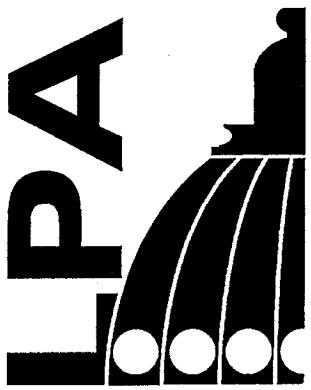

PERFORMANCE AUDIT REPORT

Examining Increases in Expenditures For Adult Care Homes

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
April 1990

90PA47

Legislative Post Audit Committee

Legislative Division of Post Audit

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PERFORMANCE AUDIT REPORT

EXAMINING INCREASES IN EXPENDITURES FOR ADULT CARE HOMES

OBTAINING AUDIT INFORMATION

This audit was conducted by Allan Foster, Cindy Lash, Ron Green, Ellyn Rullestad, and Leo Hafner, Senior Auditors, and Cindy Denton, Rakesh Mohan, Tom Vittitow, Murlene Priest, Auditors, of the Division's staff. If you need any additional information about the audit's findings, please contact Mr. Foster at the Division's offices.

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Summary of Legislative Post Audit's Findings

Beginning in 1983, Legislative Post Audit conducted a series of five audits covering issues relating to adult care homes in Kansas. Recently, legislative concerns have been raised about the increasing amounts of money the State is being asked to spend on adult care home reimbursements, particularly when caseloads appear to be relatively stable. In an attempt to address those concerns, this audit compares the current information about the Medicaid reimbursement system and costs of adult care homes with the information presented in the previous audits. Specifically, the audit answers the following two questions:

What changes have been made to the State's Medicaid reimbursement system for adult care homes? We found that Medicaid reimbursement to all adult care homes increased by 46 percent between calendar years 1982 and 1988, considerably less than the 65 percent increase in total reported costs for those homes. During that same period, the number of inpatient days increased only six percent.

The Medicaid reimbursement system has changed in ways that have both decreased and increased State costs. First, a revision in the method used to reimburse property costs led to a decrease in Medicaid reimbursements in this area. Second, the Department removed its reimbursement limit on total costs in 1988, which caused Medicaid reimbursements to rise by nearly $2.4 million annually, according to Department officials.

The costs associated with changes made to date in federal and State laws, regulations, and procedures did not appear to be significant. However, beginning in fiscal year 1991, the State implementation of new federal nursing home reform legislation is expected to substantially increase adult care home costs and reimbursements. Also, the recent federally mandated increases in the minimum wage rate could have an impact on staff costs in adult care homes.

What changes have occurred in the average costs for adult care homes, by cost center? Per-patient-day costs for the adult care homes in our sample increased nearly 50 percent between fiscal years 1983 and 1989. Increases in the health care cost center had the largest impact on costs of both intermediate care and skilled nursing facilities. Most of the increases in that cost center were attributable to increases in salaries and benefits for all types of nurses and aides, nursing consultants, and other purchased nursing services.

We would be happy to discuss the report with any legislative committees, individual legislators, or other State officials.

Meredith Williams
Legislative Post Auditor

EXAMINING INCREASES IN EXPENDITURES FOR ADULT CARE HOMES

Beginning in 1983, Legislative Post Audit conducted a series of five audits covering issues relating to adult care homes in Kansas. One factor that prompted those audits was legislative concern about the State's Medicaid reimbursement system. That system reimbursed nursing home owners for their residents who were Medicaid recipients on the basis of their costs in four cost centers: administration, property, room and board, and health care. In particular, concern was expressed that increasing amounts of the reimbursement were going for mortgage and lease costs and for administrative expenses, rather than for costs more directly related to patient care. Among those audits' findings were the following:

—changes of ownership caused substantial increases in property-related costs and Medicaid reimbursement rates
—existing controls in the State's reimbursement system would not stop the rise in property-related reimbursement
—the existing system appeared to encourage owners to sell homes
—controls over administrative salaries were complex and did not always work
—central office costs were not effectively monitored
—when homes changed hands staffing costs rose, but the total amount of staffing time did not.

The audits made a number of recommendations to address problems with the State's Medicaid reimbursement system.

More recently, legislative concerns have again been raised about the increasing amounts of money the State is being asked to spend on adult care home reimbursements, particularly when caseloads appear to be relatively stable. To address these concerns, the Legislative Post Audit Committee directed the Legislative Division of Post Audit to conduct a performance audit answering the following questions:

1. **What changes have been made to the Medicaid reimbursement system for adult care homes?**

2. **What changes have occurred in the average costs for adult care homes, by cost center?**

To answer question one, we obtained statistical information on adult care homes from the Departments of Social and Rehabilitation Services and Health and Environment. We reviewed State statutes and regulations and interviewed officials of both departments to determine how the Medicaid reimbursement system has changed since 1983. We also interviewed officials of the federal Health Care Financing Administration to determine how changes in federal regulations have affected adult care home costs.

In answering question two, we collected fiscal year 1989 statistical data from the cost reports submitted by the adult care homes to the Department of Social and Rehabilitation Services. We then collected cost and reimbursement data for these homes from the consulting firm the Department uses to set Medicaid reimbursement rates. We compared these data to similar data collected for the series of adult care home audits conducted in 1983. We also interviewed Department of Social and Rehabilitation Services' officials to obtain possible explanations for the cost increases. In conducting this audit, we followed all applicable government auditing standards set forth by the U.S. General Accounting Office.

We found that Medicaid reimbursements to all adult care homes increased by 46 percent between calendar years 1982 and 1988, noticeably less than the 65 percent increase in total reported costs for those homes. The Medicaid reimbursement system has changed in ways that have both decreased and increased State costs. First, a revision in the method used to reimburse property costs led to a decrease in Medicaid reimbursements in this area. Second, the Department removed its reimbursement limit on total costs in 1988, which caused Medicaid reimbursements to rise by nearly $2.4 million annually, according to Department officials. The costs associated with changes made to date in federal and State laws, regulations, and procedures did not appear to be significant. However, beginning in fiscal year 1991, new federal requirements are expected to substantially increase adult care home costs and reimbursements.

For the adult care homes in our sample, costs on a per-patient-day basis increased nearly 50 percent between fiscal years 1983 and 1989. Increases in health care costs—primarily because of increases in salaries and benefits for all types of nurses and aides and other nursing services—had the largest impact on costs at both intermediate and skilled nursing facilities. These and other findings are discussed in more detail in the sections that follow.

What Changes Have Been Made To the State's Medicaid Reimbursement System for Adult Care Homes?

Medicaid reimbursements to all adult care homes increased by 46 percent between calendar years 1982 and 1988, considerably less than the 65 percent increase in total reported costs for those homes. The Medicaid reimbursement system has changed in ways that have both decreased and increased State costs. First, a revision in the method used to reimburse property costs led to a decrease in Medicaid reimbursements in this area. Second, the Department of Social and Rehabilitation Services removed its reimbursement limit on total costs in 1988, which caused Medicaid reimbursements to rise by nearly $2.4 million annually, according to Department officials. The costs associated with changes made to date in federal and State laws, regulations, and procedures did not appear to be significant. However, beginning in fiscal year 1991, new federal requirements are expected to substantially increase adult care home costs and reimbursements.

Adult Care Home Costs Have Increased Substantially Since 1983, Even Though the Number of Inpatient Days Has Been Relatively Stable

We obtained statistical information from the Departments of Social and Rehabilitation Services and Health and Environment. Medicaid reimbursement data was available on a fiscal year basis through fiscal year 1988 from the Department of Social and Rehabilitation Services. The most current data available from the Department of Health and Environment was for calendar year 1988. The table on page four summarizes data on changes in costs, inpatient days, number of facilities, and number of beds. Some of the cost information in this question refers to Medicaid costs. The Medicaid program is jointly funded by the federal and State governments to pay the health care costs for Medicaid recipients. The State's share of Medicaid is currently about 45 percent; the federal share is 55 percent.

As the table shows, reported operating costs for all Kansas adult care homes increased by nearly 65 percent between fiscal years 1982 and 1988, from $246.1 million to $404.6 million. Medicaid reimbursements rose at a somewhat slower rate; they increased from $83.8 million to $122.4 million, or about 46 percent. Medicaid reimbursements actually dropped as a percent of total costs, from about 34 percent in 1982 to about 30 percent in 1988. This may mean that more of the homes' operating costs are being picked up by private-pay residents and third party sources.

The table also shows that overall inpatient days rose by only 5.7 percent between 1982 and 1988, from 8.3 million patient days to 8.7 million. Medicaid inpatient days rose by less than one percent. Thus, most of the overall increase in adult care homes' reported costs was the result of higher costs for providing nursing home services, rather than increases in the number of residents. And nearly all the increase in Medicaid reimbursements was related to increases in adult care home reimbursements rates, which are based on actual costs.

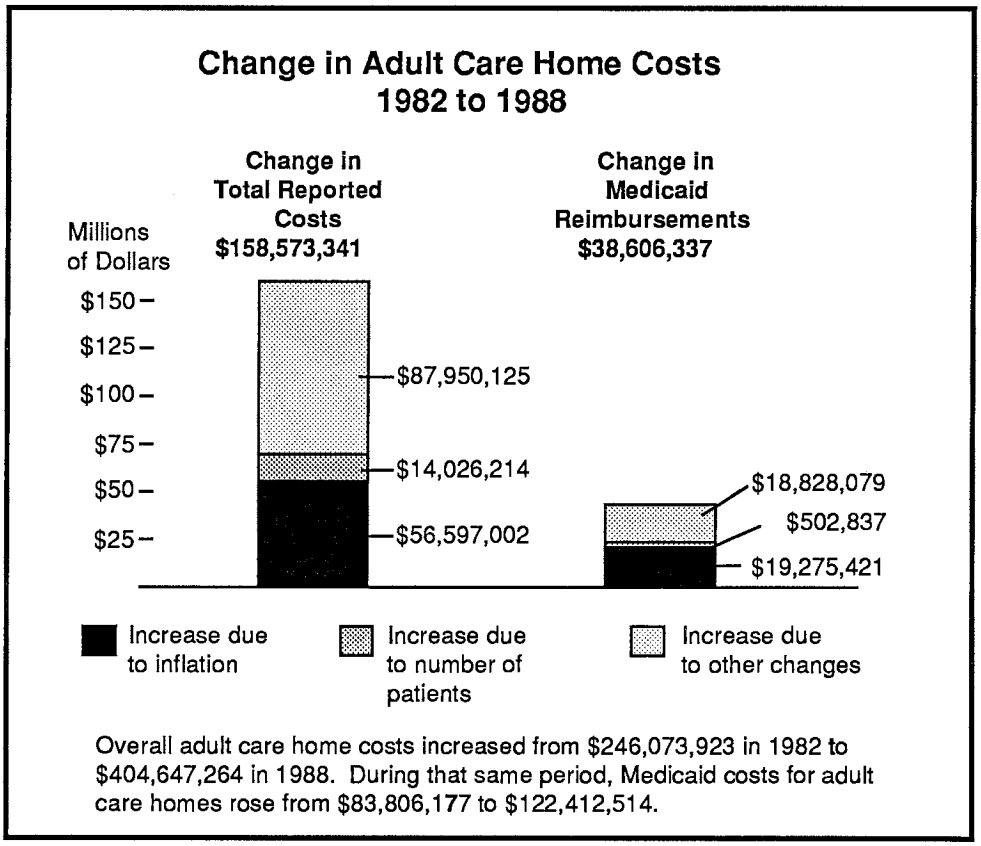
Adult Care Home Changes
1982 to 1988

Category	1982	1988	Percent Change
Overall Costs	$246,073,923	$404,647,264	64.4%
Medicaid Reimbursements	$83,806,177	$122,412,514	46.1%
Reimbursements as Percent of Overall Cost	34.1%	30.3%	
Overall Inpatient Days	8,263,668	8,737,328	5.7%
Medicaid Inpatient Days	4,621,064	4,648,157	0.6%
Medicaid Days as Percent of Overall	55.9%	53.2%	
Per-Patient-Day Cost Overall	$29.78	$46.31	55.5%
Medicaid	$18.14	$26.34	45.2%
Medicaid as Percent of Overall	60.9%	56.9%	
Licensed Adult Care Homes	369	385	4.3%
Licensed Adult Care Beds	25,617	27,343	6.7%

A number of factors can contribute to adult care homes' cost increases. The chart on the facing page shows how much of the cost increase can be attributed to specific factors.

As the chart shows, inflation accounted for about one-third of the increase in total costs, but about one-half the increase in Medicaid costs. The small increase in the number of inpatient days contributed only slightly to the increase in costs. Approximately half the increase in both total costs and Medicaid reimbursements was related to increases we called "other changes." These include changes in the homes' way of doing business, changes made in response to regulatory requirements, and costs that may have risen faster than inflation, such as nursing salaries.

As noted above, Medicaid reimbursements as a percent of total costs dropped from about 34 percent in 1982 to about 30 percent in 1988. This decrease was due in part to Medicaid patient days declining slightly as a percentage of total patient days



by 1988, and partly to a decrease in the percentage of the average daily cost that was reimbursed. If these changes had not occurred, Medicaid reimbursements in 1988 would have been approximately $137.8 million, rather than $122.4 million.

The number of adult care homes has increased slightly; most of the growth occurred in intermediate care facilities for the mentally retarded and in skilled nursing homes. Between 1982 and 1988, the number of Kansas adult care homes grew from 369 to 385, an increase of slightly more than four percent. During this period, however, the number of intermediate care facilities actually dropped by about four percent. Most of the growth occurred in intermediate care facilities for the mentally retarded and in skilled nursing facilities.

Between 1982 and 1988, the number of intermediate care facilities for the mentally retarded increased from 17 to 25, or 47 percent. Since 1988, 16 additional facilities for the mentally retarded have been opened, bringing the current total to 41. These additional homes are small facilities with fewer than 16 beds; most have only six beds. Department of Social and Rehabilitation Services officials told us that these smaller homes have higher per-patient costs, and that the Department currently caps these costs at about $150 per patient day. They indicated that the smaller units added about $3.6 million to the Medicaid cost of the program in fiscal year 1989.

Skilled nursing facilities in Kansas increased between 1982 and 1988 by nearly 80 percent, from 38 to 68. Some of these were new facilities and some were intermediate care facilities that became licensed as skilled nursing facilities.

In line with the four percent growth in the total number of facilities, the number of licensed beds Statewide increased by 6.7 percent. The greatest increase was in beds licensed for skilled care, which rose by nearly 90 percent.

Changes in the Reimbursement System Have Resulted In Both Decreases and Increases in Medicaid Reimbursements to Adult Care Homes

To summarize and simplify the reimbursement process: the Department of Social and Rehabilitation Services uses the adult care homes' reported costs as a starting point, and subjects these costs to various exclusions, restrictions, and limitations. At the end of the process, a reimbursement rate for Medicaid recipients is set for each home. Because of the Department's cost controls, a home with high costs probably will not recover all its costs. On the other hand, homes with relatively low costs may receive full reimbursement, and homes with the lowest costs can receive additional money in the form of small efficiency payments. For a more detailed description of the adult care home reimbursement system and changes to the system, see the box on the facing page.

The Department's current reimbursement system is essentially the same as it was when we audited the program in 1983 and 1984. Significant changes have occurred in only two areas.

The first significant change relates to reimbursements for property costs. Before 1985, when an adult care home changed ownership the property costs associated with the change were figured into the new owner's reimbursement rate, subject to the Department's overall limitation for the property cost center. Effective January 1985, the Department assigned a facility-specific property fee in lieu of all depreciation, mortgage interest, and rent expense. The actual ownership costs used to develop the property fee were from the last cost reports processed by the Department before July 1984. The property fee is assigned to a particular home and does not change when the home is sold. The Department made this change in response to the federal Deficit Reduction Act of 1984, which required that Medicaid reimbursements for capital-related costs could not increase solely because of a change of ownership. Department officials told us that this change resulted in significant program savings, but could provide no estimated amount.

To get some indication of the impact of this change, we examined property reimbursements in 1989 for a large sample of homes (285 of the 399 licensed facilities) and compared those figures to a similar sample from 1983. We found that Medicaid reimbursements for property costs as a percentage of total property costs dropped from 95.2 percent to 88.1 percent. Thus, the change apparently has had some of the desired effect. However, we also found that the change in property reimbursements

Changes in the Medicaid Reimbursement System

Major Attributes: 1983

1. Providers reported their costs for property, health care, room and board, and administration to the Department of Social and Rehabilitation Services, which examined them to determine their accuracy and disallowed costs for programs and services which were not applicable to Medicaid patients.

2. The Department adjusted allowable costs for inflation. Historical inflation based on the Consumer Price Index was applied to some costs on a retrospective basis, and estimated inflation based on economic forecasts and budget limitations were applied to others on a prospective basis.

3. The Department established limits annually for four cost centers and for total costs. The Department sorted the facilities by level of care and arrayed the allowable per patient day costs for the facilities from high to low, for each of the four cost centers and total costs. The percentile limitations for each cost center were as follows:

   Administration — 75th percentile
   Property — 85th percentile
   Room and Board — 90th percentile
   Health Care — 90th percentile
   Total Cost — 75th percentile

4. To protect the State from reimbursing excessive per-patient-day costs resulting from low occupancy, allowable patient-related costs were divided by the greater of the facility's total inpatient days or 85 percent of total certified bed days.

5. The Department could add an efficiency factor to the per-patient-day per diem rate. The added efficiency factor was to encourage providers to hold down costs in the administrative cost center, and the non-fixed operating costs of the property cost center. The maximum efficiency factor was $.50 per patient day, for which a facility's costs in the administrative cost center and the plant operating expenses had to be at or below the 55th percentile. Facilities which were above the 95th percentile in those areas received none of the efficiency factor.

6. A second type of reimbursement system was used for new providers. Because a new provider had no historical costs upon which to base its rates, the Department used projected costs to establish the provider's first year per patient day rates. At the end of the first year, the new provider had to submit a report of its actual costs to the Department. The Department used the actual costs to adjust the provider's first year rates retrospectively.

Changes in System: Since 1983

1. According to the adult care home reimbursement administrator, the information required to be reported by providers is the same as it was in 1983. There has been no significant change in what the Department accepts for allowable costs or in the way the Department reviews the cost reports.

2. The Department has not made any significant changes to the way it applies either historical or estimated inflation factors, according to the adult care home reimbursement administrator.

3. The percentile limits on the administration cost center, the room and board cost center, and the health care cost center have not changed.

   Property Cost Center: Effective January 1, 1985, the Department established a facility-specific property fee system. This system prevents changes in ownership from increasing the reimbursement rate in this cost center; the established property fee does not change from year to year, even though a facility's ownership changes. The plant operation part of the cost center does continue to be limited at the 85th percentile.

   Total Cost Limit: Effective July 1, 1987, the Department increased the cost center percentile limit to 87.5, and effective January 1, 1988, the limit was eliminated.

4. No changes have been made to the Department's requirement that an 85 percent minimum occupancy be used to calculate per-patient-day rates for adult care homes.

5. No changes have been made in the calculation of the efficiency factor or the amount of the efficiency factor for adult care homes.

6. For newly constructed facilities, new providers are required to file projected cost reports. A new provider for an existing facility is generally required to operate for the first 12 months at the rate established by the previous provider's actual costs. In either case, after the end of the first year, when the new provider's actual costs are reported, adjustments are made for overpayment or underpayment.

Allowed and Non-Allowed Costs For Medicaid Reimbursements

The Department of Social and Rehabilitation Services determines adult care home reimbursement rates for Medicaid residents using cost reports submitted by each eligible home. The following are examples of costs that are allowed and costs that are not allowed to be included in the rate determination.

Allowed Costs: Administrator salaries, office supplies, allocation of central office costs, utilities, maintenance and repairs, food, dietary salaries, linen and bedding, housekeeping supplies, nursing salaries, employee benefits, therapy salaries, social worker salaries, resident transport, and owner related compensation.

Non-Allowed Costs: Barber and beauty shop expense, advertising for patient utilization, public relations expense, prescription drugs, fees paid to non-working directors or officers, fundraising expenses, taxes, insurance on lives of officers and owners, cost of organizations unrelated to professional or business activities, and oxygen.

has also affected the distribution of those reimbursements. For example, under the system in effect in 1989, about 46 percent of the homes in our sample were reimbursed for more than 100 percent of their property costs (receiving an average of 77 cents per patient day extra); the remaining 54 percent of the homes had average unreimbursed costs of $2.43 per patient day. Under the old system in 1983, no homes were reimbursed for more than their actual costs. Under that system, nearly 80 percent of the homes were reimbursed in full for their property costs, while the remaining homes had average unreimbursed property costs of $1.14 per patient day.

The second major change to the reimbursement system related to removing a cap on total costs. In July 1987, the Department began a phase-out of its limitation on total costs. Before then, the Department placed a percentile limit on total costs as well as on each cost center (administration, property, room and board, and health care). When the limit on total costs was in effect, it was possible for an adult care home to have costs within the Department's limits in the four specific cost centers, yet have its reimbursement rate reduced because the total costs exceeded the overall limit. Department officials estimated that eliminating the total cost limit added about $2.4 million annually to the Medicaid cost of the program.

Department officials also indicated that they plan to make additional changes to the State's Medicaid reimbursement system beginning in fiscal year 1991 for budgetary reasons. Those changes are not yet finalized.

To Date, Changes in Federal and State Laws, Regulations, And Procedures Apparently Have Not Had a Significant Impact On Adult Care Home Costs or Reimbursement Levels

Federal and State officials reported few changes in laws, regulations, and procedures governing adult care homes since 1983. The changes that may have had the greatest effect on adult care home costs and reimbursement are described below. The estimated costs of the changes are listed, if available. Generally, these changes would not have contributed substantially to the overall cost increases experienced between 1982 and 1988.

- ***Heavy care program.*** Regulations issued by the Department of Social and Rehabilitation Services in 1987 provided for additional reimbursements for Medicaid

adult care home residents in need of "heavy care." Heavy care includes rental of such equipment as specialized beds for patients with pressure sores, and reimbursement for such services as rehabilitation for head-injured residents, and active treatment and dental services for mentally retarded residents. The Department estimates the annual Medicaid cost of this program to be $2 million.

•***Division of assets.*** The 1987 Legislature passed legislation allowing a married couple to divide its assets (both income and other resources) to prevent family impoverishment when one member of the couple entered a Medicaid-approved adult care home or community-based program. The State repealed its statute after a more liberal federal law took effect in July 1989. The Department of Social and Rehabilitation Services, which monitors this program, cannot estimate the total cost of the program. Department officials did estimate that the State's cost for division of income was $1.7 million in 1989; they could not estimate the cost of division of resources.

•***24-hour nursing care.*** In 1986, the Department of Health and Environment issued a regulation requiring adult care homes to provide 24-hour nursing care to their residents. Because of the nursing shortage, however, the requirement was waived for nearly half the State's adult care homes in both 1986 and 1987, and was ultimately repealed in 1988. In its 1986 fiscal impact statement, the Department estimated the cost of the regulation for all homes to be $2.1 million annually, approximately half of which would have been for Medicaid residents. Since then, a number of homes have voluntarily adopted the 24-hour nursing standard. The Department of Social and Rehabilitation Services does not have estimates of the current cost of 24-hour nursing for the 93 adult care homes that provide such coverage. However, officials reported that total first year costs for these facilities when they adopted 24-hour nursing care were approximately $460,000.

•***Continuing education for medication aides.*** A 1984 regulation issued by the Department of Health and Environment required medication aides to complete 10 hours of continuing education every two years. The Department estimated the cost of this training to be $162,500 annually, with the cost borne by the medication aides and the adult care homes.

•***Federal survey procedures.*** In 1986, the Health Care Financing Administration of the U.S. Department of Health and Human Services changed its procedures for surveying adult care homes, reportedly to reflect an increased emphasis on patient-care issues rather than on documentation. The Department of Health and Environment is responsible for conducting these surveys. State officials indicated that adult care homes are not being cited for more deficiencies under the new procedures, but that they are being cited for more specific patient deficiencies, to which they are reportedly more likely to respond. In addition, one representative of a professional association indicated that more documentation was required under the new procedures, because federal officials have taken the position that if patient-care procedures are not documented, they did not happen. No cost estimates are available in this area.

A number of other changes appear to have had minimal fiscal impact. These include a federal regulation that required pharmacists to review medication records every 30 days instead of every 90 days, and State regulations that changed the timing of nurse aide training, restricted smoking areas in adult care homes, required social service designees who are not licensed social workers to consult with a social worker, increased license fees for adult care homes and adult care home administrators, and increased civil penalties for deficiencies cited in licensing reviews.

Federal Nursing Home Reform Legislation Will Result In Significant Increases in Adult Care Home Costs

Major changes will occur in October 1990 when the State begins to implement the main portions of nursing home reform legislation contained in the federal Omnibus Budget Reconciliation Act of 1987. Some of the provisions of the Act will require all adult care homes to provide 24-hour nursing care, to have a designated medical director, to have a social worker on staff if the home has at least 120 beds, to conduct standardized resident assessments annually, and to care for residents in a manner that will enhance their quality of life.

Types of Adult Care Homes

Intermediate Care Facility: a facility which provides health-related care and services to residents who require 24 hours a day, seven days a week, licensed nursing supervision for observation, treatment, or care for long-term illness, disease, or injury.

Skilled Nursing Facility: a facility which provides 24 hours a day, seven days a week, licensed nursing supervision for continuous observation, assessment, and intervention for:

- a potentially life-threatening illness, disease, injury, or post operative care
- conditions which can be safely and effectively performed only by or under the direct supervision of a registered professional nurse.

Intermediate Care Facility for the Mentally Retarded: a facility which provides health-related care and services in conjunction with active treatment for persons who are mentally retarded.

Future Change: The federal Omnibus Budget Reconciliation Act of 1987 directs that the distinction between skilled nursing facilities and standard intermediate care facilities end as of October 1,1990. All such facilities are to be known as nursing facilities, and will operate under the same regulations. (This change does not include intermediate care facilities for the mentally retarded.) In addition, the Department will no longer calculate reimbursement rates separately for the two types of care.

To accomplish the latter, adult care homes must provide services in accordance with a written plan of care developed in consultation with the resident and a multi-disciplinary team, and must have a quality assessment and assurance committee that meets quarterly. In addition, the distinction between skilled nursing facilities and intermediate care facilities will be eliminated. As the box on this page notes, with the exception of intermediate care facilities for the mentally retarded, all adult care homes will be called nursing facilities and will be treated as a single group in determining reimbursement rates.

As part of this legislation, states were required to begin prescreening adult care home admissions as of January 1, 1989, to screen out mentally ill and mentally retarded individuals who did not need nursing home care. In treating these individuals, adult care homes must follow federal active-treatment requirements.

The cost of such changes really will not be known until the federal government publishes its final implementation guidelines and until State surveyors receive information about how federal officials will

interpret the guidelines. Cost estimates developed by the Departments of Health and Environment and Social and Rehabilitation Services range from $7 million to $9 million annually, while estimates developed by groups representing adult care homes range from $9 million to $19 million annually. We also surveyed a sample of 15 adult care homes to obtain their estimates of the additional costs they expect to incur as a result of the nursing home reform legislation. Their estimates ranged from no additional cost to a $7 increase per patient day, and averaged $4.10 per patient day extra. If adult care homes' costs actually increased by $4.10 per patient day, total costs would increase by $35.8 million annually.

Federally mandated increases in the minimum wage rate also could have an impact on staff costs in adult care homes. The minimum wage increased by 45 cents per hour on April 1, 1990, and will increase again by the same amount in 1991. Although Department officials told us that most facilities have few, if any, staff who are being paid the minimum wage, the Director of the Bureau of Adult and Child Care at the Department of Health and Environment noted that adult care homes probably will need to increase their wages to maintain the differential between the minimum wage and staff salaries, particularly at the lower levels.

It is not possible to determine the exact cost impact of the minimum wage increase because there is no way to predict whether, or by how how much, adult care homes will increase salaries at higher levels in response to increases at the lower levels. To develop a rough estimate of the potential effect of the minimum wage increase, we assumed that the increase would have a domino effect and might increase all salaries below the level of administrator and co-adminstrator by an average of five percent. We chose five percent because, although the minimum wage increased by 13 percent as of April 1st and will increase another 12 percent in 1991, the total increase of 90 cents per hour represents a lower percentage increase for salaries above minimum wage. That assumption produces a potential cost impact of $10 million per year in increased salaries.

What Changes Have Occurred in the Average Costs for Adult Care Homes, by Cost Center?

Per-patient-day costs for the adult care homes in our sample increased nearly 50 percent between fiscal years 1983 and 1989. Increases in health care costs—primarily because of increases in salaries and benefits for all types of nurses and aides and other nursing services—had the largest impact on costs at both intermediate and skilled nursing facilities.

Our Sample of Adult Care Homes Was Selected Using the Same Criteria as Were Used in the Previous Audits

The main source of data for our analysis was information from cost reports adult care homes submit each year to the Department of Social and Rehabilitation Services. The Department uses these reports to establish Medicaid reimbursement rates for the homes. The analysis focused on total costs per patient day of service, and on the four major cost centers that constitute total cost: administration, property, room and board, and health care.

Examples of Items in Cost Centers

Administration: Includes such items as salaries and benefits for facility administrators and other administrative employees. Also included are costs for insurance, allocations of central office costs to several facilities, and administrative supplies.

Property: Includes such items as depreciation or rent expenses, utilities, mortgage interest, and maintenance.

Room and Board: Includes such items as salaries and benefits for dietary and housekeeping employees, food, and supplies.

Health Care: Includes such items as nursing staff salaries and benefits, costs for patient activities, and other care services.

In 1989, a total of 399 adult care homes were licensed to operate in Kansas. Our sample included 285 of these homes, all of which reported actual historical costs on the reports they submitted to the Department as of April 30, 1989. We excluded from our sample any adult care homes that reported projected costs rather than actual costs (for example, a new facility that had never participated in the Medicaid program). In addition, because so few intermediate care homes for the mentally retarded had actual historical cost information, we excluded them from our sample as well.

Our sample of homes for this audit included 245 intermediate care facilities and 40 skilled nursing facilities. The previous nursing home audits, issued in 1983 and 1984, were based on a sample of 290 homes, which included 260 intermediate care facilities and 30 skilled nursing facilities.

Per-Patient-Day Costs for the Adult Care Homes in Our Sample Increased by Nearly 50 Percent Between 1983 and 1989

In examining changes in costs between 1983 and 1989, we looked at intermediate care facilities and skilled nursing facilities separately because their costs were found to be significantly different in the previous audits. The following table summarizes the changes in average costs for both types of homes in our sample. Costs are

shown on a per-patient-day basis instead of total dollars to control for differences and changes in the number of residents.

Changes in Adult Care Homes' Per-Patient-Day Costs
Fiscal Years 1983 to 1989

	Intermediate Care Facilities				Skilled Nursing Facilities			
			1983-1989 Increase				1983-1989 Increase	
Cost Centers	1983	1989	$	%	1983	1989	$	%
Administration	$2.95	$4.60	$1.65	56%	$3.76	$5.49	$1.73	45%
Property	4.89	7.58	2.69	55%	6.50	9.26	2.76	42%
Room/Board	7.47	9.56	2.09	28%	7.68	10.52	2.84	37%
Health Care	11.00	16.92	5.92	54%	14.24	21.89	7.65	54%
Total	$26.31	$38.66	$12.35	47%	$32.18	$47.16	$14.98	47%
Occupancy Rate	92.6%	92.5%			92.2%	91.5%		

As the table shows, total costs per patient day for both intermediate care facilities and for skilled nursing facilities increased 47 percent between 1983 and 1989. For intermediate care facilities, per-patient-day costs increased from $26.31 to $38.66, or $12.35 per patient day. For skilled nursing facilities, per-patient-day costs increased from $32.18 to $47.16, or nearly $15 per patient day.

Increases in the health care cost center had the greatest impact on both intermediate care and skilled nursing facilities' costs. For intermediate care facilities, the health care cost center increased by $5.92 per patient day, or nearly half the total $12.35 increase. The other cost centers for intermediate care facilities accounted for significantly less of the total dollar increase; costs in the property cost center increased by $2.69 per patient day, in the room and board cost center by $2.09, and in the administration cost center by $1.65. From 1983 to 1989, intermediate care facilities' costs in all but the room and board cost center increased by 54-56 percent. The room and board cost center increased by a comparatively small amount, 28 percent.

For skilled nursing facilities, the health care cost center increased by $7.65 per patient day, or slightly more than half the total $14.98 increase. Increases in the other cost centers accounted for much less of the total dollar increase: the room and board cost center increased by $2.84 per patient day, the property cost center increased by $2.76, and the administration cost center increased by $1.73. As the table shows, in terms of the percentage increase between 1983 and 1989, skilled nursing facilities' administration and property costs increased less than for intermediate care facilities, and their room and board costs increased more than for intermediate care facilities.

To try to identify the major factors behind these cost center increases, we reviewed the line-item cost data for each cost center. These items are described in the box on page 12. Generally, the line-item information was current as of December 31, 1989, or nine months later than the cost-report information used in computing nursing homes' 1989 average costs. Because we reviewed this line-item data only to provide

an indication of where the major cost increases were occurring within the cost centers, we determined that the discrepancy in the time period for the homes in our sample would not make a significant difference.

Most of the increase in the health care cost center was attributable to increases in salaries and benefits for all types of nurses and aides, nursing consultants, and other purchased nursing services. As mentioned earlier, the rise in nursing homes' health care costs may be due in part to preparation for the 24-hour care requirement and the advent of heavy-care services. Department officials told us that the increased use of nursing pools also has increased nursing costs in many homes. Because of the shortage of nurses in some areas of the State, some facilities have had to hire nurses from businesses that provide nurses and aides on a temporary basis; nursing services provided by such organizations are generally much more expensive.

The increases in both types of homes' administrative cost centers were primarily the result of increases in administrative salaries and benefits. Costs in the property cost centers were strongly influenced by increases in ownership costs such as mortgage interest, lease costs, and depreciation. And finally, increases in the room and board cost centers were mostly attributable to increases in the dietary area such as employee salaries and benefits, dietary consultants, food, and supplies.

APPENDIX A

Update of Adult Care Homes Audit, Part I

The following table summarizes the results of preliminary analyses of average daily costs for our sample of skilled nursing and intermediate care facilities in Kansas. The top half shows the comparisons for skilled nursing facilities, while the bottom half shows comparisons for intermediate care facilities. In each case, average costs are shown for profit and non-profit homes, and for homes with in-State and out-of-State owners. The tables break down the total costs into the four cost centers of administration, property, room and board, and health care.

Comparison of Average Daily Costs Per Patient Day For Adult Care Homes (Effective on or Before July 1, 1989)

Skilled Nursing	Profit	Non-Profit	In-State	Out-of-State
Number of Homes	27	13	28	12
Total Cost	$43.23	$55.32	$47.88	$45.51
Administration	5.08	6.35	5.20	6.18
Property	9.10	9.60	8.48	11.10
Room and Board	9.35	12.93	11.30	8.70
Health Care	19.70	26.44	22.90	19.53

Intermediate Care	Profit	Non-Profit	In-State	Out-of-State
Number of Homes	147	98	141	104
Total Cost	$37.76	$40.04	$38.37	$39.07
Administration	4.89	4.17	4.06	5.33
Property	8.39	6.37	6.49	9.04
Room and Board	9.02	10.39	10.11	8.84
Health Care	15.46	19.11	17.71	15.86

Costs were considerably greater for non-profit skilled nursing homes than for profit-making homes. For skilled nursing facilities, total costs for profit-making homes were $43.23 per-patient-day, while non-profit homes had total costs of $55.32 per patient day. This is a total cost difference of $12.09 per-patient-day between profit-making and non-profit skilled care facilities.

For intermediate care facilities, the differences were much smaller. Total costs for intermediate care profit-making homes were $37.76 per-patient-day. For non-profit homes, total costs were $40.04 per-patient-day. The difference between profit-making homes and non-profit homes was $2.28.

The table also shows that non-profit skilled nursing facilities had higher average daily costs in all four cost centers. Non-profit intermediate care facilities had higher costs in room and board and health care, while the profit-making facilities had higher

administration and property costs.

Although the scope of this audit did not allow us to determine the specific causes for these cost differences, the series of nursing home audits we conducted during 1983-84 provided some possible explanations for those cost differences. For instance, profit-making homes have an incentive to minimize total costs; non-profit homes may not have this incentive and, in fact, might receive some form of subsidy to help offset high costs.

Costs for homes with out-of-State owners are not much different than costs for homes with in-State owners. For skilled nursing facilities, homes with out-of-State owners had total costs of $45.51 per-patient-day compared to $47.88 per-patient-day for homes with in-State owners. This difference in cost -- $2.37 -- is relatively small, particularly when compared with the difference between profit and non-profit homes.

For intermediate care facilities, homes with out-of-State owners had only slightly greater ($0.70) total costs than homes with in-State owners. Costs for homes with in-State owners were $38.37 per patient day, compared to $39.07 per patient day for homes with out-of-State owners.

For both skilled nursing and intermediate care facilities, homes with out-of-State owners had greater administration and property costs than homes with in-State owners. Room and board costs and health care costs were both less for homes with out-of-State ownership than homes with in-State owners.

The 1983 - 1984 series of nursing home audits also shed some light on possible explanations for those cost differences:

- Out-of State owners tend to own chains of homes rather than single homes. These chains are more likely to have central offices. The Department allows such costs to be allocated across homes; thus, homes in such chains may show higher administrative costs.

- To the extent in-State owners of adult care homes are more familiar with incentives in Kansas Medicaid reimbursements, they would better understand the advantages of keeping administrative costs low.

APPENDIX B

Costs of Intermediate Care Facilities, by Profit Status and Ownership (All Costs Are on a Per-Patient-Day Basis)

	1983 Actual Costs	Percentage of 1983 Actual	1989 Actual Costs	Percentage of 1989 Actual	Actual Dollar Increase 1983-1989	Actual % Increase 1983-1989
For-Profit						
Administration	$2.81	11%	$4.89	13%	$2.08	74%
Property	$5.10	20%	$8.39	22%	$3.29	65%
Room & Board	$7.11	28%	$9.02	24%	$1.91	27%
Health Care	$10.19	40%	$15.46	41%	$5.27	52%
Total Cost	$25.21	100%	$37.76	100%	$12.55	50%
Non-Profit						
Administration	$3.15	11%	$4.17	10%	$1.02	32%
Property	$4.58	16%	$6.37	16%	$1.79	39%
Room & Board	$7.98	29%	$10.39	26%	$2.41	30%
Health Care	$12.15	44%	$19.11	48%	$6.96	57%
Total Cost	$27.86	100%	$40.04	100%	$12.18	44%
In-State						
Administration	$2.85	11%	$4.06	11%	$1.21	42%
Property	$4.79	18%	$6.49	17%	$1.70	35%
Room & Board	$7.49	29%	$10.11	26%	$2.62	35%
Health Care	$10.99	42%	$17.71	46%	$6.72	61%
Total Cost	$26.12	100%	$38.37	100%	$12.25	47%
Out-of-State						
Administration	$3.47	13%	$5.33	14%	$1.86	54%
Property	$5.41	20%	$9.04	23%	$3.63	67%
Room & Board	$7.41	27%	$8.84	23%	$1.43	19%
Health Care	$11.07	40%	$15.86	41%	$4.79	43%
Total Cost	$27.36	100%	$39.07	100%	$11.71	43%
Intermediate Care Facilities as a Group						
Administration	$2.95	11%	$4.60	12%	$1.65	56%
Property	$4.89	19%	$7.58	20%	$2.69	55%
Room & Board	$7.47	28%	$9.56	25%	$2.09	28%
Health Care	$11.00	42%	$16.92	44%	$5.92	54%
Total Cost	$26.31	100%	$38.66	100%	$12.35	47%

Costs of Skilled Adult Care Homes, by Profit Status and Ownership
(All Costs Are on a Per-Patient-Day Basis)

	1983 Actual Costs	Percentage of 1983 Actual	1989 Actual Costs	Percentage of 1989 Actual	Actual Dollar Increase 1983-1989	Actual % Increase 1983-1989
For-Profit						
Administration	$3.65	12%	$5.08	12%	$1.43	39%
Property	$6.08	20%	$9.10	21%	$3.02	50%
Room & Board	$7.17	24%	$9.35	22%	$2.18	30%
Health Care	$12.90	43%	$19.70	46%	$6.80	53%
Total Cost	$29.80	100%	$43.23	100%	$13.43	45%
Non-Profit						
Administration	$4.07	11%	$6.35	11%	$2.28	56%
Property	$7.65	20%	$9.60	17%	$1.95	25%
Room & Board	$9.09	23%	$12.93	23%	$3.84	42%
Health Care	$17.92	46%	$26.44	48%	$8.52	48%
Total Cost	$38.73	100%	$55.32	100%	$16.59	43%
In-State						
Administration	$3.63	11%	$5.20	11%	$1.57	43%
Property	$6.12	19%	$8.48	18%	$2.36	39%
Room & Board	$7.85	25%	$11.30	24%	$3.45	44%
Health Care	$14.24	45%	$22.90	48%	$8.66	61%
Total Cost	$31.84	100%	$47.88	100%	$16.04	50%
Out-of-State						
Administration	$4.41	13%	$6.18	14%	$1.77	40%
Property	$8.39	25%	$11.10	24%	$2.71	32%
Room & Board	$6.87	20%	$8.70	19%	$1.83	27%
Health Care	$14.25	42%	$19.53	43%	$5.28	37%
Total Cost	$33.92	100%	$45.51	100%	$11.59	34%
Skilled Care Facilities as a Group						
Administration	$3.76	12%	$5.49	12%	$1.73	46%
Property	$6.50	20%	$9.26	20%	$2.76	42%
Room & Board	$7.68	24%	$10.52	22%	$2.84	37%
Health Care	$14.24	44%	$21.89	46%	$7.65	54%
Total Cost	$32.18	100%	$47.16	100%	$14.98	47%

APPENDIX C

Agency Response

On April 18, 1990, we provided a copy of the draft audit report to the Department of Social and Rehabilitation Services. Its response is included in this Appendix.

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

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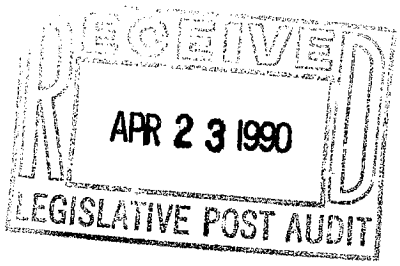
April 20, 1990



Meredith Williams
Legislative Post Auditor
Legislative Division of Post Audit
109 W. 9th, Suite 301
Mills Building
Topeka, KS 66612-1285

Dear Mr. Williams:

We appreciate receiving the draft performance audit report titled Examining Increases in Expenditures for Adult Care Homes. For the most part, the report is very factual and informative. This letter will provide our comments, corrections or clarifications by referencing the applicable page numbers in your report.

Page 7, Changes in System: Since 1983, Item 1: The second sentence states: "There has been no change in what the Department accepts for allowable costs, and no significant change in the way the Department reviews the cost report." This statement implies that we have had a stagnant system since 1983. We are continually revising or updating the Medicaid State Plan and Kansas Administrative Regulations. For clarity, we recommend the following wording. "There has been no significant change in what the Department accepts for allowable costs or in the way the Department reviews the cost reports."

Page 9, Heavy Care Program: Another type of heavy care expenditure that should be mentioned is dental services for mentally retarded clients. These services were covered by the adult dental program which was eliminated in January, 1987. Federal regulations require that dental services be available in the intermediate care facilities for the mentally retarded. We have reimbursed the cost of the clients dental services through the Heavy Care Program.

Page 10, Federal Nursing Home Reform Legislation Will Result in Significant Increases in Adult Care Home Costs, second paragraph and its reference to the box with the Types of Adult Care Homes: It should be clarified that only the skilled nursing facilities and intermediate care facilities will be combined and called "nursing facilities." The intermediate care facilities for mentally retarded

(ICF's-MR) will not be included in this new classification. The statements in the second paragraph and in the box may lead one to believe that ICF's-MR will become nursing facilities also.

Page 12, Our Sample of Adult Care Homes Was Selected Using the Same Criteria as Were Used In the Previous Audits, second paragraph, third sentence: The third sentence states: "We excluded from our sample any adult care homes that reported projected costs rather that actual costs (for example, homes that were new or had new owners)." This is not accurate or consistent with Item 6 in the Box on page 7. A new owner of an existing facility is usually not allowed to project costs for an interim rate. The following is our suggested rewording of the sentence. "We excluded from our sample any providers that reported projected costs rather than actual (for example, a new facility that never participated in the Medicaid program)."

Thank you for the opportunity to review the draft report before it is presented to the Legislative Post Audit Committee. If you have questions concerning our comments, please feel free to contact Jack Gumb at 296-3728.

Sincerely,

Winston Barton
Secretary

WB:JA:JJG:dct

cc: Commissioner Allen
Jack Gumb
Bill McDaniel