas, the per diem rates are determined on a statewide basis and are extremely insensitive to the costs reported by individual facilities. Thus it is highly unlikely that a facility or small group of

facilities can manipulate the system to receive higher Medicaid payments by overstating or inflating reported costs. This was illustrated by our audit of the Autumn Hills' central office costs in which we questioned about $250,220 (or about 18 percent) of $1.4 million total costs reported there. None of the costs we considered unallowable or questionable had any impact on what the company and other nursing homes in the State were paid under the State's rate-setting methodology. On the other hand, this methodology is not sensitive to the costs associated with the needs of individual patients.

Third, certain prospective payment systems such as in Texas can lessen somewhat the need for financial audits as compared with the retrospective systems, which reimburse each facility based on its allowable incurred costs. Prospective systems do not eliminate the need for such audits, but the audits should be designed and implemented to support the reimbursement methodology a State chooses to employ.

Finally, and most important, prospective payment systems, such as in Texas, can apparently succeed in restraining rising health care costs by providing an incentive for nursing homes to operate within the overall rates. This same incentive also creates a greater need for the States to review and monitor the quality of patient care being provided. Because direct patient care represents the largest component of costs,

it provides the greatest opportunity for cost reductions. Therefore, it is essential that cost savings not be achieved by providing care that fails to meet program standards.

EXTENT OF PROSPECTIVE PAYMENT SYSTEMS UNDER MEDICAID

For fiscal year 1981, Medicare reimbursements to the 5,000 SNFs participating in that program were about $400 million. In contrast, Medicaid payments to the 7,300 SNFs participating in that program were about $4 billion, and another $7 billion in payments were made to the several types of intermediate care facilities (ICFs). Thus, Medicaid is clearly the predominant public payer of nursing home services.

As of late 1982, at least 36 States had some type of cost-based prospective system in place to pay for these services. Attached as an appendix to my statement is a summary analysis of the principal types of nursing home reimbursement systems employed by 49 States and the District of Columbia.[1] It should be recognized, however, that under the broad classification of prospective payment systems, the rate-setting methodologies used vary widely.

Section 101(c)(3) of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) provides that the Department

[1]Arizona not included.

of Health and Human Services, in consultation with the Senate Committee on Finance and the House Committee on Ways and Means, shall develop proposals for legislation which would provide that hospitals, SNFs, and to the extent feasible, other providers be reimbursed prospectively under Medicare. The proposals were to be provided to these Committees by December 31, 1982.

Although the Department provided a report to the Congress in December 1982 concerning a proposed prospective payment methodology for hospitals under Medicare, we understand that a companion proposal for prospective payments to SNFs is still being developed.

In view of the States' broad experience in developing and using prospective payment systems we believe that their systems should be seriously looked at in developing a Federal system.

In this regard, section 249(b) of the Social Security Amendments of 1972 authorized the Department to use the SNF Medicaid rates in any State as the basis for making Medicare payments to such facilities, with appropriate increases for the items or services covered by Medicare but not included in the State rates. One purpose of this provision was to enable Medicare to move toward prospective payment for nursing home services to lessen the substantial auditing and cost reporting

expenses associated with Medicare's retrospective system. However, Medicare has never used this authority as a basis for paying nursing homes.

THE TEXAS NURSING HOME SYSTEM AND RATE-SETTING METHODOLOGY

The current Texas Medicaid payment system for nursing homes, which went into effect January 1, 1979, prospectively develops per diem payment rates which are uniform statewide for each level or class of nursing home care. All homes in the State receive payment based on the same rates for each respective day of skilled and the two levels of intermediate care provided.

The per diem rates are determined using financial and statistical information from annual cost reports submitted by about 900 participating facilities. The costs are then adjusted for various factors, such as minimum occupancy rates and inflation. These adjusted costs are then divided into four categories--patient care, dietary, facility, and administrative cost--and the patient care costs are further subdivided into the three levels of care. The actual per diem rates for each level of care are determined by selecting the 60th percentile cost from the appropriate patient care cost array and the dietary, facility, and administrative cost arrays and summing them to arrive at the statewide base rate.

In our opinion, this rate-setting methodology makes it very difficult for individual homes or small groups of homes to manipulate the system to receive higher Medicaid payments by overstating or inflating reported allowable costs. For example, even if the home at the 60th percentile included unallowable or inflated costs, the net effect on the rate would depend on the adjusted cost of the facility immediately below it on the data array--which, when rounded to the nearest penny, would likely be the same. The insensitivity of the system to unallowable costs reported by individual facilities is illustrated by the results of the State's and our audits of Autumn Hills' costs.

The State had audited the 1978 cost reports for the 17-facility Autumn Hills chain 13 of which had been included in the data used to set the statewide rates for the period January 1 through August 31, 1980. The State identified unallowable costs of about $204,000, including $187,000 in unallowable administrative costs; however, because the Autumn Hills homes were over the 90th percentile on the data arrays, none of these unallowable costs affected the State's payment rates set at the 60th percentile. Similarly our audit of the 1980 central office costs, which were included in the data to set the rates for the period beginning in September 1981, identified about $250,000 in unallowable, questionable, or undocumented costs,

but again because Autumn Hills facilities were above the 80th or 90th percentiles on the data arrays for administrative costs, none of these questionable costs affected the State's payment rates.

The major area of concern associated with these relatively significant amounts of unallowable or questionable costs is that the money was apparently not being spent on patient care.

Another area of concern, of course, is that the Texas rate-setting methodology is insensitive both to the costs associated with the needs of individual patients within the three broad levels of care and to the case mix of individual facilities. This could provide incentives to restrict access for those patients needing more expensive care.

FINANCIAL AUDITS SHOULD BE DESIGNED TO SUPPORT THE STATES' RATE-SETTING METHODOLOGY

As indicated the States have adopted a wide range of reimbursement or payment systems to pay for nursing home care. In our view, a nursing home financial auditing system should be designed to support the payment system a State elects to adopt. In Texas, the rate-setting methodology minimizes the number of nursing home audits needed because the costs of only a relatively few facilities around the 60th percentile actually determine the rates. We see little benefit, in terms of

reducing costs, from auditing facilities near the bottom or top of each array because these facilities will have little opportunity to affect the rates regardless of the allowability of costs they report or the audit results.

In the past, the State has not taken advantage of this situation in developing its audit plans. This resulted in part from the Federal Medicaid regulations, effective in January 1978, which required the State to audit all participating nursing homes by the end of calendar year 1980 and 15 percent each year thereafter. The Omnibus Budget Reconciliation Act of 1981 modified these financial auditing requirements to give the States more flexibility.
In our view, in these times of scarce Federal and State dollars, it is even more important that the costs of administering and auditing these programs be focused on areas that can produce the most cost-beneficial results.

In our October 1982 report, we recommended that this could be accomplished under the Texas nursing home program if the State were to concentrate its nursing home audit acitivites on the facilities grouped around the 60th percentile levels of each data array since the costs reported by this group of homes are more likely to affect the accuracy of the State's per diem rates.

NEED TO MAINTAIN

APPROPRIATE

STANDARDS OF QUALITY

Since the current prospective payment system in Texas was put into effect in January 1979, the per diem rates have increased by an average of about 6 percent a year. By way of contrast, in Massachusetts, which employs primarily a retrospective reimbursement system, the rate of increase has been about 10 percent a year since 1979. Thus, it appears that a prospective payment system can contribute to restraining the increase in nursing home costs by providing an incentive for operators to minimize their costs so as to operate within the pre-established payment rates. On the other hand, this same incentive places an increased obligation on the responsible Federal and State agencies to ensure themselves that patients are receiving care that meets the applicable standards for quality. One possible approach to achieving this objective would be to adopt a system of financial penalties for facilities providing substandard care as determined through appropriate quality control programs such as periodic inspections and utilization control mechanisms which are required under existing law. Several States have adopted such a payment approach.

Quality of care problems associated with the Texas City home

The Autumn Hills chain operated 17 nursing homes in 13 cities located principally in southeast and central Texas.

In 1979, the State Health Department, which conducts the nursing home inspections, began a system of grading individual SNF and ICF sections of nursing homes annually to identify and recognize those that were deemed superior. Fifteen of the Autumn Hills homes have received superior ratings in at least 1 year over the period 1979 to 1981. Three homes were rated superior all 3 years, but two have never received a superior rating. One of the latter was the Texas City home that we were asked to audit because of allegations of poor patient care. This home consisted of two distinct parts--one for each of two levels of care consisting of 60 SNF beds in one wing and 60 ICF beds in another.

The Texas City home, which was one of the higher cost homes in the chain in the patient care category, has had a history of lack of compliance with Medicaid health and safety standards.

The State withheld Medicaid payments to the facility on four occasions during 1978 and 1979 for serious health and safety deficiencies and the failure to correct them. In fact,

the Health Department had recommended that the facility be excluded from the Medicaid program in August 1979, but decided not to exclude it after the home made a number of improvements. Among the problems was a shortage of licensed nurses on duty to meet the various State and Federal staffing standards. The shortages occurred in 52 percent of the days tested by the State in 1978 and 14 percent of the days tested in 1979. For 1980 and 1981, the State identified no shortages. We examined time cards for January, June, and October 1980--which were different periods than the State tested that year--and identified 32 days where shortages occurred, principally in the ICF section.

Autumn Hills has strongly disputed our findings in this regard by pointing out that in the aggregate, for the periods we reviewed, the facility had more than enough licensed nursing personnel to meet the State's minimum staffing standards. However, we do not believe that the aggregate number of nurses is the issue. We believe that the issue is whether for each day, for each distinct part (SNF and ICF), and for each shift the facility had the appropriate licensed nursing personnel on duty to meet the State's minimum standards.

In light of Autumn Hills' comments, we have re-examined these time cards, which were the basis on which the nurses were paid, and concluded that our findings were essentially accurate.

This concludes my formal statement, and we would be pleased to respond to any questions the Committee may have.

NUMBER OF STATES USING VARIOUS TYPES OF REIMBURSEMENT SYSTEMS UNDER THEIR MEDICAID NURSING PROGRAMS AS OF LATE DECEMBER 1982

Type of Reimbursement System	Types of Facilities: Skilled Nursing Facilities	Intermediate Care Facilities	Intermediate Care Facilities For Mentally Retarded
Prospective	31	34	29
Retrospective	14	11	17
Combination (note a)	2	2	2
Negotiated (note b)	3	3	2

Note a: Some categories of costs are paid for on a prospective basis and others are reimbursed on a retrospective basis.

Note b: Although cost-based, the rates are not based on a specific formula or methodology, but are negotiated with the industry.

Source: State plans on file at Health Care Financing Administration.

PRINCIPAL TYPES OF REIMBURSEMENT SYSTEMS USED BY THE STATES UNDER THEIR MEDICAID NURSING HOME PROGRAMS AS OF LATE DECEMBER 1982

Prospective	Retrospective	Combination	Negotiated
Alabama	Alaska	Nevada	Oklahoma
Arkansas	Hawaii	Ohio	South Dakota
California	Idaho		Utah
Colorado	Iowa		
Connecticut	Maine		
Delaware	Maryland		
District of Columbia	Massachusetts		
Florida	Montana		
Georgia	New Hampshire		
Illinois	New Mexico		
Indiana	Oregon		
Kansas	Pennsylvania		
Kentucky	Tennessee		
Louisiana	Vermont		
Michigan			
Minnesota			
Mississippi			
Missouri			
Nebraska			
New Jersey			
New York			
North Carolina			
North Dakota			
Rhode Island			
South Carolina			
Texas			
Virginia			
Washington			
West Virginia			
Wisconsin			
Wyoming			

Note: Based on method of paying skilled nursing facilities.

SUMMARY OF GAO TESTIMONY

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Under the prospective reimbursement system developed in Texas, the per diem rates are determined on a statewide basis and are extremely insensitive to the costs reported by individual facilities. Thus it is highly unlikely that a facility or small group of facilities can manipulate the system to receive higher Medicaid payments by overstating or inflating reported costs. This was illustrated by GAO's audit of the

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Autumn Hills' convalescent centers where none of the costs GAO questioned had any impact on what the company and other nursing homes in the State were paid under the Texas rate-setting methodology. On the other hand, this methodology is not sensitive to the costs associated with the needs of individual patients.

GAO believes that prospective systems do not eliminate the need for financial audits, but the audits should be designed and implemented to support the reimbursement methodology a State chooses to employ.

GAO also believes that prospective payment systems such as in Texas, can apparently succeed in restraining rising health care costs by providing an incentive for nursing homes to operate within the overall rates. This same incentive also creates a greater need for the States to review and monitor the quality of patient care being provided. GAO believes that it is essential that cost savings not be achieved by providing care that fails to meet program standards.