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BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Problems In Auditing Medicaid Nursing Home Chains

Headquarters for nursing home chains engage in financial transactions with their affiliates. The nursing homes put in claims for the costs of such transactions on their cost reports--the basis on which the States reimburse them for care provided to Medicaid patients. Some of these claims are unallowable and result in the homes being overpaid.

The Secretary of HEW should direct the Administrator of the Health Care Financing Administration to

- --provide for the exchange of headquarters audit results among all affected Medicare intermediaries and State Medicaid agencies and
- --establish procedures to designate a single Medicare intermediary or State Medicaid agency as having audit responsibility for each nursing home chain headquarters.

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COMPTROLLER GENERAL OF THE UNITED STATES
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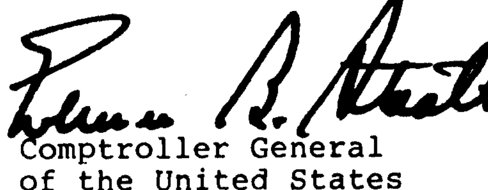
To the President of the Senate and the
Speaker of the House of Representatives

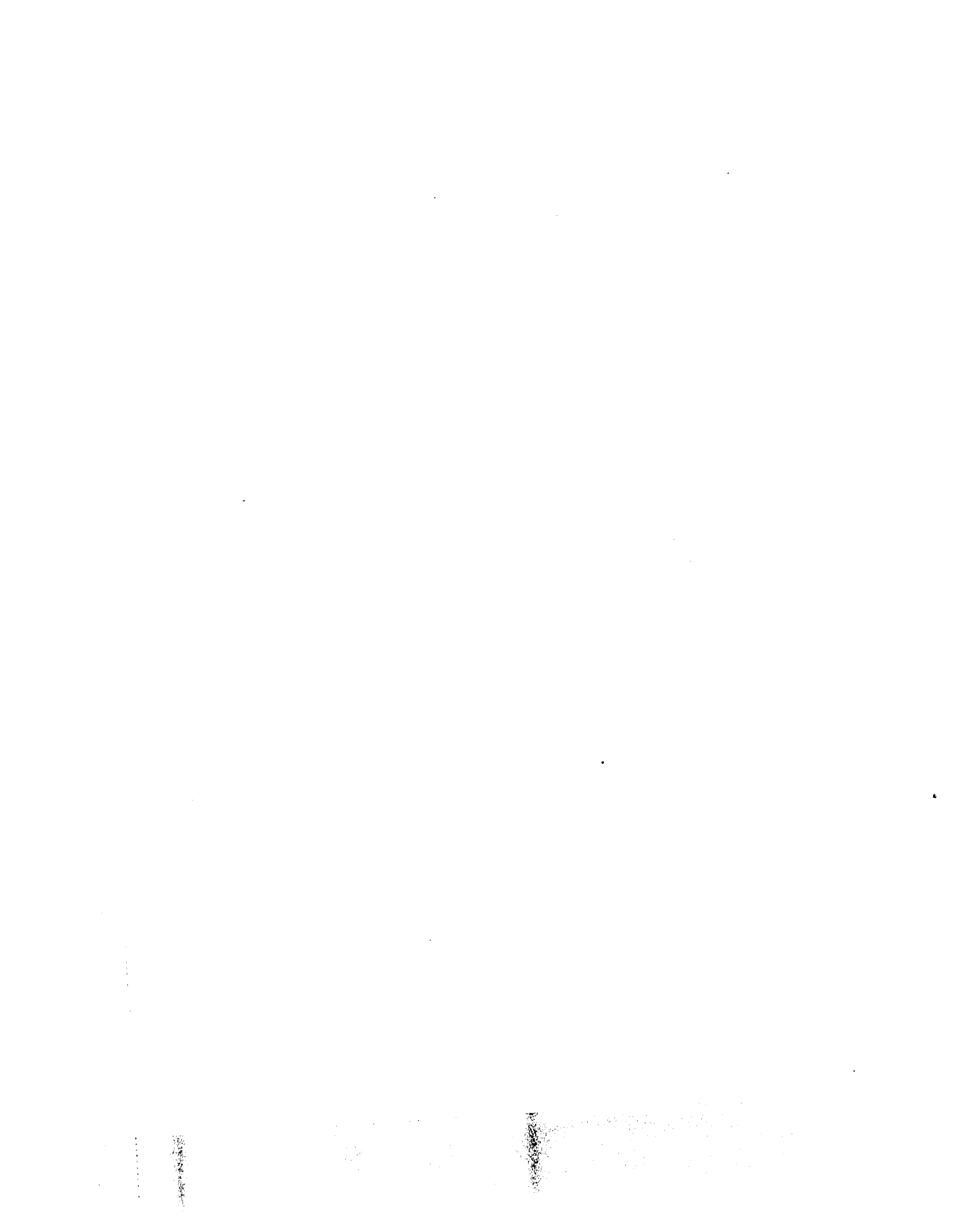
This report discusses the need for improved coordination in making onsite audits of headquarters offices of nursing home chain organizations participating in the Medicaid program. HEW and the States need to improve audit coordination and exchange audit results to expand audit coverage and eliminate overlapping audits of some headquarters offices.

We made this review 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; the Secretary of Health, Education, and Welfare; and to other interested parties.



Comptroller General
of the United States



COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

PROBLEMS IN AUDITING MEDICAID NURSING HOME CHAINS

D I G E S T

Ineffective auditing of Medicaid payments to nursing home chains--a group of two or more nursing homes commonly owned or controlled--resulted in homes being overpaid. Unallowable costs relating to homes' transactions with chain headquarters were claimed and allowed for reimbursement. (See p. 7.)

GAO made this review to determine if

--Medicaid reimbursement for nursing home chain headquarters' costs was related to patient care and

--the States effectively audit nursing home chain operations. (See p. 5.)

There are three major causes contributing to this problem.

--The States were not consistently field auditing charges from the chain headquarters. Prior to this review most of the headquarters had not been field audited by all of the States in which the chains had nursing homes. (See p. 18.)

--Results of chain headquarters audits were not shared with other affected States. (See p. 19.)

--Because of the complexity of some chain transactions and relationships, it is sometimes difficult to determine whether chain affiliations exist or transactions between related parties have occurred. However, nursing homes are now required to disclose more information about ownership, control, and business transactions than was previously required. This should minimize this problem. (See p. 20.)

HEW has no system by which Medicaid auditors can coordinate audits or exchange audit results. Medicare, by contrast, already coordinates audits of chain headquarters and exchanges audit results among Medicare intermediaries who audit Medicare cost reports; with some changes this system could be adapted for Medicaid use. (See p. 19.)

RECOMMENDATIONS

The Secretary of HEW should direct the Administrator of the Health Care Financing Administration to

--provide for the exchange of audit results at nursing home chain headquarters among all affected Medicare intermediaries and State Medicaid agencies and

--establish procedures to designate a single Medicare intermediary or State Medicaid agency as having audit responsibility for each nursing home chain headquarters. (See p. 22.)

HEW AND STATE COMMENTS

HEW agreed with GAO's conclusions and said it was taking action to carry out GAO's recommendations. (See p. 23.)

Three of the four States commenting on our draft report (Florida, Iowa, and Nebraska) agreed with GAO's conclusions and recommendations. Kansas did not comment on our conclusions and recommendations but said it was making progress in field auditing chain headquarters. (See p. 23.)

The chains' comments where received have been incorporated into the discussion of each chain.

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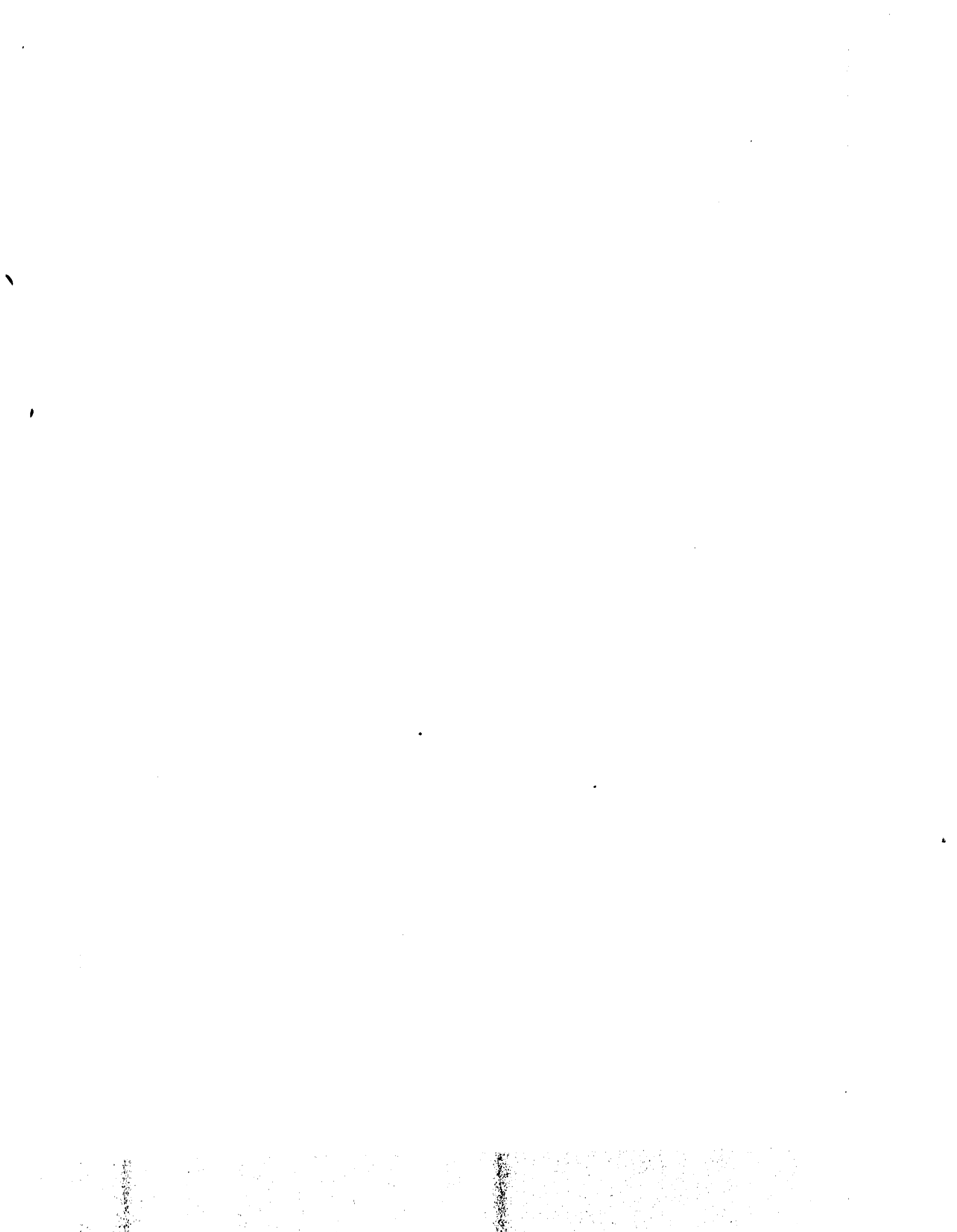
ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare



CHAPTER 1

INTRODUCTION

An organization comprising two or more nursing homes linked by common ownership or control is referred to as a nursing home chain. Available information indicates that a large and increasing number of nursing homes are affiliated with chains. Our review was made to determine if

- --Medicaid reimbursement for nursing home chain headquarters' costs was related to patient care and
- --the States effectively audit nursing home chain operations.

Medicaid--authorized by title XIX of the Social Security Act, as amended--is a grant-in-aid program under which the Federal Government pays from 50 to 78 percent of the costs incurred by States in providing medical services to persons unable to pay for such care. In fiscal years 1976 and 1977, 1/ the State programs paid about $5.4 billion and $6.4 billion, respectively, for nursing home care provided to Medicaid patients. The Federal share of these costs was about $3.0 billion and $3.6 billion for fiscal years 1976 and 1977, respectively.

At the Federal level, the Medicaid program is administered by the Health Care Financing Administration within the Department of Health, Education, and Welfare (HEW). The States have primary responsibility for administering their Medicaid programs.

Nursing home chains can be organized in a number of different ways. For example, a chain could be a corporation established for the purpose of owning and/or operating nursing homes. A corporation might control the homes directly or through subsidiary corporations wholly owned by the parent corporation. Or a chain could be created by a person or group of persons who establish separate corporations to own or operate nursing homes. In this case the link in the chain is the common ownership of the stock in the separate corporations.

1/The fiscal year figures exclude the transition quarter (July through Sept. 1976).

Representatives of two nursing home industry trade associations did not know how many nursing homes nationwide were chain affiliated. One representative estimated that, nationwide, 25 to 30 percent of the homes and 35 percent of the beds were owned or controlled by chains. Both individuals agreed that chains own or control a steadily increasing percentage of the nursing homes in the country.

NURSING HOME REIMBURSEMENT

Until July 1976 Federal regulations stated that Medicaid payments for nursing home services shall be "customary charges which are reasonable" and should not exceed the Medicare 1/ payment rate. Medicaid reimbursement rates were established on either a cost-related or fixed-fee basis. When rates were established on a fixed-fee basis, the rates could be based on (1) the cost of care, (2) the amount of State funds available to pay for care, or (3) some combination of both. When rates were established on a cost-related basis, HEW regulations provided for "appropriate audits."

Section 249 of Public Law 92-603, enacted October 30, 1972, required that, effective July 1, 1976, Medicaid nursing homes in all States be reimbursed on a "reasonable cost-related" basis. Implementing regulations issued by HEW on July 1, 1976, did not require States to comply until January 1, 1978. 2/ Included in the implementing regulations are requirements that States field audit each nursing home at least once during a 3-year period (which begins not later than January 1, 1978) and that a minimum of 15 percent of all nursing homes be field audited each year thereafter. HEW regulations also require that, except for Government institutions operating on a cash accounting basis, nursing homes report their allowable costs on the basis of generally accepted accounting principles and the accrual method of accounting.

1/Medicare, authorized by title XVIII of the Social Security Act, is the Federal health insurance program for the aged and disabled. Part A of Medicare provides hospital insurance and also covers certain posthospital care in skilled nursing facilities. During fiscal year 1977 the Medicare program paid about $380 million for skilled nursing home care--which was much less than the $6.4 billion paid by Medicaid for its nursing home care.

2/This delay has been the subject of litigation in a number of court suits.

Types of cost-related reimbursement systems

There are two general types of cost-related reimbursement systems. One is "retrospective," whereby the final reimbursement rate is calculated on the basis of actual allowable costs incurred during the year. Because the final rate cannot be calculated until after the fiscal year, an interim or temporary rate based on estimated costs is paid during the year and a final corrective settlement is made for overpayments or underpayments on the basis of the actual allowable costs incurred in providing services to Medicaid recipients.

The other type of cost-related reimbursement system is "prospective." In prospective systems, the reimbursement for one period is calculated on the basis of actual costs incurred in a preceding period and is usually adjusted for inflation. Normally, the prospective reimbursement rate is not adjusted later even if actual costs and expected costs differ. However, adjustments in the rate can be made if an audit determines that the actual costs used to establish the rate were misreported. Most States now use prospective reimbursement systems in their Medicaid programs.

Medicare reimbursement principles

HEW has issued a provider reimbursement manual which describes principles and guidelines for Medicare's cost-based reimbursement system for institutional providers such as hospitals and nursing homes. States are free to adopt some or all of Medicare's principles for their Medicaid reimbursement systems. The States we visited used all or substantial portions of these Medicare principles in reimbursing nursing homes for care provided to Medicaid patients. In all cases where State rules varied from Medicare's, we used State rules to calculate actual overpayments to individual nursing homes.

Medicare reimbursement principles, consisting of essentially three features, provide guidance to those who fill out the cost reports and to those who audit the reports on how to:

- --Determine which costs are reasonable and related to patient care and which are unrelated and, therefore, unallowable.

--Allocate overhead costs between the (1) routine care services used by all patients and (2) ancillary care services whose use depends on each patient's medical condition. (This process is known as cost finding.)

--Distribute routine and ancillary costs between Medicare and non-Medicare patients. (This process is known as cost apportionment.)

The "related organization" rule is one rule in the provider reimbursement manual. In general this rule requires that the reimbursable cost of goods or services provided to a nursing home by a related organization be whichever is lowest: actual cost to the related organization, or price of comparable goods or services available elsewhere. Organizations are deemed to be related if they are owned or controlled by the same person or persons.

Transactions between related parties or organizations are often described as "less-than-arms-length" transactions because the parties are on friendly terms and are presumed to share a common interest in each other's welfare. This contrasts to a transaction "at arms length" in which the unrelated parties are presumed to be concerned with their own welfare and would be willing to enhance their welfare at the expense of the other party, within the limits of law and custom.

Application of reimbursement principles to chain-affiliated nursing homes

Medicare guidelines provide that reimbursement to a nursing home affiliated with a chain should be computed using the same principles as if it were not so affiliated. Calculation of each nursing home's share of the chain's headquarters costs is a three-step process. First, a determination must be made as to which headquarters costs are allowable and related to patient care. Costs associated with an unrelated business that shares headquarters office space or staff, for example, would be disallowed.

The second step is the direct assignment of allowable costs to individual nursing homes or subgroups of homes if these costs apply only to one home or to a portion of the chain's homes. The only costs that should remain in the headquarters "pool" of unallocated costs after completing this step are those costs that cannot reasonably be attributed to one home or subgroup of homes. An example of a cost that would properly remain in the pool would be janitorial services in the headquarters office.

The third step is allocating the remaining pooled costs among the individual nursing homes or subgroups of homes on a reasonable basis, such as the number of beds or patient days in each home. 1/ Similarly, the allocation of costs among homes in a subgroup must be reasonable. Once all allowable costs have been allocated to individual nursing homes, the costs should be put in the proper category on the home's cost report--just as is the case with any cost originating at the home itself.

In both Medicare and Medicaid, cost is calculated on a home-by-home basis. A chain may not transfer a portion of the costs belonging to a high-cost nursing home and report it as a cost belonging to a low-cost home. Each nursing home should include on its cost report those allowable costs it incurs and its share of allowable pooled headquarters costs.

SCOPE OF REVIEW

Our review was made to determine if

--Medicaid reimbursement for nursing home chain headquarters' costs was related to patient care and

--the States effectively audit nursing home chain operations.

We visited the HEW regional offices in Atlanta and Kansas City and State Medicaid agencies in Florida, Georgia, Iowa, Kansas, Nebraska, Oklahoma, South Carolina, South Dakota, and Tennessee. We examined administrative and property costs at six for-profit and two nonprofit chains, which collectively owned or controlled 302 nursing homes in 28 States. We also examined information provided to Florida State auditors as a result of a desk audit of an eight-home chain that operated in Florida and Georgia. We attempted to independently analyze some of the financial transactions of this chain; however, we were denied access to the chain's financial records.

We wanted to review a cross-section of nursing home chains. Therefore, we reviewed large, small, for-profit, and nonprofit chains. We also reviewed chains that engaged in the nursing home business only and chains that were more diversified.

1/Effective November 1, 1976, pooled costs must be allocated to nursing homes on the basis of patient days or total nursing home costs before allocation of headquarters costs.

None of the nursing home chains discussed in this report are identified. At the time we started our fieldwork our legal authority for auditing these organizations in connection with State-operated Medicaid programs was unclear, and in order to obtain the cooperation of chain officials and access to chain organizations' records we told the chains that they would not be identified by name in our final report.

CHAPTER 2

HEW NEEDS TO HELP STATES OVERCOME PROBLEMS IN AUDITING NURSING HOME CHAINS

Nursing home chains vary greatly in size and organization as well as in the range of services the headquarters staff furnishes to their individual nursing homes. A headquarters staff normally does not provide services directly to patients in the chain's homes. However, chains often provide administrative services to their affiliated homes, loan money to them, and engage in property transactions with them.

We found that the States were not effectively auditing Medicaid payments to nursing home chains. Cost reports we examined contained costs that should have been disallowed but often were not. The States were improperly reimbursing (1) fees for headquarters administrative services which were higher than the cost of the services, (2) interest on intercompany loan transactions, and (3) charges associated with property transactions with related organizations or persons.

In most cases where we identified costs that should have been disallowed in chain-affiliated nursing home cost reports, the States had desk audited 1/ the cost reports but had not field audited the chain headquarters office. Generally, we observed that when States field audited a chain headquarters, the headquarters was located within the State.

We believe there are three major causes for State auditors allowing unallowable costs.

--State auditors failed to field audit the chain headquarters office as part of the audit of an affiliated nursing home cost report, particularly when the headquarters is out of State.

1/A desk audit normally takes place in the auditor's office and consists of an examination of cost reports and other documents submitted to the auditor. A field audit, by contrast, takes place at the chain's place(s) of business and consists of an examination of accounting records and supporting documents such as payrolls and invoices.

--Even when field audits of chain headquarters were made by State Medicaid agencies or a Medicare intermediary, 1/ the audits were not coordinated, nor were audit results exchanged.

--Because of the complexity of some chain transactions and relationships, it is sometimes difficult to determine whether chain affiliations exist or less-than-arms-length transactions have occurred.

In October 1977 the Congress passed Public Law 95-142, the Medicare-Medicaid Antifraud and Abuse Amendments. The law requires HEW to issue regulations requiring that nursing homes participating in Medicare or Medicaid disclose more information about ownership, control, and less-than-arms-length transactions than was required under earlier law and regulations. We believe that the implementing regulations could significantly reduce the information-gathering problems we identified if HEW carefully considers the information needs of State and Federal auditors.

In our opinion HEW should help the States audit nursing home chains by providing for an exchange of information--including results of audits at nursing home chain headquarters--among all affected Federal and State auditors. In addition, HEW could attain important savings in audit costs and eliminate duplicate audits by making provisions for having only one audit at an interstate chain headquarters serve all affected Federal and State auditors.

NURSING HOME CHAINS OVERCHARGING THE MEDICAID PROGRAM

Five of the eight nursing home chains we audited overcharged the Medicaid program. According to the audit work conducted by Florida's auditors, the chain which denied us access to its financial records also overcharged the Medicaid program. These overcharges involved costs in one or more of the following categories:

1/Medicare intermediaries are agents under contract to administer portions of the program and to make payments to hospitals and skilled care facilities on behalf of Medicare. Auditing is one of the responsibilities assigned to intermediaries.

--management fees paid to headquarters by nursing homes which exceeded headquarters' allowable costs;

--interest on loans between the headquarters and the nursing homes; and

--property transactions between the chain and either the nursing homes or related parties, such as chain officials and their relatives.

The related organization rule applied to some of the property transactions we reviewed. It was sometimes difficult to determine when the related organization rule applied, because the information on file with the State Medicaid agencies did not clearly show the actual relationships among the involved parties. After our audits, what initially appeared to be arms-length transactions often turned out to be less-than-arms-length transactions involving the chain and/or its officers, resulting in additional costs to the Medicaid program. Usually the less-than-arms-length transactions could not be identified unless the headquarters was field audited and cost reports from affiliated nursing homes were analyzed and compared. In one case even this did not suffice, and we had to use information on file with the Securities and Exchange Commission in Washington, D.C., to unravel the complex relationships among the people and corporations involved.

Following is a discussion of three of the nursing home chains included in our review. A discussion of three other chains is included as appendix I. (See p. 25.)

Chain A

Services provided to this large nonprofit chain's nursing homes by the headquarters included accounting, payment of general liability and unemployment insurance, and administrative services. Ten of the chain's homes participated in Medicare but most did not. Each home was assessed 4.5 percent of its gross revenue and 1 percent of its salaries to pay for these services. The fees charged to nursing homes during fiscal year 1976 totaled nearly $817,000 more than the headquarters' actual allowable costs of $3 million. The chains' nursing homes usually claimed as headquarters costs their share of the $3.8 million they were collectively billed by the headquarters and not their share of the actual cost of $3 million. A chain official stated that the charges to the nursing homes were based on an estimate of the costs of the services provided.

We examined the cost reports filed by the chain's nursing homes in four midwestern States to determine the effect of the $817,000 excess charges on Medicaid payments. In accordance with the chain's usual practice, the homes in these four States were collectively billed $554,000 over the actual costs of the headquarters office. The excessive claims resulted in overpayments of $215,000 by the four State Medicaid programs. Three of the States had prospective reimbursement systems, so the excessive claims inflated the payment rates for a subsequent period. The fourth State had a retrospective reimbursement system; we calculated the effect of the excessive claims on the interim payment rates for a subsequent period.

In its September 1978 comments on a draft of this report, the chain stated that it was "not a willful disregard of the regulations" for its nursing homes to routinely claim as fiscal year 1976 Medicaid reimbursable costs the fees charged to each home rather than the cost of the headquarters services performed. The chain stated that it had begun to claim costs rather than fees in all its homes starting with fiscal year 1977.

This chain had followed a policy of advancing any available funds at headquarters to its nursing homes. In November 1976 the board of directors were advised of a change in the chain's policy, which was designed to eliminate such advances because States were generally not permitting the homes to charge their Medicaid programs for interest expense on advances from headquarters. At the time such advances totaled nearly $3 million. Interest expense on loans from unrelated lenders is normally an allowable cost under Medicare and Medicaid, provided such loans are necessary (i.e., incurred to satisfy the providers' financial need and for a purpose reasonably related to patient care.)

Therefore, under the new policy the headquarters would invest savings at a local bank as collateral for a loan to the home, and the home would repay headquarters. According to a headquarters official the repaid advances were invested; however, no portion of the interest income earned by headquarters--amounting to about $113,000 in 1976--was applied to offset the interest expense claimed by the homes. Three of the four midwestern States where we examined this chain's cost reports followed Medicare's reimbursement principles, which state that interest expense must be reduced by investment income except when the investment income is from grants and gifts which are not commingled with other funds. The other State's policy was that all allowable costs should be

net costs. Thus, we believe that the chain should have offset its interest income against chain interest expense.

In its September 1978 comments, the chain stated that headquarters' interest income should be offset only to the extent of the headquarters' interest expense (about $25,000 in 1976) but not the total chain's interest expense. The chain also questioned how such interest income could be allocated to individual homes.

In our view, the chain's views are inconsistent with Medicare reimbursement principles. Even if headquarters' interest income was not used to offset the interest expense claimed by individual homes, the fact that the chain had sufficient excess cash to make investments would support the argument that the loans to the homes were not necessary and the related interest expense was thus not allowable. We have noted several provider appeals decisions under Medicare which would support this interpretation. In any event, the chain's change in policy for managing its excess funds should not be permitted to be used by the chain as a device to maximize Medicaid reimbursement.

We also noted where costs directly associated with the purchase of nursing homes were written off as an expense rather than being allocated to those homes to be amortized over their useful lives. Both Medicare and Medicaid follow generally accepted accounting principles, and these principles require amortization of purchase costs.

Auditors from three States and from Medicare had been at this chain's headquarters before us. We reviewed the results of the work of the Kansas, Nebraska, and Medicare auditors and concluded that these audit staffs had (1) identified the importance and amounts of the variances between the fees charged by the headquarters and its costs and (2) recommended adjustments to the extent that the overcharges pertained to nursing homes in their respective States or to the Medicare program. However, neither Kansas nor Nebraska had shared its audit results with each other or with auditors from other States, even though both audits took place at the same time. There was no evidence that the results of Medicare's audit, which covered a prior period, were communicated to the States. While both States identified the total amount of allowable costs incurred by and at the headquarters, they differed by about $450,000 in the audit adjustments to (1) directly assign some costs to individual nursing homes and subgroups of homes and (2) allocate costs remaining in the pool of allowable costs among the chain's nursing homes.

We believe these differences in recommended audit adjustments could have been avoided by exchanging audit results or by coordinating audits.

In September 1978 we talked to the Kansas and Nebraska auditors about recovery of overpayments identified during their field audits at the headquarters. The Kansas auditor reported that overpayments of about $52,000 had been identified with the Kansas homes for fiscal 1976. The auditor also stated that the State made a second field audit at the chain's headquarters for fiscal years 1974 and 1975. Those audit reports were not complete, but the repayments for 1975 were expected to exceed those for 1976.

The Nebraska auditor stated that the headquarters field audit was done in conjunction with field audits at the chain's Nebraska homes, which were not completed. Therefore, final determinations of any amounts due the State had not been made for fiscal year 1976. The auditor also stated that the State had recently finished a field audit at headquarters for fiscal year 1977, and he indicated that the chain had made quite an improvement in how it allocated and claimed headquarters costs as compared to the previous year.

Chain B

As of April 1976 this for-profit interstate chain operated 20 nursing homes in three States. Twelve homes were owned; the remaining 8 were leased. None of the homes participated in the Federal Medicare program. The chain, organized as a parent corporation with several wholly owned subsidiaries, had engaged in a number of property transactions over the years. We selected one transaction involving the sale and leaseback of two nursing homes to illustrate how complex these transactions can be.

In April 1976 the parent corporation's president and executive vice president owned 24 percent and 41 percent, respectively, of the outstanding common stock. Because of policy differences between these two principal stockholders and to avoid any harm to the parent corporation which could result from their conflicting views, the president and the corporation agreed upon the division of the business.

On June 30, 1976, the president resigned from the parent corporation, and sold part of his stock to his successor. Under an exchange agreement dated June 30, 1976, the former president traded the rest of his stock to the parent corporation for all the stock of a subsidiary corporation, to which

the parent corporation had transferred two Kansas nursing homes. The executive vice president became the new president and chief executive officer of the parent corporation. The next day the former subsidiary leased the two homes back to the parent corporation in 1-year leases for a total of $198,000.

When the former subsidiary corporation acquired the two nursing homes, it assumed the parent's existing mortgages on the homes of approximately $800,000, including nearly $67,000 owed to another wholly owned subsidiary. When it acquired the two homes, the former subsidiary executed a mortgage and assignment of rents to the parent as security for the assumption of the existing mortgages. This complicated series of transactions included several other mortgage and assignment-of-rent agreements.

After about a year, the two nursing homes were acquired by a Texas corporation whose president (1) is the father of another of the parent corporation's vice presidents and (2) had engaged in earlier mortgage and assignment-of-rent transactions with the former subsidiary corporation.

We analyzed the fiscal 1976 cost reports filed for the two homes by the parent corporation as the operator of record for the entire year ended October 31, 1976. During the first 8 months the parent corporation was also the recorded owner, and during the last 4 months the former subsidiary wholly owned by the parent's former president was the recorded owner and lessor.

The Kansas Medicaid cost report requires a lessee nursing home operator to provide a copy of lease agreements that cover the reporting period, unless the agreements were submitted with an earlier cost report. The parent corporation, as the lessee and operator of record for both homes, submitted copies as required. The State had desk audited both cost reports before our review.

Based on the information in the cost reports and lease agreements, we projected (1) the property costs which would have been incurred by the chain for the year ended October 31, 1976, had the two homes not been transferred to the former president in exchange for his stock in the parent and (2) the chain's lease payments had the chain leased the two homes from the former president for the full year. Annual property costs rose $33,000 at one home and $6,500 at the other due

to the sale and leaseback transactions, of which Medicaid's share was about $15,400 and $5,100, respectively. Kansas reimbursed both homes based on the inflated costs 1/ because it did not identify the less-than-arms-length relationship between the two owners of record from the documents submitted by the chain.

Even though we checked records on file with both Kansas and Oklahoma, we were not able to completely unravel the relationships among the people and corporations involved nor determine the true significance of the several agreements among the parties until we examined copies of the chain's filings with the Securities and Exchange Commission in Washington, D.C. Even with all the facts before us, the number and complexity of the transactions made our analysis difficult.

All of the facts about these property transactions were not readily available to the State auditors so that they could resolve the question of whether the agreements constituted a change in ownership of property or a change in stock ownership and management of the parent corporation.

We believe that the sale-leaseback was a less-than-arms-length transaction. The president of the former subsidiary corporation (lessor) had been the president, chairman of the board, and chief executive officer of the parent corporation (lessee) for several years, up to the day before the lease agreement was executed. Moreover, there was a written agreement providing that the departing president's employment contract was to be reinstated if the exchange agreement should be voided for any reason.

During the period of the leases Kansas had a related organization rule; however, unlike Medicare, the State did not have specific provisions applicable to sale-leaseback transactions even though the State auditors referred to Medicare guidelines in reviewing claimed costs during their audits. Under Medicare, for rental charges paid to be recognized as allowable costs a sale-leaseback transaction must have been at arms length, reasonable for economic and technical purposes, and not designed to increase or accelerate program costs.

1/The inflated costs actually applied to only one-third of the 1976 cost-reporting year. The remaining effect of the inflated costs was not realized until the next year.

Although this chain was given an opportunity to comment on a draft of this report, it elected not to do so. Kansas said it made an onsite audit at the out-of-State chain headquarters in 1977 and spent several staff weeks at the headquarters attempting to unravel the relationships among the individuals and corporations involved. The State said the chain ceased doing business in Kansas in April 1978.

Chain C

This Georgia-based chain owned or managed 30 nursing homes. None of this chain's homes participated in the Federal Medicare program. Our review showed that this chain engaged in what we believe were less-than-arms-length property transactions.

Under a 10-year lease dated July 30, 1974, the chain leased one of its nursing homes to a corporate officer who resigned from the corporation soon thereafter. The lessee, as administrator of the home, claimed his fiscal year 1976 lease payments of $166,000--rather than the $134,000 cost to the chain--as a reimbursable property cost. We believe that the related organization rule applied here because the administrator signed the lease agreement while he was an officer of the chain. Furthermore, the home had a management contract with the chain, and in its annual financial report the chain described the management contract income from the home as part of income from organizations "under significant influence or with substantial common ownership."

Commenting on this report, the chain stated that the elements of common ownership and control were not present in this transaction because the lessee/administrator was nominal vice president of the chain who never had any equity ownership, never had been a member of the chain board of directors, and never executed any significant influence over the chain's policy or operations. The chain stated that the lease transaction was agreed to upon termination of the lessee/administrator's employment with the chain, and the fact that he may have executed the lease while still a titular employee was purely a technical error.

We believe the circumstances of this lease indicate it was not an arms-length transaction because the competitive forces of an open and free market were not in existence at the time the lease was negotiated. The lessee/administrator was an officer and employee of the chain when the lease terms were negotiated and agreed to, and we believe the lessee was not entirely independent of the chain's control during negotiations before the lease's execution.

The chain pointed out that we had not questioned whether the lease payments represent fair rental value, and it stated that the lease agreement had been audited by contract auditors for the State in 1975 and 1977 and had not been questioned.

We did not question the reasonableness of the lease payments because we believe the primary issue involved is whether the lease transaction was between related parties. If, as we believe, the lease was a transaction between related parties, then the controlling principle is that allowable costs shall not exceed costs to the providing organization (the chain). We noted, however, that the State auditor concluded that the fair market rental value of the leased facilities was $125,349 for the year ended July 31, 1975--about $41,000 less than the lease payment.

We also noted that in 1975 the State auditors questioned whether the chain's transactions with its nursing homes were transactions between related parties. In a May 1975 letter to the State auditors on this issue, the chain contended that it met the exception to the related organization rule in the Medicare provider reimbursement manual 1/ which provides that, if specified conditions are met, the charges by the supplier to the provider for services, facilities, or supplies are allowable as costs. However, we do not agree that the exception to the related organization rule applies in this instance because the provider reimbursement manual specifies that the exception is not applicable to rentals of facilities such as nursing homes.

Georgia State officials could not explain why the question of applying the related organization rule raised by the State auditors in 1975 was apparently left unresolved. The chain also stated that

> "The notation by [the chain's] auditors that the management fees paid by the lessee/administrator's nursing home was income from an organization 'under significant influence or with substantial common ownership' with [the chain] is of little significance, since the auditing firm makes this standard notation with every nursing home facility with which [the chain] has simply a management contract. Surely the GAO does not think that a management company

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1/Georgia uses the Medicare provider reimbursement manual to determine allowable costs under its Medicaid program.

can operate a nursing home without having 'significant influence' over its operation."

By this comment, the chain seems to be agreeing that it has a significant influence over the nursing home's operation.

The chain also leased a 101-bed nursing home to the brother of the chain's president. The brother paid $96,000 in lease payments during fiscal year 1976. Costs to the chain were $72,000. We believe that the related organization rule applied under these circumstances. This lease resulted in increased nursing home property costs of $24,000; Medicaid helped pay the increase.

The chain stated that it disagreed with our application of the related organization rule in this instance. According to the chain, the brother/lessee had never been a director, officer, or employee of the chain, and the State's Medicaid law and regulations do not specify that transactions between family members ipso facto constitute related party transactions.

Georgia regulations provide that reported costs must conform to the allowable costs discussed in the Medicare provider reimbursement manual. This manual provides that the related organization rule applies when a supplier is related to the provider by common ownership or control. An HEW representative stated that transactions between close relatives (husbands/wives, parents/children, and brothers/sisters) are not considered arms-length transactions, and the related organization rule applies to these transactions.

The chain also pointed out that we did not question the reasonableness of the lease payments and that the lease agreement had been audited twice by contract auditors for the State and had not been questioned. Our review showed that State auditors determined the fair market rental value of this nursing home to be $83,017 for the year ended March 31, 1975 (about $13,000 less than the nursing home lease payments of $96,000) and $99,688 for the year ended March 31, 1976. Also, as was true in the preceding case, in 1975 the State auditors questioned whether the chain's transactions with its nursing homes were transactions between related parties.

NEED TO COORDINATE AUDITS OF INTERSTATE NURSING HOME CHAINS

The States were not effectively auditing Medicaid payments to nursing home chains. We believe there are three major causes contributing to this problem:

(1) The States were not consistently making field audits of charges from the chains' headquarters.

(2) The States have an unmet need to exchange results of chain headquarters' audits.

(3) It is difficult to determine whether chain affiliations exist because of the complexity of some chain transactions and relationships.

Most of the chain headquarters reviewed (and the chain which refused to allow us to audit its records) had not been field audited before our review by all of the States where the chains' nursing homes had charged headquarters costs to the Medicaid program. The following table shows the headquarters field audit coverage by the States included in our review.

Chain	Number of States covered by our review where chain's homes were located	States that audited head-quarters	States not auditing headquarters
A	4	2	2
B	2	-	2
C	1	1	-
D	1	-	1
E	1	1	-
F	2	-	2
G (note a)	1	-	1
H (note a)	1	1	-
I (note a)	3	1	2
Total	16	6	10

a/These chains are not specifically discussed elsewhere in this report.

As shown above, the headquarters of 4 chains (chains B, D, F, and G) had not been field audited by any of the States covered by our review where the chains' homes were located. Although the headquarters of the remaining chains had been field audited, two chains (chains A and I) had not been field audited by all of the States where the chains' homes were located.

In regulations issued in July 1976, HEW required the States to field audit all nursing home cost reports at least once during a 3-year period beginning not later than January 1, 1978. However, there were no specific provisions dealing with the field audit of chain headquarters costs charged to the individual facilities.

Need to exchange audit results

The audit results were not shared with other affected States when States audited chains' headquarters. Auditors from three States had been to chain A's headquarters before our audit (including auditors from two States covered by our review and one additional State). None of the State audits had been coordinated, nor were the audit results shared.

At the Federal level, Medicaid has no guidelines or procedures applicable to audits of interstate nursing home chains, and we believe that this is one reason why the States have not coordinated with each other on a regular basis. Medicare, by contrast, has such guidelines and procedures already developed and in use. The Medicare provider reimbursement manual describes how a single intermediary is designated as having audit responsibility for chain headquarters' costs. The designated intermediary must perform the audit and then share the results with all other affected intermediaries. The audit results must show detailed allocations of costs to the nursing homes affiliated with the chain, together with full explanations of any adjustments.

In those cases where a nursing home participates in both Medicare and Medicaid, we believe that HEW should simply direct the auditing intermediary to send copies of its audit results to the affected State Medicaid agencies. 1/ The reports and related workpapers showing details of cost allocations should have sufficient detail to enable the States to make different determinations of allowability if their cost principles vary from Medicare's.

1/In an August 1974 report ("Need to More Consistently Reimburse Health Facilities Under Medicare and Medicaid," B-164031(4), Aug. 16, 1974), we recommended that Medicare and Medicaid share the audit results of a single audit at nursing homes when the homes participate in both programs. HEW has failed to fully implement this recommendation, although agreement has been reached between HEW and most States for a common audit of providers.

In cases where a nursing home chain participates only in Medicaid, we believe that HEW should establish procedures to designate one State to perform the headquarters audit and then share the audit results with all other affected States.

The State officials we talked to seemed willing to audit nursing home chain headquarters and to exchange audit results. They said that HEW should take the initiative in organizing a system to coordinate audits and exchange audit results, and we agree. Also, we believe it would be less burdensome on the headquarters to have a single periodic audit rather than several audits by different States.

A single field audit of each chain headquarters, with results shared among all affected States, would also reduce audit costs. Considering only the eight chains we audited, if every State audited the headquarters office of the chains having an affiliated home in that State, 44 separate audits would be required; using single audits with shared results would cut that number to 8.

Problems with identifying chain affiliation

As indicated in our discussion of chain B, it was sometimes difficult to determine whether chain affiliations exist because some chain transactions and relationships were complex. In October 1977 the Congress passed Public Law 95-142, the Medicare-Medicaid Antifraud and Abuse Amendments. Most of our fieldwork was completed before the law was passed. We probably would have encountered fewer problems with identifying this instance of a less-than-arms-length transaction if the law and its implementing regulations had been in effect during our review.

Among the provisions of this law is a requirement that nursing homes participating in Medicare or Medicaid disclose more information about ownership, control, and less-than-arms-length transactions. Specifically, the requirement that direct or indirect ownership interests of 10 percent or more be disclosed to the State was lowered to 5 percent. Nursing homes are also now required to submit, upon request, (1) information about the ownership of any supplier with whom the home did more than $25,000 of business per year and (2) information concerning any significant business transactions (to be defined by the HEW Secretary) between the nursing homes and any wholly owned supplier or subcontractor.

RECENT CONGRESSIONAL PROPOSALS TO REQUIRE AUDIT COORDINATION

In August 1978 the Senate Committee on Finance recommended the approval of H.R. 5285, the Medicare-Medicaid Administrative and Reimbursement Reform Act, which was passed by the Senate in October 1978. This bill would have required that if an entity provides services on a cost-related basis under Medicare and under the Medicaid and maternal and child health programs, the audits for the purposes of the State programs are to be coordinated through common audit procedures with Medicare audits. The Senate Committee on Finance stated it had been concerned that the duplication of identical or similar auditing procedures used to determine reimbursement under various Federal health benefit programs is costly to both the programs and the entity (such as a hospital, skilled nursing facility, or home health agency) participating in the program. 1/ The Congressional Budget Office estimated that coordination of audits would cost $14.5 million a year, but would save the Medicare program $6 million and the Medicaid program $58 million, the Federal share of which would be $35 million per year.

During the 95th Congress, the House Committee on Ways and Means recommended approval of H.R. 13817 and the House Committee on Interstate and Foreign Commerce recommended approval of H.R. 6575, both of which contained the same provision as H.R. 5285, which required coordination of audits. Both bills would have required State Medicaid plans to provide that

- --the records of any entity participating in the plan and providing services reimbursable on a cost-related basis be audited as the HEW Secretary determines necessary and
- --such audits, for entities also providing services under the Medicare program, will be coordinated and conducted jointly as prescribed by the Secretary.

In September 1978 the House of Representatives passed H.R. 13817, as recommended by the Committee on Ways and Means. However, neither H.R. 13817 nor H.R. 5285 were enacted into law prior to the expiration of the 95th Congress.

1/Senate Report 95-1111.

CONCLUSIONS

Our review showed that nursing homes are being overpaid because unallowable costs relating to transactions with chain headquarters are being claimed and allowed for reimbursement. The States often did not field audit costs of nursing home chain headquarters, even though the cost reports for the individual homes were audited and the homes were known to be chain affiliated. HEW has not established a mechanism by which States can exchange audit results. Medicare has guidelines and procedures applicable to audits of interstate nursing home chains which could be adapted for Medicaid use. A single comprehensive audit of each chain headquarters with sharing of audit results would reduce audit costs.

RECOMMENDATIONS

The Secretary of HEW should direct the Administrator of the Health Care Financing Administration to

- --provide for the exchange of audit results at nursing home chain headquarters among all affected Medicare intermediaries and State Medicaid agencies and

- --establish procedures to designate a single Medicare intermediary or State Medicaid agency as having audit responsibility for each nursing home chain headquarters.

CHAPTER 3

HEW AND STATE COMMENTS

HEW COMMENTS

HEW concurred with our conclusions and recommendations. (See app. II.) HEW stated that under the Medicare program comprehensive guidelines and audit procedures are applicable to nursing home chains as well as other types of chains. Under these guidelines and procedures a single intermediary is assigned responsibility for auditing a headquarters' home office costs and the audit results (including detailed allocations of costs and full explanations of any adjustments) are forwarded to intermediaries servicing providers who are members of the chain organization.

HEW said it will expand the existing Medicare headquarters audit capability to cover the Medicaid programs by using the following groundrules.

1. The headquarters of chains with some or all members participating in Medicare but not Medicaid or chains with some or all members participating in both Medicare and Medicaid would continue to be audited by the designated Medicare intermediary. Resulting information will be shared with all affected Health Care Financing Administration components and intermediaries servicing members of the chain.

2. The headquarters of chains with some or all members participating in Medicaid but not Medicare would be audited by organizations such as State audit agencies, CPA firms, and Medicare intermediaries. HEW said it is currently studying available options to develop the most cost effective approach to audit these chains' headquarters.

STATE COMMENTS

Three of the four States commenting on our draft report (Florida, Iowa, and Nebraska) generally agreed with our conclusions and recommendations. Florida stated that our recommendations, if accepted, should help curtail abuse of the Medicare and Medicaid programs. (See app. III.) Florida also said that its audit findings at chain headquarters corroborate some of the abuses found during our audit.

Nebraska said the premise that States are unable to identify unallowable costs of home offices appears to be valid. (See app. IV.) Nebraska also said it is making progress in auditing chain headquarters and has audited the headquarters of two of the three major chains operating in Nebraska. Nebraska plans to soon audit the third chain's headquarters. Nebraska also stated that most States have only recently begun to develop the necessary audit staffing and expertise to make headquarters audits, and suggested that this is at least partially responsible for the States' slow movement in this area.

Nebraska said that it would not be easy to coordinate Medicaid audits of chains' headquarters because States are free to develop their own cost-related programs and because the audit information needs of each State are complex. Nebraska suggested that the best solution would be for a Federal agency to become involved in chain audits because the States do not have the ability to do this on their own. We agree that HEW should provide the planning and leadership necessary for coordinating and consolidating audits of chains' headquarters.

Iowa stated that it agreed that chain operations pose special audit problems and there is a need for improved audit coordination of headquarters. (See app. V.) Iowa stated that either HEW or the State where the headquarters is located should be responsible for the audit. Iowa also said it was making progress in auditing chains' headquarters and in identifying homes affiliated with chains.

Kansas did not comment on our conclusions and recommendations, but said it had recently field audited four of five chains cited in our draft report. (See app. VI.) Three of these field audits were performed after our audit of the chain headquarters.

The chains' comments where received have been incorporated into the discussion of each chain.

ADDITIONAL EXAMPLES OF NURSING HOME CHAIN OVERCHARGES TO THE MEDICAID PROGRAM

Chain D

A 25-home, for-profit interstate chain headquartered in Kansas organized itself as a series of corporations. Four of the chain's homes participated in the Medicare program. The parent corporation owned 100 percent of the stock in 15 subsidiary corporations and 50 percent of the stock in one other corporation. At the time of our review, the chain's headquarters had not been field audited by the State Medicaid agency; however, the headquarters had been audited by the Medicare intermediary.

Contrary to Kansas' related organization rule, in 1976 eight of the chain's nursing homes successfully claimed Medicaid reimbursement on the basis of lease payments to the headquarters rather than on the basis of the headquarters' costs, which were lower for five of the eight homes. The combined claims by the eight homes were $71,600 (12 percent) more than the $618,800 property costs.

We reported this matter to HEW's regional office in Kansas City and to Kansas State officials. The State later field audited the 1976 cost reports for 11 of the chain's homes (including the 8 homes discussed above) and determined that 8 homes had been overpaid $64,000 and 1 home was underpaid $4,600, making a net overpayment of $59,400. The State field audit disallowed various costs, including excessive claims for property costs. Kansas representatives informed us in October 1978 that the chain intended to appeal the overpayment amounts determined during the State's audit.

Commenting on our draft report, the chain claimed that it was covered by an exception to the State's related organization rule--which provided that if certain conditions are met, the nursing home may claim as reimbursable costs the payments to a related organization for services, facilities, and supplies. The chain stated that a State official had agreed that it was covered by this exception. However, this State official stated that this was inaccurate and the chain was not covered by the exception.

The chain stated this report fails to disclose that some of its nursing homes are not allowed to recover their full operating costs because of Kansas' ceiling on property costs. Kansas computes nursing home reimbursement rates based on the homes' reported costs, and a ceiling is placed on allowable per diem reimbursement rates. The ceiling applies to the total daily per diem reimbursement rate, and ceilings also apply separately to four components of the per diem rates for administration, property, room and board, and health care.

Even if some of the chain's nursing homes did incur unreimbursed costs because of Kansas' ceilings, we do not believe this is justification for claiming costs which are otherwise unallowable for reimbursement under Kansas' related organization rule.

Chain E

During 1976 this Kansas-based, for-profit chain operated 16 nursing homes which it owned or leased, and it managed 3 other homes under contract to the owners. None of the chain's homes had any Medicare patients. The headquarters made unsecured loans totaling over a half million dollars to nine of the nursing homes it owned in Kansas. The chain had been field audited by the State in January 1975 and the interest on intercompany loans was disallowed. However, the nine homes collectively claimed $29,000 in interest costs on these loans in their 1976 cost reports.

Kansas Medicaid regulations provide for reasonable cost-related reimbursement on the basis of generally accepted accounting principles. Inasmuch as the payment of interest by the homes to the chain headquarters was an intracompany transaction, we do not believe it meets the test of a legitimate expense according to generally accepted accounting principles and should not be considered a reimbursable expense for Medicaid purposes. The loans were, in effect, a loan by the chain to itself.

When we called this matter to the attention of State officials they agreed to take corrective action and to recover any Medicaid overpayments. Commenting on our report, the State said it had field audited this chain, disallowed the interest on intercompany loans, and identified total net overpayments of about $51,000 for fiscal year 1976. In October 1978 a State official stated the chain was appealing their audit findings through Kansas' administrative appeal process.

As was true of a number of chains, this chain charged its homes fees for management services provided by the headquarters office. However, unlike the other chains, this chain's homes correctly charged the Medicaid program the costs of the services, which were lower than the fees.

Chain F

This corporate chain is headquartered in Florida and had three nursing homes in Florida and five in Georgia. This chain's homes did not participate in the Federal Medicare program. We did not conduct an independent analysis of the costs this chain claimed for Medicaid reimbursement because during June 1977 we were denied access to the chain's financial records.

For the year ended April 30, 1976, the chain's three Florida homes had claimed headquarters costs of $294,000. As a result of a Florida desk audit the State asked the chain for more detailed data on headquarters costs to enable it to complete its desk audit. In response to this request, the chain submitted information showing total headquarters cost of $410,000, with $244,000 allocated to Florida homes and $166,000 allocated to Georgia homes on the basis of total patient days in each home. Based on this information, Florida reduced the three Florida homes' shares of home office costs by $50,000--to $244,000. The chain agreed with this adjustment.

Although the chain had reported to Florida that it had allocated $166,000 of its headquarters costs to Georgia homes, we examined the cost reports for the chain's five homes in Georgia and found that the homes had charged $291,000 in management fees on its Medicaid cost reports for the year ended June 30, 1976. Because such management fees are commonly paid to chain headquarters, in June 1977 we attempted to audit the chain's records to determine whether the chain's nursing homes were charging more headquarters costs than were actually incurred. We were denied access to all financial records at this chain. 1/

1/The enactment in October 1977 of Public Law 95-142, the Medicare-Medicaid Antifraud and Abuse Amendments of 1977, strengthens the right of Federal access to nursing home records pertaining to the Medicaid program. We now have power to subpoena nursing home records; this was not the case at the time we attempted to audit this chain.

In addition to the $50,000 reduction in headquarters costs as a result of the Florida desk audit, Florida also disallowed $74,000 of headquarters costs allocated to the three Florida homes because the salaries to the chain's president and vice president exceeded the allowable maximums. Florida also disallowed $225,000 in depreciation and equity capital expenses resulting from a revaluation of the three Florida homes. The three Florida nursing homes were acquired by the chain in 1973 through an exchange for property in Chicago. The chain contends it should be allowed to claim depreciation and return on equity based on the values of the three Florida homes at the time of the exchange. Florida contends the three Florida homes should be accounted for based on the costs to the chain of its Chicago property, which was exchanged for the three Florida homes.

In an administrative hearing, the chain challenged the basis for Florida's disallowance of property-related costs at the homes and salaries at the headquarters. The hearing officer upheld Florida's interpretation of the State regulations and guidelines upon which the cost disallowances were based.

The administrative hearing also dealt with a third issue raised by the chain. The chain stated that the three homes should be considered to be one nursing facility and be allowed to file a single cost report for the three Florida homes. The hearing officer upheld the State's refusal to allow the three homes to file as a single facility. Combining the costs of the three homes would have the effect of averaging their costs. That would mean that costs over the State's ceiling at the highest-cost home would be reimbursed to the extent that costs at the lowest-cost home were below the ceiling.

The hearing officer's decision on the property-related costs has been appealed to court. The chain's president stated that once litigation on the property-related costs is concluded, a decision will be made whether to appeal the disallowed salary issue and the three-homes-as-one-facility issue.

A Florida audit official stated in July 1978 that overpayments at one of the chain's homes should be more than $100,000, relatively small overpayments had been made to one home, and it appeared that no overpayments had been made to the remaining home because of Florida's ceiling on Medicaid payment rates to nursing homes. Efforts to collect the $100,000 overpayment have been suspended, pending completion of the chain's legal appeal on the property cost issue.

The chain's accountant said in August 1978 that in 1977 the chain's homes began to claim Medicaid reimbursement for headquarters' services on the basis of cost rather than on management fees. He also stated that he believed that auditors from one State should not be allowed to examine cost reports filed by homes in another State, and he had refused to allow Florida auditors to examine Georgia cost reports and vice versa. This refusal could prevent the auditors from learning how much total headquarters cost was claimed by the chain's homes. A Florida audit official stated that Florida and Georgia had begun to exchange information concerning this chain's headquarters costs.

Georgia audited the chain headquarters for fiscal year 1977 but did not make an audit for fiscal year 1976. Therefore, the apparent overcharges to the Georgia homes for fiscal year 1976 will go uncorrected.

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

DEC 6 1978

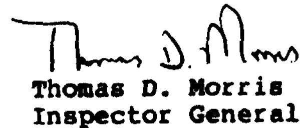
Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Problems in Auditing Medicaid Nursing Home Chains." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

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

Sincerely yours,



Thomas D. Morris
Inspector General

Enclosure

COMMENTS

Comments of the Department of Health, Education, and Welfare on the General Accounting Office's Draft Report Entitled, "Problems in Auditing Medicaid Nursing Home Chains"

GAO Recommendations

That the Secretary of HEW direct the Administrator of the Health Care Financing Administration to

- - provide for the exchange of audit results at nursing home chain headquarters among all affected Medicare intermediaries and State Medicaid agencies, and

- - establish procedures to designate a single Medicare intermediary or State Medicaid agency as having audit responsibility for each nursing home chain headquarters.

Department Comments

We concur.

As GAO points out, Medicare already has in place comprehensive guidelines and audit procedures applicable to nursing home chains - in fact, to all chains. A single intermediary is designated the responsibility for audit of the chain's home office costs. The audit results (including detailed allocations of costs and full explanations of any adjustments) are forwarded to intermediaries servicing providers who are members of the chain organization.

We believe we can and should build on the existing Medicare capability in this area. Complementary Medicaid procedures need to be established within an overall audit structure. Within this structure, we can provide a mechanism for the exchange of nursing home chain headquarters audit results.

Furthering a common provider audit program for both Titles XVIII and XIX continues to be a high priority within this Department and is one of the major thrusts of our Medicare/Medicaid integration effort. HEW already has common audit agreement with 37 States. The whole purpose of such an approach is to have one audit which will effectively serve the needs of all participating programs reimbursing the provider, while reducing the cost and avoiding the duplication of auditing effort.

In determining where the audit responsibility for nursing home chain headquarters should be placed, we have established procedures or initiated action, as indicated, in the following situations:

Chains with some or all members participating in Medicare, but not Medicaid or chains with some or all members participating in both Medicare and Medicaid

They will continue to have their headquarters or home office costs audited by the designated Medicare intermediary. Resulting information will be shared with all affected HCFA components and intermediaries servicing members of the chain.

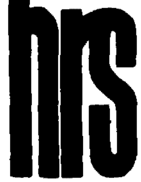
Chains with some or all members participating in Medicaid, but not Medicare

There are a number of resources that can be utilized to conduct audits of their home office costs including State auditors, CPA firms, and Medicare intermediaries. We are currently studying these and other options that may be available to develop the most cost effective approach to handle this situation.

Specific comments on the text of the report follow:

Page 3 - In the discussion of reimbursement, both Medicare and Medicaid are mentioned. Then, HEW regulations are discussed and the reader wonders whether they apply to Medicaid, Medicare, or both. The draft should be revised to clarify this point and more precisely convey its message.

Page 4 - In discussing nursing home costs at the top of the page, the draft states that nursing homes report their costs under GAAP. Actually, Medicare has its own principles of reimbursement and the various States have developed their own bases, some having adopted Medicare basis. Later sections immediately following this part seem to conflict with it.



STATE OF FLORIDA

DEPARTMENT OF
Health & Rehabilitative Services

Reubin O'D. Askew, Governor

1317 WINEWOOD BOULEVARD TALLAHASSEE, FLORIDA 32301

September 6, 1978

Mr. Gregory J. Ahart
Director
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

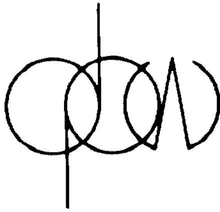
This Department endorses the recommendations found on page ii of your draft report on Problems In Auditing Medicaid Nursing Home Chains. We certainly feel your recommendations, if accepted, should help curtail abuse of the Medicare/Medicaid Programs.

Beginning July 1, 1976, this Department commenced the necessary steps to comply with 42 CFR 450.30(a)(3)(ii) which requires the states to audit 100 percent of all nursing homes over a three year period. We are pleased to report that all nursing homes in Florida operating in the Medicaid Program, including chain operations, will be audited as of June 30, 1979.

Included in our audit program is a requirement that a full scope audit of chain headquarters' costs be made by either departmental auditors or contracting Certified Public Accounting firms. Our findings from these audits corroborate some of the abuses found by your staff.

Sincerely,

William J. Page, Jr.
Secretary



State of Nebraska
Department of Public Welfare

J. James Exon, Governor
Eldin J. Ehrlich, Director

September 6, 1978

Mr. Gregory J. Ahart
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

I read with interest your draft report on problems in auditing Medicaid payments to nursing home chains. The premise that states are unable to identify unallowable costs of home offices appears to be valid.

In the case of Nebraska, however, I would dispute your first of three major reasons (states often do not field audit chain headquarters). The impression gained from this statement is that states also have no intention of field audit. There are three major chains operating in Nebraska; two of these chains have been audited by my staff and the third is scheduled for audit later this year. I think you should recognize that this is a relatively new program and that most states are only recently developing their audit staff and programs. A degree of expertise is necessary before encountering the problems of a home office audit. This may be at least partially responsible for the states slow movement in this area.

The third major reason presented (no coordination between states) may be easier to state than solve. The exchange of information among Medicare intermediaries is relatively simple since Medicare is the uniform, nationwide program. With states free to develop their own cost related program for Medicaid, things become rapidly complex in the type of information needed by each state.

The best help to be provided states would be for a federal agency to become involved in chain organization audits. The necessary "complete picture" could then be developed and carried out through audit. Individual states do not have the ability to do this on their own.

If you have any questions, please contact Tom Folmer, Audit Manager, (402) 471-3121.

Sincerely,

Eldin J. Ehrlich
State Director

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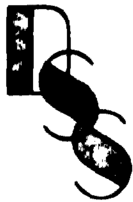

Iowa Department of Social Services

LUCAS BUILDING—DES MOINES, IOWA 50319

ROBERT D. RAY
GOVERNOR

VICTOR PREISSER
Commissioner

September 8, 1978

Mr. Gregory J. Ahart, Director
Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

I am responding to the draft report of problems noted by your office in the procedures used by states in auditing nursing home chains.

We agree that chain operations do pose problems for auditing and have taken special steps to work with these special problems.

Specifically:

1. We have field audited all but one headquarters office of chains doing business in Iowa including some as far away as California. The one office in Omaha, Nebraska, that we have not audited is being scheduled.

2. We collect ownership information and generate lists of all homes cross-referenced by name of owner, Social Security number of owner and vendor number. This system seems quite effective in determining which homes are part of chains and which are not. In fact, an HEW auditor recently used these lists for exactly that purpose.

The observation that there is a need for improved coordination of audits of chain headquarters is certainly accurate.

We believe that either HEW or the state where the headquarters is located should be responsible for the audit. The results should then be shared with every state involved with that chain.

Thank you for this opportunity to comment on this draft material.

Sincerely,

Victor Preisser
Commissioner

VP/bh
cc Linda Cottington

IOWA COUNCIL ON SOCIAL SERVICES

Lois Emanuel (Marion) | Gracie Larsen (Ames) | Dolph Pulliam (Des Moines) | Fernice Robbins (Waverly) | Madalene Townsend (Davenport)

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STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

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TOPEKA, KANSAS 66612

ROBERT C. HARDER, Secretary

Division of Vocational Rehabilitation

Division of Social Services

Division of Mental Health and Retardation

Division of Children and Youth

Division of Administrative Services

Alcohol and Drug Abuse Section

State Office Economic Opportunity

August 30, 1978

Mr. Gregory J. Ahart
Director
U.S. General Accounting Office
Washington, D.C. 20548

B - 164031(3)

Dear Mr. Ahart:

Reference your draft report on "Problems in Auditing Medicaid Nursing Home Chains". I will first respond to the statement on page 10 of the draft report which relates to the three major underlying causes for state auditors failing to disallow excessive, unallowable, and misclassified costs.

(a) Failure to field audit the chain headquarters office - of the five chain operations cited in the draft, all have been audited at the home office

[See GAO note, p. 37.]

(b) State auditors sometimes experienced difficulty in obtaining sufficient information to identify chain affiliations and to determine if the related organization rule applied - The identification of chain operations has not been a problem in Kansas. The annual cost report submitted by the nursing home contains a schedule which pertains to "Statement of Related Nursing Home Information." This schedule requests information regarding the related home's Federal I.D. number, provider number, etc.

(c) At the Federal level, Medicaid has no system under which Federal and State auditors can exchange audit information and results from nursing home chain headquarters audits - Not answerable at state level.

At 4 of the 5 chain operations cited, we have completed on-site audits. At one chain, we made on-site audits at two times for different fiscal years. Some of the chain audits have been finalized, whereas others are in the appeal stage. Following is my response which pertains to each chain:

Mr. Gregory J. Ahart

Chain A - Our first audit of this chain covered calendar year 1976. We have just received concurrence from its home office which resulted in $7,953.94 being paid to the homes and $60,143.63 due to the state. We made a second visit to the home office for the purpose of auditing home office allocations for calendar years 1975 & 1974. These audits for FY 1975 are now being finalized and show that the amount to be recouped will be greater than for FY 1976.

Chain B - An on-site audit was made [illegible] in 1977. Effective April 1, 1978, the corporation ceased to do business in Kansas since it sold its three homes to another chain in Kansas. Our auditors spent several man weeks at the home office reviewing records and attempting to unravel the relationships among the individuals and corporations involved. We effected final settlement with the corporation prior to the release of its final check for services. We believe the desk audit review now being made of cost reports is more thorough and will detect some of the deficiencies cited.

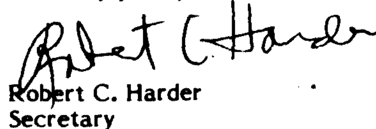
[See GAO note.]

Chain [D] - On July 17, 1978, a formal audit exit conference (administrative hearing) was held to discuss the audit findings related to the 1976 cost reports. Officials of the chain did not concur with our audit findings pertaining to the substitution of costs of ownership for lease expenses. At this time, we do not know if this chain plans to appeal. We requested that a representative of the Kansas City office of GAO be present to testify at the administrative hearing, however, our request was denied.

Chain [E] - The total net overpayments, as audited, for FY 1976 was $51,233.05. This was the figure due to adjustments made as a result of the formal audit exit conference on May 10, 1978. The interest on intercompany loans was disallowed in our field audit. Chain officials did not concur with our exception on this matter at the conference on May 10. As of this date, they have not exercised their appeal rights.

If you have any questions, please contact me.

Sincerely yours,



Robert C. Harder
Secretary

RCH:ms

GAO note: Deleted comments refer to material contained in the draft report which is not included in the final report.

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