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REPORT TO THE SUBCOMMITTEE ON LONG-TERM CARE SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

RELEASED

Examination Into Certain Claimed Practices Relating To Nursing-Home Operations In The Baltimore, Maryland, Area

B 164031(3)

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

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DEC [illegible], 1970

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D C 20548

B-164031(3)

Dear Mr. Chairman

This is the report on our examination into certain claimed practices relating to nursing-home operations in the Baltimore, Maryland, area. Our examination was made pursuant to your request of August 27, 1970.

AGC 00022

We have not obtained formal comments on this report from officials of the Department of Health, Education, and Welfare, the State of Maryland, or the nursing homes visited, however, the matters included in the report have been discussed with these officials. ID

As agreed to by the Subcommittee, we have informed the Secretary of Health, Education, and Welfare of the general subject matter and issue date of this report. We plan to make no further distribution of this report unless copies are specifically requested, and then we shall make distribution only after your agreement has been obtained or public announcement has been made by you concerning the contents of the report.

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

The Honorable Frank E. Moss, Chairman
Subcommittee on Long-Term Care
Special Committee on Aging
United States Senate SENOS 504

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COMPTROLLER GENERAL'S REPORT TO THE SUBCOMMITTEE ON LONG-TERM CARE SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

EXAMINATION INTO CERTAIN CLAIMED PRACTICES RELATING TO NURSING-HOME OPERATIONS IN THE BALTIMORE, MARYLAND, AREA

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

D I G E S T

WHY THE EXAMINATION WAS MADE

At the request of the Chairman of the Subcommittee on Long-Term Care, Senate Special Committee on Aging, the General Accounting Office (GAO) obtained information relating to certain questions raised during hearings held on August 19, 1970, by the Subcommittee regarding a salmonella outbreak in nursing homes in the Baltimore, Maryland area The questions related to the claimed practices of

--physicians' signing death certificates without viewing the bodies and perhaps charging the Medicare or Medicaid programs fees for signing the certificates,

--some nursing-home operators' collecting payments under the Medicare or Medicaid programs for nursing-home care for periods after patients' deaths, and

--nursing-home operators' purchasing food at prices lower than the amounts billed the Medicare or Medicaid programs

The Medicare program is administered by the Social Security Administration, Department of Health, Education, and Welfare; and the Medicaid program is administered at the Federal level by the Social and Rehabilitation Service, Department of Health, Education, and Welfare

In accordance with the Subcommittee's request, GAO examined into these questions at four nursing homes in the Baltimore area. GAO did not obtain formal comments on this report from the Department of Health, Education, and Welfare, the State of Maryland, or the nursing homes visited.

FINDINGS AND CONCLUSIONS

GAO's examination revealed that in Maryland it was not an uncommon practice for physicians to sign death certificates without having viewed the bodies of patients who died in nursing homes.

GAO examined 627 death certificates, of which at least 322 were for nursing-home patients Of these 627 certificates, only 196 indicated that a private physician had viewed the body prior to signing the certificate GAO's inquiries revealed also that such a practice was not illegal in Maryland, nor was it considered unethical by the Medical Society of Maryland The consensus of 17 physicians interviewed by GAO was that it was either impractical or unnecessary to view the bodies of all patients who died in nursing homes.

Most of the physicians expressed the view that the skilled nursing personnel at the nursing homes were technically qualified to determine that a patient was dead and to note any unusual developments, other than the illness for which the patient was being treated, which might have caused the death They agreed that, if a patient's death was unexpected or otherwise suspect, the body should be examined to determine the cause of death (See pp 8 to 11)

Regarding physicians' charging the Medicare or Medicaid programs fees for signing death certificates, program officials informed GAO that such a fee was not reimbursable under either program

GAO's examination of Medicare and Medicaid billing and payment records for 110 patients who died during the first 3 months of 1970 at the four nursing homes included in the review showed that, generally, physicians had not charged fees for signing death certificates. GAO's examination revealed, however, that on three occasions physicians apparently had been paid under these programs for signing the death certificates (See pp. 11 and 12)

GAO's examination of the records of 322 Medicaid and Medicare patients who died during fiscal year 1970 identified 39 instances in which payments had been made under the Medicaid program for nursing-home care for periods after the deaths of the patients No such payments were detected for Medicare services

GAO found, however, that 36 of the 39 overpayments had been detected by State employees and that adjustments had been made to correct the payments prior to GAO's bringing them to the attention of State officials. While examining into the question of payments for nursing-home care for periods after the deaths of the patients, GAO found that in some cases payments had been made to nursing homes for care on the same days under both the Medicaid and Medicare programs (See pp. 13 to 17.)

Although the procedures followed by the State have enabled it to detect and correct most of the payments made for nursing-home care for periods after the deaths of the patients, additional procedures are required to help avoid payments for nursing-home care on the same days under both the Medicaid and Medicare programs (See pp. 22 to 24.)

Regarding the claimed practice of nursing-home operators' purchasing food at prices lower than the amounts billed Medicare or Medicaid, GAO

found no irregularities GAO's examination of the homes' accounting records and supporting invoices for food purchased during the month of June 1970 revealed that the food prices used in computing the daily rate for nursing-home care were not higher than the prices paid for the food GAO noted, however, that Medicaid audits required by the State were not being made at three of the four nursing homes visited (See pp 18 to 21)

RECOMMENDATIONS OR SUGGESTIONS

GAO believes that weaknesses noted during its limited examination in Maryland may exist in other States as well The probability that such weaknesses exist in other States is supported by prior work done by GAO and by the Department of Health, Education, and Welfare Audit Agency (See pp 16 and 17)

To help improve controls over payments to physicians and nursing homes for care of Medicare and Medicaid patients, the Social Security Administration and/or the Social and Rehabilitation Service need to assist the paying agents under the Medicare and Medicaid programs in

--making a study of the feasibility of establishing procedures to ensure that payments are not made to physicians for signing death certificates, which is an unallowable cost, and

--establishing controls to ensure that duplicate payments for the same services are not made under the programs

Also, the Social and Rehabilitation Service needs to improve its monitoring of the States' administration of the Medicaid program, to ensure that required audits of nursing-home costs are made (See pp. 23 and 24)

CHAPTER 1

INTRODUCTION

In response to a request dated August 27, 1970, from the Chairman, Subcommittee on Long-Term Care, Senate Special Committee on Aging, the General Accounting Office (GAO) has examined into certain questions raised during hearings held on August 19, 1970, by the Subcommittee regarding a salmonella outbreak in nursing homes in the Baltimore, Maryland, area. The questions related to the claimed practices of

--physicians' signing death certificates without viewing the bodies and perhaps charging the Medicare or Medicaid programs fees for signing the certificates,

--some nursing-home operators' continuing to collect payments under the Medicare or Medicaid programs for nursing-home care for periods after the patients' deaths, and

--nursing-home operators' purchasing food at prices lower than the amounts billed Medicare or Medicaid.

As requested by the Subcommittee, our examination of pertinent records, procedures, and practices was made at the Bolton Hill Nursing and Convalescent Center, the Forest Haven Nursing Home, the Gould Convalesarium, and the Harbor View Nursing and Convalescent Center, which are in or near Baltimore. We also made reviews at State and Federal offices having responsibilities relating to the administration of nursing-home activities under the Medicare and Medicaid programs. In our examination we considered the views of certain individuals whose names were referred to us by the Subcommittee.

PERTINENT PROVISIONS AND PROCEDURES OF MEDICARE AND MEDICAID PROGRAMS

The Social Security Amendments of 1965 (42 U.S.C. 1395 and 1396) added titles XVIII and XIX to the Social Security Act. Title XVIII--popularly known as Medicare--provides a hospital insurance program (part A) and a supplementary

medical insurance program (part B) for the aged. Title XIX--popularly known as Medicaid--combined and expanded the existing Federal-State grant-in-aid medical assistance programs for certain categories of needy persons. The Medicare and Medicaid programs are administered within the Department of Health, Education, and Welfare by the Social Security Administration and the Social and Rehabilitation Service, respectively.

Medicare program

The Medicare program covers almost all persons aged 65 and older. Under part A of Medicare, necessary inpatient hospital services and, if required, posthospital services in an extended-care facility are paid for. The providers of medical services, such as extended-care facilities, are reimbursed for the reasonable cost of services covered under the program. Medicare payments under part A are made directly to the providers by fiscal intermediaries that have been nominated by the providers and approved by the Social Security Administration to administer the program.

Under part B Medicare makes available, on a voluntary basis, a supplementary medical insurance program which covers physicians' services. Medical insurance is financed by a monthly premium, half of which is paid by the participants and half by the Federal Government. Medicare payments under part B are made directly to the patient or to his physician by carriers under contract with the Social Security Administration.

The fiscal intermediary for the Bolton Hill and Harbor View Nursing and Convalescent Centers is Mutual of Omaha and for the Gould Convalesarium is Maryland Hospital Service, Inc. In Maryland the principal carrier under part B is Maryland Medical Service, Inc. The Forest Haven Nursing Home did not participate in the Medicare program.

Medicaid program

The Medicaid program is designed to provide medical care for needy persons of all ages, as determined by the definition of need established by each State. The program is administered by the States and is financed in part by the

State and in part by the Federal Government. For Maryland, the Federal share of the cost is 50 percent.

Certain Medicaid services--including skilled nursing-home services and physicians' services--are required by the act to be included in a State's Medicaid program. The method of reimbursement to providers of skilled nursing-home services is determined by the States. Nursing homes participating in the Medicaid program in Maryland are to be reimbursed by the State on the basis of audited allowable costs incurred in providing patient care, plus a profit of 10 percent of total allowable costs, up to a maximum daily rate established by the State. On July 1, 1970, the maximum daily rate was increased from $13.50 for fiscal year 1970 to $16 for fiscal year 1971. All four homes visited by us participated in the Medicaid program.

General data

At June 30, 1970, 89 extended-care facilities and/or skilled nursing homes were licensed to operate in Maryland. These institutions had about 7,600 beds. In May 1970 about 1,100 Medicare patients and about 3,800 Medicaid patients were in these institutions.

The following table shows the total amounts paid under the Medicare and Medicaid programs to extended-care facilities and skilled nursing homes in Maryland during fiscal years 1968, 1969, and 1970.

Provider	Fiscal year 1968	1969	1970
	——(millions)——		
Extended-care facilities (Medicare)	$ 3.8	$ 4.2	$ 4.5
Skilled nursing homes (Medicaid)	14.1	14.5	14.9

In Maryland, the Division of Medical Facilities Development of the Department of Health is responsible for licensing extended-care facilities and skilled nursing homes and for certifying these institutions as eligible for participation in the Medicare and Medicaid programs. The certifications, once made, remain in effect until withdrawn.

The Division of Medical Facilities Development is responsible also for conducting periodic inspections of such institutions to ensure continued compliance with applicable standards and for effecting necessary corrections in instances in which program standards are not met. The four institutions included in our examination were certified to participate in the Medicaid program, and all except the Forest Haven Nursing Home were certified to participate in the Medicare program.

The following table shows, for the four institutions, the number of beds, the average number of Medicare and Medicaid patients in fiscal year 1970, and the payments made to the institutions under the Medicaid and Medicare programs.

	Bolton Hill	Harbor View	Gould	Forest Haven
Number of beds in home	266	319	146	103
Average number of patients in fiscal year 1970:				
Medicaid	236	193	67[a]	75
Medicare	7	1	3[a]	-
Payments:				
Medicaid (fiscal year ended 6-30-70)	$889,690	$763,002	$114,289	$158,170
Medicare (operating year ended 7-31-70)	21,871	-	-	-
Medicare (operating year ended 12-31-69)	-	-	88,574	-
Medicare (6 months ended 6-30-70)	-	3,900	-	-

[a]Precise data not readily available; figure is GAO estimate.

CHAPTER 2

CLAIMED PRACTICE OF PHYSICIANS' SIGNING DEATH CERTIFICATES WITHOUT VIEWING THE BODIES

Our examination revealed that it was not an uncommon practice for Maryland physicians to sign death certificates without first viewing the bodies of patients who died in nursing homes. Our examination revealed also that such a practice was not illegal in Maryland, nor was it considered unethical by the Medical Society of Maryland. Further, the viewing of a body prior to signing a death certificate was not, under normal circumstances, considered necessary by those physicians whom we identified in our review as not having viewed bodies prior to signing death certificates

We examined the records of 322 Medicare or Medicaid patients who died during fiscal year 1970 at the four nursing homes included in our review. Death certificates on file with either the city of Baltimore or the State of Maryland showed that 89 bodies were viewed and 50 bodies were not viewed by the physicians prior to their signing the death certificates. For the remaining 183 patients, the death certificates signed by the physicians did not indicate whether the physicians had viewed the bodies.

We interviewed a physician who had signed 110 of the 183 death certificates on which physicians had not indicated whether they had viewed the bodies. He stated that he generally did not view the body but that a qualified nurse did; therefore, to indicate on the certificate that the body had not been viewed would be misleading.

To determine the general practice of physicians with regard to viewing bodies prior to signing death certificates, we examined the death certificates for all persons who died in Baltimore County (exclusive of the city of Baltimore) during June 1970. This sample included all deaths regardless of whether the individual was a nursing-home patient or whether he was a Medicare or Medicaid beneficiary.

Our review of the 305 death certificates showed that in 107 instances the physicians who signed the certificates had viewed the bodies, in 37 instances they had not viewed the bodies, and in 115 instances they had not indicated whether they had viewed the bodies. The remaining 46 death certificates were not signed by private physicians but were signed by medical examiners. A medical examiner takes charge of a body if the deceased was not under treatment by a physician during the terminal illness or if certain specified conditions caused or contributed to the death. These conditions include accidents, such as falls resulting in fractures or other injuries; homicides; suicides; and unknown causes.

These statistics demonstrate that in the Baltimore area it is not an uncommon practice for a physician to sign a death certificate without having viewed the body.

LEGAL REQUIREMENTS

Our examination of applicable laws of Maryland and our interviews with Maryland State Department of Health officials have revealed that Maryland does not have a legal requirement that physicians (or any other person) view the body prior to signing the death certificate. The absence of such a requirement is not peculiar to Maryland. Officials in Virginia and the District of Columbia have informed us that these jurisdictions also do not have a legal requirement that the body be viewed by anyone prior to the signing of the death certificate. In addition, Department of Health, Education, and Welfare officials have advised us that they are aware of only two States which have legal requirements that physicians view bodies prior to signing death certificates.

We also have noted from information available at the National Center for Health Statistics, Department of Health, Education, and Welfare, that 23 of 56 State and independent vital statistics registration areas do not even provide--on their death certificate forms--for the physician to indicate whether he has viewed the body prior to signing the death certificate.

PROFESSIONAL ETHICS

The national code of ethics for physicians, as established by the American Medical Association, is silent as to whether physicians should view the body prior to signing the death certificate. The executive director of the Medical Society of Maryland informed us that there had been no official ruling on this matter in Maryland. In his opinion, if a physician visited a patient frequently and was familiar with the patient's condition, it would not be unethical for a physician to accept the word of a nurse or other professional medical person at a nursing home that the patient had died and to conclude that the death had been caused by the conditions for which the patient was being treated. He further stated that, if the circumstances of death were unusual, the physician should view the body and/or notify the State medical examiner, who would look into the cause of death.

PHYSICIANS' COMMENTS AS TO NEED TO VIEW BODIES PRIOR TO SIGNING DEATH CERTIFICATES

We interviewed 17 physicians who had signed death certificates of Medicare and Medicaid patients whose death certificates were included in our examination. The certificates signed by 13 of these physicians in most instances either showed that the physician had not viewed the body or did not indicate whether he had viewed the body. The consensus of these 13 physicians was that it was either impractical or unnecessary to view the bodies of all patients who died in nursing homes. Two of them, however, expressed the opinion that the body should be viewed if practicable; one physician believed it was part of his responsibility to patients, and the other believed it contributed to the peace of mind of relatives.

The certificates signed by the remaining four physicians in most instances showed that the physician had viewed the body prior to signing the certificate. All of these physicians stated that it was impractical to view the body in all instances, and three of the four stated that it was their normal practice to view the body after death. One of these physicians stated that he generally viewed the body to assure himself that the patient was dead, and another

physician pointed out that the controlled atmosphere of a nursing home or hospital and the presence of technically qualified personnel made the determination of the cause of death more certain and less suspect than if a patient died in his own home.

Most of the 17 physicians expressed the view that skilled personnel at nursing homes were technically qualified to determine that a patient was dead and to note any unusual developments, other than the illness for which the patient was being treated, which might have caused the death. They agreed that, if a patient's death was unexpected or otherwise suspect, the body should be examined to determine the cause of death. In this connection, for patients who died during fiscal year 1970 in two of the four nursing homes visited, we compared the cause of death shown on the death certificates with the patients' medical records and in only one case was death attributed to a cause different from that for which the patient was being treated. In this case, a State medical examiner viewed the body and signed the death certificate.

FEES CHARGED TO THE MEDICARE OR MEDICAID PROGRAMS FOR SIGNING DEATH CERTIFICATES

Medicare and Medicaid program officials informed us that a fee for signing a death certificate was not a reimbursable cost under either program. Of the 17 physicians interviewed by us, 14 stated that they did not charge fees for signing death certificates. Some said that a fee was not charged because very little time was required to sign the certificate. Others stated that they did not charge a fee because signing a death certificate was a legal requirement placed on the medical profession and, therefore, was a service to the State and not to the patient. Three physicians stated that, if considerable amounts of their time were involved--such as time to research a patient's medical history--they charged fees for completing and signing death certificates

Our examination of Medicare and Medicaid billing and payment records for 110 patients who died during the first 3 months of 1970 in the four nursing homes included in our review indicated that--as shown in the following table--on

three occasions physicians apparently had been paid fees totaling $22 for signing death certificates. In each of these instances, the physician's bill indicated that the charge was for a routine nursing-home visit, an allowable cost item under both the Medicare and Medicaid programs.

Patient	Date of death	Date death certificate signed	Date of physician's service shown on bill	Amount paid: Medicare	Amount paid: Medicaid	Total
A	1- 7-70	1- 9-70	1- 9-70	$ -	$ 6.00	$ 6.00
B	3-10-70	3-11-70	3-11-70	-	6.00	6.00
C	2-19-70	2-19-70	2-19-70	8.00	2.00[a]	10.00
				$8.00	$14.00	$22.00

[a]Medicaid paid the 20-percent coinsurance due from the patient.

In two instances (patients A and B) the dates of service shown on the bills were after the dates of death but were the same as the dates on which the death certificates had been signed. In the third instance (patient C) the date of service shown on the bill was the same as the date of death but the physician stated on the death certificate that he last saw the patient alive 7 days prior to his death.

Both the Medicare carrier (Maryland Medical Service, Inc.) and the Medicaid paying agent (Maryland State Department of Health) informed us that they did not compare the date of a physician's service with the date of the patient's death, unless the physician provided the date of death in his billing information. The Medicare carrier informed us that in its opinion the administrative costs of making such comparisons would outweigh the savings that would be realized. Because our examination was necessarily limited, we cannot disagree with the position taken by the Medicare carrier.

CHAPTER 3

CLAIMED PRACTICE OF SOME NURSING-HOME OPERATORS' COLLECTING PAYMENTS UNDER THE MEDICARE AND MEDICAID PROGRAMS FOR NURSING-HOME CARE FOR PERIODS AFTER PATIENTS' DEATHS

Our examination of the records of 322 Medicare and Medicaid patients who died during fiscal year 1970 identified 39 instances in which payments had been made under the Medicaid program for nursing-home care for periods after the deaths of the patients. No such payments were detected for Medicare services. We found, however, that 36 of the 39 overpayments had been detected by State employees and that adjustments had been made to correct the payments prior to our bringing them to the attention of State officials. While examining into the question of payments for nursing-home care for periods after the deaths of the patients, we found that in some cases payments had been made to nursing homes for care on the same days under both the Medicaid and Medicare programs.

MEDICARE PAYMENT PROCEDURES

Before the fiscal intermediary can pay for services under Medicare--including extended-care services--a written request for payment must be received from the nursing home. This request must be signed by the patient on whose behalf the payment is to be made or by another person acting for him. The fiscal intermediary provides nursing homes with billing forms which, when properly completed, serve as a request for payment. The fiscal intermediary is required by Federal procedures to review the bills received from the nursing home to ascertain the correctness of the data furnished. The procedures for reviewing the bills provide for verification of the date of admission to nursing homes but do not provide for the verification of the date of discharge or death.

An official of the fiscal intermediary in Maryland (Maryland Hospital Service, Inc) informed us that it had no procedures for verifying the date of death and that it relied on established auditing procedures to disclose discrepancies in the number of days of care claimed by nursing homes.

MEDICAID PAYMENT PROCEDURES

Under Medicaid payment procedures established by the Maryland State Department of Health for skilled nursing-home care, the Department prepares "preinvoices" about the last week of each month and forwards them to participating nursing homes for use in billing for care provided in that month. The preinvoice is a listing of all Medicaid patients in the nursing home, showing for each patient such pertinent data as the number of days of care and the daily rate--based on the most current information available--upon which the nursing home's bill is to be based.

The nursing home is required to correct the preinvoice if the information recorded on the preinvoice has changed. For example, changes would be necessary if patients died or new patients were admitted during the month.

When completed by the nursing home, the preinvoice becomes the nursing home's invoice to the State for billing purposes. This invoice must be certified by the administrative officer of the nursing home and forwarded to the State Department of Health no later than the 10th working day following the last day of the month during which services were provided.

The State Department of Health's procedures provide that, before it pays the nursing home, the information on the invoice be compared with the latest information in its files for each patient and that the amounts billed be adjusted if the information indicates that the bill is not correct. For example, the State will not pay for care provided to a new patient unless it has received from the local health department a properly completed application for skilled nursing-home care. Also, when the State Department of Health receives notification from the local health department of the death or discharge of a nursing-home patient, it compares that information with bills submitted by the nursing home for care provided during the month of death or discharge and corrects the bills when appropriate.

MEDICAID PAYMENTS FOR CARE FOR PERIODS AFTER PATIENTS' DEATHS

We identified 39 instances in which payments had been made under the Medicaid program for nursing-home care for periods after the deaths of the patients. In 34 of these cases, the nursing home billed for a full month's care even though the patient had died during the month, in four cases the nursing home billed for more than a full month, and in one case an overpayment occurred because a State employee had improperly recorded the date of death.

Of these 39 overpayments, 36 had been detected by State employees and adjustments had been made to correct the payments prior to our bringing them to the attention of State officials. The three overpayments which had not been detected and corrected by State employees were for 1 day each and totaled about $30

While examining into the question of payments for nursing-home care for periods after the deaths of the patients, we found one case, among those examined at the four nursing homes, in which nursing-home care on the same days had been paid for under both the Medicare and Medicaid programs. This duplicate payment, amounting to $175.50, occurred because the Medicare fiscal intermediary (Maryland Hospital Service, Inc.) had not communicated to the Medicaid paying agent that it had reconsidered a rejected Medicare claim submitted by the Gould Convalesarium and had approved and paid the claim. In the interim the claim was paid under the Medicaid program.

To ascertain the extent to which such duplications occurred in cases other than those at the four nursing homes, we obtained a listing of Medicare claims initially rejected by the fiscal intermediary during the first 6 months of 1970 and later reconsidered for payment under the Medicare program. There were a total of 241 such claims. We found that 27 of these claims had been paid under Medicaid after initially being rejected under Medicare. Our examination of these 27 claims showed that 17 had again been rejected by the Medicare fiscal intermediary, four had been approved but not yet paid, and six had been approved and paid under

Medicare. These six duplicate payments amounted to about $2,000 and were made to four nursing homes.

A State Medicaid official informed us that program officials must rely on the nursing homes to notify them of duplicate payments. As of October 31, 1970, adjustments had not been made for these duplicate payments. After bringing the 10 claims (six paid and four approved for payment) to the attention of State program officials, we were advised that they would follow up with the nursing homes and take the necessary corrective action.

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In our report to the Congress on "Problems In Approving And Paying For Nursing Home Care Under The Medicaid Program In California" (B-164031(3), July 23, 1970), we stated that in some cases payment was approved for care for periods after the date of death or discharge of the patient. We stated also that in other cases nursing homes were receiving full payments for nursing-home care on the same days under both the Medicare and Medicaid programs.

The Department of Health, Education, and Welfare and the State of California concurred in our recommendation that guidelines be developed to help avoid improper payments for nursing-home care. The State has issued instructions requiring nursing-home operators to notify the paying agent of the death or discharge of patients. The State believes that this will help eliminate billings for nursing-home care for periods after the death or discharge of patients. The State, through the refinement of computer controls, is also attempting to resolve the problem of duplicate Medicare and Medicaid payments.

In a letter dated October 19, 1970, the Assistant Secretary, Comptroller, Department of Health, Education, and Welfare, informed us that, as a result of giving more responsibility to its regional offices, the Department expected to be able to monitor State Medicaid activities more frequently and more thoroughly than in the past and to initiate appropriate corrective action promptly. He informed us also that copies of our July 1970 report had been sent to the Department's regional offices for distribution to all

the States, to inform them of the problems and recommendations cited in the report.

Also, we have noted that reports prepared by the Department's Audit Agency on its reviews of the Medicaid program have shown the existence of widespread administrative problems relating to duplicate payments and other types of erroneous charges caused by inadequate management controls over Medicaid claims by nursing homes and others.

CHAPTER 4

CLAIMED PRACTICE OF NURSING-HOME OPERATORS' PURCHASING FOOD AT PRICES LOWER THAN THE AMOUNTS BILLED MEDICARE OR MEDICAID

Our examination of the annual cost reports of the four nursing homes and our evaluation of the bases used by these homes in arriving at amounts billed to the Medicare and Medicaid programs revealed no discrepancies in the prices paid for food and the amounts billed the Medicare and Medicaid programs. Our examination of the homes' accounting records and supporting invoices for food purchased during the month of June 1970 revealed that the food prices used in computing the daily rate for nursing-home care were not higher than the prices paid for food.

Under the Medicare program, payments to nursing homes for services provided to patients are based on the reasonable cost of such services determined in accordance with cost principles established by the Social Security Administration. Nursing homes are paid at least monthly on the basis of an interim rate that approximates the actual cost of services. Upon receipt of an annual cost report from a nursing home, the fiscal intermediary makes adjustments as necessary and, after its audit of the nursing home's reported costs, makes a final settlement with the nursing home.

Under the Medicaid program, the method of establishing payment rates for nursing-home care is a decision of the States. In Maryland the payment rate is to be based on audited allowable costs plus a profit of 10 percent of total allowable costs. The rate established under this method cannot exceed the State's prescribed ceiling on the payment rate which, for fiscal year 1971, is $16 a day. Nursing homes are required by the State to report their costs semiannually to Hospital Cost Analysis Services, Inc., a nonprofit, independent corporation under contract with the Maryland State Department of Health to obtain, audit, and analyze nursing homes' cost data and to recommend payment

rates for nursing-home care. For those homes which do not furnish this cost data, the payment rate is $7 a day.

To determine whether nursing-home operators were purchasing food at prices lower than the amounts billed the Medicare and Medicaid programs, we (1) examined food purchase invoices for the month of June 1970 and traced the prices paid for food to the accounting records and supporting payment documents, (2) examined annual cost reports submitted by the four nursing homes, and (3) evaluated the bases used by the homes in arriving at amounts billed for food. In addition, we selected a specific food account--egg purchases--and examined the accounting records and supporting invoices for purchases during the months of April, May, and June 1970. Egg purchases were examined because of their possible connection to the recent salmonella outbreak in Maryland. We interviewed nursing-home operators and their respective egg suppliers for the 3-month period. The results of this work are discussed as follows.

FOOD PURCHASES IN GENERAL

Payments to nursing homes for care provided under both the Medicare and Medicaid programs in Maryland are based on actual costs incurred by nursing homes subject to audit by the fiscal intermediary or the State. It appeared, therefore, that, for a nursing-home operator to inflate food purchases, the supporting food invoices would have to be altered or the nursing-home operator and the food vendor would have to be in collusion. Our examination did not reveal any alteration of records.

We found that the fiscal intermediary was making regular audits of nursing-home costs supporting the Medicare payment rate but that Analysis Services was not making audits on a regular basis under the Medicaid program. For example, during the 3-year period of fiscal years 1967 through 1969, Analysis Services made only two audits of nursing-home costs under the Medicaid program. These were made at the same nursing home in conjunction with audits under the Medicare program. We were informed by an official of Analysis Services that audits were not being made under the Medicaid program because sufficient State funds were not available to finance these audits.

We believe that, when payment rates are based on actual costs as reported by nursing homes, periodic audits by an independent source are an essential control over cost reporting. Although the knowledge that nursing-home cost records are subject to audit may serve as a psychological deterrent to nursing-home operators and may preclude padding or inflating costs, periodic audits would enhance proper and accurate cost reporting.

EGG PURCHASES

Our examination of accounting records and supporting invoices relating to egg purchases and our interviews with the nursing homes' five egg suppliers for the 3-month period April to June 1970 did not reveal any irregularities in the purchases of eggs. We found that the prices paid by the four nursing homes during this period ranged from $0.15 a dozen for grade A small eggs on a purchase of 750 dozen to $0.42 a dozen for grade A medium eggs on a purchase of 45 dozen.

We were informed by the egg suppliers (three egg distributors and two egg producers-processors) that egg prices were subject to daily fluctuations and that for the most part they based their prices on the daily market prices quoted in the New York egg market. To substantiate this claim, we compared the prices paid by the nursing homes to the New York egg market prices prevailing on the dates that the eggs were purchased and found that the prices at which the eggs were sold to the nursing homes during this period were reasonably in line with the market quotations, except that one egg supplier's prices were generally lower.

This egg supplier, whose prices ranged from $0.15 to $0.27 a dozen during this period, informed us that, although he might consider the New York egg market daily quotations in establishing his egg prices, he did not base his prices exclusively on these quotations. He advised us that the apparent low prices of his eggs were not due to the sale of lower quality eggs but were due to his being able at times to purchase eggs from various farmers at lower prices and his giving quantity discounts to the particular nursing home.

Because of the discussions at the recent hearings before the Subcommittee concerning cracked or checked eggs[1] as a source of salmonella, we asked nursing-home operators and their egg suppliers what their practices were for purchasing and selling such eggs. The nursing-home operators informed us that they did not purchase cracked or checked eggs. All the egg suppliers informed us that they did not, under any circumstances, sell cracked eggs. Two of the five egg suppliers advised us that they sold checked eggs but that they did not sell such eggs to the nursing homes. These suppliers stated that they sold checked eggs primarily to bakery shops and that, when such sales were made, they clearly marked the sales invoices as checked-egg sales. Our examination of the accounting records and supporting invoices at the four nursing homes did not reveal any purchases of cracked or checked eggs.

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[1]One egg supplier has advised us that there is a difference between a cracked egg and a checked egg--a cracked egg is one with a shell crack visible to the naked eye, whereas a checked egg is one with a shell crack not visible to the naked eye which can be disclosed only through candling.

CHAPTER 5

CONCLUSIONS

With regard to the claimed practice of physicians' signing death certificates without viewing the bodies and perhaps charging fees to the Medicare or Medicaid programs for signing the certificates, we found that

--It was not an uncommon practice for physicians to sign death certificates without viewing the bodies of patients who died in nursing homes GAO examined 627 death certificates, of which at least 322 were for nursing-home patients. Of these 627 certificates, only 196 indicated that private physicians had viewed the bodies prior to signing the certificates Our inquiries revealed that such a practice was not illegal in Maryland nor was it considered unethical by the Medical Society of Maryland

The consensus of 17 physicians interviewed by us was that it was either impractical or unnecessary to view the bodies of all patients who died in nursing homes. Most of the physicians expressed the view that the skilled nursing personnel at the nursing homes were technically qualified to determine that a patient was dead and to note any unusual developments, other than the illness for which the patient was being treated, which might have caused the death. They agreed that, if a patient's death was unexpected or otherwise suspect, the body should be examined to determine the cause of death.

--Generally, physicians of the Medicare and Medicaid patients whose records we examined did not charge the programs fees for signing death certificates Our examination of billing and payment records for 110 deceased patients revealed three instances in which physicians apparently had been paid for signing death certificates As discussed on page 12, neither the Medicare carrier nor the Medicaid paying agent had established procedures to compare the date of a physician's service with the date of the patient's death

With regard to the claimed practice of some nursing-home operators' collecting payments under the Medicare and Medicaid programs for nursing-home care for periods after the patients' deaths, we found that procedures followed by the State enabled it to detect and correct most of the payments made for nursing-home care for periods after the deaths of the patients While examining into this matter, however, we found also that in some cases payments had been made to nursing homes for care on the same days under both the Medicaid and Medicare programs We believe that additional procedures are required to help avoid such duplicate payments

With regard to nursing-home operators' purchase of food, we found no discrepancies in the prices paid for food and the amounts billed the Medicare and Medicaid programs Our examination of the homes' accounting records and supporting invoices for food purchases for the month of June 1970 revealed that the food prices used in computing the daily rate for nursing-home care were not higher than the prices paid for food We noted, however, that Medicaid audits required by the State were not being made by the contractor at three of the four nursing homes visited

INDICATED NEED FOR ACTION BY THE SOCIAL SECURITY ADMINISTRATION AND THE SOCIAL AND REHABILITATION SERVICE

We believe that the weaknesses noted during this limited examination in Maryland may exist in other States as well In our report to the Congress on problems in approving and paying for nursing-home care under the Medicaid program (see p. 16), we revealed the existence of weaknesses similar to those discussed in this report The Department of Health, Education, and Welfare Audit Agency has reported widespread administrative problems relating to duplicate payments and other types of erroneous charges caused by inadequate management controls over Medicaid claims by nursing homes and others.

We believe also that, to help improve controls over payments to physicians and nursing homes for care of Medicare and Medicaid patients, the Social Security

Administration and/or the Social and Rehabilitation Service need to assist paying agents under the Medicare and Medicaid programs in

--making a study of the feasibility of establishing procedures to ensure that payments are not made to physicians for signing death certificates, which is an unallowable cost, and

--establishing controls to ensure that duplicate payments for the same services are not made under the programs.

Also, the Social and Rehabilitation Service needs to improve its monitoring of the States' administration of the Medicaid program, to ensure that periodic audits of nursing-home costs are made as required by the States.