REPORT TO THE CONGRESS

Problems In Providing Proper Care To Medicaid And Medicare Patients In Skilled Nursing Homes B-164031(3)

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

MAY 28, 1971

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 problems in providing proper care to Medicaid and Medicare patients in skilled nursing homes. These programs are administered at the Federal level by the Social and Rehabilitation Service (Medicaid) and the Social Security Administration (Medicare), 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.

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

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D I G E S T

WHY THE REVIEW WAS MADE

America's "age 65 and over" population has increased from 9 million in 1940 to 20 million in 1970. As persons become older their need for care increases, and, for those requiring more intensive care, this means institutional care in hospitals or nursing homes. Nursing-home care is generally classified as:

Skilled nursing care (Medicaid) and extended care (Medicare)--Periodic medical and daily nursing care without hospitalization.

Intermediate care--Care over and above that classified as room and board but less than skilled care.

Supervised care--Primarily room and board with some supervision.

Because the cost of such care has increased beyond the financial capability of State and local governments, Federal financial assistance has been made available through the Medicaid and Medicare programs administered by the Department of Health, Education, and Welfare (HEW). For example, under these two programs the Federal Government expended in 1969 about $1 billion for skilled nursing care and extended care--primarily for the elderly.

The Congress is interested in answers to questions about skilled nursing homes, such as:

--Are skilled nursing homes providing proper care to patients?

--Are patients being provided with levels of care more intensive than needed?

The States of Michigan, New York, and Oklahoma have about 1,200 nursing homes certified as skilled In 1969 these States expended $336 million of Federal, State, and local funds to care for Medicaid patients in these homes, about half of the expenditures represented the Federal share.

Tear Sheet

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The General Accounting Office (GAO) visited 90 nursing homes (30 in each State) having 5,581 Medicaid patients and examined into whether the homes were adhering to the requirements established by HEW for participation in the Medicaid program as skilled nursing homes. For those homes which also served Medicare patients, GAO examined into whether the homes were adhering also to Medicare requirements.

GAO examined also into whether it appeared that a less intensive level of care would satisfactorily meet the patients' needs.

FINDINGS AND CONCLUSIONS

Many of the skilled nursing homes GAO visited may not have provided proper care and treatment for their Medicaid and Medicare patients. (See p 9.)

Many patients in the nursing homes GAO visited may not have needed skilled care and should have been provided with less intensive--and less costly--care (See p. 25)

Care and treatment given to nursing-home patients

Many nursing homes participating in the Medicaid program--and in some cases the Medicare program--were not adhering to Federal requirements for participation As a result, the health and safety of the patients may have been jeopardized, since the homes' providing proper skilled-nursing-home care is directly related to their meeting established requirements for skilled nursing homes.

This problem resulted primarily from weaknesses in State procedures for certifying eligibility of nursing homes and from ineffective State and HEW enforcement of Federal requirements which include State licensing requirements (See pp. 9 to 24.)

Following are examples of deficiencies by nursing homes in meeting requirements for participation in the Medicaid and Medicare programs found by GAO

--Patients were not receiving required attention by physicians. HEW requires that Medicaid and Medicare patients in skilled nursing homes be seen by physicians at least once every 30 days. Nevertheless, 47 of the 90 homes were not complying with this requirement. Of the 47 homes, 12 were approved also for Medicare

--Patients were not receiving required nursing attention. Of the 90 nursing homes visited, 16 did not have a full-time registered nurse in charge of nursing service, 27 did not have a qualified nurse in charge of each 8-hour shift, and 20 did not meet State licensing requirements for nurse-patient ratios. In total, 48 homes accounted

for the 63 nursing deficiencies. Eight of the 48 homes were approved also for Medicare.

--Many nursing homes did not have complete fire protection programs. Of the 90 homes visited, 44 did not comply with HEW regulations which require that simulated fire drills be held at least three times a year for each 8-hour shift in each home participating in the Medicaid and Medicare programs. Seven of the 44 homes were approved also for Medicare

Level of care needed by nursing-home patients

Patients have been placed in skilled nursing homes even though their needs are for less intensive and less costly care which should be provided in other facilities, however, alternative facilities in which less intensive levels of care could be provided were limited. This not only could result in unnecessary costs but also--and perhaps more important--could make unnecessary demands on professional care available for patients who are in need of such care.

GAO believes that the primary cause of this problem is that HEW has not developed a yardstick or criteria for measuring the need for skilled care under the Medicaid program. In the absence of such criteria, each State follows its own procedures for determining the need for skilled-nursing-home care. (See pp. 25 to 37)

The Social Security Administration has developed criteria defining skilled nursing care under the Medicare program.

In the absence of Medicaid criteria, the State of Michigan--to assist those persons who normally evaluate patient needs--has explicitly defined the medical and nursing-care characteristics that it believes that patients should have to qualify for skilled-nursing-home care.

In Michigan--the only one of the three States in GAO's review that had developed such criteria--the State's evaluators accompanied GAO to selected nursing homes and, at GAO's request, evaluated patient needs.

The evaluators concluded that, of the 378 patients whose needs were evaluated, 297, or about 79 percent, did not require skilled-nursing-home care. (See p. 28.)

GAO could not have similar evaluations made in New York and Oklahoma since these States had not developed such criteria The evaluators advised GAO, however, that if, in a limited test, the medical and nursing-care characteristics of New York and Oklahoma patients were

measured against the Michigan criteria, a similar high percentage (71 and 85 percent, respectively) of the patients would not require skilled care. (See pp 26 and 34)

Further, recent reviews of patient needs by professional health teams of voluntary areawide health planning agencies in 10 counties in New York, using criteria established by the agencies' staffs, showed that 25 to 35 percent of the patients in skilled nursing homes did not require the level of care provided in those homes. (See p. 30.)

GAO did not judge the reasonableness of any criteria, including Michigan's, because of the medical expertise and judgments involved GAO is of the opinion that criteria developed by HEW would help pinpoint more precisely the extent to which skilled or less costly nursing care is needed and, as a result, limited human resources could be allocated to meet more effectively the most critical nursing-care needs. Under the existing, unrealistic procedures, decisionmakers often are confronted with two choices--skilled nursing care or no care at all.

RECOMMENDATIONS OR SUGGESTIONS

The Secretary of HEW should instruct the Social and Rehabilitation Service and the HEW Audit Agency to continue and increase their monitoring of States' adherence to HEW's requirements for nursing homes' participation in the Medicaid program as skilled nursing homes (See p. 22)

The Secretary of HEW, to assist the States in determining whether Medicaid patients are in need of skilled care, should issue criteria setting forth the medical and nursing care required for patients to be classified as being in need of skilled-nursing-home care. GAO suggests that consideration be given to the experience with the criteria already developed for the Medicare program. (See p. 36.)

The Secretary of HEW should instruct the Social and Rehabilitation Service and the HEW Audit Agency to continue and increase their monitoring to ensure that States are following existing HEW Medicaid regulations relating to the admission of patients to skilled nursing homes and are periodically determining whether patients admitted to skilled nursing homes are still in need of skilled care. (See p. 36.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW stated

--That the Social and Rehabilitation Service had implemented a new monitoring and liaison program in each regional office that required the regional offices to maintain closer relationships with State agencies It required also that regional officials make more frequent visits and make detailed reviews of State Medicaid

operations, which should aid in the reduction of such deficiencies as those discussed in this report. (See p 22.)

--That the Social and Rehabilitation Service planned to issue, within 6 months, guidelines to assist the States in evaluating a patient's need for skilled nursing care and services under the Medicaid program and that, where applicable, these guidelines would consider areas of common interest, as outlined in criteria developed for the Medicare program. (See p. 37.)

The actions taken or promised by HEW should strengthen administration of the Medicaid and Medicare programs. In view of the substantial Federal and State expenditures under these programs, prompt attention should be given to the implementation of the promised administrative actions.

MATTERS FOR CONSIDERATION BY THE CONGRESS

This report contains no recommendations requiring legislative action by the Congress. It does contain information on weaknesses in HEW's administration of Medicaid and Medicare programs for nursing homes, suggestions for their correction or improvement, and corrective actions taken or promised by HEW. This information should be of assistance to committees and individual members of the Congress in connection with their legislative and oversight responsibilities relating to the Medicaid and Medicare programs.

Tear Sheet

Contents

ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
SRS	Social and Rehabilitation Service
SSA	Social Security Administration

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CHAPTER 1

INTRODUCTION

Medicaid, authorized in July 1965 as title XIX of the Social Security Act (42 U.S.C. 1396), is a grant-in-aid program in which the Federal Government participates in costs incurred by the States in providing medical care to welfare recipients and other persons who are unable to pay for such care.

Medicaid is administered at the Federal level by the Social and Rehabilitation Service (SRS) of the Department of Health, Education, and Welfare. Authority to approve grants for State Medicaid programs has been further delegated to the regional commissioners of the SRS who administer field activities through 10 HEW regional offices.

Under the Social Security Act, the States have the primary responsibility for their Medicaid programs. A State's program is described in its plan which, after approval by a regional commissioner, provides the basis for Federal grants to the State. The regional commissioner is responsible for determining whether a State is operating its program in accordance with its approved plan, Federal requirements in supplement D of HEW's Handbook of Public Assistance Administration, and SRS program regulations.

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

Depending on a State's per capita income, the Federal Government pays from 50 to 83 percent of the costs for Medicaid services. For calendar year 1969, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the 41 States then having Medicaid programs spent about $4.3 billion, of which about $2.2 billion, or about 50 percent, represented the Federal share.

In our examination of HEW's administration of the skilled-nursing-home segment of the Medicaid program, we sought answers to two questions:

--Are skilled nursing homes providing proper care to patients?

--Are patients being provided with levels of care more intensive than needed?

Where nursing homes provided care also under the Medicare program--authorized in July 1965 as title XVIII of the Social Security Act (42 U.S.C. 1395)--we ascertained whether Medicare requirements had been met. Our review was made at 90 selected nursing homes, 30 each in Michigan, New York, and Oklahoma.

MEDICAID NURSING HOMES

Nursing homes are generally defined as medical facilities which provide convalescent or inpatient care to patients who do not require hospital care but who are in need of certain medical care and services that cannot be provided in the patients' homes or in intermediate-care, residential, or custodial facilities. To participate in the Medicaid program, nursing homes must meet State licensing requirements and Federal requirements. Skilled-nursing-home care is provided to all eligible patients; however, about 80 percent of the patients being provided with such care are over 65 years of age.

During calendar year 1969, Medicaid payments for nursing-home care totaled about $1.2 billion, or 27 percent of all Medicaid costs. HEW paid about half of these costs.

OTHER NURSING OR RELATED CARE FOR ELDERLY

Medicare--administered by the Social Security Administration (SSA) of HEW--authorizes skilled nursing care to be provided in extended-care facilities to persons 65 years of age or older after they no longer need the intensive care available in hospitals. Depending on their financial circumstances, Medicare patients may be eligible for services--including skilled nursing care--also under the Medicaid

program. Patients eligible under both programs, however, must first exhaust their Medicare benefits. During calendar year 1969, payments for extended care totaled about $317 million.

A type of related care available to individuals is intermediate care. Authorized in 1967 under title XI of the Social Security Act (42 U.S.C. 1320a), the intermediate-care program provides Federal funds for care of eligible individuals not in need of skilled nursing care but in need of more intensive care than that provided in residential facilities. The intermediate care was designed as an alternative to skilled care and is not part of the Medicaid and Medicare programs. The major users of intermediate care also are the elderly.

MEDICAID PROGRAMS IN STATES REVIEWED

The State Departments of Social Services are responsible for administering Medicaid programs in Michigan and New York and the State Department of Public Welfare is responsible in Oklahoma. Responsibility for certifying that nursing homes meet the Federal requirements for participation in the Medicaid program has been delegated to the State Departments of Health. In Michigan and New York the health departments have responsibility also for determining the level-of-care needs of patients but, in Oklahoma the State Department of Public Welfare has kept this responsibility. Information on Medicaid and nursing-home programs in these States follows.

	State			
	Michigan	New York	Oklahoma	Total
HEW Regional Office	Chicago, Ill (covers six States)	New York, N Y (covers two States, Puerto Rico, and the Virgin Islands)	Dallas, Tex (covers five States)	
Medicaid programs				
Started	Oct 1966	May 1966	Jan. 1966	-
1969 expenditures				
Amount (millions)	$205	$1,034	$72	$1,311
Federal share (millions)	$102	$517	$50	$669
Skilled nursing care				
1969 expenditures				
Amount (millions)	$100	$199	$37	$336
Percent of total Medicaid expenditures	49	19	51	26
Skilled nursing homes				
Number	211	614	388	1,213
Available beds	21,000	49,000	23,000	93,000

CHAPTER 2

ARE SKILLED NURSING HOMES PROVIDING PROPER CARE TO PATIENTS?

Many nursing homes participating in the Medicaid program--and in some cases the Medicare program--were not adhering to Federal requirements for participation. As a result, the health and safety of the patients may have been jeopardized, since proper skilled-nursing-home care is directly related to meeting established requirements for skilled nursing homes. The nonadherence to requirements resulted primarily from weaknesses in State procedures for certifying eligibility of homes and from ineffective State and HEW enforcement of Federal requirements.

To participate in the Medicaid and Medicare programs as providers of skilled nursing care, nursing homes must meet and maintain Federal requirements which incorporate the individual State's licensing requirements. The requirements are designed to ensure that nursing homes are capable of providing skilled care and relate to such things as physical structure, nursing-staff qualifications, food preparation, physician services, and drug controls.

Our review at 90 nursing homes in Michigan, New York, and Oklahoma during the period October 1969 to April 1970 showed that numerous homes were not adhering to Medicaid requirements (including State licensing requirements). Since 33 of the homes were also participating in the Medicare program, we ascertained whether Medicare requirements had been met. The most significant deficiencies that we noted are discussed below, and all deficiencies that we noted are listed in appendix I.[1]

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[1]These deficiencies in each State should not be compared because of differing licensing requirements.

INADEQUATE NURSING SERVICES

HEW--under the skilled-nursing-care portion of its Medicaid and Medicare programs--requires that nursing services be provided under the direction of a registered nurse and supervised 24 hours a day by a registered nurse or a licensed practical nurse and that nursing-home staffs be composed of sufficient nursing and auxiliary employees to provide adequate services for patients at all times.

Prior to our review, HEW had not specified the number of nurses in relation to patients (nurse-patient ratio) that a skilled nursing home must have to be eligible under Medicaid or Medicare, but on April 29, 1970, HEW issued regulations requiring SRS to establish nurse-patient ratios for Medicaid. Prior to our review, Michigan, New York, and Oklahoma had established nurse-patient ratios as part of their licensing requirements.

As summarized below, we found 63 nursing-service deficiencies in 48 of the 90 nursing homes providing services to Medicaid patients in Michigan, New York, and Oklahoma. Eight of the homes in which these deficiences existed also were Medicare providers.

Deficiency	Number of deficiencies			
	Michigan	New York	Oklahoma	Total
No full-time registered nurse in charge of nursing service	1	5	10	16
Qualified nurse not in charge of each 8-hour shift	5	-	22	27
State nurse-patient ratio not met	10	10	-	20
Total deficiencies	16	15	32	63
Total homes having deficiencies	12	13	23	48

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In a letter dated March 23, 1971, from the Assistant Secretary, Comptroller, HEW (see app. II), commenting on a draft of this report, SSA expressed concern that our report implied that the absence of a nurse-patient ratio for Medicare was inherently bad and would attenuate the quality of care rendered. SSA stated that under the Medicare program the adequacy of nursing services was determined on the basis of the judgment of a survey team as it viewed the needs of a particular facility and the placing and composition of its patient load. Also an individualized determination was made on the basis of the type of care furnished, the needs of the patients, and other related factors.

SSA commented further that this view--which it considered the most desirable approach to ensuring the quality of nursing care rendered to Medicare patients--was shared by the American Nursing Association and by the Public Health Service, HEW. SSA stated also that there were some inherent dangers in the use of arithmetic ratios, including the possibility that the minimum ratios established might gain acceptance as the maximum ratios by providers and surveying agencies.

The nurse-patient ratios in Michigan, New York, and Oklahoma were established by these States as licensing requirements and thus--in these States--became Medicare and Medicaid requirements. It is not our intention to imply that these ratios--or any other ratios--are good or bad. We note, however, that the establishment of nurse-patient ratios was recommended by an SRS task force on skilled nursing homes in August 1969.

The task force reported that it had received many recommendations to assist States by developing some type of formula, standard, or ratio in the determination of the proper sizes and kinds of staff necessary to give quality care under the Medicaid program. The task force stated that the terms "adequate" and "sufficient" nursing service as contained in the Federal regulations "are difficult terms to deal with and must be clarified and defined." The task force recommended that pertinent agencies of HEW--including SSA--combine their efforts to establish a standard or ratio for inclusion in Federal regulations. As stated on page 10, regulations issued by HEW in April 1970 require SRS to carry out this recommendation; by April 1971 SRS had not issued implementing regulations.

LACK OF REQUIRED PHYSICIAN VISITS

HEW requires that a Medicaid or Medicare patient in a skilled nursing home be seen by a physician initially and at least once every 30 days, to evaluate the patient's immediate and long-term needs, prescribe a planned program of medical care, and plan for continuing care and/or discharge.

We found that in 47 of the 90 nursing homes in Michigan, New York, and Oklahoma physician visits were not always made every 30 days. For example, physician visits were made regularly in only 18 of the 30 nursing homes we visited in Michigan, physician visits in the remaining 12 homes were made irregularly ranging from 35 to 210 days apart. Of the 47 homes, 12 were certified also to provide Medicare services.

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In his letter the Assistant Secretary, Comptroller, pointed out that, although the requirement for physician visits at least once every 30 days was, to some extent, beyond the control of a facility, State agencies were working closely with facilities to have them take whatever steps were necessary to ensure that these requisite visits were being made.

ABSENCE OF SOCIAL AND DIETARY SERVICES

Social services

HEW requires that nursing homes participating in the Medicaid and Medicare programs recognize and seek help in solving social and emotional problems related to patients' illnesses, to their response to treatments, and to their adjustment to care in the facilities.

Officials of 26 of the 90 nursing homes we visited advised us that no one had been designated in their homes to identify social or emotional problems of patients. (Of the 26 homes, five were Medicare homes.) The importance of attention to such problems is illustrated by the following remarks from a June 29, 1970, HEW task force report on Medicaid and related programs.

"Some 30 to 35 percent of all recipient-patients in nursing homes have no immediate relatives, and except for the welfare agency visit, most of them have no contact with the world outside the institution. No one outside the institution is concerned with whether or not their needs are being met. The agency is out of personal touch with the patient and may be unaware of changes in his condition that might indicate changes in the care which he needs ***."

The task force report stated that the social content of the Medicaid and Medicare regulations were not adequate and recommended that:

"Each skilled nursing home should be required to include on its staff (or have the part-time services of) a capable person to develop and direct a plan or program individually tailored to the psycho-social needs of each resident. This staff person would have responsibility for marshalling community and institutional resources to serve the needs and interests of residents. The regulations should set forth the nature and purpose of such a program rather than prescribe a standardized set of procedures."

We believe that adherence to such a procedure would correct the conditions found during our review.

Dietary services

HEW requires also that professional consultations be available in Medicaid and Medicare provider facilities to ensure that nutritional standards are good and that the dietary needs of patients are met. Officials of 19 of the 90 nursing homes we visited said that they were not availing themselves of such consultations. None of the 19 homes served Medicare patients.

DEFICIENCIES IN MEETING REQUIREMENTS RELATING TO PATIENT SAFETY

To ensure that Medicaid and Medicare patients will be properly cared for in case of emergency, HEW requires that nursing homes adhere to certain laws and regulations relating to patient safety. We found that numerous nursing homes were deficient in meeting safety regulations relating to fire drills, emergency electrical service, and nurses' call systems.

Fire drills

With respect to fire safety, HEW requires--among other things--that simulated fire drills be held for each 8-hour shift at least three times a year in all nursing homes participating in the Medicaid and Medicare programs.

In Michigan, New York, and Oklahoma, we found that, of the 90 nursing homes we visited, 44 (seven of which also were Medicare providers) were not complying with the requirement for simulated fire drills, as follows:

Number of deficient homes	Number of fire drills in the 12-month period preceding our visit
27	2
7	1
10	-
44	3

Emergency electrical service

HEW requires that nursing homes have emergency electrical service. This requirement for both the Medicaid and Medicare programs can be waived by the States if (1) the requirement will result in unreasonable hardship on the home and (2) the waiver will not adversely affect the health and safety of patients. Although Michigan, New York, and Oklahoma had not waived this requirement for any of the

90 homes we visited, 52 did not have adequate emergency electrical service. Of the 52 homes, 10 were also certified to serve Medicare patients.

Nurses' call system

HEW requires that Medicaid and Medicare nursing homes have systems that register calls at the nurses' station, from each patient bed, each patient toilet room, and each bathtub or shower. This requirement, like the requirement for emergency electrical service, can be waived; but Michigan, New York, and Oklahoma had not waived it for any of the 90 homes we visited. We found deficiencies in 43 of the homes (of which eight were also Medicare providers). Of these 43 homes, 11 had no system and 32 had incomplete systems.

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In his letter, the Assistant Secretary, Comptroller, stated that State agencies had been encouraging facilities lacking emergency electrical service and nurses' call systems to install them. HEW expressed the view that, when facilities simply lacked the funds to do so immediately but otherwise were in compliance with the requirements and rendered acceptable levels of care, it was preferable to allow them to remain in the program as they tried to improve. This concept, he stated, would be true in any case in which correction of a deficiency would require a very large expenditure in relation to the resources of the facility.

FACTORS CONTRIBUTING TO NURSING-HOME DEFICIENCIES

The primary causes of nursing-home deficiencies were

--weaknesses in State procedures for certifying eligibility of nursing homes and

--ineffective State and HEW enforcement of Federal requirements.

Federal requirements

Prior to January 1, 1969, eligibility of a nursing home to participate in the Medicaid program was based on certification by (1) SSA that the nursing home met the requirements for participation as an extended-care facility in the Medicare program or (2) an appropriate State agency that the nursing home met the Medicaid requirements prescribed in supplement D of HEW's Handbook of Public Assistance Administration and SRS's program regulations. Effective January 1, 1969, only those nursing homes meeting Medicaid requirements were eligible to participate in the Medicaid program.

In June 1969 HEW published in the Federal Register interim, but binding, regulations setting forth Medicaid requirements in more detail and clearly showing that Federal payments would not be allowed to nursing homes not meeting the requirements. States, however, were permitted to continue payments for 6 months to such homes, provided:

--That the deficiencies did not jeopardize the health and safety of patients and that written justifications demonstrating this were on file.

--That the deficiencies could be corrected in 6 months and that the homes provided plans for so doing.

States could continue payments for an additional 6 months to homes having deficiencies, provided that the deficiencies were different than those for the prior period. The final regulations, published on April 29, 1970, were generally

the same as the interim regulations except that the second 6-month extension was also permissible if there had been substantial progress and effort made in correcting the prior-period deficiencies.

Michigan enforcement of Federal requirements

In 1968 the Michigan State Department of Public Health sent questionnaires to all State-licensed nursing homes and, on the basis of these questionnaires and without site visits, certified nursing homes as eligible to participate in the Medicaid program if they agreed to comply with the Federal requirements for participation by January 1, 1969. Officials of the State health department advised us that many of the homes certified through this process should not have been certified because they did not meet the requirements for participation in the program. These officials advised us also that they knew that these homes did not meet the requirements.

Our review of State inspection reports for 1968 and 1969 for the 30 homes we visited in Michigan verified that the State health department had been aware of nursing-home deficiencies. For these 30 homes, State inspectors had found 75 deficiencies similar to those which we found. For example, in 11 of these 30 homes they found deficiencies in nursing-care services and in 11 homes they found no emergency electrical service.

Officials of the State health department informed us that no action had been taken by them to enforce compliance with Federal requirements until January 1970, because revised State licensing standards for nursing homes--which incorporated the Federal requirements--had not been approved by the State until August 1969 and because the health department had allowed the homes a few months to implement the revised standards. Thus Federal payments were made through December 1969 to skilled nursing homes that may not have met Federal requirements.

After we informed State officials of the deficiencies we had found in our visits to nursing homes, they visited

two of the homes and stopped Medicaid payments to one home. As of September 1970, they started action to stop payments to the second home.

In September 1970 State officials informed us that, as a result of deficiencies found during State inspections of nursing homes, the State, after January 1970, had stopped Medicaid payments to five homes and had started actions to stop payments to seven other homes. The officials said, however, that State laws permitting appeals by nursing homes prevented the State from always adhering to the HEW requirement limiting the period of extension for homes not meeting requirements to 6 months or 1 year.

HEW regional officials responsible for Federal administration of the Medicaid program in Michigan informed us that they had not reviewed the skilled nursing care program in Michigan because of a lack of manpower. After we advised them of our findings, however, they said that they would work with Michigan officials to ensure compliance with HEW requirements.

New York enforcement of Federal requirements

The State of New York determined that nursing homes in the State--except privately owned nursing homes in New York City--met HEW requirements as of January 1, 1969, on the basis that they were licensed by the State. New York City made this determination for the privately owned homes in the city. Since the program was started in May 1966, minimum Federal requirements for skilled nursing homes have been incorporated into the State and city licensing requirements.

Our review of State inspection reports for 1969 and 1970 showed the State health department had become aware that many homes, though licensed, were not adhering to the Federal requirements. For 22 of the 30 homes included in our review, State inspectors had reported 22 deficiencies similar to those we had found.

State health department officials told us that, beginning early in 1966, they had identified, had documented, and

were quite concerned about significant deviations from New York State licensing requirements, as well as from Federal standards for program participation, among a substantial number of marginal nursing homes. They stated that from February 1, 1966, approximately 160 such facilities had closed, most of them voluntarily under the pressure of the department's application of State and Federal standards. Certain of these facilities were closed only after administrative hearings.

The officials informed us that there had been serious and continuing--and, in some geographical areas, critical--shortages of suitable alternative facilities and services for the care of chronically ill patients. They stated that it did not seem reasonable or practicable to take arbitrary and strong actions against some of these nursing homes at times when the only alternative had been to "dump" patients in the street. They stated also that it was not only these shortages that influenced decisions on such matters but also the availability of a reasonable balance between facilities and services. They said that, lacking such balance, it was difficult to make arbitrary decisions regarding any one level of care that would not have untoward effects on other levels.

In August 1970 a State official informed us that New York had not implemented the HEW requirements--by stopping payments or giving 6-month provisional certifications--but that State agencies were then notifying facilities of the requirements, drafting provider agreements, and establishing policies and procedures for implementation. Thus Federal payments were made to skilled nursing homes through at least August 1970 without State implementation of Federal requirements. State officials subsequently informed us that as of January 1, 1971, all eligible skilled nursing homes had been sent provider agreements and that the enforcement program was under way.

In discussing our findings with State officials in June 1970, they informed us that they had closed one home and that they planned to take enforcement action against another because of the numerous deficiencies, some of them serious, in both facilities.

HEW regional officials informed us that no review had been made by regional staff of the skilled nursing home program in New York due to the lack of sufficient staff.

Oklahoma enforcement of Federal requirements

Before and after January 1, 1969, the State Department of Health considered nursing homes to be eligible for the Medicaid program if they were licensed by the State and met its required nurse-patient ratio. The State, however, did not start enforcing Medicaid requirements until May 1970.

State inspection reports showed no evidence that the inspectors had been aware of deficiencies in meeting Medicaid requirements apparently because the requirements had been omitted from the State's licensing standards. A department of health official informed us that the Medicaid requirements--including provisions for stopping payments and for 6-month provisional certifications--were not incorporated in State standards until May 1970 because the State had not been aware that the absence of these requirements was resulting in inadequate inspections. The official said that it had taken a few months to implement the revised standards and that actual enforcement had not started until July 1970. Thus Federal payments were made to skilled nursing homes to July 1970, before State enforcement of Federal requirements.

After being informed of our findings in May 1970, State Department of Public Welfare officials suspended payments to six of the 30 nursing homes included in our review. These homes had a total of 69 deficiencies. Subsequently, two of the homes were closed and one was reclassified as a board-and-room facility. Payments were resumed for the remaining three homes after registered nurses were hired as directors of nursing.

HEW regional officials informed us that they had made no in-depth review of the Oklahoma skilled nursing care program from 1967 due to a lack of sufficient staff.

RECENT HEW ACTIONS

On November 25, 1969, the HEW Audit Agency initiated a multistate audit of nursing homes participating in the Medicaid program. The audit was to include a review of the procedures and controls established by the States for inspecting and licensing nursing homes. At the time our field work was completed, the HEW Audit Agency had issued three reports as a result of this audit, two of which pointed out problems similar to those noted during our review.

As shown by our review, some nursing homes may not be meeting both Medicaid and Medicare requirements, evidencing the need for close coordination among the separate HEW offices administering the programs.

HEW also has recognized this need, and on August 11, 1970, SRS pointed out, in a memorandum to State agencies, that:

> "*** it may be assumed that the title XVIII [Medicare] decisions are coordinated with the title XIX [Medicaid] actions; but, we have learned from experience that this is not always the case."

The memorandum provides that SSA advise a State when a Medicare facility has been certified or recertified, when significant deficiencies have been found during the Medicare certification survey, and when termination actions have been taken. The States are requested to provide information to SSA on violations found in their surveys of Medicaid facilities. The exchange of information, if carried out, will provide added assurance that deficiencies applicable to both Medicaid and Medicare are known to the separate groups responsible for administering these programs.

CONCLUSIONS

There is a direct relationship between HEW requirements for skilled nursing homes and the provision of proper care. Deficiencies in meeting these requirements should be a clear warning that patient health and safety may be in jeopardy and that many homes, particularly those having inadequate nursing service and those involving infrequent physicians'

visits, are not capable of providing the level of skilled nursing care that patients require.

There is an obvious need for vigorous enforcement of these requirements. To set an example, HEW may find it necessary to take strong measures--encourage States to stop payments to those nursing homes that persistently fail to meet requirements and to obtain refunds from States for the Federal share of payments made to those homes that did not meet requirements. As evidenced by the States' actions in stopping payments to homes that we found had deficiencies, it seems likely that improper payments have been made to many ineligible homes because of States' delays in enforcing HEW requirements.

The States had the responsibility for ensuring that the homes were complying with the requirements, and HEW should have been aware--through its monitoring efforts--that the States were not enforcing compliance.

RECOMMENDATION TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

We recommend that the Secretary of HEW, to help ensure that patients receive proper care, instruct SRS and the HEW Audit Agency to continue and increase their monitoring of States' adherence to HEW's requirements for nursing homes' participation in the Medicaid program as skilled nursing homes.

AGENCY COMMENTS AND ACTIONS

The Assistant Secretary, Comptroller, agreed with our recommendation for continued and increased monitoring by SRS and the HEW Audit Agency of States' adherence to Medicaid requirements for skilled nursing homes.

For Medicaid, SRS has implemented a new monitoring and liaison program with the State agencies under which primary responsibility for reviewing State programs has been given to the HEW regional offices to facilitate monitoring activities and to promote faster corrective actions. The new program requires that the regional offices maintain closer relationships with State agencies. It requires also that

regional officials make more frequent visits and make detailed reviews of State operations. HEW stated that SRS intended to specifically follow up on the corrective actions initiated in Michigan, New York, and Oklahoma.

With regard to the HEW Audit Agency's efforts, HEW stated that Medicaid nursing home programs in 27 States had been audited or had been in the process of being audited during fiscal year 1970 and that nursing home programs in another 17 States were scheduled for audit in fiscal year 1971. HEW stated also that during these audits determinations had been, and would continue to be, made as to whether patients received the proper level of care and whether payments were made only for the level of care authorized.[1]

For Medicare, HEW stated that the fiscal year 1971 plans of the Audit Agency called for greater audit emphasis on the operational aspects of the program. In addition, HEW informed us that, as the Medicare program had progressed, SSA had become increasingly aware of the pattern of deficiencies, nationally, in extended-care facilities and had been emphasizing the importance of upgrading deficient facilities.

HEW stated also that, although particular attention had been devoted more recently to fire and safety requirements (including fire drills), State agencies were working to foster upgrading in all areas. With respect to the 33 nursing homes we visited that had participated in the Medicare program, HEW stated that four of these homes had voluntarily withdrawn from the program and that SSA planned to have the remaining 29 homes resurveyed. HEW stated also that SSA planned to have the State agencies work with these homes to have the homes improved, giving particular attention to the deficiencies noted by us.

The actions taken or promised by HEW should strengthen administration of the Medicaid and Medicare programs.

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[1]As of January 1971 the Audit Agency had issued 15 reports as a result of its review. Reviews in nine States pointed out problems similar to those noted during our review.

Considering the substantial Federal and State expenditures under the programs, prompt attention should be given to the implementation of those administrative actions promised.

CHAPTER 3

ARE PATIENTS BEING PROVIDED WITH LEVELS OF CARE MORE INTENSIVE THAN NEEDED?

Many Medicaid patients in skilled nursing homes may not need skilled-nursing-home care. Patients have been placed in skilled nursing homes even though their need may be for less intensive and less costly care that is available in other facilities. What does this mean? It means that not only do unnecessary costs result but also, and perhaps more important, unnecessary demands are made on professional care available for other patients who are in need of such care. We believe that the primary cause of this problem is that HEW has not developed a yardstick or criteria for measuring the need for skilled care. In the absence of such criteria, each State has its own criteria for measuring the need for skilled care.

SRS has not issued any explicit guidance to the States on how to decide that a patient needs skilled-nursing-home care, except that admission to a skilled nursing home must be based on a physician's recommendation. HEW requires that, after admission, periodic reevaluations be made of whether a patient needs to remain in the home. Since there is no explicit guidance, however, the States develop their own procedures for judging the need for skilled care.

Because of the medical knowledge and judgment involved, we have not suggested acceptable criteria for judging whether patients are in need of skilled-nursing-home care under Medicaid. SSA has developed explicit criteria for defining skilled nursing care under the Medicare program. In the absence of Medicaid criteria, the State of Michigan--to assist those persons who normally evaluate patient needs--has explicitly defined the medical and nursing-care characteristics it believes patients should have to qualify for skilled nursing care. For example, they must need potent and dangerous injectable medications on a regular basis; restorative procedures, such as bowel and bladder training; or tube feeding.

To determine the effects of not having uniform Medicaid criteria, we examined into the procedures followed by Michigan, New York, and Oklahoma in determining the needs of patients for skilled-nursing-home care. In Michigan--the only one of the three States that had developed explicit criteria for determining patient needs--State and county medical personnel who normally evaluate patient needs accompanied us to 15 of the 30 homes reviewed for compliance with Medicaid requirements for participation. (See ch. 2.)

At our request, these personnel made determinations as to the level of care needed by 378 patients by reviews of patients' medical records; discussions with nursing personnel; and observations of the patients, if considered necessary. They concluded that about 297 (79 percent) of the 378 patients whose needs were evaluated did not require skilled care as defined in Michigan's criteria.

We could not have similar evaluations made in New York and Oklahoma, since these States had not developed such criteria; however, as discussed on page 30, recent studies in New York showed that about 25 to 35 percent of the patients in skilled nursing homes were inappropriately placed. In addition, in a limited test, we were advised by the evaluators that, if the medical and nursing-care characteristics required by New York and Oklahoma patients were measured against the Michigan criteria, a similar high percentage of patients probably would not require skilled-nursing-home care.

MICHIGAN

In the five counties we visited, either State or county public health nurses or medical-social caseworkers (evaluators) decided whether patients should be admitted to skilled nursing homes. Subsequently, three of the counties began requiring physicians' recommendations. But two of the counties--one of which had over 50 percent of the State's skilled nursing homes--continued to rely on recommendations by nonphysicians.

State health department officials informed us that they did not believe that the procedures violated HEW requirements for a physician's recommendation, because public health nurses and medical-social caseworkers (1) were provided with a physician's physical examination report, (2) were supervised by physicians, and (3) were instructed to consult with physicians when considered necessary. The officials stated that, although the Michigan criteria were applied by nonphysicians, they had been developed by physicians. In our opinion, however, supervisory physicians, to provide added assurance that they concur in the evaluators' recommendations, should record their approvals.

The officials also said that the evaluators often recognize that patients are not in need of skilled-nursing-home care but place the patients in skilled nursing homes because beds in alternative facilities providing less intensive care are not available.

The State's subsequent reevaluations of patient level-of-care needs have verified that evaluators recognized that a large number of patients in skilled nursing homes were not in need of skilled-nursing-home care. Prior to and during our review, reevaluations were made by public health nurses and medical-social caseworkers; however, provision has now been made by the State for supplementary annual observations and evaluations by physicians. On the basis of visits to 126 skilled nursing homes during the period January through July 1970, the evaluators concluded that, of 6,159 Medicaid patients whose needs were evaluated, 3,353, or about 54 percent, were in need of a level of care less than skilled-nursing-home care.

State officials advised us that 73 additional nursing homes had refused to allow the State to evaluate the needs of their patients, because the homes were afraid the State might reduce the payments for patients determined to be not in need of skilled care. In Michigan, the Medicaid rate for skilled nursing care is $2.23 a day more than for intermediate care. In September 1970 State officials advised us that action was pending to stop payments to those homes that did not permit reevaluations of patient needs but that, because of the nonavailability of alternate facilities, no action was currently planned against homes that permitted reevaluations even though some patients in these homes did not require skilled nursing care.

This shortage of alternative facilities probably will continue for some time, because (1) from January 1, 1969, through February 18, 1970, beds in skilled nursing homes increased from about 12,000 to 21,000--almost double--and beds available for lower levels of care decreased from about 11,000 to 7,000--about one third and (2) beds in skilled nursing homes were expected to increase by an estimated 8,000 in 1970, while beds in intermediate-care facilities were expected to increase at a more gradual rate.

Evaluators determine the levels of care needed by patients on the basis of criteria established by the State Department of Public Health on July 22, 1969. These criteria are explicit as to the medical and nursing-care needs required for patients to be classified as needing skilled-nursing-home care.

On the basis of these criteria, State and county medical personnel evaluated the needs of 378 patients in 15 homes we visited and concluded that 297 patients, or 79 percent, were not in need of skilled-nursing-home care. The public health nurses and a medical-social caseworker making evaluations for us said that, in their opinion, the July 22, 1969, criteria were too restrictive and that they preferred the criteria used prior to July 1969. At our request, they applied the less restrictive criteria to patients in 14 of the 15 homes visited and concluded that, of the 360 patients whose needs were evaluated, 151, or about 42 percent, did not require skilled-nursing-home care.

The State's evaluation of patients' needs for skilled-nursing-home care and the evaluations made at our request showed that, for a large percentage (42 to 79 percent) of the patients, less intensive levels of care would have been adequate; however, alternative facilities were not available. If intermediate-care homes were available and if half of the about 14,000 Medicaid patients in skilled nursing homes could be placed in intermediate-care homes, savings of about $5.7 million annually would be realized by the State and the Federal Government, because intermediate care is less costly than skilled care.

HEW regional officials informed us that they believed that uniform national criteria are needed to ensure that patients in skilled nursing homes are those in need of skilled nursing care.

NEW YORK

Except for those admitted to privately owned nursing homes in New York City, patients are admitted to skilled nursing homes on the recommendation of their physicians. Physicians acting for the State Department of Health evaluate patients before their stays in the home have exceeded 100 days, to determine their need for continued skilled-nursing-home care. Subsequently, at least annually, physicians reevaluate these needs.

For privately owned homes in New York City, physicians of the City Department of Social Services evaluate the recommendations for admission to skilled nursing homes by the patients' attending physicians. These physicians also evaluate the patients' needs before they have been in a home 100 days. Subsequently, they reevaluate the patients' needs when determined necessary by the City Department of Social Services.

The State and the city, however, have not established any written criterion defining the medical and nursing care required for patients to be classified as needing skilled-nursing-home care. Patients' physical and mental conditions are shown on evaluation forms, but no instructions are provided as to how this information is to be used in determining whether patients need skilled-nursing-home care. As a result, evaluators (physicians) establish their own criteria.

Department of Health officials informed us that several voluntary areawide health planning agencies in New York had developed rather detailed definitions of nursing homes and of the needs of patients for care in such homes and that professional health teams using these definitions in carefully designed studies had recently examined into the suitability of patients' placement in nursing homes in 10 counties. According to these officials, the studies showed that 25 to 35 percent of such patients could have been cared for more suitably, and often at less cost, in some other facilities.

Department of Health officials informed us also that, because there was a shortage of alternative facilities in which to place patients, they would not be able to enforce a well-defined criterion for determining which patients

need skilled care. They said that an intermediate-care program only recently had been introduced in New York and that there were about 12,000 beds available in intermediate-care facilities compared with about 54,000 beds in skilled nursing homes. They said also that there was a serious shortage of beds in skilled nursing homes, which was rapidly being reduced, and a much more serious shortage of beds in intermediate-care facilities. They informed us that the shortage of beds in intermediate-care facilities would not be eliminated for several years.

HEW regional officials informed us that the difficulty of establishing adequate national criteria was at least partly responsible for the absence of such criteria at the State level.

OKLAHOMA

The Oklahoma Department of Public Welfare requires that a patient be examined by a physician and that a medical-social summary be prepared by a social worker before a determination can be made as to whether a patient is eligible for admission to a skilled nursing home. This determination is made by three medical-social analysts who are not physicians but who work under the supervision of a physician. Prior to our review, a physician seldom recommended the level of care required for a patient, because the physical examination form did not specifically require such a recommendation from the physician. As a result of our review, the Department changed the form to require a physician's recommendation.

In addition to evaluating the condition of each patient initially, the social analysts reevaluate the condition of each patient annually as to continued need for skilled care. During 1969 the analysts made about 16,000 reevaluations and concluded that only 401 patients, or 2.5 percent, did not need skilled-nursing-home care.

Both the initial and subsequent evaluations of skilled-nursing-home-care needs of patients are made on the basis of the State's general criteria which require only that eligible persons be:

> "*** bedfast, chairfast, or require the assistance of another person to walk, or must by reason of other health problems as recommended by the attending physician require constant skilled nursing supervision."

Oklahoma does not have an intermediate-care program to provide for patients needing less than skilled care. A Department of Public Welfare official informed us that the department would not establish such a program unless forced to do so by the Federal Government. He said that, if intermediate care were provided in Oklahoma, rates allowed probably would be equivalent to current rates for care provided in skilled homes and that rates for skilled care, if more strictly defined, would be higher.

HEW regional officials informed us that HEW standards for determining the level of care required by patients were needed but that they should be developed at the national level.

EVALUATION OF PATIENT NEEDS USING MICHIGAN'S CRITERIA

In visits to eight New York nursing homes and six Oklahoma homes, we obtained considerable documented medical information on the conditions of 120 patients in New York and 86 patients in Oklahoma. We asked medical personnel who evaluated the needs of Michigan patients for us to evaluate the needs of these New York and Oklahoma patients, using the July 22, 1969, criteria developed by Michigan State Department of Public Health physicians. A physician also participated in these evaluations. We noted that the application of uniform criteria resulted in similar high percentages of patients in New York and Oklahoma who may not have been in need of skilled care, as summarized below.

State	Number of patients evaluated	Patients believed not in need of skilled-nursing-home care	
		Number	Percent
Michigan	378	297	79
New York	120	85	71
Oklahoma	86	73	85

As noted previously, we did not judge the reasonableness of criteria for evaluating the needs of patients--including Michigan's--because of the medical expertise and judgment involved. We believe, however, that the wide range in results--25 to 71 percent for New York and 2.5 to 85 percent for Oklahoma, depending on the criteria used--provides evidence of the need for uniform criteria.

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The Assistant Secretary, Comptroller, advised us that Oklahoma, in replying to our draft report, had stated that, although the State had no criticism of our objectives, it felt that the true test of its skilled-nursing-home program was whether the State had observed the provisions in its approved State plan rather than criteria established by another State.

In evaluating patients' needs in Oklahoma under Michigan's criteria, it was not our intention to imply that Michigan's criteria for skilled-nursing-home care be adopted and applied by Oklahoma but it was our intention simply to point out the latitude of determinations resulting from the diversity of criteria being followed by the States in determining the medical and nursing-care requirements for patients to be classified as being in need of skilled-nursing-home care.

RECENT HEW ACTIONS

As discussed in chapter 2, HEW regional offices and the HEW Audit Agency had not made reviews of the skilled-nursing-home programs of the States included in our review. The multistate audit of nursing homes participating in the Medicaid program initiated by HEW on November 25, 1969, however, is aimed at ensuring that skilled-nursing-home care is provided only when such care is required.

The audit provides for determining whether patients are receiving the proper level of care and whether payments are made only for the level of care authorized. This audit, which was partially completed at the time of our review, should, when completed, provide guidance in overcoming the problems found during our review. As noted in the footnote on page 23, as of January 1971 the Audit Agency had issued 15 reports on its audits of Medicaid nursing-home programs, of which nine reports pointed out problems similar to those found during our review.

CONCLUSIONS

The absence of uniform criteria setting forth the explicit medical and nursing-care needs of patients under Medicaid has permitted limited financial resources to be used for the development of skilled-care facilities, although a more critical need seems to be for alternative facilities in which less intensive and less costly care can be provided. Perhaps more important, the effectiveness of limited human resources, such as physicians and registered nurses, is diminished when they are required for providing skilled care for patients not in need of such care.

HEW's development of uniform criteria should in no way impinge on the professional expertise and judgment of physicians. On the contrary, physicians should be directly involved in the development and application of such criteria. In our opinion, the use of such criteria would pinpoint more precisely the extent to which skilled or less costly nursing care is needed and, as a result, limited human resources could be allocated to meet more effectively the most critical nursing-care needs. Under the existing, unrealistic procedures, decisionmakers often are confronted with only two choices--skilled care or no care at all.

RECOMMENDATIONS TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

We recommend that the Secretary of HEW, to assist the States in determining whether Medicaid patients are in need of skilled care, issue criteria setting forth the medical and nursing care required for patients to be classified as being in need of skilled-nursing-home care. We suggest that consideration be given to the experience with the criteria already developed for the Medicare program.

We recommend also that the Secretary of HEW instruct SRS and the HEW Audit Agency to continue and increase their monitoring to ensure that States are following existing HEW Medicaid regulations relating to the admission of patients to skilled nursing homes and are periodically determining whether patients admitted to skilled nursing homes are still in need of skilled care.

AGENCY COMMENTS AND ACTIONS

With regard to our recommendation that HEW issue criteria setting forth the medical and nursing care required for patients to be classified as in need of skilled-nursing-home care, the Assistant Secretary, Comptroller, stated that SRS was planning to issue, within 6 months, guidelines for the States to follow, which would clarify and be more specific in evaluating a patient's need for skilled nursing care and other services under the Medicaid program. He stated also that, where applicable, these guidelines would consider areas of common interest, as outlined in the criteria developed for the Medicare program.

With regard to our recommendation for continued and increased monitoring by SRS and the HEW Audit Agency to ensure that the proper level of care is provided, HEW stated that monitoring programs were being increased, which would aid in the reduction of deficiencies discussed in this and other of our reports. In addition, HEW informed us, with respect to Medicare, that action had been taken to educate employees of facilities on the use of the utilization review mechanism which ensures that the proper level of care is provided and that procedures had been tightened to prevent payments for improper levels of care.

The actions taken or promised by HEW should strengthen administration of the Medicaid and Medicare programs. In view of the substantial Federal and State expenditures under these programs, prompt attention should be given to the implementation of the promised administrative actions.

CHAPTER 4

SCOPE OF REVIEW

We examined into the practices of the States of Michigan, New York, and Oklahoma in (1) certifying homes as meeting requirements for participation as skilled nursing homes under Medicaid and (2) determining whether individual patients in skilled nursing homes were in need of the level of care provided. For those homes that were found to be deficient in meeting Medicaid requirements for participation, we ascertained whether the homes were serving Medicare patients and whether Medicare requirements were being met.

Our selection of States was based on the significance of Federal funds expended for skilled nursing homes both in amount and in relation to total Medicaid expenditures in the States. In selecting 90 nursing homes (30 in each State), we attempted to make our sample representative of the homes in each State.

Our examination into the need for the level of care provided was directed primarily toward determining the effects of not having explicit HEW Medicaid criteria. We did not establish acceptable criteria for measuring level-of-care needs because of the medical expertise and judgments involved nor did we judge the reasonableness of criteria established by the States.

Our review was made at HEW headquarters in Washington, D.C., and at its regional offices in Chicago, Illinois; New York, N.Y.; and Dallas, Texas. Our review was made also in each State at the responsible State and county offices and at skilled nursing homes in various counties.

As part of our review, we examined into the basic legislation authorizing the Medicaid program and the pertinent HEW regulations implementing the program. We also examined pertinent records and documents at State and county offices and at nursing homes. We also discussed with HEW, State, county, and nursing home officials matters relative to the administration of the program.

APPENDIXES

NURSING HOMES NOT FULLY IN COMPLIANCE

WITH MEDICAID REQUIREMENTS

INCLUDING STATE LICENSING REQUIREMENTS

Requirement	Medicaid homes having deficiencies (note a)				Medicare homes (note b)
	Mich	New York	Okla	Total	
Emergency electrical service	13	10	29	52	10
Adequate nursing staff (number and qualifications)	12	13	23	48	8
Physician visits every 30 days	12	8	27	47	12
Fire drills three times a year	17	5	22	44	7
Complete nurses' call system	11	13	19	43	8
Examination room	11	10	17	38	4
Designated social worker	11	4	11	26	5
Record of current health examinations for staff members on file	6	11	10	27	9
Cubicle isolation curtains	16	12	-	28	8
Adequate patient room accommodations	2	19	2	23	9
Qualified consultant dietitian	2	3	14	19	-
Written policy for patient care	4	4	6	14	2
Adequate toilet facilities	-	15	-	15	5
Transfer agreement with nearby hospital	1	3	10	14	-
Adequate day-dining area	6	5	-	11	4
Elevator	3	13	2	18	5
Written nursing-care plan for each patient	1	4	4	9	1
Nurses' station	3	5	2	10	2
Posted disaster plan	5	4	-	9	3
Qualified administration	-	6	-	6	3
Emergency drug kit	4	1	1	6	-
Adequate bathing facilities	1	6	-	7	3
Written narcotics record maintained	-	1	3	4	-
Total	141	175	202	518	108

[a]Comparisons of deficiencies in each state should not be made, because of differing licensing requirements.

[b]Homes, included in total, which also served Medicare patients and which did not meet Medicare requirements.

APPENDIX II

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

OFFICE OF THE SECRETARY

MAR 23 1971

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

Dear Mr Heller

The Secretary has asked me to respond to the draft report on the GAO review of Violations of Medicaid and Medicare Standards for Skilled Nursing Homes and Questionable Need for Skilled Nursing Home Care Enclosed are the Department's comments on the findings and recommendations in your report.

We appreciate this opportunity to comment prior to issuance of the final report We also appreciate your continuing interest in helping us improve Medicare and Medicaid administration.

Sincerely yours,

James B. Cardwell
Assistant Secretary, Comptroller

Enclosure

VIOLATIONS OF MEDICAID AND MEDICARE STANDARDS
FOR SKILLED NURSING HOMES
AND
QUESTIONABLE NEED FOR SKILLED NURSING HOME CARE

The draft audit report presents a picture of various violations of Medicaid and Medicare standards for skilled nursing homes in Michigan, New York, and Oklahoma as well as the questionable need of skilled nursing home care for certain individuals Its recommendations are generally consistent with findings of the Social and Rehabilitation Service (SRS) and the Social Security Administration (SSA) on these points

The Medicaid and Medicare programs are constantly working towards upgrading the quality of care and services rendered by participating providers of services Towards this goal, we have instituted several programs designed to evaluate the operational effectiveness of Medicaid and Medicare State agencies and to assure that participating facilities are cooperating to the fullest extent of their resources in improving their operations Coordination between Medicaid and Medicare program policies and guidelines, to the fullest extent feasible, is highly desirable and is being undertaken

[See GAO note.]

The first recommendation (page 39 of the draft report) recommends that the Secretary of HEW instruct the Social and Rehabilitation Service and HEW Audit Agency to continue and increase their monitoring of States' adherence to its Medicaid requirements for skilled nursing homes

SRS has implemented a new monitoring and liaison program with the State agencies by each of the SRS Regional Offices along with assistance from the Washington Central Office Under this new program, primary responsibility for reviewing the State program has been given to the Regional Offices in order to facilitate monitoring activities and promote faster corrective actions The scope of the new program requires a closer relationship with the State agencies along with more frequent visits and detailed reviews of State operations The initial monitoring reviews will tend to be more comprehensive in the beginning phases but will later develop into more intensive reviews of troublesome areas such as noted in this report Concerning the deficiency commented on in this recommendation, SRS will, of course give special follow-up review of the corrective actions

GAO note: The deleted comments pertain to matters discussed in the draft report but omitted from this final report.

initiated by the States While SRS plans continuing monitoring programs in these three States, as well as in the other 49 jurisdictions, they also have these three States scheduled for intensified program reviews during FY 1971

We also agree with the recommendation that the audit effort expended by HEW in this area should continue and increase With regard to Medicaid, the GAO report did note that the agency had " initiated a multi-State audit of nursing homes participating in the Medicaid program " During FY 1970, nursing home programs were audited, or audits were in progress, in 27 States An additional 17 States are scheduled for audit in FY 1971 Determinations have been and will continue to be made during these audits as to whether recipients received the proper level of care and whether payments were made only for the level of care authorized

We would also like to point out the review efforts of the Medicare program by the Audit Agency and SSA

The FY 1971 plans of the Audit Agency for Medicare call for greater audit emphasis on the operational aspects of this program This is a continuing effort away from the earliest audits which were directed in the main, towards verifying the administrative costs claimed by intermediaries and State agencies The Audit Agency has reviewed most of the State agencies responsible for the examining and certifying of extended care facilities

SSA in conjunction with the Public Health Service, performs program reviews of each State agency participating ir the Medicare program under Section 1864 SSA, and the ten health insurance regional offices conduct comprehensive reviews of State operations During these reviews, Federal surveyors do direct surveys of a sample of providers to determine, among other quality controls, the effectiveness of the State review capabilities of State surveyors and their adherence to Federal guidelines The SSA has a validation program which, among other functions, measures whether participating facilities are rendering quality services It also has a program integrity operation which evaluates consumer complaints against individual facilities where there is a likelihood that fraud is involved

SSA has also instituted measures to improve the quality of State agency professional employees The third in a series of trainirg programs for State agency survey personnel is being held at Tulane University and similar institutes are being started in three other universities About 300 surveyors will receive this training in 1971, and it is planned that all surveyors will ultimately have the opportunity of atterding such training at various SSA sponsored institutes throughout the country SSA has also been working closely with Federal and State merit system officials to upgrade and augment staffing within State Medicare agencies

As the Medicare program has progressed, SSA has become increasingly aware of the pattern of deficiencies nationally in Extended Care Facilities and has been emphasizing the importance of upgrading deficient facilities While particular attention has been devoted more recently to fire and safety requirements (including fire drills mentioned in the audit report), State agencies are working to foster upgrading in all areas

[See GAO note on p. 43.]

[See GAO note on p. 43.]

The third recommendation (page 56 of the draft report) recommends that the Secretary issue criteria setting forth the medical and nursing care required for persons to be classified as in need of skilled nursing home care and that consideration be given to the experience with the criteria already developed for the Medicare program SRS currently has such guidelines in draft form which will clarify and be more specific for the States to evaluate a recipient's need for skilled nursing care and services Where applicable, these guidelines considered areas of common interest as outlined in the criteria developed for the Medicare program SRS plans to have these guidelines within the next six months

The fourth recommendation (page 56 of the draft report) recommends that the Secretary of HEW instruct the Social and Rehabilitation Service and the HEW Audit Agency to continue and increase their monitoring to assure that States are following existing HEW regulations relating to the admission of persons to skilled nursing homes and periodically effectively determining whether persons admitted to skilled nursing homes are still in need of such care As noted above, monitoring programs are being increased which will aid in the reduction of deficiencies found in this and other GAO reports

In addition to our comments on the recommendations we have the following comments concerning various aspects of the report

Nurse-Patient Ratios (page 21)[1] - SSA is concerned that the draft implies that the absence of nurse-patient ratio for Medicare is inherently bad and would attentuate the quality of care rendered Under title XVIII the adequacy of nursing services is carefully determined based on the judgment of the survey team as it views the needs of a particular facility and the placing and composition of its patient load An individualized determination is made based on type of care furnished, the needs of the patients, and other related factors SSA's view that this is the most desirable approach to assuring the quality of nursing care rendered to Medicare patients is shared by the American Nursing Association and the Public Health Service, DHEW There are some inherent dangers in the use of arithmetic ratios, including the possibility that the minimum ratios established may gain acceptance as the maximum by providers and surveying agencies

Physician Visits (page 22)[1] - Medicare regulations, 20 CFR 405 1123, require a physician visit at least once every 30 days This condition of participation has been incorporated by reference in the Medicaid regulations It should be noted that this requirement is to some extent beyond the control of a facility However, our State agencies are working closely with facilities to have them take whatever steps are necessary to insure that these requisite visits are being made

Emergency Electrical Service (page 26)[1] and Nurse Call System (page 27) - With respect to the lack of emergency electrical service and nurse call systems, State agencies have been encouraging facilities lacking these items to install them However, when facilities simply lack the funds to do so immediately, but are otherwise in compliance with the requirements and render an acceptable level of care, we feel it is preferable to allow them to remain in the program as they try to improve This concept, of course, would be true in any case where correction of a deficiency would require a very large expenditure in relation to the resources of the facility

Level of Care (page 40)[1] - One of the methods built into the law to ensure that Medicare patients admitted to nursing homes require skilled nursing care is utilization review Admittedly, this is not perfect, but action has been taken to educate facilities and there is evidence of improvement Also, intermediaries have been tightening up their procedures to prevent payment for custodial care

[1]GAO note: The page numbers referred to in these comments are applicable to GAO's draft report.

Some Federal criteria defining "level of care" in terms of patterns of skilled nursing care and skilled care profiles have started a trend among "nursing homes" oriented more to custodial care to withdraw from Medicare and to realign so as to create distinct parts with different levels of care

Because of our concern with regard to the specific facilities visited by the auditor, we have asked the three regional offices involved to request that the State agencies re-survey 29 of these facilities that remain in the Medicare program (Four of them have voluntarily withdrawn) The State agencies will work with these facilities to improve, and particular attention will be given to the deficiencies noted by the auditors

As requested by GAO, we furnished copies of their draft report to the responsible State agencies in Oklahoma, New York and Michigan for their review and comment The State of Michigan did not submit a formal reply, but indicated they had no objections to the report Formal comments were received from Oklahoma and New York, copies of which are attached [1] While these two States have raised various objections to parts of GAO's report, these objections were not of a nature to affect our decisions on the actions we are taking on GAO's recommendations

Attachment [1]

[1]GAO note: These attachments have been considered in preparation of our final report and are not included as appendixes to the report.

PRINCIPAL OFFICIALS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE HAVING RESPONSIBILITY FOR THE MATTERS 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
COMMISSIONER, MEDICAL SERVICES ADMINISTRATION:		
Howard N. Newman	Feb. 1970	Present
Thomas Laughlin, Jr. (acting)	Sept. 1969	Feb. 1970
Dr. Francis L. Land	Nov. 1966	Sept. 1969
COMMISSIONER OF SOCIAL SECURITY:		
Robert M. Ball	Apr. 1962	Present
DIRECTOR, BUREAU OF HEALTH INSURANCE:		
Thomas M. Tierney	Apr. 1967	Present
Arthur E. Hess	July 1965	Apr. 1967

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