Administration Of Reimbursement To Community Facilities For The Mentally Retarded

December 1990

Program Evaluation Division
Office of the Legislative Auditor
State of Minnesota

Program Evaluation Division

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JAMES R. NOBLES, LEGISLATIVE AUDITOR

December 6, 1990

Senator John Brandl, Chairman
Legislative Audit Commission

Dear Senator Brandl:

Minnesota has developed an extensive network of community residential facilities to deliver services to mentally retarded persons. Currently this system depends on the private sector to own and operate facilities and the public sector to fund and oversee the system. The state retains its special responsibility to guarantee that people in need receive adequate services, and to control costs.

In May 1990, the Legislative Audit Commission asked us to investigate complaints from providers that the Department of Human Services was not paying for services in a fair and consistent manner. We studied the state's reimbursement system, interviewed providers and agency staff, and examined agency files.

Overall, we conclude that some facets of the state's public-private service delivery system are not working well. Imprecise rules for reimbursement and inconsistent agency policies and practices have impaired the working relationship between the state and private providers. There is no evidence that service quality has declined, but an atmosphere of mutual hostility does not serve the disabled. As guarantor of the system of care, the state needs to improve its administration of reimbursements without relaxing existing cost control mechanisms.

We received the full cooperation of the Department of Human Services. We also thank numerous local government officials and private providers for their assistance.

This report was researched and written by Kathleen Vanderwall (project manager) and Deborah Woodworth.

Sincerely yours,

James R. Nobles
Legislative Auditor

Roger Brooks
Deputy Legislative Auditor

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ADMINISTRATION OF REIMBURSEMENT TO COMMUNITY FACILITIES FOR THE MENTALLY RETARDED

Executive Summary

The 1980s brought a growing conviction that individuals with developmental disabilities function best in a homelike, community setting, rather than an institution. In Minnesota the most widely used community alternatives to an institution are intermediate care facilities for the mentally retarded (ICFs/MR). Currently, all Minnesota ICFs/MR but one are privately owned but financed primarily through Medicaid reimbursement. The Department of Human Services administers the reimbursement system through Rule 53.[1]

Recently, many ICF/MR providers have expressed growing concerns about how the Department of Human Services interprets and administers Rule 53. In May 1990, the Legislative Audit Commission directed us to investigate providers' complaints that DHS was not paying for services in a fair and consistent manner. These are some of the key questions we addressed:

- **Is Rule 53 clear, reasonable, and enforceable? Is the rule flexible enough to accommodate providers' cost changes in a timely manner?**
- **How well does the Department of Human Services (DHS) reimburse ICF/MR costs and monitor the appropriateness of payment claims and expenditure reports?**
- **Does the Department of Human Services administer Rule 53 efficiently and consistently? Are appeals resolved in a timely manner? Is there adequate coordination among the various DHS divisions that work with the facilities?**

Rule 53 is a good cost-containment tool.

To answer these questions, we used several methods. We surveyed providers to identify their major complaints. We selected five cases which we felt were typical of the most prevalent complaints and studied them in more detail. We analyzed data maintained by the department and examined department files. We also interviewed providers, DHS staff, and advocates for people with developmental disabilities.

Overall, we conclude that Rule 53 is a good cost-containment tool, but we think that some state policies and procedures are counterproductive and may be harmful to providers and residents of ICFs/MR. In our opinion, the De-

1 *Minn. Rules* Ch. 9553.0010 to 9553.0080.

Case Studies

	Problem	Issues
Case 1	Class A to Class B conversion	Complexity, lack of flexibility in the process
Case 2	Special needs rate exception and one-time rate adjustment	Lack of communication, cooperation to allow system to operate smoothly
Case 3	Reclassification of costs	Poor relationship, inconsistency, no method to correct auditor errors
Case 4	Reclassification of program costs	Lack of communication, inconsistency
Case 5	Interim rate for a new facility	Rigidity of system, lack of method to correct DHS errors

partment of Human Services seems unneccesarily hostile to the current public-private system for delivering ICF/MR services and has not taken appropriate steps to ensure that it operates smoothly. We recommend several specific changes that we think would help improve the system, although the effect of these changes will be diminished unless the relationship between DHS staff and providers is improved.

The Department of Human Services must firmly regulate this industry.

The relationship need not, and probably should not, be overly friendly. The department must firmly regulate this industry, which relies almost exclusively on public funds, and such regulation will inevitably result in some friction. Moreover, providers must work within the system the state has laid out if they wish to continue to participate in the ICF/MR system. In addition, providers must share responsibility for maintaining a professional, businesslike relationship with the state. Continued conflicts of the kind we observed in the course of our study can only have negative effects for ICF/MR clients.

RULE 53

The Department of Human Services developed Rule 53 in response to legislative concerns about rising ICF/MR costs and a 1983 study by the Legislative Auditor's Office, which documented weaknesses in the previous reimbursement rule, Rule 52. As a result, the department greatly strengthened cost containment measures in the new rule, which took effect in 1985. Rule 53, in our opinion, is now an effective tool for controlling costs of ICFs/MR. We found, however, that:

- **Certain parts of Rule 53 are not clear or reasonable, which inhibits the department's ability to enforce the rule and creates conflicts with providers.**

The allocation of costs between program and administrative categories, the requirements for time and attendance and time distribution records for employees of ICFs/MR, and the purchase of goods and services from related organizations, have all given rise to numerous cost disallowances and appeals.

It is important to keep costs under control in ICFs/MR, but it is equally important to assure that appropriate services are provided. Rule 53 includes an efficiency incentive that is designed to control spending on administration and maintenance, while encouraging spending at or above historical levels for program services. We found:

- **The efficiency incentive does not effectively encourage spending for resident care.**

The incentive is not very useful because providers must make expenditures for improved care before their rates can be increased. The increased rates may cover the increased expenditure in the future, but the increase in expenditures during the initial period can never be recovered. In addition, an efficiency incentive must be spent to correct deficiencies before other rate increases can be granted, so providers have little assurance that, once earned, the efficiency incentive will be available in the future.

Providers' costs may at times change due to circumstances beyond their control. We found:

- **There is no provision in Rule 53 to accommodate most cost changes that are outside of the provider's control.**

Important examples of such costs are liability insurance, workers' compensation insurance, and personnel costs. We are concerned that:

Innovation and creativity may be stifled when providers lack funds.

- **The inability to meet program cost increases may adversely affect the quality of care residents receive.**

Not all providers have cash reserves to enable them to maintain spending for program services when other costs rise. Advocates for residents of ICFs/MR expressed concern that innovation and creativity are stifled when providers lack funds for program services.

THE ADMINISTRATION OF RULE 53

The complicated nature of the reimbursement system, combined with the stringent cost containment features of Rule 53, mean that the department should administer the system in a clear, consistent, equitable manner, so that

providers can receive payments to which they are entitled. However, about 95 percent of the providers who responded to our survey reported that they had problems working with Rule 53. In response to open-ended questions about their most common problems, providers most frequently mentioned (1) lack of clear communication from DHS, (2) lack of flexibility to meet cost changes, (3) difficulty classifying program and administrative costs, and (4) lack of clarity in Rule 53.[2]

Most survey respondents reported problems with Rule 53.

Our case studies helped to pinpoint the issues that caused problems for providers. Using survey results to identify key issues, we selected several case studies for detailed examination. Case study methods allowed us to examine each issue in its context and from the points of view of all participants. Each of the five case studies presents a somewhat different set of issues. For example, the provider in one case study applied for a special needs rate exception and a one-time rate adjustment to meet the increased needs of its elderly clients. Then the provider operated for over 200 days without knowing whether it would be reimbursed for the extra expense it was incurring to provide the needed services. We learned that DHS delayed approval for a rate adjustment because it was attempting to complete long term planning, but the department never clearly explained this to the provider.

While the case studies present different circumstances and issues, in each case the problem described could have been prevented or alleviated by better communication between the provider and staff of the DHS divisions that administer the reimbursement system. We examined the way each division conducts its part of the reimbursement process to determine the causes of the problems we observed. Overall, we found that:

- **The Long Term Care Management, Audits, and Provider Appeals Divisions all have been reluctant to offer consistent interpretations of Rule 53.**

Furthermore:

- **All three divisions need to improve communications with providers.**

The Long Term Care Management Division of DHS has responsibility for developing, interpreting, and disseminating policy and rules regarding ICFs/MR. When providers or staff of other DHS divisions have questions about Rule 53, it should be the Long Term Care Management Division that answers them. The division must balance the need to control costs in ICFs/MR with the need to ensure that residents have access to necessary services. However, we found:

- **The Long Term Care Management Division gives little attention to the effects of cost containment on clients' care or the viability of providers.**

2 Providers also frequently mentioned that reimbursement levels were not adequate to meet their costs. We did not address this issue because it is outside the scope of our study, and because providers also told us that the level of reimbursements is less important than administrative problems.

Who Do ICF/MR Providers Contact at the Department of Human Services Contacts Preferred by ICF/MR Providers with Cost Report Questions

Providers are most likely to ask auditors how to apply Rule 53.

	Provider Organizations	
Contact	Number	Percent
DHS Audit Division	33	32.0%
Policy Center	13	12.6
Developmental Disabilities Division	1	1.0
Claims Processing	1	1.0
Appeals Division	1	1.0
Commissioner of Human Services	1	1.0
Non-DHS Contact[a]	21	20.3
Call No One/Don't Know Whom to Call	32	31.1
Total	103	100.0%

Survey Question: "Who at the Department of Human Services do you call when you have questions about completing your annual cost report?"

Source: Office of the Legislative Auditor analysis of ICF/MR Provider Survey responses.

[a]Non-DHS contacts named were private CPAs, the provider's staff accountant, an attorney, and consultants.

Audit Division staff conduct annual desk audits of providers' cost reports, as well as less frequent but more detailed field audits. The division establishes providers' per diem rates based on cost reports and audit adjustments. Nearly one-third of the respondents to our survey said that they turn to Audit Division staff with questions about their cost reports. We found:

Providers' Comments About the Department of Human Services Audit Division's Administration of Rule 53.

	Percent of Provider Organizations			
	Always or Usually True	Sometimes True	Rarely or Never True	Don't Know
The reasons for rate adjustments are clearly explained to us.	8.2%	39.6%	52.1%	0.0%[a]
Decisions about allowable costs are understandable.	5.2	47.1	47.6	0.0
Decisions about allowable costs are clearly linked to Rule 53.	6.5	58.7	28.9	5.9
We know which costs are allowable.	15.7	66.4	16.9	1.0

N = 103 provider organizations.

Source: Office of the Legislative Auditor analysis of ICF/MR Provider Survey responses.

[a]Percentages may not total 100 percent due to rounding.

- **DHS often communicates about Rule 53 through desk audits, field audits, and phone calls from providers to DHS auditors.**

Since providers must rely on this method to learn how to account for and report expenditures, it is important that auditors be consistent and that audit findings be clearly communicated.

There is a large backlog of appeals cases.

The Provider Appeals Division is supposed to resolve providers' appeals of their rates. We found a large backlog of appeals cases, some dating back more than ten years. We analyzed a sample of appeals that had been resolved during the past five years, and found:

- **It took an average of about 15 months to settle the appeals in our sample. About 21 percent of the appeals took two years or more to resolve.**

Change in Providers' Per Diem Rates After Appeal

Facility Type	Average Rate Before Settlement	After Rate After Settlement	Change	Average Time to Settle (days)
Single, For-Profit	$67.50	$71.04	5%	512
Single, Non-Profit	64.18	67.65	6	309
Small Group, For-Profit	65.50	71.80	11	474
Small Group, Non-Profit	77.63	83.03	8	399
Large Group, For-Profit	58.14	62.04	7	682
Large Group, Non-Profit	60.01	62.76	5	627

Source: Office of the Legislative Auditor analysis of sample data from Provider Appeals Division files.

Especially for small providers with limited access to funds, a delay of two years can cause serious difficulties.

We found that the Health Care Support Division has done a better job of communicating and cooperating with providers to solve problems. In October 1988, DHS began using a new computer system, the Residential Services Invoice (RSI) system, to reimburse ICF/MR providers for services. The system had many problems during its start-up phase. However, we found:

- **Problems with the RSI system are being resolved through cooperative efforts by providers and DHS staff.**

A series of meetings between DHS staff and providers has resulted in solutions to the problem of provider claims being suspended because of system errors. Department data show that at least 96 percent of providers' claims are now paid within 30 days.

RECOMMENDATIONS

In our opinion, the public-private service delivery system is not working well. The state and private providers must cooperate to provide services to vulnerable citizens. To be sure, providers share responsibility for the deteriorating relationship. But ultimate responsibility rests on the state to develop and maintain a service delivery system that works efficiently and effectively. To that end, we recommend:

- **The Department of Human Services needs to identify ways of making the current public-private service delivery system operate more smoothly.**

- **State reimbursement policy should be clarified and communicated consistently to department staff, providers, residents, and advocates.**

Providers should be able to predict the financial results of their business decisions from one year to the next. Clarifying the "rules of the game" will help the reimbursement system to operate more smoothly, and should remove some important reasons for conflict.

Attitudes of distrust and hostility may persist.

However, the poor relationship between DHS staff and providers has existed for some years, and attitudes of distrust and hostility may persist. We recommend:

- **The department should consider consulting with the Department of Administration, Management Analysis Division, for help in improving working relationships.**

Finally, while it is essential that the ICF/MR system operate as a partnership, we also recommend:

- **The department should maintain a strong position in regulating the ICF/MR industry. The department has done a good job of containing costs, and they should continue to do so, but under a more clear and consistent set of policy goals.**

Some of the changes we suggest will require reordering spending priorities within DHS and may require additional expenditures by the state. The Department of Human Services, like other state agencies, faces difficult budgeting decisions. Nevertheless, we think that spending for improved regulation and provider training will be cost effective in the long run, as less will need to be spent on auditing and appeals.

INTRODUCTION

The 1980s brought a growing conviction that individuals with developmental disabilities function best in a homelike, community setting, rather than an institution. The Welsch v. Gardebring suit, which was filed in 1972 as Welsch v. Liken and was settled in 1987, resulted in a decree which required the Department of Human Services to reduce the mentally retarded population in state hospitals by 30 percent. As a result, Minnesota saw the development of privately run alternatives to large public institutions and the steady deinstitutionalization of residents to community settings.

Most ICFs/MR are privately owned and publicly funded.

In Minnesota, the most widely used community alternative is the Intermediate Care Facility for the Mentally Retarded (ICF/MR). Currently most Minnesota ICFs/MR are privately owned, but supported primarily through Medicaid reimbursement. The Department of Human Services (DHS) administers the rule (Rule 53) and the process by which ICF/MR owners are reimbursed for the services they provide the state.[1]

DHS developed Rule 53, which took effect in 1984, in response to legislative concerns about rising ICF/MR costs and a 1983 legislative audit study which documented the weaknesses in the previous rule, Rule 52.[2] The department greatly strengthened cost containment measures in the new rule.

ICF/MR providers have expressed growing concerns about how the Department of Human Services has interpreted and administered Rule 53 since it took effect. Many providers claim that they will be unable to continue providing ICF/MR services because reimbursement is unpredictable. In April 1990 the Legislative Audit Commission directed us to investigate providers' complaints that the department was not paying for services in a fair and consistent manner. To do so, we asked the following questions:

- **How does the Department of Human Services reimburse ICF/MR owners and monitor the appropriateness of their payment claims and expenditure reports? How has the reimbursement system changed in recent years?**

1 *Minn. Rules* Ch. 9553.0010 to 9553.0080.

2 Office of the Legislative Auditor, *Evaluation of Community Residential Programs for Mentally Retarded Persons* (St. Paul, 1983).

- **Is Rule 53 clear, reasonable, and enforceable? Is the rule flexible enough to accommodate providers' cost changes in a timely manner?**

- **Does the Department of Human Services administer Rule 53 in an efficient and consistent manner? Do DHS staff interpret the rule consistently and reasonably? Are appeals resolved in a timely manner? Does the department's billing system operate efficiently and are error-free claims paid promptly? Is there adequate coordination among the various DHS divisions that work with ICFs/MR?**

To answer these questions we used several methods. We surveyed providers to identify their major complaints. We then selected five "problem cases" so that we could study the most common types of complaints in more depth. We also used data maintained by the Appeals and Audit Divisions, examined department files, and interviewed providers and DHS staff.

Overall, we found that:

- **While Rule 53 is generally an effective tool for controlling ICF/MR costs, some parts of the rule are unclear or unreasonable.**

- **The relationship between DHS and providers is strained to the point that it may threaten the smooth delivery of services to ICF/MR clients.**

- **Aside from the goal of cost control, DHS's administration of Rule 53 lacks clear policy direction.**

We acknowledge both the importance of regulating the ICF/MR industry and the difficulties inherent in regulation. DHS staff have tried to resolve a number of problems which the reimbursement system has created for providers. For example, the department amended the rule for a provider who suffered unanticipated financial consequences while adapting a facility to care for residents with more serious needs. The department is successfully correcting problems in the long-term care billing system, as well. However, serious problems remain, which DHS, as a state agency, is responsible for addressing and, if possible, solving. For their part, providers must work within the system developed by state and federal regulators. Moreover, providers must bear some responsibility for encouraging a businesslike relationship with the department.

Chapter 1 reports ICF/MR history and development in Minnesota. Chapter 2 examines strengths and weaknesses in the reimbursement rule. In Chapter 3, we analyze the Department of Human Services' administration of Rule 53, particularly those areas of most concern to providers.

BACKGROUND

Chapter 1

The number of privately owned Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) in Minnesota grew dramatically after the mid-1970s, particularly since 1977, when small facilities (under 16 beds) became an optional service reimbursable under Medicaid.[1] Substantial increases in both the number and the cost to the state of ICF/MR facilities prompted the 1983 Legislature to: (1) enact a moratorium on the development of new ICF/MR beds, and (2) require the Department of Human Services to develop a new reimbursement rule emphasizing cost containment.

In this chapter we describe the ICF/MR industry in Minnesota and the historical context in which the department developed Rule 53. Our discussion revolves around four major questions:

ICFs/MR depend on Medicaid funds.

- **How did the ICF/MR industry develop in Minnesota? How is the industry changing?**
- **What changes in the reimbursement system have been made in recent years? What triggered these changes and what was their purpose?**
- **How does DHS reimburse ICF/MR costs and monitor the appropriateness of payment claims and expenditure reports?**
- **What further changes does the department anticipate making in the reimbursement system?**

THE ICF/MR INDUSTRY IN MINNESOTA

For at least 30 years, the number of mentally retarded state hospital residents has been declining due to several factors identified in our 1986 study of deinstitutionalization.[2] At the same time, the number of ICF/MR facilities in Minnesota has grown dramatically. ICFs/MR have increased from just six before 1970 to about 300 in 1990.[3] Several factors stimulated this rapid growth:

1 Department of Human Services, *Assessment of the Impact of the ICF/MR Moratorium* (St. Paul, 1988), 2.

2 Office of the Legislative Auditor, *Deinstitutionalization of Mentally Retarded People* (St. Paul, 1986).

3 We could not determine the exact number of ICFs/MR because of receiverships and inconsistent record keeping among DHS divisions.

Increasing numbers of mentally retarded persons live in community settings.

- On a national level, professionals in the field of mental retardation increasingly assert that even severely developmentally disabled individuals are best served in a community, rather than an institutional, setting.

- In 1971, the Legislature required Minnesota school districts to provide special education programs, which enabled many families to keep their children in the community.

- Beginning in 1971, federal money became available under the Medicaid program to fund ICFs/MR. In 1977, Medicaid funding became available for smaller homes (fewer than 16 residents) than had previously been developed.

- The Welsch decree required the Department of Human Services to reduce the state hospital population and encourage the development of community services.

The Welsch case was brought by parents of mentally retarded youngsters concerned about the quality of care in state hospitals. A consent decree was issued in 1977 which clarified staffing and program requirements specifically at Cambridge State Hospital. A new consent decree was negotiated in 1980 which required the Department of Human Services to reduce the mentally retarded population in state hospitals by 30 percent. The mentally retarded population in state hospitals had been declining by an average of 5.3 percent annually since 1972, which helped the department meet this goal. Moreover, the department adopted a strategy of expanding the state's community services to further speed the discharge of residents from state hospitals.[4]

Currently, about 54 percent of the approximately 300 ICF/MR facilities in Minnesota are for-profit organizations and about 46 percent are not-for-profit.[5] Facilities range in size from four to 105 beds. As Table 1.1 shows, about half the facilities are medium-sized and contain 44 percent of the total beds. Approximately 81 percent of facilities belong to parent companies owning from 2 to 35 homes each, and the remaining facilities are independently owned. In total, this amounts to over 4,000 ICF/MR beds across the state.[6]

In 1982 the Legislative Audit Commission, concerned about the growing cost of ICFs/MR and the lack of alternatives available, directed our office to study community programs for the developmentally disabled.[7] Our findings that ICF/MR development and costs were increasing rapidly prompted the 1983

4 Legislative Auditor, *Deinstitutionalization*.

5 Department of Human Services, Long-Term Care Management Division data base (July 26, 1990).

6 This figure does not include regional treatment center beds.

7 Legislative Auditor, *Community Residential Programs*.

Table 1.1: Distribution of ICF/MR Beds and Size of Facility, 1990

Facility Size	Percent of Facilities	Percent of Beds
Six or Fewer Beds	34.8%	15.1%
More Than Six and Fewer Than 17	51.7	43.8
More Than 16 Beds	13.8	41.1
	100.3%[a]	100.0%

N = 302 facilities and 4,171 beds

Source: Minnesota Department of Human Services.

[a]Total exceeds 100 percent due to rounding.

Legislature to place a moratorium on further ICF/MR development and to direct the department to reduce the number of ICF/MR beds from 7,500 to 7,000 by 1986.[8] The department began denying all requests for additional ICF/MR beds submitted after March 31, 1983.[9] By 1987, the total number of ICF/MR beds had decreased to 6,818 from 7,559 in 1983.[10]

DHS is developing state-owned community facilities to serve former regional treatment center residents.

The 1989 Legislature directed the Department of Human Services to further reduce the number of mentally retarded residents in the state hospitals, now called regional treatment centers, to 350 by 1998 and 254 by 1999.[11] In response, the department is developing state-operated, community-based homes (SOCS), staffed primarily by former regional treatment center staff, to serve approximately 50 percent of the remaining developmentally disabled persons in RTCs. The other 50 percent will be placed in privately owned ICFs/MR. Construction of the first state-operated residence, in Moose Lake, began in September 1990. Department staff told us that they anticipate having six facilities under construction by winter 1990. The Legislature granted the department funding for 18 SOCS, each with six or fewer beds, to be developed by the end of fiscal year 1991.

The new state-owned community homes represent a break with the current strategy of depending primarily on private providers to develop and maintain group homes in the community.[12] The private providers have two major questions about the SOCS. First, they question whether the department will be able to follow Rule 53 requirements because union-negotiated salaries are higher in RTCs than in private facilities. In response, staff of the RTC Implementation Project, the division responsible for developing SOCS, conceded that the wage differential is a serious concern with potentially severe ramifica-

8 *Minn. Laws* (1983), Ch. 312, Article 9.

9 Department of Human Services, *Assessment of the Impact of the ICF/MR Moratorium* (January 1988), 4.

10 Department of Human Services, *Assessment of the Impact of the ICF/MR Moratorium*, 5.

11 *Minn. Laws* (1989), Ch. 282, Article 6.

12 The only county-owned ICF/MR, Lake Owasso Residence, is slated for closure, and Ramsey County may decide to move residents to privately owned homes.

tions for the industry as a whole. The state must use current employees as much as possible and is bound by union contracts covering wages and benefits. However, RTC Implementation Project staff assured us that they are following Rule 53 to develop the SOCS cost reports, and they expect close scrutiny of their procedures from both the DHS Audit Division and private providers. The Audit Division observed that the estimated costs of SOCS seem similar to the interim rates being set for new private development. This process also deserves careful oversight by the Legislature.

Second, providers expressed the fear that the department would take over the ICF/MR industry in Minnesota. The likelihood of such an outcome is uncertain. However, if the department were to take over ownership and management of all ICFs/MR, the cost to the state would be prohibitive for the reason providers have already identified—the state's high labor costs. Moreover, such an outcome would require the Legislature to alter its current policy, which encourages public-private cooperation for provision of ICF/MR services. For the forseeable future, the Department of Human Services and private providers must work in partnership to meet the needs of Minnesota's developmentally disabled population.

ICF/MR FUNDING HISTORY

The major funding source for ICFs/MR is federal-state cost sharing through Medicaid. ICFs/MR depend almost entirely on Medicaid reimbursement, unlike nursing homes, which have some private-pay patients.

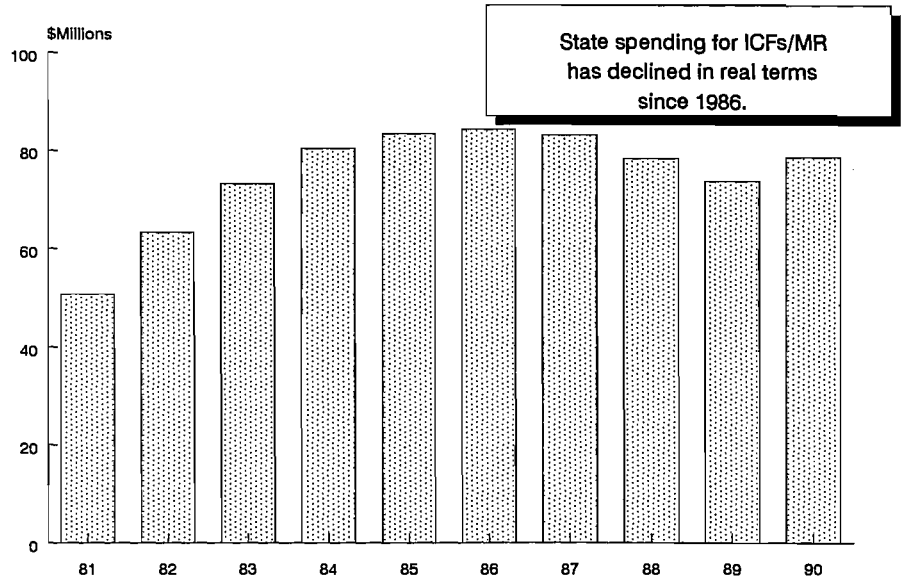
In fiscal year 1989, the cost to the state of ICF/MR services was $116.4 million, about 9 percent of the total Medicaid cost.[13] Figure 1.1 shows that the rate of increase in state ICF/MR expenditures has slowed considerably since 1984, when Rule 53 took effect. In other words, the department has successfully curbed the dramatic cost increases which the state experienced under Rule 52. DHS is controlling overall costs despite pressures such as rising health care costs, inflation, the costs associated with downsizing large facilities, and increasing resident needs and program requirements. The department has used a number of techniques to accomplish this goal, including decertification of ICF/MR beds and the development of community alternatives to ICFs/MR.

From 1973 to 1984, the department followed Rule 52 to determine ICF/MR per diem rates and reimbursements. Rule 52 was a prospective, cost-related rate-setting system. In other words, providers' per diem rates were established for the coming year, based on allowable expenses from the past year plus estimates of future cost changes and an incentive factor. Providers complained that Rule 52 was unclear.[14] Moreover, our 1983 study of community facilities found that Rule 52 had several weaknesses, particularly in the area of

13 Department of Human Services, *ICF/MR and DT&H Costs in Minnesota* (St. Paul, 1990).

14 Department of Human Services, *Report to the Minnesota Legislature on the Proposed Rate System for Payments to Intermediate Care Facilities for Persons with Mental Retardation* (St. Paul, 1989).

Figure 1.1: ICF/MR Expenditures



Source: Department of Human Services
Note: Adjusted for inflation

cost control.[15] We recommended limiting interest expense and paying an earnings allowance based on capital investment. We also recommended that administrative costs be defined more clearly and capped.

The department replaced Rule 52 in 1984 with a temporary Rule 53, which was modified and became permanent in 1986.[16] Rule 53 contains several cost control measures, including the following:

The current ICF/MR reimbursement rule tightened controls over rising costs.

- When an asset, such as a facility, is sold, DHS continues to make Medicaid reimbursements based on the historical value of the asset.
- Interest rates and administrative costs are capped.
- Providers have incentives to renegotiate high interest loans.
- Providers must make a 20 percent down payment when they acquire new capital assets.
- Providers must maintain a funded depreciation account, which is to be used when the principal portion of the provider's mortgage payment increases.

Under Rule 53, the state reimburses ICF/MR owners for expenditures after they have been incurred. The intent of this process is to keep costs from esca-

15 Legislative Auditor, *Community Residential Programs.*

16 For the remainder of this report, when we refer to Rule 53, we mean the permanent rule.

lating rapidly. Payment rates, which are based on each facility's historical costs, place upper limits on the amount each provider can be reimbursed annually.

Other factors also function, directly or indirectly, to control ICF/MR cost increases. First, DHS auditors stringently examine the appropriateness ("allowability") of expenditures under Rule 53 and disallow those that they believe are inappropriate. Second, DHS retains control of funds under dispute until desk audit appeals are settled. Third, DHS requires paybacks of costs that auditors disallow during field audits. Providers retain control of field audit paybacks until the appeal is resolved, but the finding can be used to lower future rates if it affects the cost report period currently being desk-audited. Systems used by some other states—such as negotiating rates with providers or paying them on the basis of estimated future costs—fail to give the state as many methods for keeping costs under control.

The 1988 Legislature authorized the department to institute a case-mix reimbursement rule for ICFs/MR, similar to the system currently applied to nursing home reimbursement.[17] The case-mix approach is designed to direct resources to service areas where need is greatest. Under the plan, the Department of Health would annually assess the service needs of each ICF/MR resident and classify clients by level of severity. DHS would reimburse ICF/MR providers based on the case-mix classification of residents in each of their facilities.[18]

A new reimbursement rule will direct funds to residents based on their needs.

The Department of Human Services was unable to implement the case-mix reimbursement system as planned in 1989, primarily because of industry opposition which surfaced during the public hearings. Department staff said that they still plan to put the rule into effect by 1992. Currently, a committee of about 40 DHS staff, providers, and other interested persons is meeting to revise some parts of the proposed rule, and the department anticipates holding hearings in February 1991.

METHODS

We used several techniques to study the ICF/MR reimbursement system, including interviews, file review, a provider survey, and case studies. We answered some questions using data maintained by the Department of Human Services. For instance, the DHS Health Care Support Division maintains records of claims rejections, suspensions, and payments, from which we were able to determine how quickly providers' error-free claims are paid.

We surveyed providers to identify perceived problems with Rule 53 and to gauge the prevalence of these problems. A copy of the survey with coded responses is in Appendix A. Providers had told us about a number of issues which concerned them, and we wanted to know if these were equally trouble-

17 *Minn. Stat.* §256B.501.

18 Department of Human Services, *Report to the Minnesota Legislature on the Proposed Rate System.*

some for the many providers we could not interview personally. Consequently, the survey questions emphasized problems—again, from the perspective of providers, not DHS.

We mailed 216 questionnaires to providers and received 182 responses. Our intent was to survey provider organizations and a cross-section of facilities across the state, rather than all individual facilities. The lists we obtained from the department and from the ICF/MR industry contained incomplete and sometimes conflicting information. As a result, we sometimes did not know whether an organization was independent or owned by a parent organization until the survey was returned. We sent a questionnaire to each provider on our mailing list, except that we sent only one form (1) if more than one ICF/MR was listed at one address or (2) if more than one home in the same geographic area was listed as belonging to one parent organization. Given our high response rate, we are confident that we heard from a large majority of all types of ICFs/MR, despite the inaccuracies of the original list.

We received surveys from 103 ICF/MR provider organizations.

As shown in Table 1.2, two-thirds of our respondents were ICF/MR administrators. In some cases, providers used one survey form or copied the blank form to respond for all of their ICF/MR facilities, while others responded for only one of their two or more facilities. To ensure that each provider organization had an equal opportunity to be heard, we weighted responses so that each provider organization was counted only once.

Table 1.2: Provider Survey Respondents

	Provider Organizations	
Respondent	Number	Percent
Administrator	68	66.0%
Provider's Accountant	19	18.4
Clerical Staff	6	5.8
Program Director	5	4.9
CPA Firm Staff	5	4.9
Total	103	100.0%

Source: Office of the Legislative Auditor analysis of ICF/MR Provider Survey responses.

In all, we heard from 103 provider organizations out of a total of about 128, which gave us a response rate of approximately 80 percent.

Using the survey results to identify key issues, we selected several case studies for detailed examination. Case studies are particularly useful for explaining why a problem arose and how it developed.[19] Case study methods allowed us to examine each issue in its context and from the point of view of all participants. Complaints cited frequently in provider survey responses were:

19 Robert K. Yin, *Case Study Research: Design and Methods*, revised edition (Newbury Park, California: Sage Publications, Inc., 1989).

- The inflexibility of Rule 53 and its administration.
- Communication problems between providers and DHS.
- Unclear or inconsistent definitions of allowable costs under Rule 53.

At least 25 percent of our survey respondents discussed each of these issues in open-end responses. As shown in Table 1.3, we conducted five case studies that illustrate these problems in various combinations.

We used case studies to examine frequent provider complaints.

Table 1.3: Case Studies

	Problem	Issues
Case 1	Class A to Class B conversion	Complexity, lack of flexibility in the process
Case 2	Special needs rate exception and one-time rate adjustment	Lack of communication, cooperation to allow system to operate smoothly
Case 3	Reclassification of costs	Poor relationship, inconsistency, no method to correct auditor errors
Case 4	Reclassification of program costs	Lack of communication, inconsistency
Case 5	Interim rate for a new facility	Rigidity of system, lack of method to correct DHS errors

We interviewed providers, DHS staff who were involved in the cases, and other involved individuals, such as the providers' outside accountants or legal counsel, when appropriate. We also reviewed documents given to us by providers, as well as appropriate DHS files, usually desk audit or appeals files. Findings are used as examples throughout this report. Brief case study summaries follow in Chapters 2 and 3, and more detailed versions are contained in Appendix B.

THE REIMBURSEMENT RULE FOR ICFs/MR

Chapter 2

The current reimbursement rule for ICFs/MR, referred to as "Rule 53," became effective for the rate year beginning on October 1, 1986.[1] Minnesota law requires the Commissioner of Human Services to establish procedures and rules for determining payment rates for care of ICF/MR residents.[2] The approved rates must provide for the necessary costs of quality care for residents in efficiently and economically operated facilities and services. In developing reimbursement procedures, the commissioner is directed to include:

- cost containment measures;
- limits on reimbursement for property, administrative, and new facilities' costs;
- requirements that facilities use generally accepted accounting principles;
- incentives to reward the accumulation of equity;
- provisions for revaluation on sale for certain facilities; and
- appeals procedures that satisfy the requirements of the Medical Assistance statutes and rules.[3]

The commissioner is also directed to consider the recommendations contained in the report on community residential programs for the mentally retarded published by the Legislative Auditor in 1983.

In analyzing the reimbursement rule for ICFs/MR, we asked:

- **Is Rule 53 clear, reasonable, and enforceable?**

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1 *Minn. Rules* Ch. 9553.0010 to 9553.0080.

2 *Minn. Stat.* §256B.501.

3 *Minn. Stat.* §256B.50, *Minn. Rules* Ch. 9510.0500 to 9510.0890 and 9553.0010 to 9553.0080, and 12*MCAR* 2.05301 to 2.05315 (temporary).

- **Does Rule 53 give the Department of Human Services an appropriate amount of discretion in reimbursement?**
- **Has Rule 53 placed appropriate constraints on ICF/MR costs?**
- **Does Rule 53 include incentives for facilities to provide the proper level of care for clients?**
- **Does Rule 53 enable DHS to accommodate providers' cost changes in a timely manner?**

To determine how well Rule 53 fulfills the requirements contained in statute and how the rule works for providers and clients, we drew on a number of sources. We compared current Rule 53 to the changes we recommended in our 1983 report on Rule 52. We interviewed DHS staff, providers, client advocates, and staff of the Attorney General's office. We analyzed the incentives included in Rule 53, and the language of the rule. And we surveyed providers to determine how well they understood the rule and how successful they were in working with the rule.

Rule 53 governs the way providers are reimbursed.

PROVISIONS OF RULE 53

Rule 53 governs most aspects of how ICF/MR providers are reimbursed for the costs of providing services to residents. The rule lays out a prospective payment system, in which the rate to be paid this year is based on last year's allowable costs, plus inflation. Allowable costs, as well as some specific non-allowable costs, are defined within the rule.

Costs are divided into several categories:

- **"Program costs"** are the direct costs of resident care. They include salaries of program staff, supplies, staff training, resident vacations, facility vehicles, and other costs associated directly with providing services to residents.
- **"Maintenance operating costs"** include dietary, laundry, housekeeping, and plant operations costs. These are capped at their previous year's level plus an inflation factor.
- **"Administrative operating costs"** are, in general, those costs of operating the facility which are not directly related to resident care. They include compensation for top management, clerical, and accounting staff, business office functions, general supplies, and others. Administrative costs are also capped at last year's level plus inflation.

- **"Payroll and fringe benefits costs"** are reported in a separate section of the cost report and then allocated to appropriate categories by DHS.

- **"Property-related costs"** are depreciation, capital debt interest expense, rental and lease payments, and payments in lieu of real estate taxes.

- **"Special operating costs"** include real estate taxes, license fees, insurance, and others. Real estate taxes, special assessments, and real estate and professional liability insurance are reimbursed based on current year costs.

Providers have several methods to increase per diem rates.

In addition to defining cost categories, Rule 53 governs how rates are determined, how providers must report their costs, and how providers may receive increases in their per diem rates outside of regular rate-setting procedures.

There are several methods by which providers may receive increased rates—the one-time rate adjustment, the special needs rate exception, and the life safety code adjustment. The one-time rate adjustment can be used in only a few specific situations:

1. When the Department of Health has issued an order to correct a health-related deficiency;

2. When the federal government has issued a deficiency order regarding the number or type of program staff;

3. When the Commissioner of DHS has determined that a need exists based on a determination or redetermination of need plan; or

4. When the Commissioner has approved a facility's plan to convert at least 50 percent of its beds from Class A to Class B.[4]

The facility must also document that it cannot meet the need by reallocating resources or through a special needs rate exception. A one-time rate adjustment is available to a facility only once every three years.

The special needs rate exception is defined in Rule 186,[5] but is sometimes used when a facility's rate under Rule 53 is inadequate for a particular client. The special needs rate exception is designed to fund short-term special needs of individual clients. The special needs are generally related to either a behavior problem or medical condition of a specific client. Special needs funds are used to pay for additional staff or equipment during the time the behavior problem is being corrected or the medical problem is being treated. In addition, the condition must be one that would result in the client being returned

4 Class A beds are for use by residents who are capable of self-preservation in an emergency and who are ambulatory. Class B beds are for residents, ambulatory or not, who are incapable of self-preservation. The per diem rate for Class B beds is generally higher than for Class A beds.

5 *Minn. Rules* Ch. 9510.1020-9510.1140.

to or kept in a regional treatment center if not corrected. Special needs rate exceptions are only granted after all other funding sources or alternatives have been exhausted.

The life safety code adjustment is available when the state fire marshall has issued a statement of deficiencies. The adjustment may be used for facilities with 16 or fewer beds, when modifying physical plant or adding depreciable equipment has been found to be the best method to correct the deficiencies. Again, all other funding alternatives must be used before the life safety code adjustment can be granted.

CLARITY AND ENFORCEABILITY OF RULE 53

In order for the reimbursement rule to achieve its purposes of fairly and economically paying for services the state has agreed to purchase, it must be clear, reasonable, and enforceable. Both providers and DHS staff must be able to understand the "rules of the game" so they can operate efficiently. In addition, if rules are unclear, it is more difficult to hold providers accountable when the rules are broken.

We found:

- **Certain portions of Rule 53 are not clear or reasonable. This is confusing to providers and inhibits the department's ability to enforce the rule.**

The distinction between program and administrative costs has been a source of problems.

Perhaps the most problematic area of Rule 53 is the allocation of costs between program and administrative categories. Rule 53 treats "program" costs differently from "administrative" costs. Under the rule, "program" refers to functions and activities that contribute directly to the care of residents, while "administration" means the more general activities of running any business. As noted earlier, administrative costs are limited to the lesser of last year's levels or an industry median, plus inflation, while program costs are not limited. Providers therefore have an incentive to place as many costs as possible into the program category.

Our 1983 report recommended that "administrative costs" should be more clearly defined. We suggested that clarifying the category would enable the department to reduce its efforts to review those costs. In our current study, we found:

- **After seven years, "administrative costs" are still not clearly defined in the rule.**

The department and providers have worked to clarify the meaning, but have so far been unsuccessful. As a result, even more effort is expended now than in 1983 reviewing these costs and processing appeals arising from the lack of clarity. We discuss this issue in more detail in Chapter 3.

Other parts of Rule 53 are similarly open to disagreement between the department and providers. A frequent source of appeals is the requirement for time and attendance records and time distribution records for employees of ICFs/MR. The rule is clear in requiring that payroll records for each facility must show the amount paid and days and hours worked for every employee. Disputes arise, however, over what constitutes adequate records of days and hours worked. Time distribution records are required for employees who work in more than one facility, or who perform multiple duties. Again, disagreements arise over what constitutes adequate records. Rule 53 says, for example, that providers may estimate the time spent in various activities by using "a statistically valid method." One provider used a statistical method, and hired an accounting firm to confirm its validity. Nevertheless, department auditors disallowed the costs that had been allocated, because they felt the method was not valid. The provider is unclear as to what was done incorrectly.

One particular component of the rule has given rise to civil and, in some instances, even criminal cases against some ICF/MR providers. Rule 53 currently permits purchases from a related organization if that organization's sales to non-related organizations constitute at least 50 percent of its total annual sales of comparable goods or services. If the 50 percent test is not met, the provider must report the cost, rather than the retail price, of the goods or services. The Attorney General cites this as a difficult provision to enforce, and open to misuse by providers. The provision is difficult to enforce because it is hard to determine exactly what portion of a company's sales is to non-related parties. At times providers buying goods or services from related entities may have paid too much or purchased unnecessary items, to their personal gain. The Attorney General would prefer that all related party transactions be disallowed.

COST CONTAINMENT MEASURES

In our 1983 study, we found that the reimbursement rule, and the department's administration of the rule, did not adequately control costs in ICFs/MR. Our report included a number of recommendations designed to improve cost control. We recommended that:

- **The rule should limit interest expense by setting a maximum rate which will be reimbursed, or by paying interest only on debt which does not exceed the value of the facility's fixed assets.**

- **The rule should pay an earnings allowance based on capital investment.**

- **The rule should tie any further caps to administrative costs, rather than program costs.**

- **The rule should use a 96 percent occupancy factor, or 85 to 90 percent for facilities with fewer than 11 beds, to encourage high occupancy rates.**

- **Leases should be defined using Generally Accepted Accounting Principles (GAAP).**

Rule 53 contains many cost containment provisions.

These recommendations have largely been included in Rule 53. We found that:

- **Rule 53 does include the necessary provisions to be a strong cost containment tool.**

The reimbursable interest rate is limited to 16 percent, or less in some circumstances. In addition, interest expense is allowable only for capital debt which does not exceed 80 percent of the cost of the particular asset or, together with all other capital debt, does not exceed the historical capital cost of all of the facility's assets.

In 1983 we found that some facilities had debt which exceeded the value of their assets. Our study showed that providers that reduced debt and invested additional capital in their facilities would achieve improved cash flow. We recommended that the reimbursement rule should pay an earnings allowance based on capital investment, which would reward and encourage such investment. Rule 53 includes a reward for capital investment, called the "capital debt reduction allowance," although DHS staff told us that the provision was not intended to provide a return on investment. The allowance is a fixed dollar amount which increases in increments as the percent of equity increases. This scheme produces less incentive to invest for newer or more expensive facilities than for older or less expensive ones, as the example in Table 2.1 illustrates.

Table 2.1: Capital Debt Reduction Allowance Example

	Historical Debt	Equity	Percent Equity	Allowance Per Resident Day	Resident Days	Total Allowance	Allowance/ Equity
Facility A	$100,000	$25,000	25%	$.50	5,250	$2,625	10.50%
Facility B	200,000	50,000	25	.50	5,250	2,625	5.25

Administrative costs are capped under Rule 53.

Several other features of Rule 53 are designed to contain costs and improve accountability. We have already noted that administrative costs are capped, while program costs remain uncapped. Also, certain factors in the rule reward facilities for maintaining a high level of occupancy. This increases economy, as fixed costs are spread over a larger number of residents. And, finally, leases are defined in Rule 53 to coincide with the definitions in Generally Accepted Accounting Principles (GAAP). Using the GAAP definitions helps to protect

the state from paying too much in interest and depreciation costs if the facility is sold.

INCENTIVES FOR APPROPRIATE LEVELS OF RESIDENT CARE

Rule 53 contains an "efficiency incentive" which is designed to control spending on administration and maintenance, while encouraging spending at or above historical levels for program activities. If a facility's total operating costs in the reporting year are less than the cost limits included in the rule, the provider may be paid up to the limit of $2 per resident day. However, if program spending is below the rule's limit on program costs, the efficiency payment is cancelled. We found:

- **The efficiency incentive is of limited usefulness in encouraging spending for resident care.**

Incentives for appropriate levels of resident care may not be effective.

First, providers must spend money "up front" for increases in patient care and the dollars spent may eventually be added to their future per diem. Providers may be reluctant to incur the costs in the first place, however, because the reimbursement system will always lag one year behind, so a provider will never recover the first year's increase in expenditures. Second, any efficiency incentive which a facility has received must be used to correct deficiencies before a one-time rate adjustment or a special needs rate exception can be granted. Therefore, providers have little assurance that, once earned, the efficiency incentive will be available in the future.

Established ICFs/MR may not be designed to meet the more challenging needs of former RTC patients. Rule 53 addresses this problem by allowing for Class A to Class B conversions of beds. Figure 2.1 shows a case study which illustrates the difficulties some providers have encountered when they tried to convert beds in their facilities to serve more disabled residents. As in the case of the efficiency incentive, providers find that they must spend their own money during the conversion process. If their preliminary estimates of costs are inaccurate, they may not recover those funds when their per diem rate is calculated.

ABILITY TO ACCOMMODATE COST CHANGES

Providers' costs may at times change due to circumstances beyond their control. However, we found that:

- **There is no provision in Rule 53 to accommodate most cost increases that are outside of the provider's control.**

Figure 2.1: Case 1 – Class A to Class B Conversion

Case 1 involves a 12-bed facility in Crow Wing County operated by a very large, nonprofit provider. The issue in this case is the process of converting beds from Class A to Class B. Class A beds are licensed for people who are capable of self-preservation in an emergency. Class B beds are for people who are unable to take appropriate action for self-preservation. It is often necessary to convert to Class B in order to create a community placement for former RTC residents, and the per diem for Class B beds is generally higher than for Class A. This case illustrates the lack of flexibility and the complexity of this conversion process.

Late in 1984 the provider was asked by its county to consider converting a facility from Class A to Class B. The county was attempting to plan for discharging residents from a regional treatment center to the community. The provider and the county agreed that the facility should be remodeled to accomodate both Class B and Class A residents. The provider planned to admit six Class B residents from the RTC by March 31, 1986. The provider had secured $70,000 financing from the Minnesota Housing Finance Corporation.

In August 1986 the Department of Human Services set the interim payment rate at $91.62. The effective date for the rate would be either the date the Department of Health licensed the Class B beds or the date when the Class B beds were occupied by appropriate residents, whichever was later. In January 1987, the Class B beds still had not been filled. Two Class A residents had not been moved to the community because the county had been unable to locate services for them and an RTC resident was still being held there under her doctor's orders. Remodeling had been completed and additional staff employed at the facility by that time.

In 1987 the provider converted another Class A facility to Class B. By mid-1990, the provider reported that it had incurred over $93,000 in unreimbursed expenses for these two facilities. DHS amended Rule 53 to allow providers to receive the higher rate as soon as 60 percent of new Class B beds are occupied. The provider has asked the department to repay the remaining unreimbursed costs, but the department is prevented by Rule 53 from granting any further relief to the provider.

The issues in this case arise from two sources. First, Rule 53 operates to make a conversion from Class A to Class B difficult and expensive for the provider. The provider must spend its own resources preparing for the conversion, but must rely on the county and others for the process to go forward. The second cause of difficulties in this case is inadequate planning by the county. It was the county's responsibility to arrange for alternative services for ICF/MR residents, so that their beds could be freed for use by RTC residents. Because the county was not prepared to arrange for community services for its clients, the entire process was delayed, and the provider incurred additional, unnecessary expenses.

Counties' actions sometimes delay reimbursement.

Important examples of such costs are liability insurance and workers' compensation insurance. When these costs increase the provider must pay for them for up to 21 months, after which the increased cost will be reflected in a new per diem rate. But the new per diem rate will only allow the provider to recover the increased cost in the future; it will not retroactively reimburse the

provider for the increased cost paid out while the old per diem rate was in effect.

Program costs may change either for the facility as a whole, or for an individual client. Under certain circumstances (described earlier) the provider may apply for either a one-time rate adjustment or a special needs rate exception when program costs increase. Both of these involve lengthy application and approval processes. Case study number 2, described in Figure 2.2, illustrates the problems and delays that are sometimes encountered by providers attempting to receive one of these rate increases. The provider in that case has waited over 18 months for permanent funding to meet residents' increased needs.

Program costs may also change if personnel costs increase, either because more highly-qualified staff are needed, or because higher wages are demanded. In the first case, either the one-time rate adjustment or the special needs exception may be appropriate. There is no provision for meeting

increased wage costs which are due to a change in the local labor market. We are concerned that:

- **The inability to meet program cost increases may directly affect the quality of care residents receive.**

Some providers may respond by not making needed improvements in residents' programs, or by not hiring adequate staff. Other providers may attempt to make the improvements or hire the staff. However, some may be unable to sustain that level of spending, with the potential result that they will have to go out of business, perhaps forcing residents to leave their homes.

The proposed case-mix reimbursement system should help when program costs increase because residents' needs change. However, that system will not address changes in other factors, such as wages, that may affect program costs.

APPROPRIATE DISCRETION IN REIMBURSEMENT

Rule 53 should be flexible, yet reasonably consistent.

The department should have enough flexibility to meet exceptional circumstances that may arise for individual providers, or for the industry as a whole. On the other hand, discretion should be limited so that reimbursement decisions are reasonably consistent from year to year and provider to provider. We found that:

- **Rule 53 does not always provide for an appropriate level of discretion. The rule is sometimes interpreted narrowly and other times broadly.**

Communication between DHS and providers is sometimes lacking.

Figure 2.2: Case 2—Special Needs Rate Exception and One-Time Rate Adjustment

Case 2 involves a facility located in Olmsted county, one of four six-bed ICFs/MR operated by a nonprofit provider. The problem in this case involves the steps for obtaining special needs rate exceptions and one-time rate adjustments. The case highlights the lack of communication and cooperation to help the ICF/MR system operate smoothly.

The facility's March 1989 inspection by the Department of Health showed that adequate staff were not always available to help evacuate residents in an emergency. The provider proposed to apply for a special needs rate exception for one resident and to initiate a redetermination of need with the county to address the changing needs of aging residents.

In June, when the provider began the rate exception process, additional staff had already been hired. Special needs funds were approved by DHS on August 4, for the period July 12 to January 12, 1990. The approval required the provider to apply for a one-time rate adjustment.

In October the provider applied for a one-time rate adjustment. The county granted approval but DHS did not. As a result, the provider informed the county on January 29, 1990 that the special needs client would be discharged to an RTC. On January 31 the department authorized a 90-day extension of special needs funding, effective January 13, and on March 22 the rate adjustment request was reviewed by a DHS committee. The committee did not act on the rate adjustment, but again directed the provider to apply for an extension of special needs funding.

The previous special needs extension had expired on April 11. On July 18 DHS approved the extension for the period April 12 to October 12, 1990. The provider must apply for extensions in October 1990 and January 1991.

Between July 1989 and July 1990 the provider operated for 206 days without knowing if it would be reimbursed. During that time, the provider says, it made repeated phone calls to DHS staff, but many calls were not returned.

Long Term Care Management Division staff explained that approval for special needs was delayed, in part, because the county or the provider did not supply needed information in a timely manner. In addition, when the provider requested the rate adjustment, Developmental Disabilities Division staff had been considering an A to B conversion for the facility and would not approve a rate adjustment until long-term planning was completed. Division staff concede that they may not have made the provider or Long Term Care Division staff fully aware of the reasons for not approving the rate adjustment.

Most of the problems in this case were caused by lack of communication and coordination. We were told by developmental disabilities staff that they consider this a good provider. There was no dispute over whether the clients involved actually needed the additional services. It would have been in the best interests of the clients, the provider, and the state to give the provider the information and assistance it needed to complete the application processes sooner.

Because Rule 53 is vague in some parts, the department may sometimes have too much discretion. Different auditors often make different decisions on the same issue from year to year. One example is case study number 3, described in Figure 2.3, in which nursing salaries were disallowed in 1989, because the auditor assumed that the provider could not allocate the costs appropriately.

Audit decisions are not always consistent.

Figure 2.3: Case 3—Reclassification of Costs

Case 3 involves a 12-bed facility in Sherburne county and a 6-bed facility in Ramsey county. The for-profit provider also operates two other 6-bed ICFs/MR and other services. The problem in this case is reclassification of nurses' wages from the program to the administrative category. The case shows the lack of trust between DHS staff and providers, exacerbated by lack of communication and inconsistency on the part of DHS auditors.

In June 1989 a DHS auditor requested additional information about administrative salaries included in the provider's 1988 cost reports. The provider explained that facility directors' wages could not be attributed to particular homes because each director is responsible for more than one home. Facility directors' salaries are included with central office costs and allocated among all operations.

The facility received its rate notice in September 1989, and found that nursing wages had been transferred from the program to the administrative cost category. The provider learned that the auditor had assumed that wages for nurses, who also serve more than one facility, could not be allocated because facility director salaries could not. Because the provider was already at the limit for administrative costs, the entire cost of nursing salaries was effectively disallowed.

The provider appealed in October 1989, and was informed that the appeal would not be expedited because the issue was shared by other providers. The appeal over last year's disallowance has still not been resolved, although the same salaries were allowed this year. Until the appeal is resolved, the provider will not have use of about $10,000 to which it may be entitled.

The provider asserts that "the assumption which (the auditor) made is completely wrong." Facility directors are full-time, salaried employees who often perform work that applies to more than one facility. The facility nurse position is a part-time, hourly job. Nurses maintain time records which identify the facilities they have worked in. The provider believes that the issue could have been avoided if the auditor had asked during the audit for an explanation of the way nursing wages were recorded.

The DHS auditor involved informed us that his work had been reviewed by a more senior auditor, who told the desk auditor to reclassify and allocate the nursing wages. The reclassification occurred late in August, which the desk auditor told us was too late in the audit cycle for him to request backup documentation from the provider.

It is unclear whether the reclassification of nursing wages was an error. Nevertheless, some problems exist in the way the matter was handled. First, auditors should not "assume" that a provider has done something wrong without asking for clarification. Second, it should never be too late in the audit cycle to ask for clarification. Finally, the fact that the nursing wages disallowed last year were allowed this year indicates that audits are sometimes conducted inconsistently.

In 1990 the same costs were allowed. In the Appeals Division, the director has sole discretion over the resolution of appeals, and determines which appeals will go through an expedited process (explained more fully in Chapter 3). Providers are often told that, although their appeal fits within the expedited guidelines, the department chooses not to use that process.

On the other hand, some parts of the rule are interpreted very narrowly. For example, Rule 53 does not contain an explicit provision for correcting errors made during the desk audit process, once rate letters have been sent. The department has interpreted this to mean that they may not make such corrections, even in cases where the error is a simple mathmatical one.

RECOMMENDATIONS

We found that Rule 53 generally includes adequate controls and incentives designed to keep costs of ICFs/MR to a minimum. However, the rule includes some incentives that may not have the intended effect on providers, and in other cases the rule lacks needed incentives to provide quality care to residents.

In order to improve the incentive for providers to invest in their property, we recommend:

- **The earnings allowance should be changed to a percent of equity, rather than a fixed dollar amount.**

Rule 53 could be more flexible.

Because investment per bed is already limited, this should not result in unnecessary spending on property. The incentive could be defined so as to cost no more than the current incentive, and interest costs for the state will decline as equity increases.

The state has made commitments to two groups—citizens with mental retardation and providers of ICF/MR services for those citizens. The state has agreed to provide retarded citizens appropriate care in the least restrictive environment possible and to purchase the services necessary for that care from providers. In order to meet those commitments, we recommend that:

- **A method for reimbursing providers for legitimate expenses above their per diems should be added to the rule.**

The current special needs and one-time rate adjustment processes may discourage providers from taking more difficult clients or upgrading services when they should. There is also no mechanism to reimburse providers when administrative expenses, such as insurance costs, legitimately increase. The department has worked to make Rule 53 a cost containment rule, and that work should not be eroded. Costs which would be eligible to be reimbursed outside of the rates would need to be limited and carefully scrutinized. But

we think the effort is necessary if the state is to continue to honor its commitment to residents of ICFs/MR and to their care providers.

- **The efficiency incentive, once earned by a facility, should only be recaptured by the state in a few circumstances.**

For example, providers who failed to maintain their physical plants properly should be expected to use efficiency incentives to pay for needed repairs. Similarly, if residents' skills deteriorated because the provider was neglecting their care, the state should not pay for additional staff.

Finally, certain parts of Rule 53 are unclear and have consistently led to disallowances and rate appeals. Clarity may be improved either administratively or through rule change. We discuss the needed improvements in Chapter 3.

THE ADMINISTRATION OF RULE 53

Chapter 3

While we found some weaknesses in Rule 53, as we discussed in Chapter 2, the source of most provider complaints about the ICF/MR reimbursement system is the way the various divisions of the Department of Human Services administer the rule. During the course of our study, we conducted numerous interviews with DHS staff, providers and their representatives, and advocates for people with mental retardation. We asked these questions:

- **How does the reimbursement process operate? What procedures do providers, DHS staff, and others follow?**
- **Overall, how smoothly does the system operate? What are the problem areas? How are problems solved when they arise?**

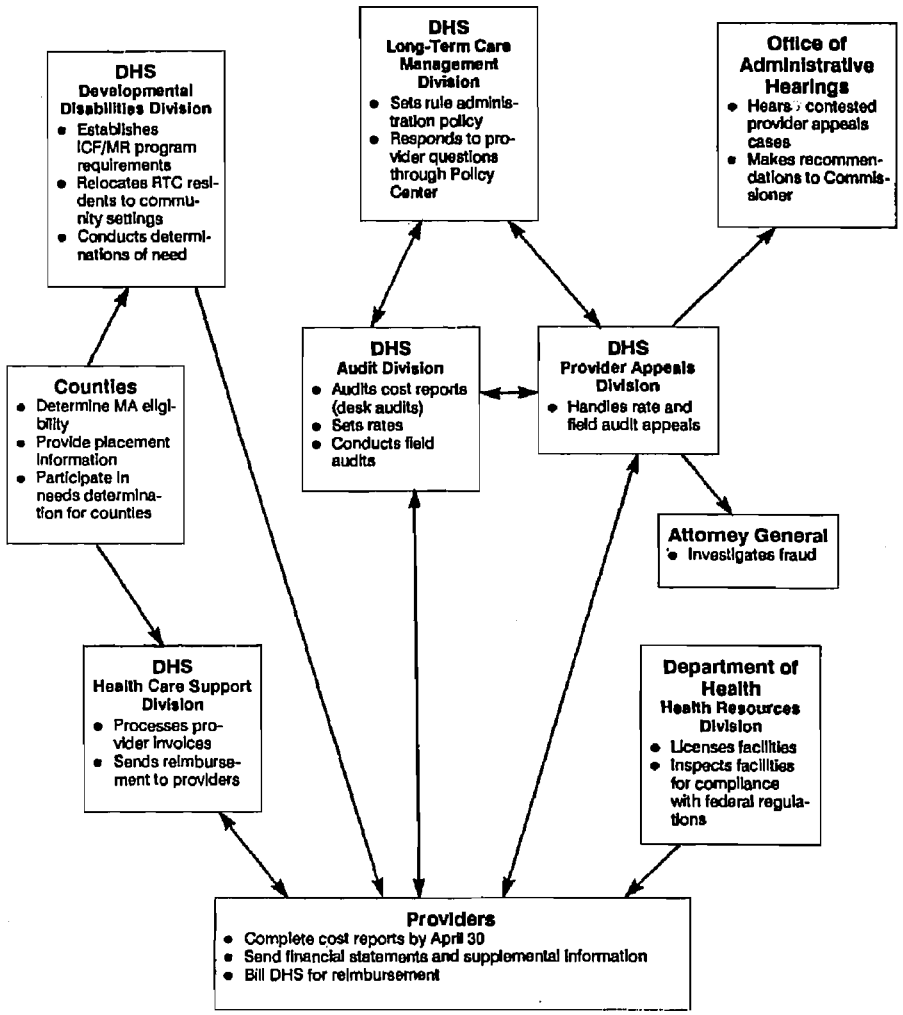
In this chapter, we discuss how the different divisions within DHS administer the reimbursement system. We explain how the process works and the steps that providers go through to obtain reimbursement. Next, we discuss individually each DHS division that is part of the reimbursement system, describing the strengths and weaknesses we found in each division and suggesting changes that we believe would make the system more effective. Finally, we conclude that the current reimbursement system, while in need of improvement, can be made to accomplish the goals of providing quality services to residents of ICFs/MR, while continuing to conserve state funds.

THE REIMBURSEMENT PROCESS

Most providers report problems with Rule 53 clarity or administration.

In our provider survey, 95 percent of respondents said that they had experienced problems with Rule 53 during 1989. In citing examples, some providers mentioned DHS auditing procedures, appeals, or billing as sources of confusion and conflict. In this section, we discuss the ICF/MR reimbursement process and the agencies that administer reimbursements. Figure 3.1 shows the process used to establish reimbursement rates for ICF/MR providers. In general, we found that:

Figure 3.1: The ICF/MR Reimbursement Process



- **The ICF/MR reimbursement system is complex, and its administration involves several agencies and divisions within agencies.**

As we discussed in Chapter 2, state law directs the Commissioner of Human Services to establish rules for determining ICF/MR rates.[1] The DHS Long-Term Care Management Division sets policy for the department's administration of the rule and is the designated authority on rule interpretation. The division staffs the "Policy Center" which fields questions from providers about rule administration or policy. The Policy Center uses an answering machine which instructs callers to state their questions and related manual or rule citations, and which assures the caller that a written response will follow within five working days. In practice one DHS staff member handles most Policy

1 *Minn. Stat.* §256.501, Subd. 3.

Center questions, sometimes after consulting with staff from other divisions, such as Audits or Provider Appeals.

Providers submit yearly cost reports.

For each rate year ending December 31, every provider must complete a detailed cost report, which must reach the DHS Audit Division by April 30 of the following year. Providers must report all ICF/MR costs, divided into categories such as program, maintenance, and administration. Sample pages of a cost report are shown in Appendix C. In addition, a provider must include a financial statement and other supplemental information.

Each cost report is then subjected to a desk audit at DHS. Initially, reviewers check for internal consistency, math errors, obvious coding errors, and completeness. If items are missing or inaccurate, the auditor asks the provider for the missing information or sends back the cost report. If the cost report is not complete by April 30 (or 21 days after Audit staff send a written request for more information), DHS can reduce the provider's rate by 20 percent until all correct information is supplied. The 20 percent reduction has seldom been applied, however.

If the cost report is complete, the auditor follows desk audit procedures for additional checks. For example, auditors look for large changes in expenditures since the previous year or for shifts in costs between categories. They also examine financial statements and supplemental information, such as time reports. Auditors sometimes move expenses from one category to another or disallow them altogether if, in their judgment, the costs seem to be misclassified. For example, they may decide that a provider has misclassified a salary as a program expense when it should be considered administrative. Disallowed costs are subtracted from cost report figures.

The desk audit findings are reviewed by a senior auditor, who may suggest changes. The initial auditor makes those changes or corrections, and the senior auditor reviews the findings again if the changes were significant. Desk auditors follow a check list and an audit manual, though staff told us, and the audit manual confirmed, that they must use a certain amount of judgment during the desk audit process.

Cost reports are audited and used to set payment rates.

Once the auditor has made adjustments to the cost report based on desk audit findings, the report is entered into a computer file. Rate-setting staff then generate each provider's per diem rate and send notices to the facilities in September for rates effective on October 1. Rates are based on historical costs and an annual cost-of-living increase, as we discussed in Chapter 2.

DHS Audit Division staff also conduct field audits of some facilities. A field audit is less frequent and more detailed than a desk audit. It is defined in rule as an "on-site examination, verification, and review of the cost report, financial records, statistical records, and related supporting documentation of the provider or provider group."[2] To complete a field audit, staff follow procedures established by the Audit Division. DHS is required by federal Medicaid policy to complete field audits for 25 percent of ICF/MR facilities per year,

2 *Minn. Rules* Ch. 9553.0020, Subp. 20.

and findings may be retroactive for up to four years. All items relating to costs reported on cost reports are subject to examination.

Providers can appeal audit findings and payment rates.

If providers disagree with desk or field audit findings, they may submit written rate or audit appeals to the DHS Provider Appeals Division.[3] The appeal must be filed within 60 days of receiving the rate notice or audit decision. Appeals may be resolved in several ways. Some are informal, but the formal processes are the expedited appeal process, which may be used for disputed amounts no larger than $100 per licensed bed, and, for contested cases, referral to the Office of Administrative Hearings, which makes recommendations to the commissioner regarding a resolution. The commissioner may choose to follow or not to follow the recommendation.

The effect of adjustments on providers differs between desk and field audits. A desk audit adjustment could affect the provider's per diem (payment) rate for the coming year. DHS retains control of disputed desk audit dollars until the appeal is settled. In a field audit, on the other hand, the provider keeps the disputed amount until its appeal of the audit findings is settled. If auditors make adjustments based on field audit findings, they may require retroactive paybacks from providers (or the department may owe paybacks to providers).

After rates are set, providers send monthly invoices that detail which clients resided in the facility, and for how many days, to the DHS Health Care Support Division. Staff of that division process providers' invoices and send checks for the amount equal to the provider's per diem rate multiplied by client days. The billing system is computerized and requires accurate information from both providers and the provider's county. County staff determine clients' Medicaid eligibility and place of residence. If either piece of information is missing or inaccurate, the provider's invoice may be rejected or suspended.

The DHS Developmental Disabilities Division is responsible for ensuring that ICF/MR residents have appropriate program services. In particular, the division is involved in determinations of need which enable facilities to receive special rates, such as one-time rate adjustments. Some providers and DHS staff told us that the division's program development role sometimes conflicts with the Audit Division's emphasis on cost control. At times, developmental disabilities staff require facilities to upgrade their services, but the facilities find that the costs they incur to do so may not be reimburseable according to Audit Division staff.

The Health Department inspects ICF/MR facilities for violations that may require more funding.

The Department of Health is involved in the reimbursement process through its inspection of facilities for health, safety, and building code violations. For example, if a facility is cited for a "life safety" code violation, such as a need for more night staff or a sprinkler system, the facility may apply to the Commissioner of Human Services for an adjustment to its special operating cost payment rate.

3 *Minn. Rules* Ch. 9553.0080.

Providers and DHS and Health Department staff alike mentioned the need to improve or simplify coordination among and within the agencies which are involved with ICF/MR reimbursement. However, providers specifically complained about unclear and inconsistent direction from the Department of Human Services.

Coordination among departments and divisions needs improvement.

We evaluated the way the ICF/MR reimbursement process is administered by the Department of Human Services. We asked:

- **Does the Department of Human Services administer the ICF/MR reimbursement system so as to encourage the economical use of state resources?**

- **Does the way the reimbursement system is administered help to ensure that quality programs and services are provided to people with mental retardation, as envisioned by the Legislature?**

Overall, we found:

- **The department does a good job of controlling costs, but pays less attention to the effects of cost controls on the quality or quantity of ICF/MR services available.**

In the following sections we discuss the Long Term Care Management, Audit, Provider Appeals, and Health Care Support Divisions individually, since most problems cited by providers concerned these divisions.

THE LONG TERM CARE MANAGEMENT DIVISION

The Long Term Care Management Division has several responsibilities with regard to ICFs/MR:

The Long Term Care Management Division has the position of coordinator.

- Develop, review, and analyze methods for reimbursing long term care services;

- Analyze cost and program data to contain costs and improve services;

- Develop rules and implement state and federal legislation; and

- Coordinate and disseminate state long term care policy.

While all DHS divisions with responsibilities for reimbursing ICFs/MR are at the same level of authority within the department, the Long Term Care Management Division has the position of coordinator. Staff of this division are responsible for developing, interpreting, and disseminating policy. When a question arises over the official interpretation of the rule, this division is

supposed to supply the answer. Since the rest of the reimbursement system depends on the policy and interpretations that emanate from the Long Term Care Management Division, the performance of its staff is critical.

We reviewed the division's work agenda and asked:

- **Has the Long Term Care Management Division developed rules and policies that tend to contain costs and improve services?**
- **Do staff within the division interpret policy consistently?**
- **How well does the Long Term Care Management Division communicate its interpretation of Rule 53 and related policies to providers and to staff of other DHS divisions?**

Developing Policy and Rules

It was clear from our interviews and written records that:

- **In general, the Long Term Care Management Division has developed Rule 53 as requested by the Legislature.**

The division was responsible for promulgating Rule 53 at the direction of the Legislature. Legislators were concerned about rapidly increasing costs in ICFs/MR, and directed the department to develop a reimbursement rule with stronger cost containment features. As we discussed in Chapter 2, Rule 53 is a strong cost-containment tool.

DHS is working to develop a case-mix reimbursement system.

The division is currently working to develop a case-mix reimbursement system, as directed by the 1988 Legislature. A case-mix system would tie reimbursement more closely to the actual needs of individual residents of ICFs/MR, because reimbursement for program expenses would be based on the actual time needed to provide services for each resident. It has the potential to be a more fair system, from the perspective of providers. A provider under the current system who wishes to improve services must first spend the necessary money, and later apply for an increased rate. Under a case-mix system, providers' rates could be updated whenever a resident's needs changed. A case-mix system also has the potential to be a better system for residents, as it can provide a financial incentive for providers to accept more difficult clients, and to provide all the services they need. Finally, a case-mix reimbursement system could allow for more efficient use of state resources, as only services required by individual residents would be purchased.

Although the department thought that its proposed case-mix system would benefit providers, when it attempted to promulgate the rule change providers raised numerous objections. The department withdrew the changes from the rule-making process, in large part because it believed the new reimbursement method could not work without the support of providers. The department

and providers are continuing to work on the rule, which DHS hopes to have in operation by October 1991.

While the Long Term Care Management Division has developed Rule 53 as mandated by the Legislature, we also found:

- **The Long Term Care Management Division focuses almost exclusively on cost control, with less attention to the effects of cost containment on clients or on the viability of providers.**

The division takes a "hands off" stance with respect to providers' financial condition.

The division has not integrated its two competing, equally important responsibilities: containing costs and ensuring that quality services are available for residents of ICFs/MR. Division staff expressed a lack of concern over failing ICFs/MR. They expressed the opinion that those providers who failed deserved to do so, because they were either bad providers or poor managers. We were told that the state has no responsibility to keep any specific provider in business. The division takes a "hands off" stance with respect to the financial condition of all providers, without regard to whether they are "desirable" providers from the state's point of view.

Interpreting Policy and Rule

Even where the division has developed rules and policy, in the area of cost reporting and cost containment, we found that:

- **The Long Term Care Management Division fails to offer full and consistent interpretations of rule or policy. Consequently, both providers and staff of other DHS divisions lack direction as to how to apply the rule.**

We found that, because of lack of direction by the division, the Audit and Provider Appeals Divisions have also become policy makers. However, neither of these divisions has a system-wide perspective on the reimbursement system. That would not be a problem if there were a clear policy for them to follow. Instead, both divisions are left to pursue their missions in isolation from broader policy issues. This is discussed further in later sections of this chapter.

Communicating with Providers

The division operates a Long Term Care Policy "hot line" which is designed to allow providers to phone in their questions about reimbursement policy. When providers phone with a question, they hear a recorded message that promises a response within five days. However, when we reviewed the Policy Center log of provider questions and division responses, we found that:

- **It sometimes took weeks for providers to get a response to their question, and some calls had not received a response even after several months.**

Of providers who answered our survey, only about 13 percent said they routinely call the Policy Center with questions about their cost reports, as shown in Table 3.1. Many more, 32 percent, call the Audit Division with such questions. Providers frequently told us that the Policy Center was too slow to respond or that they disliked using the Center's answering machine.

Table 3.1: Who Do ICF/MR Providers Contact at the Department of Human Services with Cost Report Questions

	Provider Organizations	
Contact	Number	Percent
DHS Audit Division	33	32.0%
Policy Center	13	12.6
Developmental Disabilities Division	1	1.0
Claims Processing	1	1.0
Appeals Division	1	1.0
Commissioner of Human Services	1	1.0
Non-DHS Contact[a]	21	20.3
Call No One/Don't Know Whom to Call	32	31.1
Total	103	100.0%

Survey Question: "Who at the Department of Human Services do you call when you have questions about completing your annual cost report?"

Source: Office of the Legislative Auditor analysis of ICF/MR Provider Survey responses.

[a]Non-DHS contacts named were private CPAs, the provider's staff accountant, an attorney, and consultants.

The Policy Center should be more helpful to providers.

We were told by DHS staff that the Policy Center is the only official source of department interpretation of rule and policy. We think that represents a sensible policy, one that should prevent misinterpretations or inconsistent interpretations. In order for the policy to be useful, however, it must be followed, and the Policy Center must be helpful to providers. Instead, when we reviewed the Policy Center's log of questions and responses, we found:

- **Responses to questions asked of the Policy Center were rarely specific or clear.**

Often, the response consisted only of a quote from, or copy of, the relevant part of the rule, with no guidance as to how the rule should be applied to the provider's particular situation. In one instance, a provider asked a specific question about how to calculate the amount to be deposited in his funded depreciation account. The department's reply was "our attorneys have advised us not to answer that question." Another provider asked how to classify particular staff of his facility. The response was that "Based on Rule 53's cost classification provisions, the provider must make the classification." The Pol-

icy Center has maintained consistency in its responses by not interpreting the rule.

As we described earlier in this chapter, the reimbursement system for ICFs/MR is complex. In addition, Rule 53 is complicated and in places vague. Some ICF/MR providers are large, with their own staff accountants. But others are small, with only minimal accounting and legal assistance. Because the department has done a good job of removing the opportunity for excess profit from the system, it is even more important that providers know how to work within the system. They need to know how to conduct their business so that they can be reimbursed for all legitimate expenses. It is the responsibility of the Long Term Care Management Division to disseminate information about state policy and rule interpretation. We found, however, that:

- **The Long Term Care Management Division generally does not educate providers about its interpretations of Rule 53.**

It is clear that providers need additional training on Rule 53.

Only one training session has been offered to providers. That session took place just before Rule 53 (permanent) took effect, and was designed to inform providers about the changes from the old rule. No provider had at that time filled out a Rule 53 cost report. Neither the department nor providers knew what difficulties to expect. Now, after almost five years of experience with the rule, it is clear that additional training is needed. The department has offered none, and told us that it plans to offer none in the future, except for some training related to the proposed case-mix reimbursement system.

The department also uses bulletins to disseminate information. For example, updated interest rate and investment per bed limits are transmitted in instructional bulletins, as is information about amendments to rule or recent legislation. However, the bulletins do not explain how providers should use the information for record keeping or filling out cost reports. We reviewed the bulletins sent by the Long Term Care Management Division and found:

- **Since December 1985, 15 informational or instructional bulletins have gone out to providers, but only two gave specific direction on allocating costs.**

Those two were in December 1985 and February 1986. One answered questions about the transition from temporary Rule 53 to permanent Rule 53, and the other dealt briefly with the question of estimating time spent by employees on various activities, although the answer given is vague, and has been of little help in avoiding problems since. No bulletin since 1986 has included any specific instructions or interpretation regarding Rule 53, despite repeated requests from providers for guidance and a growing backlog of appeals.

Recommendations

The Long Term Care Management Division should take the lead in improving the relationship between DHS staff and providers. If the relationship is to

succeed, the division, with guidance from the Legislature and higher levels within DHS, must formulate a coherent, consistent overall policy towards the ICF/MR system. If the state is going to continue to rely principally on private ICFs/MR, DHS must develop a plan to make the public-private partnership work better. The plan should, of course, reflect legislative policy, and it should address what types of facilities are preferred, as well as how quality care will be encouraged. The plan should also set forth a cost control strategy that is fair and consistent, and that recognizes the state's interest in a financially viable service delivery industry.

Once an overall policy direction has been determined, we recommend that:

- **In conjunction with other divisions that are part of the reimbursement system, the Long Term Care Management Division should clarify its interpretation of the rule. If necessary, the formal rule-making process should be used. But when possible the division should issue written interpretive policy statements.**

We recognize that the rule-making process is difficult. We also recognize that the question of whether or not interpretive statements require rule-making is clouded by conflicting case law. Finally, we recognize that no rule and no level of interpretation can ever result in a total absence of controversy. As much as providers demand consistent directions from the department, they also resist being told in too much detail how to conduct their business. However, the working relationship between the department and providers has deteriorated to such an extent that we believe the department must act, even though the legal and administrative processes it must follow are complex and even though it may lack the full support of providers. The impending change to a case-mix reimbursement system, with its own complexities and potential for conflict, makes it even more important that the department and providers cooperate. Therefore, we recommend:

No rule or interpretation can ever result in a total absence of controversy.

- **Together with the Audit Division, the Long Term Care Division should clarify what constitutes adequate record keeping for various ICF/MR costs.**

The department should, whenever possible, develop and disseminate forms which providers can use to meet the requirements. Vehicle-use logs and employee time records are examples of problem areas which could benefit from clearer requirements.

We also recommend:

- **The division should define administrative and program costs.**

Again, we realize this is a difficult task. The department has tried before, and continues to try, to reach agreement with providers on which costs belong in each category. However, any rational, consistent allocation of costs to each category would be preferable to the current situation in which most providers file appeals almost every year.

Once the division has formulated a policy and decided how it will interpret the various provisions of Rule 53, it must communicate that policy to providers. To assure that providers are aware of department policies, we recommend:

- **The division should prepare and make available training materials to assist providers in the proper allocation of costs and in filling out cost reports.**

Provider training need not be costly.

The training need not be onerous or costly to the department. For example, videotaped training sessions could be made available to providers, and updated periodically, without a large commitment of time or money by the department. In addition:

- **Information bulletins should include specific, detailed information about DHS reimbursement policy; and**

- **The Policy Center should answer provider inquiries within the five days it promises, or notify the provider that the response will take longer. Answers should include enough detail to be useful to the provider in its particular situation.**

Improving training and communication may require an initial commitment of state dollars, but we believe the expenditures would be economical in the long run. Audits should be less time-consuming when policy is more clearly defined, and appeals staff may spend less time defending against providers' rate appeals.

AUDIT DIVISION

The ICF/MR reimbursement process requires the DHS Audit Division staff to work closely with providers. As we explained earlier in this chapter, auditors conduct annual desk audits of facility cost reports and less frequent but more detailed field audits. As Table 3.1 shows, nearly a third of the providers in our survey said that they turned to auditors with questions about their cost reports. The relationship between the two groups is inherently difficult, but it should also be constructive. Ultimately, the ability of providers and DHS auditors to communicate effectively affects the quality and consistency of services for ICF/MR residents.

In this section we asked the following questions about the DHS Audit Division:

- **How effectively does the auditing function contain ICF/MR costs?**

- **What is the role of the Audit Division in communicating reimbursement rules to providers? Do audit staff communicate reimbursement rules clearly and consistently? Are interpretations consistent from year to year and from auditor to auditor?**

- **When auditors and providers disagree about interpretations, how do they resolve their differences? How do auditors correct errors they make during the auditing and rate setting process?**

Cost Containment Through Auditing

As we discussed in Chapter 1, our 1983 study of community residential programs for mentally retarded persons recommended that DHS develop stronger cost control measures. The department integrated most of our suggestions into Rule 53. Audit Division staff have an important role because they are in a position, through desk and field audits, to execute the cost containment stipulations in the rule. We observed during the present study that:

- **Audit Division staff have been very conscientious in their application of the cost control measures in Rule 53.**

DHS auditors carefully regulate ICF/MR expenditures.

In Figure 1.1, we showed that total ICF/MR expenditures leveled off and then declined between 1985 and 1990, following a period of dramatic increases. The 1983 moratorium on new ICF/MR development, the implementation of Rule 53, and the Audit Division's strict regulation of costs all contributed to this stabilization in ICF/MR expenditures.

Our interviews and case studies showed that auditors strictly regulated areas in which costs had skyrocketed under Rule 52, such as administrative expenses. We observed in Case 4, for example, that auditors questioned a proposed facility's estimated costs because the costs were high compared with costs for the provider's other facility. In general, the auditors' skepticism is appropriate, since the responsibility of the Audit Division is to monitor the use of state funds by private ICF/MR providers. However, as we pointed out earlier in this chapter, at times their conclusions seem to lack a firm foundation in departmental policy.

The Audit Division's Communication with Providers

As we explained in the previous section, staff of the Long Term Care Management Division are responsible for disseminating official DHS policy concerning the interpretation of Rule 53 through the Policy Center. In reality, however, we found that:

- **DHS often communicates about Rule 53 through desk audits, field audits, and phone calls from providers to DHS auditors.**

Providers are most likely to ask auditors how to apply Rule 53.

Table 3.1 shows that, of the providers who responded to our survey, nearly a third said they contacted a DHS auditor with questions about their cost reports. According to providers, the auditors are often their most frequently contacted and sometimes their only source of information about Rule 53. Therefore, the auditors' interpretations of the rule are influential.

Figure 3.2: Case 4—Interim Rate for a New Facility

Case 4 involves a provider in Ramsey County. The provider is a privately owned corporation that delivers a variety of services to developmentally disabled Minnesotans and those who work with them. The company owns two ICFs/MR, which constitute about 20 percent of its business.

On July 14, 1989, the provider submitted an estimated cost report and requested approval of an estimated interim rate for a new four-bed ICF/MR. At that time, the provider had not yet purchased a house and was hesitant to do so until DHS approved an interim rate. DHS preferred not to establish an interim rate until the provider had purchased a facility. The auditor also questioned why estimated costs were high compared with the provider's other facility. In November 1989, DHS audit staff, at the urging of Legal Aid Society staff, established an estimated interim rate so that the provider could proceed with the purchase of a house. When a house for the new facility had been purchased, the provider sent DHS a revised cost report for a projected opening date of April 1. A DHS auditor called the provider on April 13 and asked for additional supporting detail for the revised cost report because it differed from the estimated one. The provider sent the materials on April 16, and the interim rate was issued on April 17.

When the rate notice arrived, the provider noticed an error and notified the auditor, who said that he could not correct the error at that point and that Rule 53 makes no provision for appeals of interim rates. The provider would have to wait until the end of the first reporting year, the "settle-up period," to correct the problem. The provider then called an Audit Division supervisor, who corrected the error and reissued the interim rate on May 7, 1990.

The provider's representative was frustrated by the process of opening a new facility. In particular, the provider asserted that the process should be more flexible and should be completed more quickly. Audit Division staff told us that some difficulties in the case arose from complications inherent in the interim rate setting process, especially when the provider is opening a new facility and has not yet purchased the property. The provider was approved to develop two additional ICF/MR facilities but decided not to proceed because of inflexibilities in Rule 53.

Opening a new facility under Rule 53 is a complex and lengthy process.

Audit staff corrected the error in the interim rate because they discovered that, though it had officially begun, the rate had not yet been entered into the department's computer. Therefore, audit supervisors concluded that they could correct the error immediately. Had the information already been entered into the computer, auditors said they probably would have insisted on waiting until settle-up, though Rule 53 does not forbid DHS from correcting its own errors.

While the department responded to the difficulties this provider was having by establishing an estimated rate, the solution was reached in part at the insistence of an outside force, legal advocates. The department does not currently have its own system for working with providers on the opening of new facilities so that these services, which county staff have deemed necessary, can begin as quickly and smoothly as possible.

Many providers have indicated that they had difficulty understanding some parts of Rule 53 as interpreted by the Audit Division. As Table 3.2 shows, in our survey:

- **More than half of the providers said that the reasons DHS made rate adjustment were rarely or never clear to them.**

Table 3.2: Providers' Comments About the Department of Human Services Audit Division's Administration of Rule 53.

	Percent of Provider Organizations			
	Always or Usually True	Sometimes True	Rarely or Never True	Don't Know
The reasons for rate adjustments are clearly explained to us.	8.2%	39.6%	52.1%	0.0%[a]
Decisions about allowable costs are understandable.	5.2	47.1	47.6	0.0
Decisions about allowable costs are clearly linked to Rule 53.	6.5	58.7	28.9	5.9
We know which costs are allowable.	15.7	66.4	16.9	1.0

N = 103 provider organizations.

Source: Office of the Legislative Auditor analysis of ICF/MR Provider Survey responses.

[a]Percentages may not total 100 percent due to rounding.

Many providers are confused about why some of their expenditures are not reimbursed.

Providers in our case studies also commented that they had received rate adjustments with no explanation. Audit staff told us that they developed a more concise rate notice format in response to provider complaints, and in 1990 the division installed a watts telephone line so outstate providers can ask for explanations.

We spoke with providers who also complained that they could not get clear answers from DHS staff; rather, they got information through desk and field audits. Moreover, providers alleged that this information sometimes differed depending on which auditor provided it. In our survey:

- **Forty-seven percent of providers said that they rarely or never understood how DHS made decisions about what were allowable costs.**

In response to open-ended questions, about 24 percent of providers explained that they had particular trouble distinguishing program from administrative costs.

All of these communication problems were apparent in one of our case studies (Case 5), in which the provider was confused because the DHS desk auditor reclassified some 1988 program costs that had not been questioned before. In that case, the provider had failed to maintain time distribution records as required by Rule 53. This provider was one of many who said they were un-

Program and administrative costs are particularly hard to distinguish.

Figure 3.3: Case 5—Reclassification of Program Costs

Case 5 involves a provider who owns and administers two nonprofit Class A ICFs/MR. Both facilities serve adults with dual diagnoses of mental retardation and a variety of additional problems.

In April 1989, the provider submitted to the Department of Human Services cost reports for the year ending December 31, 1988. DHS Audit Division staff requested position descriptions and daily calendars or diaries to help determine the allowability under Rule 53 of the Program Director and Unit Coordinators' salaries. The provider sent position descriptions but explained that no daily diaries had been kept for these positions. The provider's staff told us that these positions had been classified as program expenses since 1979 and had not been questioned by DHS.

In September 1989, the provider received its 1990 rate notice, based on the Audit Division's desk audit of the 1988 cost reports. The department had reclassified the Program Director and Unit Coordinator positions to the administrative category, so that their salaries were no longer reimbursable as program expenses. Since the provider had exceeded the administrative reimbursement cap, DHS would not reimburse the salaries as administrative costs. Moreover, with the salaries removed from program costs, the provider had "underspent" in the program category and was required to return the difference. Paybacks were due for both 1988 and 1989. The provider's accounting firm calculated that the total payback would be more than $120,000.

In September 1989, the provider appealed the desk audit findings. DHS and the provider reached a partial settlement of the appeal in April 1990, but the program reclassification issue remained open. Payback was scheduled to begin on October 1, 1990.

The provider's administrative staff told us that they will be unable to survive financially if the paybacks are enforced. They also reported that DHS Appeals staff said they would not settle the program reclassification issue until after other such appeals have been settled by the administrative law judge, which DHS anticipated would take at least 18 months.

DHS appeals staff and the provider are negotiating to resolve this case. Since program cost reclassifications have affected many providers recently, DHS has agreed not to collect paybacks through per diem rates until appeals are settled.

In this case, it appears that both DHS and the provider have valid points. On the one hand, Rule 53 does state that staff who are not top management and who have multiple duties must keep records of time spent in each activity. The program director and unit coordinator position descriptions list many activities that appear to be administrative, indicating that the provider should have kept time distribution records. On the other hand, DHS had not questioned these costs in previous cost reports, so the provider believed that they were allowable as program costs. This case demonstrates the poor communication between the Department of Human Services and providers and also shows some inconsistency in the department's interpretation of Rule 53.

clear about how to define program costs and time distribution records. We interviewed both this provider's representatives and DHS staff and found that they were negotiating a resolution. However, the problem has involved many staff and still threatens the provider's financial viability. Using the auditing process to communicate about Rule 53 is costly and time consuming, particularly without the guidance of clearly defined policies.

Based on our case study findings, we believe that communication problems between auditors and providers are exacerbated by their suspicion of one another. In Case 4, the provider's representatives, who believed they had a good relationship with DHS before 1988, used accountants and hired an attorney to handle communication with DHS. Other providers also told us they had hired attorneys within the last few years to intervene with DHS. Some providers expressed concern that DHS auditors operate under a "quota system" requiring them to make large disallowances. We were shown a memo recommending an auditor for a merit raise in part because he had disallowed a large sum in the past year. DHS staff told us that their attorneys have prepared an affadavit denying that the department uses a disallowance "quota system" as a basis for merit increases. This interchange is an example of the anger and suspicion which characterize the relationship between DHS and ICF/MR providers.

Providers and DHS staff expressed mutual distrust.

Auditors frequently expressed to us their distrust of some providers. The auditor in Case 3 clearly demonstrated this in a note in the work papers in which he assumed that the provider was allocating nursing costs to the program category for his own benefit, without checking with the provider for additional information. We also were told by several auditors that they believe that providers "shop around" among auditors to get the Rule 53 interpretation that benefits them most.

We concluded that:

- **The negative relationship between DHS auditors and providers hinders the communication flow essential to efficient administration of Rule 53.**

Some providers we spoke with believed that high turnover and inadequate training decreased the consistency in audit findings over time. However, in our examination of audit staffing, we found that:

- **Turnover in audit staff has declined in general and is very low at the supervisory level.**

Audit supervisors told us that turnover was 28 percent during fiscal year 1988. However, in the past two years, only three out of 32 staff have resigned, and three were transferred to the Appeals Division. The turnover rate was 12.5 percent in fiscal year 1989 and 6.2 percent in 1990. At the supervisory level, no staff have left since 1986, when the previous director retired.

Entry-level DHS auditors must have a four-year accounting degree or education plus experience equal to four years, which DHS staff told us is standard for entry-level auditors. Moreover, we learned that the division usually promotes from among current staff, which may reduce turnover. We conclude that:

- **Neither lack of staff training nor high turnover explain the inconsistencies in audit findings.**

Rather, the lack of clear department policy to guide auditors better explains audit inconsistencies.

The Correction of DHS Auditing Errors

A common complaint from providers was that DHS staff seemed unwilling to correct their own errors made during the rate setting and auditing process. For instance, in one case study (Case 4), DHS staff initially told the provider that they would not correct an error the auditor had made in the provider's interim rate and that the provider could not appeal. The provider called audit supervisors, one of whom eventually corrected the error, but only because the interim rate was not yet entered into the computer.

Errors by DHS auditors are sometimes not corrected and require appeals by providers.

The department has a clear policy about error correction. Audit staff we spoke with said that they tell the provider to go through the appeals process, even if the auditor clearly made an error. Auditors told us they adhere to this policy to give themselves time to examine the alleged error carefully. While we acknowledge that this policy is prudent in general, providers can be financially damaged when no alternative exists. In Case 2, for example, a small nonprofit provider had to appeal a disallowance which auditors admitted was an error. For the provider, this error amounted to an unreimbursed expenditure of more than $14,000, a payback of about $26,000, and the loss of an efficiency incentive payment. Since most of this money had been spent, going through the appeals process put the provider in financial difficulty. Moreover, turning to the appeals process when an auditor has made an error is costly to the state.

In our review of Audit Division procedures, we found that, by their own admission:

- **Audit staff have been unable to complete the federally required annual field audits of 25 percent of ICF/MR providers.**

We believe that this problem will be eased if auditors work with other DHS divisions to clarify Rule 53 and to communicate more productively with providers. We also believe that the Audit Division would benefit from a thorough examination of the basis for desk and field auditing procedures. While compliance auditing requires that expenditures be carefully scrutinized, an important concern should be for the provision of quality services in a timely manner.

DHS, including the Audit Division, should be alert to any problems that interfere with the smooth and efficient provision of services.

Recommendations

We found that the Audit Division has done a conscientious job of administering the cost containment measures which were integrated into Rule 53 following our 1983 report. However, in both our provider survey and case studies we found that DHS and providers have a seriously strained relationship that interferes with clear communication and smooth administration of the rule. We recommend that:

- **The Audit Division should work with other DHS divisions to devise a plan for repairing their relationship with ICF/MR providers.**

The relationship between providers and auditors need not be friendly, but it should be businesslike. While providers must share responsibility for the damaged relationship, DHS is a state agency and, as such, has responsibility for providing services to Minnesota citizens with mental retardation. For the Audit Division, skepticism is appropriate and even healthy; animosity is not.

Auditors should work with other divisions to improve communication and cooperation with providers.

While Long Term Care Management is responsible for Rule 53 policy creation, interpretation, and dissemination, the Audit Division staff must participate in any attempt to improve communication with providers. Because auditors are most directly involved in the application of Rule 53 and of accounting procedures, we recommend that:

- **The Audit and Long Term Care Management Divisions should work together to define terminology in Rule 53 and to design methods and forms, such as those needed for maintaining time allocation records.**

As part of the process of improving communication between providers and the department:

- **The Audit Division should proactively seek out areas of confusion and should work with the rest of the department to help providers better understand Rule 53.**

In the long run, providers, the state, and clients will benefit when problems are solved before they result in large paybacks, lowered per diem rates, and wasted staff time.

To address the issue of error correction, we recommend that:

- **The DHS Audit Division should develop a procedure for correcting auditing errors without resorting to the appeals process.**

This recommendation applies only when Audit Division staff determine that their auditor has made an error, not when providers and auditors disagree

over whether an error has been made. Rule 53 does not prevent DHS auditors from correcting their own errors made during the rate setting and auditing process. Moreover, it is costly to insist that even calculation errors made by auditors be submitted to the Appeals Division. A period of time such as two weeks should be sufficient for auditors to determine whether they are the source of an error and, if they are, to correct the problem. If the source of the error remains unclear or if DHS staff believe that the disputed issue is not an error, then we agree that appeals are appropriate.

Appealing calculation errors made by DHS auditors is costly.

Finally, we recommend that:

- **The Audit Division should examine its own desk and field auditing procedures to identify and correct those that interfere with the smooth provision of services to clients with mental retardation.**

In general, we suggest that auditors consider their role to include helping providers to understand Rule 53 and to keep whatever records are necessary for efficient auditing. This would enable providers to deliver services more efficiently. It would also help DHS auditors fulfill their federal field audit quotas, and ultimately it would help prevent ICF/MR residents from being hurt by the effects of infrequent audits and large provider paybacks.

THE PROVIDER APPEALS DIVISION

The Provider Appeals Division is the last step in the ICF/MR reimbursement process. As such, it is important that the appeals process be open, understandable to providers, and consistent in its results. Because providers' appealed per diem rates cannot be increased until the appeal is resolved, it is important to them and to residents of their facilities that appeals be resolved as quickly as possible. We asked these questions about the Provider Appeals Division:

- **How many active appeals does the division have? Is the backlog growing or shrinking?**
- **How long does it take for appeals to be resolved?**
- **How does the division set priorities among pending appeals?**
- **How well does the division communicate with providers about the status of appeals and reasons for settlement decisions?**

The Appeals Backlog

When we studied the ICF/MR system in 1983, we found that the Provider Appeals division had a backlog of 150 appeals from ICF/MR providers. We also found that the department had no information about the characteristics of

pending appeals, and no clear set of priorities among pending appeals. New appeals were added to the backlog with no obvious effort to prioritize cases.

In 1990, we found that:

- **The backlog of appeals has grown to over 500, with an additional 200 (approximately) expected, based on the September 1990 rate notices.**

There is a growing backlog of appeals.

Some of the appeals in the backlog are more than ten years old, dating back to Rule 52, the previous reimbursement rule. Although the oldest appeals have now been set on for hearing by the Office of the Attorney General, the growth in the backlog represents a serious problem.

The Timeliness of Appeals Settlements

Of providers who responded to our survey, 52 percent said that rate appeals are rarely or never settled in a timely manner. We drew a random sample of appeals that had been filed since 1985 and have since been settled. We chose to look only at appeals filed under permanent Rule 53 because they are more representative of the work the Provider Appeals Division does today. Almost 400 Rule 53 appeals had been resolved by July 1990. We collected data on how long each appeal was open and how much the provider's rate changed as a result of the settlement. As Table 3.3 shows:

- **It took an average of about 15 months to settle the appeals in our sample. About 21 percent of the appeals took two years or more to resolve.**

Table 3.3: Change in Providers' Per Diem Rates After Appeal

Facility Type	Average Rate Before Settlement	After Rate After Settlement	Change	Average Time to Settle (days)
Single, For-Profit	$67.50	$71.04	5%	512
Single, Non-Profit	64.18	67.65	6	309
Small Group, For-Profit	65.50	71.80	11	474
Small Group, Non-Profit	77.63	83.03	8	399
Large Group, For-Profit	58.14	62.04	7	682
Large Group, Non-Profit	60.01	62.76	5	627

Source: Office of the Legislative Auditor analysis of sample data from Provider Appeals Division files.

On average, the providers' per diem rates were $4.67, or 7 percent, higher after settlement. We have no way of knowing what the per diem rates would have been based on providers' original cost reports, so we do not know if the 7 percent increase after appeal represents a gain for the department or the provider. In many cases, the final settlement may represent a compromise between the two parties.

Some providers told us they suspected that the department treats for-profit providers differently from nonprofits. Others felt that small providers had more difficulty with the appeals process. We analyzed our sample data based on the size and profit status of providers. We found:

- **On average, it took about five months longer to resolve appeals filed by for-profit providers than nonprofit providers of the same size.**

It is by no means clear that this represents discrimination against for-profits, however. For-profit providers usually have more complicated financial structures, and so present more difficult appeals cases, than nonprofit providers. Appeals by providers who operate several facilities took the longest time to resolve. These providers also have more complicated financial arrangements, so one would expect their cases to take longer. We found that:

Appeals which took the longest to resolve were from providers who operate several facilities.

- **The average time to settle for providers with several facilities was almost two years.**

Under Rule 52, while an appeal was outstanding the provider continued to receive the funds in question, and so had little incentive to resolve the appeal. Now, under Rule 53, the department holds the funds and has no financial incentive to settle. Some providers have been informed recently that the department will not address their appeals in any way until certain large, older appeals are resolved. The division estimates that it may take 18 months to resolve those appeals. However, the provider involved in several of the older appeals told us that they may never be resolved. This means that some appeals could be open for three years or longer before any attempt is made to settle them.

In some cases, such as our first and second case studies, recent appeals are based on what appear to be simply mistakes made by auditors. Yet, because the issues are in some way related to the older cases, the division refuses to settle them, and some providers must operate indefinitely with reduced rates.

The Expedited Appeals Process

The 1988 Legislature directed the department to develop an expedited appeals process. The expedited process is applicable to desk audit appeal items with a value of $100 or less per licensed bed. The division director has sole discretion to determine which appeals or issues within appeals will be expedited, although a provider may ask the Office of Administrative Hearings to review the director's decision. We found that:

- **There are no formal written rules for assigning an appeal to the expedited process.**

The department has in some cases informed providers that, while their appeals fit the guidelines for expediting, the department has declined to do so.

Often no explanation is given for the decision. For example, the text of one letter from division staff to the provider in case study number 2 reads:

> The above-mentioned appeals contain issues which qualify for treatment under the expedited appeal review process, but which are shared by other providers. The Department will not be addressing these issues through the expedited process by authority of Minnesota Statutes 256B.50, subd. 1d.(f).

As Table 3.4 shows, about half of the appeals filed in the two years the expedited process has been operating have gone through that process. However, only 33 appeals, or about 8 percent, were completely resolved that way.

Table 3.4: Results of Expedited Appeal Process

	10/1/88	10/1/89	Total
Total Desk Audit Appeals Filed	226	191	417
Appeals Subject to Expedited Process	113	100	213
100 Percent Expedited	11	22	33
Partially Expedited	102	78	180
Resolved by DHS Determination	96	84	180
Resolved by OAH Review	17	16	33
Results of OAH Review			
DHS Removed From Process	0	3	3
Conceded by DHS	10	5	15
DHS Upheld	5	7*	12
DHS Reversed	2	1*	3

Source: Department of Human Services, Provider Appeals Division.

*7 of the 8 decisions were mixed—some issues within the appeals were decided the opposite way. Appeals are listed here according to the most common result in each case, according to Appeals Division staff.

Assigning Priority to Providers' Appeals

The Provider Appeals Division has instituted a computer system on which appeals and the issues involved in each appeal are entered for each facility. But we found:

- **Appeals staff do not keep records on the importance or precedential value of each outstanding appeal, and no one in the division was able to tell us the dollar value of outstanding appeals.**

One attorney is responsible for most ICF/MR appeals, although other attorneys do handle some cases. Each attorney keeps separate records, and should know where in the appeals process each case is. In some cases, the attorneys also know approximately how much money is involved. However, there has been some turnover among the appeals attorneys and, with no formal record keeping, each new attorney must virtually start over again. The attorney who

had been handling most ICF/MR cases left the department in September, for example. She told us that when she began in the division, she first had to determine on her own the status of each case and whether it could be resolved quickly.

We also found:

- **There is still no formal system for prioritizing appeals.**

One attorney in the division told us that, when she receives new appeals, she tries to determine which ones might be resolved quickly and informally, and attempts to resolve those first. In other cases, if a provider calls repeatedly claiming that delay in resolving an appeal would cause great financial difficulty, she will devote time to that appeal. Nevertheless, we found a number of appeals that have been given low priority, even though they might have been resolved, because they are related in some way to other cases the division is intent on winning.

Communication with Providers

As is the case with the other DHS divisions that work with ICFs/MR, we found that:

- **The Provider Appeals Division resists committing itself to any binding interpretations of Rule 53.**

For example, we noted that:

- **Division staff frequently remind providers that expedited case settlements do not set precedent, and decisions by a hearing examiner are binding only on the current case.**

In one case, for example, the cost of insurance for a facility vehicle was disallowed. The provider appealed and won. The next year, the same insurance on the same vehicle was again disallowed, and the issue again had to be appealed. Appeals Division staff told us that the Office of Administrative Hearings usually takes the department's point of view. However, if the department does lose a case, staff sometimes assume that the hearing examiner made a mistake or the division's attorney did not present the case effectively. In those cases the division will force an appeal again the next year.

Providers are frustrated when they must appeal the same issue over again.

The failure of the Provider Appeals Division to develop precedents on which providers can rely has contributed to the extremely poor relationship between providers and the department. It is frustrating to providers to be required to appeal what they view as the same issue over again. At times, the division has good reasons for not settling an appeal as quickly as the provider would like. However, division staff do not communicate the reasons to providers, who are left with the impression that decisions are made capriciously.

The attitude that some division staff have adopted toward providers has exacerbated the situation. During the course of our study, we reviewed a great deal of correspondence between division staff and providers. We were surprised and disappointed at the tone taken by some staff. Some letters from staff to providers were condescending and contentious, and did not contribute to building a cooperative relationship. The following is an example.

> This issue will immediately be referred for hearing if I have not received a letter of withdrawal from you by December 18....The provider is now complaining that what it requested and received is not fair because its efficiency incentive was decreased....This provider must have or should have known that if it won this appeal its rate would decrease because the efficiency incentive would decrease. The provider cannot now complain that it has not been treated fairly or received what it asked for. The Department is merely enforcing this part of the rule exactly as written. If the provider has a complaint it is with its legislator not the Department of Human Services.[4]

Regardless of any provocation by providers, division staff have a duty as civil servants to treat the public respectfully and to act in a professional manner. This letter, addressed to a provider's representative and copied to the provider, may not be representative of the behavior of all staff. But the fact that any such correspondence is tolerated is regrettable.

Recommendations

At the current rate of disposition, the backlog of appeals by ICF/MR providers will continue to grow indefinitely. Meanwhile, some providers will wait years for their appeals to be settled. The Provider Appeals Division needs to work to reduce the current backlog of appeals. This will likely require more staff, at least temporarily, and the department should reassign existing staff to work on this project or, if it believes that all current priorities supercede this project, seek additional funding for the necessary complement.

New appeals should be resolved more quickly in the future.

New appeals should be resolved more quickly in the future. An average of almost two years to settle appeals is far too long, from the point of view of both the state and providers. We understand that it is sometimes the provider who delays settlement, and we think that should not be allowed, either. We recommend:

- **Any appeal that cannot be resolved informally within 180 days of filing should be set for hearing by the Office of Administrative Hearings.**

The Commissioner is not required to accept OAH recommendations, but the department should consider the results of previous hearings in attempting to resolve appeals. Forcing providers to appeal the same issues year after year is wasteful of state resources, which could be better spent providing care for ICF/MR residents. After five years of operating under Rule 53, the division

4 From the files of the DHS Provider Appeals Division.

has a body of settlements and court decisions with which to work. With that information, both staff and providers should be able to predict the outcome of provider decisions, and avoid appeals of issues that have been resolved in the past.

We also think that the expedited appeals process should be more certain. We recommend:

- **The Provider Appeals Division should write and adhere to guidelines for the use of the expedited appeal process.**

When an appeal or an issue within an appeal falls within the guidelines, the process generally should be used. If the division manager determines that an appeal is not within the guidelines, then the provider should promptly receive a written explanation of the decision.

Any state agency should be able to show the costs and benefits of its work. Currently, the Provider Appeals Division has no way of knowing how much benefit is gained from its work, because it has no information about what rates would have been in the absence of appeals. We recommend:

- **Together with the Audit Division, the Provider Appeals Division should begin compiling data that would show providers' rates based on their original cost reports, versus the rate established after the desk audit and appeal process.**

In our opinion, it is not strictly necessary that the two divisions recover more money than they spend. Lawmakers and citizens need to know how state money is spent, and providers need to be held accountable, even if that entails net cost to the state. But with good data both divisions would be better able to prioritize their work, concentrating more effort on cases with the potential to save significant amounts of state funds.

Finally, as with all of the divisions working with the ICF/MR reimbursement system, we recommend:

- **The Provider Appeals Division needs to improve its working relationship with providers.**

Appeals division staff should be skeptical, but not hostile.

Perhaps because of their experience and legal training, division staff take a skeptical view of providers' claims. While that is appropriate for a regulatory agency, a hostile, disrespectful attitude is neither necessary nor appropriate.

HEALTH CARE SUPPORT DIVISION

The DHS Health Care Support Division operates the residential services invoice (RSI) billing system. In October 1988, DHS began using this new computer system to reimburse ICF/MR (and nursing home) providers for their

services, based on billing invoices which providers submit each month for each facility.

The RSI system contains a number of edits. For example, the system can be used to check for duplicate claims, identify billings for hospitalized clients, and track changes in Medicaid eligibility. Many edits require a manual review, but if a problem has generally been caused by provider error, the system automatically rejects the claim and returns it to the provider. For the system to work accurately, counties must provide up-to-date information, especially about Medicaid eligibility and living arrangements.

Some providers told us that the RSI billing system has inaccurately suspended claims and was slow to process error-free claims, especially when the system first went into operation. To examine the efficiency of the RSI billing system, we asked:

- **How often are claims suspended, and for what reasons? How long are claims held in suspension?**
- **How quickly and easily are billing system errors corrected?**
- **Are error-free claims paid promptly?**

Overall, we found that:

- **The Health Care Support Division is working productively with provider representatives to resolve RSI problems.**

The Suspension of Provider Claims

Providers told us that, in general, billing problems were less troublesome to them than other issues, such as unpredictable cost disallowances. Some providers said that, while they had experienced many billing problems earlier, the situation has improved. However:

Problems with the billing system have eased.

- **Half of the survey respondents complained that they rarely or never knew how to correct claims that had been suspended.**

Provider representatives and DHS staff have met several times in the past year to discuss RSI problems. In part as a result of this cooperation, DHS decided to conduct training and refine the system.

Many providers complained about having claims held in suspension for a year or more and reported being told that after a year the claims were no longer payable. DHS invoice processing staff reported that they were aware of processing delays and would still consider older claims when the provider was clearly attempting to resolve the issue.

Both DHS staff and some providers said that sometimes counties provide inaccurate data or fail to update data promptly. Providers alleged that more than half of their suspended claims could be traced to the counties' inability to process Medicaid eligibility claims before providers submit their invoices to DHS.[5] To resolve this problem, the department is scheduling RSI training for county staff throughout the seven-county metro area and for some staff in non-metro counties where the need seems to be greatest.[6]

Correction of Billing System Errors

In our survey, some providers complained that sometimes their claims were rejected because of billing system problems, such as errors that occur during machine scanning of the claim forms. Billing staff told us that the original program lacked override capabilities, so many claims were rejected or suspended which could have been corrected manually. Currently, programmers are correcting this problem by building manual overrides into the program. Staff also said that some larger providers have begun to bill electronically, which eliminates scanner errors because providers can transmit their claims directly and correct errors at their facilities.

DHS staff believe that billing system (and other) errors will be more easily corrected with a new on-line information system, Maxis, which is planned for full production by October 1991. The Maxis system should provide quicker turnaround and will automate the determination of Medicaid eligility, so county staff will be able to provide more timely information.

Payment of Correct Claims

Some providers we spoke with said that their claims were not paid quickly enough. We used our provider survey to see if this perception was widespread. Table 3.5 shows that in our survey:

- **More than 84 percent of providers said that their invoices were generally paid within 30 days.**

The state pays most bills for ICF/MR services within 30 days.

A minority, about 15 percent of respondents, said that this was rarely or never true. Data from the billing system records, shown in Table 3.6, corroborate the providers' responses. According to records for January to June 1990:

- **At least 96 percent of claims for each month were adjudicated—that is, paid, rejected, or suspended and resolved—within 30 days.**

For example, for claims filed in January 1990, 112 out of 4,475 claims were still in suspension after 30 days. DHS records further showed that within 90 days, the number of suspended January claims was reduced to 40. Most pro-

5 David Kiely, Rick Carter, and Gayle Kvenvold, letter to Ann Wynia, Commissioner of Human Services (August 3, 1990).

6 Ann Wynia, Commissioner of Human Services, letter to Rick Carter, President of Care Providers of Minnesota (August 8, 1990)

Table 3.5: Providers' Comments About the Department of Human Services Health Care Support Division

	Percent of Provider Organizations			
	Always or Usually True	Sometimes True	Rarely or Never True	Don't Know
Our provider invoices are paid by DHS within 30 days.	38.1%	46.1%	14.8%	1.0%
When our claims are suspended, we know what to do to correct the problem.	4.9	39.0	53.7	2.4

N = 103 provider organizations.

Source: Office of the Legislative Auditor analysis of ICF/MR Provider Survey responses.

Table 3.6: ICF-MR Claims Suspended and Adjudicated for January to June 1990

	Total Number of Claims	Average Days From Data Entry to Payment or Rejection	Number of Suspended Claims	Average Number of Days in Suspension	Percent Claims Adjudicated in 30 Days
January	4,475	1.79	634	9.4	97.5%
February	4,449	1.39	852	5.17	98.6
March	4,530	2.73	2,588	3.07	98.2
April	4,526	2.14	2,392	2.77	97.8
May	4,561	3.31	2,823	3.83	96.2
June	4,463	1.05	576	3.04	97.1

Source: Department of Human Services.

viders we contacted and DHS staff seem to agree that, with a few exceptions, recent claims are paid promptly.

Recommendations

DHS claims processing staff and providers appear to be making a concerted and successful effort to resolve problems in the billing system. According to providers in our survey, these efforts are beginning to speed up the payment process, though many of these providers are still confused about how to correct errors in their claims. We encourage DHS to continue its efforts, paying special attention to provider and county staff training.

DISCUSSION AND CONCLUSIONS

Chapter 4

In this chapter, we discuss the reimbursement systems used in some other states and their potential for use in Minnesota, and we articulate our overall conclusions about Minnesota's current reimbursement system for ICFs/MR.

ALTERNATIVE REIMBURSEMENT SYSTEMS

Regulation should be thoughtful and thorough.

While we think that it is appropriate for a regulatory agency to maintain a certain distance from the regulated industry, and that provider claims should be viewed with some skepticism, regulation should be thoughtful and thorough. In addition, in order for a complex system such as Minnesota's ICF/MR reimbursement process to operate smoothly, it is important that regulators and the regulated industry work together cooperativly.

Because we have found some provider complaints about Minnesota's reimbursement system to be justified, we looked into the reimbursement systems used in several other states to see if a different way of reimbursing ICF/MR costs had potential for use in Minnesota. Providers had expressed interest in systems where the audit and rate-setting functions were contracted to private vendors, and in those systems where providers contracted with counties, rather than with the state.

One state that contracts for audit and rate-setting services is Indiana. Minnesota providers told us that Indiana's system works well and is not costly. However, we found that Indiana has a very small ICF/MR system, with less than 20 facilities. That state has not had difficulty finding private firms that are able to take over audit and rate-setting functions, and the state is able to oversee the work. Minnesota, with a much larger ICF/MR system, would find it difficult to locate firms large enough to handle the task. This is particularly true because compliance auditing is different from the type of financial auditing that private accounting firms generally conduct, and would require specialized training of auditors. The state would continue to require an Audit Division to oversee the work of contractors, so it is not clear that money would be saved and, in fact, such a system would likely be more expensive. Finally, as we explained earlier, we think Audit Division staff have been very concientious in their efforts to conserve state dollars. We doubt that private auditors would have the same motivation.

Minnesota providers also recommended to us Wisconsin's system for reimbursing some residential facilities. Wisconsin gives counties a grant to pay for several types of social services, and counties contract with providers individually. We learned that, while providers in Wisconsin are satisfied with the system, the state is less satisfied, and counties are quite dissatisfied. From the state's point of view, costs have been reasonably well-controlled, although the official we talked to expressed the opinion that the state could do a better job of controlling costs. That official said that counties do not have enough leverage with providers, and so sometimes spend more than they would like. If counties spend more than the state has provided, they must pay for it out of county funds. We think the situation would be similar in Minnesota. Counties would be in a weaker negotiating position than the state, especially where only one provider is operating in the county. In addition, in Minnesota, the counties' share of Medicaid costs is very small, so counties do not have the same incentives as the state to control costs.

The case-mix reimbursement system should be an improvement over the current one.

Finally, as we discussed earlier, Minnesota will soon move to a case-mix reimbursement system. We talked to a state official in Maryland, where a case-mix reimbursement system has been in operation for about one year. He told us that, while the system does a good job of more equitably distributing funds to providers, it cannot solve the underlying problem of insufficient funding. Minnesota undoubtedly will face the same problem. In addition, as DHS staff pointed out, the case-mix system will have little chance of succeeding without the support and cooperation of providers. Nevertheless, if the relationship between the department and providers can be improved, the case-mix system should be better than the current one for both providers and clients.

CONCLUSIONS

In this report we have recommended some changes in the way the Department of Human Services administers the ICF/MR reimbursement system. We believe the changes would make the system operate more effectively and efficiently. However, technical and administrative changes alone will not correct the overriding problems we found.

The ICF/MR system was originally envisioned as a public-private partnership designed to allow mentally retarded citizens to receive the care they need in the community, with DHS staff and providers cooperating to create a service delivery system that is financially stable and provides quality care to ICF/MR residents.

As we conducted our study, we were struck by the extremely poor relationships between DHS staff and providers. The system we found has degenerated into one of conflict, distrust, and animosity between providers and DHS staff, where too often the needs of clients are forgotten. Advocates we interviewed worried that the conflicts between DHS and providers would result in:

- **Increased spending on lawyers and accountants rather than direct services to clients;**
- **Cutbacks on programs or staffing when providers face large paybacks;**
- **Anxiety for clients and their families when faced with the threat of a facility closing; and**
- **Stifled innovation or creativity in providing services.**

Providers must share responsibility for the current situation.

Providers must share responsibility for the current situation. Because they rely almost exclusively on public funds, and because DHS staff have a duty to regulate the use of those funds, some level of friction between providers and the department is perhaps inevitable. But providers have agreed to provide ICF/MR services, and must work in a businesslike, professional manner within the reimbursement system the state creates.

Nevertheless, we believe the state must take the lead in restoring the system to one in which the needs of clients come first and reimbursement issues are resolved in a timely and professional manner. To that end, we recommend:

- **The Department of Human Services needs to identify ways of making the current public-private delivery system operate more smoothly.**
- **State reimbursement policy should be clarified and communicated consistently to department staff, providers, residents, and advocates.**

Also, to foster a better ICF/MR system, the Legislature needs to articulate an overall policy which addresses these key questions:

- **Is the state still committed to a system of community residential care that relies primarily on private sector providers?**
- **If service providers are to be principally private, should for-profit or nonprofit providers be preferred? What size provider should be preferred?**
- **What level of service is the state willing and able to provide for developmentally disabled people?**

Reimbursement policy cannot operate in isolation from the rest of the ICF/MR system. At least in the immediate future the state must rely primarily on private providers for ICF/MR services. The reimbursement system affects the viability of those providers and the care they provide. Conflicts between department staff and providers should not be allowed to deteriorate to their current level. DHS staff must maintain an objective attitude and treat providers in a professional, businesslike manner. After several years of conflict, it will be difficult to repair the relationship between providers and staff. To begin the process, we recommend:

- **The department should consider consulting the Department of Administration, Management Analysis Division, for help in improving working relationships.**

If necessary, staff should be reassigned when relations are beyond repair.

While we believe it is crucial that DHS staff and providers begin to cooperate in providing ICF/MR services, we also believe that the ICF/MR industry, like other public-private enterprises, requires strong regulation. We recommend:

- **The Department of Human Services should continue its firm regulation of ICFs/MR.**

The ICF/MR system requires vigilant regulation.

Before regulation was tightened in the ICF/MR industry, some providers were accused of misusing state funds and of not providing appropriate services to residents. A system in which public money is used to finance operations, and where clients are vulnerable people, is susceptible to such abuses and requires vigilant regulation by the state.

Other reimbursement systems which we examined probably would not do a better job of meeting the objectives of providing appropriate quality services to clients, reimbursing providers' legitimate costs, and conserving state funds. We think it is possible and appropriate to make the necessary changes to Minnesota's current reimbursement system so that it can better perform its intended function: a public-private partnership working to provide community services to developmentally disabled Minnesota citizens.

ICF/MR REIMBURSEMENT SURVEY

Appendix A

I.D.#_____

1. Since October 1988, have you had any problems working with Rule 53 (the payment rule for intermediate care facilities) or with how the Department of Human Services administers the rule? Please answer these questions based only on your own experience in your facility(ies).

94.6% a. Yes **Continue to question 2.**

5.4% b. No **Go to question 18 on page 2.** →

For each of the following statements (2 through 11), please select (circle) the response that best matches *your own* experience since October 1988. How true is each of the statements, in your own experience?

		Always/ Usually True	Sometimes True	Rarely/ Never True	Don't Know	No Response
2.	The Department of Human Services settles rate appeals within six months.	6.8%[a]	20.8%	52.4%	13.6%	6.3%
3.	We have enough information to complete our cost reports correctly.	22.4	44.3	19.3	5.7	8.3
4.	Per diems adequately cover the costs of our facility(ies).	1.9	33.1	59.1	0.5	5.4
5.	The reasons for rate adjustments are clearly explained to us.	7.8	37.5	49.3	0.0	5.4
6.	Decisions about allowable costs are understandable.	4.9	44.0	44.5	0.0	6.7
7.	Decisions about allowable costs are clearly linked to Rule 53.	5.8	53.1	26.2	5.4	9.6
8.	Our provider invoices are paid by DHS within 30 days.	36.0	43.6	14.0	1.0	5.4
9.	We know which costs are allowable.	14.6	62.0	15.8	1.0	6.7
10.	When our claims are suspended, we know what to do to correct the problem.	4.5	36.5	50.3	2.3	6.3
11.	One-time adjustments and special needs funding give us the flexibility to respond to changing costs.	1.5	26.3	51.3	14.6	6.3

[a]Responses are weighted by parent organization. That is, if one organization responded for two or more facilities, they were counted as only one response. 182 facilities responded, representing 103 provider organizations.

Do you agree or disagree with the following statements (12 through 14)?

		Strongly Agree	Agree Somewhat	Disagree Somewhat	Strongly Disagree	Don't Know	No Response
12.	Rule 53 is clearly written.	0.0%	20.0%	28.5%	45.2%	0.0%	6.3%
13.	Working with Rule 53 has become easier in the past year or two.	0.0	19.5	28.7	40.6	3.9	7.3
14.	DHS treats providers equally in decisions about allowable costs.	1.0	8.3	17.0	32.8	34.6	6.3

15. Using the statements listed above (questions 2 through 14), what are the two or three biggest problems for your facility(ies)? (Circle the statements that apply or list them below.)

1. The most frequently mentioned problems were questions 4 (37% of provider organizations, 11 (20%),
2. and 12 (22%).
3. _____

16. Please give one or two *specific* examples of *recent* problems you have had. (Use another sheet if necessary. If you have documentation that you are willing to share, please include.)

When we combined responses from questions 16, 17, and 20a, the dominant categories of complaints were: (1) lack of clear communication (15 responses); (2) lack of flexibility (25 responses); and (3) program/administrative cost classification (34 responses).

17. In the past year, what problems have you had with the cost reporting and reimbursement process that have not been covered above?

18.[b] Approximately how many claims are currently in suspension for your facility(ies)? _____ (number of claims)

18a. What is the dollar amount involved? $_____

19. How many rate appeals have you filed since October 1988? _____

19a. How many of these appeals have been decided? _____

19b. How many were decided in your favor? _____

[b]Responses to questions 18 and 19 were unreliable. Respondents interpreted the questions differently, so their answers were inconsistent.

20. Would you like to have training in how to categorize your facility's costs under Rule 53?

73.2% Yes → What areas in particular? (20a)

19.5% No

7.3% Missing

21. In what ways was the Department of Human Services helpful to you as you completed your 1989 cost reports?

	N		N
DHS not helpful	45	CPA or attorney handles cost report	14
Auditors or Policy Center answered questions	11	Other	8
Sought no help	9	TOTAL	87

22. If Rule 53 remains the same, what could the Department of Human Services do to ease the cost reporting and reimbursement process for you?

Some responses contained more than one idea. The ideas reported were:

	N		N
Clarify Rule 53 & interpretations	38	Better communication & cooperation	15
Accelerate reimbursement process	28	A personal contact in DHS	11
Training for all parties	16	Other	8
		TOTAL	103

23. Who at the Department of Human Services do you call when you have questions about completing your annual cost report?

See Table 3.1.

In the event we have any questions, please complete the following:

Name of person completing survey _____ Phone number _____

Title _____

Thank you for your help!

Please return by July 6, 1990 to:

Office of the Legislative Auditor
Program Evaluation Division
122 Veterans Service Building
St. Paul, Minnesota 55155

CASE STUDIES

Appendix B

The following pages contain the results of five case studies that we conducted as part of our study of the reimbursement system for ICFs/MR. During our study, many providers contacted us, participated in our open meeting, or responded to our survey. Each had something to tell us about difficulties they had had with the system. Many providers also sent us documentation that further explained the problems they were having.

We chose the following cases because they were representative of problems shared by a number of providers. We selected the type of problem based on the number of providers who mentioned it when they responded to our survey. Then, we chose the specific cases which we found to be the best documented, both by the provider and by DHS staff and records. The providers in these cases represent some of the major groupings of ICF/MR providers in the state. They are small and large, for-profit and nonprofit, metro and non-metro.

The issues involved in the studies are: converting beds from Class A to Class B status; the special needs rate exception and one-time rate adjustment processes; reclassification of providers' costs by DHS auditors; and the process for establishing an interim rate for a new facility. In our survey, we found that problems in each of these areas were quite prevalent. For example, over half of our respondents said that the special needs and one-time rate adjustment processes rarely or never gave them enough flexibility to to meet clients' changing needs. In response to open-ended questions, about 25 percent of respondents wrote that they had trouble properly classifying program and administrative costs.

While each case study presents a different set of issues, all have one thing in common. In each case, the problem described could have been avoided or alleviated by better communication between the provider and DHS. We think the cases show quite clearly what we found during our study. Because of the poor relationships between regulators and providers, they often conflict needlessly. Each side thinks the other is "out to get them." Both sides too often forget that those who may be harmed by their lack of cooperation are the clients.

In most cases, responsibility for the problems must be shared by providers and regulators alike. But we think that, as a state agency, DHS must take the lead in improving communication and cooperation with providers, and in ensuring

that the reimbursement process operates in a way that results in efficient, effective provision of ICF/MR services.

CASE 1: CLASS A TO CLASS B CONVERSION

The problem in this case is the process of converting a facility's beds from Class A to Class B status, so that more disabled residents can be served. This case illustrates the lack of flexibility and the complexity of the provisions in Rule 53 which are designed to meet providers' costs of caring for more disabled residents.

Methods

Case 1 involves a 12-bed facility in Crow Wing County. The facility is one of many operated by a very large, nonprofit provider. During the course of this study we spoke with the provider and collected documentation from the provider and from DHS that illustrated the steps in the conversion process.

Class A beds are licensed for ambulatory and mobile people who are capable of self-preservation in an emergency. Class B beds are for people who are unable to take appropriate action for self-preservation. Conversion from Class A to Class B is one method of increasing the state's capacity to care for former RTC residents in the community. We chose this issue for a case study because the conversion process has been a source of frequent complaints from providers.

Background

Late in 1984 the provider was asked by Crow Wing county to consider converting a facility in Brainerd from Class A to Class B. The county was attempting to plan for the discharge of some of its residents from Brainerd Regional Treatment Center to the community. The provider agreed to consider the conversion, and sought advice from the Department of Health and the Department of Human Services regarding the process for conversion.

A May 1985 letter from a DHS assistant commissioner explained how Rule 53 (temporary) would affect projected costs, and suggested that conversion plans could proceed after June 30, 1985. In October, the provider and the county agreed that the facility should be remodeled to accommodate Class B residents, but that the facility should be licensed for both Class B and Class A residents, to maintain flexibility. DHS agreed to consider using the conversion as a department pilot project. The provider planned to admit six Class B residents from the Brainerd RTC by March 31, 1986. The provider had secured financing from the Minnesota Housing Finance Corporation for the $70,000 cost of remodeling.

In February 1986, one DHS staff member recommended against approving the conversion. The recommendation was based on apparent lack of support by the county of its clients in the community, and inadequate county documentation for the need determination. The memo also noted that the rate proposed by the provider seemed excessive, and that the rate increase might be a "mechanism to prop up (the provider) which is rumored to be in some financial distress."

In March the provider formally requested approval for the conversion from the Department of Health, the DHS notified the county that approval had been granted for the need determination. In August the facility received a notice setting its interim payment rate at $91.62. The rate was to become effective when the Department of Health licensed the Class B beds or when the Class B beds were occupied by appropriate residents, whichever occurred later.

By December 1986 the facility still needed three Class B residents. Two Class A residents were prepared to move to different community settings, and Class B residents were set to be admitted from Brainerd RTC. One additional Class B resident was prevented from leaving Brainerd RTC by her physician, who was associated with the RTC. In January 1987, the Class B beds still had not been filled. Two current Class A residents had not been moved to the community because the county had been unable to locate services for them. The Brainerd RTC resident was still being held there, though the county had appealed the doctor's decision which kept her from being discharged. The provider inquired of DHS about a way to begin receiving its interim rate before all Class B beds were full. Remodeling had been completed and additional staff employed by that time. DHS responded that nothing in Rule 53 would permit reimbursement at the interim rate until all beds were in use.

Crow Wing county attempted to intervene on behalf of the provider. The county pointed out that the provider had incurred unreimbursed costs in excess of $50,000 and that DHS staff had initially encouraged the conversion and promised support.

In 1987 the provider converted another 12-bed Class A facility to Class B. By mid-1990, the provider had incurred over $93,000 in unreimbursed costs operating these two facilities. In addition to costs incurred because of the delays in occupying beds, the provider has lost money because administrative costs for Class B facilities are capped at the same level as for Class A facilities. The provider has administrative expenses which are higher for its Class B facility, because the same expenses must be spread over fewer beds, and more staff per bed must be supervised.

The Provider's Point of View

The provider states that it was originally asked by Crow Wing county to convert some of the beds in its facility from Class A to Class B. At the time, the provider was encouraged to do so by the Department of Human Services. The provider spent the necessary funds to provide for services for more de-

pendent residents, who the county was required to remove from the Regional Treatment Center, on the assumption that its costs would be reimbursed by the state.

Only after it had committed the funds did the provider encounter difficulties. Clients who had occupied some of its Class A beds were to move out to the community using Waivered Services slots. Some of those moves were delayed by the county's inability to arrange necessary services in the community. In addition, one client's move from the RTC was delayed by objections from her physician. The provider states that it had no control over these factors, but bore the cost of them.

The Department's Point of View

After meeting with the provider, DHS staff amended Rule 53 to allow the provider to receive the full payment rate when the Class B beds were 60 percent occupied. The department made the rule change retroactive so that the provider could receive payment for some prior days during which the 60 percent requirement was met.

The provider has asked the department to repay the remaining unreimbursed costs. The department position is that it has done what it could to help the provider, but is prevented by Rule 53 from granting further financial relief. The department answered the provider's most recent request for relief with the suggestion that he present his complaints to the Legislative Auditor.

Conclusions

The issues in this case arise from two sources. First, Rule 53 operates to make a conversion from Class A to Class B difficult and expensive for the provider. The provider must spend its own resources preparing for the conversion, but must rely, to some extent, on the county and others for the process to go forward. The second cause of difficulties in this case is, in fact, inadequate planning by the county. It was the county's responsibility to arrange for alternative services for ICF/MR residents, so that their beds could be freed for use by RTC residents. Because the county was not prepared to arrange for community services for its clients, the entire process was delayed, and the provider incurred additional, unnecessary expenses.

CASE 2: SPECIAL NEEDS RATE EXCEPTION AND ONE-TIME RATE ADJUSTMENT

The problem in this case involves the steps for obtaining Special Needs Rate Exceptions and One-Time Rate Adjustments. This case study illustrates the lack of communication between DHS staff and providers, and among staff of

different DHS divisions. The case also demonstrates the department's unwillingness to work with individual providers to make the ICF/MR system operate more smoothly. An additional issue in this case involves costs that were disallowed by an auditor, apparently in error, and the way the department handled the situation once the error was discovered.

Methods

Case 2 involves a six-bed ICF/MR located in Olmsted county. The facility is one of four six-bed ICFs/MR operated by a nonprofit provider. In studying this case, we spoke several times with the provider involved. We collected documentation from the provider which added to his description of the events. We reviewed files regarding the case at the Department of Human Services, and we interviewed DHS staff from the Developmental Disabilities and Long Term Care Management divisions.

Special needs rate exceptions are designed to allow providers to hire additional staff or purchase equipment that is needed to meet the temporary needs of an individual client. The special needs are generally related to either a behavior problem or medical condition. A one-time rate adjustment is a permanent increase in the facility's per diem rate. It can be used for only a few purposes, such as to correct a deficiency cited by the state health department or the federal government.

We chose this example because it highlights the only ways providers can obtain additional funds to serve more difficult clients or to upgrade services when clients' needs change. Over half of the respondents to our survey reported that the established procedures rarely or never gave them enough flexibility to handle increasing costs due to changes in clients' needs.

Background

The Minnesota Department of Health inspected this facility on March 28, 1989. The inspector found that an adequate number of staff were not always available to handle the evacuation needs of residents in case of a fire or other emergency. Because the need was thought to be based on one resident, the provider proposed to apply for a Special Needs Rate Exception for that resident. At the same time, the provider planned to initiate a redetermination of need with Olmsted county, to seek a one-time rate adjustment to address the changing needs of the elderly residents. In its response to the provider's plan, the Department of Health noted that all residents of the facility had shown deteriorating ability to respond to fire drills and other events, and that increased staffing was probably the best method for correcting the situation. Thus, the one-time rate adjustment would be the appropriate means of addressing the deficiency.

On June 20, when the provider initiated a request for a Special Needs Rate Exception with Olmsted county, the facility had already hired additional staff. Even though funding had not yet been approved, the provider was required to

correct the deficiency noted by the Department of Health inspector. The Department of Human Services approved special needs funds on August 4, effective July 12, and they were scheduled to expire on January 12, 1990. The temporary funding was to be used for one new staff member to manage one client's behavior, and for additional night staff to comply with life-safety codes and improve evacuation for that client and others. The department agreed that the needs of many of the residents had changed, and its approval of special needs funds included the requirement that the provider apply for a one-time rate adjustment, to be used to permanently increase the number of staff.

In a September 14, 1989 letter to Olmsted county the provider submitted its plan for improving the client's ability to evacuate in an emergency. On September 26, after receiving documentation from the county and the provider, DHS set the special needs amount at $12,095—enough for 12 weeks of additional staff. By then, 11 of those weeks had already passed.

On October 24 the provider applied to the county for approval of a one-time rate adjustment, noting that the client deficiencies were primarily due to degenerative disease associated with aging, and so could not be permanently corrected through special needs funding. Olmsted county approved the rate adjustment, but DHS did not. As a result, the provider informed the county on January 29, 1990 that the special needs client would have to be immediately discharged to a Regional Treatment Center, with other clients to follow.

On January 31 the department authorized a 90-day extension of special needs funding, effective January 13. DHS did not address the requested one-time rate adjustment.

On March 22 the rate adjustment request was reviewed by a DHS committee. The committee decided not to act on the rate adjustment, and instead directed the provider to apply for another extension of special needs funding. On May 10 the facility requested the extension as directed.

The previous special needs extension had expired on April 11, but the department did not approve the new extension until July 18, for the period April 12 to October 12, 1990. The provider was told to apply for additional extensions in October 1990 and January 1991. Between July 12, 1989 and July 18, 1990, the provider operated a total of 206 days without knowing whether it would be reimbursed by the department for the additional services it was supplying. During that time, the provider repeatedly attempted to contact DHS staff to learn the status of its applications. Many phone calls went unanswered.

At the beginning of September 1990, the provider received the annual rate notice for this facility, for rates effective October 1, 1990. The notice showed that the DHS desk auditor had disallowed $14,344 which, he said, represented special needs funds which should have been accounted for separately on the provider's annual cost report. The auditor stated that the additional money was disallowed because of a report which showed that the provider had been approved for $30,153 of special needs funds. The audit division was unable to produce the report, chose not to discuss the matter with the provider, and ad-

vised the provider that, even if the disallowance was an error on the part of the auditor, the provider's only recourse was through the appeal process.

The disallowance of $14,344 in program costs resulted in the provider being required to pay back $11,590 from the previous year, because of apparent underspending on program activities. The provider also lost an efficiency incentive payment because of the disallowance. The net result was a per diem rate about $15 lower than expected by the provider.

The Provider's Point of View

The provider asserts that the Special Needs Rate Exception should never have been used to support extra staffing needed to comply with life safety codes, and that the appropriate funding source for safety code corrections is the One-Time Rate Adjustment.

The provider also believes that it was unfair to make him carry the burden of continuing to provide services while at risk of never being paid for them, and to refuse to respond to his questions during the process. The provider states that on several occasions during this period extensions were approved only after he had initiated discharge proceedings for the resident, which would have resulted in the client's placement in a Regional Treatment Center. The provider asserts that it was unreasonable for the department to place the client in jeopardy in that way.

Finally, the provider states that the special needs money he did receive was accounted for correctly in his cost reports. The disallowance of additional money, he says, was based on misinterpretation by the auditor of the department's own report. Therefore, since the disallowance represents an error on the part of DHS, the provider believes it was unreasonable to force him to appeal it and to wait until the department was ready to settle the appeal to recover money which he had already spent in good faith.

The Department's Point of View

DHS staff characterized the problems encountered by this provider as caused by a lack of communication and coordination, both between DHS divisions and between the department and the provider.

Long Term Care Division staff explained that delays in special needs funding can occur for a variety of reasons. Approval for special needs funding is sometimes delayed because the county or the provider does not supply all of the necessary information in a timely manner. According to staff, this was part of the reason for the delays in this case.

Long term care staff did direct the provider to apply for a one-time rate adjustment, and special needs funding was approved only so that it would cover resident needs until the rate adjustment was approved. However, long term care staff learned later that the Developmental Disabilities Division had

changed somewhat its criteria for one-time rate adjustments. Because the Developmental Disabilities Division has been trying to plan for the discharge of most of the remaining RTC residents and for the SOCS system, division staff wanted some assurance that the increased rate would increase capacity in the county to care for its RTC residents in the future. Developmental disabilities staff therefore delayed approval of a one-time rate adjustment for this facility.

Staff of the Developmental Disabilities Division agreed that lack of internal communication had contributed to the problems in this case. At the time the provider requested the rate adjustment, the division had been considering asking the facility to convert beds form Class A to Class B status. Division staff assumed that special needs funds could be used to meet residents' needs until the conversion could be completed.

The division did not want to approve a one-time rate adjustment, which would have resulted in a permanent rate increase, until long-term planning was completed. Developmental disabilities staff concede that they may not have made the provider or Long Term Care Division staff fully aware of the reasons for not approving the rate adjustment. Staff also said that the provider may need to resolve serious financial difficulties before devoting its attention to the conversion process. Developmental Disabilities Division staff said that they might have made different decisions if they had known that the process would take so long.

The final issue in this case is the disallowed special needs funds from the provider's 1989 cost report. Audit Division staff agree that the disallowance was an error on their part. The billing system sent auditors a new report which did not clearly differentiate between rejected and accepted claims. Several other providers were affected by the problem, and the Appeals Division is attempting to resolve the issues quickly.

Conclusions

We conclude that most of the problems in this case were due to lack of communication and coordination. This is a small provider who had a good reputation among developmental disabilities staff. There is no dispute over whether the clients involved actually needed the additional services. It would certainly have been in the best interests of the clients, the provider, and the state to give the provider the information and assistance it needed to complete the application processes in a more timely way.

The error that was made during the desk audit process was understandable. What is less understandable is the need to jeopardize the financial viability of this provider and the future of the residents over what the department has agreed was simply a mistake their part. As we discuss in Chapter 3, the department lacks a method for correcting its own errors in a simple, timely manner.

CASE 3: RECLASSIFICATION OF COSTS

The problem in this case involves a decision by DHS auditors to reclassify costs from the program to the administrative category. This type of action by the state has been a source of considerable disagreement and friction between the department and providers. This case illustrates the distrust between DHS staff and providers, which in this case was exacerbated by lack of communication and inconsistency on the part of DHS auditors.

Methods

Case 3 involves a 12-bed facility in Sherburne county and a 6-bed facility operated by the same provider in Ramsey county. In studying this case, we spoke several times to the provider involved. We collected documentation from the provider which supported its description of the events. We reviewed files regarding this case at the Department of Human Services, and we interviewed DHS staff from the Audit and Provider Appeals Divisions.

Background

The provider's cost reports for 1988 showed nursing staff wages of $4,871 at one facility and $5,086 at the other. On June 27, 1989 the DHS auditor requested additional information about administrative salaries but did not ask for clarification of the nursing wages allocation.

The provider responded to the request on July 31, explaining that facility directors' wages could not be assigned to particular homes because each director is responsible for more than one home. Facility directors' salaries are included with central office costs and allocated among all operations.

The facilities received rate notices in September. The notices showed that nursing wages had been transferred from the program to the administrative cost categories. The provider requested the auditor's work papers, and from them learned that the auditor had made the assumption that, since facility director salaries could not be allocated, then neither could nurses' wages, because nurses also serve more than one facility. The auditor noted that the provider "is DIDing [directly identifying] the cost where it is to his benefit (program) and not DIDing cost where it is also to his benefit (admin)." Because the provider was already at the limit for administrative costs, the entire cost of nursing salaries was effectively disallowed.

The provider appealed the issue on October 20, 1989. The provider was informed that the appeal would not be expedited because the issue was shared by other providers. The provider requested that the appeals be resolved prior to the time new rates were issued in September 1990, because of concerns that the same disallowances would again be made and would have to be appealed. The department informed the provider that it was highly unlikely that the appeal would be resolved in that time period.

In September 1990 rate letters based on 1989 cost reports were sent. The provider's nursing wages were not disallowed on this year's report. The appeal over last year's disallowance has still not been resolved.

The Provider's Point of View

The provider asserts that "the assumption which (the auditor) made is completely wrong." Facility directors are full-time, salaried supervisory employees, responsible for the daily management of several group homes. They frequently perform work, for example developing policies and procedures, which applies to more than one facility. The facility nurse position is a part-time, hourly, non-supervisory job. Nursing staff are required to maintain continuing time records which identify the facilities they have worked in.

It is the provider's opinion that the issue could have been avoided if the auditor had asked for an explanation of the nursing wage allocation during the audit process. Now that the error has been made and the desk audit rate notice has been sent, the auditor has informed the provider that the appeal process is the only available way of correcting the error. Until the appeal is resolved, the provider will not have use of approximately $10,000 to which it is entitled.

The Department's Point of View

The DHS auditor who performed the desk audit informed us that his work had been reviewed by a more senior auditor. The reviewer told the desk auditor to reclassify and allocate the nursing wages. The reclassification occurred late in August, which the desk auditor told us was too late in the audit cycle for him to request backup documentation from the provider.

Conclusions

It is unclear whether the reclassification of nursing wages was an error. The Audit Division has had nothing further to do with the case since it sent rate letters in 1989. The Provider Appeals Division has not yet resolved the issue. Regardless of whether an error was made, the way the Audit Division handled the matter was problematic.

First, we do not think that auditors should "assume" that a provider has done something wrong without asking for documentation or clarification. Second, it should never be too late in the audit cycle to ask for that documentation. Because the auditor did not have time to clarify his findings, a great deal of time and money must now be spent to resolve the issue through the appeals process. Finally, the fact that the same nursing wages were allowed this year that were disallowed last year indicates, at least, serious inconsistencies in the way audits are conducted at DHS.

CASE 4: INTERIM RATE FOR A NEW FACILITY

This provider had difficulty obtaining a timely and error-free interim rate for a new facility. The case illustrates the way DHS interprets Rule 53 and its effect on the delivery of services for ICF/MR residents.

Methods

Case 4 involves a provider in Ramsey County. We interviewed DHS Audit Division staff, as well as the provider. We also examined DHS audit files and documents given to us by the provider.

The provider's experience with opening a new ICF/MR and obtaining an interim rate was selected as a case study because it reflects a category of provider complaints relating to communication problems with the Department of Human Services. In our provider survey, nearly half of the respondents found it rarely or never true that the reasons for rate adjustments were clearly explained to them. In response to open-ended questions, about 21 percent of providers in our survey discussed communication difficulties they had with DHS, including the complaint that DHS staff seem unwilling to correct errors made by the department.

Background

The provider is a privately owned corporation that delivers a variety of services to developmentally disabled Minnesotans and those who work with them. The company owns two ICFs/MR, which constitutes about 20 percent of its business. In addition, the organization offers home and community based waiver services, semi-independent living services (S.I.L.S.), foster and respite care, behavior analysis, and case management.

On July 14, 1989, the provider submitted an estimated cost report and requested approval of an estimated interim rate for a new four-bed ICF/MR. At that time, the provider had not yet purchased a house and did not plan to do so until DHS approved an interim rate. The provider's representative said that he hesitated to commit his organization to a mortgage and was uncertain whether a bank would even negotiate with him unless he knew what his interim rate would be. In September 1989, Audit Division staff wrote to the provider requesting copies of loan agreements, contracts, real estate tax statements, and the purchase agreement. The auditor also questioned why the estimated costs were higher for the new home than for the provider's other ICF/MR. The provider's October 13, 1989, response explained that no home had been purchased and the July cost report was an estimate, so none of the items the auditor requested had yet been developed. The provider also explained that the higher estimated costs were due to the current labor market situation and to the more severely disabled clientele expected in the new home.

The Legal Aid Society intervened with the department on behalf of the parents of a regional treatment center client who could not be moved into the community until the new facility was completed. On November 1, 1989, DHS Audit Division staff established an estimated interim rate so that the provider could proceed with the purchase of a house. In their rate notice, DHS staff told the provider that the final interim rate would be based on actual cost projections that the provider needed to submit before opening the facility. When a house for the new facility had been purchased, the provider sent DHS a revised cost report. The report was sent on February 26, 1990, for a projected opening date of April 1. A DHS auditor called the provider on April 13 and asked for additional supporting detail for the revised cost report because it differed from the estimated one. The provider sent the materials on April 16, and the interim rate was issued on April 17.

On April 18, when the rate notice arrived, the provider noticed an error. The provider called the auditor and asked for the work papers used in the calculation. The cost report was for a 10-month period, but the auditor had used 12 months to calculate the monthly interest rate. As a result, the per diem rate was lower than it should have been by $1.15. On April 19, the provider called DHS and pointed out the error. The auditor said that he could not correct the error at that point and that Rule 53 makes no provision for appeals of interim rates. The provider would have to wait until the end of the first reporting year, the "settle-up period," to correct the problem. The provider then called an Audit Division supervisor, who corrected the error and reissued the interim rate on May 7, 1990.

The Provider's Point of View

The provider's representative was frustrated by the process of opening a new facility. In particular, the provider asserted that the process should be more flexible and should be completed more quickly. The provider's representative felt he had been in danger of not receiving an interim rate unless he persistently asked for one, and he was frustrated by the department's resistance to giving him an interim rate before he committed to buying property. He was uncertain about why a DHS error could not be corrected and feared that, if it were not, he would "not get the full benefit of the provisional rate adjustment allowed in Rule 53 at settlement." That is, he was concerned that his full interim expenditures would be underrepresented in the calculation of his historical rate, upon which his facility's future payment rates would be based. The provider was approved to develop two additional ICF/MR facilities in Washington County, but decided not to proceed because of inflexibilities in Rule 53.

The Department's Point of View

Audit Division staff told us that some difficulties in the case arose from complications inherent in the interim rate setting process, especially when the provider is opening a new facility. The provider wanted an interim rate before investing in the property, and the department could not establish a rate until the provider could submit loan and other information about the property.

With the urging and assistance of staff from the Legal Aid Society, the department reached a compromise. Audit Division staff asked the provider to submit an estimated cost report, and the department calculated an estimated per diem rate, to be adjusted based on actual costs.

When the provider discovered an error in the final interim rate, Audit Division staff initially said they could not correct the problem until the settle-up period because Rule 53 expressly forbids any change in an interim rate once it has begun. Staff said that they then discovered that the interim rate, though it had officially begun, had not yet been entered into the department's computer. Therefore, audit supervisors concluded that they could correct the error immediately. Had the information already been entered into the computer, auditors said, they probably would have insisted on waiting until the settle-up period to correct the error.

Conclusions

Though the process was cumbersome, we believe the department acted appropriately when it worked with legal aid to establish an estimated interim rate for this provider. On the other hand, the error in the interim rate could have caused more difficulty than it did had the provider not pursued the matter immediately. Moreover, a less sophisticated provider might not have acted so quickly or persistently.

While the department responded to the difficulties this provider was having by establishing an estimated rate, the solution was reached in part at the insistence of an outside force, legal advocates. The department does not currently have its own system for working with providers on the opening of new facilities so that these services, which county staff have deemed necessary, can begin as quickly and smoothly as possible.

Finally, this case re-emphasizes a problem that many providers have complained about—the department's apparent unwillingness to correct its own errors. We discuss this issue in more detail in Chapter 3.

CASE 5: RECLASSIFICATION OF PROGRAM COSTS

The problem we examine in this case study is the classification of program and administrative costs. The case demonstrates the underlying issues of unclear communication and lack of consistency from DHS.

Methods

Case 5 involves a provider headquartered in Stearns County. To complete this case study, we interviewed the provider's Division Director and the Budget and Finance Director. We also interviewed Department of Human Ser-

vices Audit Division and Appeals Division staff involved in the case, and we spoke with the provider's accounting firm. We examined desk audit files and appeals files for both ICFs/MR belonging to the provider, as well as documentation given to us by the provider.

The provider experienced a problem which is representative of a complaint brought up by respondents to our provider survey: the department's disallowance of salaries previously classified as program costs. About 44 percent of respondents said that it was rarely or never true that decisions about allowable costs were understandable. In response to open-ended questions, about 25 percent of our survey respondents wrote that they had particular difficulty classifying program and administrative costs, and many of these providers specifically requested training in this area.

Background

The provider owns and administers two nonprofit ICFs/MR, one with 14 beds and one with 6 beds. Both are Class A homes serving adults with dual diagnoses of mental retardation and a variety of additional problems.

In April 1989, the provider submitted cost reports for both homes for the year ending December 31, 1988 to the Department of Human Services.[1] In early July 1989, DHS Audit Division staff sent the provider a letter requesting that it send further information within 20 days. Auditors stated that they needed the additional information to help determine the allowability under Rule 53 of the Program Director's and Unit Coordinators' salaries. The documentation requested included position descriptions and daily calendars or diaries for May, July, October, and November of 1988.

The accounting firm serving the provider responded to the auditor's request within 20 days. The accountants sent position descriptions but explained that no daily diaries had been kept for the Program Director or the Unit Coordinators. The Unit Coordinators had completed time sheets, but their duties were not itemized on these records, so they would not help to clarify the proportion of time spent on program activities. The provider's staff told us that the Program Director and Unit Coordinator positions had been classified as program expenses since 1979 and had not been questioned previously by DHS.

In September 1989, the provider received its 1990 rate notice, based on the Audit Division's desk audit of the 1988 cost reports. The department had reclassified the Program Director and Unit Coordinator positions to the administrative category, so that their salaries were no longer reimbursable as program expenses. These expenses caused the provider to exceed its administrative reimbursement cap, so DHS would not reimburse the salaries as administrative costs. Moreover, with the salaries removed from program costs, the provider had "underspent" in the program category—that is, it had not spent at least 98 percent of the program funding it had received, so was required to return the difference between the funding and expenditures. Paybacks were due for both the 1988 and 1989 rate years. The provider's accounting firm cal-

1 Since the provider had the same problem with cost reports for both homes, we discuss them together.

culated that the total payback would be more than $120,000, including the 1989 salaries which had already been paid by the time the rate notice arrived. The department told the provider that it intended to take the payback out of the provider's per diem payments for each ICF/MR for a 12-month period beginning October 1, 1990.

In September 1989, the provider submitted an appeal of the desk audit findings to the Appeals Division of DHS. The reclassification of program costs was one of four issues appealed for one home and one of seven issues for the other. In its appeal of the reclassification of Program Director and Unit Coordinator salaries, the provider cited a provision of Rule 53, which states that allowable program costs include "salaries of program staff, including the program director, unit coordinators, and nursing staff."[2] In April 1990, DHS settled some of the issues in the appeal, but the program reclassification issue remained unsettled.

The Provider's Point of View

The provider's administrative staff told us that they will be unable to survive financially if the paybacks are enforced, and they have hired a lawyer to negotiate with the department. They told us that DHS appeals staff said they would not settle the program reclassification issue until after other such appeals have been settled by the administrative law judge, which appeals staff anticipated would take at least 18 months.

The provider has sent position descriptions, time sheets, and descriptions of typical days for the program director and unit coordinators to the Appeals Division. The provider's representatives believe that the Unit Coordinator is entirely a program position and assert that administrative tasks are performed by the central office.

The provider has also initiated a more detailed time sheet on which employees attempt to classify program and administrative time. This time sheet was sent to DHS with a request for feedback about its adequacy under Rule 53. The provider told us that so far DHS has not responded to this documentation. In March 1990, the provider's accountant asked to meet with DHS to clarify the definition of program duties. A DHS auditor declined to discuss the issue and said that he preferred to receive time records.

The Department's Point of View

The department's appeals files contained information about how DHS has responded, and we talked with both Audit Division and Appeals Division staff about their work on this issue. The desk auditor for this case told us that the program costs listed on the 1988 cost report seemed high when compared with other facilities, so he asked for further detail. He received only position descriptions, which seemed to include many administrative duties for both positions under dispute. Since the provider could not provide any documenta-

2 Department of Human Services Rule 9553.0040 Subp. 1A

tion of how their staff members' time was actually spent, the auditor reclassified the Program Director and Unit Coordinators' salaries to the administrative cost category.

Legal staff of the Appeals Division report that they are negotiating with the provider's accountants and legal counsel to solve the problems presented in this case. The provider is trying to produce staff calendars or some method of demonstrating how staff spent their time. Since program cost reclassifications have affected many providers recently, DHS has agreed not to collect paybacks through per diem rates until appeals are settled. Appeals staff told us that Rule 53 is not specific about what constitutes adequate time distribution records, and that they hope to educate providers on such matters through the appeals process.

Conclusions

In this case, it appears that both DHS and the provider have valid points. On the one hand, Rule 53 does state that staff who are not top management and who have multiple duties must allocate their time "to the appropriate cost categories on the basis of time distribution records that show actual time spent, or an accurate estimate of time spent on various activities."[3] The program director and unit coordinator position descriptions list many activities that appear to be administrative, indicating that the provider should have been keeping time distribution records. On the other hand, DHS had not questioned these costs at any time since 1979, leading the provider to believe that the salaries were allowable program costs. This case demonstrates the poor communication between the Department of Human Services and providers. The case also shows that the department has been inconsistent in its interpretation of Rule 53, since it did not question the provider's program classifications from 1979 until 1988. Inconsistency of audit decisions from year to year is a complaint we heard from many providers.

3 *Minn. Rules* 9553.0030, Subp. 1D.

SAMPLE COST REPORT PAGES

Appendix C

State of Minnesota

DHS USE ONLY
Date Received
Batch Number

ANNUAL REPORT of LONG TERM HEALTH CARE FACILITIES INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

Licensed Name of Facility	Provider
Facility Address (No. and Street, City, State, Zip)	
Reporting Year	

☐ Check, if this facility is requesting an interim rate.

☐ Check, if this facility is currently on an interim rate.

TABLE OF CONTENTS

Facility Licensed Name	Provider ID	Reporting Year	Page 1

ADMINISTRATOR'S/OWNER'S CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION REQUESTED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined, prepared or directed preparation of the accompanying Cost Report and supporting schedules for the cost report period beginning _____ and ending _____.

Having read this Report, I hereby certify that to the best of my knowledge under the penalty of perjury, that the information provided is a true and complete statement prepared from the books and records of the intermediate care facility for the mentally retarded in accordance with applicable instructions. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX residents were incurred to provide resident care in this facility. All supporting records for the expenses recorded have been retained as required by Minnesota and Federal Law and will be made available to auditors upon request.

Signed (Administrator, Chief Financial Officer)	Date	Signed (Owner, Chairperson of the Board)	Date

PREPARER/REVIEWER CERTIFICATION

I/we have prepared this report from the books and records of _____ for the reporting period _____ to _____.

I/we have read the applicable regulations and the most recent Medicaid field audit report for this facility. We have discussed with the appropriate personnel the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All nonreimbursable expenses which I/we are aware of as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report. Since the scope of our work did not constitute an audit of the report in accordance with generally accepted auditing standards, we are unable to express an opinion on it.

Signed (Preparer/Reviewer)	Title	Date
Address		Phone Number ( )

GENERAL INFORMATION

All applicable information in this report must be furnished prior to acceptance by the Minnesota Department of Human Services.

1. FACILITY

0010 Facility Licensed Name _____ Provider ID _____

0015 Street Address or P.O. Box _____

0020 City, State _____ Zip Code _____ County Code _____ Telephone ( ) _____ - _____

0025 Facility Fiscal Year End — Month _____ Day _____ Reporting Year (MM-DD-YY) — Starting _____ - _____ - _____ Ending _____ - _____ - _____ Ownership Code* _____

0026 Date Facility Entered MA Program (MM-DD-YY) _____ - _____ - _____

2. CURRENT ADMINISTRATOR

0030 Legal Name — Last _____ First _____ Middle Initial _____

3. CHANGE IN OWNERSHIP/FACILITY NAME/FACILITY ADDRESS

	Type of Change	Date of Change (MM-DD-YY)	Previous Provider ID
0035	Ownership	_____ - _____ - _____	_____
0040	Facility Name	_____ - _____ - _____	_____
0045	Facility Address	_____ - _____ - _____	_____

4. FACILITY TYPE (check **all** that apply)

0050 ☐ ICF/MR - Non-Rule 80 ☐ ICF/MR - Rule 80 ☐ SNF ☐ ICF I ☐ ICF II

0055 ☐ Boarding Care ☐ Board and Lodging ☐ SILS/Apartments ☐ Supervised Living Facility ☐ Other

*Choose the most descriptive ownership code.

Proprietary
[01] Sole Owner
[02] Partnership
[03] Limited Partnership
[04] Publicly Held Corporation
[05] Closely Held Corporation
[06] "S" Corporation

Non-Profit Corporation
[07] Owned by or affiliated with a religious organization
[08] Not owned by or affiliated with a religious organization

Non-Profit Association
[09] Owned by or affiliated with a religious organization
[10] Not owned by or affiliated with a religious organization

Government
[11] State
[12] County
[13] Municipal

BED CAPACITY

CERTIFIED BEDS

	Line	ICF/MR Beds	ICF/MR Date of Certification	OTHER CERTIFIED Beds	OTHER CERTIFIED Date of Certification
Start of Reporting Year	0100				
End of Reporting Year	0105				
Changes in Certification	0110		MM - DD - YY		MM - DD - YY
Changes in Certification	0115		MM - DD - YY		MM - DD - YY

LICENSED BEDS

	Line	ICF/MR - CLASS A Beds	ICF/MR - CLASS A Date of Licensure	ICF/MR - CLASS B Beds	ICF/MR - CLASS B Date of Licensure	OTHER Beds	OTHER Date of Licensure
Start of Reporting Year	0130						
End of Reporting Year	0135						
Changes in Licensure	0140		MM - DD - YY		MM - DD - YY		MM - DD - YY
Changes in Licensure	0145		MM - DD - YY		MM - DD - YY		MM - DD - YY

REPORTING PERIOD RESIDENT DAYS

	Line	CLASS A ICF/MR	CLASS B RESIDENTIAL ICF/MR	CLASS B INSTITUTIONAL ICF/MR	OTHER	TOTAL
Medical Assistance Resident Days	0150					
Private Pay Resident Days	0152					
Total Resident Days	0154					
Resident Days for Last Three Months*	0156					

Facility Licensed Name	Provider ID	Reporting Year	Page 4

DETAIL COST STATEMENT

6100 PROGRAM OPERATING COSTS (9553.0040, Subp. 1.)

ACCOUNT	ACCOUNT NUMBER	BALANCE PER BOOKS	ADJUSTMENTS	ALLOWABLE COSTS
SALARIES	6110			
- Program Director Salary	6111			
- Unit Coordinator Salary	6112			
- Nursing Staff Salaries	6113			
- Other Staff Salary	6114			
- Payroll Taxes - (if directly identified)*	6115			
- Fringe Benefits - (if directly identified)*	6116			
- Accrued Vacation Pay*	6117			
- Accrued Sick Pay*	6118			
- Bonuses*	6119			
PROGRAM SUPPLIES	6120			
PROGRAM PURCHASES SERVICES	6130			
REPAIRS CAUSED BY DESTRUCTIVE				
RESIDENT BEHAVIOR*	6135			
EMPLOYEE TRAINING	6160			
VEHICLE OPERATION COSTS TO				
TRANSPORT RESIDENTS*	6163			
RESIDENT TRIPS or VACATIONS	6164			
RESIDENT MEMBERSHIP FEES	6165			
TELEPHONE, TELEVISION, RADIO SERVICES*	6166			

*See Instruction Manual

Facility Licensed Name	Provider ID	Reporting Year	Page 5

DETAIL COST STATEMENT

6100 PROGRAM OPERATING COSTS (continued)

ACCOUNT	ACCOUNT NUMBER	BALANCE PER BOOKS	ADJUSTMENTS	ALLOWABLE COSTS
CONSULTANTS	6170			
- Program	6171			
OTHER PROGRAM EXPENSES, TOTAL (detail on a separate schedule)	6180			
APPLICABLE CREDITS, TOTAL (detail on a separate schedule)	6190			
NET PROGRAM OPERATING EXPENSES	6100			

DETAIL COST STATEMENT

6700 SPECIAL OPERATING COSTS (9553.0040 Subp. 6)

ACCOUNT	
REAL ESTATE TAXES*	6710
SPECIAL ASSESSMENTS*	6715
MDH and DHS LICENSE FEES	6720
REAL ESTATE INSURANCE*	6725
PROFESSIONAL LIABILITY INSURANCE*	6730
AMORTIZATION OF PREOPENING COSTS*	6735
TRAINING AND HABILITATION SERVICES COSTS*	6740
PHYSICAL PLANT MODIFICATIONS OR ADDITIONAL DEPRECIABLE EQUIPMENT COSTS ALLOWED UNDER PART 9553.0061*	6745
TOTAL SPECIAL OPERATING COSTS	6700

*See Instruction Manual

DETAIL COST STATEMENT

Account Number	Explanation and Computation of Adjustments	Adjustment Amount	Total Adjustment Amount to Each Account

ADDITIONAL REQUIRED INFORMATION

For each of the following statements, check the box if the statement is true for this facility and supply any additional information requested.

0191 ☐ 1. This provider has included copies of the facility's lapsing depreciation schedule using the guidelines described in the Instruction Manual. (9553.0041, Subp. 2, item J.)

0192 ☐ 2. This provider or provider group has 48 or more licensed beds and is required annually to have a certified audit. A copy of the annual certified audit must be submitted with the cost report. (9553.0041, Subp. 1.)

0193 ☐ 3. This provider or provider group has had a certified audit prepared for the period covered by this report. If checked, submit a copy of the certified audit with this report, if not checked, submit a facility balance sheet and income statement prepared in accordance with generally accepted accounting principles (9553.0041, Subp. 2. C.)

0194 ☐ 4. This provider or provider group has purchased (owns) the physical plant or land. If checked, submit copies of the purchase agreements and other documents related to the purchase of the physical plant and land.

☐ — Also check this box if the documents have been previously submitted and no changes have been made to the documents on file with the Department. (9553.0041, Subp. 2. H.)

0195 ☐ 5. This provider or provider group leases the physical plant or land and these leases are (i) bona fide, arms-length leases or rentals, and (ii) were either incurred on or before December 31, 1983 or were renewals, renegotiations or extensions of such leases. If checked, submit copies of the leases and other documents related to the lease of the physical plant and land.

☐ — Also check this box if the documents have been previously submitted and no changes have been made to the documents on file with the Department. (9553.0041, Subp. 2. I.)

0196 ☐ 6. This provider or provider group leases the physical plant or land and these leases or rental costs are (i) not bona fide arms-length leases (as defined at 9553.0060, Subp. 7. B.), or (ii) are new lease or rental agreements entered into after December 31, 1983. If checked submit copies of the leases and other documents related to the lease of the physical plant and land including the historical capital cost of the physical plant and land, the date of purchase, facility capital loans of the lessor outstanding during the reporting year, the name of the lender, the terms of the debt, interest rate of debt, interest and principal payments this year and for all remaining years, and the original amount of the loans. (9553.0041, Subp. 2. D. and I.)

0197 ☐ 7. This provider has a payment rate for approved services for very dependent persons with special needs under Minnesota Rules part 9510.1020 to 9510.1140 (Rule 186). If checked, submit documentation detailing these costs on an individual resident basis. (9553.0041, Subp. 2. L.)

0198 ☐ 8. This provider currently has a One-Time Adjustment granted under 9553.0050, Subp. 3. If checked, complete the portion of the Reconciliation Page (pg. 13) listing the costs incurred as of the end of the reporting year and provide the following information:

One-Time Adjustment Effective Date	Total Allowable Program Salaries Granted	Total Allowable Payroll Taxes and Fringe Benefits Granted	Other Program Expenses Granted
M M - D D - Y Y			

0199 ☐ 9. This provider meets the criteria outlined in Minnesota Rules part 9553.0035, Subpart 17. A.-D., and is entitled to a special needs rate exception payment. If checked, please provide the following information: Approved Special Needs Rate Exception Payment*

*See Instruction Manual

SELECTED PROGRAM EVALUATIONS

Insurance Regulation, January 1986	86-01
Tax Increment Financing, January 1986	86-02
Fish Management, February 1986	86-03
Deinstitutionalization of Mentally Ill People, February 1986	86-04
Deinstitutionalization of Mentally Retarded People, February 1986	86-05
Management of Public Employee Pension Funds, May 1986	86-06
Aid to Families with Dependent Children, January 1987	87-01
Water Quality Monitoring, February 1987	87-02
Financing County Human Services, February 1987	87-03
Employment and Training Programs, March 1987	87-04
County State Aid Highway System: Follow-Up, July 1987	87-05
Minnesota State High School League,* December 1987	87-06
Metropolitan Transit Planning, January 1988	88-01
Farm Interest Buydown Program, January 1988	88-02
Workers' Compensation, February 1988	88-03
Health Plan Regulation, February 1988	88-04
Trends in Education Expenditures,* March 1988	88-05
Remodeling of University of Minnesota President's House and Office, March 1988	88-06
University of Minnesota Physical Plant, August 1988	88-07
Medicaid: Prepayment and Postpayment Review - Follow-Up, August 1988	88-08
High School Education,* December 1988	88-09
High School Education: Report Summary, December 1988	88-10
Statewide Cost of Living Differences, January 1989	89-01
Access to Medicaid Services, February 1989	89-02
Use of Public Assistance Programs by AFDC Recipients, February 1989	89-03
Minnesota Housing Finance Agency, March 1989	89-04
Community Residences for Adults with Mental Illness, December 1989	89-05
Lawful Gambling, January 1990	90-01
Local Government Lobbying, February 1990	90-02
School District Spending, February 1990	90-03
Local Government Spending, March 1990	90-04
Administration of Reimbursement to Community Facilities for the Mentally Retarded, December 1990	90-05
Pollution Control Agency, pending	
Teacher Compensation, pending	
Corrections Policy, pending	
State Investment Performance, pending	
Game and Fish Fund, pending	
Nursing Homes: A Financial Review, pending	

Evaluation reports can be obtained free of charge from the Program Evaluation Division, 122 Veterans Service Building, Saint Paul, Minnesota 55155, 612/296-4708.

*These reports are also available through the U.S. Department of Education ERIC Clearinghouse.