

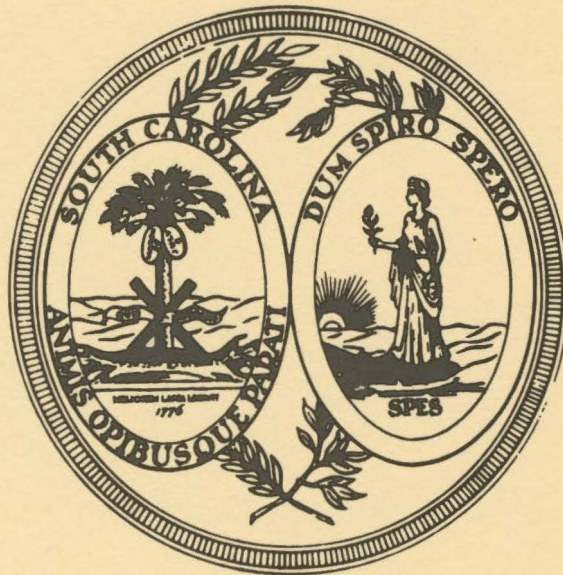
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Legislative Audit Council



South Carolina General Assembly
Legislative Audit Council
Management and Performance
Review of the
Medicaid Program in South Carolina
February 9, 1982

THE STATE OF SOUTH CAROLINA

GENERAL ASSEMBLY

LEGISLATIVE AUDIT COUNCIL

MANAGEMENT AND PERFORMANCE REVIEW

OF THE

MEDICAID PROGRAM IN SOUTH CAROLINA

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REPORT SUMMARY

The Legislative Audit Council was requested by the General Assembly to perform an audit and update its 1977 report of the State's Medicaid program, administered by the Department of Social Services (DSS). In conducting the audit, the Council examined DSS's compliance with laws and regulations, efficiency of operations and general management. Pertinent State and Federal laws, rules, regulations and DSS's Medicaid policies and procedures were reviewed. Interviews were conducted with DSS, the Department of Health and Environmental Control (DHEC), the Professional Services Review Organization (PSRO), and various governmental and private health organizations in the State. The Council appreciates their cooperation and assistance in developing this report.

Medicaid is designed to provide medical services for persons who are unable to pay for such care. It was authorized by Congress under Title XIX of the Social Security Act as a grant-in-aid program under which the Federal Government pays a portion of the costs incurred by the states. Each state initiates and administers its own program within Federal guidelines that establish client eligibility and available services. During FY 80-81, Medicaid served approximately 270,000 individuals in South Carolina at a cost of \$273 million.

Even before Federal budget cuts, the State was experiencing difficulty in funding the Medicaid program. Medicaid has required an average yearly increase in State funding of \$8.6 million since FY 77-78 and the program has incurred an average deficit of \$3.5 million in each of the last four years. With Federal participation in the program reduced, a greater burden is placed on the State to provide Medicaid services.

The Legislative Audit Council reviewed the steps taken by the Department of Social Services to control Medicaid costs. Since the Council's 1977 Medicaid report, DSS has instituted some measures to improve the program. It implemented a new reimbursement formula for nursing homes and installed a Medicaid Management Information System. However, the agency did not take advantage of the many cost-cutting options used by other states, or proposed by the State Budget and Control Board and the House Ways and Means Committee. Instead, DSS has approached cost containment by reducing services and freezing provider reimbursement rates. The Council found that some of the same problems noted in the 1977 report continue to exist. These and other problems found by the Council are summarized in the following pages.

NURSING HOMES

No System for Proper Placement Of Nursing Home Patients (p. 21)

There is no system in the State to ensure the proper placement of Medicaid patients in nursing homes. DSS has not established comprehensive, stringent and uniform medical criteria for determining placement needs of the individual Medicaid patients. The nursing home selects the patient to be admitted. Without objective criteria and coordination of patient placement, there is no assurance that a Medicaid patient most in need of a nursing home receives the necessary service.

Lack of Adequate Intermediate Care Beds Increase Costs (p. 23)

Patients requiring only an intermediate level of care are being served in the more expensive skilled care facilities, and DSS pays the

skilled rate to the facility. An intermediate care patient occupying a skilled care bed can cost the State up to an additional \$9.50 per day. As of January 1981, 3,712 intermediate care patients occupied skilled beds resulting in an estimated annual expenditure of \$4.3 to \$10.6 million more than necessary in the nursing home program. Appendix I explains the Council's methodology for determining this range.

Improper Implementation of Reimbursement Methodology (p. 25)

DSS is improperly implementing its reimbursement methodology for funding nursing homes. Although the current methodology is basically sound, DSS uses inappropriate components which increase costs to the Medicaid program.

- (1) DSS's use of the national Consumer Price Index (CPI) as an inflation factor for projecting reimbursement rates, overpaid nursing homes \$2.3 million, including \$690,000 in State funds, in 1981. The CPI is not an accurate measure of inflation for nursing homes because it measures individual consumer price changes nationwide and not price changes experienced by South Carolina's nursing homes.

In November 1981, DSS reduced the inflation factor it will use in the nursing home reimbursement formula for the five-month period from February to July 1982.

- (2) The method used for determining the reimbursement rates for Standard Services creates inequitable and, in some cases, arbitrarily high rates. Nursing home facilities are grouped by type and size in order to compute an average cost for each service to each

group of facilities. Standard services include nursing, dietary, housekeeping and administration. These services account for 76% of the costs of the nursing home program. Once the average cost of a service for a particular grouping of facilities has been computed, an 8% "quality assurance" factor is added to determine the reimbursement standard. When the standard is set, those facilities with costs above the standard receive a cost sharing allocation, facilities below the standard receive an efficiency incentive allotment.

There are several factors which contribute to problems with the standard services reimbursement rates:

- (a) Nursing home facilities are placed in groups by size and type of care for computing the average cost for each of the four Standard Services (see Table 5 (p. 31) for groupings of facilities). The groupings used by DSS are dissimilar and do not distinguish between non-profit and hospital-based facilities versus private-for-profit facilities.

The quality assurance factor is misnamed since it does not ensure quality care. It is a means of adjusting average costs upward. Generally, an adjustment factor is used when using peer group review for establishing an average to allow for reasonable cost variation. Because the current nursing home groupings are dissimilar, an 8% adjustment to the average causes inequities.

Non-profit and hospital-based facilities have higher operating costs than private facilities. The reasons for these cost differences should be investigated by DSS and

DHEC in order to determine if some other method of providing services should be considered.

- (b) DSS does not set maximums on the size of staffs for which nursing homes will be reimbursed with Medicaid funds. One-third of the nursing homes are staffed at two to three times the DHEC requirement for licensed nurses. By not limiting the size of nursing and non-licensed staffs for which Medicaid will reimburse, DSS continues to pay more than is necessary for the nursing home program.
- (c) The establishment of a "floor" for staffing hours requires Medicaid to pay for higher than necessary costs for nursing services. In determining reimbursements for nursing services, DSS established a minimum number of staffing hours, a "floor" in computing the average for nursing services costs. For example, if the 1979 standard was an average of 20 daily staff hours and in 1980 the nursing home industry reduced the average to 18 hours, the "floor" of 20 hours would be used to determine the standard. This "floor" concept inflates the standard and allows more homes to receive a higher efficiency incentive, thereby increasing the cost to the nursing home program. DSS estimated in 1980 that removing the "floor" would have saved \$696,000.
- (d) DSS is allowing higher than average salaries to be paid by Medicaid to nursing home owners and administrators. The maximum allowable salary is 150% of the average

salary computed for each class of nursing homes. Medicaid will also reimburse country club dues, personal autos and additional fringe benefits as a part of owner/administrator compensation if the salary is under the maximum allowable.

- (3) DSS did not follow the General Assembly's intent when it did not place ceilings on Mandated Services for nursing home reimbursements. In FY 81-82, these services will cost approximately \$15.4 million. The General Assembly directed DSS in the FY 78-79 Appropriation Act to set maximum reimbursement levels; instead the agency continues to reimburse all Mandated Service costs to nursing homes. Since the reimbursement system does not create incentives for nursing homes to contain these costs, the agency cannot control expenditures in a vital, expensive area of the Medicaid program.

Unreasonable Costs Allowed (p. 39)

A factor which contributes to the rising cost of Medicaid is the inadequate criteria for determining allowable costs for nursing homes. Because of this, Medicaid is paying for unnecessary and questionable expenses.

- (1) DSS has not developed guidelines for determining allowable automobile costs and does not require documentation that the autos are used for business. Nursing home owners are allowed to purchase luxury automobiles and receive reimbursement in Medicaid funds. During FY 79-80, nursing homes reported automobile, maintenance and gasoline costs of \$783,363. Medicaid's share of these costs was approximately 82% or \$642,358.

- (2) One factor contributing to the increasing cost of the nursing home program is the leasing of nursing homes. Thirty-four of the 122 facilities participating in Medicaid are currently leased. The Audit Council reviewed seven lease arrangements negotiated in 1981 and found that the lease payments for these homes increased the cost to Medicaid by approximately \$656,000 annually. This \$656,000 represents additional payments to the nursing home owners solely because of the leases. The issue is not whether nursing homes should be leased but whether Medicaid should foot the bill for a business arrangement that does not contribute to patient care. In December 1981, the DSS Board voted that Medicaid will not reimburse nursing homes for additional costs of leases negotiated after September 1981. However, this decision does not affect the 34 facilities currently leased and these additional lease costs still exist.
- (3) Nursing homes are reimbursed for legal expenses, including those costs associated with contesting decisions by DSS, regardless of the outcome of the appeal. In FY 79-80, nursing homes incurred costs of approximately \$67,000 for legal fees, part of which were associated with appeals. Medicaid's share of these costs was approximately 82% or \$54,940. If any of these costs are allowed, they should only be those costs incurred in an appeal or court case when a nursing home receives a favorable decision.
- (4) DSS has not developed adequate guidelines to determine travel costs considered allowable for reimbursement with Medicaid funds. Nursing homes have been reimbursed to attend meetings outside the State and during FY 79-80, nursing homes incurred costs of \$233,817 for seminars and training. Medicaid's share of these costs was approximately 82%, or \$191,729.

- (5) DSS is reimbursing nursing homes for dues paid to the Health Care Association, an organization registered as a lobbyist with the General Assembly. In 1981, the Council estimates nursing homes spent approximately \$153,000 for Association dues, approximately 82%, or \$125,460 which will be paid by Medicaid.

Freezing of Nursing Home Occupancy Rates (p. 44)

In an attempt to contain nursing home costs for FY 81-82, DSS has frozen the number of patients for which Medicaid will pay within a particular nursing home. Without a waiver, this measure is in violation of Federal Regulations.

HOSPITALS, PHYSICIANS AND DRUGS

Lack of Adequate Hospital Cost Containment Measures (p. 53)

DSS has not developed cost containment measures for Medicaid hospital reimbursements as directed by the General Assembly in the FY 78-79 and FY 79-80 Appropriation Acts. Instead, the agency has continued to use the Medicare reimbursement methodology, which allows little control over the level of reimbursement or the rate of increase in hospital costs. A review of cost containment measures undertaken by other states, however, indicate that there are several remedies that could have been implemented by South Carolina to achieve savings within the Medicare methodology. There are also various examples of alternative formulas, considered successful in controlling increases in hospital costs. Without a change in the Medicaid reimbursement method for hospitalization, the State faces increasing costs and more cuts in benefits.

Physician Services (p. 60)

DSS has chosen to retain the Medicare methodology for reimbursing physician services although several cost containment options exist. The limit for reimbursement for a service is set at the 75th percentile for all charges by physicians for that service. In 1977, it was recommended that the upper limit be lowered to the 60%, 55%, or 50% level. Had just the 60% level been chosen, the reimbursements could have been reduced by at least \$4.4 million. Another option used by states is to set a fee schedule. This method differs from the South Carolina method in that the state's Legislature or the Medicaid agency, sets maximum levels for physician reimbursement. Effective February 1, 1982, DSS will reduce reimbursement rates for physicians by 10%.

Medicaid Drug Program (p. 63)

In reviewing the Medicaid drug program, the Council noted several problems with the dispensing fee.

- (1) The drug dispensing fee paid to pharmacies by South Carolina's Medicaid program is the highest in the southeast and one of the highest in the nation. The fee is 24 cents above the national average and 32 cents above the southeastern regional average. Because the fee is higher than the regional average, it has required an additional \$1.4 million over the past two years, contributing to deficits incurred by the Medicaid program.
- (2) The FY 80-81 increase in the Medicaid drug dispensing fee violated Federal Regulations. DSS did not solicit input from the Medical Care Advisory Committee and it failed to issue the Federally required public notice.

- (3) DSS has increased the drug dispensing fee twice at a time when the agency was already projecting deficits for the Medicaid program. The increases required an additional \$419,000 in State funds after the General Assembly had set Medicaid funding and at a time when supplemental appropriations were made to Medicaid.

MEDICAID MANAGEMENT INFORMATION SYSTEM

Failure to Receive Full Federal Funding (p. 75)

DSS failed to receive full Federal funding for its consultant contracts on the Medicaid Management Information System (MMIS). The agency did not follow Federal Regulations when it awarded its consultant contracts. Federal Regulations allow for 90% Federal participation in funding the implementation of a MMIS. Failure to follow Federal Regulations meant \$265,894 had to be paid with State money rather than Federal funds for the MMIS installation.

Overpayment Made to Providers (p. 77)

DSS made an overpayment of \$417,904 to Medicaid providers in October 1979 because the agency turned off the computer's "edits" to process a backlog of claims. It was not until October 1981 that DSS identified and began collecting the overpayment. Now that the overpayment has been identified, Federal Regulations require DSS to recoup the funds and repay the Federal portion of the overpayments.

Improvement in Claims Processing (p. 78)

DSS has improved its processing of provider claims. A review of DSS's claims processing found that physician and pharmacist claims not suspended or rejected by the MMIS system are paid within 11 working days of receipt. These correct claims represent 96% of the pharmacy and 79% of the physician claims sampled. This performance was an improvement over the last test of the MMIS in February 1980. At that time, DSS's internal auditors found that it took 19.1 working days to process a claim and only 75% of all claims were successfully processed.

RECOMMENDATIONS

DSS SHOULD ESTABLISH COMPREHENSIVE, STRINGENT AND UNIFORM MEDICAL CRITERIA FOR DETERMINING THE PLACEMENT NEEDS OF THE STATE'S MEDICAID NURSING HOME PATIENTS.

DSS SHOULD WORK WITH THE STATE'S MEDICAL PROVIDERS TO CREATE A CENTRAL REGISTRY OF ELIGIBLE MEDICAID NURSING HOME PATIENTS. THE PATIENT NEEDS SHOULD BE RANKED AND MATCHED TO THE CAPABILITIES OF AVAILABLE NURSING HOMES FOR PLACEMENT.

DSS SHOULD REIMBURSE NURSING HOMES ONLY FOR THOSE COSTS NECESSARY TO PROVIDE THE LEVEL OF CARE APPROPRIATE TO A PATIENT'S

CONDITION. DSS SHOULD NOT PAY FOR A LEVEL OF CARE ABOVE THE LEVEL NEEDED FOR A PATIENT'S CARE.

THE GENERAL ASSEMBLY SHOULD CONSIDER LEGISLATION DIRECTING THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL TO RELICENSE EXISTING, DUALY CERTIFIED SKILLED/ INTERMEDIATE NURSING HOMES TO EITHER TOTALLY INTERMEDIATE CARE FACILITIES OR DISTINCT PART INTERMEDIATE/DISTINCT PART SKILLED CARE FACILITIES. ONE FACTOR USED IN THIS RELICENSING SHOULD BE THE PATIENT POPULATION RESIDING IN THE NURSING HOMES.

IN THE FUTURE, WHEN NEW NURSING HOMES ARE BUILT, DHEC SHOULD LICENSE THESE HOMES EMPHASIZING INTERMEDIATE CARE FACILITIES. DHEC SHOULD ESTABLISH A RATIO OF INTERMEDIATE CARE BEDS TO SKILLED CARE BEDS WHICH MATCHES THE NEEDS OF THE STATE'S PATIENT POPULATION. DHEC SHOULD TAKE STEPS TO ACHIEVE THIS RATIO THROUGH ITS CERTIFICATE OF NEED AND LICENSING PROCESS.

DSS SHOULD USE AN INFLATION FACTOR DEVELOPED BY THE STATE DIVISION OF RESEARCH

AND STATISTICAL SERVICES TO PROJECT NURSING HOME RATE INCREASES.

DSS SHOULD ESTABLISH NEW CLASSIFICATIONS OF NURSING HOMES FOR DETERMINING REIMBURSEMENTS FOR STANDARD SERVICES. HOSPITAL-BASED, NON-PROFIT NURSING HOMES AND PRIVATE, FOR PROFIT HOMES SHOULD BE SEPARATED FOR DETERMINING COST STANDARDS.

DSS SHOULD, AFTER RECLASSIFYING NURSING HOMES FOR STANDARD SERVICES REIMBURSEMENTS, CONSIDER REDUCING THE QUALITY ASSURANCE FACTOR.

DSS, WORKING IN CONJUNCTION WITH DHEC, SHOULD CONDUCT AN IN-DEPTH STUDY TO DETERMINE WHETHER PUBLIC AND NON-PROFIT NURSING HOMES ARE LESS EFFICIENT THAN PRIVATE HOMES. QUALITY OF CARE SHOULD BE CONSIDERED AND COMPARED TO PRIVATE HOMES. IF THE STUDY FINDS THAT PUBLIC AND HOSPITAL-BASED HOMES ARE INEFFICIENT, THEN CONTRACTING OR SOME OTHER METHOD OF PROVIDING SERVICES SHOULD BE CONSIDERED.

DSS SHOULD SET A MAXIMUM FOR REIMBURSEMENT FOR NURSING AND NON-LICENSED STAFFS. DSS SHOULD DISCONTINUE USING THE "FLOOR" CONCEPT AND REIMBURSE NURSING FACILITIES ONLY FOR ACTUAL HOURS NECESSARY TO DELIVER SERVICES.

DSS SHOULD ENSURE THAT OWNER'S COMPENSATION IS REASONABLE BY ESTABLISHING SPECIFIC CRITERIA SUCH AS THE MEDICARE OWNER'S COMPENSATION GUIDELINES.

DSS SHOULD PLACE A CEILING ON REIMBURSEMENT FOR MANDATED SERVICES.

DSS SHOULD DEVELOP GUIDELINES IN ADDITION TO FEDERAL HIM-15 FOR SPECIFYING ALLOWABLE COSTS IN THE NURSING HOME PROGRAM. THESE GUIDELINES SHOULD RESTRICT REIMBURSEMENT FOR TRAVEL, AUTOMOBILES, AND LEGAL FEES; AND ELIMINATE REIMBURSEMENT FOR ASSOCIATION DUES. DSS SHOULD NOT REIMBURSE ANY NURSING HOME FOR ADDITIONAL COSTS DUE TO LEASING THE FACILITIES.

DSS SHOULD IMPLEMENT COST CONTAINMENT MEASURES IN THE NURSING HOME REIMBURSEMENT

SYSTEM WHICH EITHER COMPLY WITH FEDERAL REGULATIONS OR FOR WHICH WAIVERS HAVE BEEN GRANTED.

COST CONTAINMENT ACTIONS IN THE HOSPITAL REIMBURSEMENT SYSTEM SHOULD BE IMPLEMENTED IMMEDIATELY.

- FOR THE SHORT TERM, DSS SHOULD IMPLEMENT ADMINISTRATIVE ADJUSTMENTS TO THE HOSPITAL REIMBURSEMENT SYSTEM.

- FOR THE LONG TERM, THE LEGISLATURE SHOULD CONSIDER IMPLEMENTING A PROSPECTIVE HOSPITAL REIMBURSEMENT SYSTEM, ONE WHICH INCLUDES ALL PAYERS, OR ONE WHICH COVERS ONLY THE MEDICAID PROGRAM.

DSS SHOULD CONSIDER OTHER COST CONTAINMENT MEASURES IN THE PHYSICIAN SERVICES PROGRAM BEFORE REDUCING BENEFITS TO RECIPIENTS.

DSS SHOULD REEVALUATE ITS USE OF THE METHODOLOGY FOR ESTABLISHING REIMBURSEMENT LEVELS FOR PHYSICIAN SERVICES. REIMBURSEMENT LEVELS SHOULD BE THOSE THAT BEST REFLECT THE AVERAGE CHARGE FOR SERVICES.

DSS SHOULD USE AN AVERAGE OF REGIONAL FEES IN DETERMINING FUTURE INCREASES IN THE DRUG DISPENSING FEE.

DSS SHOULD ADHERE TO FEDERAL REGULATIONS CONCERNING THE MEDICAL CARE ADVISORY COMMITTEE'S PARTICIPATION IN AGENCY POLICY DEVELOPMENT AND PROGRAM ADMINISTRATION.

DSS SHOULD FOLLOW FEDERAL REGULATIONS ON THE ISSUANCE OF PUBLIC NOTICE OF CHANGES IN AGENCY POLICY.

DSS SHOULD ADHERE TO THE APPROPRIATION ACT AND REFRAIN FROM IMPLEMENTING FEE INCREASES DURING THE FISCAL YEAR WHICH RESULTS IN PROGRAM DEFICITS.

DSS SHOULD CONTINUE TO TRY TO RECOVER THE \$265,894 IN FEDERAL MATCHING FUNDS FOR THE MMIS INSTALLATION CONTRACTS.

DSS SHOULD COLLECT THE TOTAL AMOUNT IDENTIFIED AS OVERPAYMENTS MADE TO PROVIDERS.

CHAPTER I
BACKGROUND AND HISTORY

Medicaid is a program designed to provide medical services for persons who are unable to pay for such care. Authorized by Title XIX of the Social Security Act, as amended (42 USC) 1936) Medicaid is a grant-in-aid program under which the Federal Government pays a portion of the costs incurred by states. The program authorizes health care coverage for persons entitled to public assistance under the Social Security Act. These people, called categorically needy, include all persons eligible under the programs of Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) (aged, blind, and disabled).

During FY 80-81, Medicaid served approximately 270,000 individuals in South Carolina at a cost of \$273 million. The Federal matching share of this expenditure was 70.77% and it is expected to decrease by approximately 3% in FY 81-82. In FY 75-76, when the Audit Council first examined the Medicaid program, the program provided services to 294,000 individuals at a cost of almost \$110 million. The Federal share at that time was 73.58%.

TABLE 1
MEDICAID GROWTH IN SOUTH CAROLINA FROM
FY 76-77 TO FY 80-81

| <u>Fiscal Year</u> | <u>Total Medicaid Expenditures</u> | <u>% Increase From Previous Year</u> |
|------------------------|--|--|
| FY 76-77 | \$137,411,834 | 25.0% |
| FY 77-78 | \$169,798,935 | 23.6% |
| FY 78-79 | \$192,665,533 | 13.5% |
| FY 79-80 | \$230,580,084 | 19.7% |
| FY 80-81 | \$273,424,432 | 18.6% |

Each state initiates and administers its own Medicaid program within Federal guidelines. Under such guidelines, each state sets the eligibility factors governing who will be included in the program and what services they will be entitled to receive. The Department of Social Services is responsible for administering Medicaid in South Carolina. Within DSS, the Office of Health Care Financing is responsible for managing the Medicaid program in accordance with the State plan. Services provided to South Carolina's Medicaid recipients include:

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Rural health clinic services.
4. Laboratory and radiology services.
5. Early periodic screening and diagnostic testing.

6. Family planning services.
7. Medical transportation.
8. Home health services.
9. Durable medical equipment.
10. Podiatrist, optometrist and chiropractic services.
11. Clinic and emergency hospital services.
12. Dental services.
13. Physical, occupational and speech therapy.
14. Inpatient psychiatric hospital services for patients under age 22.
15. Inpatient hospital services for patients age 65 or older in institutions for Tuberculosis or mental diseases.

In FY 80-81, Medicaid expenditures amounted to \$273,424,432, of which 67.2% went to pay for hospitals, nursing homes, physician services and drugs. The Departments of Mental Health, Mental Retardation, and Health and Environmental Control received \$50 million which flowed through DSS. These funds were not audited by the Council. The following table illustrates Medicaid expenditures by service for the last five years.

TABLE 2

SOUTH CAROLINA MEDICAL ASSISTANCE PAYMENTS

BY SERVICE FOR FIVE FISCAL YEARS

FY 76-77 TO FY 80-81

| Services | <u>FY 76-77</u> | <u>FY 77-78</u> | <u>FY 78-79</u> | <u>FY 79-80</u> | <u>FY 80-81</u> |
|---|----------------------|----------------------------|----------------------------|----------------------|----------------------------|
| Hospital: | | | | | |
| In Patient | \$ 29,562,235 | \$ 35,676,166 ¹ | \$ 39,758,067 | \$ 46,260,715 | \$ 58,045,518 |
| Out Patient | 4,369,537 | 4,935,281 ¹ | 5,598,960 | 6,564,737 | 9,053,840 |
| Total Hospital | \$ 33,931,772 | \$ 40,611,447 | \$ 45,357,027 | \$ 52,825,452 | \$ 67,099,358 |
| Nursing Homes: | | | | | |
| Skilled and | | | | | |
| Intermediate Care | \$ 45,514,505 | \$ 54,616,582 ¹ | \$ 67,506,493 ¹ | \$ 84,971,545 | \$ 87,374,938 ⁵ |
| Physicians Ser. | \$ 10,481,303 | \$ 12,416,336 ¹ | \$ 13,129,293 ¹ | \$ 16,313,459 | \$ 23,288,107 |
| Dental Services | 3,438,024 | 3,571,523 | 3,291,492 | 4,012,709 | 5,900,107 |
| Drugs | 11,354,086 | 11,542,186 | 13,622,539 | 15,715,257 | 21,081,580 |
| SMI Premiums ² | 5,147,468 | 7,048,276 | 6,488,284 | 7,544,637 | 7,197,400 |
| Co. Ins. & Ded. ³ | 6,466,991 | 8,463,849 | 8,430,795 | 5,266,435 | 11,794,114 |
| Other Services ³ | 8,534,435 | 10,472,286 | 9,313,979 | 7,799,898 | 8,862,927 |
| Less Refunds & Cancellations | (2,678,285) | - | (2,865,573) | (8,883,809) | (10,006,409) |
| Less Audit Collections | - | - | (2,897,342) | - | - |
| Total Medical Care - DSS | \$122,190,299 | \$148,742,485 | \$161,376,987 | \$185,565,583 | \$222,592,122 |
| Miscellaneous General Operations | - | - | - | 678,003 | - |
| Mental Health Comm. ⁴ | \$ 7,573,707 | \$ 7,934,419 | \$ 10,056,802 | \$ 12,438,582 | \$ 11,207,790 |
| Dept. of Health & Environ. Control ⁴ | 66,610 | 65,606 | 137,700 | 46,771 | 1,955 |
| Mental Retard. ⁴ | 7,581,218 | 13,056,425 | 21,094,044 | 31,851,145 | 39,622,565 |
| TOTAL Assistance Payments | \$137,411,834 | \$169,798,935 | \$192,665,533 | \$230,580,084 | \$273,424,432 |

¹Includes Mid wife Services

²Includes Regular and Medical Assistant only

³Includes Podiatrist, Chiropractor, Transportation, Family Planning, etc.

⁴Medicaid Flow-Through Funds

⁵Figure shown reflects expenditures for only 11 months.

CHAPTER II
NURSING HOMES

Nursing home costs are a significant factor in the rising cost of Medicaid. Its portion of the program's budget has increased 158% from FY 75-76 to FY 81-82. DSS estimates the nursing home program will cost \$100 million in FY 81-82, absorbing 43% of DSS's Medicaid budget while serving only 3.6% of the total Medicaid patient population. Medicaid has become the primary source of revenue for the nursing home industry, paying for 82% of the 10,885 beds in the nursing homes that contract with DSS.

The Audit Council reviewed the agency's nursing home reimbursement system, its method of determining allowable costs, and the system for patient placement. DSS has not established reimbursement, and patient placement systems for ensuring that Medicaid patients receive the level of care needed. DSS has improperly implemented the nursing home reimbursement methodology and there are inadequate guidelines for determining allowable costs.

No System for Proper Placement of Nursing Home Patients

There is no system in the State to ensure the proper placement of Medicaid patients in nursing homes. DSS has not established comprehensive; stringent and uniform medical criteria for determining placement needs of individual Medicaid patients. For example, if ten hospital patients are awaiting a nursing home bed, the patients are not ranked and admitted based on medical need or any objective criteria. The nursing home selects the patient to be admitted. -

In 1977, the Audit Council recommended that DSS establish statewide, uniform medical criteria for admission to the Medicaid nursing home program. However, DSS did not take the initiative to establish standards for placing patients in nursing homes. Since no standards were developed, nursing homes control which patients they will admit.

There are three agencies involved in the regulation of nursing home services: DSS, DHEC and the Professional Services Review Organization (PSRO). DSS establishes client eligibility and reimbursement rates, DHEC licenses homes, and until December 31, 1981, PSRO conducted patient care assessments. Beginning January 1, 1982, DSS took over PSRO's responsibilities for patient assessments. DSS has not coordinated the functions of these three agencies to develop placement standards; a ranking or priority system; a central patient registry for placement; or any type of patient placement based on medical need.

Since funds are limited, the Medicaid program must ensure that the people with the greatest needs are served at the most economical cost. Patients should be placed in nursing homes according to objective criteria that define and rank a patient on medical needs, matching them to the capabilities of individual nursing homes.

The present system does not ensure that the sickest patient is placed in a home over a patient who has less need of this service. Because DSS has not taken the responsibility for coordinating patient assessment and placement, nursing homes are in an extremely advantageous position to choose what type of patient they will admit. Economically, it is more advantageous for a nursing home to choose patients who do not require high levels of care. Without objective criteria and coordination of patient placement, there is no assurance that a Medicaid patient most in need of a nursing home receives the necessary service.

Lack of Adequate Intermediate Beds Increase Costs

Patients requiring only an intermediate level of care are being served in the more expensive skilled care facilities, and DSS pays the skilled rate to the facility. An intermediate care patient occupying a skilled care bed can cost the State up to an additional \$9.50 per day. As of January 1981, 3,712 intermediate patients occupied skilled beds resulting in an estimated annual expenditure of \$4.3 to \$10.6 million more than necessary in the nursing home program. Appendix I explains how this range was computed.

Intermediate care patients are placed in skilled beds because there are not enough licensed intermediate beds in the State. There are approximately 2,100 Medicaid patients in nursing homes requiring a skilled level of care, and approximately 6,900 Medicaid patients requiring an intermediate level of care; a 1 to 3 ratio. However, the ratio of licensed skilled beds to intermediate beds is 2 to 1. In many licensed skilled nursing homes there are actually more patients requiring intermediate care than patients requiring skilled care. Table 3 uses three nursing homes to demonstrate the problem. As shown in these examples, the majority of Medicaid patients in skilled nursing homes are intermediate care patients. A breakdown of intermediate care and skilled care patients for each nursing home participating in the Medicaid program can be found in Appendices II and III.

TABLE 3
TYPE OF MEDICAID PATIENTS IN THREE LICENSED SKILLED
NURSING HOMES

| <u># of Beds</u> | <u>Nursing Home</u> | <u># of Licensed Skilled Beds</u> ¹ | <u>Type of Medicaid Patient</u> ² | |
|------------------|---------------------|--|--|---------------------|
| | | | <u>Skilled</u> | <u>Intermediate</u> |
| 0-60 | A | 40 | 2 | 38 |
| 61-99 | B | 86 | 1 | 58 |
| 100+ | C | 176 | 16 | 128 |

¹Licensed by DHEC.

²Patient assessment performed by PSRO.

³The difference in the number of beds licensed and the number of Medicaid patients is made up of Medicare, V.A., and private patients.

There are several causes for the inappropriate placement of Medicaid nursing home patients.

1. DSS's reimbursement system pays for the cost of the nursing home and not the level of care required by the patient.
2. Nursing homes inform the State of the level of care they will provide. The agency responsible for licensing nursing homes, DHEC, does not exercise control over the type of facility licensed. DHEC only determines the need for a nursing home; it does not exercise its authority through the certificate of need procedure in deciding what type of nursing home is most needed. After a nursing home is licensed, DHEC has no authority to force a skilled nursing home to relicense as an intermediate care home.

3. DSS has not established comprehensive and uniform medical criteria for placing Medicaid patients in nursing homes (see p. 21). There is also no emphasis on discharge planning for those patients who no longer require skilled care and either need intermediate care or no longer require nursing home care.
4. Skilled nursing homes have no incentive to relicense as intermediate care facilities. Due to the reimbursement system and the lack of a proper system for placement of patients, it is economically advantageous for a nursing home to be licensed to provide a skilled level of care while serving a majority of intermediate care patients.

Medicaid should not pay for a higher level of care than a patient requires. The licensing, reimbursement, and patient placement systems should be designed so that Medicaid pays only for the level of care a patient requires.

In 1977, the Council reported that there were more than 500 persons inappropriately placed in nursing homes at an annual cost of \$1.1 million. The number of inappropriate placements has increased to approximately 3,712 costing an estimated \$4.3 to 10.6 million annually (see Appendix I). Because of the reimbursement and licensing systems in effect, the State is paying for a higher level of care than patients require.

Improper Implementation of Reimbursement Methodology

DSS is improperly implementing its reimbursement methodology for funding nursing homes. Although the current methodology is basically sound, DSS uses inappropriate components which increase costs to the Medicaid program.

The Council noted several areas where standards used by DSS in its current methodology have created problems. The inflation factor used in projecting costs is inappropriate and too high. Classifying dissimilar facilities together for determining average costs creates inequitable and, in some cases, arbitrarily high rates. DSS does not limit the size of nursing staffs for which Medicaid will pay and compensates nursing homes for staffing hours not actually used. Maximum limits for reimbursement have not been placed on mandated services. The maximum allowed for owner/administrators' salaries is unreasonably high and can include payment for country club dues and personal autos.

Before discussing these findings in detail, a simplified explanation of the reimbursement methodology is presented for a better understanding of the problems. The current system reimburses each facility according to its reported cost of operation. Reimbursement rates are based on the prior year's (October 1 - September 30) operating costs and are projected to the forthcoming calendar year. Costs are divided into two primary categories.

Mandated Services - In the Mandated Services category, DSS pays actual costs. These services include:

- Rehabilitative services
- Medical records
- Utilities
- Payroll taxes & fringe benefits
- Licenses
- Medical supplies

Standard Services - For Standard Services, the facilities are grouped by type and size in order to compute an average cost for each service to each group of facilities. Standard services include:

- Nursing
- Dietary
- Housekeeping
- Administration

Once an average has been computed for a service, 8% is added as a "quality assurance factor" and this amount becomes the standard. If a nursing home's cost for that service is above the standard, a cost-sharing allocation helps absorb part of the above-average cost. If the cost is below the standard, the nursing home can receive up to \$2.26 per patient, per day as an efficiency incentive.

Inflation Factor - The actual costs of the Mandated Services and the computed amounts for Standard Services are multiplied by an inflation factor in order to project the increases in expenses in the coming year.

Other Costs - Both the cost of capital and a return on the amount of owner's equity is figured into the final reimbursement amount.

Incorrect Inflation Factor Used for Setting Nursing Home Rates

DSS's use of the national Consumer Price Index (CPI) as an inflation factor for projecting reimbursement rates overpaid nursing homes \$2.3 million, including \$690,000 in State funds, in 1981. Despite requests not to use the CPI from the Federal Department of Health and Human Services (HHS) and the State Budget and Control Board, DSS continues to use this index to project inflation.

The CPI is not an accurate measure of inflation for nursing homes because it measures individual consumer price changes nationwide and not price changes experienced by South Carolina's nursing homes. In January 1981, HHS told the Department that the CPI did not reflect reasonable industry cost trends. HHS stated that the Producer Price Index and other indices more accurately reflect the inflationary trend in the nursing home industry. DSS was asked to, "... please explain the reasonableness of using the general CPI as a trend factor."

Prior to this inquiry by HHS, the State Budget and Control Board told DSS that use of the CPI, "... is inappropriate for institutions." The Board suggested that DSS use the inflation factor developed by the State Division of Research and Statistical Services, however, DSS retained the CPI as the inflation factor.

The State Division of Research and Statistical Services computed an inflation rate for 1981 of 10.4% for increases in costs of nursing home services and goods, however, DSS used the CPI rate of 12.6%. As shown in Table 4, using the CPI as the inflation factor increased payments to nursing homes by \$2,340,521.

TABLE 4
OVERPAYMENTS MADE TO NURSING HOMES IN 1981
USING THE CPI AS AN INFLATION FACTOR

| <u>Skilled Nursing Facilities</u> | <u>Overpayments</u> |
|--------------------------------------|---------------------|
| 0-60 Beds | \$ 233,602 |
| 61-99 | 507,711 |
| 100+ | 445,819 |
| | |
| <u>Intermedicate Care Facilities</u> | |
| 0-60 Beds | 120,906 |
| 61-99 | 118,438 |
| 100+ | 104,296 |
| | |
| <u>SNF/ICF</u> | |
| 0-60 Beds | 31,650 |
| 61-99 | 196,139 |
| 100+ | 581,960 |
| TOTAL | <u>\$2,340,522</u> |

DSS should use a projected rate of inflation which more accurately reflects increases in the cost of services it provides in South Carolina. When the General Assembly enacted the Education Finance Act, it recognized the need for using an inflation rate which reflected the costs of specific services in South Carolina. Therefore, the EFA requires an inflation rate, developed by the Division of Research and Statistical Services, which projects only increases in educational costs within the State.

In the past, DSS officials have stated they would use a more accurate index for inflation. DSS told the Council this index will be used the next time nursing home reimbursement rates are revised. In

its November 1981 cost containment actions, DSS reduced the inflation factor to an annualized rate of 8% for the five-month period February to July 1982.

Improper Rate Setting Method

The method used for determining the reimbursement rates for Standard Services creates inequitable and, in some cases, arbitrarily high rates. Standard Services, nursing, dietary, housekeeping, and administration, account for 76% of the costs of the nursing home program. There are several problems with the rate-setting method for standard services. Dissimilar facilities are currently classified together for determining averages for costs and an 8% "quality assurance" factor is used for adjusting the average upward to set a standard.

Facilities are placed in groups by size and type of care for computing the average cost for each of the four Standard Services (see Table 5 for groupings of facilities). Once the average cost of a service for a particular grouping of facilities has been computed, an 8% "quality assurance" factor is added to determine the reimbursement standard. When the standard is set, those facilities with costs above the standard receive a cost-sharing allocation, facilities below the standard receive an efficiency incentive allotment.

The groupings used by DSS do not distinguish between non-profit and hospital-based facilities versus private-for-profit facilities. As Table 5 demonstrates, the costs of care differs for these facilities.

TABLE 5
COMPARISON OF PRIVATE AND PUBLIC NURSING HOMES AVERAGE
ALLOWABLE COSTS REPORTED FOR STANDARD SERVICES
TO SET 1981 RATES

| <u># of Facilities</u> | <u>Type Facility</u> | <u>Size</u> | <u>Private for Profit costs¹</u> | <u>Hospital-based and Non-profit costs¹</u> | <u>Standard Used</u> |
|------------------------|----------------------|-------------|---|--|----------------------|
| 18 | SNF | 0-60 | \$26.95 | \$39.78 | \$30.57 |
| 21 | SNF | 61-99 | 24.08 | 33.86 | 26.26 |
| 17 | SNF | 100+ | <u>24.73</u> | <u>26.55</u> | <u>26.77</u> |
| Average | | | \$24.92 | \$35.42 | \$27.81 |
| 18 | ICF | 0-60 | 21.54 | 26.22 | 23.19 |
| 8 | ICF | 61-99 | 18.33 | 20.49 | 20.57 |
| 4 | ICF | 100+ | <u>18.30</u> | <u>none</u> | <u>18.58</u> |
| Average | | | \$20.09 | \$25.18 | \$22.17 |
| 2 | SNF/ICF | 0-60 | 24.58 | 27.20 | 29.57 |
| 11 | SNF/ICF | 61-99 | 23.46 | 32.93 | 26.51 |
| 23 | SNF/ICF | 100+ | <u>21.80</u> | <u>27.57</u> | <u>25.29</u> |
| Average | | | \$22.39 | \$29.31 | \$26.40 |

¹Per patient day

Source: DSS Nursing Home Cost Reports

The quality assurance factor is misnamed since it does not ensure quality care. It is a means of adjusting average costs upward. Generally, an adjustment factor is used when using peer group review for establishing an average to allow for reasonable cost variation. Because the current nursing home groupings are dissimilar, an 8% adjustment to the average causes inequalities.

The current cost standards permit only 26% of the non-profit, hospital-based facilities to recoup all of their costs. For these facilities, the cost-sharing allocation will pay only a maximum of 15% of their costs which are above the standard costs. Under the current system, private-for-profit facilities benefit in two ways. First, because the non-profit hospital-based facilities inflate the average cost and the 8% quality assurance increases the standard, 81% of the private facilities are able to recoup all their costs. Second, because the average costs are high, all 81% qualify for the efficiency incentive factor which can be up to \$2.26 per patient, per day.

In order to set reasonable and equitable cost standards for the Medicaid nursing home program, facility classifications need to differentiate between private-for-profit facilities and non-profit, hospital-based facilities. Until the classifications are changed, the 8% adjustment to the average cost (quality assurance factor) is inappropriate.

As shown in Table 5, non-profit and hospital-based facilities have higher costs than private facilities. No studies have been performed by DSS or DHEC to determine why non-profit and hospital-based facilities have higher operating costs than private facilities, and it was not within the scope of this audit to examine these costs.

No Cap on Nursing Services

DSS does not set maximums on the size of staffs for which nursing homes will be reimbursed with Medicaid funds. A minimum number of staff is established by the South Carolina Department of Health and Environmental Control (DHEC) in order to obtain and keep a nursing home license. However, facilities can staff over the minimum requirement for nurses and non-licensed staff and these costs will be used by DSS in determining cost standards.

The average staffing level for licensed nurses in South Carolina nursing homes in the Medicaid program is 66% above the DHEC minimum, and the average level for non-licensed personnel is 31% over the minimum (see Table 6). One-third of the nursing homes are staffed at two to three times the DHEC requirement for licensed nurses. For example, one home with a DHEC staff requirement of five nurses and 13 non-licensed personnel, had 14 nurses and 23 non-licensed employees on its staff. Two other nursing homes had DHEC non-licensed staff requirements of 35 and 25, yet their actual staff sizes were 68 and 65.

TABLE 6

A COMPARISON OF MINIMUM STAFFING LEVELS REQUIRED BY DHEC
AND STAFFING LEVELS EMPLOYED BY NURSING HOMES

| <u>No. of Facilities</u> | <u>Type Facility</u> | <u>DHEC</u> | | <u>Nursing Homes</u> | | <u>DHEC</u> | | <u>Nursing Homes</u> | |
|------------------------------|----------------------|---|----------------------------|-------------------------|--|----------------------------|-------------------------|----------------------|--|
| | | <u>Minimum Licensed Nurses Required</u> | <u>Number Employed</u> | <u>% of Minimum</u> | <u>Minimum Non-licensed Staff Required</u> | <u>Number Employed</u> | <u>% of Minimum</u> | | |
| 18 | SNF 0-60 | 84 | 117.70 | 140% | 192.60 | 283.6 | 147% | | |
| 20 | SNF 61-99 | 174 | 249.50 | 143% | 502.60 | 107.90 | 140% | | |
| 17 | SNF 100+ | 222.60 | 336.60 | 151% | 665 | 809.60 | 122% | | |
| 17 | ICF 0-60 | 25.20 | 74.7 | 296% | 156 | 167.95 | 108% | | |
| 8 | ICF 61-99 | 23.8 | 69.1 | 290% | 141 | 156.70 | 111% | | |
| 4 | ICF 100+ | 19.6 | 45.75 | 233% | 111 | 127.10 | 115% | | |
| 2 | SNF/ICF 0-60 | 12.8 | 19.8 | 155% | 32 | 31.80 | 99% | | |
| 11 | SNF/ICF 61-99 | 59.6 | 114.1 | 191% | 207 | 250.90 | 121% | | |
| <u>23</u> | SNF/ICF 100+ | <u>246.2</u> | <u>414</u> | <u>168%</u> | <u>850.20</u> | <u>1,208.80</u> | <u>142%</u> | | |
| <u>122</u> | TOTALS for State | <u>867.80</u> | <u>1,441.25</u> | <u>166%</u> | <u>2,847.40</u> | <u>3,738.35</u> | <u>133%</u> | | |

As of September 1981.

In 1980, the DSS Board voted to cap nursing services at 125% of the DHEC licensing requirement for calendar year 1981, but the Board reversed this decision. Then, in 1981, DSS proposed capping nursing services at 110% of DHEC's licensing requirement. The agency's staff estimated this cap could save \$5.4 million, including \$1.62 million in State funds for FY 81-82.

By not limiting the size of nursing and non-licensed staff for which Medicaid will reimburse, DSS continues to pay more than is necessary for the nursing home program. With the rising cost of Medicaid, DSS must be committed to implementing adequate cost containment measures. Good management principals require that DSS pay no more than necessary for the delivery of nursing services.

Establishing Staffing Hour Standards

The establishment of a "floor" for staffing hours requires Medicaid to pay for higher than necessary costs for nursing services. In determining reimbursements for nursing services, DSS established a minimum number of staffing hours, a "floor," to be used to compute the standard for nursing services. DSS estimated in 1980 that removing the floor would have saved \$696,000.

The present "floor" is based on 1979 actual hours. For example, if the 1979 standard was an average of 20 daily staff hours and in 1980 the nursing home industry became more efficient by reducing the average daily hours to 18, the "floor" of 20 would still be used to determine reimbursement. Nursing homes operating under the 20 "floor" hours are then able to realize more profits.

DSS officials stated that a "floor" was established because it provides an incentive for high cost providers to reduce their staffing hours in order to share in the efficiency incentives. However, this system reimburses homes for costs that do not exist. Cost standards should be established in an equitable manner and based on actual hours necessary to deliver nursing home services. In October 1980, the Budget and Control Board's "ad hoc" Medicaid Committee recommended to DSS:

...removal of the "floor concept" which is utilized in the rate standard computation. The removal... would allow the State to benefit from economics demonstrated by the facilities used to compute the rate standards without impacting or threatening patient care.

In October 1980, the DSS Board voted to eliminate the "floor" concept but reversed that decision in December and reestablished a floor standard based on 1979 actual hours. As a result, efficiently operated nursing homes provide Medicaid with no savings in nursing costs, therefore, the state is paying more than is necessary for the nursing home program.

Owner/Administrator Compensation

DSS is allowing higher than average salaries to be paid by Medicaid to nursing home owners and administrators. The maximum allowable salary is 150% of the average salary computed for each class of nursing homes. Medicaid will also reimburse country club dues, personal autos, and additional fringe benefits as a part of owner/administrator compensation if the salary is under the maximum allowable. The agency obtains the average salary for each nursing home group and multiplies it by 150% to obtain the maximum allowable administrator salary paid by the program. Table 7 lists maximum allowable owner/ administrator salaries for 1981.

Medicare guidelines exist which evaluate the reasonableness of owner's compensation, but DSS does not use these guidelines. In 1979, the DSS Commissioner considered guidelines which were much more restrictive than those presently used. These guidelines set maximum salaries ranging from five percent below the mean to 15% above the mean for administrators. The guidelines used length of experience, facility size and staffing size as criteria for determining the range for allowable salary costs, however, the 1979 guidelines were not implemented.

TABLE 7
MAXIMUM ALLOWABLE SALARIES FOR NURSING HOME
OWNER/ADMINISTRATORS
FOR 1981

| <u>Size and Class Facility</u> | <u>Average Salary</u> | <u>Maximum Allowable Salary</u> |
|--------------------------------|-----------------------|---------------------------------|
| SNF/ICF and SNF | | |
| 0-60 beds | \$22,399 x 150% | \$33,599 |
| 61-99 beds | 31,090 x 150% | 46,635 |
| 100 + beds | 31,096 x 150% | 46,644 |
| ICF | | |
| 0-60 beds | \$20,359 x 150% | \$30,539 |
| 61-99 beds | 26,361 x 150% | 39,542 |
| 100 + beds | 29,777 x 150% | 44,666 |

By inflating maximum salaries to 50% above the average, DSS is paying for more than reasonable salaries with Medicaid funds. The

inclusion of country club dues and personal autos, as a part of compensation which can be reimbursed with Medicaid funds, is a questionable use of taxpayer dollars.

No Ceiling On Mandated Services Costs

DSS did not follow the General Assembly's intent when it did not place ceilings on Mandated Services for nursing home reimbursement. The General Assembly directed DSS in the FY 78-79 Appropriation Act to set maximum reimbursement levels, however, the agency reimburses all Mandated Service costs to nursing homes. In FY 81-82, these services will cost approximately \$15.4 million.

DSS management, by not limiting reimbursement for Mandated Services, has not implemented adequate cost containment measures in the nursing home program. For example, DSS pays nursing homes for the full cost of utilities whether the facilities are energy efficient or not.

In October 1980, the Budget and Control Board's "ad hoc" Medicaid Committee recommended capping all mandated costs at the 90th percentile.

The Board stated:

This action will make providers more aware of the "market basket" of licensed service providers as well as making them more cost conscious in high cost areas such as utilities.

The DSS board approved restricting mandated costs at the 90th percentile, but in December 1980, the Board reversed this decision.

DSS has not specified the "...maximums above which the State will not participate for Mandated Services." Because the intent of the General Assembly was not followed, nursing homes have little incentive to contain these costs and DSS cannot control expenditures in a vital, expensive area of the Medicaid program.

Unreasonable Costs Allowed

The inadequate criteria for determining allowable costs for nursing homes contribute to the rising cost of Medicaid. Because of this, Medicaid is paying for items such as luxury automobiles, unnecessary travel expenses, costly lease arrangements, audit appeal costs, and other questionable expenses.

DSS uses the Federal Health Insurance Manual (HIM-15) as a guideline for auditing nursing home facilities, but HIM-15 contains vague terms and lacks specific standards for auditing. The manual does not give explicit directions for determining allowable costs; instead it uses terminology such as "reasonable costs" or "prudent and cost conscious buyer."

The agency has not established specific standards clarifying the loose and vague directions of HIM-15 in order to prevent paying for unnecessary and luxury items in the Medicaid program. The lack of adequate guidelines for defining a nursing home's allowable costs and acceptable upper bounds are adding unnecessary costs to the Medicaid program. The following findings discuss in more detail problems noted by the Council with DSS's standards for allowable nursing home costs.

Purchase of Luxury Automobiles

DSS has not developed guidelines for determining allowable automobile costs and does not require documentation that the autos are used for business. Nursing home owners are allowed to purchase luxury automobiles and receive reimbursement in Medicaid funds.

In a letter to the State Department of Health and Environmental Control's Commissioner in May 1981, the DSS Commissioner said:

"We only recognize the cost of one median cost automobile and only the percentage associated with business use." Contrary to the Commissioner's statement, DSS has allowed costs of a \$41,500 Mercedes Benz, Cadillacs, Lincolns, Corvettes and a Datsun 280 ZX. DSS has allowed purchases of more than one vehicle to be charged to Medicaid. One home, for example, purchased three Buicks and a GMC Pickup Truck which were considered allowable costs under Medicaid (see Table 8).

TABLE 8
EXAMPLES OF MEDICAID ALLOWABLE VEHICLE COSTS

| <u>Facility</u> | <u>Automobile(s)</u> | <u>Total Purchase Price</u> |
|-----------------|---|-----------------------------|
| Facility 1 | 1979 Mercedes Benz 450-SEL | \$41,500 |
| Facility 2 | 1978 Mercedes Benz | \$14,872 |
| Facility 3 | Chevrolet Corvette | \$16,629 |
| Facility 4 | 1977 Continental ¹ 1977 Corvette ² | \$19,524 |
| Facility 5 | 1978 Buick, 1978 Buick | \$17,925 |
| Facility 6 | Oldsmobile | \$13,855 |
| Facility 7 | 1976 Lincoln | \$11,856 |
| Facility 8 | 1979 Datsun 280 ZX | \$ 9,617 |
| Facility 9 | 1974 Cadillac | \$ 8,020 |
| Facility 10 | 1979 John Deere Tractor | \$ 7,622 |
| Facility 11 | 1977 Ford LTD | \$ 5,138 |

¹DSS disallowed 25% of this cost because facility reported 25% was personal use.

²DSS disallowed 50% of this cost because facility reported 50% was personal use.

When an automobile is claimed as a business expense, facilities do not have to document that the auto is used for nursing home business. No verification is required of the amount of time the car is used for business. If a facility reports an automobile is used 100% for business purposes, the agency will allow Medicaid payment for the entire purchase price. During FY 79-80, nursing homes reported automobile, maintenance and gasoline allowable costs of \$783,363. Medicaid's share of these costs was approximately 82%, or \$642,358.

The lack of strict guidelines on automobile expenses not only increases the cost of Medicaid, but results in payment for luxury items. The taxpayers are subsidizing unnecessarily high costs in the nursing home program during a time when the Medicaid program is experiencing Federal budget cuts.

Lease Arrangements

One factor contributing to the increasing cost of the nursing home program is the leasing of nursing homes. Thirty-four of the 122 facilities participating in Medicaid are currently leased. The Audit Council reviewed seven lease arrangements negotiated in 1981 and found that the additional payments due to the leases for just these seven homes increased the cost of Medicaid by approximately \$656,000 annually.

Medicaid reimburses for the cost of buildings, equipment, and mortgage interest. When a nursing home owner leases the business, Medicaid continues to pay for these costs, plus an additional amount due to the lease. DSS will allow the lease amount if it falls within the agency's guidelines, which are based on the value of the building and current interest rates. The individual leasing the business, therefore,

can pass the cost of the lease on to Medicaid. For example, one nursing home owner was reimbursed for building, equipment and mortgage costs of \$36,661. After the facility was leased, the reimbursement increased to \$124,691, the \$88,000 increase to Medicaid occurring because of payments to the owner.

The issue is not whether nursing homes should be leased or not but whether Medicaid should foot the bill for a business arrangement which does not contribute to the quality of patient care. The cost to Medicaid, for the seven lease arrangements reviewed by the Council, was an average of \$2.76 per patient day. In December 1981, the DSS Board voted that Medicaid will not reimburse nursing homes for additional costs of leases negotiated after September 1981. However, this does not affect the 34 facilities currently leased and these additional lease costs still exist.

Legal Costs

Nursing homes are reimbursed for legal expenses, including those costs associated with contesting decisions by DSS, regardless of the outcome of the appeal. For example, when DSS determined that a beach condominium was not related to patient care and disallowed it, the nursing home could have appealed and Medicaid would have paid the attorney costs associated with the appeal.

In FY 79-80, nursing homes incurred costs of approximately \$67,000 for legal fees, part of which were associated with appeals. Medicaid's share of these costs was 82%, or \$54,940. The current system encourages nursing homes to appeal audit decisions because they are able to recover these costs from Medicaid, regardless of the outcome. Should a nursing home decide to pursue its case in the

courts, the State can be placed in the position of reimbursing a nursing home for expenses incurred while suing the State. The number of appeals filed may soon increase for DSS is currently auditing all nursing homes, a procedure that has not been done in the past. Should the number of audit exceptions increase, nursing homes can appeal the decisions and the increase in costs will be passed on to the taxpayer.

Travel Costs

DSS has not developed adequate guidelines to determine travel costs considered allowable for reimbursement with Medicaid funds. Nursing homes have been reimbursed to attend meetings outside the State and during 1979-80, nursing homes incurred costs of \$233,817 for seminars and training. Medicaid's share of these costs was 82%, or approximately \$125,460.

DSS auditors have stated that if a meeting or seminar is related to patient care, they will consider this an allowable expense to be reimbursed with Medicaid funds. For example, the current standards allowed the cost to two nursing homes of \$6,863 for a meeting in Hawaii to be considered as an allowable cost.

The National Governor's Association has recommended, among other things, that travel costs outside the State not be an allowable Medicaid expense. The lack of restrictions and rules for reimbursing travel expenses, has added to the cost of the nursing home program.

Health Care Association Dues

DSS is reimbursing nursing homes for dues paid to the state, regional and national Health Care Associations. The State Health Care

Association is an organization registered as a lobbyist with the General Assembly. In 1981, the Council estimates nursing home costs for association dues were approximately \$153,000, approximately 82% or \$125,460 will be paid by Medicaid. In addition, in 1981, Tucker Center, a State nursing facility operated by the Department of Mental Health, paid association dues of \$5,280. As a result, not only are Medicaid funds being used to lobby for the nursing home program but also State funds.

DSS officials have stated that association dues are allowable because they are related to patient care. However, not all association functions are related to patient care. In 1980, the South Carolina Health Care Association reported expenses of approximately \$18,000 for lobbying activities.

The National Governor's Association report entitled "State Guide to Medicaid Cost Containment" stated that Medicaid should not recognize association dues as an allowable cost. By allowing Health Care Association dues as a legitimate Medicaid cost, DSS is increasing the cost for the Medicaid program more than is necessary.

Freezing of Nursing Homes Occupancy Rates

In an attempt to contain nursing home costs for FY 81-82, DSS has frozen the number of patients for which Medicaid will pay within a particular nursing home. DSS chose this measure to reduce costs rather than implement the cost containment measures previously mentioned. Without a waiver from HHS, this measure is in violation of Federal Regulations.

In order to meet the funding reduction legislated in the FY 81-82 Appropriation Act for the Medicaid program, DSS reduced the nursing

home budget by \$6.1 million. To accomplish this, DSS froze the Medicaid occupancy rate at the April 1, 1981 level, for FY 81-82, and the reimbursement rate was frozen, effective January 1, 1982. According to DSS, these cost containment options were the most expedient and least disruptive than any of the options considered.

DSS chose this option in spite of the fact that one other state was unsuccessful in obtaining a waiver to freeze nursing home occupancy and reimbursement rates. The Mississippi Medicaid Commission attempted to limit the occupancy rate that Medicaid would reimburse in nursing homes. The Department of Health and Human Services ruled in part:

... A State must either enter into a provider agreement for all certifiable beds in the facility or decline to enter into a provider agreement for "good cause." The State does not have the option of denying a proportion of beds in all facilities. [Emphasis Added]

Although the occupancy rate was frozen July 1, 1981, DSS did not request a waiver from HHS until September 1981, and at the time of this audit it had not been approved.

RECOMMENDATIONS

DSS SHOULD ESTABLISH COMPREHENSIVE, STRINGENT AND UNIFORM MEDICAL CRITERIA FOR DETERMINING THE PLACEMENT NEEDS OF THE STATE'S MEDICAID NURSING HOME PATIENTS.

DSS SHOULD WORK WITH THE STATE'S MEDICAL PROVIDERS TO CREATE A CENTRAL REGISTRY OF ELIGIBLE MEDICAID NURSING HOME PATIENTS. THE PATIENT NEEDS SHOULD BE RANKED AND

MATCHED TO THE CAPABILITIES OF AVAILABLE NURSING HOMES FOR PLACEMENT.

DSS SHOULD REIMBURSE NURSING HOMES ONLY FOR THOSE COSTS NECESSARY TO PROVIDE THE LEVEL OF CARE APPROPRIATE TO A PATIENT'S CONDITION. DSS SHOULD NOT PAY FOR A LEVEL OF CARE ABOVE THAT NEEDED FOR A PATIENT'S CARE.

THE GENERAL ASSEMBLY SHOULD CONSIDER LEGISLATION DIRECTING THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL TO RELICENSE EXISTING, DUALY CERTIFIED SKILLED/ INTERMEDIATE NURSING HOMES TO EITHER TOTALLY INTERMEDIATE CARE FACILITIES OR DISTINCT PART INTERMEDIATE/DISTINCT PART SKILLED CARE FACILITIES. ONE FACTOR USED IN THIS RELICENSING SHOULD BE THE PATIENT POPULATION RESIDING IN THE NURSING HOMES.

IN THE FUTURE WHEN NEW NURSING HOMES ARE BUILT, DHEC SHOULD LICENSE THESE HOMES EMPHASIZING INTERMEDIATE CARE FACILITIES. DHEC SHOULD ESTABLISH A RATIO OF INTERMEDIATE CARE BEDS TO SKILLED CARE BEDS WHICH MATCHES THE NEEDS OF THE STATE'S PATIENT

POPULATION. DHEC SHOULD TAKE STEPS TO ACHIEVE THIS RATIO THROUGH ITS CERTIFICATE OF NEED AND LICENSING PROCESS.

DSS SHOULD USE AN INFLATION FACTOR DEVELOPED BY THE STATE DIVISION OF RESEARCH AND STATISTICAL SERVICES TO PROJECT NURSING HOME RATE INCREASES.

DSS SHOULD ESTABLISH NEW CLASSIFICATIONS OF NURSING HOMES FOR DETERMINING REIMBURSEMENTS FOR STANDARD SERVICES. HOSPITAL-BASED, NON-PROFIT NURSING HOMES AND PRIVATE, FOR PROFIT HOMES SHOULD BE SEPARATED FOR DETERMINING COST STANDARDS.

DSS SHOULD, AFTER RECLASSIFYING NURSING HOMES FOR STANDARD SERVICES REIMBURSEMENTS, CONSIDER REDUCING THE QUALITY ASSURANCE FACTOR.

DSS, WORKING IN CONJUNCTION WITH DHEC, SHOULD CONDUCT AN IN-DEPTH STUDY TO DETERMINE WHETHER PUBLIC AND NON-PROFIT NURSING HOMES ARE LESS EFFICIENT THAN PRIVATE HOMES. QUALITY OF CARE SHOULD BE CONSIDERED AND COMPARED TO PRIVATE HOMES. IF THE

STUDY FINDS THAT PUBLIC AND HOSPITAL-BASED HOMES ARE INEFFICIENT, THEN CONTRACTING OR SOME OTHER METHOD OF PROVIDING SERVICES SHOULD BE CONSIDERED.

DSS SHOULD SET A MAXIMUM FOR REIMBURSEMENT FOR NURSING AND NON-LICENSED STAFFS. DSS SHOULD DISCONTINUE USING THE "FLOOR" CONCEPT AND REIMBURSE NURSING FACILITIES ONLY FOR ACTUAL HOURS NECESSARY TO DELIVER SERVICES.

DSS SHOULD ENSURE THAT OWNER'S COMPENSATION IS REASONABLE BY ESTABLISHING SPECIFIC CRITERIA SUCH AS THE MEDICARE OWNER'S COMPENSATION GUIDELINES.

DSS SHOULD PLACE A CEILING ON REIMBURSEMENT FOR MANDATED SERVICES.

DSS SHOULD DEVELOP GUIDELINES IN ADDITION TO FEDERAL HIM-15 FOR SPECIFYING ALLOWABLE COSTS IN THE NURSING HOME PROGRAM. THESE GUIDELINES SHOULD RESTRICT REIMBURSEMENT FOR TRAVEL, AUTOMOBILES, AND LEGAL FEES; AND ELIMINATE REIMBURSEMENT FOR ASSOCIATION

DUES. DSS SHOULD NOT REIMBURSE ANY NURSING HOME FOR ADDITIONAL COSTS DUE TO LEASING THE FACILITY.

DSS SHOULD IMPLEMENT COST CONTAINMENT MEASURES IN THE NURSING HOME REIMBURSEMENT SYSTEM WHICH EITHER COMPLY WITH FEDERAL REGULATIONS OR FOR WHICH WAIVERS HAVE BEEN GRANTED.

CHAPTER III
HOSPITALS, PHYSICIANS, DRUGS

Introduction

Efforts by the Reagan Administration to cut Federal spending in the Medicaid program resulted in a major debate in the 97th Congress. The Medicaid Amendments of 1981, passed during the first session of Congress, have been called "sweeping," and are described as having a significant impact on states' Medicaid programs. The amendments provide states with greater flexibility in administering the program and reduce Federal payments to the states.

The immediate effect of the changes will be a three-year reduction in Federal funds which begins October 1, 1981. Federal participation will be reduced 3% in Federal FY 81-82, by 4% in FY 82-83, and by 4.5% in FY 83-84. For South Carolina, this cut in the Federal share of funding will increase the required State match from approximately 29% to 33.5%. This loss will have to be met with State funds, in addition to the historical funding increases required, if the Medicaid program is to continue at its current level. The estimate of the loss in Federal funds for FY 81-82 is approximately \$5 million, for FY 82-83, \$9 million, and for FY 83-84, \$11.4 million.

For the South Carolina Medicaid program, Federal funding cuts come at a time when the State has already experienced difficulty in funding the program. Medicaid has required an average yearly increase in State funding of \$8.6 million since FY 77-78. The program has grown from \$38 million in FY 77-78 to \$64 million for FY 80-81. In each of these four years, the program has had an average deficit of \$3.5 million.

The Medicaid amendments include several provisions for easing the impact of the budget cuts. A state may experience an easing of the reductions in funding if it meets certain criteria:

- (1) hospital review commission established by statute,
- (2) high unemployment,
- (3) significant recoveries from fraud and abuse,

For each criterion met, the reduction is cut 1%. South Carolina will meet none of these three provisions, however.

There is a fourth provision which allows a state meeting a specific performance standard to obtain a dollar-for-dollar offset against the amount of the Federal reduction. If South Carolina's rate of increase is less than 109% of the estimate made in February 1981, the benefit of the offset will be received in the next fiscal year. DSS expects South Carolina to be slightly below the target for Federal FY 81-82, but to exceed the target in FY 82-83 and FY 83-84.

States may also implement the "flexibility" provisions contained in the amendments. These provisions allow states substantial latitude to make changes which would result in a more cost effective and efficient Medicaid program. Since the Federal Government is considering further cuts to entitlement programs for FY 82-83, containing costs in Medicaid is of increasing importance.

The Legislative Audit Council reviewed the steps taken by the Department of Social Services to control costs in the last three years. Four programs were examined: hospital in-patient and nursing homes reimbursement formulas, physician and drug payments. The Council found that the Department did not take advantage of the leeway allowed under the pre-1981 Medicaid law to reduce costs.

Some provider reimbursements were increased at a time when the program was already experiencing deficits and, in one case, without complying with State and Federal Regulations.

Medicaid benefits to recipients have been reduced for FY 81-82 in an attempt to stay within the program's budget. The number of days of hospitalization for which Medicaid will pay has been reduced from 40 to 12 days. Nursing homes' Medicaid occupancy rate has been frozen at the April 1, 1981 level. Visits to hospital clinics, doctors and/or emergency rooms have been cut from an unlimited number to 18. The Medicaid Drug Program has discontinued payment for over-the-counter drugs and cut the number of prescriptions for which the program will pay. Physicians' reimbursement rates also have been reduced 10% from the FY 80-81 level.

The 1981 amendments to the Medicaid law provide another opportunity to South Carolina for "creative financing" of the State's program. This chapter reviews the cost containment steps attempted in the hospital, physician, and drug programs, examines other options that are available, and describes measures taken by other states. The nursing home program is discussed in Chapter II.

Lack of Adequate Hospital Cost Containment Measures

In the FY 78-79 Appropriation Act and again in the FY 79-80 Act, the Legislature directed DSS to prepare a hospital reimbursement system as a cost containment action, "in order that the current fiscal crisis in the Medicaid not continue unabated..." The system was to provide incentives for prudent management and maximums above which the State would not participate. The Department of Social Services did not develop cost containment measures for Medicaid hospital reimbursements as requested by the Legislature. None of the various cost cutting methods used by other states or the options discussed at the time by the 1978 Governor's Task Force on Medicaid have been implemented by DSS's Office of Health Care Financing.

Instead, the State has continued to use the Medicare methodology for determining hospital reimbursements. Under the Medicare system, hospitals are reimbursed "reasonable costs" whereby they are allowed to pass costs directly to the State and Federal payers. The State's Medicaid system, regardless of how large the total liability may be, pays its share of total costs of inpatient care. According to the Commissioner, DSS did not prepare an alternative hospital reimbursement system because the Medicare methodology met the intent of the proviso.

Analysts of hospital costs argue, however, that the Medicare system creates incentives for hospitals to spend more because it is based on costs that are determined after the care is provided. The reimbursement methodology is considered to be a major factor in the rate of inflation in health care costs. It allows little control over the level of reimbursement or the rate of increase. States have little leeway in determining payments with the Medicare method since it is stringently governed by Federal Regulations.

There are several indications that this State should have developed alternatives to Medicare reimbursement for Medicaid and that changes are needed at this time. From 1976 to 1980, Medicaid payments for hospitalization increased 147%, reaching \$47.5 million in 1980, while utilization increased 24%. Funding for Medicaid now faces restrictions in several areas. The reductions in Federal contributions to Medicaid come at the same time State revenues have "leveled off" and budget constraints have been placed on Medicaid expenditures.

For FY 81-82, DSS has attempted to "contain" the increase in cost to the State for Medicaid hospitalization by reducing benefits. The number of days of hospitalization for which Medicaid will pay has been reduced and the number of visits to hospital clinics, doctors, or emergency rooms has been limited.

With changes in the Medicaid law, Federal Regulations have been eased. For example, the reasonable cost requirement has been eliminated and states are now allowed to establish rates that are reasonable and adequate to meet the cost of efficiently run facilities. States implementing cost containment methods and developing alternative formulas should find it easier to receive Federal approval for implementation.

Hospital costs are the largest single component of personal health care expenditures nationally, constituting 45% of health expenditures. Historically, South Carolina has experienced relatively low costs for hospitalization, ranking 43rd nationally in expenditures per case. However, the rate of increase for this State is above the national average for the 1970-79 period, only 17 states have experienced higher increases.

A review of cost containment measures undertaken by other states indicates that there are several remedies that could have been implemented by South Carolina to achieve savings within the Medicare methodology. There are also various examples of alternative formulas, considered successful by the Department of Health and Human Services (HHS) which the State should consider. A few of the possibilities are discussed briefly in order to indicate the wide range of options available to South Carolina for containing Medicaid hospital costs.

Administrative Options

There are adjustments which can be undertaken within the Medicare reimbursement methodology that can reduce the cost to the State for Medicaid hospital payments. The advantages of administrative adjustments are that they are implemented more easily than an alternative reimbursement system and that they do reduce costs to the State. Such adjustments can be criticized as being "piece-meal" and "cost shifting," however, rather than cost containing. A reduction in benefits or in reimbursements may cause a shift of the cost of services to the private sector. The funds required to meet the needs of Medicaid recipients may be obtained from higher charges to private pay and insurance pay patients.

Examples of possible administrative adjustments are:

Occupancy Rates - The Medicaid share of hospital costs is determined, in part, by computing the percentage of a hospital's available "patient days" used by Medicaid patients. The share is computed as if the hospitals experienced a 100% occupancy rate, although the average occupancy rate for the State is 70%. While it must be acknowledged that there are costs for maintaining the

unoccupied beds, a more realistic occupancy rate, other than 100%, should be used. This would enable Medicaid to avoid paying for a disproportionate share of empty beds. With an occupancy adjustment, hospitals with lower occupancy rates could have costs computed at an 85% occupancy level, for example, rather than the 100% currently used. This rate was recommended by a Governor's Task Force in 1978 and at the time, DSS estimated this would save over \$5 million for FY 77-78 and FY 78-79.

Legal Expenses - Medicaid pays its share of a hospital's legal expenses. The State can be placed in the position of reimbursing hospitals for expenses incurred while suing the State. The National Governors' Association has recommended that states consider eliminating political contributions and association dues as a part of the cost "pass throughs" Medicaid now pays.

Weekend Admission - The State should consider disallowing all costs associated with a weekend admission for non-emergency cases. Such admissions of patients who are to have surgery during the week are often unnecessary and add to the expense.

Laboratory and X-ray Reimbursement - A state can set payment at levels no higher than prices charged by large, private automated labs, at least for all non-emergency, out patient service. This would encourage more economical practices and cooperation between hospitals in using available resources. The new Medicaid provisions allow States to purchase laboratory services and medical devices through competitive bidding.

Alternative Reimbursement Systems

An alternative reimbursement system can be implemented by a state only after it has received approval of HHS. An advantage of an alternative system is that it can provide a coordinated method for controlling the overall inflation in hospitalization costs. The disadvantages of the alternative system can be the time and effort required to develop a payment method for such a complex area.

Twenty-six states have some form of hospital rate review. Twelve states have developed and received Health and Human Service approval for alternative reimbursement systems. The common feature of these systems is that they are prospective systems. The State sets the rates of payment ahead of time rather than paying for costs after they are incurred. Hospitals, therefore, have an incentive to become more efficient since higher costs will not yield higher reimbursement, but lower costs may provide additional revenue since rates have already been established for the year.

The various methods of determining payment fall into two categories. The first is a budget review system, under which cost inflation in a hospital's budget is compared with budget increases for other similar hospitals. Increases beyond those of other hospitals may be disallowed for Medicaid payment (Georgia has this system). The second general category is a percentage increase, which is based on typical increased costs of various hospital goods and services (Mississippi and Florida have such systems).

Some states' prospective systems cover only Medicaid while other states include all payers. In South Carolina, attempting to contain Medicaid costs alone faces two major problems. First, the lack of uni-

form regulations of rates paid by third parties permits hospitals to shift costs among the various payers. Second, Medicaid payments comprise a relatively small share of the State's hospital market, less than 10% in South Carolina.

Two studies of states with prospective rate setting systems found that the rates of hospital cost increases were reduced. For seven states which include all payers in a mandatory rate review, increases were annually 3% less than rates of increase for the other states for 1976-78 (See Table 9). Costs were held down in total expenditures and in expense per admission. Had South Carolina Medicaid hospital expenditures experienced a similar slowing of increases, the three year savings would have been \$3.5 million, over \$900,000 in State funds.

TABLE 9
ANNUAL PERCENTAGE INCREASE IN
TOTAL HOSPITAL EXPENDITURES*

| | <u>1976-77</u> | <u>1977-78</u> | <u>1978-79</u> | <u>1970-79</u> |
|--|----------------|----------------|----------------|----------------|
| Seven States with Mandatory Review Systems | 9.7 | 8.6 | 10.8 | 12.6 |
| Other 43 States | 15.7 | 14.0 | 14.3 | 15.1 |
| United States | 14.2 | 12.6 | 13.4 | 14.5 |
| South Carolina | 20.1 | 8.9 | 14.7 | 15.8 |

*Based on American Hospital Association data.

While the methods and specifics of these states' reimbursement systems vary, the General Accounting Office (GAO) has found seven essential elements of successful rate regulation. The elements important in program effectiveness are:

- mandatory coverage of all hospitals
- uniform reporting of costs and uniform accounting
- coordination of health planning and rate setting
- focus on total hospital expenditures (including utilization)
- coverage of all payers
- use of statistical screens
- an appeals and exceptions process allowing hospitals to question rate decisions

Without a change in the Medicaid reimbursement method for hospitalization, the State faces increasing costs and more cuts in benefits. The reduction in the amount of Federal funds available for matching State funds makes a reduction in costs even more of a necessity. States with mandatory rate review have been more successful in slowing the increase in costs than have other states. With the involvement for all payers in the rate setting, costs cannot be shifted from Medicare or Medicaid patients to private pay patients. Should South Carolina adopt this method for containing costs, the State can place emphasis on increasing the efficiency of the institutions and on educating the public to alternative means of service rather than on the reduction in benefits.

Physician Services

DSS has chosen to retain the Medicare methodology for reimbursing physicians services although several cost containment options exist. The limit for reimbursement for a service is set at the 75th percentile for all charges by physicians for that service. In 1977, it was recommended that the upper limit be lowered to the 60%, 55%, or 50% level. Had one of these levels been chosen, the reimbursements could have been reduced by at least \$4.4 million. Another option used by states is to set a fee schedule. This method differs from the South Carolina method in that the states' Legislature or the Medicaid agency, sets maximum levels for physician reimbursement.

South Carolina uses the Medicare reimbursement plan even though the State has the option to set reimbursement rates lower than the Medicare upper limit. Reimbursement for physician services in Medicaid is based on Medicare's "reasonable charge" for services rendered. A "reasonable charge" is the lower of three amounts: the physician's actual charge, the physician's customary charge for a service, or the area's "prevailing" charge. The upper limits of the prevailing charge is set at the 75th percentile for all charges by physicians for a particular service.

In 1977, DSS and the General Assembly's Nursing Home Study Committee developed a cost containment plan because of continuing funding deficits in the Medicaid program. The plan recommended the upper limit for reimbursement for physicians' services be set at lower percentiles, not at the 75% level. The decision not to make reductions resulted in an increase in funds required for reimbursement.

Inquiries into reimbursement practices of other states revealed some states use the fee schedule method for establishing physician's reimbursement. This method differs from the South Carolina method in that the state's legislature or the Medicaid agency, not charges for services by physicians, sets maximum levels for reimbursement. With a fee schedule, a price is assigned to each basic procedure and consequently to all other procedures.

Mississippi uses a fee schedule adopted by the Legislature. Under this schedule the maximum fee allowed for the most difficult surgical procedure is \$450. In South Carolina, the maximum allowed reimbursement for the same surgical procedure is \$3,200. In Maryland, fees for services are fixed for most procedures. Other fees, such as office visits, vary within a defined price range. Fee schedules in New York and California use the relative value method which assigns a value and price to each medical procedure in relationship to the value and price assigned to a basic procedure.

Using the schedule method allows reimbursement for services to take into consideration state budgetary limitation. Establishment of a fee schedule eliminates both the need to maintain records of physicians' charges and uncertainty about the allowed charge for any services.

In order to contain increasing cost for physician services, the Department of Social Services has cut benefits and reduced physician reimbursement rates. Prior to July 1981, the number of times a Medicaid recipient could see a doctor, go to a hospital clinic or emergency room was unlimited. On July 1, 1981, DSS began limiting patient visits to any combination of 18 visits. Effective February 1, 1982, DSS reduced reimbursement rates for physicians by 10%. The reduction in reimbursement rates means that DSS will continue to use charges submitted

during 1980 to determine "reasonable charge" for physicians' services. Claims will be priced based on the lower of submitted charges, a provider's usual and customary profile or the areawide prevailing charge less 10%.

The decision by DSS to reduce reimbursement rates to 10% of the FY 80-81 level provides the agency with an opportunity to evaluate its reimbursement policy in light of existing funding problems. The failure to implement cost containment measures in the physicians' services program in the past has contributed to deficits in the Medicaid program. DSS resorted to cutting back on services before using other methods of cost containment.

Medicaid Drug Program

Background

The South Carolina Medicaid Drug Program is one of the optional programs provided as a part of Title XIX of the Social Security Act. This program provides prescription services to all Medicaid recipients and its basic objective is to provide needed drugs for short or long-term illnesses and to avoid the need for hospitalization. In FY 80-81, an average of 72,800 individuals received 253,000 prescriptions each month.

Pharmaceutical providers participating in the Medicaid Drug Program must enter into a contractual agreement with DSS. Providers include Retail Stores, Institutional Pharmacies and Dispensing Prescribers (for example, doctors). In 1980, there were approximately 850 providers certified in the program.

Prior to FY 80-81, Medicaid paid for all drugs. Beginning with FY 81-82, however, DSS has discontinued payment for over-the-counter drugs, drugs available without a doctor's prescription, except for the Family Planning Program's clients. The number of prescription drugs for which the program will pay has been reduced from an unlimited number to four prescriptions a month.

Medicaid limits the amount of reimbursement for any prescription to the lowest of three measures.

1. The Federal mandated maximum allowable cost (MAC) of the drug, plus a reasonable dispensing fee (only 32 drugs have a MAC).
2. The South Carolina estimated acquisition cost (SCEAC) which is the drug's Average Wholesale Price (AWP) less 7.5%, plus a reasonable dispensing fee.

3. The provider's usual and customary charge to the general public for the prescription.

The amount reimbursed is also based on the type of drug, type of provider, and whether the client is participating in the Family Planning Program (FPP) or Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). Most Medicaid recipients must pay 50 cents to providers for each prescription, however, for FPP and EPSDT clients, Medicaid pays all costs involved including the 50 cents co-payment.

In reviewing the drug program, the Audit Council found several problems with the dispensing fee. Since 1979, the drug dispensing fee paid by South Carolina Medicaid has been the highest in the region. Increases in the fees in FY 78-79 and FY 79-80 were granted at a time when Medicaid was already incurring repeated deficits. DSS did not comply with Federal and State Regulations in granting the second increase.

Drug Dispensing Fee Highest in Region

The Drug Dispensing Fee paid to pharmacies by the South Carolina Medicaid program is the highest in the southeast and one of the highest in the nation. South Carolina's dispensing fee of \$3.03 is 24 cents above the national average and 32 cents more than the Southeast regional average of \$2.71.

In the past five years, the dispensing fee in South Carolina increased 59%, the fastest in the region, while the average for the region was 35% (see Table 10). During this period the drug dispensing fee has been increased three times. The first increase was a co-payment, a direct payment of 50 cents to pharmacists by Medicaid recipients in 1977.

In 1979-80 and 1980-81, the dispensing fee was raised by 42 cents and 21 cents, respectively, and paid by the Medicaid program at estimated increases in costs of \$966,000 and \$493,500. Both increases resulted in fees higher than the national average, as indicated in Table 10.

In determining drug dispensing fee increases, DSS compared dispensing fees in the region but chose to grant increases that were substantially above those in the region. At the time of the last two increases, 1978-1980, DSS was experiencing problems with timely reimbursements. This delay caused financial hardships for some pharmacies, causing them to threaten to leave the program. If DSS had used the regional average in increasing the dispensing fee, the program would have required an additional \$700,000. Instead, the increases required \$1.4 million, twice the amount needed if the regional average had been used. The following table shows the dispensing fees for the southern states from 1976 to 1980.

TABLE 10
DISPENSING FEES FOR SOUTHERN STATES FROM
1976 TO 1980 AND PERCENTAGE INCREASE

| <u>State</u> | <u>Dispensing Fee¹</u> | | | | | <u>Total Increase Percentage</u> |
|-----------------------------|-----------------------------------|-------------|-------------|-------------|-------------|--------------------------------------|
| | <u>1976</u> | <u>1977</u> | <u>1978</u> | <u>1979</u> | <u>1980</u> | |
| Alabama | 1.90 | 2.25 | 2.25 | 2.25 | 2.75 | 18 |
| Florida ² | N/A | 2.40 | 2.75 | 2.75 | 2.75 | 15 |
| Georgia | 2.00 | 2.19 | 2.35 | 2.35 | 2.85 | 42 |
| Kentucky ² | 1.80 | 1.80 | 2.22 | 2.35 | 2.35 | 31 |
| Mississippi | 1.75 | 2.25 | 2.25 | 2.50 | 2.70 | 54 |
| North Carolina | 2.50 | 2.50 | 2.50 | 2.68 | 2.80 | 12 |
| Tennessee ² | 2.10 | 2.10 | 2.30 | 2.60 | 2.75 | 24 |
| Average | 2.01 | 2.21 | 2.37 | 2.50 | 2.71 | 35 |
| National Average | N/A | N/A | 2.48 | 2.61 | 2.79 | - |
| South Carolina ³ | 1.90 | 2.40 | 2.40 | 2.82 | 3.03 | 59 |

¹Includes co-payment unless noted.

²These states have not implemented a co-payment requirement.

³Co-payment began January 1, 1977.

Source: Medicaid Title XIX Prescribed Drugs Reimbursement Schedules 1975-1981, compiled by National Pharmaceutical Council.

Because the dispensing fee is higher than the regional average, an additional \$419,000 in State funds has been required in the last two years, contributing to deficits incurred by the Medicaid program. In an attempt to remain within the FY 81-82 budget, DSS has chosen to reduce services to drug program recipients. The number of prescriptions paid for by Medicaid has been reduced from an unlimited number to four per client per month.

Violation of Federal Regulations

The FY 80-81 increase in the Medicaid drug dispensing fee violated two Federal Regulations. Input was not solicited from the Medical Care Advisory Committee and DSS failed to issue the Federally required public notice.

Federal Regulations requires that the Medical Care Advisory Committee:

...have opportunity for participation in policy development and program administration, including furthering the participation of recipient members in the agency program. (42 CFR 431.12 e)

One area which the Committee should consider is fee schedules, according to Federal guidelines on the Committee's activities.

Federal Regulations also require public notice 60 days in advance of a change in a level of reimbursement for a service. This is required if the change results in an increase or decrease in Medicaid payments by 1% or more. The public notice must be printed in the State's newspapers (42 CFR 447.205). DSS's dispensing fee increase resulted in a 7% increase in payments for drug services.

When the Governor's Office asked why DSS had not complied with the Federal Regulations, the Commissioner of DSS stated:

We did not feel it was necessary under the regulations to present this increase in the dispensing fee to the Medical Care Advisory Committee. This was not a new benefit or an increase or decrease in a current benefit. However, in retrospect since the increase would affect the drug program cost by more than 1%, we should have published notices as required in 42 CFR 447.205. Even though we will not meet the sixty-day provision of this regulation, we will publish through the media as required.

However, the DSS Public Information Office could find no record that a public notice was sent to the media for announcement. The "public notice" of the dispensing fee increase was published in the

State Register in February 1981, four months after the increase became effective.

The failure of DSS to consult the Medical Care Advisory Committee on decisions of this nature, could leave the Department open to legal action. In 1977, Hawaii's Committee sued Hawaii's Medicaid agency. The U.S. District Court directed the agency to

...consult the Committee for advise and suggested solutions before making decisions affecting policy development or program administration. Such consultation should occur as far in advance of decisions involving policy development and program administration as is necessary to enable the committee to have meaningful input.

The Court added that the Committee was to be a vital part of the Medicaid program, providing input from the community. DSS's failure to consult the Medical Care Committee and to publicize the proposed increase violated Federal Regulations and calls into question whether the agency is performing its duties in the best interest of the public.

Deficit Spending Practices

DSS has increased the drug dispensing fee twice at a time when the agency was already projecting deficits for the Medicaid program. The increases, which required over \$419,000 in State funds, were made after the fiscal year had begun and in years when supplemental appropriations had to be made. In January 1979, the Commissioner, appearing before the Medical Care Advisory Committee, presented an update on the status of Medicaid expenditures and projected a deficit for FY 79-80. Nevertheless, in August of 1979, DSS increased the drug dispensing fee 42 cents at a total cost of approximately \$966,000. DSS was forced to request a supplement appropriation of \$2 million for FY 79-80.

In August 1980, the Commissioner told the General Assembly's Health Care Planning and Oversight Committee that there would be a deficit in the FY 80-81 Medicaid program. In spite of this, DSS increased the dispensing fee by 21 cents in October 1980; requiring an additional \$493,500. The Medicaid program overspent its budget and required an additional \$3.5 million for FY 80-81.

The Appropriation Act of 1980-81 states:

All departments, institutions, and agencies of the State are hereby directed to budget and allocate the appropriations herein made to them as quarterly allocations so as to provide for operation on uniform standards throughout the fiscal year and in order to avoid a deficiency in such appropriations.

DSS's action of instituting fee increases during the fiscal year demonstrates a disregard for the legislative mandate to operate within the Appropriation Act. This practice does not assure that the State's resources are being used efficiently. The ultimate result is an ever-increasing demand for funds, with an associated need to reduce services or increase the tax burden on the citizens of the State.

RECOMMENDATIONS

COST CONTAINMENT ACTIONS IN THE HOSPITAL REIMBURSEMENT SYSTEM SHOULD BE IMPLEMENTED IMMEDIATELY.

- FOR THE SHORT TERM, DSS SHOULD IMPLEMENT ADMINISTRATIVE ADJUSTMENTS TO THE HOSPITAL REIMBURSEMENT SYSTEM.

- FOR THE LONG TERM, THE LEGISLATURE SHOULD CONSIDER IMPLEMENTING A PROSPECTIVE HOSPITAL REIMBURSEMENT SYSTEM, ONE WHICH INCLUDES ALL PAYERS, OR ONE WHICH COVERS ONLY THE MEDICAID PROGRAM.

DSS SHOULD CONSIDER OTHER COST CONTAINMENT MEASURES IN THE PHYSICIAN SERVICES PROGRAM BEFORE REDUCING BENEFITS TO RECIPIENTS.

DSS SHOULD REEVALUATE ITS USE OF THE MEDICARE METHODOLOGY FOR ESTABLISHING REIMBURSEMENT LEVELS FOR PHYSICIANS SERVICES. REIMBURSEMENT LEVELS SHOULD BE THOSE THAT BEST REFLECT THE AVERAGE CHARGE FOR SERVICES.

DSS SHOULD USE AN AVERAGE OF REGIONAL FEES IN DETERMINING FUTURE INCREASES IN THE DRUG DISPENSING FEE.

DSS SHOULD ADHERE TO FEDERAL REGULATIONS CONCERNING THE MEDICAL CARE ADVISORY COMMITTEE'S PARTICIPATION IN AGENCY POLICY DEVELOPMENT AND PROGRAM ADMINISTRATION.

DSS SHOULD FOLLOW FEDERAL REGULATIONS ON
THE ISSUANCE OF PUBLIC NOTICE OF CHANGES
IN AGENCY POLICY.

DSS SHOULD ADHERE TO THE APPROPRIATION
ACT AND REFRAIN FROM IMPLEMENTING FEE IN-
CREASES DURING THE FISCAL YEAR WHICH RE-
SULTS IN PROGRAM DEFICITS.

CHAPTER IV

MEDICAID MANAGEMENT INFORMATION SYSTEM

Introduction

The Audit Council's 1977 Medicaid report cited DSS for its failure to implement a Medicaid Management Information System (MMIS). MMIS is a comprehensive electronic data processing information system designed to process and pay Medicaid claims and provide information for the planning, control and reporting necessary to effectively manage the Medicaid program.

MMIS is comprised of six subsystems: Recipient, Provider, Claims Processing, Reference File, Surveillance and Utilization Review (SURS), and Management and Administrative Reporting (MARS). The first four approve and process claims for payment while the last two, SURS and MARS, provide information for planning, control and reporting. The Federal Government will provide 90% matching funds for MMIS implementation and 75% for its operation after certification of the system.

In November 1971, the U.S. Department of Health, Education and Welfare (HEW) first surveyed and analyzed South Carolina's need for a MMIS. HEW estimated it would cost \$379,000 to install and develop the system. Although DSS submitted an Advance Planning Document (APD) in 1973 to receive federal funding for MMIS, by 1977 the agency had not taken any action to develop a system.

In May 1977, DSS appointed a project team to implement a MMIS and in September submitted another APD to HEW stating that the system would cost \$1,197,603 to install. The South Carolina General Assembly

also placed a proviso in the FY 77-78 Appropriations Act which required DSS to have a certified MMIS by April 1, 1979.

The actual development of MMIS was the joint effort of DSS, Touche Ross, Inc. and Clemson University's Division of Information Systems Development. DSS signed contracts with Touche Ross and Clemson University in June 1978. During 1979 the agency extended Touche Ross's original contract and negotiated another contract with Professional Health Research, a Touche Ross subcontractor, to develop the SURS and MARS subsystems of MMIS.

Originally, South Carolina was to transfer an operational MMIS from Minnesota, a state of similar population and program structure. But once DSS began the transfer, extensive design changes were made to the system. These design changes caused long delays in getting MMIS ready for Federal certification.

On July 22, 1980, the Director of the Budget and Control Board's Computer Systems Management wrote a memorandum to the State Auditor concerning MMIS. The Director noted that the Minnesota system, "... was never really installed as the basis for the South Carolina MMIS." His memorandum concluded:

The subsequent decision to radically change the system design is considered to be a major factor in the continuing delay in our MMIS implementation.

DSS officials told the Council that the design changes caused delays in implementing the system and was responsible for the agency's unpreparedness during its first certification review. In order to receive Federal funding the MMIS must be critiqued and certified by Federal officials. The system is tested to learn if its programs and subsystems perform their design functions and each process interrelates properly.

Once the MMIS is certified, it is considered implemented and the State receives approval for Federal funding.

DSS underestimated the funding and time needed to install a system as complex as MMIS. Consequently, the agency was never able to meet its deadlines for implementation. The actual implementation of MMIS required far more time and money than originally estimated. Costs rose from an estimated \$1,197,603 in 1977 to \$4,161,054 in 1981, and DSS failed its first Federal review for certification in November 1980. A second test was conducted in May 1981 at which time DSS successfully completed the certification process, more than two years after the original deadline imposed by the General Assembly.

During the three and one-half years DSS took to install its MMIS, the cost for this system increased by \$2,963,451 or 247% over the original estimates. In addition, DSS failed to receive full Federal funding for its original Touche Ross contract. The U.S. Department of Health and Human Services (HHS) also denied funding for the extension to the Touche Ross contract and the full Professional Health Research contract. The following findings explain in detail the deficiencies noted by the Council in its review of MMIS during 1981.

Failure To Receive Full Federal Funding

DSS failed to receive full Federal funding for its consultant contracts on the Medicaid Management Information System (MMIS). Federal Regulations allow for 90% Federal participation in funding the implementation of a MMIS. Failure to receive this funding means the State paid \$265,894 additional State money to fund its MMIS installation.

DSS received bids from four separate consultant companies to define the MMIS requirements and provide consultation during its development. However, the agency did not follow Federal Regulations when it awarded the contract to the highest bidder, Touche Ross, Inc. and it was awarded without prior approval from the Department of Health, Education and Welfare (HEW). Although DSS and the Budget and Control Board's Computer Systems Management office both selected Touche Ross as the most qualified firm to install and implement MMIS, DSS sent documentation to HEW which stated that Consultec, a qualified, lower bidder on the project, "...could successfully complete the proposed contract."

After DSS awarded the contract to Touche Ross, Inc., HEW informed DSS in a letter dated July 28, 1978, that Federal Regulations require a State to submit for approval, a proposed contract, the final contending proposal and a report from the selection committee, with criteria used. DSS did not follow this procedure and was told by HEW:

We understand that the Touche Ross bid was accepted by your agency and the contract was signed prior to our approval of the contract. Without prior approval of the contract, DSS proceeded at its own risk regarding the amount of FFP (Federal Financial Participation) that may be approved for the project.

HEW also told DSS that the same consultant services could have been procured from Consultec for \$367,122 rather than the \$416,060 paid to Touche Ross. HEW concluded that:

Based on your statement that either company could successfully complete the project it is likely that our financial participation in the systems development activities will be limited to the lower of the two bids.

In 1979, DSS extended the original Touche Ross contract and contracted with one of its subcontractors, Professional Health Research (PHR) to implement the SURS subsystem. During December 1979, HEW disapproved funding for the extension to the Touche Ross contract and the PHR contract. HEW told DSS that no justification was provided which proved the need for an extension and the PHR contract was a duplication of services provided under the original Touche Ross contract.

Failure to receive Federal funding for the entire Touche Ross and PHR contracts was due to DSS's poor management of the MMIS project. An HEW assessment of DSS's Medicaid management in April 1980 found that the agency had lost Federal funding because of noncompliance with Federal competitive bid requirements. HEW's report stated:

...the continuous surfacing of problems of non-compliance by the South Carolina Department of Social Services with Federal ADP procurement practices reflects either a (1) lack of understanding or (2) a studied disregard of these requirements. Perhaps this has occurred because of time or other constraints. Whatever the reason, the result has been a loss of FFP that likely could have been averted. (Emphasis Added)

During the time Touche Ross worked as a consultant on the MMIS, its contract costs rose 30% from \$416,060 to \$542,760 while PHR's contract totaled \$119,800. Since the Federal Government will pay a 90%

match of \$330,409 on the low bid of \$367,122 made by Consultec, the State paid an additional \$265,894 to fund the Federal share of remaining Touche Ross and the total PHR contract costs. This expenditure of State funds could have been averted had DSS followed proper procurement procedures.

Overpayment Made to Providers

During October 1979, the DSS Commissioner ordered the "edits" on the MMIS turned off in order to process the large backlog of claims which had accumulated. This action resulted in an overpayment of \$417,904 to the providers. This claims problem occurred during the implementation of MMIS and DDS did not determine the total amount of overpayments until October 1981.

The backlog of claims occurred because DSS was having difficulty in getting the MMIS working properly. Because of the backlog, the S.C. House of Representatives passed a Resolution in FY 79-80 directing DSS to:

...take whatever measures are necessary in personnel management and technical assistance to expeditiously correct the backlog of reimbursements to medical providers at the earliest possible date and to insure reimbursement of future claims on a consistent and timely basis.

Agency officials told the Council that the delay in getting the system working properly and certified prevented DSS from resolving the overpayments made in October 1979. A computer run of the claims in October 1981 showed the overpayment to be \$417,904.

Since DSS has now identified the overpayments made in October 1979, the Code of Federal Regulations requires the agency to account for the funds. Section 447.296 of the regulations state:

§447.296 Accounting for overpayment found in audits.

The agency must account for overpayments found in audits on the quarterly statement of expenditures no later than the second quarter following the quarter in which the overpayment was found.

Now that the overpayment has been identified DSS must make an effort to recoup the funds. The State is now obligated to repay the Federal share of the overpayments. DSS must collect the funds from the providers to avoid violating Federal Regulations and losing tax money.

Improvement Claims Processing

DSS has improved its processing of provider claims. A review of DSS claims processing found that physician and pharmacist Medicaid claims not suspended or rejected by the MMIS system are paid within 11 working days of receipt. These correct claims represent 96% of the pharmacy and 79% of the physician claims sampled. This processing time was for new claims received and accepted into the system.

The Audit Council examined the method used by DSS to process Medicaid claims through the Medicaid Management Information System (MMIS). To test the system the Council randomly sampled a set of claims submitted by physicians and pharmacists, the two largest provider groups processed by MMIS. Physician claims are submitted on a form containing one claim and pharmacist forms contain as many as eight claims per form. During the MMIS process, claims can be rejected by the computer due to incorrect or insufficient coding information. A claim can also be processed but payment is suspended due to a conflict with a previously submitted claim. Payment on a claim is then held in suspense until the conflict is resolved.

On July 28, 1981, the Council randomly sampled 129 physician and 981 pharmacist claims received on 1,612 physician and 2,275 pharmacist forms that day. DSS was able to process and pay 102 physician and 942 pharmacist claims within 11 working days of receipt. Of the physician claims, seven were not accepted into the system due to incorrect information supplied by the providers and were returned to them that day. In the Council's sample, 15 physician claims were rejected by the system and five claims were suspended. These errors were resolved and returned to the providers 15 working days after receipt of the claims. The pharmacy sample had 38 claims which were rejected for incorrect or insufficient coding and one claim was suspended for duplicate payment. All 39 claims were returned to the providers within 11 working days.

DSS's performance on the Council's sample was an improvement over the last test of the system conducted by the agency's internal auditors in February 1980. The agency's auditors found that it took 19.1 working days to process a claim and that duplicate claims were paid. In addition, the internal auditors found that 75% of all new claims were accepted for processing while 25% were suspended. The Council found that 94% of its sample claims were processed while only 6% were either rejected or suspended. In addition, no duplicate claims were paid by DSS, instead the MMIS suspended these claims and they were returned to the providers.

Conclusion

The Council's 1977 report stated that DSS's late start in implementing a MMIS should benefit the State. Mistakes made by other

states and their experiences with MMIS could have been used to avoid unnecessary delays. The Council said the project would need close cooperation with Federal officials to obtain funding. However, DSS failed to benefit from these experiences and did not properly estimate the time or money needed to implement MMIS. It also failed to follow proper procedures and lost Federal funding.

Despite these errors the Department has been able to implement a MMIS within 33 months after letting its first contract while many states take approximately three to five years to implement such a system. However, the presence of a MMIS in itself is not a cure-all for the problems besetting Medicaid. Management must be committed to using the system to more effectively administer the program.

RECOMMENDATIONS

DSS SHOULD CONTINUE TO TRY TO RECOVER
THE \$265,894 IN FEDERAL MATCHING FUNDS FOR
THE ENTIRE TOUCHE ROSS AND PHR CONTRACTS.

DSS SHOULD COLLECT THE TOTAL AMOUNT
IDENTIFIED AS OVERPAYMENTS MADE TO PRO-
VIDERS.

APPENDICES

APPENDIX I
ANALYSIS OF ADDITIONAL COSTS OF INTERMEDIATE PATIENTS
OCCUPYING SKILLED BEDS

The range of \$4.3 to \$10.6 million in the estimated cost of intermediate care patients occupying skilled beds, referred to on pages 3 and 26-28, was arrived in the following manner.

1. Low Range -

The average daily patient cost of a distinct part skilled, distinct part intermediate (SNF/ICF) care facility was subtracted from the average daily patient cost of a skilled facility. The difference (\$4.89) is multiplied by the number of intermediate care patients who are occupying skilled care beds in skilled nursing facilities (2,416) times 365 (days/year). This will yield the low range annual cost of \$4.3 million.

| <u>Type Facility</u> | <u>Avg. cost per day</u> | <u>Difference in rates</u> | | <u># Intermediate patients in skilled beds</u> | | <u># days in year</u> | <u>Estimated overpayment</u> |
|----------------------|--------------------------|----------------------------|---|--|---|-----------------------|------------------------------|
| Skilled | \$43.62 | - | | - | | | |
| Skilled/Intermediate | 38.73 | \$4.89 | X | 2,416 | X | 365 | = \$4,312,197 |

2. High Range -

To arrive at the upper limit of \$10.6 million, subtract the average daily intermediate patient cost from the average daily patient cost of skilled nursing homes. The difference (\$9.50) is multiplied by the number of intermediate patients in skilled facilities (2,416) by 365 which equals \$8,377,480. Next, subtract the average daily intermediate patient costs from the average daily patient SNF/ICF cost. This difference (\$4.61) is multiplied by the number of intermediate patients in the skilled portion of skilled/intermediate care facilities (1,296), by 365 which equals \$2,180,714. The total gives the upper limit of the range of \$10,558,194.

| <u>Type Facility</u> | <u>Avg. cost per day</u> | <u>Difference in rates</u> | <u># Intermediate patients in skilled beds</u> | <u># Intermediate patients in skilled part of SNF/ICF</u> | <u># days in year</u> | <u>Estimated overpayment</u> |
|--------------------------|--------------------------|----------------------------|--|---|-----------------------|------------------------------|
| Skilled | \$43.62 | - | - | - | | |
| Intermediate | 34.12 | \$9.50 | 2,416 | - | X 365 | = \$ 8,377,480 |
| Skilled/ Intermediate | 38.73 | - | - | - | | |
| Intermediate | 34.12 | 4.61 | - | 1,296 | X 365 | = <u>2,180,714</u> |
| TOTAL | | | | | | <u>\$10,558,194</u> |

APPENDIX II

ANALYSIS OF INTERMEDIATE CARE MEDICAID PATIENTS IN LICENSED SKILLED
DUALY CERTIFIED NURSING HOMES AS OF FEBRUARY 1981

| <u>Proprietary Facilities</u> | # Licensed ¹ Beds | <u>Type of Patient²</u> | |
|------------------------------------|---------------------------------|--|---|
| | | <u># Intermediate Care Medicaid Patients</u> | <u># Skilled Care Medicaid Patients</u> |
| Abbeville Nursing | 50 | 19 | 23 |
| Aiken Nursing | 86 | 58 | 1 |
| Alta Vista | 103 | 56 | 42 |
| Anne Maria | 120 | 68 | 26 |
| Bay View Nursing | 132 | 50 | 44 |
| Betheden | 88 | 59 | 22 |
| Camphaven Nursing | 176 | 128 | 16 |
| Capital Conv. | 120 | 77 | 13 |
| Charleston Nursing | 132 | 56 | 42 |
| Cheraw | 94 | 64 | 23 |
| Commander Nursing | 133 | 87 | 12 |
| Conway Nursing | 130 | 79 | 32 |
| Cypress Nursing | 88 | - | 77 |
| Greer Health Care | 132 | 56 | 14 |
| Hampton Nursing | 88 | 12 | 65 |
| Hermina Traeye | 88 | 38 | 16 |
| Honorage Nursing | 88 | 60 | 14 |
| Inman Nursing | 40 | 38 | 2 |
| J. Health Care | 88 | 63 | 8 |
| Jolley Acres | 43 | 30 | 7 |
| Keisler Holdsedt | 212 | 94 | 102 |
| Lakeview | 44 | 36 | 3 |
| Latham | 44 | 25 | 6 |
| Myrtle Beach Manor | 50 | 20 | 0 |
| North Charleston | 132 | 96 | 14 |
| Oakhaven, Inc. | 86 | 57 | 19 |
| Oakmont East | 132 | 45 | 67 |
| Oakmont North | 22 | 3 | 16 |
| Orangeburg Nursing | 69 | 49 | 16 |
| Pines Nursing | 84 | 32 | 38 |
| Pinewood Conv. | 95 | 73 | 13 |
| Ridgecrest | 88 | 79 | 5 |
| Rock Hill Conv. | 141 | 89 | 42 |
| Williamsburg Nursing | 100 | 28 | 53 |
| Winyah Extended Care | 84 | 63 | 6 |
| Subtotal Proprietary Facilities | 3,402 | 1,887 | 899 |
| <u>Non-Profit Facilities</u> | | | |
| Allendale | 44 | 28 | 1 |
| A. Sam Karesh | 88 | 55 | 18 |
| Bailey Memorial | 43 | 26 | 7 |
| Bamberg | 22 | 18 | 1 |
| Barnwell County | 40 | 33 | 1 |

APPENDIX II (CONTINUED)

| <u>Non-Profit Facilities</u> | # Licensed ¹ Beds | Type of Patient ² | |
|-----------------------------------|---------------------------------|--|-------------------------------------|
| | | # Intermediate Care Medicaid Patients | # Skilled Care Medicaid Patients |
| Chester County | 62 | 27 | 15 |
| Coastal Center- C-1 | 11 | - | 11 |
| Coastal Center- D-3 | 64 | - | 51 |
| Coastal Center-Live Oak | 50 | - | 49 |
| Divine Savior | 51 | 37 | 7 |
| Ellen Sayar Nursing | 64 | 39 | 8 |
| Grace White | 155 | 95 | 25 |
| Grady H. Hipp | 102 | 65 | 12 |
| Greenwood Methodist | 102 | 37 | 12 |
| Loris Community | 40 | 15 | 18 |
| Midlands Center- Mary E. White | 88 | - | 88 |
| Midlands Center-Nine | 22 | - | 21 |
| Piedmont-Med. A | 54 | - | 44 |
| Roger Huntington | 80 | 54 | 8 |
| Thad E. Saleeby | 92 | - | 85 |
| University Hospital | 60 | - | 1 |
| Subtotal Non-Profit Facilities | 1,334 | 529 | 483 |
| TOTAL SNF Facilities | <u>4,736</u> | <u>2,416</u> | <u>1,382</u> |

¹Beds licensed by DHEC.

²Patient classification determined by Physician Service Review Organization.

³The difference in the number of beds licensed and the number of Medicaid patients is made up of Medicare, V.A., and private patients.

APPENDIX III

ANALYSIS OF INTERMEDIATE CARE MEDICAID PATIENTS IN SNF/ICF

FACILITIES AS OF JANUARY 1981

| <u>Proprietary Facility</u> | <u># of Beds Licensed¹</u> | | <u>Type of Patient²</u> | |
|---------------------------------|---------------------------------------|--------------------------|--|---|
| | <u>Intermediate Care Beds</u> | <u>Skilled Care Beds</u> | <u># Intermediate Care Medicaid Patients</u> | <u># Skilled Care Medicaid Patients</u> |
| Anderson | 56 | 146 | 123 | 45 |
| Brian's Center | 60 | 60 | 62 | 28 |
| Brigg's | 26 | 38 | 57 | 4 |
| Brookview House | 4 | 84 | 78 | 5 |
| CSFR Corp. (Faith) | 104 | 44 | 112 | 24 |
| Driftwood | 25 | 77 | 67 | 21 |
| Dundee Corp. | 24 | 87 | 48 | 51 |
| Edisto Conv. | 43 | 43 | 76 | 5 |
| Ellenburg | 88 | 88 | 144 | 12 |
| Forest Hills | 111 | 146 | 189 | 22 |
| Greenwood Nursing | 19 | 89 | 70 | 15 |
| Jenkins | 36 | 22 | 39 | 18 |
| Kelley Nursing | 26 | 44 | 51 | 4 |
| Laurel Hill | 20 | 60 | 64 | 10 |
| Laurens Nursing | 44 | 88 | 36 | 4 |
| Manor Care of Lex | 40 | 73 | 11 | 7 |
| Marion County | 26 | 62 | 66 | 19 |
| Meadow Haven | 88 | 44 | 112 | 8 |
| Morrell Memorial | 44 | 88 | 96 | 27 |
| Newberry | 18 | 44 | 40 | 13 |
| NHE/Greenville | 43 | 86 | 109 | 4 |
| Oakwood Health Care | 20 | 112 | 106 | 11 |
| Piedmont | 35 | 44 | 61 | 1 |
| Rikard Conv. | 44 | 63 | 61 | 41 |
| Spartanburg Conv. | 44 | 148 | 150 | 15 |
| Sunny Acres | 54 | 57 | 93 | 9 |
| | | | | |
| Subtotal Proprietary Facilities | 1,142 | 1,937 | 2,121 | 420 |
| | | | | |
| <u>Non-Profit Facilities</u> | | | | |
| Cherokee County | 24 | 20 | 40 | 2 |
| C. M. Tucker | 200 | 100 | 101 | 16 |
| Golden Years | 14 | 74 | 59 | 22 |
| J. F. Hawkins* | 3 | 40 | 16 | 14 |
| Lila Doyle | 39 | 40 | 59 | 11 |
| Lowman Home | 44 | 85 | 70 | 11 |
| Mountainview | 44 | 88 | 108 | 17 |

APPENDIX III (CONTINUED)

| <u>Proprietary Facility</u> | <u># of Beds Licensed¹</u> | | <u>Type of Patient²</u> | |
|--------------------------------|---------------------------------------|--------------------------|--|---|
| | <u>Intermediate Care Beds</u> | <u>Skilled Care Beds</u> | <u># Intermediate Care Medicaid Patients</u> | <u># Skilled Care Medicaid Patients</u> |
| Orangeburg Methodist | 80 | 43 | 8 | 2 |
| Saluda Nursing | <u>44</u> | <u>88</u> | <u>61</u> | <u>44</u> |
| Subtotal Non-Profit Facilities | 492 | 578 | 522 | 139 |
| TOTAL SNF/ICF Facilities | <u>1,634</u> | <u>2,515</u> | <u>2,643</u> | <u>559</u> |

¹Beds licensed by DHEC

²Patients classified by the Physicians Service Review Organization

³The difference in the number of beds licensed and the number of Medicaid patients is made up of Medicare, V.A., and private patients.

*Relicensed as a 78 bed skilled dually certified facility on 4/1/81.



South Carolina
Department of Social Services



P. O. BOX 1520
Columbia, South Carolina 29202

February 1, 1982

VIRGIL L. CONRAD
COMMISSIONER

Mr. George L. Schroeder, Director
Legislative Audit Council
620 Bankers Trust Tower
Columbia, South Carolina 29201

Dear Mr. Schroeder:

Under cover of this letter I am submitting to the Legislative Audit Council the Department of Social Services comments on the Legislative Audit Council's audit of the DSS Medicaid program. Our comments include a narrative commentary to the report and a follow-up/responsibility matrix for each recommendation. Some of our comments reflect federal or state changes which have taken place recently, such as changes in federal regulations effective on or after October 1, and our adaptations to these regulations. Other comments are offered to clarify some issues that may not be apparent to the recipients of the report who are less familiar with the intricacies of the Medicaid program. We have referenced material which we have filed with you and which is also available at DSS.

We have appreciated the diligence of your staff in relation to this audit. They have spent many hours in an effort to be thorough in their review. They have also maintained a professional and cooperative demeanor through this process. We are always grateful for reviews of our programs which may yield viable suggestions for program improvements.

Sincerely,

Virgil L. Conrad
Commissioner

VLC/pw

Enclosures

Department of Social Services Comments

Report of the Legislative Audit Council's Audit of the DSS Medicaid Program

January 1982

Summary - Chapter I

Some of the statistics used appear to relate to the entire South Carolina Medicaid program including Mental Retardation and Mental Health expenditures.

The deficits in prior years were incurred after the Agency presented budget needs to the General Assembly, who both deficit funded the program and directed no reduction in services. Supplemental funding during this period was an acknowledged practice at this time. Current cost containment measures are being implemented to ensure that the FY'82 expenditures will not exceed appropriated amounts.

Nursing Homes - Chapter II

No System for Proper Placement

The regulations re amount, duration, and scope and non-discrimination by diagnosis do not permit setting priorities for patients and thus controlling which patients eligible for care are admitted.

The Department of Social Services, through the Community Long Term Care Project, has assumed responsibility for preadmission functions. A central register has been developed. Criteria for determining need for and appropriate level of nursing home care are available at DSS. Determination of need relates to the need for an array of services in a setting, not just to medically defined conditions. By July 1, 1982, this same effort will have expanded statewide in relation to case management and emphasis will be placed on planning for discharge and community placement, when feasible. The Agency is emphasizing the development of adult foster homes, as an alternative community placement for patients who could be cared for in a lower level of care setting than ICF. The Agency also developed a Care Worker project which served six counties with CETA funds. This project trained AFDC mothers and employed them to take care of clients eligible for nursing home care in their own home. The Agency requested funding from the General Assembly to continue the project when CETA funds were withdrawn; however, this program was not funded. The Department of Social Services applied for and has just received notification of a demonstration grant award through Medicaid, available under new regulations, to reinstitute this program. This grant covers four years and is for \$4,700,000.

ICF Beds - The Department of Health and Environmental Control does consider the patient mix when establishing certification requirements. This does effect the cost per day, but the impact is not clear. It appears that PSRO was very conservative in classifying patients as skilled. Thus, the patient mix as currently classified may not represent the true need for type of beds. Many patients also fluctuate from needing hospital acute care, to skilled care, to intermediate care and the reverse fairly often. A system of separately classified beds would necessitate movement of patients from facility to facility and across county lines based on the availability of the appropriate bed type. The dual licensure of nursing homes was implemented subsequent to the 1976 LAC report which recommended dual licensure. We do not concur that it is to the economic advantage for a skilled home to serve ICF patients. When homes converted to dual, a composite rate was developed to avoid an artificial increase in cost.

Improper Implementation of Reimbursement Methodology

Since most hospital based nursing homes either file their cost reports too late to be included in the standards calculations, or are so high for their category that their costs are eliminated from the standards calculations, a separate category would cause higher rates and cost the State money. It appears that the higher rates for hospital based facilities may relate more to their administrative cost and cost allocation methodologies than to a difference in level of care. We do not believe that we should set up groupings that would increase costs.

Staff Levels - It appears that your charts may reflect calculations based on a 40-hour week rather than a 56-hour week and that part time staff may have been counted as full time. You also need to consider the staff for which we reimburse based on the standard, rather than the number employed. Our staff is continuing to work with your staff to determine the average staffing levels and we may wish to comment further.

Nursing Home Administrators - The standard is based on salaries. The other expenses may be paid only if an individual salary is below the standard. Audited allowable costs are reduced if they exceed the standard before payment. The nursing home suit against Medicare re reasonable administrative costs had just been issued at the time that alternatives to the present method were considered.

Mandated Services - It would not seem appropriate to apply a ceiling to some costs, e.g., property taxes which vary greatly from county to county. Also, some homes emphasize restorative services in an effort to rehabilitate and return patients to the community, while others do not and incur no expenses for such services.

Leases - While it is true that the most recent leases have significantly increased the per day cost of patient care, not all of the leases in place have contributed to such cost increases. Six of the leases are with related parties; therefore, no cost increases were incurred. The older leases reflect much smaller increases. In all cases, leases were recognized in accordance with Medicare guidelines.

Freezing of Nursing Home Beds for Which Medicaid Will Pay - No funds have been disallowed from S. C. or any other state for this approach. S. C. is appealing the disapproval of the state plan amendment related to the freeze on occupancy rates. Because new beds were added, more Medicaid funded beds are available than were used without restrictions last year.

Nursing Homes, General Comments - The requirement that states adjust rates annually has been rescinded. The amounts paid by the Department of Social Services to nursing homes may be adjusted in two ways. First, if the amount exceeds the related standard, the amount paid is less than costs. Second, if the audit findings yield disallowances, the disallowances are deducted from payments.

The Department of Social Services has been actively reviewing the nursing home rate methodology for the last several months in an effort to further reduce costs. This effort is continuing and the Agency is cooperating fully with the Subcommittee of the Health Care Planning and Oversight Committee established to review nursing home costs. Many of the issues which you have raised, including automobile costs, are also those we have identified for this Subcommittee to consider. The limitation of automobile costs to that of a medium cost automobile was a limitation being considered for implementation during the next rate setting cycle. We did not receive a report from the Budget and Control Board study. Reference letters from Commissioner Conrad to Senator Leatherman of December 1981 and January 1982 in our files.

Hospitals, Physician Services, and Drugs - Chapter III

Hospitals - The Appropriations Act directed that a standard chart of accounts be established, which is in place. Our procedures follow Medicare guidelines in establishing reasonable costs, and some costs such as bad debts are disallowed. Under the regulations prior to October 1, any measurable impact on hospital costs would have required a control system, such as a rate setting commission which would govern all charges, not just Medicaid drugs. DSS endorses the establishment of a rate setting commission for hospitals and nursing homes. Ref. letter from Commissioner Conrad to Senator Leatherman of January 26, 1982, available in our files.

The present and past law clearly permits limits on the number of days of hospital coverage. Since public and Hill Burton hospitals must provide indigent care, the net effect of a limit on days of coverage does limit hospital reimbursement with minimal impact on patient care. This is the most administratively efficient method of control of Title XIX expenditures for hospital care. The S. C. Medicaid system clearly does not pay its share, no matter how large, of the total cost for inpatient care. The limit on number of days of coverage controls the total expenditure.

The current DSS estimates for savings if an 80% occupancy level was enforced is approximately \$1,500,000 and at 85%, \$3,000,000. However, such a policy would target the small rural hospitals, thus increasing the indebtedness of a group of hospitals that already face severe financial problems. The likely result of an 85% policy would be that several small hospitals would close and the geographic distribution of services would be further disrupted.

To eliminate payment of legal fees, political contributions, and association dues, DSS would have to establish its own audit review and cost settlement procedures. The resulting administrative cost to DSS would likely offset the savings.

Prior to October 1, 1981, PSRO had full authority to determine necessity of stay in a hospital, including weekend admissions, for the Title XIX program. By federal statute, the Medicaid program could make no rulings in this area. We have contracted with PSRO, effective January 1, 1982, to continue our acute care review. Reduction of preoperative days has been, and continues to be, one of their objectives and an area of significant activity on their part.

We believe, to be effective, any recommendation related to a prospective rate setting system or commission should govern all payors.

Physicians Services - The net effect of freezing the rates at the FY'81 level and thus reducing the rates by 10% February 1, 1982, is the same as reducing the percentile. A fee schedule is being implemented for dentists in February 1982 and for other fee for service providers, including physicians, by July 1, 1982.

Drugs - The dispensing fee is one of the highest only if copay amounts are included. If you consider only the state's liability, i.e., the dispensing fee paid by the state, North Carolina, Florida, Georgia, Mississippi, and Tennessee paid higher fees in 1980. South Carolina's fee paid by the State was only \$2.53, well below the regional and national averages. Only Alabama and Kentucky have lower rates.

We have followed public notice requirements diligently since this time. The sixty day notice requirement and the 1% rule have been rescinded in December 1981. The dispensing fee adjustment was made under a system that provided all other providers routine increases and a time when the Agency was directed by the General Assembly to continue, not reduce, its program.

MMIS - Chapter IV

All of the October 1979 overpayment has been collected, or are set up on a negotiated repayment plan with reductions made each month.

We appreciate the opportunity to provide these comments.

| Recommendation | Responsibility | Follow-up/Comments |
|--|--|--|
| DSS should establish complete, stringent, and uniform medical criteria for determining the placement needs of the state's nursing home patients. | DSS Medical Director with Community Long Term Care Director. | These criteria are developed and have been in place since January 1, 1982. Prior to this, PSRO carried out this responsibility under federal mandate. |
| DSS should work with the state's Medicaid providers to create a central registry of eligible Medicaid nursing home patients. The patient needs should be ranked and matched to the capability of available nursing homes for placement. | Community Long Term Care Director. | Federal regulations prohibit discrimination among clients who are eligible for a service. The administering agency cannot direct a provider to accept a client. A central registry has been developed. |
| DSS should reimburse nursing homes only for those costs necessary to provide the level of care appropriate to a patient's condition. DSS shouldn't pay for a level of care above the level needed for a patient's care. | DSS, Institutional Services Director. | When homes were converted to dual licensure, a composite rate was established and no increase in cost was experienced. |
| The General Assembly should consider legislation directing the DHEC to relicense existing dually certified skilled/intermediate nursing homes to either totally ICF or distinct part intermediate/distinct part skilled care facility. This relicensing should be performed on the patient population residing in the nursing homes. | General Assembly | Dual licensure was recommended by the LAC in their 1976 audit of Medicaid. Dual licensure was enacted subsequent to this recommendation. Reversion to a separate system would cause much physical movement of patients from wing to wing and facility to facility. |
| In the future when nursing homes are built, DHEC should license these homes emphasizing intermediate care facility. DHEC should establish a ratio of ICF beds to skilled beds which matches the needs of the state's patient population. DHEC should take steps to achieve this ratio through its contract and licensing process. | DHEC | |
| DSS should use an inflation factor developed by the State Division of Research and Statistical Services to project nursing home rate increases. | DSS, Director of Institutional Services. | The inflation factor has been reduced effective February 1, 1982. The State Division of Research and Statistics has now developed a methodology to set an inflation factor and this will be used in the next contract period (July 1, 1982). |
| DSS should establish new classifications of nursing homes for determining reimbursements for standard services. Hospital based, non-profit nursing homes, and private for profit nursing homes should be separated for determining cost standards. | DSS, Director of Institutional Services. | Such separation would increase the cost to the Medicaid program. Hospital based nursing homes cost more per patient day. This increase in cost may be associated with higher administrative costs and the cost allocation system, rather than quality of care. |
| DSS, working in conjunction with DHEC, should conduct an in-depth study to determine whether public and non-profit nursing homes are less efficient than private homes. Quality of care should be considered and compared to private homes. If the study finds that public and hospital based homes are inefficient, then contracting with some other method of providing services should be considered. | DSS, Director of Institutional Services, DHEC | DSS will initiate such a study. |

| Recommendation | Responsibility | Follow-up/Comments |
|--|--|--|
| DSS should after reclassifying nursing homes for standard service reimbursement, consider reducing the quality assurance factor. | DSS, Director of Institutional Services. | DSS is reviewing each factor in its reimbursement system, including quality assurance. We are currently awaiting recommendations from the HCP & O Committee before determining final adjustments. Reference letter from Commissioner Conrad to Senator Leatherman dated 12-6-81. |
| DSS should set a maximum for reimbursement for nursing and non-licensed staffs. | DSS, Director of Institutional Services, DHEC. | Some limit is in place by virtue of the standards system. DHEC needs to establish licensure and certification standards that reflect patient needs. |
| DSS should discontinue the floor concept and reimburse nursing facilities only for hours actually necessary to deliver services. | DSS, Director of Institutional Services. | The floor is adjusted every two years and is used in establishing the standard. Reimbursement is limited by the standard. The two year adjustment in the floor is to discourage decreasing staff to a level below that needed for patient care in order to earn an incentive payment. |
| DSS should place a ceiling on reimbursement for mandatory services. | DSS, Director of Institutional Services. | The establishment of ceilings for some factors, such as taxes and rehabilitative services would be inappropriate. DSS is reviewing each mandatory service to determine which ones could be capped. |
| DSS should develop guidelines in addition to federal HIM-15 for specifying allowable costs in the nursing home program. These guidelines should restrict reimbursement for travel and automobiles, and eliminate reimbursement for base costs, legal fees, and association dues. DSS should not reimburse any nursing home for any additional costs due to leasing. | DSS, Director of Institutional Services with the advice of the Health Care Planning and Oversight Committee. | DSS is reviewing each of these items and is awaiting recommendations from the HCP&OC before making a final determination re each limit. Reference letter from Commissioner Conrad to Senator Leatherman, 1-6-82. DSS has established policy that does not recognize additional costs of leases for any new lease. DSS is studying the appropriate policy for existing leases and will adopt such policy to be effective July 1, 1982. |
| DSS should ensure that owners comp is reasonable by establishing specific criteria such as the Medicare owner's comp guidelines. | DSS, Director of Institutional Services. | Medicare guidelines only refer to reasonable cost and are not strictly defined. Our guidelines set parameters and we will review this area to identify any appropriate restrictions. |
| DSS should implement cost containment measures in the nursing home reimbursement system which either comply with federal regulations or for which waivers have been granted. | DSS, Director of Institutional Services. | Only the limit per home on number of beds under contract has been ruled against by HHS. This is currently under appeal. DSS has implemented a reimbursement system which has contained costs well under the inflation level for the last five years. |
| Cost containment actions in the hospital reimbursement system should be implemented immediately. -for the short term, DSS should implement administrative adjustments to the hospital reimbursement system. -for the long term, the legislature should consider implementing a prospective hospital reimbursement system either one which includes all payors or one which covers only the Medicaid program. | DSS Commissioner and General Assembly | DSS uses the Medicare system for determining reasonable and allowable costs. It would be more expensive for DSS to have to institute its own auditing system than it would save on the minor administrative adjustments recommended. DSS does agree in concept with these recommendations. The limit on the number of days covered does effectively limit the Medicaid payments to hospitals. Since Medicaid payments are only 9% of the revenue of hospitals, some broader rate setting system would be necessary to impact cost and avoid cost shifting. DSS endorses the concept of a rate setting commission for all payors. |

| Recommendation | Responsibility | Follow-up/Comments |
|---|--|--|
| DSS should consider other cost containment measures in the Physicians' Services program before reducing benefits to recipients. | DSS, Director of Non-Institutional Services | DSS has and continues to do this. |
| DSS should reevaluate its use of the Medicaid methodology for establishing reimbursement levels for Physicians' Services. Reimbursement levels should be those that best reflect the average charge for services. | DSS, Director of Non-Institutional Services. | DSS will establish a fee schedule for reimbursement in FY'83. A fee schedule for the dental program will be implemented in FY'82. |
| DSS should use an average of regional fees in determining future increases in the drug dispensing fee. | DSS, Director of Non-Institutional Services. | The state liability (i.e., excluding patient co-pay) is below the regional average. |
| DSS should adhere to federal regulations concerning the MCAC participation in Agency policy development and program administration. | DSS, Director of Non-Institutional Services. | DSS, except the one time noted, has and continues to carefully adhere to these regulations. DSS commits to continue to follow these. |
| DSS should follow federal regulations in the issuance of public notice of changes in Agency policy. | DSS, Directors of Non-Institutional and Institutional Services. | DSS is carefully following all federal regulations. These regulations have been made more lenient. |
| DSS should adhere to the Appropriations Act and refrain from implementing fee increases during the fiscal year which results in program deficits. | DSS Commissioner | DSS has implemented a comprehensive cost containment program to ensure that expenditures do not exceed appropriations. |
| DSS should continue to try to recover the \$265,894 in federal matching funds for the entire TR and PHR contracts. | DSS, Executive Assistant for Office of Administrative Services & Legal Services. | DSS is currently appealing this disallowance. |
| DSS should collect the total amount identified as overpayments made to providers. | DSS, Director of Non-Institutional Services and Executive Assistant for Office of Administrative Services. | DSS now has a system in place which identifies overpayment, establishes a receivable and deducts overpayment from payments if the provider does not remit. |