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# REPORT TO THE CONGRESS

## Problems In Approving And Paying For Nursing Home Care Under The Medicaid Program In California <sup>B-164031(3)</sup>

Social and Rehabilitation Service <sup>33</sup>  
Department of Health, Education,  
and Welfare <sup>33</sup>

BY THE COMPTROLLER GENERAL  
OF THE UNITED STATES

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COMPTROLLER GENERAL OF THE UNITED STATES  
WASHINGTON D C 20548

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

This is our report on problems in approving and paying for nursing home care 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 sent to the Director, Bureau of the Budget, and to the Secretary of Health, Education, and Welfare

A handwritten signature in cursive script that reads "James B. Stacks".

Comptroller General  
of the United States

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ABBREVIATIONS

GAO General Accounting Office

HEW Department of Health, Education, and Welfare

D I G E S T

WHY THE REVIEW WAS MADE

Under Medicaid, a grant-in-aid program administered at the Federal level by the Department of Health, Education, and Welfare (HEW), the Federal Government pays from 50 to 83 percent of costs incurred by States in providing medical care to individuals unable to pay. About \$3.9 billion was paid by States for Medicaid services in 1968, of which \$1.1 billion, or about 30 percent, was for skilled nursing home services. HEW paid for about half of these expenditures.

Because large amounts of Medicaid funds are expended for skilled nursing home care, the General Accounting Office (GAO) examined into selected aspects of costs incurred for such care provided to recipients in four counties in the State of California. Payments to nursing homes in California during 1968 totaled about \$160 million, of which \$80 million was paid by the Federal Government.

FINDINGS AND CONCLUSIONS

GAO's review revealed weaknesses in the procedures and practices for approving and paying for nursing home care under the Medicaid program in California. Also, no uniformity existed for making determinations on the necessity for nursing home care.

On the basis of GAO's observations of approvals of nursing home care and conclusions of studies by three counties in California that a high percentage (35, 22, and 20 percent) of patients were not in need of such care, GAO believes that Medicaid recipients were receiving nursing home care without adequate determinations that such care was warranted.

In addition, GAO found

--that, in some cases, care was approved for periods after the date of death or discharge of the patients,

--that, in 22 of 260 cases examined, claims were paid for periods after a recipient had died or had been discharged from the nursing home (see pp 17 to 19), and

--that, in 12 of 76 additional cases examined, nursing homes were receiving full payments under both the Medicare and Medicaid programs for the same days of nursing home care. (See pp. 20 to 22.)

In view of the weaknesses in procedures and practices and the high incidence of questionable payments (34 of 336 cases examined), GAO believes that the results of its review sufficiently demonstrate the need for corrective measures to strengthen controls over the approval and payment for nursing home care

In Calendar year 1968, about 100,000 Medicaid recipients received nursing home care in California in about 1,250 nursing homes and, in view of the costs of the program, the lack of adequate control over the approval and payment for nursing home care can result in significantly increased program costs

#### RECOMMENDATIONS OR SUGGESTIONS

The Secretary, HEW, should provide for the development or evaluation of administrative and program requirements for the States' use in approving the initial placement of Medicaid recipients in nursing homes, approving the extension of approved care in nursing homes, and paying for nursing home care (See p. 24.)

Also the Secretary, in HEW's monitoring of State Medicaid activities, should provide measures designed to (1) determine the extent to which HEW requirements are being implemented by the States and (2) effect corrective action where warranted (See p. 24 )

#### AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW evaluated its policy guidelines relating to the placement and retention of Medicaid recipients in nursing homes and concluded that the guidelines were adequate. In its opinion, the deficiencies relating to placement and retention were attributable to the failure of county agencies and personnel to follow HEW policy and State guidelines. The State advised HEW that special efforts were being undertaken to improve the processes of authorization and reauthorization of skilled nursing home care (See pp. 24 and 25 )

Both HEW and the State concur in GAO's recommendation that guidelines be developed to avoid improper payments for nursing home care. The State has issued instructions which it believes will improve control of billings after death or discharge of recipients. The State also is attempting to resolve the problem of duplicate Medicaid payments through the refinement of computer controls (See p. 25.)

HEW informed GAO that the recent reorganization of the Medical Services Administration, Social and Rehabilitation Service, recognized the need for

development of payment procedures and controls and consultation with State agencies on management systems. As staff increases are realized, HEW expects the problems in timeliness of approvals and controls, as pointed out in this report, to receive high priority and the overall monitoring of the States' programs to be more effective (See pp 25.)

The administrative actions taken or promised by HEW and the State should tend to reduce the type of payment errors found by GAO. The recent reorganization and the filling of additional staff positions should permit HEW to increase its monitoring of Medicaid activities.

MATTERS FOR CONSIDERATION BY THE CONGRESS

This report is being issued to the Congress because of expressed congressional concern over the rising costs under the Medicaid program and the significant amount of Federal expenditures being made for skilled nursing home care

## CHAPTER 1

### INTRODUCTION

GAO has examined into selected aspects of costs incurred for nursing home care provided to recipients under the medical assistance program (Medicaid) in the State of California. The Medicaid program--authorized by title XIX of the Social Security Act, as amended (42 U.S.C. 1396)--is a grant-in-aid program in which the Federal Government participates in costs incurred by the States in providing medical assistance to individuals who are unable to pay for such care. Medicaid is administered at the Federal level by the Social and Rehabilitation Service of HEW.

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. Such additional services as dental care and home health care and the provision of prescribed drugs may be included in its Medicaid program if a State so chooses.

The Federal Government pays from 50 to 83 percent (depending on the per capita income in the States) of the costs incurred by States in providing medical services under their Medicaid programs. For calendar year 1968, the 42 States and jurisdictions having Medicaid programs reported expenditures of about \$3.9 billion, of which about \$2 billion represented the Federal share. As of June 1970, 48 States and the District of Columbia, Guam, Puerto Rico, and the Virgin Islands, had adopted a Medicaid program.

Our review was undertaken in California because of the significant amount of expenditures for nursing home care in that State. During calendar year 1968 Medicaid payments to nursing homes in California--which was limited to a maximum of \$14 per patient-day--totaled about \$160 million, of which about \$80 million was the Federal share. On a nationwide basis, Medicaid expenditures for nursing home care totaled about \$1.1 billion for calendar year 1968.

Our review was made in four counties in California. We directed our efforts primarily to an examination of the State's policies and the counties' practices and procedures in initiating and terminating nursing home care for Medicaid patients and to a review of the State's controls over payments made for such care--areas which appeared to be in particular need of attention--rather than to an evaluation of the total program in the State. The scope of our review is described on page 27.

#### ADMINISTRATION OF MEDICAID PROGRAM

The Secretary of HEW has delegated the responsibility for administering 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 are responsible for the field activities of the program. HEW field activities are administered through 10 regional offices.

Under the act, the States have the primary responsibility for initiating and administering the Medicaid program. The nature and scope of a State's Medicaid program is contained in a State plan which, after approval by a Regional Commissioner, 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 with 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 Social and Rehabilitation Service 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.

#### ELIGIBLES UNDER MEDICAID PROGRAM

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. Persons whose income or other financial resources exceed standards set by the States to qualify for public assistance but 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. Those persons receiving public assistance payments are generally referred to as categorically needy persons, whereas other eligible individuals are generally referred to as medically needy persons.

Medicare, which was enacted in July 1965 as title XVIII of the Social Security Act (42 U.S.C. 1395), provides medical and hospital insurance for most persons 65 years of age and over. Depending upon their financial circumstances, Medicare recipients may also be eligible for assistance under the Medicaid program. Individuals who are eligible for assistance under both programs, however, must first exhaust the related benefits available under the Medicare program before receiving assistance under the Medicaid program.

#### MEDICAID PROGRAM IN CALIFORNIA

The Medicaid program in California became effective March 1, 1966, and is referred to as Medi-Cal. In California the Department of Health Care Services (formerly the Office of Health Care Services) was established as part of the Human Relations Agency to administer the program. The Federal Government pays 50 percent of the medical services and administrative costs of the program and 75 percent of the expenditures attributable to the compensation and training of skilled medical personnel and supporting staff.

California reported to the Federal Government that Medi-Cal expenditures for fiscal year 1969 amounted to about \$808 million; the Federal share of these expenditures was about \$405 million.

The Department of Health Care Services is responsible for making State policy determinations, establishing fiscal and management controls, and performing reviews of Medi-Cal program activities. In addition, this Department is charged with the responsibility of 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, the Department of Health Care Services 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 performing periodic inspections and evaluations of medical facilities (such as hospitals and nursing homes) and for making recommendations to the Department of Health Care Services concerning the certification of such facilities for participation in the program.

Since the inception of the Medi-Cal program, the Department of Health Care Services has contracted with certain private organizations--such as the California Physicians Service, the Hospital Service of California, and the Hospital Service of Southern California--to assist it in administering the program. These private organizations--acting in the capacity of fiscal agents of the State--are responsible for coordinating program operations between the State and the institutions or persons who provide medical services under the program. In addition, the fiscal agents are responsible for reviewing, processing, and paying claims submitted by the providers for services rendered to program recipients.

California Physicians Service processes claims for services provided by doctors, dentists, and other individual providers of medical services to recipients under the

Medi-Cal program. Hospital Service of California processes claims submitted by medical facilities located in the northern counties of California, and Hospital Service of Southern California processes claims submitted by those located in the southern counties of the State.

## CHAPTER 2

### PROCEDURES FOR INITIATING, EXTENDING, AND

#### TERMINATING NURSING HOME CARE

#### UNDER THE MEDI-CAL PROGRAM

Under the Medi-Cal program various medical services--including nursing home care--are provided to eligible recipients. Nursing homes are generally defined as medical facilities in which convalescent or inpatient care is provided to individuals who do not require hospital care but who are in need of certain medical care and services that cannot be provided in the individuals' homes or in residential- or custodial-type facilities.

#### INITIATING AND EXTENDING NURSING HOME CARE

Supplement D of HEW's Handbook of Public Assistance Administration provides that persons be admitted to nursing homes only upon the recommendation of a physician and after joint consideration by the physician and the social worker of the pertinent medical and social factors, including consideration of alternative arrangements for the patients' care.

Under Medi-Cal regulations, approval by a State or county official (known as a Medi-Cal Consultant) to place a recipient in a nursing home must be requested within 5 days after such placement. Most recipients are placed in nursing homes by their physicians without prior approval from the Consultant and, contrary to HEW requirements, without discussing the placement with the social worker. A request for approval for nursing home care is subsequently initiated by the operator of the nursing home and submitted to a Medi-Cal Consultant. This request is submitted on a form entitled "Treatment Authorization and Payment Request for Nursing Home Care" (form MC 170). This form is signed by the recipient's physician certifying that, in his opinion, the recipient is in need of nursing home care.

The Medi-Cal Consultant--usually a medical doctor employed on behalf of the State or county--is responsible for reviewing the form MC 170 and determining whether the individual for whom such care has been requested is in need of such care. Form MC 170 is to contain certain information concerning the medical history of the recipient. Under Department of Health Care Services guidelines, measures suggested for making a proper determination concerning the needs of the individual for nursing home care range from reaching a decision solely on the basis of information contained on the form MC 170 to calling upon the local medical society for its opinion on the case. In the final analysis, under State guidelines, the approval or disapproval of a request for nursing home care rests with the Consultant. In fact, Medi-Cal regulations specifically prohibit the delegation of such authority to other individuals.

The initial approval for nursing home care by the Medi-Cal Consultant generally covers a 2- to 3-month period and approval for additional periods of time may be granted--in 3-month increments--upon submission of subsequent requests. After approval by the Consultant, four copies of form MC 170 are returned to the nursing home. At the end of each month, up to the maximum of 3 months, the nursing home operator completes the appropriate sections of one of the copies of the approved forms and submits it to the fiscal agent for payment. The fiscal agent makes payment to the nursing home operator on the basis of the number of days for which services were provided to the recipient as shown on the form MC 170. The fourth copy of the approved form MC 170 is retained by the nursing home.

#### TERMINATING NURSING HOME CARE

Under Medi-Cal regulations, nursing home operators are required to notify the Consultant of the death or discharge of a Medi-Cal recipient within 48 hours of such event. To achieve uniformity in the reporting of such information, the Department of Health Care Services developed a form entitled "Medi-Cal Notification of Patient Disposition" (form MC 171). Under a procedure established by the Department of Health Care Services, the individual nursing home operators are to notify the Medi-Cal Consultant of

termination of care, he, in turn, is to forward copies of the form MC 171 to the county welfare office and to the fiscal agent.

Department of Health Care Services officials advised us that the fiscal agents (Hospital Services of California and Hospital Services of Southern California) requested that the form MC 171 not be submitted to them because they were not prepared to incorporate this information into their claims processing system. In October 1968--the same month in which the standardized procedure for notifying the Medical Consultant of the death or discharge of a recipient was implemented--the Consultants were instructed by the Department of Health Care Services to discontinue submitting the form MC 171 to the fiscal agents.

## CHAPTER 3

### NEED TO STRENGTHEN CONTROLS OVER

#### APPROVAL AND PAYMENT FOR NURSING HOME CARE

Our review revealed weaknesses in the practices and procedures for approving and paying for nursing home care under the Medi-Cal program in Alameda, Fresno, Los Angeles, and Santa Clara Counties in California. Also, no uniformity existed in the methods used in reaching decisions concerning the need for nursing home care for recipients.

On the basis of our observations of approvals for nursing home care and the conclusions of studies by three counties in California that a high incidence of patients were not in need of such care, we believe that Medi-Cal recipients were receiving nursing home care without adequate determinations that such care was warranted.

In addition, we found

- that Medi-Cal Consultants approved nursing home care for periods after the date of death or discharge of the patients,
- that, for 22 of 260 patient cases examined, fiscal agents paid claims covering periods of time after the recipients had died or had been discharged from the nursing home; and,
- that, for 12 of 76 patient cases examined, nursing homes received full payment under both the Medi-Cal and the Medicare programs for the same days of nursing home care.

√ In view of the high incidence of cases in which payments to nursing homes were questionable--about 10 percent of the 336 cases we examined--and in which weaknesses in procedures and practices were noted, we are of the opinion that the results of our review sufficiently demonstrate the need for corrective measures to strengthen controls over the approval and payment for nursing home care.

On the basis of data obtained from State agencies, we established that, on the average, there were about 35,000 Medi-Cal patients in 1,250 nursing homes in California during each month of calendar year 1968. During this year, payments were made for nursing home care on behalf of approximately 100,000 recipients that amounted to about \$160 million; the Federal share of these payments was about \$80 million.

The details of our findings and weaknesses, with respect to the approving and paying for nursing home care under the program, follow.

#### METHODS FOR DETERMINING NEED FOR NURSING HOME CARE

As discussed previously (see pp. 9 and 10), Medi-Cal Consultants approve or disapprove requests for nursing home care for program recipients. Guidelines issued by the Department of Health Care Services, among other things, allow the Consultant to reach a decision concerning the need for nursing home care on the basis of the information shown on the request form, form MC 170. This information is to include (1) a diagnosis by the attending physician of the recipient's medical condition, (2) the location of the recipient prior to admission to the nursing home, (3) any functional limitations which the recipient may have, and (4) any special treatment or nursing procedures which the recipient may require. The guidelines provided to the Medi-Cal Consultants encourage, but do not require, Consultants or their duly authorized representatives (such as public health nurses or caseworkers) to visit the recipient for the purpose of evaluating his need for nursing home care.

In two of the four counties included in our review, county officials advised us that, in making an initial decision concerning whether nursing home care was needed, a registered nurse or Medi-Cal Consultant visited the recipient. In the third county, a county official advised us that the initial approval of nursing home care was granted after the welfare caseworker--generally a nonmedical person--visited the recipient and recommended approval of such care. In the fourth county, a county official advised us that the initial decision concerning the need for nursing

home care was generally made on the basis of information contained in the request for such care (form MC 170) but that a visit was seldom made to the recipient.

With respect to the approval of nursing home care, Medi-Cal regulations require that the Medi-Cal Consultant review requests for such care and provide that the authority to approve the request not be delegated. We found that (1) in two of these counties the Consultant was approving requests for nursing home care, (2) in one county either a Consultant or a public health nurse was approving requests for nursing home care, and (3) in one county the Consultant was approving only initial requests for nursing home care, and medical-social workers or trained clerical staff of the county were approving most of the requests for an extension of such care.

During the period July 1968 through March 1969, one of these counties reported to the Department of Health Care Services that about 70,000 requests for nursing home care had been approved. About 54,000 of these requests, or about 77 percent, represented an extension of previously approved care. Officials of the county advised us that, for the most part, the extensions were approved by persons who--according to Medi-Cal regulations--were not authorized to grant such approvals. The officials advised us further that, because of the large number of Medi-Cal patients in the county, it was impossible for the Consultant to review all requests for nursing home care.

In another of these counties, about 12,000 requests for nursing home care had been approved during the period July 1968 through February 1969. Officials of that county advised us that approximately half of these requests, or about 6,000, had been approved by registered nurses. We were advised also that registered nurses were approving requests for such care because of a shortage of Medi-Cal Consultants.

We recognize that the absence of visits to recipients by a Consultant or a duly authorized county representative or the failure of the Consultant to personally approve requests for nursing home care does not demonstrate that such care was not, in fact, needed. Nevertheless, it is our

opinion that, in view of the significant amount of expenditures under the program for nursing home care, such visits and level of approval would serve as an important control to help ensure that only those in need of such care are actually being served. The need for this level of approval was recognized by the State when it established such a requirement for the Medi-Cal program. We note that, in an effort to improve this aspect of the program, the Department of Health Care Services is activating medical-social review teams to complement the work of the Medi-Cal Consultants. ✓

The need for improvements in the present system of approving nursing home care for Medi-Cal recipients was reported to the State in an HEW Audit Agency report dated June 25, 1969, on its review of the Medi-Cal program. In that report the HEW Audit Agency pointed out that the results of nursing home studies conducted by three counties--two of which (Alameda and Santa Clara) were included in our review--indicated that significant numbers of Medi-Cal recipients who were in nursing homes did not appear to be in need of such care. In Santa Clara County, an evaluation of the records of 96 program recipients indicated that 34, or about 35 percent, were not in need of nursing home care and should be discharged or relocated in other types of facilities, such as boarding homes. In San Diego County, an evaluation of the records of 426 recipients indicated that 93, or about 22 percent, were not in need of nursing home care. In Alameda County, an evaluation of the records of 275 recipients indicated that 56, or 20 percent, were not in need of nursing home care.

The HEW Audit Agency report stated that the basic reason for the large number of persons in nursing homes who did not need such care appeared to be related to the lack of acceptable alternate facilities in which to place these recipients. The report added, however, that a lack of coordination between those individuals who are responsible for determining the type of care those recipients require (attending physicians, Medi-Cal Consultants, and social workers) may also have contributed to the placement of recipients in nursing homes who may not have been in need of such care.

APPROVAL OF CARE AFTER  
PATIENTS' DEATH OR DISCHARGE

We noted that, in some cases, Medi-Cal Consultants (or other county representatives) approved requests for additional nursing home care even though the patient had died or had been discharged from the nursing home.

As noted earlier (see p. 10), nursing home operators are required to notify the Consultant within 48 hours of the death or discharge of Medi-Cal recipients. Such notice was to be given through the use of form MC 171. Although information on the termination of care to patients was being provided to the Consultants within the specified 48 hours, we noted instances where the information relating to the death or discharge of patients was apparently not being used by Consultants in acting upon subsequent requests for the approval of nursing home care. Consequently, Medi-Cal Consultants approved some requests for nursing home care even though the patient had died or had been discharged from the nursing home. Following are several examples of nursing home care approved after the patient's death or discharge for future periods of time.

<u>Medi-Cal patient</u>	<u>Date of death or discharge</u>	<u>Date ad- ditional nursing home care was ap- proved</u>	<u>Number of days elapsed between date of death or discharge and date of approval (note a)</u>
A	1-10-68	4-23-68	104
B	11-14-68	3-24-69	130
C	8-18-68	9-17-68	30
D	12- 6-68	1- 8-69	33
E	3- 5-69	3-26-69	21

<sup>a</sup>The nursing homes in these cases did not bill the Medi-Cal program for services beyond the date of death or discharge of the patient.

We recognize that it seems improbable to have a nursing home, on one hand, notify the Consultant of the death or

discharge of a patient and to have that same nursing home, on the other hand, subsequently request and obtain the Consultant's approval for the continuation of nursing home care. Nevertheless, this situation occurred and further illustrates, in our opinion, the ineffectiveness of the present system of controls in approving nursing home care under the program.

PAYMENTS AFTER PATIENTS'  
DEATH OR DISCHARGE

Our review revealed that nursing homes claimed, and were paid under the Medi-Cal program for, nursing home care after the patients had died or had been discharged from the nursing home. This condition, in our opinion, was caused, in part, by the failure of the Department of Health Care Services to adequately assure itself that the fiscal agent had established adequate controls to preclude such payments.

Of 260 Medi-Cal recipients who had received nursing home care, we found 22 cases in which nursing home operators were paid for periods of time after the recipients' death or discharge. Our selection of the cases reviewed was made of all recipients for whom services were recently terminated and for whom records were available in the 10 nursing homes at the time we made our visits. The number of days of care for which these nursing homes were paid after services had been terminated ranged from 1 to 21 days, and the amount of payments ranged from \$11 to \$289. In total, 123 excess days claimed resulted in excess payments of \$1,577. The following schedule presents this information for each county.

<u>County</u>	<u>Nursing homes visited</u>	<u>Number of patient cases examined</u>	<u>Number of cases in which payments were made for periods after death or discharge</u>	<u>Excess</u>	
				<u>Days claimed</u>	<u>Amount paid</u>
Alameda	2	53	4	24	\$ 330
Fresno	2	21	1	16	188
Los Angeles	4	128	9	30	354
Santa Clara	<u>2</u>	<u>58</u>	<u>8</u>	<u>53</u>	<u>705</u>
Total	<u>10</u>	<u>260</u>	<u>22</u>	<u>123</u>	<u>\$1,577</u>

In 20 of the above 22 cases, neither the nursing home nor the fiscal agent was aware of the overpayments, and in two cases, the nursing home--upon discovery of the error--had initiated action to offset the excess amounts paid against subsequent claims. Officials of the fiscal agent advised us that they would make the necessary adjustments for the excess amounts paid in the cases we identified. The following schedule shows the range of excess days.

<u>Number of recipients</u>	<u>Number of excess days paid</u>
12	1
5	2 to 10
4	11 to 20
<u>1</u>	21
<u>22</u>	

HEW has not issued any specific guidance to the States on the payment policy to be followed in paying for care on the date of admission or the date of discharge. Department of Health Care Services officials advised us that, from the beginning of the Medi-Cal program, it had been their policy to pay nursing homes for the date of admittance but not for the date of death or discharge of the patient. Although this policy had not been included in the Medi-Cal regulations, these officials advised us that the fiscal agents had been informed of this policy on several occasions since the inception of the program in March 1966. In November 1966, Hospital Service of Southern California advised the nursing home operators located in its geographical area that payment would not be made for the last day of nursing home care. Hospital Service of California officials, on the other hand, advised us that they had not issued such a statement to the nursing homes operators in its area. Hospital Service of California officials stated, however, that their claims examiners were instructed to disallow claims for the last day of care. These officials added that they were aware that this policy had not been consistently applied by their claims examiners.

In discussing the cases of overpayment with the various nursing home officials, we were told that the excess claims were generally caused by errors made by their clerical staff and the fiscal agents' inconsistency in paying claims. Fiscal agent officials advised us that they had processed these claims because they had no way of knowing that a patient had died or had been discharged and that the claims were submitted on an approved form MC 170

Under existing procedures, the fiscal agents must rely solely upon the nursing home operators to submit accurate information relating to the period of time for which nursing home care is provided to the program recipient. Such information is not submitted to the fiscal agent from any other source (such as the county social worker or Medi-Cal Consultant), nor are any periodic examinations performed by the fiscal agent for the purpose of ascertaining when service to a recipient was discontinued.

PAYMENTS BY BOTH MEDICARE AND MEDI-CAL PROGRAMS

Our review showed that nursing home operators were being paid for nursing home care to certain patients for the same periods of time by both the Medicare and Medi-Cal programs.

As part of our review of the controls that the State and/or fiscal agents established for the purpose of ensuring that payments to nursing home operators were correct, we selected records of 76 recipients who had recently received nursing home care under the Medicare program prior to becoming Medi-Cal recipients. In 12 cases, the nursing home operators had received full payment under both programs for services provided to the recipient on the same days. In eight of the 12 cases, erroneous payments were made only for the last day of care under the Medicare program and the first day of care under the Medi-Cal program; however, in the remaining four cases, payments were made under both programs for 12, 25, 26, and 60 days. Erroneous payments ranged from about \$21 to \$817 and totaled \$1,699.

The following schedule shows the payments made under the Medi-Cal program for which payments were also made under the Medicare program.

<u>County</u>	<u>Nursing homes visited</u>	<u>Number of cases examined</u>	<u>Number of cases in which payments were made under both Medicare and Medi-Cal for the same days</u>	<u>Excess</u>	
				<u>Days claimed</u>	<u>Dollars paid</u>
Alameda	2	8	2	13	\$ 178
Fresno	2	6	1	26	324
Los Angeles	4	54	8	32	380
Santa Clara	<u>2</u>	<u>8</u>	<u>1</u>	<u>60</u>	<u>817</u>
Total	<u>10</u>	<u>76</u>	<u>12</u>	<u>131</u>	<u>\$1,699</u>

Officials of the fiscal agent advised us that their procedures required the nursing home operators to show, on their claims for payment under Medicare, whether the recipient was also eligible for coverage under another program. In these cases, a copy of the Medicare claim was sent to the fiscal agent's organization responsible for making payment under the Medi-Cal program. These officials added, however, that, when the nursing home operator fails to indicate that the recipient is eligible for assistance under another program, the claim is processed and no effort is made to determine whether payment for the service is being claimed (or had been paid) under another program. These officials advised us that they would initiate action in all cases cited by us for the purpose of offsetting the overpayments against future nursing home claims.

We discussed this matter with the officials of the nursing homes who stated that they were unaware that overlapping claims were made and could offer no explanation as to why such claims had been made.

Representatives of the fiscal agents acknowledged the weaknesses in their claims-processing system and stated that, in their opinion, inadequate billing instructions to their claims examiners and to the nursing homes in their geographical areas were responsible, to a great degree, for the deficiencies noted. We were advised by Hospital Service of California that it is in the process of preparing a nursing home billing procedures manual to assist nursing homes. In addition, both fiscal agents advised us that they plan to conduct workshops designed to train nursing home personnel in the proper procedures to be followed in the submission of claims for nursing home services. We were advised further that claims-processing manuals were being developed or updated for the guidance of the claims examiners. ✓

We believe that the actions proposed above should help to strengthen controls over the processing of Medi-Cal claims for nursing home services. We believe, however, that a need exists--in the administration of this aspect of the program--for (1) promptly notifying fiscal agents of the date of termination of nursing home care so that payments to nursing homes are not made for services beyond that date and (2) coordination between the Medicare and Medi-Cal

paying agents so that payments are not made to nursing homes for the same day of care under both programs.

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Department of Health Care Services officials advised us that they had not reviewed county operations with respect to the procedures for approving nursing home care. These officials added that a Bureau of Field Services was established under their Department in July 1968 to perform periodic examinations of the administration of the Medi-Cal program and to initiate such corrective measures as were warranted by these examinations. Although the Bureau was established in July 1968, we were advised by State officials that the lack of available staffing precluded the Bureau from performing periodic examinations of the program administration, including reviews of the Medi-Cal Consultants' activities.

These officials added that Bureau offices would be established in selected regions of the State for the purpose of providing direct assistance to counties in their administration of the Medi-Cal program. In addition, we were informed that the Bureau plans to develop and issue to the counties specific instructions and standards governing the counties' responsibilities for the review and approval of nursing home care for program recipients.

With respect to excess payments for nursing home care, Department of Health Care Services officials informed us that, at their direction, the fiscal agents were conducting audits of nursing homes participating in the Medi-Cal program. These officials stated that such audits would include an examination of claims for services submitted by nursing homes. In addition, attention would be directed to ascertaining whether the nursing home operators claimed payment for services under both the Medicare and the Medi-Cal programs.

Department of Health Care Services officials added that, as a result of our bringing to their attention examples of cases in which excess payments were made to nursing homes for services billed beyond the date of death or discharge of the recipient, procedures would be developed

to provide the fiscal agents with information on the final date that services were provided to recipients by the nursing homes.

### CONCLUSIONS

The cost of nursing home care represents a significant portion of expenditures for the Medicaid program. Weaknesses in the administration of nursing home care can, therefore, result in significant losses of funds. During our review of the procedures for initiating, terminating, and paying for nursing home care under the Medi-Cal program, we noted program weaknesses relating to each of these aspects of the program. Also, we noted no uniformity for making determinations concerning the necessity for nursing home care. On the basis of our observations of approvals of nursing home care and conclusions of studies by three counties that a high percentage (35, 22, and 20 percent) of patients were not in need of such nursing care, we believe that Medi-Cal recipients are being admitted to nursing homes without adequate determinations being made by appropriate authorities that such care is warranted.

In our opinion, the weaknesses noted in this report can be attributed, at least in part, to the absence of specific guidance to the States by HEW in controlling nursing home admissions, terminations, and payments or in evaluating the adequacy of the implementation of guidelines. We believe that appropriate standards should be formulated by HEW to require (1) the fiscal agent and/or the State agencies responsible for making Medicaid payments to be advised timely of all deaths and discharges of Medicaid patients receiving nursing home care and (2) the establishment of controls to avoid duplicate payments for nursing home care under the Medicare and Medicaid programs.

We believe also that the guidelines relating to the placement and retention of Medicaid recipients in nursing homes should be evaluated, in light of the conditions noted in this report, to ascertain whether the problems experienced under the Medicaid program in California were caused by any inadequacy in the existing guidelines which may have led to the failure of the State to properly implement them. Appropriate action, based upon the findings of such evaluation, should then be taken.

## CHAPTER 4

### RECOMMENDATIONS, AGENCY COMMENTS AND ACTION

#### RECOMMENDATIONS TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

✓ We recommend that, to improve the administration of the Medicaid program, the Secretary of HEW provide for the development or evaluation by the Social and Rehabilitation Service of administrative and program requirements for the States' use in (1) approving the initial placement of Medicaid recipients in nursing homes, (2) approving the extension of care in nursing homes, and (3) paying for nursing home care.

✓ We recommend also that, in HEW's monitoring of State Medicaid activities, the Secretary provide measures designed to (1) determine the extent to which HEW standards are being implemented and (2) effect corrective action where warranted.

#### AGENCY COMMENTS AND ACTION

By letter dated April 20, 1970, the Assistant Secretary, Comptroller, HEW, furnished us with HEW and Department of Health Care Services comments on our findings and recommendations. (See apps. I and II.)

HEW advised us that, in accordance with our suggestion, it had evaluated the Social and Rehabilitation Service policy relating to the placement and retention of Medicaid recipients in nursing homes and that, in its opinion, the guidelines provided to the States were adequate, if followed, to ensure that proper determinations are made concerning the need for skilled nursing care. HEW concluded that both the Service's policy and the State's guidelines were not being followed in many instances by county agencies and personnel and that this had resulted in the deficiencies, as discussed in the report, relating to approving admissions to, and authorizing continued care of patients in, skilled nursing homes.

The State advised HEW that special efforts were being undertaken through field visits, consultant conferences, and other means to improve the processes of authorization and reauthorization of skilled nursing home care. Although not planning to develop additional guidelines in this area at this time, HEW informed us that it would continue to evaluate the adequacy of existing guidelines in light of information developed through its monitoring of State programs or through other sources.

Both HEW and the State concur in our recommendation that guidelines be developed to avoid improper payments for nursing home care. The State advised HEW that it had re-instituted instructions requiring that the notification of patient disposition (form MC 171) be distributed to the fiscal intermediaries, which should result in better control of billings after death or discharge of recipients. The State advised HEW also that it was attempting to resolve the problem of duplicating Medicare and Medicaid payments by working with the intermediaries on refinement of computer controls.

HEW stated that the recent reorganization of the central office of the Medical Services Administration, Social and Rehabilitation Service, recognized the need for the development of payment procedures and controls and consultation with State agencies on management systems. HEW stated further that, as projected staff increases are realized and the newly formed Division of Management Information and Payment Systems and Division of Technical Assistance and Training become operational, it was expected that problems in timeliness of approvals and controls over payments, such as those pointed out in the report, would receive high priority and could be handled more effectively than in the past.

In commenting on our recommendation relating to HEW's monitoring of State Medicaid activities, HEW stated that the Social and Rehabilitation Service had advised States of the need for corrective action where it had been found that HEW guidelines were not being properly implemented. Also, as staff increases are realized, it is expected that monitoring of the States' programs will be more effective.

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The administrative actions taken or promised by HEW and the State should tend to reduce the types of payment errors discussed in this report. Also, the recent reorganization of the Medical Services Administration and the filling of additional staff positions should permit HEW to increase its monitoring of Medicaid activities.

## CHAPTER 5

### SCOPE OF REVIEW

Our review consisted principally of examining into the practices and procedures followed by the counties (1) in evaluating the basis upon which nursing home care is approved, (2) in terminating payments for care to patients who had died or had been discharged from nursing homes, and (3) in paying for nursing home care for recipients covered under the Medicare and Medicaid programs.

Our review was performed at the HEW headquarters in Washington, D.C., the State agency offices in Sacramento, California, and at county welfare offices and selected nursing homes in Alameda, Fresno, Los Angeles, and Santa Clara Counties. These four counties were selected because they accounted for about 50 percent of the amounts paid to nursing homes in the State of California for services rendered to recipients under the Medi-Cal program.

As part of this review, we examined into the basic legislation authorizing the Medicaid program; examined pertinent records and documents; and discussed with HEW, State, and county officials matters relative to the administration of the program. We also reviewed records at the county offices, the offices of the fiscal agents, and selected nursing homes.

**APPENDIXES**



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

OFFICE OF THE SECRETARY

APR 20 1970

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

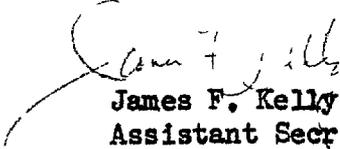
Dear Mr. Heller:

The Secretary has asked that I reply to the draft report of the General Accounting Office on its determination of the need for improvements in controls over payments for patient days of nursing home care under the Medicaid program in California.

Enclosed are the Department's comments on the findings and recommendations in your report, including the response by 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

Enclosures

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COMMENTS ON GENERAL ACCOUNTING OFFICE DRAFT REPORT

NEED FOR IMPROVEMENTS IN CONTROLS  
OVER PAYMENTS FOR PATIENT DAYS OF NURSING  
CARE UNDER THE MEDICAID PROGRAM IN CALIFORNIA

The draft of the General Accounting Office report on its review in California points up problems in the approval of nursing home care for Medicaid patients and attendant problems of payment. The GAO concludes that the weaknesses noted during its review are attributed, at least in part, to the absence of specific guidance to the States by HEW in controlling nursing home admissions, terminations, and payments or in evaluating the adequacy of the implementation of those guidelines which had been promulgated.

GAO recommends that SRS develop or re-evaluate criteria used by the States in approving the initial placement, and continuation, of Medicaid recipients in nursing homes and in making payments for such care. It is recommended also that, in monitoring the State's Medicaid programs, HEW determine the extent to which guidelines have been implemented by the States and to obtain corrective action where warranted.

SRS policy--mentioned by GAO on page 6 of its draft report--which is intended to guide State and local agencies in approving admissions to and authorizing continued care of, patients in skilled nursing homes, provides that (underscoring supplied)

Long-term care of patients in medical institutions is provided in accordance with procedures and practices that include the following

- (1) Care is authorized only on recommendation by a physician and 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.
- (2) There is a medical-social plan for each patient which includes consideration of alternate types of care and which is reassessed periodically.
- (3) In making placements, the record is precise as to the medical reason for admission. It shows what alternative

methods, such as family care home, social care institution, home health aide, homemaker, etc., have been considered by the admitting physician and the caseworker and specifies the medical-social plan of treatment for the individual.

- (4) Each patient is under the care of a physician who has responsibility for continued medical care and planning for that patient, and who visits him at least once a month.
- (5) There is a periodic review of the care, treatment and plan for each patient by a physician, nurse and social worker, acting as a team.

The GAO draft report states that most Medi-Cal recipients are placed in nursing homes without prior approval and without discussing the placement with the social worker. The request for authorization is initiated by the nursing home operator within 5 days after admission. Requests for extension are also initiated by the nursing home. There is no indication that the patient's physician and caseworker have a regular role in this process and the GAO reports that in at least one county, extensions were approved by persons not authorized to grant such approvals.

We share the concern expressed by the GAO over the lack of visits to patients and the approval of care after death or discharge of the patient. The lack of individual attention to nursing home patients by State or local agency staff members continues to be a serious weakness in the Medicaid program and a source of problems with respect to payments for care as well as the well-being of patients. Serious questions are raised by the cases cited in the report in which extensions of authorization for skilled nursing home care were issued after the patient had died or been discharged from the home.

We have evaluated the SRS policy as it relates to admissions to nursing homes and extensions of nursing home care. In our opinion, the guidelines provided to the States are adequate, if followed, to ensure that proper determinations are made by appropriate authorities relating to the need for skilled nursing care. From the findings and discussion in the draft report, it seems to us that both the SRS policy and the guidelines issued by the State

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agency are not being followed in many instances by county agencies and personnel. The State agency implicitly acknowledges this in its comments to us on the GAO draft report and advises that special efforts are being undertaken through field visits and consultation to improve the processes of authorization and reauthorization of skilled nursing home care. Accordingly, at this time we do not plan to develop additional guidelines in this area. We will, however, continue to evaluate the adequacy of these guidelines in light of information brought to our attention through our continuing monitoring of State programs or from other sources.

We agree that HEW guidelines are needed with respect to payment procedures and controls. The GAO report discusses problems of duplicating Medicare and Medi-Cal payments and inadequacies in procedures for terminating payments when the patient's care is ended by death or discharge from the nursing home. With regard to the problem of duplicating Medicare and Medi-Cal payments, the State agency is aware of this problem, as indicated in their comments to us on the draft report, and is attempting to resolve it by working with the intermediaries on refinement of computer controls. The State has also reinstated instructions requiring that the notification of patient disposition (MC-171) be distributed to the fiscal intermediaries and anticipates better control of billings after death or discharge of beneficiaries.

The development of payment procedures and controls and consultation with State agencies on management systems has been recognized as a gap in the role of the Medical Services Administration Central Office. The recent reorganization of MSA has given much greater emphasis to these functions. As the projected staff increases are realized and MSA's newly formed Division of Management Information and Payment Systems and Division of Technical Assistance and Training become operational, it is expected that problems in timeliness of approvals and controls over payments, such as those pointed out in this report, will receive high priority and can be addressed much more effectively than in the past.

Concerning GAO's recommendation relating to HEW's program for monitoring State Medicaid activities, SRS has advised States of the need for corrective action in any areas where it has been found that HEW guidelines were not being properly implemented. Again, as staff increases are realized it is expected that our monitoring of the programs will be more effective.

Attachment

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DEPARTMENT OF HEALTH CARE SERVICES

714 P STREET  
SACRAMENTO CALIFORNIA 95814



January 16, 1970

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

Dear Miss Beach

This is in response to your request (Ref. SRS-IX-14) that we comment upon the General Accounting Office's (GAO) draft report on their recent review of Medi-Cal's controls over payment for patient days of nursing home care. We appreciate both the opportunity to comment upon this draft and the additional time allowed us for completing this review

The Medi-Cal program welcomes review of its payments method system and appreciates the efforts of the GAO auditors in bringing their findings to our attention. We do concur with the conclusions and recommendations at the close of the draft report and we share in concern over the number of instances in which overpayment is found

Our present audit controls are designed to detect improper payments made to providers, but we have not yet perfected a preventive mechanism which precludes all payment of double billings. We have reinstated instructions which require MC-171 (Notification of Patient Disposition) distribution to our fiscal intermediaries and anticipate better control of billings after death or discharge of beneficiaries. Our fiscal intermediaries are attempting to initiate computer and other controls which will further reduce the types of overpayments noted in the draft report. The problems of control through computer analysis are many. They are complicated by a multitude of factors such as numerical code systems which do not identify beneficiaries receiving institutional care or the beneficiaries' ever changing medical condition. A further difficulty in implementing preventive computer control of overlapping payments between Medicare and Medi-Cal is the multiplicity of carriers and intermediaries. An obvious solution to this problem would be a single integrated payment system in California for cases involving cross-over benefits of these programs.

Despite current medical review and authorization systems, we realize that some beneficiaries are authorized care in skilled nursing homes when the need for such care may be medically questionable. We must, however, guard

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Miss Gene Beach

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January 16, 1970

against any nonmedical finding that a given patient does not qualify for nursing home care, and weight must be given to the medical judgment of the attending physician.

The draft audit report correctly stated that nursing home placement is reviewed by a state or county employed Medi-Cal consultant. The Medi-Cal program is attempting through field visits, periodic consultant conferences, and other means to enable these Medi-Cal consultants to make sound decisions in a uniform manner. While some problems remain, we are continuing our efforts to improve the system of uniform decision making with respect to nursing home placement and the other prior authorization facets of this program.

Coupled with efforts to improve the Medi-Cal consultant phase of our program, the Department is activating medical-social review teams which are scheduled for early implementation and full operation by July 1970. Through this mechanism, we plan to complement the work of the Medi-Cal consultant, the facility's utilization review committee, and the fiscal intermediary.

California will develop an intermediate care program as soon as legislative approval is obtained and a timetable set for implementation. Hopefully, this will increase the opportunity for alternate placement of program beneficiaries whose physical condition now precludes placement in residential settings.

If we can be of assistance to the Federal Government in developing, field testing, or reviewing guidelines which might improve the effectiveness of Title XIX programs, we would be pleased to participate.

Sincerely,



CAREL E. H. MULDER  
Director

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PRINCIPAL OFFICIALS OF THE  
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE HAVING  
RESPONSIBILITY FOR THE ACTIVITIES  
DISCUSSED IN THIS REPORT

	<u>Tenure of Office</u>	
	<u>From</u>	<u>To</u>
SECRETARY OF HEALTH, EDUCATION AND WELFARE:		
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