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Report to the Region IV Administrator, Health Care Financing Administration

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MEDICAID

Making Georgia's Nursing Home Reimbursement More Equitable

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Human Resources Division
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May 12, 1986

Mr. George Holland
Region IV Administrator
Health Care Financing Administration
Department of Health and Human Services
Atlanta, Georgia 30323

Dear Mr. Holland:

We recently reported to the Secretary, Department of Health and Human Services (HHS), on the effectiveness of states' efforts to establish prospective payment systems for nursing homes.[1] We concluded that although the Omnibus Reconciliation Act of 1980 gave states more flexibility in designing their nursing home reimbursement systems, HHS' Health Care Financing Administration (HCFA) remains responsible for ensuring that states' payment methods will result in all nursing homes receiving reimbursement that is reasonable and adequate to meet the costs incurred by an efficient and economical home in providing quality care.

In that report we recommended that HCFA provide technical assistance to the states in developing prospective payment systems. We also recommended that HCFA establish and use guidelines to require states to make assurances that they have performed studies to ensure that the grouping of nursing homes for reimbursement purposes results in reasonable and adequate reimbursement for all nursing homes within each group. Although states generally group nursing homes according to certain characteristics, such as level of care, and set different prospective payment rates for each group, none of the states included in that report[2] had done adequate studies to ensure that groupings reflected legitimate differences in the costs to operate an efficient, economical nursing home.

In a related effort—the results of which are discussed below—we found that Georgia had not conducted studies or analyses to serve as a basis for establishing appropriate groupings of nursing homes for reimbursement purposes. Furthermore, HCFA accepted, without adequate supporting analysis, Georgia's assurance that its nursing home reimbursement rates were reasonable and adequate. Our analysis showed that the grouping method Georgia uses does not ensure that the

[1] Medicaid: Methods for Setting Nursing Home Rates Should Be Improved, GAO/HRD-86-26, May 1986.

[2] Arkansas, Georgia, Illinois, Kentucky, Minnesota, South Carolina, and Texas.

reimbursement rates for intermingled nursing homes are reasonable and adequate to meet the costs that must be incurred by all efficiently and economically operated facilities.

About 66 percent of Georgia's nursing homes are classified as free-standing intermingled homes, meaning that they can provide care for residents requiring either skilled nursing or intermediate care. But the state's grouping method for these facilities does not consider their resident mix, which is a significant cost determinant. Consequently, reimbursement may not be adequate for some homes with a high concentration of skilled care residents and few intermediate care residents. Such homes may find it more difficult to provide quality skilled care for Medicaid beneficiaries because they are unable to fully recover their costs for services residents need. Conversely, such a system may provide higher reimbursement to some intermingled nursing homes having primarily intermediate care residents, who incur lower nursing-related costs.

We further believe that Georgia could reduce nursing costs in intermingled homes, and therefore reduce Medicaid costs, by basing its minimum nursing standards on residents' actual care requirements rather than facility classification. Currently, Georgia requires all intermingled nursing homes to meet minimum staffing levels for skilled nursing homes. But we found that the majority of residents in most intermingled homes are classified as needing intermediate—not skilled—care.

Background

Medicaid, authorized by title XIX of the Social Security Act, as amended, is a grant-in-aid program under which the federal government pays from 50 to 78 percent of the states' costs to provide health care services to certain categories of low-income persons. Medicaid is administered at the federal level by HCFA. HCFA's role in the program is generally to issue regulations and guidelines, review and approve state Medicaid plans for federal financial participation, and monitor the states' performance.

In Georgia, the Department of Medical Assistance administers the Medicaid program, and the federal government pays 67 percent of the state's Medicaid operating costs, according to a state official. In federal fiscal year 1984, Georgia's Medicaid expenditures, including federal and state resources, were about $603 million, of which about $246 million was for nursing home care.

During federal fiscal year 1984, about 37,000 (80 percent) of Georgia's 46,000 nursing home residents were supported by Medicaid, according to a state official. Persons residing in nursing homes have traditionally been classified as requiring one of two levels of care:

1. Skilled nursing care is provided 24 hours a day to patients on the basis of physicians' orders and approved nursing care plans. Skilled care patients require convalescent and/or restorative services furnished by or under the general supervision of licensed nursing personnel. States are required to provide skilled nursing home care under their Medicaid program.

2. Intermediate care includes health-related services for individuals who do not require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition, require services above the level of room and board that can be made available to them only through institutional facilities. A registered or licensed practical nurse is required only on day shifts, as opposed to a 24-hour basis for skilled nursing facilities. Intermediate nursing home care is an optional service under Medicaid.

Georgia's Medicaid program provides both intermediate and skilled nursing home care for beneficiaries in a variety of settings, as indicated in table 1.

Table 1: Characteristics of Georgia Nursing Homes (As of Feb. 1, 1985)

Type of facility[a]	Number of facilities	Percentage of total	Average daily reimbursement rate
Free-standing intermingled	217	66	$30.69
Free-standing intermediate care facility (ICF)	45	14	26.86
Free-standing skilled nursing facility (SNF)	17	5	37.25
Other[b]	50	15	[c]
Total	**329**	**100**	

[a]Definitions:
Free-standing—a nursing home that is not physically part of another facility, such as a hospital.
Intermingled—a nursing home licensed as a SNF that maintains two levels of care (skilled and intermediate) without a distinct part certification.
Hospital-based—a nursing home that is an integral and subordinate part of a hospital and is operated with other departments of the hospital under common governance and professional supervision.
Distinct part—a nursing home with separate, identifiable units for different levels of care, such as entire wards, wings, floors, or buildings, which would separately provide for residents requiring skilled nursing and intermediate care.

[b]Hospital-based, intermediate care facility for the mentally retarded (ICF/MR), and distinct part homes.

[c]Not applicable.

Almost two-thirds of Georgia's nursing homes are intermingled facilities. According to state and nursing home officials, the major advantage of such facilities is that they allow greater flexibility in caring for patients. Because intermingled homes provide both skilled and intermediate care, their residents do not have to be moved to another facility or section of a home if their level of care changes.

Through enactment of the Omnibus Reconciliation Act of 1980 (Public Law 96-499), the Congress gave states greater flexibility in designing their nursing home reimbursement systems. Specifically, the act replaced the requirement that nursing homes be paid on a reasonable cost-related basis. Instead, the act required that each state provide assurances satisfactory to the HHS Secretary that the state's payment rates are reasonable and adequate to meet the costs that must be 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. States must provide assurances to HCFA whenever a significant change is made in payment methods and standards, but at least annually. HCFA's role in reviewing states' assurances is set out in its State Medicaid Manual as follows.

"HCFA's acceptance of a State's assurances is based on its evaluation of the information submitted. HCFA evaluates assurances to determine whether the State has made a finding to substantiate that the payment rates are reasonable and adequate . . . . HCFA's review is not directed to reviewing or accepting a State's payment methods and standards 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."

The State Medicaid Manual also provides that states may—but are not required to—submit quantitative data to enhance its assurances.

Georgia has developed a prospective payment system for its nursing homes, under which homes are paid a predetermined daily rate based on prior cost experience. This encourages efficient and economical operations because if costs exceed the predetermined payment, the nursing home suffers a loss, whereas if its costs are less than the payment, it makes a profit. Under Georgia's system each nursing home's prospective payment rate is based on its own allowable per diem costs for some base period—up to a ceiling—adjusted for inflation.

For reimbursement purposes, the state groups nursing homes according to (1) 13 types of facilities, such as free-standing SNF, hospital-based SNF, and free-standing intermingled nursing home, and (2) size of facility, such as 50 beds or fewer, 51 to 100 beds, and more than 100 beds. Furthermore, the state sets separate reimbursement ceilings within each group based on expenses in five cost centers—routine and special services;[3] dietary; laundry, housekeeping, and operation and maintenance of plant; administrative and general; and property. Routine and special services constitute the largest cost center, accounting for an average of about 40 percent of a nursing home's total costs.

Georgia's reimbursement system includes incentives for homes to operate efficiently and economically. Within the routine and special services cost center, the state groups intermingled homes according to bed size (50 or fewer and more than 50), then ranks the homes in each group, from highest to lowest, based on actual expenses. The state fully reimburses each facility up to the 75th percentile of the ranking. For example, intermingled homes with more than 50 beds currently have a 75th percentile ceiling of $13.33 per patient day for the routine and special services cost center. Intermingled homes whose routine and special services expenses are less than this ceiling will be fully reimbursed for their actual Medicaid costs. However, the homes whose expenses are in the upper 25th percentile would have their reimbursement limited to $13.33 per patient day. In addition, a nursing home may receive an incentive payment if its expenses are below the ceiling. For fiscal year 1985, Georgia capped the incentive payment for routine and special services at 53 cents per patient day. Therefore, by keeping costs low, a nursing home can avoid exceeding the 75th percentile cost ceiling and also receive an incentive payment.

Objective, Scope, and Methodology

The objective of our work was to determine whether Georgia's reimbursement system for free-standing intermingled nursing homes results in an efficient use of Medicaid resources. In view of the large number of free-standing intermingled nursing homes, we attempted to determine whether (1) Georgia's grouping methodology for reimbursement purposes resulted in equitable reimbursement for intermingled homes and (2) applying minimum nursing standards resulted in appropriate payment levels.

[3]Routine service expenses include the costs of providing both skilled and intermediate nursing care, such as salary and wages, employee benefits, supplies, and other direct expenses. Special service expenses include the costs of providing ancillary services, such as speech, physical, respiratory, or recreational therapy.

We conducted detailed audit work between March and September 1985. We interviewed officials of HCFA headquarters and Region IV; the Georgia Department of Medical Assistance, which administers Medicaid; the Office of Regulatory Services of the Georgia Department of Human Resources, which sets minimum nursing standards; the Georgia Medical Care Foundation, with whom the state contracts to conduct classification and other nursing home reviews; and the Georgia Health Care Association, which represents for-profit nursing homes. We reviewed pertinent documents, such as HCFA and state regulations, fiscal year 1984 Medicaid cost reports, and descriptions of Georgia's reimbursement system. We also reviewed the sections of Georgia's Medicaid plan pertaining to nursing home reimbursement. In addition, we visited eight nursing homes, including four with high and four with low percentages of residents requiring intermediate care.

Our work did not include audits of individual nursing homes' cost reports. Therefore, we have drawn no conclusions as to the reasonableness of the homes' costs or the economy and efficiency of their operations.

We conducted our work in accordance with generally accepted government auditing standards, except that we did not assess the reliability of Georgia's Medicaid Management Information System.

Better Groupings of Intermingled Homes Would Make Reimbursement More Equitable

Because homes with different characteristics and patient mixes provide different kinds of services and incur different costs, selecting appropriate groupings of facilities is essential to ensure that all nursing homes receive reasonable, adequate payments. Although Georgia groups nursing homes according to type and size of facility, it has not conducted studies or analyses to serve as a basis for such groupings. HCFA accepted Georgia's assurance that its nursing home reimbursement rates are reasonable and adequate, but did not determine whether its grouping method was substantiated by any studies or analyses. Georgia groups together all intermingled nursing homes for reimbursement purposes. But most such homes have heavy concentrations of residents requiring only intermediate nursing care, while a few have a high concentration of skilled nursing patients who require more costly care. Grouping all intermingled homes together, regardless of resident mix, does not necessarily provide reasonable and adequate reimbursement for efficiently and economically operated nursing homes.

No Analytical Basis for Current Grouping Method or Assurances

None of the Georgia or HCFA officials we contacted were aware of any special studies or analyses that served as a basis for the state's current grouping of nursing homes for reimbursement purposes. Furthermore, we believe HCFA has not adequately evaluated the acceptability of Georgia's findings and assurances that its rates to be paid to long-term care facilities are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities. HCFA apparently accepts Georgia's assurances that it has made findings to support the reasonableness and adequacy of its rates without evaluating any supporting documentation.

In the absence of an official HCFA criterion for what constitutes a reasonable and adequate rate, a HCFA Region IV official informed us that its unofficial criterion is that rates may be considered to be reasonable and adequate if at least 50 percent of nursing homes are reimbursed their costs. Although Georgia officials have demonstrated that their reimbursement rates meet this criterion, we believe it does not sufficiently take into account the range of intermingled homes with significantly different resident mixes. In our opinion, this criterion does not necessarily provide reasonable and adequate reimbursement for all efficiently and economically operated facilities. Rather, it tends to reward homes with light-care residents and lower costs and penalize homes with heavy-care residents and higher costs.

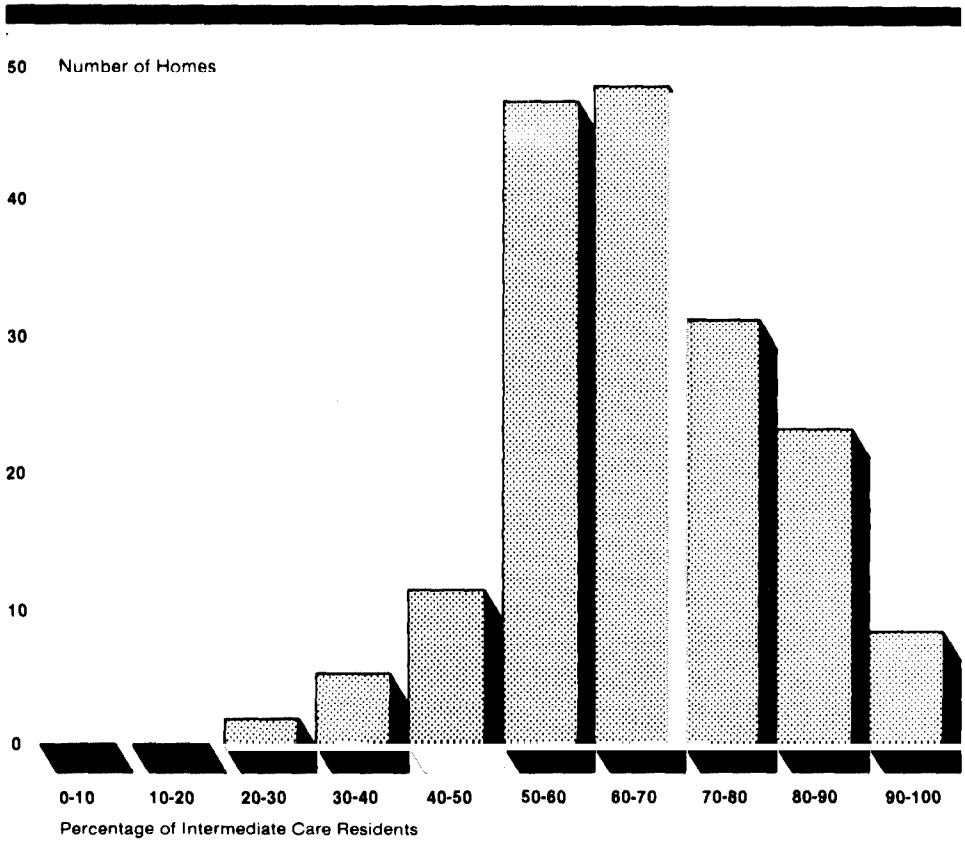
Intermediate Care Residents Are Less Costly Than Skilled Care Residents

In Georgia, residents requiring skilled care generally require more nursing time and incur significantly greater nursing-related costs than those needing intermediate care. This is because skilled care residents have more serious medical conditions. State regulations require that nursing homes be staffed to provide a daily minimum of 2.0 nursing hours for skilled care residents and suggest a minimum of 1.5 hours for intermediate care residents. In fiscal year 1984, free-standing SNFs with more than 50 beds provided an average of 2.7 hours of nursing care a day to each resident. Residents in free-standing ICFs received an average of 1.7 hours of nursing care a day. Furthermore, the 1985 ceiling for nursing-related costs was $17.69 a day for residents in free-standing SNFs with more than 50 beds, as compared to $9.26 a day for residents in free-standing ICFs of similar size.

Intermingled Nursing Homes Have Heavy Concentrations of Intermediate Care Residents

Georgia's intermingled nursing homes have varying mixes of residents requiring intermediate and skilled care, with the intermediate care caseload per home ranging from 24.3 to 99.7 percent. However, as figure 1 illustrates, the majority of residents in most intermingled homes require intermediate care.

Figure 1: Percentage of Intermediate Care Residents in Intermingled Homes
(Fiscal Year 1984)



More specifically, 157 (90 percent) of the 175 free-standing intermingled homes we reviewed had 50 percent or more intermediate care residents.

The large number of homes with high percentages of intermediate care residents resulted from two major factors:

1. Nursing homes may selectively admit primarily intermediate care residents, according to state and nursing home officials we contacted. Because these residents generally cost less to care for, selective admission helps assure full reimbursement of expenses and higher incentive payments. In a January 1985 report to the Congress on the Medicare SNF

benefit, HCFA indicated that it was to an intermingled nursing home's financial advantage to admit primarily intermediate care residents.

2. Some facilities had changed from ICFs to intermingled homes, but still had a resident mix that reflected the prior resident load. For example, a free-standing ICF that had just become an intermingled nursing home could still have 99 percent intermediate residents yet begin to receive a higher reimbursement rate. Of the 175 intermingled homes we reviewed, the 8 with the highest concentration of intermediate care residents had been converted to intermingled homes during fiscal year 1984.

Current Grouping Does Not Necessarily Provide Reasonable and Adequate Reimbursement

Grouping all intermingled homes together for reimbursement purposes, regardless of resident mixes, does not ensure that payment rates are reasonable and adequate for efficiently and economically operated facilities. Rather, it tends to reward some homes with predominantly intermediate care residents and to penalize some homes with predominantly skilled care residents.

Homes with high percentages of skilled residents more often exceed the cost ceiling than do homes with high percentages of intermediate care residents. Because skilled residents are more costly, we believe this increased incidence of exceeding the cost ceiling may be a reflection of the home's resident mix rather than its operating efficiency. To illustrate, the 25 homes we reviewed with the highest percentages of skilled residents had a median cost per resident of $12.89 for routine and special services, and 10 of them were over the ceiling. On the other hand, the 25 homes with the highest percentage of intermediate residents had a median cost per resident of $12.14 for routine and special services, and only 4 of them were over the ceiling.

State officials, nursing home association officials, and nursing home administrators we spoke with agreed that, considering the range of resident mixes, it would be more equitable to establish additional subgroupings rather than group all intermingled homes together for reimbursement. After reviewing our analysis, they acknowledged the current system increases the likelihood that homes with high percentages of skilled residents will exceed the cost ceiling. We believe this can affect the ability of such homes to provide quality care because they are unable to fully recover their costs for services residents need.

Additional groupings, based on more similar resident mixes, would result in a more equitable reimbursement system. This would reduce the

cost ceiling for the group of homes with the highest percentages of intermediate care residents and increase the ceiling for the group with higher percentages of skilled care residents.

Possible Alternatives

We discussed possible reimbursement alternatives with state officials, nursing home association officials, and nursing home administrators. They generally agreed that grouping intermingled homes into two or three groups, depending on resident mix, and establishing separate cost ceilings for each group was a more effective way to address the inequity in the state's current reimbursement system.

We reviewed the effect of grouping 175 free-standing intermingled homes[4] into two or three groups based on resident mix. To identify the percentage of intermediate care residents in each home, we used Medicaid inpatient day data from fiscal year 1984 cost reports and calculated the annual average number of full-time equivalent skilled and intermediate care residents for each home. We obtained actual routine and special services costs and incentive payments from the state's Medicaid Management Information System.

The cost ceilings for the suggested alternative groupings were developed using the same reimbursement methodology the state employs, with the exception of grouping the homes by resident mix. We developed an array of the intermingled homes by percentage of intermediate care residents, split the array into two and three groups, and then developed new cost ceilings at the 75th percentile for each of these separate groupings. We used only routine and special service costs because these costs directly relate to patient care requirements and represent the largest proportion of a nursing home's costs.

As shown in table 2, the state could separate intermingled homes into two groups based on resident mix. One group could have from 62.0 to 99.7 percent intermediate care residents; the second group, from 24.3 to 61.9 percent. Thus, the reimbursement ceiling would be based on nursing homes having a more similar resident mix.

Similarly, the table shows that if Georgia's intermingled homes were separated into three groups based on resident mix, the cost ceiling for

[4]We excluded 42 such homes from our analysis because they did not identify inpatient days according to skilled and intermediate levels of care or provided only part-year reports (29 homes); had fewer than 50 beds, which is a separate reimbursement class (10 homes); or averaged 15 or fewer Medicaid residents per day (3 homes).

the homes with the highest percentages of residents needing skilled care would increase from the current $13.33 to $14.57 per day. For a facility with 100 Medicaid patients that is at the $13.33 ceiling, this increased ceiling could provide an additional $45,260 a year in operating income. Conversely, by reducing the cost ceiling for homes with 75 percent or more intermediate care patients to $13.11, reimbursement, including incentive payments for many such facilities, would be reduced.

Table 2: Current and Alternative Nursing Home Groupings

Number of groupings	Groupings by percentage of intermediate care residents	Number of homes per group	Cost ceiling for routine and special services
1	24.3 to 99.7	175	$13.33
2	62.0 to 99.7	99	13.20
	24.3 to 61.9	76	13.66
3	74.6 to 99.7	48	13.11
	49.5 to 74.5	109	13.40
	24.3 to 49.4	18	14.57

Some examples further illustrate the impact of these alternative groupings. Using three groups, we found that 12 of the 18 homes with more than 50 percent skilled care residents would have their reimbursement increased by an average of $34,693 a year. The annual increases would range from $4,880 to $101,850 per home. Conversely, 25 of the 48 homes with 74.6 percent or more intermediate care residents would have their reimbursement decreased by an average of $5,333 a year. The annual reductions would range from $631 to $14,330 per home.

Grouping intermingled homes into two or three groups would not significantly affect Medicaid routine and special service expenses. Dividing intermingled homes into two groups would have increased annual Medicaid costs about $172,656, or 0.2 percent, for the 175 homes we reviewed. Likewise, dividing the same homes into three groups would have increased annual Medicaid costs about $376,563, or 0.5 percent. Thus, rather than significantly increasing Medicaid costs, such groupings would redirect resources to some homes with more skilled care residents and from some homes with more intermediate care residents.

Staffing Standards for Intermingled Homes Do Not Consider Resident Mix

Intermingled homes with high percentages of intermediate care residents may be incurring more nursing costs than necessary because of the state's requirement to staff at a skilled level regardless of resident mix. Although we could not quantify the specific dollar effect, we found that intermediate care residents in intermingled facilities tend to receive more nursing hours of care than their counterparts in free-standing ICFs.

To assess the cost of applying minimum skilled nursing standards to intermingled nursing homes, we first determined that in fiscal year 1984, free-standing SNFs provided an average of 2.7 hours of nursing care a day to each resident whereas free-standing ICFs provided an average of 1.7 hours. Using total days of care, regardless of payment source, we then identified 36 intermingled homes that had greater than two-thirds intermediate care residents. By applying the average nursing hours provided to residents in free-standing SNFs and ICFs to each of the 36 intermingled homes' actual resident mix, and comparing this result to the average per patient nursing hours the homes actually provided, we concluded that nursing costs may have exceeded the demands of the homes' resident mixes in all but 2 of the 36 homes.

By assuming that residents' level of care requirements are essentially the same regardless of physical location—that is, intermediate care residents in both free-standing ICFs and intermingled homes have essentially the same needs—we estimated that in 1984 these 36 homes may have incurred as much as $1.17 million in excess nursing costs. However, the Georgia Health Care Association, which represents proprietary nursing homes, believes this excess cost is overstated because intermediate care residents in intermingled facilities require more care than their counterparts in free-standing ICFs. The association could not document this perceived difference in care requirements.

We attempted to document differences in impairment levels, and associated nursing costs, between intermediate care patients in intermingled homes and similarly classified residents in free-standing ICFs by reviewing a random sample of the state's nursing home preadmission screening forms for persons classified as requiring intermediate care. Our random sample consisted of 110 persons admitted to free-standing ICFs and 110 persons admitted to free-standing intermingled homes. We analyzed the data detailing residents' nursing care requirements at the time of admission, which included indications of medical, mental, and behavioral status.

We found that, at time of admission, intermediate care residents in intermingled homes appear to be more impaired than intermediate care residents in free-standing ICFs. For example, 29 percent of sampled intermediate care residents in intermingled homes were dependent or needed assistance with eating, compared to 17 percent of sampled residents in ICFs. As a result, some additional nursing hours, and associated costs, may be necessary to care for intermediate care residents in intermingled homes. In effect, this may reduce the estimated $1.17 million in excess nursing costs developed by assuming that intermediate care residents in both free-standing ICFs and intermingled homes have essentially the same needs. However, sufficient nursing cost report data were not available to permit us to specifically quantify the effect of these differences on nursing costs.

In view of the state's intent to raise its current skilled nursing standard, the cost implications of basing minimum nursing standards on facility classification rather than residents' nursing requirements may be exacerbated. According to a state official, the state is proposing that, effective July 1986, the minimum nursing standard for SNFs be increased from 2.0 to 2.5 hours of nursing care per patient each day in order to provide additional resources for heavy-care nursing home residents. The official also stated that the suggested minimum standard for ICFs will remain at 1.5 nursing hours per patient day. Because intermingled homes must meet SNF minimum staffing levels, this increased nursing requirement will apply not only to Georgia's SNFs (about 30 facilities) but also to its 217 intermingled homes. For intermingled homes with predominantly intermediate care residents, this may result in a commitment of nursing resources greater than the residents' nursing requirements. Minimum nursing standards should be applied to residents' actual care requirements, rather than the facility's classification.

Conclusions

Georgia should conduct studies or analyses to assure that appropriate grouping methods are used in order to provide more equitable reimbursement rates for intermingled nursing homes. Specifically, establishing additional groupings and reimbursement ceilings for intermingled facilities should result in increased reimbursement levels for some homes with high concentrations of skilled nursing residents, which generally have higher patient care costs, and lower reimbursement levels for some homes with high concentrations of intermediate care residents.

In addition, setting minimum nursing standards for intermingled facilities according to resident mix, rather than facility classification, could

result in reduced nursing costs. Establishing minimum nursing standards based on resident needs is especially important in view of the state's intent to increase the minimum staffing standard for skilled nursing facilities—a requirement that will also apply to intermingled nursing homes.

Recommendation

We recommend that you require Georgia to perform adequate studies or analyses to support its findings and assurances that its payment rates for intermingled nursing homes are reasonable and adequate to meet the costs incurred by efficiently and economically operated homes.

We are sending copies of this report to appropriate Georgia officials and to other interested parties on request. We would appreciate being informed of any actions you plan to take in response to the matters discussed in this report.

Sincerely yours,

James R. Linz
Group Director

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