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

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Improvements Needed In Managing And Monitoring Patients' Funds Maintained By Skilled Nursing Facilities And Intermediate Care Facilities

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

Mismanagement of patients' personal funds in Medicaid facilities in five States and proposals for dealing with the problem are the subjects of this report.

It deals with

--the adequacy of Federal and State regulations and guidelines for the handling of Medicaid patients' personal funds in the custody of facilities,

--how selected facilities have handled patient funds, and

--the adequacy of the States' monitoring activities regarding facility compliance with regulations and guidelines.

MWD-76-102

MARCH 18, 1976

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

B-164031(3)

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

Dear Mr. Chairman:

This report discusses improvements needed in managing patients' funds maintained by skilled nursing facilities and intermediate care facilities participating in the federally assisted Medicaid program. The report points out inadequacies in the Department of Health, Education, and Welfare's regulations and the States' monitoring of nursing facilities, as well as deficiencies in handling patients' funds at selected facilities.

Our review was made pursuant to your request of December 19, 1974. As your staff requested, we have not given the Department of Health, Education, and Welfare; the States; or the selected nursing homes an opportunity to review and formally comment on our report. However, we have discussed our findings with departmental representatives and communicated our findings to the States and facilities involved.

This report contains recommendations to the Secretary of Health, Education, and Welfare. As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on the actions taken on our recommendations to the House and Senate Committees on Government Operations not later than 60 days after the date of the report and the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report. We will be in touch with your office in the near future to arrange for release of the report so that the requirements of section 236 can be set in motion.

Sincerely yours,

Comptroller General
of the United States

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ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HUD	Department of Housing and Urban Development
ICF	intermediate care facility
SNF	skilled nursing facility
SRS	Social and Rehabilitation Service
SSI	Supplemental Security Income

CHAPTER 1

INTRODUCTION

In a December 19, 1974, letter, the Chairman, Subcommittee on Long-Term Care, Senate Special Committee on Aging, asked us to review certain areas of nursing home costs under Medicaid. In a later discussion, the Subcommittee asked us to make a separate review of the controls over Medicaid patients' personal funds maintained by skilled nursing facilities (SNFs) and intermediate care facilities (ICFs).

THE MEDICAID PROGRAM

Medicaid--authorized by title XIX of the Social Security Act, as amended--is a grant-in-aid program in which the Federal Government pays part of the costs (50 to 78 percent) incurred by States in providing medical services to persons who are unable to pay. The Social Security Act requires that State Medicaid programs provide skilled nursing home services. Services in intermediate care facilities, which provide care to patients that do not require skilled nursing services, are an optional Medicaid service. About 7,100 SNFs and 8,400 ICFs are participating in the Medicaid program. About 4,000 SNFs also participate in Medicare.[1]

At the Federal level the Medicaid program is administered by the Social and Rehabilitation Service (SRS), within the Department of Health, Education, and Welfare (HEW). States have the primary responsibility for initiating and administering their Medicaid programs under the Social Security Act.

SOURCES OF PATIENTS' FUNDS

For Medicaid patients residing in Medicaid facilities, one source of personal funds is the Federal Supplemental Security Income (SSI) program which was established by title XVI of the Social Security Act. The program became effective in January 1974 and replaced and broadened the previous

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[1]Medicare, authorized by title XVIII of the Social Security Act, is the Federal health insurance program for the aged and disabled. Part A of Medicare provides hospital insurance and also covers certain posthospital care in SNFs or in a patient's home.

federally assisted, State-administered cash assistance programs for the aged, blind, and disabled.

Section 1611(e) of the act provides that an SSI recipient residing in a Medicaid facility will receive a reduced SSI payment of up to $25 a month (provided the recipient's other retainable income is less than $25) to provide for the patient's personal needs. In conformance with the SSI payment level, Medicaid regulations require that the personal needs maintenance level for any institutionalized aged, blind, or disabled Medicaid recipient be a minimum of $25 a month. However, a State may set a higher personal needs allowance level. Any income above the personal needs level must be applied to the cost of facility care. This application of excess income reduces the amount paid by Medicaid.

In addition to SSI benefits, patients' funds may come from a variety of sources, including social security benefits, veterans' benefits, disability compensation, and contributions from relatives.

SCOPE OF REVIEW

The objectives of our review were to determine

--the adequacy of Federal and State regulations and guidelines for handling Medicaid patients' personal funds in the custody of facilities,

--how selected facilities have handled patients' funds, and

--the adequacy of the States' monitoring activities regarding facility compliance with regulations and guidelines.

Our review included work at HEW headquarters in Washington, D.C.; HEW regional offices in Atlanta, Chicago, Kansas City, New York, and San Francisco; and State agency offices in California, Florida, Michigan, Missouri, and New York. These States were selected to give wide geographical distribution and to insure that only one State was located in each of the HEW regional offices reviewed. We also visited 30 SNFs or ICFs in the 5 States. These institutions were selected on the basis of size; location within the State; and type of facility such as proprietary, private nonprofit, and public. We reviewed the procedures and practices used to manage and account for patients' funds at

each facility. We interviewed appropriate facility officials, reviewed available accounting records, tested transactions in individual accounts, and interviewed patients.

CHAPTER 2

HEW's AND SOME STATES' REGULATIONS AND GUIDELINES FOR HANDLING PATIENTS' FUNDS ARE INADEQUATE

HEW and the five States in our review have issued regulations and/or instructions for SNFs and ICFs on the handling of patients' funds. However, HEW regulations and guidelines have been limited and the scope and substance of State regulations and guidelines varied considerably.

FEDERAL REGULATIONS AND GUIDELINES

For SNFs, Federal regulations (20 CFR 405.1121(k)(6)) require that patients be allowed to manage their personal financial affairs or be given at least a quarterly accounting of financial transactions made on their behalf if the facility accepts written delegations of the responsibility in conformance with State law.

For ICFs, Federal regulations (45 CFR 249.12(a)(1)(iii)) require that a written account be maintained and available to the residents and their families.

We could locate little of HEW interpretive instructions pertaining to such matters as (1) how patients' funds should be safeguarded and accounted for, (2) the services or items provided by the institution that could be properly considered as personal needs and charged to the patients' personal funds and what services or items were to be considered as part of the Medicaid reimbursement to the facility, or (3) how personal funds were to be disposed of upon the death or discharge of patients.

The HEW interpretive instructions included an SRS headquarters memorandum dated July 31, 1974, to the SRS Kansas City regional office which stated that items such as wheelchairs, walkers, and crutches should be considered part of normal SNF services and thus should not be charged to the patients and that a State should stipulate in its agreements with facilities the items and services expected as part of routine care.

Another SRS headquarters memorandum dated August 18, 1975, to the SRS New York regional office stated that a nursing home was not allowed to charge a fee for managing patients' funds and that interest earned on patients' funds should accrue to the individual patients.

STATE REGULATIONS AND GUIDELINES

Each of the five States we visited had issued some instructions to nursing homes with regard to the handling of patients' personal funds. However, these instructions varied from the rather comprehensive regulations issued by California to a booklet which Missouri provided to nursing homes that included a section listing items for which Medicaid patients' personal funds could or could not be charged. A summary of the regulations in the five States follows.

California

Facilities participating in Medicaid must be licensed by the State, and in California the licensing regulations included detailed requirements concerning the use, custody, and disposition of patients' personal funds. These requirements included the following:

1. No licensee shall use patients' moneys or valuables as its own or mingle them with its own.

2. Each licensee shall maintain adequate safeguards and accurate records of patients' moneys and valuables entrusted to its care.

3. Patients' moneys not kept in the facility shall be deposited in a checking account in a local bank.

4. A person, firm, partnership, etc., which is licensed to operate more than one facility shall maintain a separate checking account for each facility and shall not mingle patients' funds in different facilities.

5. When the total amount of a patient's moneys entrusted to a licensee exceeds $500, all moneys and valuables in excess of $500 shall be deposited in a demand trust account.

6. Upon patient discharge, all moneys and valuables of that patient which have been entrusted to the licensee shall be surrendered to the patient in exchange for a signed receipt. Those moneys kept in a demand trust account shall be made available within 3 normal banking days.

7. Within 30 days following the death of a patient, all moneys and valuables of that patient shall be surrendered to the person responsible for the patient.

8. Upon change of ownership of a facility, a written verification by a public accountant of all patients' moneys which are being transferred to the custody of the new owner shall be obtained by the new owner in exchange for a signed receipt.

Florida

Like California, Florida required that facilities (1) not use patients' moneys nor mingle them with the facilities' own, (2) keep complete and accurate records of all funds and other effects and property of their patients, and (3) provide for safekeeping of personal funds.

Michigan

Michigan had regulations that (1) did not permit the mingling of patients' funds with the facilities' funds and (2) required the facilities to report the amounts of a deceased patient's funds to the person responsible for the patient or to the county. Michigan also required its facilities to secure bonds covering trust funds and to give a quarterly accounting of all patients' funds to the patient.

Missouri

Missouri published a Medicaid Instruction Manual in May 1974 which was distributed to nursing facilities in the State and which specified those services not covered by the State's reimbursement rate. These noncovered services were categorized as either personal items which could be charged to the patient or specified medical items which could be charged to third parties such as relatives. An SRS Kansas City regional office official said, however, that this section of the manual was not in compliance with Federal regulations because some of the items or services listed as noncovered Medicaid items should have been covered by Medicaid.

New York

New York had regulations which specified the items and services that must be included in the basic rate of the facility. These included board, including special diets;

lodging; laundry service for personal clothing items; and the use of walkers, wheelchairs, and other supportive equipment.

Although New York had not issued any regulations directly related to the use, custody, and disposition of patients' funds at the time of our fieldwork, the State issued an administrative letter on December 10, 1975, which detailed how patients' funds were to be administered.

CONCLUSIONS

HEW has issued limited regulations and guidelines to the States on managing patients' funds. HEW has relied on the States to specify and control the methods to be used by SNFs and ICFs to manage patients' funds. Certain States have detailed regulations on managing patients' funds while others have limited regulations or guidelines. Accordingly, there is a need for HEW to establish minimum standards for the management of patients' funds maintained by SNFs and ICFs participating in Medicaid.

RECOMMENDATIONS TO THE SECRETARY OF HEW

The Secretary of HEW should direct the Administrator of SRS to issue regulations setting forth the minimum standards that the States are required to follow in establishing requirements for patients' funds maintained by SNFs and ICFs participating in Medicaid. These standards should cover such matters as

- --how patients' funds should be safeguarded and accounted for,
- --the services or items that could be properly considered as a personal need and charged to the patients' funds and the services or items that should be considered as part of the Medicaid reimbursement to the facility, and
- --how personal funds should be disposed of upon death or discharge of patients.

The Secretary should also direct the Administrator of SRS to require Missouri to modify its Medicaid manual to comply with Federal regulations.

CHAPTER 3

DEFICIENCIES IN MANAGING PATIENTS' FUNDS AT SELECTED FACILITIES

The 30 facilities in the 5 States we visited included 18 proprietary, 5 private nonprofit, and 7 public facilities. At each of the 30 facilities we identified either major and/or procedural deficiencies in managing patients' funds. A major deficiency is one which, unless corrected, results in measurable losses to patients or their estates; whereas a procedural deficiency involves noncompliance with requirements or poor accounting practices. In some instances a procedural deficiency may have resulted in losses to patients, but we were unable to establish that such a loss actually occurred. In summary, we found that:

--The 18 proprietary nursing facilities reviewed had 11 major deficiencies and 72 procedural deficiencies.

--The 7 public facilities reviewed had 6 major deficiencies and 19 procedural deficiencies.

--The 5 nonprofit facilities had 5 major deficiencies and 15 procedural deficiencies.

A summary of the deficiencies identified in each of the facilities, including those deficiencies which represented violations of HEW or State requirements, is shown in appendix I.

MAJOR DEFICIENCIES

Following are the major deficiencies identified.

1. Shortages between patients' ledger balances and the bank accounts.

The most common method used by the facilities to account for patients' funds consisted of maintaining individual ledger accounts and a bank account in which patients' funds were deposited. The bank account amount should equal or be reconciled to the ledger balances, but at three facilities in three States, the bank accounts had fewer funds than the individual ledger balances showed there should have been. These shortages amounted to $445, $9,044, and $23,275. The $445 shortage was replaced by the facility's administrator soon

after we brought it to his attention. The other two shortages go back several years and were further complicated by changes in ownership. We reported these two shortages to State or Federal officials.

An example of a shortage involved a proprietary nursing facility in North Miami, Florida, where the available records indicated a shortage of $9,044 at July 28, 1975. At that time, the patients' ledger cards showed a balance of $10,447 applicable to Medicaid and non-Medicaid patients. Of this amount, $4,286 consisted of inactive accounts of discharged or deceased patients with the dates of last-recorded transactions in the individual accounts ranging from April 1971 to November 1974 and $6,161 consisted of the active accounts of patients in the home.

The bank statement balance for inactive and active accounts was $1,403, or $9,044 less than the patients' ledger accounts. We noted that the home had changed ownership in April 1971, at which time about $5,000 had been withdrawn from the patients' fund bank accounts. According to the home's accountant, the seller had withdrawn the funds and given the buyer credit on the purchase price. The buyer was supposed to replace the funds, but we were unable to confirm that this was done. This facility regularly commingled patients' funds with its operating funds.

2. Charging patients for medical supplies and services.

Federal regulations (45 CFR 250.30 (a)(7) (1975)) require that Medicaid facilities accept the rate established by the State as payment in full for services provided.

The regulations and related instructions were not specific in this area, and at six facilities in three States, patients' funds were being charged for items or services which we believe should have been provided as part of routine care. These included wheelchair rentals, restorative services, and routine medical supplies.

One facility in Missouri charged patients $60 a month for medical supplies and services whether or not they used this amount. All funds received by the patient up to $60 were used to pay this arbitrary charge. These charges included moneys over the patient's personal allowance that should have been applied to reduce the Medicaid payment to the facility but were not.

Another facility in Missouri charged one patient $262 for the period January to July 1975 for medical supplies and services.

3. Retaining funds of deceased and transferred patients.

Federal regulations are silent as to the disposition of the personal funds of transferred or deceased patients. Two of the five States we visited had regulations concerning the disposition of deceased patients' personal funds. They provided that funds of deceased patients are to go to their estates, families, or the State. In California, one of the States with such regulations, one facility was retaining funds of deceased or transferred patients. Also, eight facilities in three other States without such regulations were also retaining funds of deceased or transferred patients. At one facility, as of April 1975, the balance of deceased patients' funds totaled $17,762, of which $11,013 had belonged to patients who had died before April 1, 1974. An official at this facility said these funds would eventually be transferred to the facility's operating account.

4. Keeping interest earned on patients' funds.

As previously discussed, an SRS memorandum dated August 18, 1975, stated that interest earned on a patient's funds belongs to the patient.

At four facilities in three States we noted that interest earned on patients' funds was being kept by the facilities. At one facility the interest earned amounted to $13,200 since 1969 and at another facility the interest earned from October 1968 through December 1974 amounted to $1,639.

PROCEDURAL DEFICIENCIES

In addition to the major deficiencies discussed above, we also identified the following procedural deficiencies:

--11 facilities in 5 States mingled patients' funds with their own and used such funds to pay operating expenses. One facility in California had used patients' funds as collateral for a loan for operating purposes.

--20 facilities in 5 States had poor procedures for documenting transactions in patients' fund accounts. A common weakness was not properly documenting with receipts how funds were spent by third parties, such as relatives, on a patient's behalf.

--5 facilities in 2 States allowed patients to accumulate personal funds above the State resources limit instead of applying the excess funds toward the patients' cost of care.

--16 skilled nursing facilities in 4 States did not provide patients with at least a quarterly accounting of their accounts as required by Federal regulations.

ILLUSTRATIONS OF DEFICIENCIES AT TWO SELECTED FACILITIES

Following are two extreme examples of how specific proprietary facilities in California and Missouri improperly handled patients' funds.

California facility

As of July 1, 1975, there were 91 patients in this facility, 77 of whom were covered by Medicaid. The State inspected this facility for participation in the Medicaid program in March 1975 and the inspection report did not identify any deficiencies involving patients' funds. The inspectors indicated that the facility was in compliance with patients' funds requirements.

HEW regulations (45 CFR 250.30(a)(7)(1975)) require that Medicaid facilities accept the rate established by the State as payment in full for services provided. We believe that medical supplies should be provided as part of routine care. This facility charged Medicaid patients for such medical supplies as gauze dressing, catheters, and tubing.

This facility had a central supply unit to provide medical supplies for patients. An individual schedule of use was prepared for each patient, except for Medicaid patients, showing the supplies used by each. A single list was prepared for Medicaid patients showing the total supplies used. There was no listing of individual Medicaid patient usage.

The facility's bookkeeper stated that Medicaid patients were charged on the basis of their ability to pay and not their actual usage. She said this was done to reduce the facility's medical supply expenses because not all Medicaid patients had enough funds to pay for the medical supplies that they used.

This facility charged some patients $3 per month for maintaining their funds. The bookkeeper stated that the $3 service charge was assessed when (1) a patient receives a

check which has to be split between the cost of care and the personal allowance and (2) when a patient has "many" withdrawals from the trust account during the month. The bookkeeper further stated that there were no criteria for how many transactions constituted many withdrawals.

We discussed this service charge with the administrator. He stated that all patients should have been assessed this service to compensate for the amount of time the facility's accounting staff spent on patients' funds. As previously discussed, an SRS memorandum dated August 18, 1975, stated that a facility may not charge a Medicaid patient for managing his personal funds.

The California regulations provide that money of deceased patients entrusted to a licensed facility be turned over to the patient's estate or that the county public administrator be notified within 30 days of death. Seven deceased patient accounts we examined had balances that were not surrendered to the patients' estates. Balances in these accounts ranged from $12 to $1,041, with dates of death as early as January 1974. The facility used the funds in several of these accounts to offset bad debts losses. We found no evidence that these patients' next of kin or the public administrator were advised of the existence of the balances of the patients' funds in these accounts.

This facility also (1) had incomplete documentation for patients' funds spent by facility employees on behalf of the patients, (2) commingled patients' funds with the facility's operating funds in violation of the California regulations, and (3) failed to provide patients with a quarterly accounting of transactions in violation of Federal regulations.

Missouri facility

As of June 25, 1975, there were 162 Medicaid patients in this facility. The State last inspected this facility for participation in the Medicaid program in January 1975. At that time, the inspection report did not identify any problems involving patients' funds.

The Department of Housing and Urban Development (HUD) had foreclosed a mortage on this facility on April 4, 1974, after the facility had been in receivership from February to April 1974. At the time of our fieldwork, the facility was being managed by a private management corporation on behalf of HUD. A HUD official said that, during the period this facility was in receivership, the agency became aware

of a shortage in the patients' funds but did not know the amount of the shortage.

In March 1975 the comptroller for the management firm reconciled the patients' accounts as of April 8, 1974, and found the shortage in patients' funds was $23,275, which represented the difference of the balance in the patients' ledger accounts of $59,562 and an adjusted bank balance of $36,287. A HUD official said that he had requested that the HUD Office of Inspector General in the Kansas City, Missouri, regional office make an audit of the patients' trust fund accounts. We informed the HEW Kansas City regional office and Missouri officials about this shortage because the interests of Medicaid patients were involved.

As stated previously, Federal regulations require that the facility accept the rate established by the State as payment in full for medical supplies and services provided as routine care. Further, the Missouri Medicaid manual specifies those services that cannot be charged to patients. Nevertheless, this facility charged patients for services and supplies which the State said could not be billed to patients. For example, four patients at this facility were charged $125, $206, $262, and $88 for such services and items as wheelchair and equipment rentals, medical and surgical supplies, and restorative services for the period January to June 1975. The comptroller of the home said that the home operated on the theory that charges not covered in the State's Medicaid per diem rate were to be billed to whomever could pay.

In addition to the patients' fund shortage and the charging of patients for routine medical supplies and services, this home

--did not set aside $25 each month for the personal needs of the patients,

--did not provide a quarterly accounting of transactions to the patients,

--had no written procedures for the handling of patients' funds, and

--commingled patients' trust funds with its own operating funds.

CONCLUSIONS

For the 30 institutions we visited in 5 States, we identified an average of 4 major and/or procedural deficiencies in the facilities' management of patients' funds. Because our selection of institutions for review was not based on any prior knowledge of facilities with deficiencies, we believe it is logical to conclude that the mismanagement of patients' funds in the custody of SNFs and ICFs participating in Medicaid is likely to be widespread. Further, because we found major deficiencies at all types of facilities (e.g., proprietary, private nonprofit, or public) we believe that none of the types could be considered any better or worse than any other type of facility.

CHAPTER 4

STATE MONITORING OF FACILITIES' MANAGEMENT OF PATIENTS' FUNDS HAS BEEN INEFFECTIVE

The States' monitoring activities pertaining to patients' funds involve the annual inspections required for certification for participation in Medicaid, usually by the State Department of Health and periodic audits of such facilities by various State auditing organizations.

CERTIFICATION INSPECTIONS COULD BE IMPROVED WITH TRAINING

Regarding inspections, HEW regulations require that each SNF and ICF certified for Medicaid be inspected at least annually by State inspectors to determine whether the facility is in compliance with Federal regulations.

State inspectors, as part of the certification process for SNFs, are required to determine whether (1) the facility has written policies with regard to patients' rights (including management of patients' funds) and (2) the staff of the facility is trained and involved in implementing these policies. For ICFs, State inspectors must assure themselves that the facility maintains on a current basis, and makes available to residents and their families, an accounting for each resident's fund balance with written receipts for all disbursements made to, or on behalf of, the resident.

Michigan did not include patients' funds in its certification inspection process until August 1975. We identified items of noncompliance with Federal and State requirements in the six facilities visited in Michigan. In 21 of the 24 nursing homes and intermediate care facilities in the other 4 States visited, State inspection reports showed that the facilities were in compliance with the standards for handling patients' funds. For 15 of these 24 facilities, the deficiencies we identified included items which represented noncompliance with one or more specific HEW or State requirements. Although we identified various deficiencies in managing patients' funds in each of the 30 facilities visited, for about half the facilities which had been previously inspected by the States and where the inspections covered patients' funds, we found items of noncompliance with specific HEW or State requirements which had not been identified by the State inspectors.

Moreover, there is some question as to the inspectors' ability to determine whether a facility has properly implemented the policies and procedures for handling patients' funds. For example, in Missouri the facility survey is performed by a two-person team consisting of a sanitary engineer and an institutional advisory nurse.

During the survey, the sanitary engineer is concerned with such areas as the physical condition of the facility, fire safety, and sanitation. The nurse is responsible for completing the parts of the survey form that involve patients' funds and/or patients' rights.

The supervisor of the State's Bureau of Institutional Advisory Nurses said that during a facility survey a nurse visually checks to see if ledger cards or something similar has been prepared for the patients. The nurse also checks whether the facility has written procedures for managing patients' funds. The supervisor further informed us she doubted any of her nurses performed any verification of the transactions shown on patients' ledger cards because her nurses did not know how to verify that written procedures for patients' funds were being followed. The supervisor said that she had asked the HEW regional office to conduct training seminars on how to review patients' funds, but that none had been provided in that region.

The Social Security Amendments of 1972 authorized 100-percent Federal funding of expenditures under approved State Medicaid plans for the compensation and training of inspectors of long-term care institutions through June 30, 1974. There are currently about 2,000 State inspectors, many of whom have been trained under this program.

According to HEW officials, the period authorized for 100-percent Federal financial support for developing and operating State programs for inspecting long-term care institutions was not long enough to permit all the States to develop the capability to properly inspect long-term care institutions. Therefore, the authorization for 100-percent Federal reimbursement of State expenditures for inspectors of long-term care facilities was extended for 3 years through June 1977 by Public Law 93-368, approved August 7, 1974.

Because a review of patients' funds involves simple cash transactions and related fundamental questions of adequate documentation and internal controls, we believe that with the establishment of clearcut requirements, State

inspectors could be trained to identify deficiencies in a facility's management of patients' funds. The more complicated or serious problems could be referred to appropriate State or Federal auditing or investigating agencies for further development.

Thus, it seems to us that while the authority for 100-percent Federal funding of inspections and related training exists, HEW or the States have an opportunity to emphasize the review of patients' funds in their training program.

STATE AUDITS COULD BE AUGMENTED BY MEDICARE AUDITS

Although State Medicaid plans are required to assure appropriate audits of nursing home records by the State, HEW does not require that the plans specify the frequency of such audits or that patients' funds be included in the audits.

In three of the five States we visited, State audit agencies made, or were making, a number of audits of patients' funds. In New York, which has approximately 540 facilities, the State audit agency had completed 25 audits and another 36 were in progress as of April 1975. These were comprehensive audits of the facilities which included (1) the determination of eligibility for Medicaid, (2) the propriety of billings submitted by the facility, and (3) the propriety of procedures used in the receipt, maintenance, and use of personal funds paid to Medicaid recipients. The final reports or report drafts included the following deficiencies:

--Proper records of receipts and disbursements of patients' personal funds were not maintained.

--One nursing home had used about $7,000 of a total of $16,000 in patients' funds to meet operating expenses.

--One facility kept patients' funds in separate envelopes bearing the patients' names. This facility made bulk purchases of clothing for patients. Then an employee collected the funds for payment for such purchases from all the envelopes without regard to who benefited from the purchases.

We visited two of the facilities in New York approximately 7 months after the reports were issued to the facility to determine whether corrective actions had taken place. In each of these facilities we found that corrective actions had not been taken.

In Florida, which has 251 SNFs and 8 ICFs participating in the Medicaid program, the Florida audit agency had issued one report on patients' funds as of May 30, 1975. This January 31, 1974, report cited activities of three Dade County nursing homes and questioned the handling of about $75,588 in patients' funds. Activities questioned by the Florida audit agency included charging for wheelchairs and bedspreads, clothing which patients testified they did not receive, physical therapy, and recreational programs. However, in January 1975, when an additional 23 nursing home audits were in progress, all nursing home audits were suspended and the audit effort was directed to other areas. These audits were resumed in October 1975.

Michigan made periodic audits of nursing homes. Audits of nursing homes in 1973 and 1974 disclosed 18 instances where nursing homes were commingling patients' funds with operating funds.

California and Missouri have not made audits of patients' funds maintained by SNFs and ICFs.

In summary, New York and Florida had audit coverage pertaining to patients' funds for about 10 percent of their facilities. The extent of Michigan's audit coverage was not determinable and we could identify no specific coverage of patients' funds by State audit groups in California and Missouri.

Common audit agreements between Medicare and Medicaid

Historically, the Medicare and Medicaid programs have both required that inpatient hospital services be reimbursed on the basis of reasonable costs. To assure that this was being achieved, a provider audit function has been needed under both programs. Therefore, in order to eliminate duplication of auditing effort, the Social Security Administration and SRS, among others, developed a common audit agreement. The purpose of the agreement was to have one audit of a participating hospital which would serve the needs of all programs reimbursing the hospital, with such programs sharing the audit's cost. As of June 30, 1975, 33 States had agreements with Medicare fiscal intermediaries for common audits of hospitals.

Usually the Medicare intermediaries also make cost reimbursement audits of SNFs participating in Medicare.[1] Of the 7,100 SNFs participating in the Medicaid program, about 4,000 also participate in Medicare, whereas only 337 of the SNFs participating in the Medicare program did not participate in Medicaid. Of the 30 Medicaid facilities in our review, 27 were SNFs, of which 6 also participated in Medicare. As of September 30, 1975, the Medicare intermediaries had started 1,981 field audits of the 4,419 SNFs (45 percent) that had filed cost reports for reporting periods ending during fiscal year 1974.[2] Therefore, it may be possible that the States could modify their common audit agreements with fiscal intermediaries to include making reviews of Medicaid patients' funds at SNFs where the Medicare intermediaries were already making field audits.

CONCLUSIONS

Monitoring efforts by the States have not been effective in assuring compliance by SNFs and ICFs with requirements for managing patients' funds. A basic problem appeared to be that State inspectors may not have been qualified to make inspections of matters involving accounting or auditing skills. There has been a lack of formal training by HEW and the States in this area. Both the inspections and related training are currently financed entirely by the Federal Government.

State audits in three of the five States disclosed deficiencies similar to the ones we identified; however, such audits of patients' funds involved relatively few of the facilities participating in Medicaid in these States.

In our view, the management of patients' personal funds by SNFs and ICFs is an area that has been neglected and/or overlooked by the States. Our review indicates that there is a need to obtain more extensive coverage in this particular problem area.

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[1] Medicare posthospital institutional inpatient coverage is limited to SNFs.

[2] Under SSA policy, the frequency and scope of provider audits for any particular reporting period is a matter of an intermediary's judgment. However, audits must be initiated within 3 years.