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# REPORT TO THE CONGRESS

## Need To More Consistently Reimburse Health Facilities Under Medicare And Medicaid

B-164031(4)

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

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AUG. 16, 1974



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

B-164031(4)

To the President of the Senate and the  
Speaker of the House of Representatives

This is our report on the need to more consistently reimburse health facilities under Medicare and Medicaid. Both programs are administered at the Federal level by the Department of Health, Education, and Welfare.

Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

A handwritten signature in cursive script that reads "James B. Stacks".

Comptroller General  
of the United States

## C o n t e n t s

		<u>Page</u>
DIGEST		i
CHAPTER		
1	INTRODUCTION	1
	Administration of Medicare and Medicaid	2
	How hospitals and skilled nursing facilities are paid	4
2	NONUNIFORM APPLICATION OF REIMBURSEMENT PRINCIPLES TO MEDICARE PROVIDERS	5
	SSA interpretations on cost principles not made available to all intermediaries	5
	Regulation and guideline terminology not adequately defined	11
	Conclusions	16
	Recommendations to the Secretary of HEW	17
	HEW comments and our evaluation	17
3	PROGRESS IN EXCHANGING AUDIT INFORMATION UNDER MEDICARE AND MEDICAID	20
	Common audit agreements	20
	Medicare and Medicaid audit information not exchanged in California	21
	Conclusions	25
	Recommendation to the Secretary of HEW	26
	HEW comments and our evaluation	26
	Matters for consideration by the Congress	29
4	SCOPE OF REVIEW	30
APPENDIX		
I	How hospitals and skilled nursing facilities are paid under Medicare and Medicaid	31
II	Example of SSA communication to an intermediary providing specific interpretations of the cost principle on related organizations	36
III	Example of SSA communication to an intermediary providing specific guidance on cost reports for distinct parts of a facility	39
IV	Letter dated June 15, 1973, from the Acting Commissioner of Social Security to the General Accounting Office	41

APPENDIX

V	Letter dated March 25, 1974, from the Assistant Secretary, Comptroller, Department of Health, Education, and Welfare to the General Accounting Office	46
VI	Principal officials of the Department of Health, Education, and Welfare responsible for administering activities discussed in this report	50

ABBREVIATIONS

AHA	American Hospital Association
ECF	extended care facilities
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
SNF	skilled nursing facility
SRS	Social and Rehabilitation Service
SSA	Social Security Administration

# COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

NEED TO MORE CONSISTENTLY  
REIMBURSE HEALTH FACILITIES  
UNDER MEDICARE AND MEDICAID  
Department of Health, Education,  
and Welfare  
B-164031(4)

## D I G E S T

### WHY THE REVIEW WAS MADE

About \$33.6 billion in Medicare benefits were paid from July 1966 through June 1973 for care provided in hospitals and skilled nursing facilities (SNFs). Medicaid payments for hospital and SNF care from January 1966 through June 1973 totaled about \$22 billion, including a Federal share of about \$11.3 billion.

Department of Health, Education, and Welfare (HEW) regulations have required that most Medicare and Medicaid payments to hospitals and Medicare payments to SNFs be based on the same reasonable cost criteria. Neither Federal law nor HEW regulations have required that Medicaid payments to SNFs be made in accordance with the Medicare reasonable cost criteria.

GAO reviewed reimbursements to proprietary hospitals and SNFs because of the many controls which have been built into the reimbursement process dealing with cost reimbursement problems unique to such institutions.

### FINDINGS AND CONCLUSIONS

#### Basic facts

Most Medicare payments were made by 10 private organizations (called intermediaries) under contracts with HEW, including the Blue Cross Association and 73 Blue Cross plan subcontractors. Medicaid payments were made by 49 States, 4 other

governmental jurisdictions, or their subcontractors--called fiscal agents.

At the Federal level, both programs are administered by HEW. Medicare is administered by HEW's Social Security Administration (SSA) and Medicaid is administered by HEW's Social and Rehabilitation Service (SRS).

GAO reviewed 3 Medicare intermediaries, 5 subcontract intermediaries, 4 State Medicaid agencies, 11 proprietary (for profit) hospitals, and 19 proprietary SNFs to find out whether Medicare and Medicaid payments to hospitals and the Medicare payments to SNFs were made on a uniform and equitable basis by the various agencies, their contractors, and subcontractors.

In California, which was one of about 20 States or jurisdictions where there was no arrangement for exchanging audit information between Medicare and Medicaid, GAO reviewed the programs' audits for an additional 27 proprietary hospitals to assess the problem.

#### Need for SSA to give wider distribution of its advice on Medicare reimbursement matters

Intermediaries, using the same published SSA guidelines, made different interpretations about whether and how much of certain costs were allowable or reimbursable by Medicare. In some cases the inconsistent treatment resulted in overpayments for several years.

Of the 30 hospitals and SNFs reviewed, GAO identified Medicare and Medicaid overpayments of \$1,000 or more totaling about \$648,000 at 18 institutions. (See p. 5.)

Although these overpayments had occurred for a variety of reasons, GAO noted instances where overpayments might have been avoided or discovered earlier by an intermediary had SSA's advice to one intermediary on a specific reimbursement question been made available to others. For example:

--SSA informed one intermediary that all SNF service was to be considered a routine service cost and not a special service (ancillary) cost. Another intermediary, unaware of SSA's advice on this matter, permitted an SNF to include part of its nursing service expense in ancillary costs.

Medicare's share of the ancillary costs was more than its share of the routine costs. This resulted in Medicare overpayments over a 5-year period totaling \$102,000. (See p. 6.)

--Medicare does not recognize profits involved in transactions between organizations related by common ownership or control as a reimbursable cost. An intermediary was given SSA's advice in a case where a lease was negotiated between related organizations and the lease remained in effect after the relationship between the lessor and the lessee was dissolved.

SSA concluded that since the original lease was not negotiated at "arm's length," the intermediary should not pay the lease charges but should limit Medicare reim-

bursement to the lessor's costs.

Another intermediary, with a similar situation, was unaware of the above SSA advice and overpaid an SNF about \$62,000 over a 2-year period. (See p. 8.)

Although not identified with specific Medicare overpayments, GAO noted other instances where important SSA advice to one intermediary was not made available to all intermediaries. (See p. 9.)

#### New legislation

In October 1972, the Congress enacted the Social Security Amendments of 1972 which included authorization for a Provider Reimbursement Review Board. This Board is to review and adjudicate disputes concerning intermediaries' determinations of the allowability of costs claimed under Medicare for annual reporting periods ending on or after June 30, 1973. (See p. 33.)

This Board could function more effectively if it had available, in a codified and usable form, all precedent setting interpretations, decisions, and advice by SSA. (See p. 16.)

#### Regulation and guideline terms not adequately defined

SSA has not adequately guided intermediaries in interpreting such terms as "excessive" and "reasonable." These and similar judgmental terms appear throughout the regulations and related guidelines.

GAO noted that in determining costs to be allowed, intermediaries applied widely varying interpretations in defining reasonable owners' compensation (see p. 11) and often ignored the

requirement for considering excessive cash on hand in computing payment for return on owners' equity. (See p. 14.)

GAO recognizes the difficulties inherent in establishing uniform definitions but believes a more consistent and fairer administration of Medicare could be achieved if SSA were to develop more definitive guidelines.

#### Progress in exchanging Medicare and Medicaid audit findings

Progress has been made in achieving a single common audit of individual hospitals--with audit costs shared by Medicare and Medicaid.

There was no apparent systematic exchange, however, of audit information in about 20 States and jurisdictions where the common-audit arrangement did not exist or where audits were not made by the same organization functioning as an intermediary and as a fiscal agent. (See p. 21.)

In California, where audits for Medicare and Medicaid were made by two separate organizations, GAO's comparison of these audits for 27 proprietary hospitals showed that the combined program expenditures could have been reduced by \$352,000 if each organization had used the other's audit adjustments in settling the hospitals' claims. (See p. 21.)

In March 1973 GAO brought this problem to SSA's attention and SSA acknowledged that to provide an incentive for the States to join in a common audit, thus reducing audit costs, it had been reluctant to provide Medicare audit information to the States free of charge.

SSA advised GAO, however, that pending completion of certain studies, audit information would be exchanged by the two programs in California. (See p. 24.)

The Social Security Amendments of 1972 amended the Medicaid law so that States could develop their own reasonable cost criteria for paying inpatient hospital care, provided the costs do not exceed amounts determined as reasonable under Medicare. This provision can be complied with at individual hospitals only if the States are made aware of Medicare's audit findings. (See p. 25.)

#### RECOMMENDATIONS

GAO recommends that the Secretary of HEW direct SSA to:

- Catalog and make available on request to intermediaries, Medicaid State agencies, providers, and the Provider Reimbursement Review Board all SSA decisions or specific interpretations affecting determination of Medicare's share of hospital or SNF costs. (See p. 17.)
- Establish more definitive guidelines and criteria for intermediaries to follow in making judgmental decisions involving reasonable owners compensation and excessive cash. (See p. 17.)

The Secretary should also direct that SSA and SRS:

- Require a full exchange of Medicare and Medicaid audit information when no common audit agreement has been reached between a Medicare intermediary and a Medicaid State agency or its fiscal agent. (See p. 26.)

## AGENCY ACTIONS AND UNRESOLVED ISSUES

Actions proposed by HEW are generally responsive to the recommendation for providing intermediaries with more definitive guidelines in making judgmental decisions.

HEW said SSA did not distribute advice given to one intermediary on a specific question to all intermediaries because the questions raised dealt with a given case and did not have general application. Also, SSA letters did not contain the substantial factual material needed to make them useful as precedents. However, GAO believes that these letters would be understandable to intermediary personnel specializing in reimbursement matters--at least as a basis for identifying the basic issues involved. (See p. 17.)

GAO also believes that determining whether a specific question raised by an intermediary has general application is relative because there are over 10,000 hospitals and SNF's participating in Medicare. Further, the program has been operating about 8 years and, hopefully, most reimbursement questions having general applicability have been identified and resolved.

Regarding the full exchange of Medicare and Medicaid audit information, HEW said its future progress in negotiating common audit agreements with State Medicaid programs was contingent on its policy to charge Medicaid agencies that did not join in common audits for any Medicare audit information they requested.

When audit information already developed by one federally supported program could be beneficial in reducing the costs to another, such

information should be exchanged, particularly since the Federal Government pays at least 50 percent of the allowable Medicaid administrative and medical assistance costs.

Timely identification and recovery of overpayments to providers under Medicare and Medicaid should be a principal matter of concern to HEW. As of September 30, 1973, Medicare overpayments to providers, identified through audit and desk reviews of cost reports, amounted to about \$208 million, of which \$105 million was not recovered.

About half of the \$208 million in overpayments was applicable to providers in those States and jurisdictions with no apparent systematic exchange of audit information. This suggests that substantial overpayments identified during Medicare audits may not have been communicated to Medicaid. It is also possible that Medicare audit coverage could be enhanced through the exchange of audit information with Medicaid. (See p. 27.)

GAO believes a recent SSA decision to make Medicare audited and unaudited cost reports available to the general public tends to compromise HEW's rationale for not exchanging Medicare audit information with Medicaid free of charge. (See p. 28.)

## MATTERS FOR CONSIDERATION BY THE CONGRESS

In view of previous congressional actions aimed at improving coordination between the Medicare and Medicaid programs (see p. 28) and the decision to make Medicare audited and unaudited cost reports available to the general public, legislative committees having jurisdiction over these programs may wish to further discuss the full exchange of audit information with HEW officials.

## CHAPTER 1

### INTRODUCTION

The Social Security Amendments of 1965, approved July 30, 1965, established title XVIII (Medicare) and title XIX (Medicaid) of the Social Security Act (42 U.S.C. 1395 and 1396). The Medicare and Medicaid programs were established to protect eligible persons against the costs of health-care services.

The Medicare program, as originally enacted effective July 1, 1966, helped finance health care for eligible persons aged 65 and over. The Social Security Amendments of 1972 (86 Stat. 1329) extended Medicare protection (effective July 1, 1973) to (1) individuals who have received social security cash benefits for at least 24 consecutive months because they were disabled and (2) individuals with chronic kidney disease.

The Medicare program provides for two basic forms of health care protection. One form of protection, designated as Hospital Insurance Benefits for the Aged and Disabled (part A), covers inpatient hospital services and post-hospital care in skilled nursing facilities (SNF's) and in the patients' homes. Part A benefits are generally financed by special social security taxes collected from employees, employers, and self-employed persons. During fiscal years 1967 through 1973, benefit payments under part A were about \$33.9 billion, of which about \$31.7 billion was for inpatient hospital services, \$1.9 billion was for skilled nursing care, and \$.3 billion for home health services.

Under part A the beneficiary is responsible for paying a deductible of \$84 for the first through the 60th day of inpatient hospital services, coinsurance of \$21 a day for the 61st through the 90th days during a benefit period, and \$42 a day for the 91st through the 150th days if he elects to use his 60-day lifetime reserve of hospital benefits 1/.

Part A also covers skilled nursing care provided to a beneficiary admitted to an SNF after a hospital stay of at least 3 consecutive days. Part A benefits pay for all covered services in an SNF for the first 20 days and all but \$10.50 a day for up to 80 more days during a benefit period.

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1/ Medicare covers up to 90 days of hospital bed care for each benefit period. A benefit period starts when the beneficiary is admitted to a hospital and ends when the beneficiary has not been a bed patient in a hospital (or facility mainly providing skilled nursing care) for 60 consecutive days. There is no limit to the number of benefit periods a beneficiary may have. On the other hand, the lifetime reserve of 60 additional days is like a bank account of extra days which can be drawn upon if needed. Each lifetime reserve day used permanently reduces the total remaining.

A second form of Medicare protection, designated as Supplementary Medical Insurance Benefits for the Aged and Disabled (part B), is a voluntary program and covers (1) physicians' services, including physicians employed by or compensated through hospitals, and (2) a number of other medical and health benefits, including outpatient hospital services and certain home health care. Part B is financed by premiums collected from each eligible beneficiary electing to be covered by the program and by matching amounts appropriated from the general revenues of the Federal Government. During fiscal years 1967 through 1973, benefit payments under part B were about \$12.4 billion, of which about 90 percent was for physicians' services.

Under part B usually the beneficiary is responsible for paying the first \$60 for covered medical services in each year (the deductible). Medicare pays 80 percent of the reasonable charges for covered services in excess of the \$60 deductible (\$50 before January 1, 1973) in each year with the beneficiary responsible for the remaining 20 percent (coinsurance).

Under Medicaid, a grant-in-aid program which became effective January 1, 1966, the Federal Government shares with the States the costs of providing medical assistance to persons--regardless of age--whose incomes and resources are insufficient to pay for health care.

State Medicaid programs are required by the Social Security Act to provide inpatient and outpatient hospital services, laboratory and X-ray services, SNF services, physicians' services, home health-care services, family planning services, and early and periodic screening and treatment of eligible persons. Additional services, as specified by the act, may be included in its Medicaid program if a State so chooses.

In fiscal year 1973 about 23.5 million people received Medicaid benefits in 49 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. The only State without a Medicaid program is Arizona. Depending on the per capita income in each State, the Federal Government pays from 50 to 81 percent of the costs incurred by the States under their Medicaid programs. During fiscal years 1966 through 1973, Medicaid benefit payments for inpatient hospital care totaled about \$13.3 billion, of which the Federal Government funded about \$6.8 billion. During this period Medicaid payments to SNFs totaled about \$8.7 billion including the Federal share of about \$4.5 billion.

#### ADMINISTRATION OF MEDICARE AND MEDICAID

The Department of Health, Education, and Welfare (HEW) has overall responsibility for administering Medicare and Medicaid at the Federal level. Within HEW the Social Security Administration (SSA) administers Medicare and the Social and Rehabilitation Service (SRS) administers Medicaid. SSA and SRS are responsible for developing program policies, setting standards, and insuring compliance with Federal legislation and regulations.

## Medicare

HEW contracted with various private organizations to act as intermediaries in the administration of Medicare payments involving institutional providers, such as hospitals and SNFs. The intermediaries' responsibilities include

- paying the providers, at least monthly, on an estimated cost basis for covered services furnished to Medicare beneficiaries,
- consulting with providers to develop accounting procedures which will insure that the providers receive equitable payment under the Medicare program,
- communicating to providers information or instructions furnished by the Secretary of HEW and serving as a channel of communication from the provider to the Secretary,
- making the necessary audits of the providers' records to insure proper payment, and
- making final annual determinations, usually on the basis of audits, of the amounts of payments to be made to or amounts due from the providers.

SSA reimburses intermediaries for administrative costs incurred in performing these various functions. During fiscal years 1967 through 1973, the intermediaries' administrative costs to Medicare amounted to about \$594 million, of which about 27 percent was for auditing the records of hospitals and other institutional providers of services.

As of June 30, 1973, SSA had contracted with 10 private organizations to act as intermediaries for 6,592 hospitals and 3,911 SNFs. In addition, 181 hospitals and 82 SNFs had elected to deal directly with SSA. The number of hospitals and SNFs serviced by the various intermediaries is summarized in the following table.

<u>Intermediary</u>	<u>Hospitals serviced</u>	<u>SNFs serviced</u>
Blue Cross Association	6,154	2,133
Mutual of Omaha Insurance Company	26	670
The Travelers Insurance Company	114	559
Aetna Life and Casualty	141	366
The Prudential Insurance Company of America	35	79
Nationwide Mutual Insurance Company	8	73
Inter-County Hospitalization Plan, Inc.	51	13
Hawaii Medical Service	26	14
Kaiser Foundation Health Plan, Inc.	23	3
Cooperativa de Seguros de Vida de Puerto Rico	14	1
Total	<u>6,592</u>	<u>3,911</u>

The Blue Cross Association has subcontracted most of its intermediary functions to 73 local Blue Cross plans.

### Medicaid

The States are responsible for initiating and administering their Medicaid programs. The nature and scope of a State's Medicaid program are contained in a State plan which, after approval by HEW, provides the basis for Federal grants to the State.

The States may contract with private organizations to help administer their programs. The responsibilities assigned to the contractors, referred to as fiscal agents, may vary depending on the contractual arrangements established by the States. Some States administer the entire program through their State agencies.

### HOW HOSPITALS AND SKILLED NURSING FACILITIES ARE PAID

Under HEW regulations Medicare and Medicaid are to reimburse hospitals on the basis of reasonable costs determined by the same rules and guidelines. Medicare also pays SNFs' reasonable costs under those rules and guidelines, whereas Medicaid pays SNFs under widely varying methods. The Social Security Amendments of 1972, enacted in October 1972, authorized more diversity between the two programs in paying for hospital services but encouraged more uniformity in paying for SNF services. Further, the 1972 amendments authorized a Provider Reimbursement Review Board to resolve disputes involving Medicare reimbursements to hospitals and SNFs.

We made our review to determine the extent that federally prescribed regulations and guidelines governing Medicare and Medicaid reimbursement to participating institutions were being consistently applied by the various Medicare intermediaries and, where applicable, by the various State Medicaid paying agencies.

Additional information on the methods of payment under the two programs and on recent pertinent legislative changes is contained in appendix I.

## CHAPTER 2

### NONUNIFORM APPLICATION OF REIMBURSEMENT

#### PRINCIPLES TO MEDICARE PROVIDERS

Intermediaries, using the same published guidelines, made different interpretations about whether and how much of certain costs were allowable or reimbursable under the Medicare program. As a result, hospitals and SNFs were not treated uniformly with regard to the amount of payments received. In some cases, the inconsistent treatment resulted in substantial overpayments over several years.

The reasons for differing interpretations and related payments to providers included:

- SSA had not, in many cases, made available to all intermediaries timely advice on specific cost and reimbursement interpretations that it had furnished to a single intermediary.
- SSA had not adequately defined certain terminology used in the regulations and guidelines, such as, "excessive" and "reasonable."

#### SSA INTERPRETATIONS ON COST PRINCIPLES NOT MADE AVAILABLE TO ALL INTERMEDIARIES

Intermediaries needing assistance in interpreting the regulations and related guidelines may seek advice directly from SSA. These requests for assistance are usually generated in cases where

- the regulations and guidelines are unclear or appear to be in conflict with each other,
- the hospital or SNF representatives do not agree with the intermediaries' interpretations,
- the fairness of the guidelines might be questioned, and
- the guidelines are allegedly in conflict with generally accepted accounting principles.

SSA directs its response on each inquiry to the requesting intermediary. Such advice is not communicated to others unless SSA considers it to have general application to other intermediaries or providers. There were instances when the SSA advice was restricted to one intermediary when it would have been beneficial to others. This has contributed to (1) program overpayments and underpayments to hospitals and SNFs and (2) inconsistent treatment of hospitals and SNFs in similar circumstances.

Of the 30 hospitals and SNFs included in our review, we identified Medicare and Medicaid overpayments of \$1,000 or more at 18 institutions. These overpayments totaling about \$648,000 <sup>1/</sup> applied to 7 hospitals (\$73,000) and 11 SNFs (\$575,000) and in some instances were applicable to several years' audited costs reports. Although these overpayments had occurred for a variety of reasons, including some of the same reasons discussed in an earlier GAO report dealing with hospital reimbursement under Medicare <sup>2/</sup>, and often involved rather complicated reimbursement issues, we noted a number of instances where such overpayments might have been avoided or identified earlier had SSA's advice to one intermediary on a specific reimbursement question been made available to others.

Examples of SSA advice to one intermediary which could have been beneficial to other intermediaries follow.

#### Classifications of nursing service costs

In 1968 one intermediary included in our review requested SSA to review the validity of an SNF's contention that it be allowed to include nursing service costs as an ancillary rather than a routine service cost. Under the apportionment method used by the SNF, Medicare's share of ancillary costs would have been greater than the program's share of routine service costs. Therefore, the more costs the SNF could charge to ancillary costs, the higher the SNF's reimbursement from Medicare.

The SNF official was aware that SSA guidelines provided that nursing be considered as a routine service; however, he expressed the opinion that other SSA directives conflicted with this position.

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<sup>1/</sup>Our findings were discussed with and turned over to the cognizant intermediaries for corrective action. Our followup indicated that as of June 30, 1973, at least \$238,000 had been recovered and other recoveries were pending.

<sup>2/</sup>Our earlier report entitled "Problems Associated with Reimbursements to Hospitals for Services Furnished under Medicare," (B-164031(4), Aug. 3, 1972), indicated the need for improved Medicare hospital audits because overpayments resulted from (1) the inclusion of nonallowable and nonpatient care expenses, (2) the failure to offset certain nonpatient care revenues against allowable costs, (3) inequitable costs' allocations between patient and nonpatient care activities, and (4) inaccurate statistical data used in preparing cost reports. In addition to the comparable examples cited on pages 6 and 7 in this report, about \$104,000 of the overpayments identified in this review were related to the same problem areas.

SSA reviewed the facts and arguments in the above case and in a February 1969 letter to the intermediary, advised that nursing service costs could not be allocated to an ancillary service. SSA stated further that other SSA directives did not modify or change the requirement that all SNF nursing services, regardless of the level of care involved, be considered as part of routine services furnished by an SNF.

SSA's advice in this case was neither manualized nor communicated in writing to the other intermediaries. As a result, another intermediary in our review continued to permit one of its SNFs to charge part of its nursing costs to various ancillary cost centers. This resulted in Medicare overpayments to the SNF over a 5-year period totaling \$102,000.

Representatives of the intermediary said they were unaware of SSA's February 1969 decision.

#### Change in method of allocating mortgage interest expense

An SSA cost reimbursement interpretation given to one intermediary in effect changed the method by which mortgage interest expense was allocated to Medicare and non-Medicare reimbursable activities carried out in the same building, such as a hospital or SNF. This change, however, was not communicated to other intermediaries until a year later.

The old allocation method permitted mortgage interest expense to be distributed to various activities or cost centers on the basis of the total direct costs (salaries, supplies, etc.) plus depreciation expense identified with each cost center. Using this method, mortgage interest expense allocated to activities where Medicare does not share in the costs (private offices and private clinics that are operated by entities other than the hospitals) was grossly understated because the cost centers had very little or no direct expense but may have taken up considerable space.

One intermediary believed that it would be more appropriate to allocate mortgage interest expenses on the same basis as depreciation (square feet) and therefore requested SSA to review the matter. In December 1971 SSA said that the old allocation method was originally developed on a basis recommended in a 1957 American Hospital Association (AHA) publication but that a 1968 revision of the AHA publication recommended mortgage interest be allocated on the same basis as building depreciation expense. Therefore, SSA concurred with the intermediary's proposal that mortgage interest be allocated on the same basis as depreciation. 1/

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1/We noted that before this intermediary received SSA's advice, one SNF included in our review had received about \$7,800 more than it otherwise would have received because mortgage interest expense was allocated to non-Medicare activities on the basis of direct costs rather than on the basis of square feet.

This SSA advice was not manualized or otherwise formally communicated in writing to the other intermediaries until December 1972 by a letter containing various changes in the cost reporting format. One of the hospitals in our review did not allocate its mortgage interest expense between the hospital and a clinic located in the same building in accordance with the AHA and SSA recommended method. As a result, Medicare overpaid the hospital \$1,700.

#### Transactions between related organizations

HEW regulations provide that, with some exceptions, transactions between organizations related to each other--directly or indirectly by significant affiliation, ownership, or control--are includable in the provider's allowable costs at the cost to the related organization. In these cases, however, ownership costs may not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

In an earlier review <sup>1/</sup>, we requested SSA to make a determination in a case where a lease was negotiated between related organizations and where the lease remained in effect after the relationship between the lessor and lessee was dissolved. In February 1972 SSA concluded that since the terms of the lease were not originally negotiated at "arm's length" the lease payments were not an allowable cost for Medicare reimbursement purposes. Accordingly, SSA advised the intermediary to disallow the rental charges and substitute ownership costs--depreciation, insurance, property taxes, etc.--as allowable Medicare expenses. (See app. II.)

Another intermediary, included in this review, had a similar situation. A lease had been negotiated between related organizations and the relationships were later dissolved through subsequent sales of stock. The lease agreements involved three facilities which the same SNF organization operated. Although this intermediary had not investigated the facts of this case, by applying the related organization rule, Medicare's share of the cost was overstated for a 2-year period by about \$62,000.

As late as August 1972, this intermediary was unaware of SSA's position that a relationship which existed at the time the lease was negotiated was considered to be significant even after the relationship was dissolved. After we brought the facts and SSA's February 1972 opinion to the intermediary's attention, the intermediary took action to recover the overpayments and to make appropriate adjustments on all unsettled and future cost reports.

#### Early year operating losses cannot be considered as startup costs

One intermediary included in our review had incorrectly permitted an SNF to classify early year operating losses as startup costs which can

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<sup>1/</sup>Report to the Commissioner of Social Security dated December 22, 1971.

be amortized by a provider and reimbursed by Medicare. As a result of this incorrect interpretation, the intermediary overpaid the SNF about \$154,100 over a 5-year period.

SSA defines startup costs as costs to operate and maintain an institution from its creation until the first patient--Medicare or non-Medicare--is admitted. For institutions in existence before July 1966, such costs may be capitalized as deferred charges and amortized over 60 months starting with the month in which the first patient is admitted.

Between 1967 and 1971, one SNF amortized \$287,900 in startup costs. The \$287,900 represented operating losses incurred--from November 1965 through December 1966--before the SNF's participation in the Medicare program. Of this amount \$154,100 was charged to the Medicare program.

A senior accountant of the accounting firm representing the SNF advised us that he was aware that early year operating losses were not within SSA's definition of startup costs. He argued, however, that it was a generally accepted accounting principle for businesses to amortize such losses over the profitable years. He stated further that he believed a few other SNF's followed the same practice; however, he was unaware of specific instances where it was being done.

In June 1972 we brought the facts of this case to the attention of SSA representatives who concluded that a loss is not a cost but only the excess of costs over revenues. SSA further noted that startup costs, as defined in Medicare guidelines, include only preopening expenses, and do not include any costs incurred after the first patient, whether Medicare or non-Medicare, was admitted for treatment.

We suggested that SSA widely distribute its advice in this case because of the possibility that the practice was not limited to the institution included in our review. At that time an SSA representative said that SSA would direct its written response to the Blue Cross Association, the prime contractor, who then could inform the local Blue Cross intermediary involved in this case as well as other Blue Cross plan intermediaries. The SSA opinion was dated July 5, 1972, and was addressed only to the local Blue Cross subcontractor. We believe this SSA advice should have been made available to all intermediaries.

We were informed that the local intermediary agreed with SSA's advice and has recovered the \$154,100 in Medicare overpayments.

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Other SSA determinations not made available to all intermediaries

SSA has advised individual intermediaries on various other Medicare cost principle clarifications and interpretations which were not generally

made available to all intermediaries. Examples of such SSA advice, for which we did not identify specific cases of Medicare overpayments, but which we believe would have been of benefit to all intermediaries included:

- An April 1970 opinion that where a facility is certified and qualified to participate in Medicare in its entirety, it must file a cost report for the entire facility and not for a distinct part of the facility. (See app. III.)
- A June 1970 opinion that the costs of an abandoned expansion program may be charged to current expenses rather than capitalized.

REGULATION AND GUIDELINE  
TERMINOLOGY NOT  
ADEQUATELY DEFINED

SSA has not usually defined terms such as "significant," "excessive," "appropriate," and "reasonable." These and similar terms appear throughout the HEW reimbursement regulations and related SSA guidelines. Two reimbursement requirements containing undefined terms which posed problems to intermediaries involved determining (1) what constituted reasonable owners' compensation and (2) what represented excessive uninvested cash on hand for the purpose of computing return on equity to proprietary institutions.

We noted that intermediaries have applied widely varying interpretations to such terms or have simply ignored the related requirements. In either event, this has resulted in unequal treatment being given to hospitals and SNFs participating in Medicare.

Intermediaries' different interpretations  
of reasonable owners' compensation

The allowability of the amount of compensation paid to owners of proprietary facilities is one of the major areas of differing interpretations among intermediaries. The regulations provide that a reasonable allowance of compensation for owners' services is an allowable cost provided that the services are necessary and are actually performed.

SSA has established, by geographic areas, ranges of reasonable compensation allowable to owner-administrators. These ranges were based on intermediary surveys of administrator salaries paid by proprietary and nonproprietary institutions in the same geographical areas.

Intermediaries are responsible for determining where, within the range of reasonable compensation, an individual owner should be placed. The intermediary is to consider factors such as the owner's actual duties, education, and experience. Compensation outside the approved range is only permitted in unusual circumstances, such as when certain characteristics of the facility or the special qualifications or experience of the owner do not facilitate comparison with others.

For positions other than top executive positions, SSA expects the intermediaries to have adequate knowledge of the general range of compensation being paid.

Intermediaries use different techniques and formulas to determine when and how much owners' compensation is allowable. The reasonable amount eventually allowed will often differ depending on how the intermediaries resolve the following difficult questions:

- Within the range established by SSA, how much compensation is reasonable for a given facility in a given location?
- How many administrative positions, other than administrator, are necessary and how much owners' compensation for these positions is reasonable?
- What constitutes a full-time administrator: 40 hours a week or consideration of total hours a week actually worked?

Use of SSA-approved compensation ranges for a given facility

Three of the eight intermediaries included in our review, determined allowable owner-administrator compensation by applying formulas and point systems to the SSA-approved range of compensation. These point systems used certain numbers of points up to specified maximums for such factors as years of experience, level of formal education, and the degree of other duties. Four other intermediaries applied the range of compensation on the basis of their best judgment. However, one of the four increased the range by 12 percent--to cover fringe benefits--before applying its best judgment.

The remaining intermediary did not use the SSA-established range to determine the reasonableness of compensation. An official of this intermediary stated that the guidelines were to be applied only to proprietary institutions and his definition of a proprietary institution was an institution having only one owner (sole proprietorship). He indicated that this intermediary applied its best judgment regarding the allowability of owner's compensation on a case-by-case basis. SSA's manualized instructions define proprietary as being operated for profit.

The different methods used to determine allowable owner-administrator compensation resulted in widely varying treatment of owner-administrators in similar circumstances. For example, one facility was located in an area where the SSA-approved compensation range for that size of facility was between \$10,600 and \$19,080. The intermediary, which did not use the SSA-approved compensation range as a guide, allowed \$31,900 in owners' compensation for the board chairman and medical director, each of whom claimed to spend 60 percent of his time on facility activities.

Another intermediary (a Blue Cross plan) which used the Medicare criteria for determining allowable owners' compensation in paying this same facility under its commercial health insurance policies allowed only \$1,360 in owners' compensation, because the facility employed a full-time administrator. The \$1,360 allowance plus the administrator's salary equaled the \$19,080 amount provided for by the SSA-approved compensation range. The effect on Medicare payments of this difference in interpretation was about \$12,000 a year.

Compensation for  
non-administrator positions

Three intermediaries had guidelines establishing reasonable compensation for owner-assistant administrators but none had established guidelines on how many assistant administrators, or business directors were needed by various types and sizes of facilities.

Of the intermediaries which established guidelines for assistant administrators, two established the rate at 75 percent of the administrative salary guideline for the administrator's position. The third intermediary established a range based on the ratio of salaries for administrators and assistant administrators developed by the State for its medical assistance programs before Medicaid. Depending on the size of the facility, this intermediary allowed assistant administrators anywhere from 66 percent to 94 percent of the administrator's salary range. Only one intermediary had established guidelines of allowable owners' compensation paid for positions other than administrators and assistant administrators.

Four intermediaries used their best judgment in dealing with the question and, as indicated on page 12, the remaining intermediary ignored the problem entirely.

What constitutes a  
full-time administrator?

Intermediaries also differ in how much time an owner must devote to his facility to be considered a full-time administrator. In 1971 a technical advisory group made up of representatives of commercial insurance companies which also function as Medicare intermediaries, made a survey of owners' compensation policies followed by their companies.

The results of the study showed that two intermediaries considered an owner to be a part-time administrator if he devoted any working hours to activities other than the hospital or SNF. For example, if an owner worked a total of 40 hours per week as an administrator and 20 hours per week at another job, these two intermediaries consider him to be a part-time administrator and therefore eligible for only two-thirds (40 hr.) ÷ (60 hr.) of the approved owner-administrator salary range. The other three intermediaries responding to the survey would have considered the 40 hours of administrative activities to make the owner eligible for the full amount of the owners' compensation approved for a full-time administrator.

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Notwithstanding the inherent difficulties in establishing uniform answers to the foregoing complex and perhaps controversial questions, we believe that a more consistent and fairer administration of Medicare

could be achieved if SSA, after consulting its intermediaries, were to develop more definitive guidelines for intermediaries to follow in determining reasonable owners' compensation.

Excessive uninvested cash on hand

Under the Medicare and Medicaid programs, proprietary hospitals <sup>1/</sup> are allowed a return on equity capital which is used in providing patient care. The percentage of return on equity capital for Medicare purposes is equal to one and one-half times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the providers' reporting period.

The amount of return varies depending on the time covered by a cost reporting period. For example, the allowable rate of return for annual reporting periods ending between January 1 and December 31, 1973, ranged from about 9 percent to 10 percent.

According to the regulations assets not related to patient care are to be excluded from equity capital. Such assets would include property held for future expansion, investments, and excessive working capital which would include cash balances. Officials of two intermediaries said they did not try to evaluate the amount of excess uninvested cash included in owners' equity, because SSA has not defined what constitutes cash excessive to patient needs.

In the absence of an established criteria, we did not attempt to determine whether the facilities serviced by the intermediaries included in our review had been overpaid because of excessive cash amounts on hand. We did note, however, that the amount of cash on hand varied significantly. An analysis of 115 proprietary hospital cost reports settled by 3 of the intermediaries included in our review for reporting periods ending 1968, 1969, and 1970 showed cash balances ranging from 0 to \$4,600 per bed.

<u>Uninvested cash per bed</u>	<u>Number of hospital cost reports</u>	<u>Percent</u>
\$ 0 - \$1,000	74	65
1,001 - 2,000	23	20
2,001 - 3,000	6	5
3,001 - 4,000	5	4
4,001 - 4,600	7	6
Total	<u>115</u>	<u>100</u>

<sup>1/</sup>Similar allowances are authorized for proprietary SNF's under Medicare and may be authorized under Medicaid if the State had adopted Medicare's reimbursement principles for paying SNF's.

As shown in the above schedule, 10 percent of the cost reports indicated that certain facilities had more than \$3,000 cash on hand for each bed. This represented from 42 to 118 days of operating cash on hand which appeared high for normal working capital requirements.

We recognize that situations exist where large yearend cash balances may be justified; however, we are concerned that these large amounts are not identified and evaluated by the intermediaries because of a lack of guidance from SSA.

The need for intermediary evaluation and SSA guidance was demonstrated when partners of two accounting firms said they advised their clients not to invest excess cash in income producing activities when a larger return can be received from return on equity.

The circumstances under which it would be to the provider's advantage to retain excess cash are demonstrated below by using the following set of assumptions.

- A provider has \$200,000 which he is considering investing in 6-percent certificates of deposit yielding \$12,000 in per annum interest income.
- The provider also has \$50,000 of allowable interest expenses which, under Medicare regulations, would be reduced by any interest income from the certificates.
- Medicare and Medicaid allow the provider a 9-percent return on equity.

The following table shows the amount of return to the provider at various combined Medicare and Medicaid percentages of use--if the \$200,000 of excess cash was invested at interest as compared with the reimbursement that the provider would receive from Medicare or Medicaid or if the \$200,000 in excess cash was not invested and kept on hand for computing return on equity.

Percent of total Medicare or Medicaid utilization (note a)	Return to provider if \$200,000 is invested and interest-income is deducted from interest expense			Medicare or Medicaid reimburse- ment to provider if \$200,000 is left in assets for payment of return on equity			Additional or less income to provider if funds were not invested
	Medicare or Medicaid reimbursement of			Interest expense	Return on equity	Total	
	net interest expense	Interest income	Total				
35	\$13,300	\$12,000	\$25,300	\$17,500	\$6,300	\$23,800	-\$1,500
40	15,200	12,000	27,200	20,000	7,200	27,200	0
45	17,100	12,000	29,100	22,500	8,100	30,600	1,500

a/The additional income to the provider will increase \$1,500 for each 5-percent increase in Medicare or Medicaid utilization rate.

A savings to the Medicare and Medicaid program is realized when excessive cash is invested because (1) allowable interest expense is reduced by the amount of interest income and (2) invested funds cannot be included in computing owners' equity. Using the information in the

BEST DOCUMENT AVAILABLE

preceeding schedule, the savings to the Medicare and Medicaid programs if the funds are invested would be:

<u>Percent of Medicare or Medicaid utilization</u>	<u>Cost to the programs if funds are invested</u>	<u>Cost to the programs if funds are left in assets for payment of return on equity</u>	<u>Savings to the programs if funds are invested</u>
35	\$13,300	\$23,800	\$10,500
40	15,200	27,200	12,000
45	17,100	30,600	13,500

As shown by the preceeding table, the cost to the Medicare and Medicaid programs is out of proportion to the potential financial benefit to the provider of not investing excess cash. The potential significance of increased program costs makes it important that excessive cash balances be identified and eliminated from allowable equity capital. Accordingly, SSA should (1) provide intermediaries with specific guidance in identifying cash balances in excess of patient needs, and/or (2) require providers to justify the need for their un-invested cash balances.

## CONCLUSIONS

Intermediaries differ in their interpretation and implementation of cost reimbursement principles as set forth in the Medicare law, regulations, and instructions. To the extent that State-administered Medicaid programs use Medicare reimbursement criteria, they could also make varying cost reimbursement interpretations.

The various interpretations resulted in part because:

- SSA has not, in many instances, provided all intermediaries with its interpretations of the law, regulations, and instructions.
- SSA has delegated to the intermediaries the responsibility for making certain judgmental decisions such as how many hours must be worked before an owner-administrator can be considered a full-time employee.

We recognize that precise uniformity in all applications of the Medicare reimbursement principles is neither practicable nor perhaps desirable. On the other hand, it is reasonable to expect that institutions will be treated equally under similar circumstances--particularly since variations in interpretations has meant differences in reimbursement to individual providers of tens of thousands of dollars.

Further, in order for the newly authorized Provider Reimbursement Review Board to function effectively, it seems important that the Board have available for its consideration, in a codified and usable form, all precedent setting interpretations, decisions, and advice

made by SSA, irrespective of whether or not the Board ultimately concurs with SSA. Further, these interpretations, decisions, and rulings, along with Review Board decisions, could be made available to all intermediaries and providers for use in preparing their appeals to the Review Board or in resolving their differences without appeal.

#### RECOMMENDATIONS TO THE SECRETARY OF HEW

The Secretary of HEW should arrange for SSA to take the following actions:

- Catalog and make available on request to the intermediaries, Medicaid State agencies, providers, and the Provider Reimbursement Review Board all SSA decisions or specific interpretations effecting the determination of Medicare's share of hospital or SNF costs.
- Establish more definitive guidelines for intermediaries to follow in making judgmental decisions in the matters of owners' compensation and excess cash in computing return on equity.

#### HEW COMMENTS AND OUR EVALUATION

In responding to the recommendation for wider dissemination of SSA decisions and interpretations concerning reimbursement questions, HEW stated that:

"\* \* \* The reason we have not established a general policy of distributing all such letters is that in most instances the questions raised relate to a given case and the limited circumstances present do not have any general application. In addition, in most cases the letters do not contain a full set of particulars nor the substantial factual recitation needed to make them useful as precedents in the future. It is primarily for this reason that we do not agree with GAO's recommendation that it would be useful to catalog and make available to the intermediaries and other interested parties the decisions or interpretations to all questions or issues that may be raised. Nevertheless, we do recognize that there are situations, including several of those cited in the GAO report, where there is a need for wider distribution of some decisions and interpretations. As indicated above, we think that this can best be done by incorporating them in existing instructional vehicles. Accordingly, in the future SSA will seek to promptly incorporate in its manuals or other instructional materials any decisions or interpretations that may have broad application."

The prompt manualization of SSA interpretations and decisions is useful in minimizing inconsistencies because such instructional materials

are the primary reference source for providers and intermediaries. On the other hand, determining whether a specific question raised by an intermediary may have broad application is relative. There are about 6,800 hospitals and 4,000 SNF's participating in Medicare and as of June 1974, the program will have been in operation for 8 years. Hopefully, most reimbursement questions having general applicability have been identified and resolved. We reviewed 30 proprietary institutions and at 3 identified overpayments totaling about \$166,000 involving situations where SSA advice on the overpayment issue had previously been communicated to other intermediaries, but the intermediary making the overpayment was not aware that such advice existed.

We acknowledge that for persons not familiar with Medicare reimbursement principles, SSA advisory letters might not be particularly meaningful for setting precedents; however, most intermediary personnel specializing in reimbursement matters would not fall into this category. Our review of SSA's advisory letters indicated that they were generally understandable--at least as a basis for identifying the basic issues involved. For examples of SSA advisory letters see appendixes II and III.

In our view, it would not be necessary to distribute each advisory letter to all potentially interested parties, but merely to catalog or index by subject matter such decisions or advice in order that intermediaries, providers, and others can be aware that SSA has made a decision relating to a particular subject and can request the specific letter for their consideration and guidance.

In responding to our recommendation for more definitive guidelines for making judgmental decisions in the areas of owners' compensation and determining excess cash for computing return on equity, HEW stated that:

"The purpose of the [existing] guidelines is to assist the intermediary in evaluating, on an individual basis, the reasonableness of the compensation paid for on owner's services. Reasonableness in this setting depends on many variables, some of which are not quantifiable and others not readily defined. To introduce a further degree of rigidity into the system by providing very precise or definitive criteria would, in our opinion, lead to inequities far outweighing any inconsistent application among intermediaries that might currently exist. However, in line with GAO's recommendation, SSA will (1) revise its manual instructions to more clearly define what constitutes "full-time" services of owner-administrators, (2) emphasize to intermediaries the importance of following the prescribed guidelines, and (3) provide clarification in those areas where GAO noted some intermediary misunderstanding. In addition, SSA will study the practicability of developing guidelines for

intermediary use in identifying a provider's excess uninvested cash for computing the return on equity capital. "

We believe that the actions proposed by HEW are generally responsive to our recommendation and, if implemented, would tend to encourage more consistent application of the Medicare cost principles. It should be pointed out, however, that as discussed on pages 12 and 13, three of the eight intermediaries included in our review were applying formulas and point systems to the SSA-approved ranges of compensation for owner-administrators. These same three intermediaries had established specific rates for owner-assistant administrator positions. Thus, at some intermediaries, further rigidity has already been introduced into the system for determining reasonable owners' compensation.

## CHAPTER 3

### PROGRESS IN EXCHANGING AUDIT INFORMATION

#### UNDER MEDICARE AND MEDICAID

Hospitals must be eligible to participate in Medicare in order to participate in Medicaid. Also, HEW regulations have provided, in the past, that the same cost reimbursement principles be used under Medicare and Medicaid for paying for inpatient hospital services. Therefore, the most logical area for coordinating audit activities under these two programs would involve hospitals, because it is likely that Medicare and Medicaid would be dealing with the same institutions and paying for services under the same rules and guidelines.

Although progress has been made in achieving a single common audit of hospitals under Medicare and Medicaid, there is apparently no systematic exchange of audit information where the common audit arrangement does not exist or where the same organizations do not perform the audits. Our review of Medicare and Medicaid settlements for 27 southern California proprietary hospitals indicated that combined program expenditures could have been reduced by \$352,000 if each program had used the others' audit adjustments in settling the institutions' claims.

#### COMMON AUDIT AGREEMENTS

About 20 of the State Medicaid agencies have contracted with outside organizations, such as Blue Cross plans, to act as fiscal agents in paying and/or auditing hospitals under their Medicaid programs. In most instances these organizations also function as intermediaries under the Medicare program. The dual relationship of these organizations to the same hospitals should result in a degree of cost reimbursement consistency between the two programs because the fiscal agents-intermediaries have direct access to SSA, its issuances, and interpretations relating to Medicare reimbursement principles.

Other State agencies and fiscal agents may not have this direct access. Their guidance is received from SRS which maintains a working relationship with SSA and serves as a conduit to State agencies for changes in Medicare reimbursement policies concerning Medicaid. In this connection SSA and SRS have developed a joint cost report form which may be used by providers--mostly hospitals--for claiming reimbursement under both programs.

In December 1970 SSA and SRS agreed to encourage the negotiation of common audit agreements between the various Medicare and Medicaid audit organizations. The common audit agreements provide for a single Medicare-Medicaid audit at those hospitals requiring an audit. The programs are to share the audit's cost in direct proportion to the amount of payments made to the hospital by each of the programs.

As of December 1973 common audit agreements between Medicare and Medicaid had been negotiated for all or part of 27 States including 11 States where a Medicare intermediary (usually Blue Cross) was also the State fiscal agent for paying for hospital services. In the four jurisdictions with Medicaid programs (the District of Columbia, Guam, Puerto Rico, and the Virgin Islands), there were neither fiscal agent arrangements nor common audit agreements. Thus, in about 20 States or jurisdictions, there was neither a single fiscal agent-intermediary organization to audit hospitals nor a common audit agreement.

Difficulties in successfully negotiating common audit agreements included disagreements among SSA, its intermediaries, and the State agencies involving such issues as

- the methods of allocating the audits' costs,
- mutually agreeable audit programs,
- the selection of institutions for audit, and
- the lack of State agency funds to pay its share of the audit costs.

Also, according to SSA, some States with very limited audit activity in the past have been reluctant to enter into common audit agreements because of the increased costs involved.

The 11 hospitals included in our review were located in 4 States and were serviced by 4 intermediaries. The State Medicaid agencies in Louisiana and Tennessee had entered into common audit agreement with two of the intermediaries. Texas used a Blue Cross plan as its fiscal agent for paying and auditing hospitals. Because this Blue Cross plan was also a Medicare intermediary for most of the hospitals in the State, there was apparent communication of audit adjustments between the two programs. The fourth intermediary (Travelers)<sup>1/</sup> was one of six intermediaries operating in California. In this State two Blue Cross plans served as fiscal agents in paying hospital claims, but the State Medicaid agency had assumed the Medicaid audit responsibilities since January 1971. No common audit agreements had been negotiated in California as of December 1973.

#### MEDICARE AND MEDICAID AUDIT INFORMATION NOT EXCHANGED IN CALIFORNIA

Efforts to negotiate a common audit program between the Medicare intermediaries and the State agency in California have been unsuccessful. The reasons given by SSA for the lack of progress in making common

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<sup>1/</sup> Travelers operates as a Medicare intermediary for hospitals in 11 States including California.

audit agreements were (1) California had not agreed to adopt the combined Medicare and Medicaid cost report developed by SSA, and (2) California statutes required that Medicaid cost reports be audited within 18 months of receipt. At the time of our review, SSA's Medicare guidelines required audits within 3 years.

In November 1972 there were about 550 California hospitals participating in both the Medicaid and Medicare programs. About 200 of these hospitals were proprietary institutions. Of these, 27 southern California proprietary hospitals had cost reports settled by the State Medicaid agency and the Los Angeles Blue Cross intermediary 1/ from January 1, 1971, through February 14, 1972. By comparing audit adjustments, we found that program expenditures could have been reduced by \$352,000 if each program had used the other's audit findings as follows:

Medicaid adjustments not made by Medicare	\$127,300
Medicare adjustments not made by Medicaid	<u>224,700</u>
Total	<u>\$352,000</u>

The following are examples of adjustments made by one program's auditors but not the other's:

1. At one hospital Medicare auditors disallowed \$137,300 in administrative expenses claimed for 2 years. The Medicaid program settled the cost reports for these years by a desk review only and did not adjust the administrative expenses. The Medicare adjustments were for compensation paid to nine owners who had formed a committee to carry out functions usually performed by an administrator and an assistant administrator. Medicare auditors, therefore, limited total allowable compensation to the intermediary's interpretation of the SSA guidelines for those two positions. The adjustments reduced the costs reimbursed by Medicare by \$23,500 and, if communicated to the State agency and used, could have reduced the costs reimbursed by Medicaid by \$19,100.

2. One hospital claimed compensation for two of its owners of \$84,800 in its 1969 cost report of which Medicaid auditors disallowed \$73,900. Medicare had audited the cost report but made no adjustment to owners' compensation. The Medicaid audit workpapers showed that the Medicaid auditors computed allowable compensation in accordance with SSA reimbursement guidelines and determined that only \$10,900 of the \$84,800 claimed was allowable. The adjustment reduced the costs reimbursed by Medicaid by \$18,900 and, if communicated to the intermediary and used, could have reduced the costs reimbursed by Medicare by \$10,900.

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1/ The Blue Cross intermediary for northern California (Oakland) was not involved in this review.

3. Medicare auditors disallowed \$23,300 of return on equity and \$31,800 of interest expense claimed by one hospital in its 1968 cost report. Medicaid had audited the cost report but did not make adjustments to either return on equity or interest expense.

Medicare auditors' workpapers showed that, although not allowable by reimbursement guidelines, the hospital had claimed return on equity for \$209,900 in accounts receivable due from owners. The hospital also eliminated \$196,800 from the liabilities to be deducted in the equity computation, contending that it represented a mortgage payable to owners. The auditors found that the mortgage was not payable to owners. Medicare auditors also found that the hospital overaccrued \$300 of interest expense and claimed \$31,500 as interest expense which was actually an escrow fee that should have been capitalized. The various adjustments reduced Medicare's reimbursement by \$11,300 and, if communicated to the State agency and used, could have reduced Medicaid's reimbursement by \$9,500.

4. A hospital claimed costs of \$154,300 in management fees--identifying \$89,800 specifically as management fees and including \$64,500 in other administrative expenses. Medicare auditors disallowed \$86,300 of these costs. Medicaid also audited this hospital's cost report but disallowed only \$21,800.

The Medicare auditors examined expenses of the parent organizations that provided the management services. They found that much of the allocated costs of these organizations were for unallowable nonpatient care related functions, such as legal services in acquiring additional hospitals. The Medicare auditors determined that only \$68,000 of the \$154,300 claimed was allowable.

A representative of the accounting firm that did the Medicare audit said that he informally told the Medicaid auditors the amount of management fees determined to be allowable, but the Medicaid auditors did not have access to Medicare workpapers nor were they told the amount of all Medicare adjustments. As a result the Medicaid auditors disallowed \$21,800 by adjusting only the \$89,800 specifically identified as management fees down to the \$68,000--the amount allowable by Medicare.

A California Medicaid official said that, unlike the Medicare program, the State had not audited the parent corporation's books. The difference between the Medicare and Medicaid adjustment for management fees was \$64,500, which had the effect of reducing Medicare reimbursement by \$12,700. Had the same adjustment been made by Medicaid the program's cost would have been decreased by \$6,300.

Regional SSA and SRS officials believed our comparison demonstrated that (1) both programs would benefit by sharing audit data, and (2) each program's auditors had directed their attention to different selected areas making the best use of limited audit funds.

We noted that as early as July 1971 the State had attempted to establish an agreement whereby Medicare and Medicaid audit information would be exchanged free of charge to either program, but SSA had disapproved this proposal.

SSA reluctant to exchange  
audit information free of charge

In March 1973 we brought the matter of potential program savings through exchange of audit information to SSA's attention. In response to our inquiries, (see app. IV) SSA stated in June 1973 that in administering the hospital benefits' aspect of the Medicare program, SSA efforts have been directed toward the achievement of two important but, to a degree, divergent objectives: (1) insure that reimbursement to a hospital represents the actual cost incurred for services to Medicare patients and (2) insure that the intermediary's administrative costs, of which auditing is a major part, are kept to a minimum. In working toward these objectives, SSA has encouraged intermediaries and State agencies to agree to use and share the cost of a common audit.

SSA acknowledged that it generally insisted that the intermediary not furnish the Medicaid State agency, free <sup>1/</sup> information on the results of Medicare's hospital audits unless the State agency agreed to participate in common audits. SSA noted that the use of common audits can result in substantial administrative cost savings. The policy of not furnishing States with Medicare audit information without charge has functioned as an incentive to many State agencies to join with the intermediaries in common Medicare-Medicaid audits.

Regarding the lack of common audit or exchange of audit information agreements between the two programs in California, SSA noted that it was in the process of planning two pilot studies aimed at exploring alternate ways of achieving common hospital audits. <sup>2/</sup> According to SSA, the importance of the studies made it advisable to defer considering a

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<sup>1/</sup> Under SSA's policy intermediaries were to charge State Medicaid agencies for Medicare audit information pertaining to a particular provider on the basis of a pro rata share of the cost of the audit allocated on the basis of the respective program's reimbursement.

<sup>2/</sup> In one study the State agency would review 20 hospital audits completed by the southern California Blue Cross intermediary to determine whether Medicare audits were adaptable for Medicaid. In the second study, the State agency together with the northern California Blue Cross intermediary would have input in establishing the scope of 20 upcoming hospital audits. According to SSA, the State would share in the costs of the audits involved.

general policy of furnishing free audit information to the California State agency. However, SSA agreed to exchange such information while the pilot studies were going on.

SSA to consider common federally financed  
audit for Medicare and Medicaid  
hospital activities

In its June 1973 letter, SSA noted also that it has been seeking alternative measures to speed up and to insure the use of common audits in all States. One alternative being looked into would make common audits mandatory for those hospitals providing services under federally supported programs--such as Medicare and Medicaid--with the Federal Government paying for the audits. SSA pointed out, however, that before a decision can be made on formalizing this proposal, additional work had to be done including the making of cost-benefit analyses and obtaining other views both within and outside HEW.

CONCLUSIONS

We believe that the two pilot studies in California may go a long way toward eliminating the obstacles to common Medicare and Medicaid hospital audits. If, however, the studies do not result in common audits, we believe the free exchange of information on audit adjustments between the two programs should be encouraged. Without a common audit or an exchange of audit information, continued program overpayments to hospitals can result.

The costs of audits should be viewed in proper perspective. Overall, the costs of provider audits under Medicare amount to about 1/2 of 1 percent of benefit payments. Because of the relatively large payments to individual hospitals as compared to other types of providers (SNFs and home health agencies), we believe that the ratio of benefit payments to audit costs for hospitals would be somewhat lower. Nevertheless, the primary purpose of making audits under both the Medicare and Medicaid programs is to furnish some insurance that providers are correctly paid. Therefore, although we agree that SSA should actively pursue its goal of obtaining common Medicare and Medicaid audits, achieving this goal should not override the primary purpose of making the audits.

Sufficient incentives apparently exist in terms of lower costs and increased efficiency for States to participate in a program aimed at fostering common audits. Accordingly, it should not be necessary for SSA to pursue its policy in such a way that it could result unnecessarily in making overpayments to providers.

Further, the enactment of section 232 of the Social Security Amendments of 1972 would seem to make an exchange of audit information even more important. Under this amendment, the States would be permitted

to develop their own methods and standards for determining reasonable costs of inpatient hospital care under Medicaid, provided the costs allowed do not exceed the amount that would be determined as reasonable cost under Medicare's cost reimbursement principles. This provision could be uniformly complied with at individual hospitals only if the States are made aware of Medicare's audit adjustments.

We believe SSA's proposal for a federally financed common audit of hospitals that provide services under federally supported programs should be explored. It should be noted, however, that such an undertaking would probably require legislative authorization and in some cases could conflict with State laws because some programs--such as Medicaid--are State administered and partially State financed.

#### RECOMMENDATION TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW require that there be a full exchange of Medicare and Medicaid audit information in those instances where no common audit agreement has been reached between a Medicare intermediary and a Medicaid State agency or its fiscal agent.

#### HEW COMMENTS AND OUR EVALUATION

In responding to our recommendation for the full exchange of Medicare and Medicaid audit information, HEW stated that:

"This progress in persuading States to adopt the common audit has been due in large part to the fact that participation in common audits would be less costly to them than separate Medicaid audits or the charge that Medicare could impose for access to its hospital audit information. If we were to tell those States that have not yet agreed to the common audit that we will furnish Medicare audit information and results to them free-of-charge, it would be very unlikely that they would agree to join in the common audit and to share in the costs of those audits. Moreover, those States which already use the common audit would probably want to reconsider and perhaps abandon it. In short then, under present circumstances, we believe that the common audit program and its continued use and growth is contingent upon our decision to charge State Medicaid agencies, that do not join in common audits, for any Medicare audit information they request."

It has not been our intention that the State Medicaid programs be encouraged to enjoy a "free ride" in connection with Medicare's provider audit activity. We believe, however, that where audit information already developed by one federally supported program could be beneficial in reducing costs to another, such information should be exchanged particularly since the Federal Government pays at least 50 percent of allowable Medicaid administrative and medical assistance costs.

We believe that the early identification and recovery of overpayments to providers under both programs should be a principal matter of concern to HEW. As shown by the following table, our analysis of Medicare intermediary overpayment reports indicated that as of September 30, 1973, identified Medicare overpayments to providers amounted to about \$208 million, 1/ of which 82 percent was identified through field audits of provider cost reports.

Overpayments identified through	Status of Medicare overpayments as of September 30, 1973		
	Total	Recovered	Outstanding balance
	(millions)		
Audited cost reports	\$170	\$ 81	\$ 89
Desk reviews of cost reports	<u>38</u>	<u>22</u>	<u>16</u>
Total	<u>\$208</u>	<u>\$103</u>	<u>\$105</u>

About one-half of the \$208 million of identified overpayments was applicable to providers in those States and jurisdictions having no common intermediary-fiscal agent for making audits or common audit agreements. This suggests that substantial overpayments identified during Medicare audits may not have been communicated to Medicaid.

Further, under SSA instructions provider audit by the intermediary must be initiated within 3 years of the receipt of a cost report or recovery action--in the absence of fraud--is precluded. In those States and jurisdictions without arrangements for exchanging audit information, about 2,500 Medicare hospital cost reports for reporting periods ending on or before June 30, 1971, 1972, and 1973 were due but had not been audited or had been settled without audit as of December 31, 1973. Possibly Medicare audit coverage could be enhanced through exchange of audit information with Medicaid at those institutions where a Medicaid audit had been made.

In addition to the potential benefits to both programs from the full exchange of audit information, a recent proposal by SSA--to change its policy by making Medicare cost reports available on request to members of the public, would seem to seriously undermine HEW's strategy of encouraging States to join in common audits by charging the State Medicaid agencies that do not join in common audits for any Medicare audit information they request.

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1/ This amount excludes outstanding overpayments of about \$250 million principally attributable to outstanding current financing payments or failure to file cost reports and about \$25 million in outstanding Medicare overpayments which had been furnished to SSA, GAO, or the Department of Justice for collection.

In April 1974 the SSA Commissioner announced that based on the Freedom of Information Act (5 U. S. C. 552) the agency believed it was required to make Medicare cost report information available upon specific written request to the public and proposed to implement this policy change on May 1, 1974.<sup>1/</sup> The instructions implementing the proposal state that the information to be made public, at a standard charge of 25 cents a page, would include the cost report as originally submitted by the provider and the final audited cost report as filed by the intermediary.

In discussing SSA's April proposal, an SSA official acknowledged that any information made available to the general public would also be made available under the same conditions to State Medicaid agencies. SSA still believed, however, that the States should share in the costs of the Medicare audits that were of potential benefit to them. Further under the instructions, SSA would not be required to make available Medicare audit adjustments or workpapers. The SSA official also said that the State Medicaid agencies would have to wait until the audited Medicare cost reports were finalized whereas under common audit agreements audit information would be available on a more timely basis.

Because the Medicare audit adjustments and workpapers may not be available to the general public (including Medicaid agencies), the benefits of a full exchange of audit information may not be realized under SSA's implementation of the Freedom of Information Act. Nevertheless, the State Medicaid agencies could obtain the audited and unaudited figures and determine the net amounts of Medicare audit adjustments by line item of cost and in total without having to share in the audit's cost.

In our view the decision to make Medicare audited and unaudited cost reports available to the general public at a nominal charge tends to compromise HEW's rationale that the future of its common audit program is contingent on charging State Medicaid agencies on the basis of the audits' costs for any Medicare audit information they request.

#### Congressional action to improve Medicare and Medicaid coordination

With the enactment of the Social Security Amendments of 1972, Congress took a number of actions improving coordination between

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<sup>1/</sup> The American Hospital Association (AHA) filed suit May 13, 1974, in U. S. District Court for the District of Columbia to prevent SSA from implementing a program to release Medicare cost reports until adequate procedural safeguards were included. As a preliminary step in the suit, the AHA requested a temporary restraining order which was denied May 15, 1974.

Medicare and Medicaid and promoting more uniformity between these two federally supported health programs. For example:

- The amendments liberalized the level of care requirements for covered posthospital extended care services in SNFs and made the same requirement apply to SNF services under Medicaid.
- The provision for Professional Standards Review Organizations to establish a new system of peer review for institutional care was made applicable to services paid for under both Medicare and Medicaid.
- The amendments gave HEW authority to terminate or suspend Medicare payments furnished by providers and suppliers found to be overcharging; furnishing excessive, inferior, or harmful services; or making false statements to obtain payment. Under the act, providers and suppliers excluded from Medicare program payment are also excluded from payments under Medicaid.
- The prohibition against the reassignment of claims by physicians or other suppliers under part B of Medicare was also made applicable to comparable claims under Medicaid.
- The amendments required that SNFs receiving Medicaid skilled nursing payments must meet the same health, safety, environmental, and staffing requirements as institutions participating in Medicare with HEW deciding whether a facility qualifies to participate as an SNF under both Medicare and Medicaid.
- To facilitate the recovery of overpayments from institutions terminating their participation in Medicare, the amendments authorized HEW to withhold Federal financial participation in State Medicaid payments to institutions which withdrew from Medicare without refunding overpayments or without filing final cost reports.

#### MATTERS FOR CONSIDERATION BY THE CONGRESS

In view of previous congressional actions aimed at improving coordination between the Medicare and Medicaid programs and the decision to make Medicare audited and unaudited cost reports available to the general public, the legislative committees having jurisdiction over these programs may wish to further discuss the full exchange of audit information under these programs with HEW officials.

## CHAPTER 4

### SCOPE OF REVIEW

The fieldwork was done principally during 1972 at SSA headquarters in Baltimore, Maryland; at SRS headquarters in Washington, D. C.; at 8 Medicare intermediaries and subcontract intermediaries; 4 State Medicaid agencies and their fiscal agents; 11 hospitals; and 19 SNF's.

<u>Intermediary</u>	<u>Number of facilities reviewed</u>	
	<u>Hospitals</u>	<u>SNF's</u>
Inter-County Hospitalization Plan, Inc., Jenkinstown, Pennsylvania	-	2
Mutual of Omaha Insurance Company, Omaha, Nebraska	-	10
The Travelers Insurance Company, Los Angeles, California	2	-
Blue Cross Plans (subcontract intermediaries):		
Baton Rouge, Louisiana	3	-
Chattanooga, Tennessee	3	-
Dallas, Texas	3	-
Los Angeles, California	-	4
Philadelphia, Pennsylvania	-	3
Total	<u>11</u>	<u>19</u>

We reviewed the basic legislation establishing the Medicare and Medicaid programs; the related regulations prescribed by the Secretary of HEW for administration of the programs; and the various manuals, memorandums, and other documents which establish program guidelines and interpret the applicable laws and regulations. We also reviewed other pertinent records, reports, and documents and interviewed officials of the SSA, SRS, intermediaries, State Medicaid agencies, fiscal agents, hospitals, and SNF's.

Our selection of hospitals and SNF's for review was based on the sizable amounts of Medicare payments involved and the proximity of the date of intermediaries' audits to the dates of our visits in 1972. Proprietary institutions were selected because of the many controls which have been built into the regulations and guidelines dealing with reimbursement problems generally unique to proprietary institutions (allowability limitations of owners' compensation, disallowance of profits realized in dealings between related organizations, and payments for return on equity capital).

In addition, in California which was one of about 20 States and jurisdictions where there was no arrangement for the sharing of audit information between Medicare and Medicaid, we reviewed the audits and related settlements for an additional 27 proprietary hospitals to assess the effect of this problem.

## HOW HOSPITALS AND SKILLED NURSING

## FACILITIES ARE PAID UNDER MEDICARE AND MEDICAID

Under HEW regulations, before the enactment of the Social Security Amendments of 1972 in October 1972, payments to hospitals under the Medicare and Medicaid programs should have been based on the same rules and guidelines. However the two programs paid SNF's under widely varying methods. The Social Security Amendments of 1972 authorized more diversity between the two programs in paying hospitals but encouraged more uniformity in paying SNF's. Information on the payment methods under the two programs and on recent pertinent legislative changes follow.

MEDICARE

Under Medicare payments to hospitals and SNF's are to be made on the basis of reasonable costs. The Medicare law authorizes the Secretary of HEW to prescribe regulations establishing the method or methods to be used in determining reasonable costs. The law states that such regulations should provide for making suitable retroactive corrective adjustments when, for any accounting period, the aggregate reimbursement to a facility proves to be either inadequate or excessive.

In implementing these requirements, HEW issued regulations which established the principles and procedures to be used by hospitals, SNF's, and intermediaries in determining reasonable costs. HEW intended that these principles and procedures recognize all necessary and proper costs incurred in furnishing services to Medicare patients and exclude any costs of providing care to non-Medicare patients.

To help intermediaries and providers implement and interpret the law and regulations, SSA issues and updates certain manuals and a series of numbered memorandums to the intermediaries. The manuals and memorandums provide guidelines and policies to be followed in implementing the cost principles set forth by regulations.

Intermediaries and providers which need further assistance in interpreting the guidelines and policies may seek advice directly from SSA. If SSA officials believe that any question and related interpretations have general applicability, the interpretations are manualized. If not, SSA's response is limited to the requester and no further distribution is made.

Hospitals and SNF's are paid on the basis of their estimated costs during the year. These "interim payments" are intended to approximate, as nearly as possible, the actual costs in order to minimize the amounts of the retroactive adjustments at audit and settlement.

## APPENDIX I

The principal document used in the settlement process is the Medicare cost report submitted by a hospital or SNF. SSA developed this report form in consultation with provider and intermediary groups and it was designed to show the portion of a provider's total allowable cost applicable to covered services provided to Medicare beneficiaries.

### Preparation of cost reports

Although HEW regulations have offered providers several alternatives in arriving at the amounts to be claimed for reimbursement, the preparation of a cost report essentially consists of four steps, as follows:

1. Determination of allowable costs. Under this step, costs which are unreasonable or not necessary for patient care are to be excluded as nonallowable. In addition, the regulations and guidelines identify certain specific costs, such as bad debts for non-Medicare patients, which should be excluded.
2. Allocation of allowable costs to routine and ancillary services, such as X-ray and laboratory. Under this step, the allowable costs are allocated to those activities or services for which the providers make a charge to patients. For accounting periods starting after December 31, 1971, smaller hospitals (less than 100 beds) and SNFs must allocate their inpatient costs to routine care; to total routine care in special units, such as intensive care; and to the aggregate ancillary services, such as X-rays, laboratories, and operating rooms.
3. Apportionment of allowable costs between Medicare and non-Medicare patients. For accounting periods starting before January 1, 1972, hospitals and SNFs had the option to chose one of several apportionment methods. To simplify reimbursement requirements for subsequent periods, the smaller hospitals and SNFs are required to apportion the routine care and special unit routine care costs on the ratio of Medicare inpatient days to total inpatient days and the aggregate ancillary service costs on the ratio of Medicare patient charges for ancillary services to total patient charges for such services. The larger hospitals also must use the patient-day method of apportioning routine care and each special unit routine care costs. The hospitals must apportion the costs of each ancillary department on the ratio of Medicare patient charges to the total charges for each department.
4. Consideration of amounts received or due from the patients and the intermediary. Under this step, the deductible and coinsurance amounts paid or payable by the Medicare patients and

the interim payments received or due from the intermediary are deducted from the allowable costs apportioned to Medicare patients to determine the amount due to or due from the Medicare program.

Establishment of Provider Reimbursement Review Board and other legislative changes

Before the enactment of the Social Security Amendments of 1972, there was no specific legislative provision permitting a provider of services to appeal an intermediary's reasonable cost determination.

The 1972 amendments established a 5-member Provider Reimbursement Review Board to be appointed by the Secretary of HEW to review and adjudicate disputes concerning the intermediaries' determinations of costs' allowability claimed under the Medicare program. The appeals must involve disputes of \$10,000 or more for one provider or \$50,000 or more for a group of providers where the dispute involves a common issue. The disputes reviewed will be for cost reports filed for accounting periods ending on or after June 30, 1973. The decisions of the Review Board are to be final unless reversed or modified by the Secretary of HEW within 60 days. If the reversal of the Secretary is adverse to the provider, the provider will have the right to judicial review.

Other legislative changes involving the methods of paying hospitals and SNFs under Medicare included provisions to:

- Authorize HEW to set in advance the limits in costs to be recognized as reasonable on the basis of the costs incurred by similar providers in the localities and authorize the provider to charge the Medicare patient for additional amounts over the cost limitations.
- Limit reimbursement under Medicare (and Medicaid) to the lower of the reasonable costs of the services provided or the usual charges to the public of such services.
- Require experiments with prospective reimbursement under Medicare and Medicaid where a payment rate is set before the institution's accounting period begins with no retroactive adjustment based on the actual costs incurred.

MEDICAID

Hospital reimbursement requirements

The Medicaid law, before the enactment of the Social Security Amendments of 1972, required that each State plan provide for

## APPENDIX I

reimbursing inpatient hospital services on a reasonable cost basis developed in accordance with standards approved by the Secretary of HEW. The standards prescribed by HEW regulations required that in making Medicaid payments for inpatient hospital services, States should use the same standards, cost reporting periods, cost reimbursement principles, and methods of cost apportionment as used in Medicare reimbursements to the same hospitals. For hospitals not participating in the Medicare program, Medicaid payments were also to be made in accordance with Medicare principles of reimbursement.

A February 1970 report prepared by the staff of the Senate Committee on Finance <sup>1/</sup> challenged the HEW regulations requiring that the Medicare cost reimbursement formula be applied in paying hospitals under Medicaid. The staff expressed the belief that it was the intent of the Congress that the States be permitted to define reasonable costs within more general guidelines established by HEW and recommended that the congressional intent in this regard be clearly established.

The 1972 Amendments revised the Medicaid law effective July 1, 1972 (or earlier if the State plan so provided) to permit the States to develop their own methods and standards for reimbursing hospitals for inpatient services rendered to Medicaid patients. To be used, such methods and standards have to (1) be based on reasonable cost, (2) result in payments which would not exceed what would have been made using Medicare principles, and (3) be approved by the Secretary of HEW.

### SNF reimbursement requirements

Under Medicaid the States have been free to develop their own methods for reimbursing SNFs for care provided to Medicaid patients provided such reimbursement did not exceed the reimbursement made for similar services under Medicare.

States, in the absence of HEW criteria, have adopted methods for establishing rates of payment for SNF care, which have resulted in differing payment policies and rates. The matter of differing Medicaid reimbursement rates for SNFs was the subject of a GAO report entitled "Problems in Providing Guidance to States in Establishing Rates of Payment for Nursing Home Care Under the Medicaid Program," (B-164031(3) Apr. 19, 1972.) In this report, we pointed out that HEW had not

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<sup>1/</sup>Medicare and Medicaid; Problems, Issues, and Alternatives, February 9, 1970.

- formulated and issued appropriate criteria and requirements to guide the States in establishing rates of payment for nursing home care,
- enforced the requirement in the Medicaid law that State plans include a description of the methods and procedures used in establishing payment rates, and
- instituted effective policies and procedures for reviewing and evaluating methods and procedures actually being used by the States in establishing payment rates.

Congress, when considering the Social Security Amendments of 1972, was concerned that some Medicaid SNF's may be overpaid and others paid too little. On the other hand, the Congress was aware also that Medicare's retrospective reasonable-cost method of reimbursement had been criticized as being too detailed, expensive, and cumbersome.

Accordingly, the Social Security Amendments of 1972 required that the State Medicaid administrators develop cost-related methods of reimbursement for setting rates for SNF care. These methods must be approved by the Secretary of HEW and be ready for implementation under the Medicaid program by July 1, 1976. A State's payment rates could then also be used for Medicare reimbursement purposes if the rates could be appropriately adjusted to take into account specific factors related to Medicare which are not considered by the States.

APPENDIX II

EXAMPLE OF SSA COMMUNICATION TO AN INTERMEDIARY  
 PROVIDING SPECIFIC INTERPRETATIONS OF THE  
 COST PRINCIPLE ON RELATED ORGANIZATIONS

Our evaluation of the facts presented in the case of three providers follows.

a. ABC Nursing Home and XYZ Nursing Home  
 (See GAO note.)

(1) Based on the summarization of findings by GAO, we found that at one time ABC Nursing Home, XYZ Nursing Home, and the Associates were three separate partnerships owned by the same principals consisting of three brothers and a group of doctors. The Associates' sole business was that of leasing the premises housing the two extended care facilities. On August 1, 1966, the brothers sold their interest in the ECFs to the doctors and the doctors sold their interest in The Associates to the brothers. The doctors (provider-lessee) rented the facilities housing ABC Nursing Home and XYZ Nursing Home for \$85,000 and \$120,000 per year plus property taxes from The Associates (lessor).

(2) The doctors retained Bill Smith, one of the brothers who is a partner in The Associates, as the executive administrator for both extended care facilities. Bill Smith commanded a salary as follows:

Bill Smith	<u>ABC Nursing Home</u>		<u>XYZ Nursing Home</u>		<u>Total</u>	
	<u>Time Spent Hours</u>	<u>Compen-sation</u>	<u>Time Spent Hours</u>	<u>Compen-sation</u>	<u>Time Spent Hours</u>	<u>Compen-sation</u>
1967	35	\$22,000	35	\$22,000	70	\$44,000
1968	35	26,700	35	26,700	70	53,400
1969	35	27,700	35	29,620	70	57,320
1970	35	27,200	35	27,200	70	54,400

(3) In addition to leasing the ABC Nursing Home from The Associates, the doctors have entered into agreements with No. 1 Service Corporation for cleaning services and No. 2 Service

GAO note: The names of the facilities, other organizations, and individuals were changed. Otherwise, this represents verbatim excerpts of SSA's advice to the intermediary.

Corporation for dietary services for the facility. The XYZ Nursing Home also uses No. 2 Service Corporation for dietary service. Cleaning service is provided by the No. 3 Service Corporation. These organizations are equally owned by Bill Smith and his two brothers.

(4) As you may know, regulation section 405.427 "Cost to Related Organizations" provides that costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organizations. Regarding the question relating to control, the considerations for determining control should include not only evidence of actual control, but also should include evidences of potential control or the ability to exercise control. This concept is brought out in section 1004.4 of the Provider Reimbursement Manual, where illustrations are given of individuals having presumptive powers to influence and direct actions of separate organizations. Accordingly, Mr. Bill Smith as executive administrator of the ABC Nursing Home and XYZ Nursing Home and one third owner of The Associates, No. 1 Service Corporation, No. 2 Service Corporation, and No. 3 Service Corporation, has the power to influence or direct both the provider-lessees and the lessor in addition to the service corporations. Additionally, the sale by the brothers of their interest in the ECF's to the doctors and the doctors selling their interest in The Associates to the brothers indicates a community of interest has been established between the doctors and brothers whereby they collectively benefit. For these reasons, we have concluded that the provider-lessees, lessor, and service corporations are related to each other by common control.

b. News Nursing Home  
(See GAO note on page 36.)

(1) In this case, GAO pointed out that the News Nursing Home is equally owned by three partners. One of the partners was also a general partner of the Olds Company which owns the building occupied by the ECF. News leases the facility from Olds for \$120,000 a year plus property taxes.

(2) Additional facts revealed by GAO showed that prior to News' commencing operations in the newly constructed facility, the partner which owned an interest in the lessor (Olds Company) and the provider-lessee (News Nursing Home) executed a document dated July 31, 1967, divesting himself retroactive to May 1, 1967,

## APPENDIX II

as a general partner in the lessor company. News' first cost report covered the period May 1, 1967, through December 31, 1967, even though it did not begin to take patients until July 25, 1967. GAO also pointed out that the partner which relinquished his ownership in the lessor company was in an administrative position in the provider-lessee. His duties encompassed the negotiating and signing of contracts for services, equipment, and supplies.

(3) GAO based its decision that a "cost to related organizations" situation exists because of (1) the partner's former ownership interest in the lessor organization, (2) the proximity of the dates of his divestiture of that interest and the beginning of the ECF's operations, and (3) his responsibility of negotiating contracts for the ECF.

(4) We agree with GAO's contention that a "cost to related organizations" situation exists since the partner was in a position to "significantly" influence the amount of rentals under the lease. Therefore, a lease transacted under these circumstances would not be considered transacted at "arm's length," and in lieu of rent the provider-lessee would include costs of the ownership of the facility such as depreciation interest on the mortgage, real estate taxes, and other expenses attributable to the leased facility.

Finally, by copy of this letter, we will inform the Travelers Insurance Company that for the cases reviewed, the claimed rental expenses by the providers as reimbursable Medicare costs will have to be limited to the costs of the related lessor organizations. This will comply with GAO's request that they be informed of what actions SSA contemplates taking.

EXAMPLE OF SSA COMMUNICATION TO  
AN INTERMEDIARY PROVIDING SPECIFIC GUIDANCE  
ON COST REPORTS FOR DISTINCT PARTS OF A FACILITY

This refers to your telephone conversation with a member of my staff concerning a cost settlement made by Mutual of Omaha with the ABC Convalescent Hospital. (See GAO note.) As you know, our San Francisco Regional Office called to our attention the situation wherein Mutual of Omaha made a final cost settlement with ABC based on the costs of a distinct part of the facility when the facility was certified in its entirety. We understand Mutual of Omaha takes the position that, where a provider's accounting records are of sufficient sophistication, the provider may file cost reports for reporting periods beginning before January 1, 1969, as a distinct part extended care facility, regardless of whether or not it was certified as a distinct part.

Section 1861(j) of the Social Security Act provides that a "distinct part" of an institution may be certified and qualify as an extended care facility under the program. The statutory recognition of a "distinct part" of an institution as a qualified provider of services was intended to authorize participation in the program by so much of the institution which, as a separate operating unit of the whole, meets the conditions of participation, even though other parts of the institution may not meet the required conditions. In such cases, the "distinct part" is the provider. However, where the facility is certified in its entirety, this certification is an affirmation that the entire facility meets the conditions of participation and provides ECF level care throughout. In such case, the entire facility is the provider.

Section 405.452 of the regulations provides that "total allowable cost of a provider shall be apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries." (Underscoring supplied.) Therefore, where an institution is entirely certified, allowable costs of the entire facility must be apportioned between Medicare patients and other patients. Conversely, where a facility has a distinct part certified for Medicare participation, the facility must determine the allowable costs of the distinct part and then apportion the costs of the distinct part between Medicare patients and other patients.

This has been the Administration's policy since the inception of the Medicare program and in the interest of equity to all providers

GAO note: The name of the facility was changed. Otherwise, this represents verbatim excerpts of SSA's advice to the intermediary.

### APPENDIX III

and of uniformity in the application of our policy, cost finding and cost reporting must be made in accordance with the certification. Accordingly, the cost report prepared by the ABC Convalescent Hospital for the calendar year 1967 as a distinct part facility, when the facility was certified in its entirety, has not been filed in accordance with regulations, and therefore, is not an acceptable report. The cost report should be resubmitted and the costs determined in accordance with the cost finding procedures applicable to an entirely certified institution.

Further, in any other cases, where providers have submitted cost reports prepared on a basis not consistent with the provisions of certification, the providers should be required to resubmit their cost reports in accordance with the regulations.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION  
BALTIMORE, MARYLAND 21235

REFER TO:  
OA:APL

OFFICE OF THE COMMISSIONER

JUNE 15 1973

Mr. Robert E. Iffert, Jr.  
Assistant Director  
Manpower and Welfare Division  
U.S. General Accounting Office  
Washington, D.C. 20548

Dear Mr. Iffert:

Enclosed are the Social Security Administration's comments to your letter of March 19 dealing with the exchange of hospital audit information between the Medicare intermediaries and Medicaid State agency in California.

We appreciate GAO's interest and efforts in aiding us in strengthening the administration of the Medicare program, and are glad to furnish these comments to you.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "Arthur E. Hess".

Arthur E. Hess  
Acting Commissioner of Social Security

Enclosure

## APPENDIX IV

### COMMENTS ON GAO'S LETTER TO SSA ON THE NEED FOR AN EXCHANGE OF HOSPITAL AUDIT INFORMATION BETWEEN THE MEDICARE AND MEDICAID PROGRAMS IN CALIFORNIA

In reviewing Medicare and Medicaid reimbursement to proprietary hospitals in California, GAO noted that the same hospitals were separately audited by the Medicare intermediary and the State Medicaid agency; moreover, although cost adjustments disclosed by these audits were often applicable to both programs, there were no formal arrangements between the intermediaries and the State agency for exchanging this information. By comparing the cost adjustments shown in the separate Medicare and Medicaid audits of 27 hospitals, GAO concluded that Medicare reimbursement to these hospitals could have been reduced by \$127,300 if the intermediary had had access to and applied the adjustments contained in the Medicaid audits and, by the same token, Medicaid reimbursement could have been reduced by \$224,700 if the State agency had used the Medicare audit adjustments.

As a result of these findings, GAO has asked for SSA's views on (1) the advisability of exchanging without charge Medicare and Medicaid audit information in California, and (2) any legal obstacles which would prohibit such an exchange.

In developing policies for administering the hospital benefits aspects of the Medicare program, SSA's efforts have been directed toward achievement of two important but, to a degree, divergent objectives. On the one hand, we want to assure that reimbursement to a hospital represents the actual cost incurred for services to Medicare patients and, on the other hand, we want to make sure that the intermediary's administrative costs, of which hospital auditing is a major part, are kept to a minimum. In working toward these objectives, we have for some time been encouraging intermediaries and State agencies to agree to a single or common audit of a hospital's Medicare and Medicaid costs with each program sharing the expense of the audit. To facilitate the hospital's allocation of its costs to these programs, and to aid the auditor in making sure that these allocations are correct and that each program bears only those costs that are allowable and properly chargeable to it, SSA has developed a combined hospital cost report which incorporates both Medicare and Medicaid costs in one form.

Savings resulting from the use of common audits--as opposed to separate audits--obviously can be substantial. And it is primarily for this reason that we have generally insisted that unless a Medicaid State

agency agrees to participate in common audits of hospitals and share the auditing costs, the intermediary should not furnish the State agency, free of charge, information on the results of Medicare's hospital audits. Undoubtedly, this policy has functioned as an incentive to many State agencies to join with the intermediaries in common Medicare-Medicaid audits.

As GAO's letter indicates, the California intermediaries and the State agency have not entered into a common audit agreement. One reason is that the State agency has not agreed to adopt the combined hospital cost report developed by SSA. Another, and more important reason, is that under California law a hospital's Medicaid costs had to be audited within 18 months of the receipt of its cost report, whereas under SSA guidelines that same hospital's Medicare costs could be audited within three years. In the past the intermediaries could not give assurance that hospitals would be audited within 18 months and, consequently, the State agency felt it necessary to undertake its own audits in order to satisfy this statutory requirement. Recently, the State agency has sought to have the legislature adopt a longer audit time limitation. And SSA, in its budget guidelines for fiscal year 1974, has asked intermediaries to schedule their audits so that all hospitals' Medicare costs can be settled within a 12-month period. In light of these actions and other cooperative measures discussed below, we believe that the factors which have worked against the use of common audits in California are being resolved.

At the present time our San Francisco Regional Office is working closely with the California intermediaries and the State agency in planning two pilot studies aimed at alternate ways of achieving, in effect, common audits of hospitals. In one study, the State agency will review 20 hospital audits already completed by the Southern California intermediary to determine whether Medicare audits are adaptable for purposes of determining Medicaid costs. The other study will involve 20 upcoming hospital audits by the Northern California intermediary. Here the State agency, together with the intermediary, will have input in establishing such things as the scope of the audit, the areas to be given special audit attention, and other factors necessary to tailor the audit to the specific needs of both programs. Planning for these studies has gone forward with the understanding that the State agency will share the expenses of the audits involved.

The importance of these studies--leading as they do toward single or common hospital audits--make it advisable to temporarily defer consideration of a general policy of furnishing Medicare audit information free of charge to the California State agency. To institute this kind of policy now would remove much of the State agency's motivation for cooperating in the studies and could thwart or seriously delay them. However, to assure consideration, by both Medicare and

## APPENDIX IV

Medicaid programs, of the results of any other hospital audits made while these pilot studies are going on, we will notify the Regional Office to work with the California intermediaries and State agency in making arrangements for the exchange of audit information during this interim period. We will also work with these intermediaries and State agency in considering the feasibility of amending previous hospital cost settlements wherein one program may not have taken into account the audit adjustments of the other.

In a large majority of the States, the exchange of Medicare and Medicaid audit information is not a problem; either the State agencies are participating in common audits, or the same organization functions as both Medicare intermediary and Medicaid fiscal agent. However, there are still some States that have separate Medicare and Medicaid fiscal organizations which, as in California, do not participate in common audits. Should we find, in any of these States, that audit information is not being exchanged or is not available to the other party, we will take steps to try to make sure that in the future each program considers the audit adjustments of the other.

Earlier we mentioned the savings--and there are other important advantages--that are inherent in the use of common audits as opposed to separate audits. These savings or advantages are compounded and become particularly significant when the use and effect of the two types of audits are considered and compared over the long-term. In light of this, the Bureau of Health Insurance has been seeking alternative measures to speed-up and assure the use of common audits in all States. One alternative being looked into would make common audits mandatory for those hospitals providing services under Federally-supported programs--such as Medicare and Medicaid--with the Federal Government bearing the entire cost of the audits. While many aspects of this proposal appear attractive, additional work has to be done, including the making of cost-benefit analyses. And the viewpoints of components both within and outside the Department have to be considered before a decision can be made on formalizing the proposal.

In asking for SSA's views on whether any legal obstacles stand in the way of the free exchange of audit information between Medicare and Medicaid in California, GAO's letter makes reference to our earlier advice to the San Francisco Regional Office to the effect that since amounts charged to the trust fund were not to be used for non-Medicare purposes, the State agency should assume its share of the cost of any Medicare audits that it wanted to use in administering the Medicaid program. We further advised the Regional Office to increase its efforts to obtain the State agency's agreement to the use of common audits. We believe that this advice was proper since it recognized that in continuing to make separate Medicare and Medicaid audits,

both programs would be bearing auditing costs that could be lessened if the State agency were to agree to engage in common audits. As we indicated above, considerable headway has been made toward this agreement. In answer to GAO's question, where a Medicare audit has been made and the expense of furnishing the audit adjustments to the State agency would be minimal, such as copying or duplicating, we do not believe that there would be any legal problems to the exchange of such information without charge.

As a side issue, the letter mentions that Section 232 of the 1972 Amendments permits the States to develop their own methods and standards for determining reasonable costs for inpatient hospital care under Medicaid, but limits these costs to the amounts that would have been determined as reasonable had Medicare's reimbursement principles been used. GAO has asked how this provision can be uniformly complied with at individual hospitals if State agencies are not made aware of Medicare's audit adjustments. At this time we do not know which State agencies, if any, will elect to apply this provision or what methods and standards they may use. Assuming that some do decide to implement it, we will then issue guidelines aimed at making sure that, wherever appropriate, State agencies will be advised of hospitals' Medicare costs as adjusted by audit.

APPENDIX V



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
OFFICE OF THE SECRETARY  
WASHINGTON, D.C. 20201

MAR 25 1974

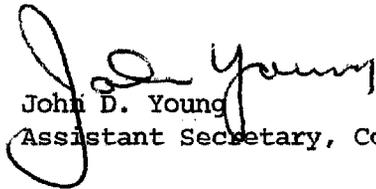
Mr. Ronald F. Lauve  
Assistant Director  
Manpower and Welfare Division  
General Accounting Office  
Washington, D.C. 20548

Dear Mr. Lauve:

The Secretary asked that I reply to your request for comments on your draft audit report entitled, "Need for More Consistent Application of Principles to Hospitals and Skilled Nursing Facilities Participating in Medicare and Medicaid." Our comments are enclosed.

The opportunity to comment on this report in draft form is greatly appreciated.

Sincerely yours,

  
John D. Young  
Assistant Secretary, Comptroller

Enclosure

COMMENTS ON GAO'S DRAFT REPORT ENTITLED, "NEED FOR MORE CONSISTENT APPLICATION OF REIMBURSEMENT PRINCIPLES TO HOSPITALS AND SKILLED NURSING FACILITIES PARTICIPATING IN MEDICARE AND MEDICAID"

Our comments on the individual recommendations in GAO's report are set forth below.

Recommendation: Catalog and make available to the intermediaries and Medicaid State agencies, providers, and the Provider Reimbursement Review Board all SSA decisions or specific interpretations affecting the determination of Medicare's share of hospital or SNF costs.

SSA's principal method of disseminating provider reimbursement policy is by publishing regulations followed by intermediary and provider manual instructions, intermediary letters and instructions on the preparation of cost reports. These instructions furnish both general and specific guidance on the methods and procedures to be followed to insure a uniform application of the reasonable cost provisions of the law and regulations. Using those guidelines, an intermediary or provider can determine the allowability of a cost and the method of allocating costs in given situations.

Sometimes, of course, questions may be forwarded to SSA for resolution because a better understanding of the rule is needed before applying it to a particular case. When it comes to the attention of SSA that program instructions or guidelines are incomplete, lack clarity, or are in conflict with each other, necessary action is taken to correct the situation by revising or expanding the existing instruction where indicated. Sometimes, the intermediary cannot decide which rule to apply in a given factual situation. In these cases--many of which may be one-of-a-kind--a general instruction to all intermediaries is not needed, only a letter of explanation to the intermediary involved. Lastly, cases are brought to SSA's attention because either a provider or intermediary has not complied with SSA rules. The examples cited in GAO's report reflect those various situations.

We would like to point out that on a highly selective basis SSA does give general distribution of our individual letters to an intermediary providing advice on the interpretation or application of a particular reimbursement principle in a specific case. The reason we have not established a general policy of distributing all such letters is that in most instances the questions raised relate to a given case and the limited circumstances present do not have any general application. In addition, in most cases the letters do not contain a full set of particulars nor the substantial factual recitation needed to make them useful as precedents in the future. It is primarily for this reason that we do not agree with GAO's recommendation that it would be useful to catalog and make available to the intermediaries and other interested parties the decisions or interpretations to all questions or issues that may be raised. Nevertheless, we do recognize that there are situations, including several of those cited in the GAO report, where there is a

## APPENDIX V

need for wider distribution of some decisions and interpretations. As indicated above, we think that this can best be done by incorporating them in existing instructional vehicles. Accordingly, in the future SSA will seek to promptly incorporate in its manuals or other instructional materials any decisions or interpretations that may have broad application.

Recommendation: Establish more definitive guidelines and criteria for intermediaries to follow in making judgmental decisions in the matters of owners' compensation and excess uninvested cash in computing return on equity.

The regulations state in effect that proprietary providers may claim "reasonable" compensation for the services of owners if the services are necessary and are actually performed. As GAO mentions, SSA has issued guidelines and instructions establishing, by geographic areas, ranges of reasonable compensation. The ranges are based on the intermediaries' surveys of administrator salaries paid by proprietary and nonproprietary institutions in the areas.

The purpose of the guidelines is to assist the intermediary in evaluating, on an individual basis, the reasonableness of the compensation paid for on owner's services. Reasonableness in this setting depends on many variables, some of which are not quantifiable and others not readily defined. To introduce a further degree of rigidity into the system by providing very precise or definitive criteria would, in our opinion, lead to inequities far outweighing any inconsistent application among intermediaries that might currently exist. However, in line with GAO's recommendation, SSA will (1) revise its manual instructions to more clearly define what constitutes "full-time" services of owner-administrators, (2) emphasize to intermediaries the importance of following the prescribed guidelines, and (3) provide clarification in those areas where GAO noted some intermediary misunderstanding. In addition, SSA will study the practicability of developing guidelines for intermediary use in identifying a provider's excess uninvested cash for computing the return on equity capital.

Recommendation: Require that there be a full exchange of Medicare and Medicaid audit information in those instances where no common audit agreement has been reached between a Medicare intermediary and a Medicaid State agency or its fiscal agent.

Several years ago the Social Security Administration and the Social and Rehabilitation Service developed a combined cost report form to be used primarily by hospitals for claiming reimbursement under both the Medicare and Medicaid programs. At about the same time, SSA and SRS began encouraging Medicare intermediaries and Medicaid State agencies to negotiate common audit agreements calling for a single audit of a hospital's costs, with the cost of the audit being shared by both programs. The principal advantage of a single or common audit is, of course, the avoidance of duplicate audit effort and unnecessary auditing costs.

Twenty-eight States--or nine more than GAO's report mentions--have signed agreements as of December 31, 1973. In addition, as of that date common audit agreements were in process in two other States and the District of Columbia, and we are hopeful that an agreement will be reached in California upon completion of two pilot studies. As of the end of December, negotiations or discussions were being carried out in eleven additional States.

This progress in persuading States to adopt the common audit has been due in large part to the fact that participation in common audits would be less costly to them than separate Medicaid audits or the charge that Medicare could impose for access to its hospital audit information. If we were to tell those States that have not yet agreed to the common audit that we will furnish Medicare audit information and results to them free-of-charge, it would be very unlikely that they would agree to join in the common audit and to share in the costs of those audits. Moreover, those States which already use the common audit would probably want to reconsider and perhaps abandon it. In short then, under present circumstances, we believe that the common audit program and its continued use and growth is contingent upon our decision to charge State Medicaid agencies, that do not join in common audits, for any Medicare audit information they request.

As the report mentions, we are exploring an alternative course whereby common audits would be mandatory for those hospitals providing services under Federally supported programs--such as Medicare and Medicaid. While many aspects of this proposal appear attractive, additional work has to be done including determinations about its cost effects and whether it could be put into force through administrative regulations or whether legislation would be needed.

APPENDIX VI

PRINCIPAL OFFICIALS OF  
 THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
 RESPONSIBLE FOR ADMINISTERING  
 ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	<u>From</u>	<u>To</u>
<b>SECRETARY OF HEALTH, EDUCATION, AND WELFARE:</b>		
Caspar W. Weinberger	Feb. 1973	Present
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
<b>ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:</b>		
James S. Dwight, Jr.	June 1973	Present
Francis D. DeGeorge (acting)	May 1973	June 1973
Philip J. Rutledge (acting)	Feb. 1973	May 1973
John D. Twiname	Mar. 1970	Feb. 1973
Mary E. Switzer	Aug. 1967	Mar. 1970
<b>COMMISSIONER OF SOCIAL SECURITY:</b>		
James B. Cardwell	Sept. 1973	Present
Arthur E. Hess (acting)	Mar. 1973	Sept. 1973
Robert M. Ball	Apr. 1962	Mar. 1973