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Medicare / Nursing Homes

REPORT TO THE CONGRESS

Continuing Problems In Providing Nursing Home Care And Prescribed Drugs Under The Medicaid Program In California B-164031(3)

Social and Rehabilitation Service
Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

AUG. 26, 1970

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

B-164031(3)

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

This is our report on continuing problems in providing nursing home care and prescribed drugs under the Medicaid program in California. Medicaid is a grant-in-aid program administered at the Federal level by the Social and Rehabilitation Service, Department of Health, Education, and Welfare. Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

Copies of this report are being sent to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

Acting Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

CONTINUING PROBLEMS IN PROVIDING NURSING HOME CARE AND PRESCRIBED DRUGS UNDER THE MEDICAID PROGRAM IN CALIFORNIA

Social and Rehabilitation Service,
Department of Health, Education,
and Welfare (B-164031(3)

D I G E S T

WHY THE REVIEW WAS MADE

Problems in providing nursing home care and controlling payments for prescription drugs under the medical assistance program for welfare recipients in California were pointed out by the General Accounting Office (GAO) in an August 1966 report to the Subcommittee on Health of the Elderly, Special Committee on Aging, U.S. Senate.

California, in March 1966, replaced its medical assistance program with Medicaid, a grant-in-aid program administered at the Federal level by the Department of Health, Education, and Welfare (HEW). Expenditures for its nursing home care program increased from about $67 million in 1965 to about $160 million in 1968. HEW paid about half of the amount each year.

Because of that substantial increase and the concern of the Congress over the rising costs of medical care, GAO examined into the actions taken by HEW and the State of California to correct the problems discussed in its August 1966 report.

FINDINGS AND CONCLUSIONS

Actions taken by HEW and the State to correct the previously reported problems were generally ineffective. Coordination between State agencies still is insufficient to successfully implement the Medicaid program. (See p. 36.)

Some problems continue because California's Medicaid plan, as approved by HEW, does not provide adequate guidelines. GAO's review shows that

--payments are not stopped for Medicaid patients in nursing homes where significant substandard conditions persist (see pp. 10 to 18),

--narcotics and other drugs in nursing homes are not controlled properly (see pp. 20 to 23), and

--patients are transferred from one nursing home to another for the benefit of the attending physician or nursing home operator (see pp. 34 and 35).

Improper practices continue also because the State does not have adequate procedures to help ensure compliance with guidelines. GAO's review showed that

--controls over authorizations for medication and treatment were inadequate (see pp. 19 and 20),

--drugs for patients who had died or had been discharged were not destroyed or proper records of their destruction were not kept (see pp. 24 and 25),

--supplemental payments, prohibited under Medicaid, were made to nursing homes for services covered by the rates paid to the homes (see pp. 26 to 28),

--patients' personal funds were not always properly safeguarded (see pp. 28 to 30), and

--some nursing home advertising was misleading and advertising was not being policed (see pp. 31 to 33).

The continuing nursing home problems are attributable, at least in part, to the inadequacy of administrative reviews by HEW regional representatives. (See pp. 36 and 37.)

GAO has found also that the procedures for payment of prescribed drugs do not ensure that payments are made only for prescribed drugs actually delivered for use by program recipients in nursing homes or other institutions, or private homes, or that drugs are dispensed by pharmacies in quantities and in frequencies consistent with physicians' dosage instructions. (See pp. 39 to 45.)

RECOMMENDATIONS OR SUGGESTIONS

The Secretary, HEW, should

--direct HEW regional representatives to review State agencies' implementation of HEW regulations on the care of Medicaid patients in nursing homes,

--impress upon State officials the need to clarify the roles of State and county agencies involved in the Medicaid program,

--help the State find solutions to the problems discussed in this report, and

--urge the State to see that payments for prescribed drugs are made only for drugs actually delivered for the use of program recipients and that drugs are dispensed in quantities and in frequencies consistent with physicians' instructions. (See pp. 37 and 44.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW informed GAO that it would review Federal regulations relating to the quality of nursing home care and their application with California officials. Similar reviews would be made in some other States and possibly in all States eventually, HEW said.

HEW agreed that the State agencies responsible for administering California's Medicaid program should make sure that other agencies assisting them are aware of their responsibilities. HEW promised to discuss that issue, as well as other GAO findings, with State officials, and to assist the State in determining corrective actions.

HEW stated that it would review with the State the implementation of HEW regulations designed to ensure delivery of proper quantities of drugs and the new pharmacy billing form designed by the State to improve drug claim processing and determine whether further action would be necessary. (See pp. 38 and 44.)

MATTERS FOR CONSIDERATION BY THE CONGRESS

GAO is sending this report to the Congress because of the congressional interest in the Medicaid program and in the provision of quality nursing home care to program recipients. The report should be useful to the Congress in its consideration of planned legislative changes to the Medicaid program.

Contents

ABBREVIATIONS

DHCS	Department of Health Care Services (State)
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare

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CHAPTER 1

INTRODUCTION

GAO has reviewed the procedures and practices of HEW and appropriate agencies of the State of California in providing nursing home care to, and in controlling payments for drugs prescribed for use by, recipients under the Federal-State program of medical assistance for the needy (Medicaid).

In a prior report[1] to the Chairman, Subcommittee on Health of the Elderly, Special Committee on Aging, U.S. Senate, we pointed out certain weaknesses and deficiencies in the administration of the former medical assistance program in providing nursing home care and prescribed drugs to welfare recipients in California. In California expenditures for nursing home care increased from about $67 million in 1965 to about $160 million in 1968. The purpose of our most recent review was to appraise the effectiveness of the actions taken by Federal and State agencies in response to our prior report.

Since our review was limited to those specific matters covered in our prior review, the findings in this report should not be considered typical of the entire Medicaid program in California. The scope of our review is described on page 46.

The medical assistance program under which welfare recipients obtained nursing home care in California at the time of our prior review no longer exists. In its place, California adopted a new plan for medical care to conform to the requirements of title XIX (Medicaid) of the Social Security Act, as amended (42 U.S.C. 1396). This plan became effective in California on March 1, 1966.

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[1] "Examination into Alleged Improper Practices in Providing Nursing Home Care and Controlling Payments for Prescribed Drugs for Welfare Recipients in the State of California" (B-114836, August 8, 1966).

The Medicaid program is a grant-in-aid program under which the Federal Government pays from 50 to 83 percent (depending upon the per capita income in each State) of the costs incurred by the States in providing medical services to individuals who are unable to pay for such services. For calendar year 1968, the 42 States and jurisdictions that had Medicaid programs reported expenditures of about $3.9 billion of which about $2 billion represented the Federal share. About 30 percent of these expenditures was for nursing home care. By August 1970, 52 States and jurisdictions had adopted a Medicaid program.

The major differences between the Medicaid program and the prior medical assistance program are (1) increased number of recipients under the Medicaid program and (2) additional health services provided to these recipients.

MEDICAID PROGRAM COVERAGE

Persons receiving public assistance payments under other titles of the Social Security Act (title I, old-age assistance; title IV, aid to families with dependent children; title X, aid to the blind; title XIV, aid to the permanently and totally disabled; and title XVI, optional combined plan for other titles) are entitled to benefits of the Medicaid program. Also, persons whose income or other financial resources exceed standards set by the States to qualify for public assistance programs but whose resources are not sufficient to meet the costs of necessary medical care may also be entitled to benefits of the Medicaid program at the option of the State. This latter category of persons was not covered under the predecessor medical assistance program.

State Medicaid programs are required to provide inpatient hospital services, outpatient hospital services, laboratory and X-ray services, skilled nursing home services, and physicians' services. Additional services, such as dental care and prescribed drugs, may be included in a State's Medicaid program if it so chooses.

ADMINISTRATION OF THE MEDICAID PROGRAM

At the Federal level, the Secretary of HEW has delegated the responsibility for the administration of the Medicaid program to the Administrator of the Social and Rehabilitation Service. Authority to approve grants for State Medicaid programs has been further delegated to the Regional Commissioners of the Service who administer the field activities of the program through HEW's 10 regional offices.

Under the act the States have the primary responsibility for initiating and administering their Medicaid programs. The nature and scope of a State's Medicaid program are contained in a State plan which, after approval by a Regional Commissioner of the Service, provides the basis for Federal grants to the State. The Regional Commissioners are also responsible for determining whether the State programs are being administered in accordance with Federal requirements and the provisions of the State's approved plan. HEW's Handbook of Public Assistance Administration provides the States with Federal policy and instructions on the administration of the several public assistance programs. Supplement D of the handbook and the Service's program regulations prescribe the policies, requirements, and instructions relating to the Medicaid program.

At the time of our review, the HEW regional office in San Francisco, California, provided general administrative direction for medical assistance programs in Alaska, Arizona, California, Guam, Hawaii, Nevada, Oregon, and Washington. The HEW Audit Agency is responsible for audits of the manner in which Federal responsibilities relative to State Medicaid programs are being discharged. A listing of principal HEW officials having responsibility for the activities discussed in this report is included as appendix III.

MEDICAID PROGRAM IN CALIFORNIA

The Medicaid program in California is referred to as Medi-Cal. In California the Department of Health Care Services (DHCS) was established as part of the Human Relations Agency to administer the program. For fiscal year 1969 California reported Medi-Cal expenditures of about

$808 million; the Federal share of these expenditures was about $405 million.

DHCS is responsible for making State policy determinations, establishing fiscal and management controls, and performing reviews of Medi-Cal program activities. In addition, DHCS is responsible for approving, disapproving, or canceling the certification of medical facilities (such as hospitals and nursing homes) for participation in the Medi-Cal program. In carrying out its responsibilities, DHCS is assisted by the State Department of Social Welfare and the State Department of Public Health. The Department of Social Welfare, in conjunction with each county welfare department, is responsible for determining the eligibility of recipients for aid under the program and also for providing social services to such recipients. The Department of Public Health is responsible for making periodic inspections and evaluations of medical facilities and making recommendations to DHCS concerning the certification of such facilities for participation in the program.

CHANGES IN PROCEDURES RELATING TO NURSING HOME CARE UNDER MEDI-CAL

Under the former medical assistance program for welfare recipients in California, the responsibility for evaluating the quality of nursing home care rested primarily with the county welfare agencies. To evaluate the adequacy of care, county medical-social review teams--which included a medical consultant and a medical-social worker--were required to visit annually 10 percent of the welfare recipients in nursing homes. These visits supplemented the licensure compliance inspection by the Department of Public Health and represented an added measure of surveillance over the quality of care being received by these recipients.

The State plan for the Medi-Cal program does not provide for the use of county medical-social review teams to monitor the quality of care provided to Medicaid recipients in nursing homes. However, the Medi-Cal program has retained the county medical consultant feature of the former program. These Medi-Cal Consultants--medical doctors employed on behalf of the State or county--are responsible for reviewing requests for nursing home care and for

determining whether the individual, for whom such care has been requested, is actually in need of such care.

A nursing home cannot be paid for services provided to a Medi-Cal recipient unless the services have been authorized by a Consultant. However, Medi-Cal Consultants or their duly authorized representatives (such as public health nurses or caseworkers) are not required by State regulations to visit recipients in nursing homes in order to evaluate the quality of care being provided by the homes. Therefore, under the Medi-Cal program the only State or county organization required to periodically visit nursing homes and report to DHCS on the quality of care being provided to Medi-Cal recipients is the Department of Public Health.

Another area in which Medi-Cal differs substantially from the former program is the method used by the State to reimburse the providers of medical services. Formerly, this was primarily a county function. Since the inception of the Medi-Cal program, DHCS has contracted with certain private organizations, such as the California Physicians Service, the Hospital Service of California, and the Hospital Service of Southern California, for assistance in administering the program. These private organizations--acting in the capacity of fiscal agents of the State--coordinate program operations between the State and the institutions and persons who provide medical services under the program. In addition, the fiscal agents review, process, and pay claims submitted by the providers for services rendered to program recipients.

CHAPTER 2

PRACTICES IN PROVIDING NURSING HOME CARE

In our report dated August 8, 1966, we concluded that the provisions of the California State plan were deficient in that they did not set forth criteria for evaluating the adequacy of care furnished welfare patients in nursing homes or provide adequate guidelines or requirements relating to the transfer of welfare patients to other nursing homes. Further, although the State plan did contain provisions regarding supplemental payments to nursing homes, protection of patients' personal funds, control and administration of medications and treatments, and misleading advertising, adequate procedures had not been established in these areas for control purposes or to fix the responsibility and authority for taking corrective action.

We expressed the view that the California State plan then in effect needed improvement to clarify the respective responsibilities of the State and county welfare agencies and of the Department of Public Health to provide the surveillance necessary to disclose deficiencies in the care, services, or treatment provided welfare recipients in nursing homes and to effect corrective action, and to provide adequate guidelines as to the policies and procedures to be followed by the respective agencies in carrying out these responsibilities.

In commenting on our earlier report, HEW and the State and the local agencies expressed their general agreement with our findings and conclusions and outlined certain corrective actions which had been taken or were being contemplated. Further, HEW and the State agencies expressed the view that, with the initiation of the Medi-Cal program, there would be changes in procedures and practices which would help to correct the problems discussed in our report.

In general, our most recent review has shown that, as a result of the State's implementation of Medi-Cal, the State plan now sets forth provisions designed to correct certain problems identified in our prior report. The plan includes criteria for evaluating the adequacy of care

furnished Medi-Cal patients and describes the responsibility and authority of the various State agencies involved in administering the Medi-Cal program--the Human Relations Agency and its constituent agencies, DHCS, the Department of Public Health, and the Department of Social Welfare. Although these provisions have been incorporated in the State plan, we found that problems with regard to nursing home care continued to exist because the State plan has not been effectively implemented to ensure that adequate care is being provided to Medi-Cal recipients.

In the following sections of this chapter, we are presenting the results of our most recent examination into the practices of providing nursing home care as they relate to

--standards of care (pp. 10 to 18),

--controls over medication and treatment for Medicaid patients (pp. 19 to 25),

--supplemental payments for Medicaid patients (pp. 26 to 30),

--advertising of physical therapy facilities (pp. 31 to 33), and

--transferring patients between nursing homes (pp. 34 and 35).

In a letter dated June 15, 1970, commenting on a draft of this report, the Assistant Secretary, Comptroller, HEW, agreed that problems warranting the careful attention of the State agency and HEW continued to exist in many of the areas examined. (See apps. I and II.)

STANDARDS OF CARE

The State plan for the Medi-Cal program specifies the standards which must be met by nursing homes in order to participate in the program and the standards by which the care to Medi-Cal patients in such nursing homes is to be evaluated. HEW has imposed still other standards relating to the adequacy of medical care to be given to nursing home patients. For a nursing home to participate in the Medicaid

program, the home must (1) with a few exceptions be licensed by the State and (2) meet all additional requirements imposed by HEW. State licensing requirements are set forth in the California Administrative Code.

The State's standards that govern the care to be provided to Medi-Cal patients in nursing homes have been substantially upgraded as illustrated by the following requirements which were not in effect at the time of our prior review.

1. A registered or licensed nurse must be on duty at all times.
2. Patients must be visited by their physicians at least once a month.
3. Written policies and procedures for patient care must be maintained.
4. Menus must be planned and supervised by a qualified dietary consultant.

Although other requirements have been established, those listed above are, in the opinion of State Department of Public Health officials, some of the more significant requirements which a nursing home must meet in order to participate in the program.

Title 17 of the California Administrative Code contains provisions for revoking a nursing home license for failure to meet State licensing requirements. In addition to a nursing home's removal from the program through a license revocation, HEW regulations require the suspension of payments to a nursing home for failing to meet standards designed to ensure that medical care is of acceptable quality.

The State has Medi-Cal Consultants throughout the State who are responsible for approving program recipients' requests for nursing home care. Title 22 of the California Administrative Code provides that the Consultant may cancel any authorization for nursing home care in effect if services or placement are not appropriate to the needs of the patient.

Violations of nursing home standards

The Department of Public Health is responsible for periodically inspecting nursing homes. As part of our examination, we reviewed the Department's inspection reports--covering the period January 1, 1966, through November 15, 1969--for 70 nursing homes located in 16 counties. These inspection reports showed numerous nursing home violations of State licensing and HEW requirements for participation in the Medi-Cal program. For example, there were

--219 violations at 57 nursing homes involving medications given to patients without signed physicians' orders, or medications not administered as prescribed or not recorded in the patients' records,

--138 violations at 69 nursing homes involving inadequate general maintenance or inadequate cleaning and disinfection of dishes,

--118 violations at 49 nursing homes involving inadequate nursing care supervision or inadequate or unqualified nursing staff,

--119 violations at 44 nursing homes involving incomplete patient records,

--80 violations at 41 nursing homes involving improper labeling, handling, storage, or disposal of drugs,

--68 violations at 34 nursing homes involving the absence of employee health examinations,

--38 violations at 23 nursing homes involving inoperative patient call systems, and

--38 violations at 17 nursing homes involving inadequate diets and menus.

We have been informed by DHCS and Department of Public Health officials that, at any given time, violations of varying intensity of certain of the State requirements for nursing homes can be found in most of the approximately

1,250 nursing homes in the State. However, these officials have informed us also that, because action to revoke a nursing home license--or to otherwise suspend the nursing home from the program--must be based on a well-documented record and must stand the test of formal administrative proceedings, it is the State's policy to give nursing home proprietors every opportunity, through both routine notifications of inspection findings and informal disciplinary conferences, to correct deficiencies noted during inspections before formal disciplinary action is initiated.

In March 1967, HEW notified all States that, effective January 1, 1969, nursing homes participating in the Medicaid program must provide nursing service on a 24-hour basis and the service must be directed by a registered professional nurse employed full time by the homes. Also, at all times, the nursing service must be in the charge of a professional registered nurse or a licensed practical nurse. In this connection, the HEW Audit Agency in a report dated June 25, 1969, on its review of the Medi-Cal program stated that about 200 nursing homes which had not met professional staffing requirements were allowed to continue to participate in the program beyond the January 1, 1969, deadline. The report concluded that, as a result, Medi-Cal patients had not received the quality of care that had been anticipated under the Medicaid program. The State advised each of the approximately 200 nursing home operators of the noted violations and stated that the participation of these homes in the Medi-Cal program would be terminated unless the homes met the staffing requirements. Our review showed that, by July 31, 1969, 12 of these homes had voluntarily withdrawn from the program; 65 homes had their certificates to participate in the program withdrawn by the State; and, about 123 homes had apparently made required staffing changes and thus were able to continue in the program.

The State plan does not specify which State agency, if any, has the authority and responsibility to withhold payment for Medi-Cal patients in nursing homes in which substandard conditions exist. We noted that, in a letter dated April 4, 1967, the Administrator of the Human Relations Agency advised the HEW regional representative that the Medi-Cal Consultant may deny requests for nursing home care

for Medi-Cal recipients in nursing homes which fail to meet program standards.

As noted on page 11 of this report, title 22 of the California Administrative Code provides that the Medi-Cal Consultant may also cancel any previously approved authorization for nursing home care when services or placement are not appropriate to the needs of the patient. Notwithstanding this provision, DHCS officials have advised us that, in their opinion, a Consultant may not cancel a previously approved authorization for nursing home care simply because the standards of care specified by the State or HEW are not being met. They have advised us also that a patient's physician is primarily responsible for evaluating the quality of care being provided by a nursing home and for removing the patient from the nursing home if he is dissatisfied with the quality of care being provided to his patient. DHCS officials have advised us further that a Consultant may not cancel any previously approved authorization--on the basis of noncompliance with nursing home standards--until all legal and administrative due process has been afforded to the nursing home.

Accordingly, it appears that under current State practices, the removal of a patient from a nursing home which is not providing the quality of care required is possible only through (1) time-consuming formal administrative and/or legal proceedings or (2) action of the patient's physician.

In our report dated August 8, 1966, we pointed out that serious substandard conditions had existed at many of the nursing homes for long periods of time without action being taken to revoke the license of the operators. Further, where formal revocation action had been taken, many months elapsed before final decisions were rendered. During our most recent review, we noted that this situation continued to exist.

Officials of the Department of Public Health have advised us that license revocation proceedings generally take from 3 weeks to 22 months and that, since a license revocation affects the proprietor rather than the nursing home, a revocation proceeding can be stopped through a change in ownership of the home. Following is an example of an action

by the Department of Public Health to revoke the license of the operator which illustrates, in our opinion, the need for establishing procedures authorizing Medi-Cal Consultants to cancel authorizations for nursing home care for patients who are in nursing homes where substandard conditions exist.

In March 1967 the State placed a nursing home operator on 3 years' probation, in lieu of revoking his license, for numerous violations of licensing requirements. The conditions of probation were that the operator meet all such requirements in the future.

During the following 13 months, five inspections of the nursing home disclosed 18 violations of State licensing requirements. Department of Public Health officials consulted with the nursing home operator on three separate occasions during this period. In April 1968 the Department recommended that the State Attorney General take action to revoke the nursing home operator's licesne. During the next 4 months, five more inspections disclosed 28 violations of State licensing requirements. In September 1968 formal license revocation hearings were held for 5 days. In February 1969 the operator was placed on probation (this time for 5 years) again contingent upon his compliance with all State licensing requirements.

Almost 2 years elapsed from the start of formal action against the nursing home operator until the case was decided. In the meantime, the State was paying the nursing home for services provided to Medi-Cal patients. We cannot say whether this situation resulted in any harm to the patients, since this could only be determined through a full evaluation of all facts and circumstances involving individual patients by persons having requisite skills in the medical and/or social welfare fields.

We believe that, if the Consultant had threatened to cancel--or had canceled--authorizations for treatment of Medi-Cal patients in this home, it would have induced the operator to promptly comply with State licensing requirements. In our opinion, so long as the State does not take such action, patients may be provided care of a lesser quality than called for by the Medicaid regulations.

We agree with DHCS that a patient's physician has the responsibility of removing his patient from a nursing home if he is not satisfied with the quality of care being provided to a patient. We believe, however, that a physician's decision to place or retain a patient in a nursing home which is not complying with Medicaid standards should not be interpreted as requiring the Consultant to approve requests for care in such homes. Also, the role of the physician does not relieve DHCS of its responsibility for ensuring compliance with HEW standards for skilled nursing homes. Moreover, there are situations where we believe the Medi-Cal Consultant should be relied upon to safeguard a patient's welfare. For example, in homes wholly or partially owned by physicians or in homes in which they otherwise have a pecuniary interest, we believe that an objective decision by the physician to remove a patient under these circumstances would be more difficult. Also, our review of medical records in 14 nursing homes indicated that Medi-Cal patients were not always being visited by a physician at least once each month as required by HEW and the State. Therefore, in our opinion, such physicians were not in a position to monitor the quality of care being received by their patients. On the basis of our review of nursing home records and State and HEW requirements, we estimate that 1,234 physicians' visits were required for 106 Medi-Cal patients from February 1966 through May 1969. Our review showed that 215 physicians' visits were not made.

Neither DHCS nor the Department of Public Health advises the patients' physicians of nursing homes' violations of State and HEW requirements; therefore, the physicians--unless they inspect the home or make inquiries at the appropriate State or county offices--may not know whether a nursing home (1) has adequate professional staff, (2) has proper food preparation and service, (3) has adequate general maintenance, (4) is providing services to the proper number of patients consistent with the licensed capacity, (5) has adequate fire protection, (6) has required its employees to take periodic health examinations, or (7) meets accepted professional practices in the labeling, handling, storage, and disposal of drugs. We doubt that many physicians are making such inspections or inquiries nor do we believe that it is practical for them to do so.

Although HEW and the State have taken certain actions to substantially upgrade the quality of care provided to nursing home patients under the program, we believe that further actions are necessary to ensure that Medi-Cal patients do not remain in nursing homes that violate State and HEW requirements for long periods of time. In this regard, there still remains a need to precisely define the specific authority and responsibility of agencies and individuals involved in the evaluation of the adequacy of care provided to patients in a nursing home and the enforcement of nursing home standards.

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On April 29, 1970, final HEW regulations to implement section 1902(a)(28) of the Social Security Act--relating to standards for skilled nursing homes to participate in the Medicaid program--were published in the Federal Register (45 CFR 249.33). These regulations provide that, if a home is not in substantial compliance with the standards for payment for skilled nursing home care, the home may not participate in the Medicaid program. If the home is found to be in substantial compliance (that is, is in compliance except for deficiencies), the State agency may permit the home to participate in the program for a period of 6 months, provided there is a reasonable prospect that the deficiencies can be corrected within that time and that the deficiencies do not jeopardize the health and safety of the patients. No more than two agreements for successive 6-month periods may be executed with any one home and a second agreement may not be executed if a deficiency previously noted continues unless the home has made substantial effort and progress toward its correction.

The HEW regulations, if properly implemented by the States, should help to resolve problems such as those noted during our review. We believe that forceful monitoring by HEW of the States' implementation of the regulations relating to discontinuing payments to homes and granting extensions of certifications when homes are in substantial compliance with standards for payment, will be necessary to ensure that patients receive the quality of care called for by the Medicaid regulations.

Agency comments and actions

In commenting on a draft of this report, HEW stated that its regulations governing the certification of skilled nursing homes to participate in the program are sufficient, if properly implemented by the State, to eliminate the weaknesses reported relating to the standards of care in California. HEW stated also that there may be some misunderstanding by the State agency as to the provisions of certain Federal requirements and that the HEW regional office staff will attempt to clarify the requirements for the State agency.

In a letter dated March 4, 1970 (see app. II), the State advised HEW that, in an effort to strengthen the effectiveness of the Medi-Cal Consultants, new standards for operation of the Medi-Cal Consultant units throughout the State are being developed with a view toward obtaining a more uniform and more effective application of program policies, rules, and regulations. We noted that these standards, which were incorporated in State regulations in April 1970, provide for periodic on-site visits to nursing homes by staff members of the Medi-Cal Consultant units to evaluate the quality of care.

CONTROLS OVER MEDICATION AND TREATMENT FOR MEDICAID PATIENTS IN NURSING HOMES

Authorizations for medication and treatment

The State licensing requirement that there be signed physicians' orders for medication and treatment administered to nursing home patients which was in effect at the time of our prior review, was still in effect at the time of our recent review. In addition, after our prior report, the California State Board of Pharmacy issued guidelines for providing pharmaceutical services in nursing homes. These guidelines emphasize the importance of signed physicians' orders and accurate recordings on the patients' charts of medications administered.

DHCS officials advised us that they relied on inspections by the Department of Public Health to disclose deficient nursing home practices in administering medication and treatment to patients. Officials of the Department of Public Health told us that their inspections of nursing homes did not include tests of compliance with the State Board of Pharmacy guidelines because compliance with these guidelines was not mandatory and because their inspections covered only compliance with State licensing requirements and Medi-Cal regulations.

We reviewed 1 month's medical records of 106 Medi-Cal patients at 14 nursing homes. These records showed that 734 doses of medication were administered without any signed physicians' orders; 311 doses were administered in quantities in excess of those prescribed; and 1,210 prescribed doses were not administered.

As previously noted on page 12, State inspection reports for 70 nursing homes showed that State requirements regarding authorizations for medication and treatment were violated more frequently than other requirements. A total of 219 violations of this type were recorded at 57 nursing homes.

Where records showed that medications had been administered without physicians' orders, we were told by nursing

home personnel that the physicians had neglected to write or sign the order. In those instances where records showed that medications had been administered in greater quantities than prescribed or had not been administered at all, nursing home personnel told us that (1) there were errors on the patients' medical charts and the medications had been correctly administered and (2) the medications were given on an as-needed basis and, in some cases, the patients did not need the medications at the time it was supposed to have been administered.

We believe the results of our review clearly show that improper nursing home practices regarding authorizations for medication and treatment continue to exist and that there is still a need for the State to adequately control medication and treatment administered to patients.

Accounting for drugs and quantities of drugs on hand in nursing homes

Accounting for narcotics

HEW requires that a record be maintained on separate sheets for each type and strength of narcotic, showing the quantity on hand, the date and time a dose is administered to a patient, the name of the patient, the name of the physician, the signature of the person administering the dose, and the quantity remaining on hand.

The State plan for Medi-Cal does not require nursing homes to maintain special records to account for narcotics. However, guidelines issued by the State Board of Pharmacy for providing pharmaceutical services in nursing homes call for various physical and accounting controls over narcotics. As noted previously, DHCS and the Department of Public Health have no means to ensure that the guidelines are being followed because compliance with these guidelines is not mandatory. The California Narcotic Act requires the person who prescribes, administers, or dispenses a narcotic to record the transaction; however, State officials told us that they interpret this requirement as applying to physicians and pharmacies but not to nursing homes because the homes do not have a narcotic license but act only in behalf of

patients by keeping custody of their medications and administering them when necessary.

Our review at 13 nursing homes showed that narcotics were being kept in locked cabinets and that, usually, a physical count was made once on each nursing shift, or at least once a day, to ensure that the quantity of narcotics on hand agreed with the quantity shown on the control sheet maintained for each narcotic.

At five of these 13 nursing homes, we compared for 29 selected patients the narcotics dispensed during a 1-month period, as shown by the narcotic drug control sheets maintained by the dispensary, with patients' medical charts. Our comparison showed that 86 doses of the narcotics dispensed had not been administered, according to the patients' medical charts. On the other hand, the patients' medical charts showed that 24 doses of narcotics were administered to these patients, but the drug control sheets did not show that the narcotics had been dispensed. Nursing home officials advised us that the discrepancies were attributable to poor recordkeeping.

We were advised by Department of Public Health officials that their inspectors would not make the types of comparisons that we had made and that, therefore, these types of discrepancies in accounting for narcotics would not be disclosed. They also stated that nursing homes were not required by the State plan or licensing requirements to maintain drug control sheets. DHCS officials stated that inspections were the only means they had of systematically evaluating nursing home controls over narcotics.

We believe that the results of our review indicate a need for the State to examine into the accounting for narcotics in nursing homes and, on the basis of such an examination, to institute controls over the administration of narcotics in nursing homes, including periodic compliance inspections by the Department of Public Health. We believe that such measures are particularly needed in view of (1) the State's interpretation that the California Narcotic Act does not apply to nursing homes because the homes act only in behalf of patients by keeping custody of their medications and administering them when necessary and (2) HEW

requirements that a record of narcotics dispensed and administered be maintained in detail.

Accounting for drugs other than narcotics

In our August 8, 1966, report, we expressed the view that (1) nursing homes should maintain records of the quantity of incoming drugs, (2) pharmacists should be required to indicate the quantity of drugs on the labels of the containers of drugs for welfare patients, and (3) nursing homes should be required to check these quantities, at least on a test basis. It was our belief that maintaining records of incoming drugs, the added labeling requirement, and periodic test counts could serve as bases for further inquiry or investigation in those instances where there were indications that significant units of drugs were unaccounted for or that quantities of drugs purchased substantially exceeded anticipated needs.

Subsequent to the issuance of that report, the State of California advised HEW that guidelines issued by the State Board of Pharmacy would meet and surpass the standards suggested by GAO. We note that the Board's guidelines concerning pharmaceutical services provided in nursing homes state that "Accurate records shall be kept of all medication received by the facility and administered to the patient" and that "All prescription medication for the individual patient shall bear on the label the name, dose size, expiration date if indicated, and amount of the drug contained." (Underscoring supplied.) It should be noted that adherence to these guidelines by nursing homes and pharmacies participating in the Medi-Cal program is not obligatory. We noted also that neither the State licensing requirements for nursing homes nor Medi-Cal regulations require that test counts of incoming drugs be made.

During our recent review we found that none of the 12 nursing homes which we visited maintained records of the quantity of incoming drugs other than narcotics. At these 12 nursing homes we inquired as to whether test counts were made of incoming drugs--other than narcotics--and whether pharmacists recorded the quantity of drugs on the label of the drug container.

We were advised at 11 of these homes that test counts of incoming drugs from pharmacies were not made and at the remaining home that test counts were made infrequently. Also, at five of the 12 homes, we were advised that pharmacies never showed quantities of drugs on the labels; whereas, at five other homes, we were advised that the pharmacies always showed quantities on the labels. At the two remaining nursing homes, we were advised that some pharmacies showed quantities on the container labels whereas others did not.

The need for control and accountability over the quantity of prescribed drugs received by nursing homes still exists, because current guidelines relating to drug control are not mandatory and do not require verification of quantities of incoming drugs. As illustrated in the following table, at one nursing home visited, significant proportions of drugs prescribed for three Medi-Cal patients during the period October 1, 1969, through January 6, 1970, were not on hand and could not be accounted for by nursing home officials.

Medication	Patient	Quantity purchased	Quantity administered per orders and charts	Unaccounted for difference
Mellaril tablets	A	310	265	45
Darvon compound capsules	B	60	29	31
Benadryl capsules	C	281	267	14

In view of the continuing lack of control and accountability over the quantity of drugs received, we believe that DHCS should require pharmacies and nursing homes participating in the Medi-Cal program to adhere to recordkeeping and labeling guidelines set forth by the State Board of Pharmacy. Also, we continue to believe that nursing homes should be required to verify, on a test count basis, the quantities of incoming drugs and to record the dates and results of such tests.

Drugs on hand

State licensing requirements regarding the disposition of drugs for deceased patients or for patients who have left nursing homes have been revised since the issuance of our prior report. These requirements now state that individually prescribed drugs shall be destroyed when a patient dies or is discharged from a nursing home unless the attending physician orders otherwise. The State requires nursing homes to record the destruction of individually prescribed drugs. The home's records are required to show the patient's name, the name of the medication, the quantity destroyed, the date of destruction, and the signatures of two witnesses.

Our review at 11 of 12 nursing homes indicated that individually prescribed drugs for deceased or discharged patients were being destroyed in accordance with State licensing requirements. At the remaining nursing home, however, we found that individually prescribed drugs had not been destroyed for patients who were deceased or discharged. An official at this nursing home advised us that it was their policy to collect these drugs and return them for destruction to the pharmacy from which they were purchased. At the time of our visit, we noted that drugs for such patients had been packaged for delivery to the pharmacy but records of the disposition of these drugs--or drugs previously disposed of in this manner--were not maintained. Department of Public Health officials agreed with us that returning drugs to the pharmacy from which they were purchased was not in accord with State licensing requirements.

We examined State inspection reports for 70 nursing homes for the period January 1, 1966, through November 15, 1969 (see p. 12). These reports cited 80 violations at 41 homes of State licensing requirements relating to the handling, storage, and disposal of drugs; 23 of the violations related to the improper disposal of drugs at nursing homes.

Department of Public Health officials advised us that, despite the revised licensing requirements, the disposal of prescription drugs by nursing homes was a very difficult area for their inspectors to police. They were of the

opinion that a nursing home operator could conceal from the inspectors drugs belonging to deceased or discharged patients by maintaining the required records of destruction (while not actually destroying the drugs) and routinely obtaining the signatures of his employees as witnesses. These officials did not cite any specific instances where such concealment had been detected. We believe that the Department should direct its inspectors to examine into the authenticity of the signatures of witnesses and the manner in which such signatures were obtained on a periodic test basis and in every instance in which it is suspected that drugs are being improperly retained by a nursing home in violation of State licensing requirements.

We believe that improvements have been made in the State's procedures governing the disposal of individually prescribed drugs for patients who have left nursing homes. Nevertheless, continued efforts by State licensing inspectors are warranted in view of the concern expressed by State officials relating to the possible concealment of drugs purported to be disposed of.

Agency comments and actions

In commenting on a draft of this report, HEW and DHCS agreed that continued effort to improve controls over the prescribing and dispensing of drugs for nursing home patients appeared warranted. HEW stated that it planned to discuss the matter with State officials and DHCS stated that it was in the process of developing detailed Medi-Cal program requirements for the prescribing and dispensing of drugs in nursing homes.

SUPPLEMENTAL PAYMENTS TO NURSING HOMES FOR MEDICAID PATIENTS

Supplemental payments by patients or others to nursing homes under the Medicaid program are prohibited by HEW regulations. Supplement D of HEW's Handbook of Public Assistance Administration states that participation in the program is limited to providers of service, including nursing homes, that accept, as payment in full, the amounts paid in accordance with the fee structures established by the State. The California State plan for Medi-Cal contains the same prohibition.

We noted that State and county agencies had issued a number of informational brochures advising recipients of the medical services covered under the Medi-Cal program. These brochures, however, do not (1) describe the nature of supplemental payments, (2) specify the items of service or care included in the rate paid to nursing homes, or (3) specifically state that supplemental payments by patients or others for items included in the rate should not be made. We noted also that the State had, on several occasions, advised fiscal agents, nursing homes, Medi-Cal Consultants, and county welfare offices, that supplemental payments were prohibited. We found, however, that the State did not systematically review nursing home practices to ascertain whether supplemental payments were being received and that investigations were made on a complaint basis only.

Since initiation of the Medi-Cal program, DHCS has investigated complaints that supplemental payments were being made to 42 nursing homes. At the time of our recent review, many of these investigations had not been completed. In nine cases, DHCS determined that supplemental payments had, in fact, been collected by the nursing homes. Three examples follow.

1. Between March 1966 and September 1969, a nursing home collected over $1,400 from 34 patients for services which were covered in the daily rate paid by Medi-Cal. This home also collected $250 at the rate of $25 per month in "under the table" payments from the family of one Medi-Cal patient. The investigation disclosed that all of the improper

transactions were attributable to the home's former administrator and former bookkeeper. Since these violations were by the employees of the home, DHCS did not bring formal action to remove the proprietors from the program. We were advised by DHCS officials that arrangements to recover the overpayments were being made and that amounts collected would be returned to those who made the payments.

2. Another investigation resulted in a nursing home being placed on probation for 3 years in lieu of being suspended from the program. This home had collected about $2,000 in supplemental payments--$100 a month during the period April 1967 to December 1968--made in behalf of a Medi-Cal patient.

3. Another nursing home was charging Medi-Cal patients $10 a month for personal laundry even though, in some instances, no such expenses were incurred and, in other instances, these expenses may have been less than the $10. This charge was made only to Medi-Cal patients in the home. As a result of their investigation, DHCS recovered about $1,300.

DHCS officials stated that they did not have statistics on the number of complaints received regarding supplemental payments under the former medical assistance program but that the number of complaints received concerning supplemental payments had probably increased because of the expanded coverage of the Medi-Cal program and the increased number of participants.

We noted that a report issued in November 1968 by the Attorney General of the State of California stated that an investigation of the Medi-Cal program had disclosed that many nursing homes required patients or their relatives to pay money "under the table" to secure admission of the patient and that often supplemental payments were required each month that the patient remained in the home. The Attorney General's report further stated that many Medi-Cal patients in nursing homes were not aware of the benefits to which they were entitled and could be billed by the nursing home for services which, unknown to the patient, had already been paid for under the program.

A Department of Public Health official advised us that a review to determine whether supplemental payments had been made was not included in their inspections of nursing homes. DHCS officials advised us that, despite a substantial increase in their investigative staff since the start of the Medi-Cal program, there was still not sufficient staff to systematically review nursing home records to determine whether supplemental payments had been received and, therefore, such reviews were made only when a complaint was received.

In considering the (1) substantial increase in the coverage of the Medi-Cal program over the prior medical assistance program, (2) increased number of complaints being received by DHCS concerning supplemental payments, (3) determinations by DHCS in cases examined that supplemental payments were, in fact, being received by nursing home operators, and (4) findings of the State's Attorney General, we believe that an effective State program to discover, investigate, and eliminate supplemental payments to nursing homes is needed. Such a program could include (1) letters of inquiry to relatives of the patients, (2) discussions with patients during routine visits by State employees, and (3) notices to recipients when periodically mailing their Medi-Cal identification cards.

We believe that, so long as reviews at nursing homes do not include a determination for compliance with the HEW regulations prohibiting supplemental payments, such payments will continue to be made principally because most persons making such payments are either unaware that the payments are not required or are concerned that a complaint could result in the patients' not receiving adequate care. Further, we remain of the opinion that dissemination of information to Medi-Cal recipients and other interested parties, as to the nature of supplemental payments and what services or care are covered in the rate paid under the program, would tend to deter supplemental payments to nursing homes for Medi-Cal patients.

Safeguarding patients' personal funds

The California Administrative Code requires nursing home operators to maintain adequate safeguards and accurate records of Medi-Cal patients' money and valuables.

California State officials advised us that the State had not issued uniform procedures for use by nursing homes in accounting for, and handling of, patients' personal funds, although suggested in our August 1966 report. We were told that corrective action had not been taken on this matter because of higher priority projects.

During our recent review at 12 nursing homes, we again found considerable variance in the procedures and records used by the homes to account for patients' funds. For example:

--four homes maintained patients' personal funds in checking accounts at local banks while three homes retained patients' funds in individual envelopes in the nursing homes,

--six homes maintained individual ledger accounts for each patient's funds while three homes merely made notations of deposits and withdrawals on envelopes containing the funds,

--two homes did not issue receipts to patients for funds and four homes did not obtain patients' signatures for withdrawals from their personal accounts, and

--three homes were members of separate nursing home chains and the patients' personal funds were maintained at the chains' central offices.

We noted also that the State Attorney General's November 1968 report on the Medi-Cal program disclosed instances in which the $15 per month personal expense money, for such items as cigarettes, candy, and haircuts, which Medi-Cal patients received from the county welfare offices had been misappropriated by some nursing homes. The report cited, as an example, one nursing home that was in possession of about $2,000 which belonged to Medi-Cal patients who had died or had been discharged from the home. Department of Public Health officials advised us that, during their inspections of nursing homes, they ascertained whether the home had adequate facilities to safeguard patients' personal funds and whether the home had records to account for such funds. The Department does not, however, routinely

examine into the propriety of the types of charges made against the accounts or the adequacy of documents supporting deposits and withdrawals.

Regulations of the California Department of Social Welfare require that patients in nursing homes be visited at least once a year by a county social worker to verify that the patient's continued residence in the nursing home is consistent with his social needs. A Department of Social Welfare official has advised us that, during these visits, the social workers inquire into the status of the personal funds of patients only if requested to do so by the patient or someone acting in the patient's behalf or if the patient has previously been judged incompetent.

We believe that the results of our review, together with the report of the State Attorney General, demonstrate the need for action by the State to strengthen controls over the handling of patients' personal funds.

Also, we continue to believe that there is a need for the State to establish standard procedures to be used by nursing homes in handling and accounting for Medi-Cal patients' personal funds. Such action, supplemented by appropriate surveillance during visits by State representatives would, in our opinion, substantially assist the State in guarding against misuse of these funds.

Agency comments and actions

In commenting on a draft of this report, HEW agreed with our suggestion that information on services and care covered under the Medi-Cal daily rate paid to nursing homes and restrictions concerning supplemental payments should be provided to patients' relatives and other interested persons. The State advised HEW that it had adopted this suggestion and was preparing an information leaflet for circularization.

HEW agreed also that better controls over the handling of patients' personal funds by nursing homes were needed and stated that it would discuss with State officials the feasibility of establishing standard procedures to be followed by the homes and surveillance by the State.

ADVERTISING BY NURSING HOMES OF PHYSICAL THERAPY FACILITIES

The California Administrative Code specifies that providers of services may be suspended from the Medi-Cal program for unlawful or unethical advertising or advertising which holds forth the advertiser as one specifically authorized or certified to render services available under the program.

We inquired into the advertising practices at 12 nursing homes. Three homes did not advertise; seven homes used various types of advertising which appeared to be consistent with the Medi-Cal regulations; but the advertising of the two remaining nursing homes appeared not to be in accord with the regulations.

One nursing home's advertising brochure stated that a fully equipped physical therapy room was available on the premises; however, our visit to the physical therapy room revealed that the only equipment available was a set of parallel bars. The nurse in charge at this home informed us that the parallel bars represented the only physical therapy equipment in the home. She stated that, in preparing the advertising brochure, she referred to other nursing home advertisements in the yellow pages of the telephone directory and took excerpts from the various advertisements.

A second home--part of a chain of nursing homes--was using the same advertising brochure cited in our August 1966 report as containing misleading information regarding physical therapy facilities. We noted that, except for the front and back covers which contained the names and exterior pictures of the individual nursing homes, this advertising brochure was being used by at least eight other homes in the chain. The home advertised that it possessed

1. a physical therapy department under the direction of a well-qualified registered therapist,

2. 12-foot parallel bars,

3. exercise steps,

4. a tilt-top table,

5. exergenie wall pulleys,

6. a Burdick ultrasound and electric stimulator,

7. diathermy,

8. a traction table, and

9. a hydrocollator for moist heat.

Our inspection of the physical therapy room at this nursing home revealed that the only items of equipment available were the parallel bars and the exercise steps. The administrator of this nursing home acknowledged that these two items of equipment were the only pieces of physical therapy equipment at this home; however, she said that the remainder of the advertised equipment was located in other nursing homes in the chain but was portable and could be made available to patients in this home.

We discussed the results of our review with DHCS and Department of Public Health officials who advised us that they had no program to review nursing home advertisements. We were told that their investigative staffs reviewed nursing home advertisements only on a complaint basis or when one of these staff members happened to notice a questionable advertisement. Furthermore, DHCS officials stated that, in their capacity as the single State agency responsible for administration of the Medi-Cal program, they were concerned only with those who advertise services, supplies, or equipment as being reimbursable under the Medi-Cal program. DHCS and Department of Public Health officials stated that the policing of advertising was not their responsibility.

In our opinion, no action has been taken by the State to improve controls over advertising by nursing homes. We believe that Medi-Cal patients or their families could be misled by the types of advertisement which we have noted. We believe that, to help avoid misleading advertising by nursing homes, DHCS--as the single State agency--should either assume the responsibility for policing advertising practices relating to the program or ensure that such

responsibility is specifically assigned to, and carried out by, some other State agency.

Agency comments and actions

In commenting on a draft of this report, HEW agreed that DHCS should either assume the responsibility for policing advertising practices relating to Medi-Cal or ensure that such responsibility is specifically assigned to, and carried out by, some other State agency. In this connection, the State advised HEW that consideration would be given to increasing efforts to detect cases of misleading advertising.

HEW stated that, while advertising practices described in our report might mislead a Medi-Cal recipient or his family, it is expected that the patient's caseworker will be familiar with nursing home conditions and services in an area and will advise the patient and/or his family in instances of misleading advertising.

TRANSFERRING PATIENTS BETWEEN NURSING HOMES

State Medi-Cal regulations require that transfers of patients between nursing homes be approved by the Medi-Cal Consultant prior to such transfers. The regulations do not, however, specify the manner in which prior approval is to be obtained. Guidelines issued by DHCS to the Consultants for their use in authorizing nursing home care are not addressed to the circumstances under which interhome transfers of patients are to be permitted. We were advised by Medi-Cal Consultants that prior approval for transferring a Medi-Cal patient was usually obtained from the Consultant by telephone and that no permanent record of such approval had been maintained.

We inquired into the reasons for the interhome transfers of 60 Medi-Cal patients at eight of the 14 nursing homes we visited. Since the nursing homes are not required to maintain records of the reasons for interhome transfers of patients, it was necessary for us, in most instances, to rely on the recollections of the nursing homes' staffs about the reasons for the transfers.

On the basis of the recollections of the nursing homes' staffs and our review of available records, it appears that, of the 60 transfers, 34 were made primarily for the benefit of the patient. For 13 transfers, there was not sufficient evidence to enable us to reach an opinion as to who benefited primarily from the transfer. We believe, however, that the remaining 13 transfers were made for the benefit of someone other than the Medi-Cal patient. We found that:

--Six transfers were made primarily for the benefit of the nursing homes making the transfers because operators of the homes wanted the beds occupied by these patients for use by prospective Medicare or private patients for whom a higher daily rate could be collected. In one of these six transfers, the family of the patient was not aware of the transfer until after it had taken place.

--Two transfers were made at the instigation of the former owner of a nursing home who had opened a new home.

--Five transfers were made because the attending physician wanted the patient in a nursing home of which he had become part owner.

In each of these 13 transfers, the Medi-Cal Consultant determined that nursing home care was needed by the patient. The approval document for such care, however, is not designed to disclose any information relevant to the reasons for the transfer of a Medi-Cal patient from one home to another. In our opinion, the Medi-Cal Consultant did not receive all the information necessary to reach a decision concerning the need for, or reasonableness of, interhome transfers.

We believe that criteria under which Medi-Cal patients may be transferred at the initiative of the nursing home should be established; that policies and procedures under which nursing homes would have to obtain the written approval of the Medi-Cal Consultant before effecting such transfers should be developed; and that these criteria, policies, and procedures should be made a part of the State plan.

Agency comments and actions

In commenting on a draft of this report, HEW agreed with our suggestion that authorizations for transfer be in writing and include the reasons for transfer. HEW stated that it planned to recommend to the State that, in each instance of a proposed transfer, an interview with the patient by his caseworker be required and that the caseworker make a written record of the reasons for the transfer.

CONCLUSIONS, RECOMMENDATIONS, AND AGENCY COMMENTS AND ACTIONS

Our recent review of practices in providing nursing home care showed that, for the most part, weaknesses in the administration of California's Medi-Cal program continue to exist. Although HEW and the State instituted measures designed to correct some of the weaknesses pointed out in our August 1966 report, such measures were generally ineffective in resolving the problems noted. Also, we found weaknesses in the administration of one aspect of the program--accounting for narcotics--which we had examined into during our prior review and found not to be a problem.

Extensive coordination of the various State agencies is vital to the success of any program--such as Medicaid--wherein there are divergent interests and/or multiple levels of responsibility. We believe, however, that the degree of coordination necessary to enable California to successfully implement its Medicaid program has not been achieved. For example:

1. Results of Department of Public Health inspections of nursing homes which revealed significant deficiencies relating to State licensing and HEW requirements had not been made known to attending physicians either through Medi-Cal Consultants or through local medical societies or had not been used by DHCS to carry out its responsibilities under HEW regulations to require compliance with, or to terminate a nursing home's participation in, the program.

2. DHCS had not required that guidelines promulgated by the California State Board of Pharmacy be followed by nursing homes.

3. DHCS had not fixed the responsibility for the policing of nursing homes' advertising practices.

We believe that the State plan for Medi-Cal, which has been approved by HEW, remains deficient in that it does not provide adequate guidelines for (1) discontinuance of payment for the care of Medi-Cal patients in nursing homes in which substandard conditions exist, (2) controls over the

administration of narcotics and other drugs, and (3) protection of the patients from interhome transfers for the benefit of others. Although the State plan contains guidelines relating to supplemental payments, protection of patients' personal funds, authorizations for medications and treatment, destruction of drugs for deceased or discharged patients, and nursing home advertisements, we believe that adequate procedures to help ensure compliance with these guidelines by nursing homes have not been implemented by the State nor have appropriate reviews been made by the State or HEW to highlight the need for additional corrective measures.

Primary responsibility for the quality of medical care under the Medicaid program rests with the States. HEW is responsible for assuring itself, through appropriate administrative reviews and audits of States' program activities, of the adequacy of States' program administration. We believe that administrative reviews by HEW regional representatives generally have been inadequate to ascertain whether nursing homes providing care to Medi-Cal patients have met the HEW requirements governing the quality of care or whether the patients' interests have been safeguarded. We noted that, on November 25, 1969, the HEW Audit Agency furnished to its regional offices audit guidelines for a multi-State audit of nursing homes participating in the Medicaid program. One of the stated objectives of the Audit Agency's review was to determine whether Medicaid patients were being provided with adequate care and facilities.

Recommendations to the Secretary of Health, Education, and Welfare

In the interest of providing the surveillance necessary to help minimize deficiencies in the care, services, or treatment given to Medicaid patients in nursing homes and to effect corrective action where such deficiencies are found, we recommend that the Secretary of HEW, through the Administrator of the Social and Rehabilitation Service:

--Direct HEW regional representatives to review the manner in which State agencies are implementing HEW regulations relating to the quality of care being provided to Medicaid patients in nursing homes.

--Impress upon State officials the importance of clarifying the respective responsibilities and authority of the State and county agencies involved in the administration of the Medicaid program.

We recommend also that HEW regional representatives assist DHCS in determining action needed to help resolve the problems discussed in this report.

Agency comments and actions

In commenting on a draft of this report by a letter dated June 15, 1970 (see app. I), the Assistant Secretary, Comptroller, HEW, stated that the HEW regional office staff would be instructed to review with the California State agency the several Federal regulations relating to the quality of nursing home care and to discuss with them the applicability of these regulations to the observations made in our report. He stated also that, since there appears to be a lack of full understanding of these regulations in California and other States, HEW was planning visits by teams of central office and regional office staffs to review activities and procedures of State agencies and to provide consultation on full implementation of the regulations.

The Assistant Secretary, Comptroller, informed us that HEW planned to visit a few selected States within the next 3 months and would, on the basis of this experience, consider visiting all Medicaid States. He informed us also that HEW agreed that the single State agency administering the Medicaid program should assure itself that employees of assisting agencies were fully aware of the responsibilities which had been established.

Further, in accordance with our recommendations, HEW officials will discuss these matters with DHCS officials and will assist them in determining the actions needed to ensure correction of the problems noted. He also stated that, if these discussions revealed a need for assistance by the Division of Management Information and Payment Systems or the Division of Technical Assistance and Training of the Medical Services Administration, Social and Rehabilitation Service, in Washington, such assistance would be made available.

CHAPTER 3

CONTROLS OVER PAYMENTS FOR PRESCRIBED DRUGS

In our report of August 1966, we concluded that the prepayment and postpayment audit procedures recommended in the State plan to provide assurance that payments were made only for correctly priced drugs prescribed under proper authority and actually delivered for the use of eligible recipients had not been fully and adequately implemented at the county level. We stated that (1) the State had not adequately carried out its responsibilities for evaluating county activities to determine that the objectives of the State plan relating to payment for prescribed drugs had been achieved and (2) HEW had not utilized the review processes necessary to ascertain the quality of the administration of this aspect of the program.

We suggested that HEW provide its field representatives with specific guidelines relating to the prescription drug program for their use in making continuing reviews of State and local administration as required in HEW regulations. We suggested also that consideration be given to including in the State plan certain additional requirements and procedures to better ensure that drugs for which payments were made were actually delivered for the use of eligible welfare recipients.

During calendar year 1964, payments of about $21.3 million were made in the State of California for more than 5.8 million drug prescriptions for welfare recipients; during 1968, payments of $47.3 million were made for 11.8 million drug prescriptions under Medi-Cal. The Federal share of these expenditures was about 50 percent.

On the basis of our most recent review, we believe that the procedures for payment of prescription drugs under the Medi-Cal program generally are inadequate to preclude a continuation of problems cited in our prior report. Social and Rehabilitation Service regulations, issued in March 1969, require that States institute procedures for reviewing the

use of medical services, including prescription drugs, and for safeguarding against misuse of such services. We found that DHCS had not specified procedures to be followed by the fiscal agent to effectively control Medi-Cal drug payments. Further, HEW and the State were not making systematic and independent verifications to ascertain whether payments to private pharmacies for prescription drugs were limited to prescriptions for recipients for whom the drugs were prescribed and whether the drugs were dispensed by the pharmacies in quantities and in frequencies consistent with the physicians' dosage instructions.

Prior to Medi-Cal, each county in the State was responsible for processing, paying, and auditing claims for prescription drugs for welfare program recipients. For Medi-Cal, the State contracted with California Physicians Service to act as fiscal agent for all 58 counties in the State. The contract requires the fiscal agent to process, pay, and audit drug claims under the program and to install controls to prevent fraud and misuse of the drug program by providers and recipients.

The HEW Audit Agency reviewed the claims processing procedures of California Physicians Service. This review, which covered the period March 1966 through June 1968, included evaluations of the effectiveness of controls over the processing of claims and resulted in a number of recommendations for improving operations. The HEW Audit Agency's report, issued in October 1968, did not deal with the problems discussed in our August 1966 report. The HEW Audit Agency also reviewed selected areas of the Medi-Cal program for the period March 1966 through December 1968, and, in a June 1969 report, the Audit Agency made recommendations to DHCS for improving administration of the program. This review also did not include an examination into claims for prescribed drugs under the Medi-Cal program.

The prepayment and postpayment audit procedures used by the fiscal agent did not provide for routine verifications that prescribed drugs had been received by recipients for whom the prescriptions were written. For example, prepayment audit procedures did not require the claims reviewer to examine the prescription drug form to ensure that the signature acknowledging receipt of the drug was (1) not

made by someone employed by the dispensing pharmacy or (2) that of the Medi-Cal recipient or someone duly authorized by him to receive the drugs.

Our examination of 300 Medi-Cal prescription forms for evidence of receipt of drugs by the recipient or persons authorized to act in their behalf showed that:

--10 prescription forms contained a certification of receipt executed by an employee of the dispensing pharmacy.

--139 prescription forms were receipted by persons whose relationships to the Medi-Cal recipients were not identified on the prescription forms.

DHCS plans to adopt a new Medi-Cal drug billing form which, it believes, will provide faster and more accurate processing of the drug claims. The new form will eliminate the practice of obtaining the signature of the recipient or his authorized representative as evidence of receipt. In our opinion, obtaining the signature of the person receiving the drug serves a useful purpose--as a means of control--in the administration of the prescribed drug aspect of the program and should be retained.

We believe that the administration of this aspect of the Medi-Cal program could be strengthened by requiring persons who receive prescribed drugs on behalf of recipients to record on the new billing forms their identities and capacities or authorizations for acting on behalf of the recipients. This practice could assist in ensuring that the recipients actually receive the drugs.

We recognize that, because of the large volume of prescriptions, it would be impracticable to verify the authority of every person certifying receipt of drugs on behalf of Medi-Cal recipients. However, verification on a test basis would provide reasonable assurance that prescription invoices submitted by pharmacies represent drugs actually dispensed by the pharmacies and received by eligible recipients. Verification procedures might include comparing the names and/or signatures of persons certifying receipt on behalf of eligible recipients with the names of persons

residing in the household--as shown in Department of Social Welfare case files--who would normally be expected to receive drugs for the recipients. The names or signatures of persons authorized to receive prescribed drugs for Medi-Cal recipients residing in institutions, such as nursing homes, could be submitted for inclusion in Department of Social Welfare records. Where test results raise questions as to the proper use of the drug program--by an individual recipient, an institution, or an individual pharmacy--a field investigation would be indicated to determine whether a misuse of the drug program occurred.

In our prior report we noted an overlapping of prescriptions as indicated by the pharmacies dispensing prescribed drugs over periods of time in quantities and in frequencies greater than required by dosage instructions. In one of the cases which we cited, five separate prescriptions were issued to a welfare recipient for a total of 120 tablets of the same drug during an 18-day period. According to dosage instructions, only 18 tablets should have been used during that period. During our recent review, we noted that the State Attorney General's November 1968 report disclosed instances of pharmacies' dispensing prescribed drugs in greater quantities than specified by physicians.

We found that patient profiles (history of medical services received by individual recipients) were not routinely produced to assist California Physicians Service in carrying out its responsibility as fiscal agent for preventing fraud and misuse of the drug program. Therefore, it was not practicable for us to attempt to identify instances of overlapping prescriptions which, when compared with the prescribed dosage, would indicate the dispensing of drugs over periods of time in quantities greater than specified. In the absence of such profiles, and since drug claims are processed individually as received, the fiscal agent's audit procedures cannot detect an irregular pattern of drug purchases over a period of time.

In our opinion, DHCS should require the fiscal agent to institute postpayment audit procedures to help identify instances in which it appears that excessive quantities of drugs are being dispensed to Medi-Cal recipients. Instances so identified could provide a basis for inquiry or investigation to determine whether misuse of the program exists.

We noted that, during the period October 1967 through November 1968, DHCS reviewed the drug payment procedures followed by its fiscal agent and found that overpayments to pharmacies were not being detected primarily because the auditors were not consistently following their audit procedures and because, in some instances, these audit procedures were not adequate to disclose instances of fraud or misuse. Efforts of the fiscal agent to correct the problems noted in the DHCS review were not effective. We therefore believe that additional efforts are required.

CONCLUSIONS, RECOMMENDATIONS, AND AGENCY COMMENTS AND ACTIONS

DHCS has not instituted procedures to ensure that (1) payments are made only for prescription drugs actually delivered to Medi-Cal recipients and (2) drugs are being dispensed in quantities and in frequencies consistent with physicians' dosage instructions. In view of the large volume of prescriptions written for Medi-Cal recipients and in view of the cost of such prescriptions, we believe that strengthened controls over these aspects of the Medi-Cal program are warranted. In our opinion, a requirement that persons who receive prescribed drugs on behalf of program recipients identify their authority to receive such drugs would help to prevent the receipt of drugs by unauthorized persons. Also, the use of patient profiles--which would indicate irregular patterns of drug purchase--will highlight instances where a field investigation is warranted to determine whether a misuse occurred.

Recommendation to the Secretary of Health, Education, and Welfare

We recommend that the Secretary of HEW, through the Administrator of the Social and Rehabilitation Service, encourage DHCS to institute additional procedures designed to ensure that payments are made only for prescribed drugs which are actually delivered for use of program recipients and that drugs are dispensed in quantities and in frequencies consistent with physicians' instructions. We believe that the State should require persons receiving and signing for prescribed drugs on behalf of program recipients to record on the prescription forms their identities and capacities or authorizations for acting on behalf of the recipients.

Agency comments and actions

In a letter to us dated June 15, 1970 (see app. I), the Assistant Secretary, Comptroller, HEW, agreed that controls must be instituted by the fiscal agent to detect irregular patterns of drug purchases. He stated that the program regulation issued by the Social and Rehabilitation Service in March 1969, if adequately implemented, would

(1) ensure that excessive quantities of drugs were not prescribed and (2) contribute to a system of control over claims and payments to ensure that purchased services were actually delivered. He stated also that the HEW regional representatives had been advised to review with the State the status of the implementation of this regulation and its applicability to the problems identified in our report.

With respect to our suggestion that the State require persons receiving drugs to sign for them and to indicate their identities and authorizations to act on behalf of the recipients, DHCS advised HEW (see app. II) that the requirement for signature on receipt of drugs had been irritative and nonproductive but that the newly designed pharmacy billing form did call for certification by the pharmacy that the services were provided. DHCS also stated that the new form would allow improved claims processing by computerized techniques and a review of pharmacy claims that were not within prescribed limits. HEW advised us that it planned to review the new billing form and to determine whether further action, possibly as we suggested, would be necessary.

CHAPTER 4

SCOPE OF REVIEW

Our review of HEW and State procedures and practices in providing nursing home care to, and in controlling payments for drugs prescribed for use by, Medicaid recipients in the State of California was directed toward determining and evaluating the effectiveness of actions taken to correct the weaknesses and deficiencies discussed in our August 1966 report on the former medical assistance program.

Our work was performed at HEW headquarters in Washington, D.C., at HEW's regional office in San Francisco, California, and at the Sacramento headquarters of DHCS, the Department of Public Health, and the Department of Social Welfare. We also visited the offices of California Physicians Service in San Francisco.

We reviewed the enabling legislation and examined pertinent procedures, records, and documents relating to the Medicaid and Medi-Cal programs. We held discussions with HEW, State, and California Physicians Service officials responsible for the administration of the program. In addition, we visited 14 nursing homes located in Alameda, Fresno, Los Angeles, and Santa Clara counties. These counties were selected because they accounted for a significant amount of Medi-Cal expenditures. We did not review all matters discussed in this report at every home we visited. Factors which we considered in selecting nursing homes were their bed capacity and the number of Medi-Cal recipients served. We reviewed case files for 106 patients at the 14 nursing homes which we visited. For the most part, these case files, which covered transactions during calendar years 1966-70, were selected for Medi-Cal recipients residing in the home at the time of our visit.

In addition, we selected 70 nursing homes located in 16 counties in northern California and reviewed all inspection reports of the Department of Public Health for these homes during the 1966-69 period. Again, the factors we used in selecting these homes were their bed capacity and the number of Medi-Cal recipients served.

APPENDIXES

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

OFFICE OF THE SECRETARY

JUN 15 1970

Mr. John D. Heller
Assistant Director
Civil Division
U.S. General Accounting Office
Washington, D. C. 20548

Dear Mr. Heller:

The Secretary has asked that I reply to the draft report of the General Accounting Office on its review of actions taken to improve practices in providing nursing home care and controlling payments for prescribed drugs for Medicaid recipients in California.

Enclosed are the Department comments on the findings and recommendations in your report and the comments on certain points in the response of the Department of Health Care Services of the State of California.

We appreciate the opportunity to review and comment on your draft report and welcomed your suggestion that the appropriate State officials be afforded the same opportunity.

Sincerely yours,

James F. Kelly
Assistant Secretary, Comptroller

Enclosure

COMMENTS ON DRAFT REPORT
OF THE GENERAL ACCOUNTING OFFICE

PROBLEM AREAS RELATING TO NURSING HOME CARE AND PRESCRIBED DRUGS UNDER THE MEDICAID PROGRAM IN THE STATE OF CALIFORNIA

The draft report by the General Accounting Office is an evaluation of the extent to which problems identified in 1966, in the provision of care to nursing home patients in California under the medical assistance to the aged program, have been corrected or persist under Medicaid. On the basis of the findings reported by GAO, we agree that problems warranting the careful attention of the State agency and the Department of Health, Education, and Welfare continue to exist in many of the areas examined.

Following are our comments on each of the matters discussed in the draft report.

STANDARDS OF CARE IN NURSING HOMES

The GAO reports, on its review of the maintenance of standards in skilled nursing homes, findings which clearly indicate problems in this area. The report correctly points out that HEW has imposed upon States, standards for facilities and services which must be met by nursing homes to participate in the Medicaid program. Final regulations to implement Section 1902(a)(28) of the Social Security Act - relating to standards for skilled nursing homes - were published in the Federal Register on April 29, 1970 (45 CFR 249.33); the interim regulations were published on June 24, 1969.

The draft report seems to emphasize licensing violations noted by the California Department of Public Health inspections. While meeting licensing standards is one of the prerequisites for participation in the program, a skilled nursing home may meet State licensure requirements but nevertheless not be qualified to participate in the program because of a failure to meet HEW standards for certification of eligibility to provide services to Medicaid patients.

A revocation of a facility's license would make the facility ineligible to participate in the Medicaid program. While revocation may be the appropriate action for the State's purpose,

the appropriate avenue for the single State agency administering the Medi-Cal program to follow (in this case, the Department of Health Care Services) is outlined in the Medicaid regulations. Specifically, if a home is found not to be in substantial compliance with the standards for payment for skilled nursing homes that home may not receive Medicaid payments. If the home is found to be in substantial compliance (i.e., is in compliance except for deficiencies), the State agency may permit the home to participate for a period of 6 months provided there is reasonable prospect that the deficiencies can be corrected within that time and that the deficiencies noted do not jeopardize the health and safety of the patients. No more than two successive six month agreements may be executed with any one home and no second agreement may be executed if a previous deficiency continues unless the facility has made substantial effort and progress in correcting the deficiency.

If properly implemented, the HEW regulations governing the certification of skilled nursing homes to participate in the program are sufficient to correct the weaknesses relating to standards of nursing home care pointed out in this report. The draft report brings to our attention matters which suggest that there may be some misunderstanding on the part of the State agency of the provisions of certain Federal requirements relating to eligibility of nursing homes to provide service and receive payments under the program. SRS Regional Office staff will discuss these findings with officials of the State agency in an effort to clarify the regulations.

CONTROLS OVER MEDICATIONS AND TREATMENT FOR MEDICAID PATIENTS IN NURSING HOMES

We agree that California Department of Public Health inspections of nursing homes - which are made on behalf of the Department of Health Care Services for Medicaid certification purposes - should ascertain that all State and HEW requirements relating to drugs are met. We plan to discuss this point with State officials in connection with Medicaid skilled nursing home standards and certification.

On the basis of the facts reported, continued effort to improve controls over prescribing and dispensing of drugs for nursing

home patients appear warranted. We note that in its comments on the GAO draft report, the Department of Health Care Services agrees with this point and is in the process of developing requirements to be adopted in regulations.

SUPPLEMENTAL PAYMENTS TO NURSING HOMES FOR MEDICAID PATIENTS

The GAO draft report establishes that problems still exist with respect to (1) improper supplemental payments being demanded or accepted from relatives of Medi-Cal recipients and (2) the handling of patients' personal funds.

We concur in the suggestion that information on services covered by program payments and restrictions on additional payments be provided to relatives and other interested parties. We note that the State agency has adopted this suggestion and is preparing an informational leaflet for this purpose.

We concur also that better controls over the handling of patients' personal funds by nursing homes is warranted. We plan to discuss with State officials the feasibility of establishing standard procedures to be followed by the homes as well as appropriate surveillance by the State.

MISLEADING ADVERTISING BY NURSING HOMES OF PHYSICAL THERAPY FACILITIES

Misleading advertising on the part of nursing homes is to be deplored and should receive the attention of appropriate State authorities. Accordingly, we agree that the Department of Health Care Services should either assume the responsibility for policing advertising practices relating to Medi-Cal or see to it that such responsibility is specifically assigned to, and carried out by, some other State agency on a systematic basis. In this connection, the State has advised us that consideration will be given to greater case-detection efforts; however, cost considerations must be weighed against the benefits to be derived.

While advertising practices such as shown in the GAO draft report might mislead a Medi-Cal recipient or his family, it is expected that the patient's caseworker will be familiar with the conditions and services in nursing homes in the area and will advise the patient and/or his family in any instance where such a situation is known to exist.

[sic]

HEW regulations require that long-term care be authroized only after joint consideration by the physician and the social worker of the pertinent medical and social factors, including consideration of alternative arrangements for the patient's care. Also, we note in the State's comments on the GAO draft reports that a plan is being considered to make a social evaluation of Medi-Cal nursing home placements within 30 days after admission. Full implementation by the State of the HEW requirement for prior medical-social evaluation should, if properly carried out, minimize instances where facilities are not appropriate to the needs of the patients.

TRANSFERRING PATIENTS BETWEEN NURSING HOMES

The GAO review found that in a least 13 of 60 cases examined, transfers of Medicaid patients from one home to another appeared to have been made for the benefit of persons other than the patient. In the discussion of this problem in the draft report we found no mention of the involvement of the patients' caseworkers, and assume, therefore, that no caseworker contact was found. Although the Handbook of Public Assistance Administration does not expressly require that the caseworkers be consulted before transfers of patients are made - as it does in the case of initial admissions - we believe that the intent of Federal policies relating to social services available to patients strongly suggest that this should be done.

We agree with the GAO suggestion that authorizations of transfer be in writing and should state the reasons for transfer. We plan to recommend to the State that an interview with the patients by their caseworkers be required in each instance of proposed transfer and that the caseworkers make a written record of the reasons for transfers.

CONCLUSIONS AND RECOMMENDATIONS

GAO has recommended that SRS Regional representatives be given direction and assistance for reviewing the manner in which State agencies are implementing Federal regulations relating to the quality of care being received by Medicaid patients in nursing homes.

Regional Office staff will be instructed to review with the California State agency, the several Federal regulations which

relate to the quality of care and discuss with them the applicability of these regulations to the observations recounted in the report. Since there appears to be a lack of full understanding of these regulations in California - as well as other States - we are currently developing plans for visits by teams of both Central Office and Regional staff to review current activities and procedures of the State agencies and to provide consultation on full implementation of the regulations. We plan such visits in a few selected States within the next three months and will evaluate the desirability of extending them to all Medicaid States on the basis of this experience.

GAO recommends also that SRS impress upon responsible State officials the importance of clarifying the respective responsibilities and authority of the various State and county agencies involved in the administration of the Medicaid program.

The report indicates that the Department of Health Care Services is the single State agency responsible for administering the Medi-Cal program and is assisted by the Department of Public Health and the Department of Social Welfare. We agree that the single State agency should assure itself that the employees of the assisting agencies (such as inspectors, Medi-Cal Consultants, and caseworkers) are fully aware of the responsibilities which have been established. In this regard, we will discuss the issues raised by GAO with the State agency.

GAO has recommended further that the matters in their report be discussed with officials of the Department of Health Care Services and the SRS Regional representatives assist them in action needed to ensure correction of these practices. The action suggested by this recommendation will be taken; if discussions reveal a need for assistance by the Division of Management Information and Payment Systems or the Division of Technical Assistance and Training of the Medical Services Administration, SRS, such assistance will be made available.

CONTROLS OVER PAYMENTS FOR PRESCRIBED DRUGS

The GAO draft report identifies problems relating to excessive quantities of drugs being prescribed and prescribed drugs being purchased which may not have been delivered for the recipient's use. We agree that controls must be instituted by the fiscal

agent to detect irregular patterns of drug purchases over a period of time. Such controls are implicit in SRS regulations relating to utilization reviews by the States.

CONCLUSIONS AND RECOMMENDATIONS

GAO recommends that SRS encourage the Department of Health Care Services to institute additional procedures designed to ensure that prescribed drugs are actually delivered for use of program recipients and that excessive quantities of drugs are not prescribed for them.

SRS Program Regulation 40-9 issued in March 1969 requires State agencies to institute procedures for review of utilization of services, including drugs, and to safeguard against over-utilization. This regulation, if adequately implemented, should meet the problem of assuring that excessive quantities of drugs are not prescribed and should contribute substantially to a system of controls over claims and payments designed to assure that services purchased are actually delivered. We have asked SRS Regional staff to review with the State the status of implementation of this regulation and its applicability to the problems raised in the GAO draft report.

In connection with the above recommendation, GAO has suggested that the State should require persons - receiving and signing for prescribed drugs on behalf of program recipients - to clearly indicate on the prescription forms their identity and capacity or authorization for acting on behalf of the recipients.

With respect to this suggestion, we note in the State agency's response to the GAO report that they do not consider this procedure to be appropriate and that they have designed a new pharmacy billing form as a part of an improved system of computer controls over claims processing. We plan to review the new billing form and determine whether further action, possibly as suggested, is necessary.

STATE OF CALIFORNIA—HUMAN RELATIONS AGENCY RONALD REAGAN, Governor

DEPARTMENT OF HEALTH CARE SERVICES
714 P STREET
SACRAMENTO, CALIFORNIA 95814

March 4, 1970

Miss Gene Beach
Associate Regional Commissioner
Medical Services Administration
Social and Rehabilitation Services
Department of Health, Education and Welfare
50 Fulton Street
San Francisco, California 94102

Dear Miss Beach:

This is in response to your letter of February 10, 1970, concerning the General Accounting Office draft report to Congress of the Review of Actions Taken to Improve Practices in Providing Nursing Home Care and Controlling Payments for Prescribed Drugs for Medicaid Recipients in the State of California.

This Department has expended considerable effort, with varying degrees of success, to solve the problems set forth in this review. We understand however that many of these same problems exist in other Medicaid programs throughout the country, and have proved difficult or impossible to solve.

The review indicates that the State has failed to set forth in its state plan criteria for evaluating the adequacy of care provided in nursing homes. Aside from staffing standards and requirements relating to equipment and structure, standards relating to the adequacy of care are at best intangible and difficult to define for a spectrum of patients. The Department will conduct on site review of patient care programs as it implements the Medical-Social Review Team requirements set forth in the 1967 amendments to the Social Security Act. It must be recognized, however, that time must be allowed, along with a considerable amount of effort, to bring about the effective operation of this process. The scope of this undertaking in California is formidable since there are more than 1,200 nursing homes providing services to almost 48,000 program beneficiaries.

In an effort to strengthen the effective functioning of the Medi-Cal consultants throughout the State, the Department is in the process of of formulating standards for the operation of the many consultant units at county levels. On adoption and promulgation of these standards, it is anticipated that a more uniform and more effective application of the program's policies, rules and regulations will result.

Denial of care to the program's beneficiaries because of nursing homes' deficiencies in meeting standards for participation cannot be accomplished by evading due process of law. In today's legal climate, a Medi-Cal consultant cannot act in an arbitrary or capricious manner to remove or restrict a provider's livelihood. To expect a Medi-Cal consultant to act in an injudicious manner in this regard, is to oversimplify a number of very complex problems, and would serve only to abridge the legal rights of providers. Actions contemplating revocation of licenses or culminating in program suspensions must similarly consider the legal rights of providers of services.

The removal of patients from a nursing home is not a function of the Medi-Cal program. Rather, the disapproval of an authorization request by the Medi-Cal consultant for nursing home placement or continued care is a denial of payment for services which are judged to be not medically necessary or not covered by the program.

Concerning control of medications being administered to program beneficiaries in nursing homes, despite our efforts and those of the State Board of Pharmacy, we are still dissatisfied with the handling of drugs in many of these facilities. The present method is a mixed-breed system which ineptly combines the method of dispensing drugs for patients at home with methods used for patients in hospitals, and as it has developed, highlights the worst features of each. The Department is in the process of developing its own detailed program requirements for prescribing and dispensing drugs in nursing homes and plans to adopt these requirements by regulations.

The draft suggests strengthening of the requirement for persons receiving prescribed drugs to sign for them and indicate their identity and authorization to act on behalf of the recipient. Our experience has been that the requirement for signature on receipt of drugs has been irritative and non-productive. This is why this requirement was not designed into a new pharmacy billing form recently developed by the Department. The new form, however, does call for certification by the pharmacy that the services were provided. In addition, this new form has been designed to permit improved claims processing by computerized techniques, and review of pharmacy claims that are not within designated parameters.

With regard to supplemental payments for nursing home care, the draft report sets forth a valid suggestion to circularize information to interested persons concerning the program's role in payment. Immediate action is being taken to develop a leaflet concerning Medi-Cal's nursing home benefits. A draft copy of the proposed leaflet is attached for your convenience. (See GAO note.) As to control by direct surveillance, the feasibility of doing this on a large scale is obviously limited by the number of program beneficiaries currently in nursing homes.

GAO note: Draft copy of proposed leaflet is not reproduced here.

Preliminary discussions have been initiated about a plan to institute a social evaluation of all Medi-Cal nursing home placements within 30 days of admission. This would encompass an explanation to the patient, his family and relatives, and the facility, as to the program's financial responsibilities, and alert all concerned about the prohibition against supplemental payments for program covered services.

Current regulations incorporate provisions against unlawful and unethical advertising and have significantly reduced this problem. Here again, however, the Department is faced with the practicality of direct surveillance of advertising material in all media. Consideration will be given by the Department to greater case-detection efforts, but the cost factor of doing this must be weighed against the return and the low incidence of this problem.

As indicated in the draft report, a regulatory requirement for authorization of nursing home transfer of patients is in effect. The major problem of mass transfers and bartering of patients between nursing home facilities has been eliminated, and there have been almost no instances brought to our attention of patients being moved against their wishes. When these have been brought to our notice, investigative actions have been undertaken. Here too, clear definitions of circumstances under which transfers may be permitted are difficult in the face of the federal requirement for free-choice of provider of service.

The Department recognizes the potential benefits of establishing beneficiary profiles, and as the availability of more sophisticated computer equipment and programming techniques permits, this will be pursued. Such an undertaking will be costly however, and consideration must be given to establishing priorities in accordance with program needs. The feasibility of such profiles will be the subject of intensive study in the course of operating the prototype system of claims handling recommended by the Lockheed Missiles and Space Corporation.

We appreciate the opportunity to review and comment on this draft report, and we concur in the identification of the problem areas. Nevertheless, the nearly four years of operation of this program have incontrovertibly established a Title XIX axiom; that the many problems inherent in this and other Medicaid programs are more readily identified than solved. We will continue to welcome workable suggestions for program improvements, and we will be keenly interested in learning of successful solutions in other states to the kinds of problems reviewed in this draft report.

Sincerely,

Earl W. Brian, Director Designate

for CAREL E. H. MULDER
Director

Attachment

PRINCIPAL OFFICIALS

OF THE

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HAVING RESPONSIBILITY FOR THE ACTIVITIES

DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Elliot L. Richardson	June 1970	Present
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	May 1968	Jan. 1969
John W. Gardner	Aug. 1965	May 1968
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
John D. Twiname	Mar. 1970	Present
Mary E. Switzer	Aug. 1967	Mar. 1970

From
BARBER B. CONABLE, JR.
U. S. HOUSE OF REPRESENTATIVES
35th District, New York

FOR RELEASE
Tuesday, March 26, 1974

Washington, March 26 -- Representative Barber B. Conable (35th Dist., N.Y.) today proposed establishment of a new program of long-term care for the elderly that would provide alternatives to institutionalizing persons by expanding the types of care available to the elderly. In a measure introduced in the House today the Congressman called for a system of community long-term care centers in every area to coordinate and direct long-term care services for the elderly, including homemaker, health, nutrition, and day care, as well as institutional care.

"There is a tremendous need to provide broader and more flexible care than is presently available to elderly citizens who need it," the Congressman declared in explaining his proposal. "There is too great a reliance on placing people in institutions today when many of them could be cared for better in other surroundings, including their own homes. In too many cases what we are doing amounts to incarceration rather than considerate care. This is a major concern among senior citizens.

"A broader, coordinated system could better serve older people without comparable increases in cost," the Congressman insisted. "Since government programs pay for long-term medical care but not non-medical care, a great many of the elderly who need only a modest degree of assistance are being placed in medical facilities which are the most costly to maintain. We need other realistic alternatives."

The system proposed by Mr. Conable would be administered by state long-term care agencies through community long-term care centers. The centers would be governed by a board comprised at least in half of people eligible for benefits. The centers would determine the kind of care required in consultation with each individual and family.

Financing of the program would be by a $3 monthly premium paid by those who enroll and the remainder contributed by state and federal governments. These would not be completely new costs, according to the Congressman, because many of the services provided would replace those presently furnished through the more costly medicare and medicaid. State and federal governments presently spend more than $4 Billion annually under these two programs for long-term care.

* * * * *

EXECUTIVE CHAMBER
HUGH L. CAREY, GOVERNOR

Robert Laird, Press Secretary
518-474-8418
212-977-2716

FOR RELEASE:
IMMEDIATE, FRIDAY
JANUARY 10, 1975

State of New York
Executive Chamber

EXECUTIVE ORDER NO. 2

E X E C U T I V E O R D E R

When public funds are channeled through private hands to finance health and residential services, government must insure that those funds are used honestly and efficiently in the promotion of the public welfare. The compassionate purpose of programs of residential and health care must not be subverted by the improper diversion of public funds for private benefit, nor through the inability of government to control the use of such funds under present regulatory structures.

A serious public concern has been expressed as to the quality of care provided by nursing homes and residential facilities sheltering the aged, the disabled, the mentally ill and retarded, receiving public financial assistance and subject to supervision by State agencies, but owned by private interests.

State government is deeply involved in the supervision of such facilities, but the public has lost confidence in the methods through which government finances these facilities, and in the government's ability to assure the efficient delivery of health and related services.

It is necessary, therefore, that there be an official inquiry into the mechanisms of State and Federal funding, particularly reimbursement under the Medicaid system. Current methods of funding must be evaluated to determine if they contribute to exploitation of the poor, aged, and infirm and to profiteering in public funds.

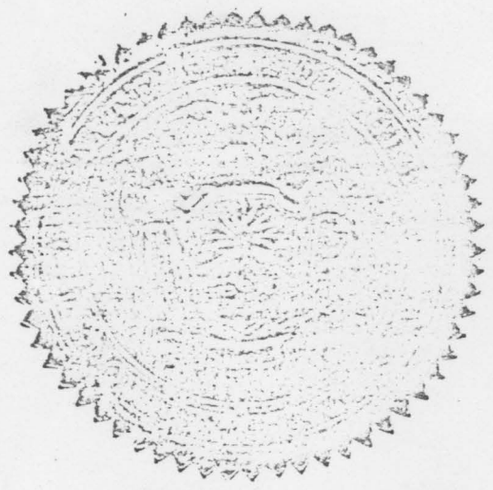
In addition, the State regulatory structure must be evaluated to insure that nursing homes and homes which shelter the aged and disabled provide the highest quality of care with the greatest degree of economy.

This inquiry must also look into the ownership, financing and control of nursing homes and residential facilities and must thoroughly examine any allegations of improper conduct by publicly elected officials or members of their staffs with respect to the operation of State agencies charged with the responsibility of regulating these institutions

Now, therefore, I, Hugh L. Carey, pursuant to Section Six of the Executive Law, have appointed and by these present do appoint Morris B. Abram as Commissioner to study, examine, investigate, review and make recommendations with respect to the management and affairs of any department, board, bureau, or commission of the State exercising any direction, supervision, visitation, inspection, funding or control of any non-governmental nursing home, residential facility or home which provides health, residential or allied services, and which receives any Federal, State or local financial assistance or payment, directly or indirectly, or which provides care or services to any individual

The Commissioner is hereby empowered to subpoena and enforce the attendance of witnesses, to administer oaths and examine witnesses under oath and to require the production of any books, records or papers deemed relevant or material and I hereby give and grant to the Commissioner the powers and authorities which may be given or granted to persons appointed by me for such purpose under authority of Section Six of the Executive Law.

Every State department, division, board, bureau, commission, council and agency shall provide to the Commissioner every assistance, facility and cooperation which may be proper or desirable for the accomplishment of the purposes for which the Commissioner is hereby appointed.



G I V E N under my hand and the Privy Seal of the State at the Capitol in the City of Albany this tenth day of January, in the year of our Lord one thousand nine hundred seventy-five.

BY THE GOVERNOR

/s/ Hugh L. Carey

Secretary to the Governor

/s/ David W. Burke

PROPOSED QUESTIONS TO BE PRESENTED TO THE MORELAND COMMISSION
FOR INCLUSION IN THEIR STUDY OF THE NURSING HOME INDUSTRY IN NEW YORK STATE

1. Based upon the current cost of inpatient care in proprietary nursing homes in upstate New York which is approximately $30 per patient per day, would the commission conclude that this cost is excessive taking into account the fact that the cost for voluntary nursing homes in upstate New York is approximately $35 per patient day and the cost of a moderate hotel room in New York City is $40 per day, where nursing homes provide 24 hour nursing care, meals, etc.?

2. It has been suggested in the media that some or all professional employee in nursing homes such as physicians, nurses, aides, dieticians, physical therapists, etc. are improperly caring for patients. Would the commission conclude that if this were the case, that the same professional employees who work in hospitals and state medical facilities are not doing the same job

3. It has been suggested by governmental officials that the cost of care in nursing homes is excessive, clearly leading one to the conclusion that only this one segment of the health care industry is responsible for high costs. Taking into account the high costs of inpatient hospital care and the cost of care in state facilities, would the commission conclude that only one segment of the health care industry would be responsible for excessive cost when all inpatient providers are reimbursed basically under the same formula?

4. Does the commission believe that the regulatory authorities in New York state regarding reimbursement (New York Health Department) should have a uniform reporting system (i.e. chart of accounts and specific guidelines for allowable cost) which would clearly deliniate what types of expenses it considers allowable; or should the authorities continue under the current system whereby each facility is left on its own to make its determinations and then upon audit is told in many instances that certain expenses may retroactively be declared not allowable?

5. Does the commission believe that field auditors who are paid solely to find fault and make on-the-spot decisions should have these decisions final or should the facility have the right to appeal?

6. Can the commission determine the basis for governmental authorities who have approved programs for construction under the New York State Article 28A and 28B construction program that have allowed facilities to be built and equipped at costs from 25% to 125% above the cost allowed to proprietary facilities, where it is clear under state and federal statutes that the level of care, staffing and space requirements are identical? The state then uses federal funds to pay back these higher costs as well as tax free interest on bonds to investors who bought the bonds in the first place.

7. Can the commission determine why the New York State Health Department has consistently allowed many non-profit facilities, staff and equipment far greater than that allowed for proprietary facilities thereby clearly discriminating against patients in proprietary facilities, apparently in violation of the law?

8. Can the commission determine why the New York State Health Department groups non-profit facilities separately from proprietary facilities for reimbursement purposes? Could it be that the higher cost of these facilities due to exorbitant construction costs and higher operating costs can more easily be hidden and then reimbursed without comparing the non-profit operation to proprietary operation in terms of cost of operation?

9. Can the commission explain or justify the higher and fully reimbursable construction and operational cost in non-profit facilities particularly those funded under the 28A program? Does not this higher cost directly affect the total Medicaid dollar thereby requiring the state to stringently control the cost on other facilities because the higher dollar value paid for construction takes away from direct patient care?

10. Can the commission explain why the New York Health Department changes Part 86 without notice and without hearing? Specifically, last year a major change occurred in computing reimbursement for movable equipment with a ceiling being established with no notice given which would appear to be a violation of Part 86.21(I) of the Health Department's own regulation.

11. Can the commission justify the Health Department's right to penalize a nursing home under Part 86.14(C) to keep the nursing home's reimbursement at the group average where facilities have "significant operational deficiencies"? What is a significant operational deficiency? Who determines what it is, and what is the criteria? There is no guideline and apparently this regulation is enforced indiscriminately.

12. Can the commission explain why the public health council who legally has the right to establish new operations on the basis of character, competence and financial ability, does not apply and does not publish what criteria this council uses in making a determination? The record clearly shows that non-profit and voluntary sponsors obtain approval in 2 to 4 months and proprietary sponsors take a year or more to obtain approvals, and one wonders how the same criteria can be applied to both sponsors when proprietary sponsors must have all financial resources in hand when many voluntary sponsors are regularly approved without having any financial resources other that what it can borrow from the state. Should not the criteria for all applicants be the same? Should not there be a specific time period allowed for all applicants?

13. Can the commission explain why the Health Department takes 6 months to a year to schedule a hearing on applications thereby causing 2 or 3 year delays in projects?

14. Why does the Health Department add to all of its letters requesting information that the applicant has 30 days to answer "or else" when the Health Department itself many times does not act for 2 years?

15. Can the commission explain why the media believes that facilities who are reimbursed for their legal expenses in bringing actions against arbitrary state decisions should not continue to be reimbursed as legitimate expenses, or would the commission believe that the Health Department itself in many instances is the cause of these legal expenses because of delays, arbitrary decisions and little or no guidelines in the decision making process? It would appear that if the commission determines that these legal expenses were not to be reimbursed, then the commission should also recommend that in instances where governmental officials take actions which are overturned in the courts, that the commissioner of the department or the governor should become individually liable for these legal bills in defending arbitrary state action without the tax payers having to pay taxes to pay for these legal bills on behalf of the state.

16. Can the commission explain why the State Health Department Bureau of Health Economics does not publish a guideline determining exactly what are considered allowable costs (somewhat like IRS). Under the current situation field audits are conducted subsequent to expenses being incurred and requests for facilities to reimburse the government for non-allowable costs are made 2 or 3 years later. In many instances these costs were considered allowable by the auditor for the facility and then thrown out by the state. It has also been suggested that interest and penalties be incurred on the amounts considered due to the state and that would be justifiable only if the state would agree to pay interest and penalties on moneys owed to facilities from both Medicare and Medicaid which are overdue.

17. Can the commission explain the anomaly which exists between the Bureau of Health Economics and the regional survey teams where one agency is charged with controlling the cost and the other agency is charged with improving and increasing care? There appears to be no correlation between these agencies as to what costs are involved in doing the job.

18. Can the commission explain why the Health Department does not publish standard definitions of what it considers to be direct care nursing hours? Each regional office appears to work with a different definition.

19. Can the commission explain why current regulations promulgated by the New York Health Department are replete with phrases such as "as the department shall require"? Should not the department stipulate what their requirements are rather than leave it open to ununiform interpretation?

20. Can the commission explain why federal and state agencies have not been able to put a dollar value on new regulations which have been effective since December 1973? These regulations have had a tremendous impact on cost, yet the agencies who promulgate these regulations do not chose to believe that there is any cost involved and facilities were required to comply with these regulations during the federal government's economic stabilization program, and in many instances were not reimbursed.

21. Is the commission aware that many nursing homes must pay lower wages to many employees than hospitals or voluntary nursing homes who have allowed their facilities to become organized by labor unions. If a facility wishes to increase employee benefits, it must incur the cost, then request an appeal from the Health Department, where as if a facility becomes organized by a labor union, an immediate increase is given to that facility. Of course, it becomes apparent that there is no collective bargaining because the labor unions are aware that whatever demands they make will be paid for by the state and that there is no true collective bargaining.

22. Can the commission explain why the Department of Mental Hygiene in 1971 restricted admissions to state mental facilities to people who were 65 and under thereby forcing the group 65 and over who had psychiatric problems to be admitted to nursing homes who in many instances were not prepared to accept these types of patients?

23. Is the commission aware that nursing homes can be considered deficient by federal and state regulation if the attending physician does not see the patient every 30 days, but that the facilities have no control to force physicians to comply with this regulation? The same situation exists regarding the prescribing of drugs.

24. Can the commission explain why commissioners of social services regularly admit patients who need intermediate or skilled care to proprietary homes for adults where the patients do not receive adequate care.

25. Can the commission explain why members of boards of governors of many voluntary facilities conduct business with their own facilities?

26. Does not the commission believe it is illegal for an employee or owner of a nursing home to contact his congressman, senator or other elected official in order to discuss a problem which may be effecting his livelihood, or should personnel who work or own nursing homes be exempt from this constitutional privilege?

27. Does the commission believe that because many legal suits have been brought by institutions involved in health care against governmental agencies and won these legal suits, that these facilities have hired better lawyers, or could it possibly be that these facilities were correct in fighting arbitrary governmental decisions?

28. It would appear that the charge of this commission is to look into the nursing home component of the health care industry. As we are all aware, the health care industry includes physicians, dentists, hospitals, nursing homes, laboratories, etc. Can this commission explain why the nursing home component is being isolated when the same personnel are involved in al segments of the health care industry? Could it also be concluded that problems which exist in nursing homes also exist to the same extent in hospitals, state facilities, etc.?

WHEREAS, the nursing home profession in the State of New York is involved in numerous investigations; Federal, state and local, both criminal and civil, and

WHEREAS, the Governor of the State of New York has appointed a special commission known as the Moreland Commission to investigate alleged abuses and practices in the nursing home field including but not limited to; financing of construction, ownership and sponsorship of facilities, provision of medical, nursing, rehabilitative and other services, and the methods of financing the same, and said Commission has been charged with the task of recommending corrective legislation and,

WHEREAS, as set forth in the Moss Reports it is recognized that the problems described in the State of New York are characteristic of those which may prevail in the nation as a whole and,

WHEREAS, resulting legislation will have a strong impact upon, and possibly serve as a model for, similar legislation nationally, both Federal and State and,

WHEREAS, the American Nursing Home Association is the appropriate body to assume a leadership role in the formulation and presentation of constructive approaches in shaping legislative proposals which are the lifeblood and future of long-term care as it is known today,

Now therefore, it is hereby unanimously resolved by the Board of Directors of the New York State Health Facilities Association, Inc., that the American Nursing Home Association be requested to assist the New York State Health Facilities Association, Inc., both financially and administratively, in the preparation and presentation of those points of view, and legislative and financial proposals which will advance and enhance the delivery of high quality patient care while assuring reasonable and efficient expenditure of public funds.

II C

State Panel's Fix For The Homes

By ROBERTA B. GRATZ

The Stein Commission today recommended five changes in the state's nurs-

length and non-arms length real property transactions and instead using a historic cost for reimbursement. This proposal would ignore all

ment is defined in the Health Code as a 10 per cent or less ownership interest, said commission executive director Terrence Moon, who wrote

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New York Post 2/18/75

HEALTH - ENGINEERS

From
THE LEGISLATIVE INDEX COMPANY
100 So. Swan St., Albany, N.Y.

February 11, 1975

Assembly 3253 By Mr. Stein

AN ACT to amend the public health law, in relation to the bidding and letting of contracts with respect to health facilities

Section 1. Article one of the public health law is hereby amended by adding thereto a new title, to be title three to read as follows:

TITLE III

BIDDING AND LETTING OF CONTRACTS FOR HEALTH FACILITIES

Section 100. Declaration of policy.
101. Definitions:
102. Public bidding.
102-a. Exceptions to public bidding.
103. Qualifications of bidders.
104. Advertising for bids.
105. Statement of non-collusion.
106. Conspiracies to prevent competitive bidding.

§100. Declaration of policy. It is hereby found, declared and determined that hospitals and other health facilities of the state are of foremost concern and essential in providing comprehensive care and treatment for the ill and infirm, both physical and mental, and are thus vital to the protection and the promotion of the health, welfare and safety of the people of the state of New York.

It is further declared to be the policy of this state that this article shall be construed in the negotiation of contracts for works and purchases to which any health facility is a party so as to assure the prudent and economical use of public moneys for the benefit of all the inhabitants of the state and to facilitate the acquisition of facilities and commodities of maximum quality at the lowest possible cost.

§101. Definitions. 1. "Board" shall mean the board of trustees or board of directors in control of a health facility.

2. "Commissioner" shall mean the commissioner of health of the state of New York.

3. "Construction" shall mean site exquisition, planning design, erection, building, alteration, reconstruction, renovation, improvement, extension, enlargement, replacement or modification and the inspection or modification thereof.

4. "Health facility" shall include, but not be limited to, general hospitals, psychiatric hospitals, tuberculosis hospitals, ambulatory hospitals and centers, chronic disease hospitals, nursing homes, extended care facilities, dispensaries and laboratories and any other related facilities, and any combination of the foregoing, both public and private, participating in the state medicaid program

5. "State" shall mean the state of New York.

§102. Public bidding. Any contract let by a health facility for works or purchases shall be publicly let to the lowest responsible bidder furnishing the required security after advertisement for sealed bids in the manner provided by section one hundred four.

§102-a. Exceptions to public bidding. 1. Section one hundred two does not apply to situations otherwise expersly provided for by an act of the state legislature or by a local law adopted prior to September first, nineteen hundred seventy-four.

2. Section one hundred two does not apply to situations where the cost of a contract does not exceed five thousand dollars for works or one thousand five hundred dollars for purchases.

3. Section one hundred two may be waived by the board in situations where competition is so limited that it would be impracticable or detrimental for the health facility to comply with the public bidding requirements of that section. However, at no time shall the board act in an arbitrary or capricious manner.

4. Section one hundred two may be waived upon the adoption of a resolution by a unanimous vote of the board. Such a resolution should contain a full explanation of the reasons for its adoption. All purchases made pursuant to such a resolution shall be subject to audit and inspection by the commissioner.

5. Section one hundred two may be waived in the case of a public emergency arising out of an accident or other unforeseen occurence or condition whereby circumstances effecting a health facility or the life, health, safety or property of patients or employees therein require immediate action and cannot await competitive bidding. In these situations contracts for works or the purchase of supplies, material or equipment may be let by the appropriate officer, board or agency of the health facility. Notice of such action should be filed with the commissioner not later than two weeks after validation of the contract.

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6. Surplus and second hand supplies, material or equipment may be purchased from the federal or state government, or from any other political subdivision or district, without competitive bidding.

7. The exceptions of section one hundred two-a are not applicable to situations where they are employed to result in a contract that enables an interested member of the board to reap financial gains.

§103. Qualifications of bidders. 1. A health facility may make rules and regulations governing the qualifications of bidders entering into such a contract where the cost of such a contract exceeds twenty-five thousand dollars. The bidding may be restricted to those who shall have qualified prior to the receipt of bids according to standards fixed by the health facility, provided however, that notice or notices for the submission of qualifications shall be published in an appropriate trade journal published in the city, county or state, or, if no such journal exists, in a newspaper with a general circulation in the city or county concerned, at least once. This publication should be not less than ten days prior to the date fixed for filing of qualifications.

2. Each contract for the construction of a health facility may include a provision that the architect who designed the facility, or the architect or engineer retained or employed specifically for the purpose of supervision, shall supervise the work to be performed through to completion and shall see to it that the materials furnished and the work performed are in accordance with the drawings, plans, specifications and contracts thereof.

§104. Advertising for bids. 1. Advertisements for bids shall be published in a newspaper or trade journal designed for such purpose. Copies of all such advertisements shall be filed with the Commissioner. Such advertisements shall contain a statement of the time when and place where all bids received pursuant to such notice will be publicly opened and read. The board seeking such bids may by resolution designate any officer or employee to open the bids at the time and the place specified in the notice. Such designee shall make a record of such bids in such form and detail as the board shall prescribe and present the same at the next regular or special meeting of such board. All bids received shall be publicly opened and read at the time and place so specified. At least five days shall elapse between the first publication of such advertisement and the date so specified for the opening and reading of bids.

2. In any case where a responsible bidder's gross price is reducible by an allowance for the value of used machiner, equipment, apparatus or tools to be traded in by the health facility, the gross price shall be reduced by the amount of such allowance, for the purpose of determining the low bid.

3. In cases where two or more responsible bidders submit identifical bids as to price, such officers or board may award the contract to any of such bidders. Such officer or board should not reap personal financial gain from the ensuing contract. Such officer or board may, in his or its discretion, reject all bids and readvertise for new bids in the manner provided in this section.

§105. Statement of non-collusion. Every contract hereafter made or awarded by a health facility, pursuant to bid, for work or services performed or to be performed or for purchases, shall contain the following statement subscribed by the bidder and affirmed by such bidder as true under the penalties of perjury:

(a) By submission of this bid, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of knowledge and belief:

(1) The prices in this bid have been arrived at independently without collusion, consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder or with any competitor;

(2) Unless otherwise required by law, the prices which have been quoted in this bid have not been knowingly disclosed by the bidder and will not knowingly be disclosed by the bidder prior to opening, directly or indirectly, to any other bidder or any other competitor; and

(b) A bid shall not be considered for award nor shall any award be made where paragraphs one, two and three of subdivision (a) of this section have not been complied with; provided however that if in any case the bidder cannot make the foregoing certification, the bidder shall so state and shll furnish with the bid a signed statement whih sets forth in detail the reasons therefor. Where paragraphs one, two and three of subdivision (a) of this section have not been complied with, the bid shall not be considered for award nor shall any award be made unless the commissioner, or his designee, determines that such disclosure was not made for the purpose of restricting competition.

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The fact that a builder (a) has published price lists, rates, tariffs covering items being procured, (b) has informed prospective customers of proposed or pending publication of new or revised lists for such items, or (c) has sold the same items to other customers at the same prices being bid, does not constitute, without more, a disclosure within the meaning of paragraph one of subdivision (a) of this section.

§ 106. Conspiracies to prevent competitive bidding. A person or corporation who shall wilfully, knowingly and with intent to defraud, make or enter into, or attempt to make or enter into, with any other person or corporation, a contract, agreement, arrangement or combination to submit a fraudulent or collusive bid, to refrain from submitting a bona fide competitive bid to any health facility on a contract for work or purchase which has been advertised for bidding, shall be guilty of a misdemeanor, and on conviction thereof shall, if a natural person, be punished by a fine not exceeding five thousand dollars or by imprisonment for not longer than one year, or by both such fine and imprisonment, and if a corporation, by a fine not exceeding twenty thousand dollars. An indictment or information based upon a violation of any provision of this section must be found within three years after its commission.

§ 2. This act shall take effect on the first day of September next succeeding the date on which it shall have become a law.

Referred to Health Com.

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II F1c

From
THE LEGISLATIVE INDEX COMPANY
100 So. Swan St., Albany, N.Y.

February 11, 1975

Assembly 3254 By Mr. Stein

AN ACT to amend the public health law and the insurance law, in relation to the promotion of efficiency in the delivery of health services

Section 1. Legislative findings. The legislature hereby finds that a factor contributing to the problems of some of the hospitals and health care institutions facing severe financial crises in New York state is a lack of adequate and effective management and administrative practices; that no comprehensive management or performance audit of individual hospitals and health facilities is currently required or conducted in connection with the allocation of publicly provided or regulated reimbursements; that the conduct of annual financial audits of private hospitals has been delegated to non-profit insurance corporations without any regular or effective public supervision or evaluation of the corporations' performance of this task; that major decisions affecting the existence of some hospitals are being made with little attention to the economic impact on the financial future of the institution and its ability to continue to deliver health services to the community; that the maintenance of the public health is dependent on the continued effectiveness of both public and private hospitals and health facilities and that all of these institutions must be viewed as a public resource; and that the powers and responsibilities of the commissioner of health and superintendent of insurance are limited and not clearly defined with regard to the initiation of actions which encourage, promote and insure the efficient and financially sound operation of the hospitals in New York state.

§2. Section twenty-eight hundred of the public health law, as amended by chapter eight hundred sixty-two of the laws of nineteen hundred sixty-eight, is hereby amended to read as follows:

§2800. Declaration of policy and statement of purpose.***** pursuant to section three of article seventeen of the constitution, the department of health, acting through the health commissioner, shall have the central, comprehensive responsibility for the development and administration of the state's policy*****

§3. Section twenty-eight hundred one of such law is hereby amended by adding thereto a new subdivision, to be subdivision eight, to read as follows:

8. "Impact statement" means a statement demonstrating economic impact of all major decisions, including but not limited to the following: construction, renovation, or replacement of facilities; new equipment costs exceeding fifty thousand dollars; merger, acquisition or creation of subsidiary by a hospital or health-related service; initiation of a new program of highly specialized or technologically sophisticated health services, research or education by a hospital or health-related service not presently under taken; and any alteration in service provided by the hospital or health-related service which would decrease hospital service or health-related service presently provided by the hospital or health-related service.

§4. Subdivision one of section twenty-eight hundred three of such law, as amended by chapter nine hundred eighteen of the laws of nineteen hundred seventy-two, is hereby amended to read as follows:

1. (a) The commissioner shall have the power to inquire into the operation of hospitals and home health agencies and to conduct periodic inspections of facilities with respect to the fitness and adequacy of the premises, equipment, personnel, rules and by-laws, standards of medical care, hospital service, including health-related service, home health service, system of accounts, records, and the adequacy of financial resources and sources of future revenues. (NEW MATTER BEGINS HERE)

(b) (i) The commissioner shall have the power to establish by rule and regulation, within six months of the date on which this subparagraph shall have become law, specific criteria for the determination of hospital efficiency and to provide for the determination of hospital efficiency and to provide for the dissemination of such criteria to the public and hospitals. Only after public hearing, which must be held every two years if not sooner, may such hospital efficiency criteria be revised.

(ii) Notice of such hearing shall be published on three successive days in at least two newspapers having general circulation within the territory or district where the hearing will be held. The notice of hearing shall state the purpose thereof, the time when and the place where the public meeting shall be held. The public hearing shall be held at a time and location deemed by the commissioner to be most convenient to the public. At such hearing, any person may be heard in favor of or against the revision of hospital efficiency criteria.

(c) (i) The commissioner shall have the power to initiate consolidation of programs and/or services offered by two or more hospitals and/or health-related services;

(ii) No action hereunder shall be taken without a hearing. The commissioner shall fix a time and place for the hearing. A copy of the proposed action, together with the notice of the time and place of the hearing, shall be served in person on or mailed by registered mail to the hospital or health-related service at least thirty days before date fixed for the hearing. The hospital or health-related service shall file with the commissioner, not less than eight days prior to the hearing, a written statement concerning such proposed action. (NEW MATTER ENDS HERE)

§5. Subdivision one of section twenty-eight hundred six of such law, as amended by chapter nine hundred twenty-three of the laws of nineteen hundred seventy-three, is hereby amended, and a new subdivision, to be subdivision five, is hereby added thereto to read, respectively, as follows:

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HEALTH

From
THE LEGISLATIVE INDEX COMPANY
100 So. Swan St., Albany, N.Y.

January 14, 1975

Assembly 993

By Mr. H. Posner

AN ACT to amend the public health law, in relation to the rights of patients in certain medical facilities

Section 1. The public health law is hereby amended by adding thereto a new section, to be section twenty-eight hundred three-c, to read as follows:

§2803-c. Rights of patients in certain medical facilities.

1. The commissioner shall require that every nursing home and health related facility, as defined in subdivisions two and three (b) of section twenty-eight hundred one of this article, shall adopt and make public a statement of the rights and responsibilities of the patients who are receiving care in such facilities, and shall treat such patients in accordance with the provisions of such statement.

2. Said statement shall include, but not be limited to the following:

a. A guarantee that the patient's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, will not be infringed and that the facility will encourage and assist in the fullest possible exercise of these rights.

b. A guarantee of the patient's right to have private and unrestricted communications with his physician, attorney, and any other person.

c. A guarantee of the patient's rights to present grievances on behalf of himself or others, to the facility's staff or administrator, to governmental officials, or to any other person without fear of reprisal, and to join with other patients or individuals within or outside of the facility to work for improvements in patient care.

d. A guarantee of the patient's right to manage his own financial affairs, or to have a monthly accounting of any financial transactions in his behalf, should the patient delegate such responsibility to the facility for any period of time.

e. A guarantee of the patient's right to receive at least adequate and appropriate medical care, to be fully informed of his medical condition and proposed treatment, and to participate in the planning of all medical treatment, including the right to refuse medication and treatment and know the consequences of such actions.

f. A guarantee of the patient's right to have privacy in treatment and in caring for personal needs, confidentiality in the treatment of personal and medical records, and security in storing and using personal possessions.

g. A guarantee of the patient's right to receive courteous, fair, and equal treatment and services and a written statement of the services provided by the facility, including those required to be offered on an as-needed basis.

h. A guarantee of the patient's right to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by a doctor for a specified and limited period of time.

i. A statement of the facility's regulations and an explanation of the patient's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of the other patients.

j. A guarantee that, should the patient be adjudicated incompetent and not be restored to legal capacity, the above rights and responsibilities shall devolve upon a sponsor or guardian who shall see that the patient is provided with adequate, appropriate, and respectful medical treatment and care and all rights which he is capable of exercising.

3. Each facility shall make available a copy of the statement to each patient and to each patient's guardian at or prior to the time of admission to the facility, and to each member of the facility's staff.

4. Each facility shall prepare a written plan and provide appropriate staff training to implement each patient's right included in the statement.

§2. This act shall take effect on the sixtieth day after it shall have become a law.

Referred to Health Com.

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II F3a

1. A hsopital operating certificate may be revoked, suspended, limited or annulled by the commissioner on proof that;*****to provide for necessary emergency care and treatment for an unidentified person brought to it in an unconscious, seriously ill or wounded condition(NEW MATTER BEGINS HERE); or (c) the hospital has failed to furnish the commissioner of health with an impact statement prior to acting, or, having been furnished with an impact statement prior to acting, the commissioner neither certifies the proposed action as improving the efficient delivery of health care services nor certifies such action as critical to the public health, and the hospital acts on its proposed action.

5. In addition to the power to revoke, suspend, limit or annul the hospital operating certificate, the commissioner may, in the event of a violation by a hospital or health-related service of any provision of the certificate of incorporation or any order of the commissioner or of any rules and regulations duly promulgated pursuant to the provisions of this chapter, remove any or all of the existing directions of the hospital or health-related service and appoitn such person or persons whom the commissioner deems advisable, including officers and employees of the department, as new directors to serve in the places of those removed. Directors so appointed by the commissioner who are officers or employees of the department shall serve in such capacity without compensation, and any directors so appointed by the commissioner shall serve only for a period coexistent with the duration of such violation or until the commissioner is assured in a manner satisfactory to him against violations of a similar nature. (NEW MATTER ENDS HERE)

§6. Subdivision three of section twenty-eight hundred seven of such law, as amended by chapter nine hundred eighteen of the laws of nineteen hundred seventy-two, is hereby amended to read as follows:

3. Prior to the approval of such rates, the commissioner shall determine and certify to the superintendent of insurance and the state director of the budget that the proposed rate schedules for payments for hospital and health-related service, including home health service, are [reasonably related to the costs of efficient production of such service] rates of payment which are directly related to the efficient delivery of health care services as determined according to the specific criteria set forth by the commissioner. In making such certification, the commissioner shall take into consideration the elements of cost,*****

§7. Such law is hereby amended by adding thereto a new section, to be section twenty-eight hundred seven-a, to read as follows:

§2807-a. Impact statements. The contents of all impact statements submitted pursuant to this article shall be public information and such statements shall be available for public inspection under such conditions as the commissioner shall prescribe. The department shall prepare an analysis of each impact statement for the commissioner. The commissioner shall certify for all impact statements either that the proposed action improves the efficient delivery of health care services, that the proposed action is critical to the public health, or that the proposed action shall not be undertaken and the rationale therefor.

§8. Subsection two of section two hundred fifty-five of the insurance law, as amended by chapter six hundred ten of the laws of nineteen hundred sixty-two, is hereby amended to read as follows:

2. No corporation subject to the provisions of this article shall enter into any contract with a subscriber unless and until it shall have filed with the superintendent of insurance a full schedule of the rates to be paid by the subscribers to such contracts and shall have obtained the superintendent's approval therof. The superintendent's approval shall not be granted until after the approval of the commissioner of health. The superintendent may refuse such approval*****

§9. Paragraphs (a) and (b) of subsection two-a of section two hundred fifty-five of such law, as added by chapter five hundred seventy-two of the laws of nineteen hundred seventy, are hereby amended, to read, respectively, as follows:

(a) Notwithstanding any other provision of law, no rate filing with respect to contracts,*****except in compliance with the provisions of this subsection as well as other applicable provisions of law. The superintendent shall annually evaluate the management practices, operating policies and financial and administrative procedures of all corporations organized and operating in accordance with article nine-c of the insurance law.

(b) Prior to any such filing or application by or on behalf of a corporation, such corporation, when directed by the superintendent, shall conduct a public hearing with respect to the terms of such filing or application. Notice of such hearing together with the annual evaluation shall be published on three successive days in at least two newspapers*****

§10. This act shall take effect on the thirtieth day after it shall have become a law.

Referred to Health Com.

***** means same as old law
[ ] means old matter omitted
_____ means new matter

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S 269
1975

MEMORANDUM IN SUPPORT OF

Senate Bill No. 269
by Senator John E. Flynn

AN ACT to amend the Public Health Law in relation to the appointment of an advisory council on complaints arising with respect to nursing homes.

SUMMARY OF PROVISIONS:

Adds a new subdivision to be subdivision 9 of §2896a of the Public Health Law to allow the Commissioner power to appoint at least one senior citizen in each county and upon the recommendation of the Chief of the appropriate Social Services district therefor, one senior citizen shall be appointed to investigate specific complaints arising with respect to nursing homes, and report his findings to the Commissioner.

JUSTIFICATION:

It is a well known fact that the citizens of our State are very concerned with the conditions existing in nursing homes. The Department of Public Health makes diligent efforts to investigate complaints concerning nursing homes as they arise. It is felt, however, that the present system could be greatly improved by the addition of Senior Citizen Investigators, deputized to investigate specific complaints arising in the counties in which they reside. This proposed system would add a large investigatory arm to the Department of Public Health and would result in a more prompt and efficient handling of nursing home complaints, enabling the Department of Health to take speedier action to remedy abuses. At the same time, it is felt that the Senior Citizens who have a "special interest" involved in this area will do a very thorough and conscientious job in this appointive capacity.

EFFECTIVE DATE:

Thirty days after it shall have become law.

II F 4

A.83

WERTZ

MEMORANDUM IN SUPPORT

AN ACT to amend the mental hygiene law, in relation to defining certain terms

PURPOSE OF BILL:

This bill is designed to clarify the intent of the Legislature by statutorily defining various terms.

SUMMARY OF PROVISIONS:

Section 1.05 of the Mental Hygiene Law is amended to: (a) include family care homes, hostels and halfway houses within the definition of "facility;" (b) excludes a home, in which domestic care and comfort are provided to a person by a relative, from the definition of "facility;" and (c) separately defines "domestic care and comfort," "family care home," "hostel,", "halfway house," "aftercare services," and "conditional release."

The bill would take effect immediately.

LEGISLATIVE HISTORY:

None.

JUSTIFICATION:

Family care homes have been providing services to the mentally disabled for nearly forty years. Currently, there are close to 2,000 such homes servicing nearly 7,000 residents. The development of hostels and halfway houses as alternatives to large institutions is expected to increase. The bill acknowledges both the important role family care homes have played in providing services and the expanded role hostels and halfways are expected to play. "Domestic care and comfort,""family care home," "hostel," "halfway house," "aftercare services," and "conditional release" have been separately defined in an effort to clarify the meaning of such terms.

FISCAL IMPLICATIONS:

None.

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4635 #1.84

MEMORANDUM IN SUPPORT

Ass Weitz

A.84

AN ACT to amend the executive law, in relation to giving the board of social welfare the responsibility for setting standards and approving the operation of certain residential facilities for adults, to repeal section seven hundred fifty-eight thereof and to make an appropriation therefor

PURPOSE OF BILL:

This bill is designed to assure that all residential facilities for adults meet and maintain minimum standards and to assign the responsibility for approving, inspecting and investigating such facilities to one governmental agency.

SUMMARY OF PROVISIONS:

This bill amends section 755 of the Executive Law by no longer permitting the board of social welfare to delegate its responsibility for visiting, inspecting and supervising private proprietary homes for adults with a capacity of four or less to local commissioners of social services districts.

The bill also repeals section 758 of the Executive Law and replaces it with a new expanded section which, while retaining certain parts of the original section, makes these substantial changes:

1. defines "boarding house," "foster home for adults," and "hostels;"

2. gives the board responsibility for approving, inspecting and supervising the operation of these additional facilities;

3. provides that no person shall operate any facility as a private proprietary home for adults or as a foster home for adults after August 31, 1974 without the written approval of the board;

4. provides that no person or corporation shall operate any facility as a residence for adults, boarding house or hotel after August 31, 1974 without the written approval of the board;

5. provides that the board shall not grant its approval for the operation of any private proprietary home for adults, residence for adults, foster home for adults, boarding house or hotel after August 31, 1974 unless a member or member's of the board's staff have personally visited and inspected the facility requesting its approval and are satisfied that the person or corporation requesting its approval is: financially responsible; prepared to make social, recreational and other supportive services available to all its residents; that the buildings, equipment, staff, standard of care and records to be employed in the operation of such facility comply with applicable provisions of law and rules of the board; and that any license or permit required by law for the operation of such facility has been issued to the applicant;

6. provides that any person or corporation which operates any of these facilities in violation of the provisions of this act shall be guilty of a misdemeanor;

7. provides the board with the power to revoke, suspend or limit its approval of any of these facilities under certain circumstances;

II F6a

8. provides that any order of revocation, suspension or limitation of the board's approval shall be subject to judicial review; and

9. provides the board with a $550,000 appropriation to effectuate the provisions of this act.

The bill would take effect next September first.

JUSTIFICATION:

No one state agency exercises any control over boarding houses and hotels. It is these types of unregulated facilities which are generally providing substandard accommodations to large numbers of adult public assistance recipients. While the board already has responsibility for private proprietary convalescent homes, private proprietary home for adults, and residences for adults, it has delegated its responsibility for visiting, inspecting and supervising proprietary homes for adults which have a capacity of four or less residents to local social services commissioners. As a result of the absence of any control over boarding houses and hotels, and the lack of accountability that has resulted from the board's delegation of certain of its responsibilities, a large number of the state's socially incapacitated citizens are living in substandard residential facilities. This bill is designed to assure that all residential facilities for adults meet and maintain certain minimum standards. It accomplishes this by giving the board of social welfare full responsibility for approving, inspecting, investigating and supervising all these facilities and by permitting the Board to withdraw its approval whenever facilities are not complying with applicable provisions of law or its own rules.

The bill provides that, in addition to meeting the standards prescribed by the board, all such residential facilities requesting approval after August 31, 1974, must make social, recreational and other supportive services available to all its residents. These services are mandated because the individuals who reside in group residential facilities of these types, are those who have various social problems which limit their ability to function independently, effectively and competitively in society.

FISCAL IMPLICATIONS:

The board has estimated that it would require an additional $300,000 for staff if it were to assume full responsibility for approving, visiting, inspecting and supervising the approximately 1,000 proprietary home for adults with a capacity of four or less residents which local social services commissioners are presently responsible for. There are no accurate estimates of the number of boarding houses and hotels presently being operated in the state, although we know from recent experiences in Long Beach and New York City that the use of single room occupancy accommodations is rapidly increasing. An additional $250,000 is being appropriated to the board to assist it in identifying and regulating these expanding facilities.

II F6

6858

HEALTH

MEMORANDUM

S. _____ By Mr. Lombardi

A. _____ By

AN ACT to amend the public health law, in relation to determining eligibility standards for the granting of state aid to certified public and non-profit home health agencies

PURPOSE: To provide funding for grants in aid to public and non-profit certified home health agencies to allow these agencies to expand and enhance their services.

SUMMARY OF PROVISIONS: Amends section 2801 of the public health law to provide for a program of State grants to public and non-profit certified home health agencies. Such grants would be available for a maximum of five years. An agency may not apply for a grant of more than $50,000. For the first two years grants would be made without requiring the agency to match funds. For an agency to continue to receive funds for the third, fourth and fifth year, the agency will have to provide its own funds on a sliding scale as follows:

	State Funds	Agency Funds
First Year	100%	00%
Second Year	100%	00%
Third Year	75%	25%
Fourth Year	50%	50%
Fifth Year	25%	75%

In order to receive State grants, public and non-profit certified home health agencies must submit plans to expand the types of services provided, increase the number of personnel they utilize, make home health care available on a seven-day-a-week basis, develop training programs for agency personnel, and develop programs to coordinate the work of the agency with other community resources.

JUSTIFICATION: The type of home health services available varies substantially from one area of the State to another. In some communities, persons can return home early from the hospital and receive comprehensive high quality care at home. Such care is advantageous to both the patient and the family and can be provided at greatly reduced costs. In other communities the same patient would have to stay in the hospital and possibly be forced to enter a nursing home.

This uneven development across the State is inequitable to some and acts as a barrier to sound proposals to provide greater home care inclusion in insurance, governmental programs and new health delivery developments. In addition, the lack

II F 7a

of home health agencies providing an adequate range of services stands as a block to prevent overuse of facilities through stepped-up utilization reveiw and PSRO developments.

A program of State aid to public and non-profit certified home health agencies as authorized by this legislation will provide these agencies with the financial resources to expand and enhance the services they provide. The expansion of home health agencies will allow patients to truly realize the types of savings home health care can provide.

The real potential for savings of health dollars can be effective only if strong home health agencies exist. A most important aspect of this, of course, is the key role of the physician in the use of home care. A physician will not send a seriously ill patient home, no matter how much dollar coverage is available, unless there is an agency capable of providing the range and quality of care his patient needs. This legislation addresses itself directly to this problem.

With the additions to home health agency responsibilities (increasing the number of types of therapeutic and related services and adding the services of homemakers) and certification requirements which have come from the 1972 and 1973 legislation, the gradual increase in the over 65 age group in New York State, the federal curtailment of reimbursable services under Medicare and the greater availability of insurance coverage for home health care, it is important to develop a statewide home health agency financial assistance program.

The success of the State aid program proposed by this legislation can follow the most favorable experience found under the 1965-67 Medicare "start-up" grant funds which the Health Department administered and from which this proposal is patterned.

FISCAL IMPLICATIONS: There will be no cost to the State until April 1, 1976.

LEGISLATIVE HISTORY: A similar bill (S. 9188) passed the Senate only in 1974.

EFFECTIVE DATE: This act will take effect immediately, however, grants of State aid will not be made available until April 1, 1976.

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S 574

1975

In support of Senate Bill No. 574
Introduced by Senator John J. Santucci

"An Act to amend the executive law and the mental hygiene law, in relation to approval of certain private proprietary homes for adults."

This bill would require that any private proprietary home for adults where ten percent or more of the persons admitted to such home had been patients at a Department of Mental Hygiene facility within the previous two years, must be approved by the Commissioner of Mental Hygiene, in addition to the State Board of Social Welfare.

In addition, Section 7.05 of the Mental Hygiene Law is amended by a new subdivision, (e), which mandates that the department shall set up standards for those proprietary homes which fall within its jurisdiction.

Within the past two years, the State Department of Mental Hygiene has been releasing patients from its state mental hospitals at a much greater rate than ever before. Many of these ex-mental patients are finding their way into proprietary homes for adults because they have no other place to go. These facilities are presently under the exclusive jurisdiction of the State Board of Social Welfare without any specific standards, programs, etc. geared toward these ex-mental patients. As a result, chaos is rapidly developing in many of these proprietary institutions.

It is important that the Department of Mental Hygiene's responsibility for the aftercare of these people be mandated in two respects. One, the department should be responsible for the licensing of these facilities to make sure that they do provide the necessary facilities, programs and personnel for effective aftercare and also that the department have responsibility for follow-up via visits and inspections to make sure that the facilities they approved are living up to their standards.

Additional fiscal costs to the Department of Mental Hygiene will be necessitated by the additional personnel required for the administration of this program.

Respectfully Submitted

John J. Santucci

II F 8

By FRANK VAN RIPER and WILLIAM SHERMAN   Staff Correspondents of The News   Last of a series

Washington, Feb. 19—The lauded promise of free, high quality nursing home care for the nation's indigent elderly, passed nine years ago by the "Great Society"

He did not explain how much additional money the incentive plan would cost nor did he say how it would eliminate the fraudulent inflation of costs by many owners in states like New York where reimbursement is calculated according to expenses — such as

system, that would also be available to

the public in layman's ... would allow private ... more informed choices on where to place their relatives. Homes will be ... according to quality of care, nursing supervision, activities for the elderly, physical plant and food.

... his dignity and remaining health when he stands at the nursing home door.

Nat'l Rating System

Cost of care index

(Nat'l Training Programs. Uniform Codes

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Prof.# 75-5588

NEW YORK STATE HEALTH FACILITIES ASSOCIATION
MORELAND COMMITTEE

New York State Health Facilities Association is desirous of preparing a study of certain aspects of the nursing home component of the health delivery system in New York State. The members of this association are the true experts in the field, and will provide direct input through a task force approach in order to develop specific proposals in specified areas of concern. We recognize, however, that there are people outside of our association who have extreme competence in our field, and from time to time these individuals will be called upon to work with the task forces in order to develop proposals.

Purpose of Study

In order to help focus attention on the positive aspects of nursing home care, our study will have to recount the history of the nursing home system as well as develop statistical and other pertinent data. The existing components such as government regulation, reimbursement and patient care will have to be analyzed and where deficient, specific proposals will have to be made in order to support our theses. The actual proposal must take into account legitimate public concern over patient care and reimbursement; however, it should be understood we are not going to attempt to rewrite all existing laws and regulations, as this would be an impossible task. It is our specific purpose to focus on specified areas and to point out the necessary role which the proprietary sector has played and will continue to play

in the delivery of quality nursing home care, for truly there are no alternatives.

Areas Of Concern

Real estate

Reimbursement

Patient care

Definition of a public policy regarding nursing home care

Abuses, public accountability and quality assurance

The firm selected to assist in this project will be responsible for providing directed research, coordination of task forces, guidance as to approach to presentation, assistance in presentation, research staff, resource personnel both in and out of house. The firm will work under the direction of the New York State Health Facilities Association Committee and its legal counsel, and it is expected the final report will be completed in six months with interim reports within thirty days. It must be pointed out that it is the committee's feeling that no one single consulting firm has the capability to produce a complete study, and from time to time individuals in specified areas will also be called in to participate in our work. Therefore, it should be understood that the roll which the major consulting firm will play would be somewhat akin to that of a general contractor in a construction project with prime additional subcontractors participating.

The firm selected will be required to provide a representation to the Association that it has no affiliation either direct or indirect with any individual, corporation or company who has any interest whatsoever in a nursing home either directly or indirectly. Further the representation must also include a statement that the firm has not employed any officers, directors, staff members or members of the New York State Health Facilities Association within the last three years and that no remuneration of any nature has been or will be made to any of the above.

N.Y. Times 3/19/76

f-
nurse homes

BOARDING HOMES FOR AGED SCORED

Senate Panel Tells of Profit From Mentally Ill Through Federal Welfare Funds

By NANCY HICKS

That effort, begun by President Kennedy, sought to end warehousing in state institutions through the development of about 4,500 community-based mental health centers, most of them clinics. Only 443 are in operation, and Federal support has been reduced.

In the interim, the Federal Government enacted and began in 1974 the Supplementary Security Income program for the elderly poor and disabled—as former inmates of mental hospitals are classified—and set a basic level of out-of-institution support for them.

'Hungry People Begging'

"I have seen broken windows letting the cold air into rooms without radiators," he said. "I have seen leaking roofs and holes in ceilings. I have seen hungry people with their faces up against vending machines begging for a quarter.

"It became evident to me," he continued," that operators were cutting corners every way they could in order to maximize profits. Apparently, mental patients are a good invest-

Big HEW Survey Cites Nursing Home Faults

Washington

The Department of Health, Education and Welfare, in what it said was the first national study of nursing homes ever undertaken

tion of nursing home associations in the 50 states, had no comment on the report.

The report found that 48 per cent of nursing home patients had not been exam-

home, as is also required by federal regulations.

The report found that 44.8 per cent of nursing home patients were being given tranquilizers

f - nurs homes

Residents of City Adult-Care Homes Tell of Abuses

By NATHANIEL SHEPPARD Jr.

Residents of city adult-care facilities testified at a United States Senate subcommittee hearing here yesterday that they frequently lived in terror

been a resident of the Palace Hotel, an adult-care facility in Long Beach, L.I., since 1973, told the subcommittee she had been forced to pay a $2 bribe to employees before she was

switchboard operator at the facility.

A spokesman for the facility referred all questions to the proprietor, Rabbi Menachem Blum, but added that the rabbi

strung, however, by a lack of jurisdiction because of opposition by the State Board of Social Welfare.

Under questioning by Representative Edward I. Koch, Ber-

Wash. Star-News 3/19/76

f - Nursing Homes

Nursing Home Horrors Detailed

By Edmund Pinto
Associated Press

A new government report says some mentally ill patients in private nursing homes are living with hunger, cockroaches, leaking roofs, exposed electrical wires and doors made of cardboard and burlap.

The report, released

Sen. Frank E. Moss, D-Utah, chairman of the panel, said the conditions were being fostered by government policy that provides a financial incentive to move patients from public institutions into private-care facilities.

"I have seen hungry people with their faces up

When it approved Social Security in 1935, Moss said, Congress barred giving Social Security funds to residents of public institutions, but if boarded in a private home they could receive the money.

"In short, Congress created the scandal-ridden, for-profit nursing home industry," he said.

Patients in many of these private institutions are confronted with poor care and abuse, deliberate physical abuse and unsanitary conditions, he said.

He claimed also they face poor food, high incidence of theft, inadequate control on drugs, fire hazards, reprisal if they complain about conditions, use of restraints

United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 93d CONGRESS, SECOND SESSION

Vol. 120 WASHINGTON, TUESDAY, MARCH 26, 1974 No. 41

House of Representatives

H.R. 13720: MEDICARE LONG-TERM CARE ACT OF 1974

The SPEAKER per tempore. Under a previous order of the House, the gentleman from New York (Mr. CONABLE) is recognized for 5 minutes.

Mr. CONABLE. Mr. Speaker, today I have introduced H.R. 13720, the Medicare Long-Term Care Act of 1974. This proposal will establish a new program of long-term care of the elderly that will provide alternatives to expensive and confining medical care by expanding the options available. By including services as well as institutional medical care in the program, we can offer our elderly citizens who need it a more secure and less worrisome future, less family strain, and less demands on their savings.

The resources of older people can be wiped out by a long stay in a nursing home since neither medicare nor private insurance covers long-term care. The only program that does provide some funds is medicaid—the program of health care for the poor.

In too many cases what we are doing today amounts to incarceration, rather than considerate care, because too great a reliance is put on placing people in institutions when many of them could be cared for better in other surroundings, including their own homes. That is why the emphasis of the bill I have introduced today is on care in the home or on an outpatient basis. This proposal calls for a system of community long-term care centers in every area of the country to coordinate and direct long-term care services for the elderly, including homemaker, health, nutrition, and day care, as well as institutional care.

In the past efforts to secure assistance for older Americans have not been successful mainly for three reasons. First, we do not have an effective and rational method of meeting the costs of long-term care services, including institutional care when it is required. Older people with chronic conditions have been left to their own devices because the costs to any public program of institutionalized care are prohibitive. So we have resisted program involvement and we have developed a defeatist attitude toward one of society's most vexing problems.

Second, a great majority of our communities do not have available the types of services which are better alternatives to institutionalization.

And third, in most communities, no single person or agency, public or private, takes full responsibility for helping older people and their families meet their needs as health and family status changes.

I have deliberately constructed H.R. 13279 to deal directly with these problems. My bill is modeled on the medicare program and would meet the first problem by establishing a new program under medicare which would provide protection against the costs of long-term care, both institutional and noninstitutional, without concern about drawing an arbitrary and unnecessary line between health care services and nonhealth care services.

The bill would meet the second problem, the lack of adequate community services, in several ways. First, the benefits covered by the bill would include services which can be alternatives to institutionalization. Provision of these services can help people in their own homes or other family settings. Second, the bill would require that placement in an institution could occur only after all other avenues have been explored. And third, even when placement in a nursing home has been designated as the only possible alternative the patient will have a continuing opportunity to move out of the home or improve his situation in the home.

And finally, my bill would meet the third problem by creating for every community a long-term care center which would act as the coordinator and paying agency for long-term care services. Whenever a question arose in a family about what to do about a change in health or family situation, the center would be responsible for helping find the best answer and for providing the needed services, after careful consultation with the individual and his or her family.

The bill contains certain other features I would like to highlight.

While the program would be national in application, just like medicare now, the administration of the program would be decentralized and involve, on a local basis, the people who are to be served by the program. Specifically, a new State agency would be established which would divide up the State geographically, assure the establishment of a community long-term care center in each area, approve such centers for participation in the program, and pay the centers for services furnished.

The community long-term care center would be required to have a governing board with at least half of its members from among persons who are eligible for benefits. In addition, one-quarter of the board would be elected by eligible people in the area and one-quarter appointed by officials of local government.

The program would be financed by a $3 premium paid by those aged who choose to enroll in the program, by a contribution from States of 10 percent of program costs with the balance from Federal general revenues. My bill would increase by $3 the amount of SSI benefits to everyone receiving them so the program will represent no additional cost to these individuals.

No estimates of the cost of the bill have been made, largely because making estimates in this area is very difficult. However, the States and the Federal Government now pay more than $4 billion a year for nursing home care under the medicaid program. Medicare pays an additional several hundred million dollars for extended care services. Numerous studies have shown that large numbers of older people now in nursing homes do not need to be there, particularly if realistic alternatives are available. Thus, I think it is fair to conclude that under my bill the costs of institutional care would be held in check.

But regardless of how the costs might turn out, the important point is that we need to rationalize the system of providing long-term care and I believe my bill has the potential to do that with possibly no increase in overall costs.

An outline of H.R. 13720 is attached. I urge Members, people with special interest in the aging, and the general public to study the bill carefully. I have introduced this bill so that this subject will get the attention it deserves in a rapidly aging society. I am hopeful that hearings can be held on the bill so that it can be fully explored.

The information follows:

H.R. 13720, MEDICARE LONG-TERM CARE ACT OF 1974, INTRODUCED BY THE HONORABLE BARBER B. CONABLE, JR.

1. Brief Description: Amends the Medicare program by adding a new voluntary Part D to Title 18 of the Social Security Act which would:

Establish a comprehensive program of long-term care services available to those who enroll under the program;

Provide for the creation of community long-term care centers in all areas of the nation and State long-term care agencies as part of a new administrative structure for the organization and delivery of long-term care services; and

Provide a significant role for people eligible for long-term care benefits in the administration of the program.

2. Eligibility: Anyone who is (1) eligible for hospital insurance under Part A of Medicare (aged or disabled), or (2) is age 65 and a resident, or (3) is eligible for supplemental security income (SSI) benefits is eligible to enroll under the new program if he has also enrolled under the Part B medical insurance part of Medicare. Enrollment procedures are similar to those which now apply to the Part B program.

Premiums of $3 a month would be collected just as Part B premiums are now collected.

3. Financing: A Federal Long-Term Care Trust Fund would be established to handle the financial operations of the program.

The Trust Fund would receive its monies from the $3 premiums of those who enroll, 10% from the States and the balance from Federal general revenues.

4. Functions of Community Long-Term Centers: Provide directly or through arrangements covered items and services to each individual residing in the area who is eligible;

Provide evaluation and certify the long-term needs of individuals through a team approach involving the individual and his family;

Maintain a continuous relationship with individuals receiving any items or services; and

Provide an organized system for making its existence and location (which must be accessible in the community) known to the individuals in the service area.

In carrying out the above, a community long-term care center shall not certify the need for inpatient institutional services for an individual unless a determination has been made that the needs of such individual cannot be met through covered types of care or other community resources.

5. State Long-Term Care Agency: Each State must establish an agency—either a separate agency, or major division of the health department—which will:

Designate service areas in the State;

Certify the conditions of participation for a community long-term care center;

Promote and assist in the organization of new community long-term care centers in areas where they do not exist; and make payments to and monitor the activities of all long-term care centers in the State; and

Provide local government offices where a nonprofit agency does not exist.

6. Conditions of Participation for Community Long-Term Care Centers: Community Long-Term Care Centers must:

Have policies, established by a group of professional personnel and approved by the governing board;

Maintain medical and other records on all beneficiaries;

Have an overal plan and budget;

Meet other conditions the Secretary may prescribe; and

Be either a public or non-profit organization.

The governing board of a community long-term care center must be composed as follows: one-half of people covered under the program who reside in its service area; at least one-quarter have been elected by the people covered under the program; and at least one-quarter appointed by locally elected government officials.

Members can serve only two terms and full membership must change at least every six years.

7. Detailed Definitions of Covered Services:

a. Nutrition Services.

Limited to meals on wheels and similar programs and services provided in the place of residence of such individual by a nutritionist.

b. Homemaker Services.

Services provided in the home designed to maintain the individual in his home.

Preparing and serving meals in the home of an individual.

c. Institutional Services

Extended care benefits in a skilled nursing facility (same as social security defintion)

Intermediate care services

Institutional day care services

d. Home Health Services (Same as under present Medicare program.)

e. Day Care and Foster Home Care Services

Care provided on a regular daily basis in a place other than the individual's home; and

Placement of individual on a full-time basis in a family setting.

f. Community Mental Health Center Outpatient Services

8. Payment Method for Community Long-Term Care Centers:

Secretary will develop prospective payment methods after consultation with states and other interested parties, and States will follow them in paying the community long-term care centers.

9. Miscellaneous Provisions:

If an individual stays in a nursing home for more than 6 months, beginning with the 7th month his social security cash benefits are reduced by ⅔ (in recognition of such a person's reduced living costs) and the ⅔ is deposited in the long term care trust fund. As soon as the recipient leaves the nursing home, full benefits are restored immediately.

The bill would increase SSI benefits by $3 a month so that the premium payment could be met without a reduction in cash income.

10. Effective date:

Benefits would first become payable on July 1, 1976, thus allowing sufficient time for the organization of the new system.

FOR IMMEDIATE RELEASE APRIL 29, 1976

OFFICE OF THE WHITE HOUSE PRESS SECRETARY
(Houston, Texas)

THE WHITE HOUSE

REMARKS OF THE PRESIDENT
TO THE
ANNUAL MEETING
OF THE
TEXAS NURSING HOME ASSOCIATION

HYATT REGENCY HOTEL

10:18 A.M. CDT

It is nice to see some more friendly faces here.

Mr. Pendergast, Senator John Tower, members of the Texas Nursing Home Association:

It is a privilege and a pleasure for me to have the opportunity to stop by and make some observations and comments and thank you for the good job that you have done, not only here in Texas with your organization but with comparable organizations throughout the United States.

I know from personal experience in my State of Michigan that the organization of the Association there has done a good job, and I am sure that is likewise true here, and I congratulate you and compliment you.

But let me talk for just a few minutes about some of the things that I am trying to do to make certain, to make positive that the 32 million or 33 million Americans who are the beneficiaries of Social Security and other Federal programs are properly taken care of.

You, I am sure, know that in the State of the Union message that I submitted to the Congress in January of 1976, I recommended the full cost of living increase for Social Security recipients, and it is my understanding that based on the calculations that have been made by the proper authorities that will be 6.4 percent, as I recall, as of July 1 of this year.

I believe that we, as a Nation, hold an obligation to that part of our society. They bought and paid for the benefits that are coming and ought to be given to them under the law.

Another program that I feel Congress ought to act on is what is commonly known as catastrophic insurance. It has been my experience as I traveled around the country to see in many, many instances individuals who were good citizens and saved their money and planned for their retirement all of a sudden be hit with a catastrophic illness where the costs were great, where the time that they had to spend in a hospital or a nursing home was very, very extended.

MORE

I am told under Medicaid that there are roughly 3 to 4 million of our fellow citizens who are adversely affected by the catastrophic illness. I think we owe an obligation to them because they, under no circumstances, could pay the cost to maintain adequate care during this tragedy.

So I recommended to the Congress that something be done about it. Unfortunately, no action has transpired at the present time. Unfortunately, the prospects do not look good. Believe me, I feel an obligation, and I think those of us who are healthy, whether you are young or old, owe an obligation to that segment of our society that are tragically hit by these unfortunate illnesses.

I likewise know that your organization has raised a good many questions about HEW's 1972 regulations. I am sure you are not the only organization, because I am informed that other State organizations comparable to you have done likewise.

It does appear to me -- and I have talked to the Secretary of HEW about it -- that there is an overzealous interference attempted by those regulations, and I hope we can do something affirmatively to change them.

I have repeatedly said that we want to get the Federal Government off the backs of people and out of their pockets. We have recommended tax decreases, additional tax reductions. We are making some headway in reducing Federal paperwork.

About six months ago I directed the Office of OMB to make a 10 percent reduction in the total paperwork as far as all Federal agencies and departments are concerned. That 10 percent reduction is to be achieved by July 1 of this year.

Let me put it as simply, but I think it is as safely as I can, as it affects what all of you are trying to do: Your emphasis should be on taking care of patients, not making out forms.

It has been a great privilege and pleasure to be here and to say hello to you and to give you the benefit of some of my views and programs, policies that we are seeking to implement for the benefit of all of the 215 million Americans.

I thank you for the opportunity to be here.

END (AT 10:25 A.M. CDT)

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

OCT 8 1976

MEMORANDUM TO SPENCER JOHNSON

Attached is the brief talking points you requested on the status of long term care policy.

Marjorie Lynch
Under Secretary

Attachment

STATUS OF LONG-TERM CARE POLICY

- The Federal Government now provides about $4 billion financial support for care in skilled nursing homes and intermediate care facilities through primarily the Medicaid and also the Medicare program. For the past several years, HEW has put particular emphasis on programs to insure the safety of the facilities and enforcement of other standards.

- In our effort to provide needed nursing home care for those who need it, we may have unnecessarily placed persons in institutional care who could be better cared for in their homes. HEW is just now completing hearings held throughout the country to explore improvements in home health care as an alternative to institutional care.

- In addition, the Federal efforts to insure that facilities for the elderly, the sick, the disabled and the retarded are safe and appropriate for their care have led in some cases not to better care, but rather endless regulations and bureaucratic red tape. As part of my regulatory reform initiative, HEW is conducting a thorough review in cooperation with state and local governments to separate the needed from the useless regulatory provisions.

- Finally, we need to rethink the proper Federal-State and local roles in providing long-term care. While the Federal government's financial support for such care is appropriate, it is probably more appropriate that state and local agencies have the primary responsibility for tailoring the care provided to each individual's needs.