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REPORT TO THE CONGRESS

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

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

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

AUG. 26, 1970

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D C 20548

B-164031(3)

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

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

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

Acting Comptroller General
of the United States

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ABBREVIATIONS

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

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

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

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

D I G E S T

WHY THE REVIEW WAS MADE

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

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

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

FINDINGS AND CONCLUSIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS OR SUGGESTIONS

The Secretary, HEW, should

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

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

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

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

AGENCY ACTIONS AND UNRESOLVED ISSUES

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

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

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

MATTERS FOR CONSIDERATION BY THE CONGRESS

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

CHAPTER 1

INTRODUCTION

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

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

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

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

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

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

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

MEDICAID PROGRAM COVERAGE

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

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

ADMINISTRATION OF THE MEDICAID PROGRAM

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

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

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

MEDICAID PROGRAM IN CALIFORNIA

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

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

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

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

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

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

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

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

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

CHAPTER 2

PRACTICES IN PROVIDING NURSING HOME CARE

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

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

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

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

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

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

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

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

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

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

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

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

STANDARDS OF CARE

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

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

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

1. A registered or licensed nurse must be on duty at all times.

2. Patients must be visited by their physicians at least once a month.

3. Written policies and procedures for patient care must be maintained.

4. Menus must be planned and supervised by a qualified dietary consultant.

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

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

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

Violations of nursing home standards

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Agency comments and actions

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

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

CONTROLS OVER MEDICATION AND TREATMENT FOR MEDICAID PATIENTS IN NURSING HOMES

Authorizations for medication and treatment

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

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

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

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

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

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

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

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

Accounting for narcotics

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

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

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

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

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

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

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

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

Accounting for drugs other than narcotics

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

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

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

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

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

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

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

Drugs on hand

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

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

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

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

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

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

Agency comments and actions

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

SUPPLEMENTAL PAYMENTS TO NURSING HOMES FOR MEDICAID PATIENTS

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

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

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

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

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

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

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

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

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

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

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

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

Safeguarding patients' personal funds

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

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

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

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

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

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

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

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

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

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

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

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

Agency comments and actions

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

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

ADVERTISING BY NURSING HOMES OF PHYSICAL THERAPY FACILITIES

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

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

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

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

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

2. 12-foot parallel bars,

3. exercise steps,

4. a tilt-top table,

5. exergenie wall pulleys,

6. a Burdick ultrasound and electric stimulator,

7. diathermy,

8. a traction table, and

9. a hydrocollator for moist heat.

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

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

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

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

Agency comments and actions

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

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

TRANSFERRING PATIENTS BETWEEN NURSING HOMES

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

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

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

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

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

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

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

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

Agency comments and actions

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

CONCLUSIONS, RECOMMENDATIONS, AND AGENCY COMMENTS AND ACTIONS

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

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

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

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

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

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

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

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

Recommendations to the Secretary of Health, Education, and Welfare

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

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

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

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

Agency comments and actions

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

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

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

CHAPTER 3

CONTROLS OVER PAYMENTS FOR PRESCRIBED DRUGS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSIONS, RECOMMENDATIONS, AND AGENCY COMMENTS AND ACTIONS

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

Recommendation to the Secretary of Health, Education, and Welfare

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

Agency comments and actions

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

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

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

CHAPTER 4

SCOPE OF REVIEW

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

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

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

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

APPENDIXES

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

OFFICE OF THE SECRETARY

JUN 15 1970

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

Dear Mr. Heller:

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

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

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

Sincerely yours,

James F. Kelly
Assistant Secretary, Comptroller

Enclosure

COMMENTS ON DRAFT REPORT
OF THE GENERAL ACCOUNTING OFFICE

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

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

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

STANDARDS OF CARE IN NURSING HOMES

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

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

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

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

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

CONTROLS OVER MEDICATIONS AND TREATMENT FOR MEDICAID PATIENTS IN NURSING HOMES

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

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

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

SUPPLEMENTAL PAYMENTS TO NURSING HOMES FOR MEDICAID PATIENTS

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

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

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

MISLEADING ADVERTISING BY NURSING HOMES OF PHYSICAL THERAPY FACILITIES

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

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

[sic]

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

TRANSFERRING PATIENTS BETWEEN NURSING HOMES

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

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

CONCLUSIONS AND RECOMMENDATIONS

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

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

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

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

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

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

CONTROLS OVER PAYMENTS FOR PRESCRIBED DRUGS

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

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

CONCLUSIONS AND RECOMMENDATIONS

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

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

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

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

STATE OF CALIFORNIA—HUMAN RELATIONS AGENCY RONALD REAGAN Governor

DEPARTMENT OF HEALTH CARE SERVICES
714 P STREET
SACRAMENTO CALIFORNIA 95814

March 4, 1970

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

Dear Miss Beach

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

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

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

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

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

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

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

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

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

GAO note Draft copy of proposed leaflet is not reproduced here

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

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

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

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

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

Sincerely,

Earl W. Brian, Director Designate

for CAREL E. H. MULDER
Director

Attachment

PRINCIPAL OFFICIALS

OF THE

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HAVING RESPONSIBILITY FOR THE ACTIVITIES

DISCUSSED IN THIS REPORT

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