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Testimony before the Senate Special Committee on Aging; by Gregory J. Ahart, Director, Human Resources Div.

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The management of patients' funds at Kane Nursing Home included the practice of charging to patient funds for services that should have been paid by Medicare and Medicaid. Erroneous charges were also made to patients' funds for facility-based physician services and laboratory and x-ray services that could have amounted to as much as $600,000 from 1972 through 1974. In April 1970, Kane began investing patients' personal funds in interest bearing savings certificates. A comparison was made of Medicare and Medicaid audited reports for 1972-1974. In addition to charges made to Medicare Part B, Kane also charged Medicaid for the costs of the same facility-based physician services and x-ray and laboratory services. The true overpayment was the Federal share of the overcharges, or about $655,000, which was in addition to the erroneous charges to patients' funds. A check on staffing practices revealed that seven part-time doctors were receiving length-of-service credit for the county retirement system as if they were full-time employees. Also, the number of general care nursing hours available to Kane patients during February 1976 did not meet minimum State requirements. No evidence was found of coercion in obtaining contributions from patients' families, but it did not appear that Kane adequately explained that contributions were voluntary. (SW)

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STATEMENT OF
GREGORY J. AHART, DIRECTOR
HUMAN RESOURCES DIVISION
BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
ON THE
REVIEW OF JOHN J. KANE
HOSPITAL: A COUNTY NURSING
HOME IN PITTSBURGH, PENNSYLVANIA

Mr. Chairman and members of the Committee, we are pleased to appear here today to highlight portions of our May 6, 1977, report to the Committee entitled, "Lack of Coordination Between Medicaid and Medicare at John J. Kane Hospital. Kane is a public nursing home operated by Allegheny County near Pittsburgh, Pennsylvania. This facility received most of its financial support from the Medicaid program, with the Federal Government paying 55 percent and Allegheny County absorbing the remaining 45 percent. For the period covered by our review, the State did not participate in the costs of public nursing home care under Medicaid. Kane also provided skilled nursing home care under the Federal Medicare program and received payments under Part A for post-hospital inpatient services and under Part B for physicians services and X-ray and laboratory services largely for patients whose Part A benefits were exhausted or were not applicable.

Our review at Kane was made at the request of the Chairman of the former Subcommittee on Long Term Care of this Committee and we were specifically asked to

--Review the management of patients' funds;

--Audit the 1974 Medicaid cost report;

--Ascertain whether employees were actually working or otherwise properly accounted for; and

--Determine whether Kane was requiring relatives of patients to make payments for the county's share of Medicaid reimbursement.

A summary of our findings on these matters follow.

Management of patients' personal funds

From strictly an accountability standpoint, the management of patients' personal funds at Kane was probably the most difficult and complicated situation we have ever encountered in our various financial type reviews at nursing homes. Because so many things were handled incorrectly in relation to Medicaid and Medicare requirements, we did not attempt to reconstruct the net effect of what might have occurred if the management of such funds were handled correctly and the Medicare and Medicaid benefits effectively coordinated.

For example, following State requirements, which were contrary to Federal Medicaid regulations, Kane routinely allowed too much money--as much as $900--to accumulate in the personal accounts of its patients over the first 6 months of their stays at the facility. This happened because

the State was requiring Kane to set aside in each patient's account up to $150 a month as a home maintenance allowance even though Federal regulations authorized such set asides only if an individual was likely to return home within 6 months and a physician certified to that likelihood. Otherwise, such income or resources should have been applied to the cost of care--thereby reducing Medicaid's nursing home costs. On the other hand, these personal funds which the patients should not have had in the first place were not used to maintain homes but were used by Kane to pay for

--patients' services which were covered by and payable by either the Medicare Part B or the Medicaid program or both;

--patient Medicare Part B deductible and coinsurance amounts--which under the approved State plan--were payable by Medicaid; and

--amounts in excess of Medicare's Part B reasonable charge allowances which were not payable by the patients or either program.

In addition to the charges to patient funds for covered services that should have been paid by Medicare and Medicaid, erroneous charges to patients' funds for facility-based physician services and for laboratory and X-ray services could have amounted to as much as $600,000 from 1972 through 1974 even though the costs of such services were also included in Medicaid's reimbursement rates as certified by the State Auditor General.

To further complicate the accountability problem, beginning in April 1970, Kane began investing patients' personal funds in interest bearing savings certificates. As of January 1976 the accumulated interest earnings

amounted to about $217,000, none of which had been distributed to individual patients' accounts. As early as August 1975, HEW had concluded that interest on patients' funds should accrue to individual patients, but in November 1976 the State issued proposed regulations which would give nursing homes the option of applying earned interest to each patients' account or to use the interest for specific activities benefiting all patients as a group.

We made recommendations to HEW designed to assure that

--the State stop requiring the accumulation of home maintenance allowances except where such allowances were justified under Federal regulations,

--Kane patients' personal funds not be used to pay for services covered by Medicare and Medicaid by requiring the State, Kane, and other providers of service to follow proper billing procedures; and

--money earned through the investment of patients' funds be fairly distributed.

Audit of Medicaid Cost Reports

Because there had been no exchange of audit information between Medicaid and Medicare at Kane, our review featured a comparison of Medicare and Medicaid audited cost reports for 1974 which was expanded to include cost reports for 1972 and 1973. We found that Kane had charged both Medicare Part B (which was appropriate) and Medicaid for the costs of the same

facility-based physician services and X-ray and laboratory services. For the 1972-1974 period, the total Medicaid overcharges were about $1.2 million; however, because Allegheny County, which operated Kane absorbed about 45 percent of Kane's Medicaid costs, the true overpayment was the Federal share of the overcharges or about $655,000. This overpayment is in addition to the erroneous charges to patients' funds for physicians and X-ray and laboratory services which we previously discussed. These erroneous charges could have amounted to as much as $600,000 and represented the Medicare Part B deductible and coinsurance amounts which related to costs also included in the Medicaid reimbursement rates.

We recommend that HEW

--recover the Federal share of Medicaid overpayments to Kane, and

--provide for the exchange of audit information between Medicare and the State Auditor General.

In addition, because Medicare Part B deductible and coinsurance charges for Medicaid eligibles were properly chargeable to Medicaid under the State plan, we recommended that collections from Medicaid patients' personal funds for Part B services cease and that restitution be made to patients or their estates for previous erroneous charges.

We understand that for the 1975 Medicaid cost report, the State Auditor General did disallow $273,000 for physician salary costs paid by Medicare but that prior overpayments had not been recovered.

Review of staffing practices

In line with the Subcommittee's request, we made an unannounced time and attendance check of a random sample of employees. Everybody in the sample was either on the job or could be accounted for. On the other hand, we did note that seven part-time doctors were receiving length-of-service credit for the county retirement system as if they were full-time employees without the concurrence of the county retirement board. This practice has stopped and, in any event, it did not result in increased costs because contributions to the pension fund were based on salary--not hours worked.

In addition, we noted that the number of general care nursing hours available to Kane patients during February 1976 did not meet minimum State requirements. Since our field review, the State has made at least three reviews of Kane's staffing. According to the related reports, Kane has made improvements by hiring more nursing personnel and reducing the patient census.

Family Contributions

We did not find evidence of coercion in obtaining contributions from patients' families. Only about 5 percent of the patients had family members making contributions and total collections were less than $5,000 per month. The contributions were correctly used to offset Medicaid payments for each patient's care. We interviewed five contributing relatives. All five stated that they did not believe the quality of care their relatives was getting depended in any way on their contributions.

On the other hand, it did not appear that Kane Hospital adequately explained that contributions are supposed to be completely voluntary. We have been told that Kane Hospital no longer sends its regular contributors monthly reminders that both Kane and the family members we interviewed referred to as "bills".

This completes the summary of our report, which we request be included in the record in its entirety.

We shall be happy to answer any questions that the Committee might have.