FRAUDULENT PAYMENTS IN THE MEDICAID PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON FEDERAL SPENDING PRACTICES, EFFICIENCY, AND OPEN GOVERNMENT

OF THE

COMMITTEE ON GOVERNMENT OPERATIONS UNITED STATES SENATE

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CONTENTS

APPENDIX

FRAUDULENT PAYMENTS IN THE MEDICAID PROGRAM

TUESDAY, AUGUST 17, 1976

U.S. SENATE,
SUBCOMMITTEE ON FEDERAL SPENDING
PRACTICES, EFFICIENCY, AND OPEN GOVERNMENT,
COMMITTEE ON GOVERNMENT OPERATIONS,
Miami, Fla.

The subcommittee met, pursuant to notice, on Tuesday, August 17, 1976, at 9 a.m. at the Commission hearing room, Dade County Court House, Miami, Fla., Hon. Lawton Chiles, chairman of the subcommittee, presiding.

Present: Senator Lawton Chiles.

Staff member present: Robert F. Harris, chief clerk.

OPENING STATEMENT OF SENATOR CHILES

Senator CHILES. Good morning. Today, the Government Operations Subcommittee on Federal Spending Practices begins an inquiry into the problems found in the medicaid system.

This hearing today actually continues considerations that the subcommittee began with a study of certain problems in the medicare program.

Let there be no confusion about where I stand on the issue of high quality health care.

Without question, I am interested in expanding on those positive features of our present health care delivery system and in making the system work, particularly for the poor and elderly.

However, there is deep concern in Congress that the system is not working as Congress intended.

There is concern that with many organizations, the dedication is not to the patient or the client, but rather to gaining a profit.

Congressional committees in both Houses of Congress have spent a lot of time investigating abuses and fraud in the medical programs but new revelations spring up daily.

So, I think the concern of Congress is altogether proper.

There is concern by Congress that, in providing for variety in medicaid administration, we have also provided for a general hodgepodge of individual State program operation.

I recognize, indeed, I have fought for the need for the States to have some flexibility in administration and I hope States can maintain some flexible aspects because I do not believe that the solutions to all problems can be found in Washington.

I guess it boils down to the fact that we have heard so much about the problems in medicaid and medicare that we have finally started to listen and be concerned.

We hear about the long delays that persons filing for reimbursement have to suffer. We hear about the incredible complex medicaid forms that have to be filled out by patients seeking care.

We hear that patients' families are being coerced into making so-called donations to nursing homes as a requirement for their loved ones being accepted.

We hear all of this and we say that clear violation of the social security law cannot be tolerated and violators must be firmly dealt with if public credibility for the medicaid program is to be maintained.

I am aware that there are countless nursing homes in the State of Florida that are doing a fine job of providing quality care to the elderly and they are to be commended.

In focusing on the problems, we do not ignore the contributions. I have been told that many health care providers do not want to accept medicaid assignment because the rates are so unusually low—approximately 40 percent of the prevailing rate.

This fact alone makes it all the more remarkable that valid contributions are made by many nursing homes.

Federal and State taxpayers are shelling out some $38 billion in fiscal 1977 for health programs, and I believe that the American people are willing to support these programs as long as they believe the programs are being administered efficiently, effectively, and compassionately.

The thrust of the matter goes beyond the dollars involved, although that's a valid concern but, rather, it goes right to the point that our health delivery system involves people, not cold statistics.

Florida has over 150,000 individuals involved in the medicaid program and I am told by medicaid officials that the number will go even higher next fiscal year.

Every client, every taxpayer, every family, has the right to expect high quality care and effective enforcement of the proper laws.

Every example of fraud and abuse that occurs seriously compromises the quality and efficiency of health services for the poor and elderly.

We welcome the witnesses today who will relate the problems as they know them.

Our first witness will be Mr. Doug Whitney of the department of health and rehabilitative services.

We appreciate your appearing here today.

TESTIMONY OF DOUG WHITNEY, OF THE FLORIDA DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES, ACCOMPANIED BY KEN CONNORS, MEDICAID AUDIT DEPARTMENT; JOHN COPPINGER, FIELD SUPERVISOR; MRS. KATHERINE EVANS, DIRECT SERVICES SUPERVISOR; AND MRS. MARIES ROMERO, SUPERVISOR OF ADULT PAYMENTS

Mr. WHITNEY. Senator, I am glad to be here today.

May I first of all preface my remarks by saying that I am here only as the lead in an investigation regarding the contribution problem in nursing homes. I have no standing as to discuss the question of rates or schedule of payments or anything of that nature.

That is a policy matter and I am merely a staff attorney handling this one aspect of the nursing home situation.

Basically, I regret that a report [1] requested through your office had not reached your office prior to this hearing. I will try to summarize it in just a few words if I may, here again dealing strictly with the contribution aspect.

Prior to 1976, the department had received scattered complaints about contributions being required of relatives of medicaid patients in nursing homes.

These complaints were investigated at the local administrative level; however, it was determined at the upper administrative level that the investigations did not show sufficient evidence under the existing laws to take any affirmative action.

However, towards the end of 1975 and the first part of 1976 these complaints became more prevalent and more centered and gave us a focal aspect of things that we needed to look into and the secretary of the department mandated a thorough investigation be commenced on this matter.

Now, the legal staff of the department was given the lead to utilize department resources in investigating and determining what action was available to the department as a result of the investigation.

It was approached and is continuing to be approached in two aspects.

First of all, the financial determination of possible abuses and the contribution aspect through internal audit.

Second, to obtain witnesses who were willing to state that they were making these contributions upon conditions that were not truly contributions as the word is known.

The audits were commenced and are continuing.

They are an ongoing situation that is continuing right today.

I have with me the supervisor, Mr. Ken Connors of our audit department, medicaid audit department, and his associate, the field supervisor in this phase of the investigation, Mr. John Coppinger.

The second aspect has been a little slowed down, Senator, I must confess. I am not making an apology or as one says, poor mouthing.

We have been in the throes, our department of reorganization, the State legislature mandated on us a year ago and as a result of which our legal staff is in the turmoil of establishing patterns, staffing patterns and staffing up.

As a result of which our investigation into the actual obtaining of witnesses, names of individuals, interviewing them and so forth has been a little slowed down.

We are anticipating that this will be changed within about approximately 30 to 60 days and we will be back going into this at great depth from that aspect of the investigation.

It has been found, essentially in our investigations, that to date that this eliciting of contributions of all these conditions by nursing homes is fairly widespread.

However, it amazingly seems to center in two geographical areas. One is the northwest part of Florida and the other one is commonly called the gold coast, the southeast part of Florida.

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[1] See appendix p. 49.

Even today there are scattered reports only through other parts of the State. I mean it is going on in other parts of the State but we work basically upon where we receive the bulk of the complaints from.

Generally the problem arises in two aspects.

First, a relative determines that he or she can no longer care in the home for a medicaid eligible client and seeks to place this client in a nursing home under medicaid.

A given nursing home will then require of the relative a contribution to the nursing home as a condition of admission. These contributions vary in a general range from $50 to say $300.

We have found one, I believe, as high as $400.

Senator CHILES. A month?

Mr. WHITNEY. Yes; a month.

The second way that this situation usually occurs, and this is a condition of continued care, if a patient is in the hospital on medicaid and then is transferred into a nursing home for rehabilitative care and then the medicare expires and they go onto medicaid.

At this point the nursing home will approach the relative and request a contribution from them to continue caring for the patient in the nursing home.

The department feels that it has, after developing sufficient evidentiary information, several alternative resources.

It may institute a legal action for breach of contract against a nursing home.

It may determine that the nursing home has breached regulations sufficient to assess an administrative fine against the nursing home.

It may seek, through the appropriate branch of government, a revocation or a disciplinary action against the nursing home administrator's license.

It may forward any evidentiary matter of possible criminal activity to the State attorney's office for further action.

It may determine that sufficient evidence exists to seek revocation of the nursing home license.

As previously stated with staff limitations, the department is continuing its investigatory aspect and anticipates within 2 to 4 months of having sufficient evidentiary information to take one or more of the above-described actions against several nursing homes in the State.

The main concern of the department is not to place a nursing home out of business as the service is needed for the recipients or clients, but the action that may be determined to be taken is to require the nursing home to comply with both State and Federal statutory and regulatory requirements in this situation.

The Legislature of the State of Florida in its 1976 session made considerable revisions in that part of its laws relative to that which is commonly known as "medicaid fraud" and particularly in dealing with the contribution aspect.

This law, with certain qualifications, in effect causes contributions made as a condition of admission or continued care of a medicaid client or patient to be designated as crimes, both misdemeanors and felonies, depending upon the amounts of the contributions.

The law becomes effective October 1, 1976. The department feels that this law will strengthen its position in being able to effectuate action in dealing with this problem.

The legislature further passed additional laws directly relating to this problem which would affect the licensure and medicaid portions relative to nursing homes and effectively strengthen the department's position.

I will be happy now to answer any specific questions.

I have here Mrs. Katherine Evans who is the direct service supervisor who has received numerous complaints and could give specific examples and I could stand here all day and give specific reports.

I also have here Mrs. Marie Romero, who is supervisor of adult payments of our department.

Senator CHILES. Maybe if Mrs. Evans could stand up with you as I ask questions it may be helpful to have her.

Mr. WHITNEY. And, of course, I stated earlier Mr. Connors and Mr. Coppinger are here and they could give good examples of audit problems.

Senator CHILES. Thank you very much for your statement.

How many cases do you actually have that have come to your attention now?

Mr. WHITNEY. Now when you are referring to cases, are you meaning individuals or do you mean nursing homes?

Senator CHILES. How many nursing homes are we talking about that are involved in this that have come to your attention?

Mr. WHITNEY. I have reports on roughly 50 to 60 nursing homes.

Senator CHILES. All right. That 50 to 60 have come to your attention so far by way of complaints that have been made?

Mr. WHITNEY. Yes.

Senator CHILES. Now, knowing that there are many people that don't know that this is a fraudulent practice or that this practice is improper and knowing that perhaps there are many people that have not complained, what are you doing to try to determine whether this practice is more widespread or how much more widespread it is?

Mr. WHITNEY. We are limited staffwise, not just from the legal but other aspects.

I have had one investigator assigned to me. I have been using him when we go into a specific home and receive enough individual names to talk to the people.

You see, we have got to develop our evidence, not just from the audit, but from live witnesses who are willing to stand up and state these facts.

We are really on the witness side.

Generally our procedure will be to send out letters to people, to all medicaid patients in the home. They will then respond indicating. If they indicate and we get three, four, five, six in one nursing home that indicate they are making contributions and these are in fact under conditions then we will send the investigator out to talk with these people.

Senator CHILES. Are you sending these letters to all medicaid patients?

Mr. WHITNEY. They will be sent to relatives of medicaid patients.

Senator CHILES. All or just where you have the complaints?

Mr. WHITNEY. Where we have the complaints in a given home.

Senator CHILES. Maybe you are the wrong person to ask this question because you have told me that you are in charge of the investi-

gation of where there are complaints, but what I'm trying to find out is what is HRS [1] doing to try to determine—we have said the main thing we are trying to do here is to stop this practice.

Mr. WHITNEY. Yes, sir.

Senator CHILES. Making cases against some of the people that are involved in it, yes, that is necessary but for the protection of the people the main thing we want to do is stop it.

It seems to me the first thing we have to find out is, you know, who all is involved; how many people are involved and to make sure that they are not going to get caught just as somebody makes a complaint, but there is going to be some rigid enforcement by the State.

So, it seems like either you have to survey the nursing homes and certainly you could send out some kind of questionnaire form that requires them, under some kind of penalty, to report to you whether they are involved in any kind of practice like this; or, two, some kind of survey of the patients themselves or their relatives so that they get an opportunity to find out that this is a fraudulent practice, that something like that is very necessary to do.

Mr. WHITNEY. Yes.

Senator, may I state that in the past when we have received complaints, when the department has received complaints, they are sent letters to the specific nursing home where the complaints have been received from and in every case right down the line there has been a denial.

I have determined anyhow, from my standpoint, that it is a fruitless way of handling this.

To me it is much better to go to the relatives of the patients to ascertain this. The auditors have done this type of situation. They have received, for instance, in one home, they received—I think Mr. Connors could state better than I could, but as a generality say 20 letters and out of those it came back that 6 or 7 said, maybe a little more than that, maybe 10, said, "Yes, I made contributions under conditions."

Three or four will say they are making contributions voluntarily. Several will say they are making no contributions.

This is the aspect of that.

Senator CHILES. But you have not told me; those letters, are they being sent to every home, covering every home?

Mr. WHITNEY. Those homes that we are conducting audits in is where these will be sent.

As we go into a home to conduct an audit, these letters will be sent out and we have not done it on a general basis because we don't have the staff to do it statewide.

It would be an impossible task to coordinate in everything in this type of proceeding. That is why we have to take it on an individual nursing home basis where the complaints are being received from.

Senator CHILES. Well, I still have a great concern that you have to get a complaint before, when we know that the practice is spread to the point that you now have 50 to 60 cases.

Mr. WHITNEY. Yes.

[1] State of Florida Department of Health and Rehabilitation Services.

Senator CHILES. It seems to me that unless you could at least go into every area of the State and pick out some homes, enough that you are going to get a reflective sample and tell some of the relatives in that home or send a questionnaire or form, you are not going to really pinpoint whether it is going on and you don't know about it because the people don't know enough to complain.

Mr. WHITNEY. Yes, sir.

Senator CHILES. Hopefully from publicity that will go out people will find out that this is a bad practice, but as you say its been going on for a while.

Obviously it's something that becomes lucrative to the home. They are taking a chance in violating some rules and losing their accreditation and losing their funds, even criminal penalties and yet they are doing it. That seems to be because they don't think they are going to get caught.

Mr. WHITNEY. Well, let me explain. Actually there are no criminal penalties for this type of practice per se.

It would only be a situation of some fraudulent aspect that might be developed. Then it would be up to the nursing homes—I mean the individuals—when brought to their light.

Now, we have had some press coverage in this area as you are well aware of.

We have had reports back that many people have stopped making contributions as a result of this coverage. This has occurred in many, many instances.

I agree with you that we do indeed need to go into every area of the State. However, where we know this practice is being conducted more prevalently, we feel it is incumbent upon us to concentrate in those areas.

Senator CHILES. I think, as I said in talking to you, I am not sure you are exactly the person that I should be talking to. I think we are talking about two things.

We are talking about investigating actual cases of which reports have been made and which complaints have been made.

Mr. WHITNEY. Yes.

Senator CHILES. That is one thing.

The other thing, which is really more important, is how do we stop the practice and how do we find out how widespread it is occurring and how do we stop it.

It seems to me that starting to send out some questionnaires or starting to get some information in the hands of people out there to inform them that this is a practice that they don't have to put up with and to let the nursing homes know that this is something that we are checking on, is very essential to be done.

Mr. WHITNEY. I agree on the first aspect.

On the second aspect, the nursing homes are well aware we are going into this matter.

There was one other point I had in my mind that I have forgotten now. It slipped my mind. Maybe it will come back.

Senator CHILES. How many investigators do you have?

Mr. WHITNEY. We have an audit team of four, supervisor and three internal auditors that are going into the nursing homes.

Now, as to actual investigators, we borrow our investigators through the other units. There is the adult abuse investigator in a given area. I have only had one assigned to me because this information is just developing and we have not had the opportunity to really go into it.

I have had him go to various parts of the State.

Now I remember what that one point was that I was going to mention before.

What we have a very difficult time of doing is getting people that are willing to come forward. They are afraid that there are retributions.

Senator CHILES. Sure.

Mr. WHITNEY. On their loved ones in the nursing homes.

Senator CHILES. I am sure that is true.

And that is certainly going to remain to be true until they know that that is not going to happen and they know that some rigid and valid enforcement is going to be made and until they find there are enough people standing with them.

Mr. WHITNEY. I want to say one further thing. We do have two letters in preparation that are being drafted and approved through management level at this point to advise all medicaid relatives, responsible parties as they are otherwise called, they don't under the law have to make this contribution.

In other words, we are sending the problem out to them in these letters.

Senator CHILES. Good.

Mr. WHITNEY. That is in process. I didn't mean to mislead you that we were not doing anything in that respect.

Senator CHILES. I hope you also tell them in this letter that if this practice is taking place that they know of they should contact you.

Mr. WHITNEY. Yes, sir, very definitely. That is in the letter too.

Senator CHILES. That is what I was trying to get at in the earlier questions.

Mr. WHITNEY. Right. I am sorry. Yes.

Senator CHILES. Mrs. Evans, what area in particular are you working in? Are you working in one area of the State now?

Mrs. EVANS. Yes; Dade and Monroe Counties.

Senator CHILES. How many cases do you have that you know about? How many homes do you know about that you have in this area?

Mrs. EVANS. We have 37 nursing homes in Dade and 1 brandnew one in Monroe. It just started about a month ago.

We have at the moment about 2,400 medicaid clients in these homes in Dade County. We have not had any clients in Monroe until these last 2 weeks.

In response to the comment that he was making to your question: In my direct contacts with the relatives, myself and my staff, we have never been able to assure them that there wouldn't be any retribution.

Sometimes it's having to leave that home where they have been satisfied. It also gets down to moving them to the less desirable part of the nursing home, to a four bedroom instead of a two.

We have no way to stop that and that action is taken.

So that I think that is part of why they won't tell us.

Also, through the years we have had many, many complaints where we have been absolutely forbidden to use their names or to make inquiries into nursing homes.

I think that they think that we could do something magical involving them. This is my understanding of the situation. It is a very serious question and it is growing.

Senator CHILES. Well, I think again you are pointing out something that if we are talking about credibility of the system and if we are talking about credibility of our form of life, if you have a situation in which people are afraid and as you are now saying they have every reason to be afraid, we really have a breakdown and we really have to do something about that.

Because these people are the ones that could least afford to look after themselves in their own right.

Mrs. EVANS. Yes. As far as my staff is concerned we have wished that we did have some way to protect the person asked to leave.

What we do do, first, is find them another place and we are still fortunate enough to have nursing homes that do not ask for contributions.

But often they are not as nice a physical plant.

Senator CHILES. It seems to me that someone that would take this kind of action against a person for complaining about something that is wrong, which they are doing to start with, the only way that you really are going to get those people in line a little bit is if they are going to feel like a dark cloud is going to hang over them if they do something wrong like this.

So you are going to have to convince some of them that their licenses are going to be revoked; that they are going to be taken off the accreditation list and are going to be vigorously prosecuted if they carry out actions like this.

And only if they know that if they think they are free to turn around and take steps against these people they are going to do it.

Mrs. EVANS. The other thing that has happened to my staff is many times on an informal basis the home admits to us they do this. They refuse to take the client.

When it is obviously reported they deny it as Mr. Whitney said, but they said it to all of us, many, many of them.

Senator CHILES. Again, it seems to me now we are talking about whether we could make a case against somebody or not.

What do you think that you need down here in the way of investigators or in the way of auditors to be able to enforce, to be able to follow this.

Mrs. EVANS. Of course, we are delighted with the start, you know, that Mr. Whitney made, because frankly it is the first official thing that has happened.

I don't know how much more staff we need, but I would like to in some way know that the homes would know that there are penalties that are going to be enforced against them, and I think this would help a great deal.

Senator CHILES. What about decertifying from being a recipient?

Mrs. EVANS. That is done locally. That is done on the State level.

Senator CHILES. It is done by the State level, but still HRS——

Mrs. EVANS. Oh, yes, sure.

Senator CHILES. Have you ever recommended that someone be decertified or lose their certification?

Mrs. EVANS. Yes.

Senator CHILES. What has happened to that recommendation?

Mrs. EVANS. Replies that I didn't have enough proof.

Senator CHILES. That again comes back to whether you have adequate personnel, whether you have investigators to be able to look into this.

Mrs. EVANS. Yes.

One more thing, Senator. Now what is adequate proof? I am not an attorney. We are social workers and we realize we don't know how to work up a case, of course.

Senator CHILES. One of the best ways I always felt was for someone to convince me whether it was adequate proof or not, if somebody tried to bring a case and failed. I have spent a lot of time by people saying there is not adequate proof, but they never quite tried to bring the case and they kept on saying, "Go get me some more."

It is like they used to tell us in the State legislature, the law isn't specific enough, but they never tested the law out to show you that it wasn't specific.

They used it just as an excuse.

Do you know whether any cases have been brought in trying to take away their certification?

Mrs. EVANS. Not for this reason.

Senator CHILES. Well, I worry about the bureaucracy that says we have to have a little more proof.

Mr. WHITNEY. Senator, if I may interject, there is one case pending right now up in north Florida. It is not for this reason. It is for other reasons.

There is a case right now that is pending on decertification, revocation of license.

Mrs. EVANS. Oh, yes, that happened.

I am aware of that, but not for this reason.

Mr. WHITNEY. It is not for this reason. I am sorry, it is for revocation of license.

Senator CHILES. So, for this reason the State has not closed down any nursing homes and they have not decertified or taken away the certification of any homes for medicaid payments.

Mr. WHITNEY. No, because the laws at this moment do not have that much strength in them.

We have the remedies outlined, but for instance, if one goes into court on a breach-of-contract suit, you know how long and how drawn out something like that is.

Under the new laws that have been passed, as I stated before, I think we will have very good remedies for proceeding.

Senator CHILES. You think you do have that authority now under the new law?

Mr. WHITNEY. No. The new law goes into effect October 1.

Senator CHILES. Do you have any assessment on the value of Federal guidelines in the medicaid program? Are there guidelines from the Federal Government regarding abuses?

Mr. WHITNEY. The guidelines could honestly be a little more specific on the abuse question. I believe so.

The Federal regs could be tightened up. Of course, the Federal regs are all formulated under what is required under the State plan, and, of course, as long as the State plan meets the specifications and HEW approves there is no problem.

However, the rates could be tightened up for more specific provisions within the State plan, required in the State plan, that would set this a little more in detail and give it a little more effectiveness.

Senator CHILES. What is the funding arrangement between the Federal Government and the State government in regard to administration and enforcement of the plan?

Mr. WHITNEY. As best as I can recall, though it varies in some aspects, it is basically 50–50 contribution.

Senator CHILES. The State puts up 50 percent and the Federal Government puts up 50 percent?

Mr. WHITNEY. Yes. It is entirely administered by the State.

Senator CHILES. If the State wanted to have more people in the enforcement provision, auditors, investigators, attorneys; if the State went into that and made that a part of their plan, would the Federal Government share in that with 50 percent or do you have to get some specific amount or is there some formula set on the basis of the amount that you can receive?

Mr. WHITNEY. Senator, that I cannot answer. I am not that familiar with the internal budgetary aspects.

Senator CHILES. If you would refer that question to the department for me I would like to have an answer in writing because I want to find out if we need to do something from the Federal level to try to provide you with more investigators and more auditors because it's obvious to me that you have a situation here in which you need more enforcing help.

Mr. WHITNEY. That is very true, Senator.

Senator CHILES. When do you think this letter will be ready to go out?

Mr. WHITNEY. Probably in 3 to 4 weeks.

Part of it. I hate to keep reiterating, but since the legal section does have the lead on the whole thing, they are in the throes of restaffing.

Bear in mind this is one of many aspects of the department's work that I handle and in other situations I have in excess of I would say 100, 110 active cases in various levels of courts and administrative, before administrative bodies.

So, it is a very difficult situation.

We do expect by the new staffing patterns that we are developing that as soon as that is developed then we won't have that much problem. We will still be understaffed to handle everything that we are supposed to handle but we will at least get some relief and we will be able to direct more attention to matters as this.

Senator CHILES. Again, I would appreciate it if you would submit to us a rough draft as soon as you have it of that letter so that we could look at it.

Mr. WHITNEY. Yes. I will be more than happy to.

Senator CHILES. Thank you very much for your testimony here today, and Mrs. Evans, thank you for being here today also.

Our next group of witnesses will be a panel composed of Mrs. Gladys Simmons, Mrs. Leah Ball, Mr. Irving Glassman, Mr. William B. Beckman, Mr. Max Friedson, Mr. Harry Plissner, and also Mr. Mitchell Porris.

I appreciate very much you all coming. Will you raise your right hand?

[Whereupon, the above-mentioned people were duly sworn by Senator Chiles and testified as follows:]

Senator CHILES. For the reporter, if you would give us your name the first time before you speak or answer a question, then he will try to pick it up—maybe each time because he will get fouled up.

I want to thank you all for appearing here today and giving us the opportunity to listen to you. Of course, we are interested in hearing about specific instances as some of you can refer to them and the situation surrounding the alleged donations that you or others that you specifically know about have paid to local nursing homes, and if you would just first relate that to us and we will get into general questions after that.

TESTIMONY OF IRVING GLASSMAN, MAX FRIEDSON, LEAH BALL, GLADYS SIMMONS, WILLIAM B. BECKMAN, HARRY PLISSNER, AND MITCHELL PORRIS, A PANEL

Mr. GLASSMAN. My name is Irving Glassman. With reference to my mother, Dora Glassman, a former resident of the Greynolds Nursing Home on Dixie Highway in North Miami Beach.

Prior to entering the home my mother was a patient at South Shore. From South Shore Hospital she was admitted to the home. After 100 days of medicare—no problems at that point—however, I was called into the office and told that I had to put down $750, a check of which I have a photostatic copy endorsement and so forth, plus a contribution of $250 a month.

I stated that I couldn't handle that. I was on a pension.

Finally, it was brought down to $100 a month. I kept photostatic copies of everything, transactions of what I signed and what I didn't sign from their point.

My mother died in July.

Senator CHILES. If I might stop you as you are going along here; if you didn't make this contribution what happens?

Mr. GLASSMAN. They sat back in their chair and told me that is the story. You either pay or else, for the medicaid part.

That became medicaid after 100 days of medicare was over with.

Senator CHILES. What was the "or else"?

Mr. GLASSMAN. We don't accept her.

You have to take her out. If she was ambulatory I would have taken her out. She was an invalid at that point.

Senator CHILES. You are saying that you cannot take her out?

Mr. GLASSMAN. No.

Senator CHILES. All right. How long did this go on? How long did this last?

Mr. GLASSMAN. After the medicare stopped May 28 or 29 she thereupon went on medicaid.

From that point on until July 6 at 11:20 that night she died.

I gave them my $750 check plus $100 a month which was brought down from $250 through the good graces of the social service worker in the home there.

And at that time the owner said, "We don't take this kind of money."

I said, "Well, this is what I was told." They finally settled for that amount.

Let me say this now: I asked them to please return my check of $750 which I had written on the face of it that it will be returned intact which they promised me. They made me cross that out and put my initials on that part of it and they took the check at that point.

I wrote on this check, "Will be returned intact," that is the $750 when medicaid pays them their bills. That was the whole crux of it, that they keep my money until medicaid, not medicare, medicaid paid those bills because they were supposed to be very, very slow in paying. That is what I was told.

Senator CHILES. So, originally you were told that they had to have the $750 like a deposit?

Mr. GLASSMAN. Right.

Senator CHILES. And when medicaid started paying they would return that check to you?

Mr. GLASSMAN. He made me cross that out. I had no choice.

Senator CHILES. When did that happen?

Mr. GLASSMAN. The day I gave them the check.

He said, "No, you cross that out and you initial that you are crossing that out."

I had no choice. I had to do that.

He said, "We want $100. We will settle at $100 a month," and I gave them that also.

Senator CHILES. They still told you that they would return the $750?

Mr. GLASSMAN. Verbally.

Senator CHILES. Did they?

Mr. GLASSMAN. No. I have been fighting them ever since and I have been getting a lot of runaround. They tell me that the owner is in Brazil on a medical conference. They tell me to call back at 1:30; 1:30 comes and they tell me, "Don't come down. There is nobody here to see you. Come back today at 2:30."

I threatened to go to Tallahassee and write to the officials and I said, "I am going to do it. I am not going to take no for an answer on this."

They said, "Come down, maybe we could do something for you." I called yesterday and I was told to come back today at 2:30.

Senator CHILES. Today?

Mr. GLASSMAN. Yes; and I told them where I was going. I said that somebody has to stand up and be counted on this thing. This is bad. This is a racket. This is a good racket.

I have everything here, all the evidence. I have their signature, their endorsement on the checks, where it was crossed off. Everything

is here. They even made me sign that I would have to pay $100 a month for 12 months, $1,200. This is a form that they made me sign.

He said, "I'm a lawyer and I know what I am doing." The owner said that.

Senator CHILES. The owner said that he was a lawyer?

Mr. GLASSMAN. That is right.

Senator CHILES. This was not a voluntary contribution?

Mr. GLASSMAN. No; this is good arm twisting.

Senator CHILES. We will take that packet and include that as part of the record. Thank you for your testimony.

Mr. Friedson?

Mr. FRIEDSON. My name is Max Friedson. I am president of the Congress of Senior Citizens.

We have had many, many complaints but they refuse to start. I was ready to go to court with them but they refused to go to court. They were afraid that the people they are paying for in the nursing homes that they would be mistreated. That is probably the reason that it didn't come out before until we got these people down here.

I am only telling you that it is the worst situation that I ever seen and anybody would rather die than to go into the snakepits. That is all they are. There are a few good ones. Most of them are snakepits. And I hope the Federal Government, through your graces and through the Congressmen, should change the whole system around and keep us at least living like human beings and not like we are living in the snakepits.

That is all I could tell you.

Senator CHILES. Well, we thank you for your appearance and I could well understand people not wanting to complain if they think their relatives or their loved ones are going to be taken out. I think that is terrible.

I think that is the worst thing that I could think about that in this country people can't stand up for their rights, and yet it appears it is true.

Mr. FRIEDSON. Very true.

Senator CHILES. But you know as I know that the only way that you reverse that is if you get enough people to stand up for their rights——

Mr. FRIEDSON. That is right. That is right.

Senator CHILES. And then the people on the other side cower and they run into their holes and change their practices.

Mr. FRIEDSON. I will get the people now that I know that gave us their names and addresses and make sure they are also part of this investigation.

Senator CHILES. Great.

I hope that we could get enough of us now that will stand so that we can change this.

I agree that when just a few are trying to do it and no one else is trying to protect them it is very hard to do it.

Mr. FRIEDSON. Thank you, Senator.

Senator CHILES. Yes?

Mrs. BALL. Senator, my name is Leah Ball. My father was at the Royal Glades Nursing Home from May 1974 until the day he died on December 12, 1975.

When he was placed in the nursing home he was placed as a private patient because a patient was not allowed to have more than $600 in the bank at the time.

So, from his funds, which amounted to at the time $2,700, I paid for him monthly. When his funds were down to $500, which was about 3 months later, $650 at the time, I was told that he could go on medicare.

I was to apply at the social service office. I went there. I had to sign a paper which said medicaid would pay, whatever the arrangements are between medicaid, the social security check, and for the State. I was told that I would have to make arrangements with the home before they could make arrangements with me.

I asked what arrangements were, very foolishly, but that is what I was told. But I also said——

Senator CHILES. What are the arrangements?

Mrs. BALL. Well, that comes next.

Senator CHILES. Yes, ma'am.

Mrs. BALL. First I had to sign a paper which said that the amount of money that was going to be paid by medicaid and the social security was to be in full payment for any services to my father.

I then asked what on earth would any additional money be necessary for. I was told that the nursing home business was a very lucrative institution. I went to the nursing home. I was told that I would have to pay $175 a month over and above what medicaid and social security amounted to.

That was the story from August of 1974 until December 1975.

On December 8 I received a letter [1] or December 10 from HRS which inquired how I was approached as to making payments.

I mailed an answer [2] with all the payments I had made and made myself available.

I said, "I am available to give details of the service if you want them. I do appreciate that someone is interested in inquiring. My phone number is available and I am available any other time that you want."

I did not hear from them until I saw the announcement of your hearing in the paper. I think it was last week. That is all I know.

Senator CHILES. So, you got sort of a routine letter from them and you replied to that and you never heard anything else?

Mrs. BALL. Never.

Senator CHILES. When did you reply to HRS?

Mrs. BALL. December 12. Unfortunately my father passed away that night.

Senator CHILES. When these arrangements were made with the nursing home of $175 a month, why did you have to make those arrangements?

Mrs. BALL. Well, one reason was that Royal Glades was the only available Kosher home that exists in the area for us. This was a necessity for us.

Senator CHILES. What if you had not made the arrangements?

Mrs. BALL. Then they wouldn't keep him. Then I would have to take him someplace else.

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[1] See appendix, p. 75.
[2] See appendix, p. 76.

Senator CHILES. Did they tell you that?
Mrs. BALL. Yes. They wouldn't keep him.
Senator CHILES. Was he in Royal Glades at the time?
Mrs. BALL. Yes.
Senator CHILES. He had been in there?
Mrs. BALL. Yes.
Senator CHILES. Through his own payment?
Mrs. BALL. Yes. He was in as a private patient.
Senator CHILES. He exhausted his funds?
Mrs. BALL. Right.
Senator CHILES. Then he was certified for medicaid?
Mrs. BALL. Right. Of course, then the funds were ours, which I didn't mind making except that I knew that it was illegal.

I had signed a paper at the social service office which said that any moneys that we were paying were in complete payment of any services to him.

Senator CHILES. So, your government made you sign a paper?
Mrs. BALL. Yes. I couldn't believe it.
Senator CHILES. That all of your funds were in complete payment?
Mrs. BALL. I could not believe it.
Senator CHILES. Thank you for your appearance today.
Yes.

Mrs. SIMMONS. My name is Gladys Simmons and I am concerned about the nursing home that my mother is in now because they are charging her, first off, $12 a month for laundry that they are not doing. The nursing home is not doing it. They are allowing her to do her own laundry in the bathroom sink at the nursing home.

They have written me one letter telling me that it is my responsibility to get her social security check transferred over. I can't do this because they wouldn't give me any information as to whether, I am assuming she is a medicaid patient, she has no funds other than a disability, survivor's benefit social security check, and she was receiving an SSI check also which is being sent back.

Last week when the SSI check came the woman in the office went in and said to her, "If you don't send this check back you are going to be put out of this nursing home."

My mother said, "My daughter is sending it back," which I am.

I kept on sending the check back.

Senator CHILES. Where do you send the SSI check to?

Mrs. SIMMONS. I sent one back to Birmingham. Then I sent this last one to the local office, 1408 Northwest 76th Street.

Senator CHILES. You think your mother is a medicaid patient now?

Mrs. SIMMONS. I think so, but I cannot find this out.

Senator CHILES. I think maybe if you check with Mrs. Evans she could tell you. Check with Mrs. Evans before you leave. She might be able to help you.

Let her check with you and see if you can straighten it out with her.

Mrs. SIMMONS. The only thing I am concerned is the patient's funds and the $12 a month they are charging for laundry that they are not doing and they are allowing her to do the laundry in the bathroom sink, and I know this could cause quite a problem.

Senator CHILES. We will look into that. Thank you. She's got a problem on the SSI check.

Yes?

Mr. BECKMAN. Good morning, Senator. My name is William B. Beckman and I am here in reference to my wife.

Now, I have heard you speak while sitting here wanting to know of specifics. I don't represent an organization at all, but it seems funny to me, sir, that my wife is under the medicare and medicaid program and she gets a letter from the family service here in Dade County saying that she owes $174 and change after signing forms that she has to sign every time she makes a visit to family service at 1501 Northwest 15th Street.

This seems peculiar to me because the forms she fills out comes under the medicaid and medicare program. I wonder why is she billed for $174 and change?

Senator CHILES. Who is she billed by?

Mr. BECKMAN. She is billed by Family Service. And it is sent to Mr. and Mrs. Beckman and this I don't understand. I don't understand this at all.

I told her yesterday when she showed me the letter I said, "No; this is not right. This is a ripoff of some kind," and it is.

If she is covered by these programs why should she pay cash money to Family Service?

Senator CHILES. I don't know, Mr. Beckman, but we will try to find out something in just a minute that could get you an answer to that question if you will take a seat we will try to find an answer.

Mr. BECKMAN. Thank you.

Senator CHILES. Yes?

Mr. PLISSNER. My name is Harry Plissner. My wife died after 3 years in a nursing home.

I have been an ombudsman and have been appointed by the senior citizens to try to be a liaison between the nursing homes and the county or State authorities.

I am not here to criticize a nursing home at all. I am here to criticize our government, both State and Federal, which amounts to about $20 a day to take care of indigent people in nursing homes.

This same government, especially the county, operates the nursing home and the cost of handling its patients in these county-operated nursing homes is twice what the State allows nursing homes to handle indigent people. They just can't do it.

What is happening is this: This I know from personal experience, that nursing homes which take in medicaid patients, they also take private patients, and they charge private patients as much as nursing homes do that do not take medicaid patients.

The result is that the quality of service in these nursing homes that take medicaid patients is reduced.

Having such a situation facing me in Miami Beach and not being happy with the way this place was run, although I can't speak too harshly of it, I took my wife to a point 25 miles away so I traveled 50 miles almost every day to see her. Those people who elected to put their wives or husbands in the nearby nursing homes at Miami Beach

did so because they had no alternative. They had no means of transportation to go a greater distance to find a better nursing home.

Why doesn't our government know the truth. Why doesn't our government pay these nursing homes that take medicaid patients a realistic sum so that better treatment could come to these people.

Now it is believed that nursing homes who take medicaid patients if they got more money from the government might not improve their services.

Well, in that situation they should be pursued mercilessly from enforcement to keep up to standards.

All that is really needed to improve conditions of indigents in the nursing homes is more personnel.

Now, if we say to the nursing home we will give you more money but we want you to increase your staff, then there would be better service to the persons that they supervise.

Now, it is a fact that they require donations to supplement the money they get from the State, and I think they have no alternative.

While I deplore the practice of coercing people, I know for a fact that there are many people under medicaid who have children, who have relatives who could well afford to help, but they are indifferent.

There are many statements made to nursing homes by relatives to show their incapacity to pay. That is not the truth at all.

I am personally acquainted with such situations.

While I find myself in the rather questionable situation talking for the nursing homes when everybody is so unanimous in condemning them, I know the need for them.

Senator CHILES. I think we all recognize the need and I think we all know there are many nursing homes that should be charged with this brush because they are trying to operate their home in the best manner and I think you make a valid point, I know that you do, that part of the problem is that the charge is not sufficient that is being made, but I think the other point that we have is we have the credibility of the Federal Government and the credibility of all governments that are sort of on trial when you hear a lady that comes up and tells that I have to sign a form with my Federal Government and that is the only payment that is going to be made, and then I have to turn around and make some other payment.

We cannot have that and there is no way in the world we can, but I appreciate your statement and I think it is a valid point and one that should be made in this hearing.

Mr. PLISSNER. I personally can't benefit from anything anymore.

Senator CHILES. Right.

Mr. PLISSNER. But I hope that a realistic view can possibly be placed upon this situation which seems unable to be resolved.

Senator CHILES. Thank you for your statement.

Mr. PLISSNER. Thank you.

Mr. PORRIS. My name is Mitchell Porris.

My mother-in-law is in the home. She has been in the Royal Glades Home for 2 years. Prior to that for 1½ years she was in another home.

And at the time she went in we had her in our home for 2 years and my wife was sick and had a heart attack and she couldn't take care of her.

We went to Royal Glades. I had to put up $600 at once and then $200 monthly. That was a must, otherwise they wouldn't take her into the home.

It was about 4 months after she went in that I was working up until that time when I——

Senator CHILES. She is a medicaid patient?

Mr. PORRIS. Yes. She was a medicaid person when she went in.

Senator CHILES. All right.

Mr. PORRIS. And I didn't work. About 6 months after she went in I didn't work. My wife was sick so we couldn't afford to pay this $200 a month.

I went to the administrator and he said that is a must and we have to do it. I said, "Reduce it some." He reduced it to $150.

And then time went on. I wasn't working. My wife was sick. We couldn't afford to pay that much. But they insisted upon the $150.

I have a letter [1] with me which definitely states—it is quite a large letter if you care to read it. It states, the last paragraph:

> We regret this imposition but we haven't any choice and must ask that you make other arrangements to have Mary Kaufman transferred out from our facility if you are unable to continue your original pledge to our Torah Fund.

The other one says "supplementary," and I was paying close to 2 years for that.

In December of 1974, the latter part of December, they transferred her without our knowledge. Without our knowledge they transferred her to another home.

Senator CHILES. Without your knowledge?

Mr. PORRIS. Without our knowledge.

The other home called us up to say that Mary Kaufman was in their home.

Senator CHILES. If you would give us that and let us copy that letter for the record that will be fine. Thank you very much for your testimony.

I wanted to ask you, the $600 that you put up originally, what were you told that was for?

Mr. PORRIS. They said it takes quite a long time before they get paid from medicaid when she goes into a home, and we would get it back or something would be done about it, but I never received a penny back from that $600.

Senator CHILES. You were told that you would get that back when medicaid started paying?

Mr. PORRIS. Yes.

Senator CHILES. You didn't receive anything back on that?

Mr. PORRIS. I would get credit for it, but I never got any credit for it.

Senator CHILES. Thank you for your statement.

We will take a 5-minute recess and then we will continue as soon as the recess is over and our next witness will be Senator Graham.

[Whereupon, after a short recess the following proceedings continued:]

Senator CHILES. Our next witness will be Senator Robert Graham, chairman of the Florida State Senate Committee on Health and Re-

[1] See appendix, p. 78.

habilitative Services. He is a long-time worker in this field and a person that entered into this area of abuse long before it came to my attention, and we are delighted to have you here, Senator Graham, and to have you share with us your information on this and what you think we could do about it.

TESTIMONY OF HON. ROBERT GRAHAM, A STATE SENATOR, 33D DISTRICT, STATE OF FLORIDA, CHAIRMAN, FLORIDA SENATE COMMITTEE ON HEALTH AND REHABILITATION SERVICES

Senator GRAHAM. Thank you, Senator. I appreciate your coming to our community today to undertake this hearing. The senate committee on health and rehabilitative services in conjunction with house committee did hold hearings beginning last fall through the last winter on a variety of issues relating to the elderly, including nursing homes.

The testimony which was developed then was significant in legislation which was introduced and passed at the last legislative session which I would like to review and also will be valuable in a continuing monitoring and oversight of operations of these programs.

In that regard some of the testimony which you have received today would be very valuable to our committee and its responsibility in terms of monitoring the State agencies which have a responsibility in this area.

Frankly, some of the figures that have been alluded to as to the instances of abuse today are significantly higher than evidence which we received 6 months ago which would indicate that either people today are more willing to come forward with the information or the problem has escalated in its severity or some combination of that.

Senator CHILES. Or maybe a combination of both.

Senator GRAHAM. The fact that you are considering these issues here in Florida and in this community is particularly appropriate as we know Florida has the highest percentage of persons over the age of 65 of any State in the Nation—17½ percent.

By the year 2000, it is projected that 1 in 4 Floridians will be 65 years of age or older.

A significant number of these elderly Floridians are institutionalized in nursing homes—almost 30,000. Of that number half are receiving medicaid assistance.

A majority of Florida's elderly moved to our State after, or shortly prior to retirement.

Senator CHILES. By the year 2000 I hope to be one of those statistics.

Senator GRAHAM. As fortuitous circumstances happens that I will become 65 in the year 2000 and so I share your interests in being those of 1 in 4.

Because of the nature of our elderly population, with a high percentage of persons who came to Florida at or near retirement, they are in a real sense multiple-State residents.

They have an association with the community in which they live, their youth and their middle years and until their retirement.

This cosmopolitanism makes it appropriate that the Federal Government accept a significant role—in partnership with Florida—in

assuring that programs cover the entire range of the needs of elderly persons, while achieving efficiency and effectiveness through productive interaction.

The Florida Legislature in 1976 enacted a comprehensive program addressed to the needs of Florida's elderly.[1] Two objectives of this program were: To enable elderly persons to remain in their homes and communities by providing supporting programs which will encourage full and independent lives, and avoid premature institutionalization, and, to increase the quality of care of the institutionalized elderly.

During the period from October 1975, to February of this year, the Florida Senate Committee on Health and Rehabilitative Services held nine hearings throughout the State on concerns of the elderly.

One reoccurring theme was that many of the 15,000 medicaid-assisted nursing home patients are not institutionalized for a medical reason.

For example, in St. Petersburg, a physician with the State department of health and rehabilitative services stated that 70 percent of the medicaid-assisted nursing home patients in that community could be satisfactorily cared for in their homes or communities, if adequate community facilities and programs were available.

To encourage the provision of these community-based programs, the Community Care for the Elderly Act was proposed and adopted.

This act directs the department of health and rehabilitative service to conduct or to contract for demonstration products in at least three areas of the State to test alternatives to institutionalization for the elderly.

Such projects may include home-delivered service programs, multiservice senior center programs, and family placement programs as needed to assist elderly persons to remain living independently in their own homes and communities rather than be subjected to unnecessary or premature placement in a nursing home or other long-term care facility.

Health maintenance services, homemaking and chore services, and mobile meals services would be available through home-delivered service programs.

Multiservice senior center programs would provide the same services as a home-delivered service program, and in addition, would provide counseling, telephone reassurance, and information and referral services.

Each type of program would add additional services, such as transportation, legal, and employment services, depending on local needs and resources.

Family placement programs would attack the problem of unnecessary institutionalization from a different aspect by providing for placement of an elderly person in the home of a caretaker, who would assist the elderly person in meeting the normal demands of daily living and could be reimbursed for providing such assistance.

An additional aspect of the State provides for the establishment of programs of day care for the elderly as part of a multiservice senior center program, or in a hospital or nursing home.

[1] See Florida State bills S. 578 and H. 3140 in appendix, p. 79.

Such program would provide a protective daytime environment for frail elderly persons who have a regular home, but who might require admission to acute or long-term health care in the absence of such programs.

Day-care programs would provide a sheltered physical environment, at least one meal a day, rest facilities, and social activities.

Agencies desiring to contract with the department of health and rehabilitative services to conduct a community care program may become eligible to do so by providing at least 25 percent of project funding.

Existing community resources and the use of volunteers are to be maximized in operating programs. Additionally, the legislature in the 1976–77 general appropriations act authorized the use of various funds under the medicaid program to pay for services provided by community care programs.

The department of health and rehabilitative services is to evaluate the effectiveness of coordinated programs of community services as a means of delaying or avoiding the placing of elderly citizens in long-term care facilities and report its findings and recommendations to the Florida Legislature.

Even with adequate community programs, some elderly will still require the close medical supervision of an extended-care nursing home.

Although most nursing home administrators have exercised a professional and humane concern for their patients, the continuing abuses within the industry led to the adoption of the Florida Nursing Home Reform Act.

Upon its effectiveness on October 1 of this year, this act will set the framework for the State's regulation of Florida nursing homes.

In the area of greatest concern to the subcommittee—the unconscionable practice of some nursing homes requiring "donations" as a condition of accepting or retaining an elderly relative as a medicaid patient—the Nursing Home Reform Act, contains provisions mandating civil penalties in the form of denial, suspension, or revocation of a nursing home's license for soliciting or receiving contributions which are tied to the admission, maintenance, or treatment of a nursing home patient.

Reinforcing the deterrent of such civil penalties, additional legislation passed during the past session, revised and strengthened Florida law relating to medicaid fraud.

Under this statute, with certain exceptions, contributions made as a condition of admission, or continued care of a medicaid patient, constitute a crime, either a misdemeanor or felony, depending on the amount.

These two laws, taken together, should provide an effective deterrent to the illegal solicitation of contributions and should significantly strengthen the ability of the executive branch in dealing with this problem.

The Nursing Home Reform Act prohibits unfair business practices, provides for a rating system based on quality of care standards and a reimbursement system which in part takes such ratings into account, and serves to safeguard patients' rights.

The rights and welfare of patients who are residents of a facility which voluntarily closes are protected by requiring a 90-day notice of the closing in order to allow adequate time to arrange for transfer.

Transfer of patients who receive assistance under the medicaid program is made a responsibility of the department of health and rehabilitative services.

The department must have a representative in the facility at least 30 days prior to closing and must monitor the transfer of patients to other facilities and to insure that patients' rights are protected.

The act provides that at least one unannounced inspection of each nursing home shall be made annually, and provides penalties for the giving of advance notice of such inspections.

Provisions are made to insure adequate public availability of records and reports of nursing home inspections.

Promulgation of standards for the quality of care in nursing homes is mandated, as well as the establishment of a system of rating nursing homes.

Such ratings, based on inspection results, are to be publicly posted and included in all advertising, and will in part form the basis for levels of State assistance payments for services rendered to patients, with higher rated homes receiving higher levels of payment.

A system of classifying inspection deficiencies is also mandated to allow quick recognition and understanding of the severity of a deficiency.

Adoption by a nursing home of a public statement of the rights of its patients is required. Among other things, the statement must assure each patient: Civil and religious liberties, adequate and appropriate health care, the right to present grievances, the right to manage his or her own financial affairs, privacy, freedom from mental and physical abuse and unnecessary restraints, and the right to be informed of his or her medical condition and proposed treatment.

In order to increase the skill and knowledge of health practitioners in the care and treatment of nursing home patients, the department of education is directed, in cooperation with the department of health and rehabilitative services, to develop appropriate educational programs.

Practical education courses may be conducted in nursing homes which have received high quality ratings and which contract to provide such an educational setting.

I spoke earlier of a State-Federal partnership for the elderly. Some of the elements of that partnership should be:

Encouragement to States to increase the options for elderly and thus to reduce the reliance of institutionalization. Close coordination of health, nutritional, transportation, and social service programs is a key element in providing these options. Greater flexibility in the use and integration of the relevant titles of the Social Security and Older Americans Act would be helpful.

Continued emphasis on health, rather than sickness, for the elderly. In the 1976–77 fiscal year, the Florida Legislature appropriated $2 million of medicaid funds for the purchase of prepaid medical services through health maintenance organizations. Federal encouragement

could increase Florida's effort and cause other States to institute programs directed at health maintenance. The maintenance of high standards of care within nursing homes. The vulnerability of nursing home patients is illustrated by the tragic deaths last week of five elderly persons in Boynton Beach, Fla.

Continued Federal interest in and support for adequate and efficient enforcement of standards, and the training of current and potential nursing home employees is required.

It has been said that the test of any society is how it treats its old and its young. With an effective partnership in our Nation and this State, we can discharge that obligation with respect, humanity and love. Thank you.

Senator CHILES. Thank you, Senator Graham, very much for your very comprehensive statement and very much for the work that you have done in this field.

I am delighted to see that Florida has passed the reform act that you referred to here.

I know that you concur with me that it would be much better to have and to allow the State government to administer a program like medicare, because then the State government could fit it into the other programs that they are trying to adopt, as we have here, and could have some flexibility knowing that Florida's problems are perhaps completely different from Maine or some other State, and if we have a Federal system we will have some kind of rigid enforcement or regulations with no flexibility and that would be the worst thing that we could have happen.

From our standpoint and I am sure, of course, you know how the Federal system works where there is a vacuum and where the States are failing to enforce or be accountable for a program then moving into that vacuum is always a provision to have the Federal enforcement and to take away the State's flexibility and that certainly could happen here and will happen here unless we could show that it is going to be enforced by the States and there is going to be a proper program enforced by the States.

Senator GRAHAM. Yes, Senator, I would agree with both of your observations.

First, that the State is the more appropriate level to respond to the diversity of the needs of the elderly.

There is a great temptation when homes such as nursing homes is taken on at a national level and to isolate it from the mainstream. As I indicated the position of the State of Florida is to try to diminish our reliance on nursing homes by using them as the place of last resort and increasing community services that will be available to allow persons to continue to live in their homes.

But, I also recognize that there is that inevitable and proper feeling that if one level of government fails to discharge its responsibility rather than have the patient or the family bear the burden of that failure, that another level of government will step in and assume it.

And the burden is definitely on our State and other States to see that effective laws are passed and then that those laws are properly implemented.

I think that in terms of legislative action that we now have in Florida a statutory framework that will give the legal authority to act in case of these abuses.

Our further legislative responsibility is to assure that there is an adequate level of support for nursing homes, so that they are not driven to attempt to avoid the law out of financial necessity.

And second, that there are adequate enforcement staffs in the appropriate State agency to see that the laws are properly monitored.

It is then the responsibility of the executive branch to see that with those resources that the laws are enforced aggressively for the benefit of the patients.

Senator CHILES. I think that probably in medicaid we probably have an area where the Federal Government is allowed more flexibility than almost any of the Federal programs.

I think that is very properly so and I hope we could keep it that way.

Florida many times is sort of the point in many of these programs that deal, whether it be home health care or abuses there or whether it be abuses in the nursing home because of the fact that we do have so many elderly it seems many of these problems turn up here before they turn up somewhere else.

But if they are going to occur here then they are going to occur in other States, too.

Is it your committee or through the different compacts that we have, is there any system that we are setting up now within the States of which they can be aware of the problems that we are beginning to experience here and we could be aware of whether they are having similar problems and of what they are doing to enforce those problems.

I would hate to see Florida correct the problems here and get dragged down because other States fail.

Senator GRAHAM. Senator, I can't answer that question effectively.

In certain areas the States have developed an effective interstate compact to share information and ideas. This has been particularly true in education.

Senator CHILES. Yes.

Senator GRAHAM. I am not aware that a similar multi-State relationship has existed in social service programs and specifically programs for the elderly.

Your suggestion is a good one and causes me to want to contact some of the appropriate agencies such as the Council of State Governments to see if they would undertake the establishment of networks and information so that what we have learned here in Florida can be made available to other States and we can be the beneficiary of other States' experiences.

We certainly want to avoid either the alternative of having to go to a fully federalized system in order to have some nationwide experience and standards.

On the other hand, we want to avoid each State to reinvent the wheel, as it were, through its own experiences with these abuses.

Senator CHILES. I think you also put your finger on a need to see that we have adequate staffing for enforcement, investigation enforcement.

It is pretty clear to me from the testimony that we have had this morning that we don't have that right now.

If a nursing home feels like, well, chances are they are never going to get around to me, then perhaps the abuse is going to continue.

On the other hand, if they know we do mean what we say, that now we have the new act and it is going to be enforced then they are going to start policing themselves and that is going to help solve the problem.

I am trying to find out just what the magic share is. It seems to me to be 50–50.

Senator GRAHAM. No. Last year in 1975–76 it was 57 percent Federal and 43 percent State across the board in medicaid programs.

I can't tell you exactly if that was the same percentage that applied to nursing home reimbursement but it is substantially that.

Senator CHILES. Well, I want to join with you in trying to see that we have sufficient staff for investigation and for enforcing the law and any way that I could help you in that regard from the Federal level I want to do that because I think that is very necessary and I think we have got to have our people know that if they come forward we are going to do something about it and they will be protected and their loved ones and relatives will be protected and no abuse would be carried out on them.

I wonder if you would look at the new statute that you have written and determine whether you think we need to put something in that statute that would specifically say, if a nursing home tries to penalize a patient where there has been information of a complaint made, that this would be a specific ground for losing their certification or for whatever other penalties we want to set forth.

Make that very clear because it seems to me some protection is really necessary here and that we have got to assure people they are going to be protected.

Senator GRAHAM. I would agree with that, Senator, and that was one of the reasons which led to the establishment 2 years ago of an ombudsman committee in each of the 11 regions of the State for nursing home abuses.

Those committees are relatively new in their establishment and organization, but they are composed of citizens in the community and are designed to be the place where patients and their families can go with allegations of complaint knowing that their allegation will be treated in a confidential manner, but in an aggressive advocate way on their behalf.

When we have had a somewhat greater experience with this system it might be one that you would like to look at to see how effective that use of a citizens' intermediary ombudsman agency is in terms of breaking down the barriers of resistance of patients to bring these concerns to the proper party's attention.

Your suggestion of strengthening that further by strong penalties where patients are intimidated is a good one and will be noted.

Senator CHILES. Mr. Doug Whitney with HRS is in charge of carrying out this investigation. He informed us they are getting ready to send a letter to all of the, if not the recipients, the people that have signed up for the recipients that put them in for medicaid informing them of their rights under the program, that they do not have to pay

additional funds and included in the letter is the fact that they can come forward and provide information.

It might well be also, Mr. Whitney, if we could put in that letter a provision informing them there are these ombudsman groups in their area that they could come forward to, that is another way they could be assured of getting this information out.

Thank you very, very much for your testimony. It was very helpful.

Senator GRAHAM. Thank you.

Senator CHILES. Our next witness will be Harry Schneider, the administrator of Miami North Shore Nursing Home.

Mr. SCHNEIDER. Thank you.

[Whereupon, Harry Schneider was duly sworn by Senator Chiles and testified as follows:]

TESTIMONY OF HARRY SCHNEIDER, ADMINISTRATOR OF NORTH SHORE NURSING HOME

Mr. SCHNEIDER. Thank you, Senator, for inviting me. Thank you, Bob Harris.

My name is Harry Schneider. I am the administrator of the North Shore Nursing Home.

We have heard some remarks here today which somewhat were adverse in connection with the nursing homes and we had one individual who was the opposite way. He thought nursing homes were not getting a fair share.

Now, I have several observations to make here, Senator. All nursing home operators want to provide the best possible care to their residents.

However, this takes dollars. The State regulations specify the minimum staffing and other requirements which if the nursing homes do not meet them are considered deficiencies.

The monthly allowance to nursing homes for medicare is fixed and does not take into consideration any grounds of inflationary costs, increases in supplies, services, and salaries.

As I see it from the above on the one hand the nursing homes are forced to operate under a fixed income and actually on the other hand the nursing homes are told by the powers that be, "I dare you to."

The subject of donations is humiliating and demeaning to me.

The basis for an admission to a nursing home should never be a donation. And if it is in effect and you want it to be eliminated, the only way to do that, in my opinion, is for the powers that be to produce sufficient funds so that nursing homes can operate with a fair return.

It is also to be understood that our nursing homes are not tax exempt. There is an awful lot of money that was invested.

If one would invest a million dollars in an enterprise he would expect a fair return. Why not the same fair return for nursing homes?

In actuality a nursing home is a business. It has to pay salaries, taxes, et cetera, and it must have a fair rate of return, fair rate of income in order to result in a fair rate of return.

When steel prices go up car manufacturers raise the cost of their cars.

When inflation hits our costs go up and our nursing home costs go up. Why shouldn't nursing homes renegotiate to cover the increase.

I know that the government, at all levels, talks about our senior citizens. We have to take care of them, et cetera, et cetera, et cetera. It is rhetoric. But without the correct amount of funds it will always remain rhetoric. That is the extent of my statement.

Oh, yes, one more thing, sir. In this State a nursing home is paid $630 a month for a skilled resident. That equals to the magnificent sum of only $21 a day. If a patient is classified as intermediate, it is $560 a month with a daily rate of $18.66.

And the lowest level on our intermediate care is $500 a month which is a daily rate of $16.66. Now, we have physicians. We have registered nurses. We have LPN's. We have aides and orderlies, the dietary department.

We have everything that a hospital has. Yet, I repeat, we have everything that a hospital has to offer yet when I go to a hospital I pay $90 a day or $100 a day.

I see my RN four times a day when she comes in for the dispensation of my, whatever medicine my doctor has ordered. However, in a nursing home our residents are continually under care. They are old. They cannot walk. We help them to walk. They are incontinent. We have to service them all day, all afternoon and all night. We feed them. We entertain them. We bring in outsiders, volunteers and some of our own staff to give them games and keep them as happy as we can depending on the mental capacity.

But nursing homes work 24 hours a day. The staff is on the floor all the time and I am bringing this forward to compare nursing home care versus hospital care.

Imagine $630 a month, which is only $21 a day, but most of the nursing home patients that I have are $560 at the rate of $18.66 a day, and if that same individual gets sick enough to go to a hospital medicare will pay whatever the hospital rate is, $80, $90, $100 a day and the government says nothing.

Why doesn't the government think a little more about nursing homes in this regard?

Senator CHILES. I think the point that you made is, as I said earlier, there is not sufficient funds for the daily care and there needs to be a better way of gaging, that against what costs are is very valid.

Mr. SCHNEIDER. That is right, Senator.

Senator CHILES. Agreeing with that, I think we still have a problem here and when we require someone that is putting a relative into a nursing home and the Federal Government requires them to sign that form, this is the only payment that is going to be made and your nursing home, as I understand it, all of them are not required to take medicaid patients. You could elect not to take any medicaid patients.

When you sign up under the program you do so of your own free will as a private institution. If you are going to sign up under that program then I think you have to be signing up to agree to follow the rules and regulations of that program and follow the law and the law says that there won't be any contributions required or made for the thing, and we have to have that or we don't have any credibility for the government.

If it reaches the point where enough homes say, "We are not going to sign up, we can't," then perhaps that is the way of forcing us, the Federal Government, to do something about that.

I wonder if you would tell me: Do you or have you required a donation in order for a patient to remain at North Shore Nursing Home?

Mr. SCHNEIDER. The answer to your inquiry is negative. I have never insisted that I receive an advance donation or whatever other semantic word somebody wants to use for a basis for admission to my nursing home.

What I do is this—well, anyway, most of the residents of my home are retired, fathers and mothers who have sons and daughters who are barely eking out a living on their own. So, I do not insist. I do not ask. I do not make it a basis for admission that you give me or else.

"Else" meaning you cannot come in. My nursing home is not affiliated with medicare. We are strictly medicaid and also private, and I have never done it and I never will do it.

And, sir, if we want to do away with the so-called donations then the answer is the nursing homes must be furnished additional funds. That is the key.

Senator CHILES. Our next witness will be Mr. Arthur Harris, the president of the Florida Nursing Home Association.

TESTIMONY OF ARTHUR HARRIS, MINISTER OF FLORIDA MANOR NURSING HOME, ORLANDO, FLA.

Mr. HARRIS. My name, Senator, is Arthur Harris. I am the minister of the Florida Manor Nursing Home in Orlando. It is owned and operated by the Catholic Diocese of Orlando.

I also am president of the Florida Nursing Home Association, and for the past 6 years have been the liaison between the nursing homes in Florida and the State agency that handles the medicaid program.

I have been to every meeting that they have had in the last 6½ years regarding the funds, the amount that has been requested from the State legislature and the other programs.

I also have, for the last 5 years, been a member of the Medicaid Advisory Committee to the State of Florida.

It's now been reorganized as a medicaid subcouncil. So, I have sat with all the people that have made all the decisions in the last 5 years regarding medicaid.

I, too, have been to all the meetings that Senator Graham held and we are very appreciative of his bill this year that set up alternatives in January of 1975 and I have enclosed it in your packet here.

We recommended all the things that you did include in his bill in 1976.

The medicaid program in Florida has been in trouble from the time it started in 1970. We have had a divided responsibility: The health department setting rules as to staffing, facilities, et cetera and the division of family services setting the rate of pay and doing the utilization reviews.

It has been difficult in some facilities for the health department to enforce its rules as strictly as they would like because of the very low payments that the Florida Governors and the legislators have provided on the advice of people in the division of family services who had little or no knowledge of health care or business knowledge to recognize costs and cost changes as they occur.

In 1969 the Aetna Insurance Co., the largest medicare intermediary for nursing homes in Florida, stated the average cost of care was $17 per day, not including medicines or ancillary services. This amounts to over $500 per month.

The Florida Division of Family Services chose to ignore these audited figures and recommended to the State the payment of $300 per month plus up to $20 per month for prescription medicines and completely ignored the ancillary services.

Up to that time we were getting $120 per month from the State, most counties were adding to that and besides we were collecting from the families. Most of us were getting far in excess of the $300 per patient per month.

Following closely after the start of medicaid the State department of health issued more stringent rules on staffing, buildings, et cetera. Most of the requirements were well above anything medicare was requiring at that time.

We felt the rules were needed and were fair but funds were not sufficient to pay for the old rules, much less the added rules.

When we complained to the health department they stated their responsibility was patient care and they had nothing to do with payments.

When we complained to the division of family services they stated they had nothing to do with the rules and were pledged to hold down costs and would not pay for any changes.

It became apparent that the only nursing homes that could survive were those having some type of supplementation to make up the deficit caused by the inadequate payments—such as county and church affiliated.

Because of the extreme hardship on other facilities we met with the division of family services staff in late 1970 and told them we could not carry the load alone.

On December 2, 1971, the division of family services issued a policy allowing contributions to all nursing homes on a regular basis as long as the donor filled out a form stating his intentions.

It was the statement of the division of family services staff at that meeting that this policy was to give the nursing homes a method to get funds to care for all the patients and not for the care of any particular patient.

The extra money was to come from whomever we could get it and at that time it was agreed that we could even send the contributors a reminder, if needed.

Because of the gap which the State had set, payments continued to be far too low for some areas. In the lower east coast and some other high cost areas, this practice has had to continue and today is needed all over the State because of the events over the past 9 months, brought about by the department of health and rehabilitative services.

The names of the agencies have changed but the advice is still coming from the same people for the most part as it did in 1969.

We will now go to the present problem.

In October 1972 the U.S. Congress passed Public Law 92-603 which, among other things, required the classification of patients to be the same under medicaid as medicare.

As low as Florida reimbursement was for skilled care, it was $100 per month lower for intermediate care. To accommodate this low reimbursement, $200 per month to start, the type of patient in this category required very little care. The department of health developed staffing rules very low in an effort to match the staff to the care required.

When the above-mentioned law was passed, we met with the department of health and Glenn Collins, then chief of the bureau of medical facilities. We agreed that we could not care for the patients who would be reclassified to intermediate care with this very small staff.

Dr. Collins suggested that we have three levels of care and develop staffing for a level between our former skilled and intermediate.

In early 1973, we met with the division of family services and asked that they develop three levels of care so proper planning could be done by both departments, and the three levels instituted by the time required by Health, Education and Welfare.

Three levels of care criteria were developed by division of family services in 1974 but never issued and never to the health department.

In November 1975 we heard a rumor that new rules for skilled and intermediate classification had been developed and would go into effect November 25, 1975.

All the laws in Federal, State and everything said that before these regulations were promulgated they should be given public hearings and should be consulted with the other agency and the other people involved. They were not.

We contacted the health department and learned that the new rules had not been coordinated with them. They stated we could not take care of reclassified patients with our intermediate care staff if they did not meet the old intermediate qualifications but would have to continue their care with our skilled staff.

When we contacted the division of family services we were told not to worry, that the new rules would not change any of our patients from skilled to intermediate, but would most likely change some of the intermediate to skilled.

We asked for a copy of the new rules. Using these rules we checked patients in three facilities and our findings showed that again division of family services knew nothing about the subject. Our study showed that about 70 percent of our patients would be classified intermediate and 30 percent would be classified skilled.

This would be a change of approximately 60 percent from skilled to intermediate care. Since that time the State has changed its mind regarding the number to be reclassified.

On the 24th of November 1975, we met with the department of health and rehabilitative services officials in Tallahassee. We asked them to put off the date of the new rules and give time for proper planning for three levels of care.

Even though most States in the country did postpone new rules, the department of health and rehabilitative services officials felt they could not.

Up until this time if a patient was changed from skilled to intermediate care and no intermediate care facility beds were available, the State continued to pay for the care at the skilled rate until a bed became available.

New rules were instituted in January 1976 that would only allow the skilled rate to be paid for 1 month, after which, even though the patient could not be moved, the rate would be $100 per month less.

The department of health and rehabilitative services staff had told Secretary Page that only approximately 500 patients would be involved and they were mainly in the Duval County area.

I think you will find there is over 4,000 involved instead of the 500 figure.

We had several meetings in late December 1975 with the Lieutenant Governor, Secretary Page and his staff. It was decided to develop three levels of care. The secretary stated the State was in a deficit position as far as medicaid funds were concerned and help was needed.

The three levels of care were developed and rules for staffing for the middle level were written. We told the secretary that we would try to take care of the three levels for $630 for skilled care, $570 for intermediate care No. 1 and $500 for intermediate care No. 2.

In February 1976 rules for three levels of care were signed but there were still provisions for only two levels of payment—$600 for skilled and $500 for both levels of intermediate care.

Many excuses were given but not until the middle of April 1976 did we start receiving payment for the three levels and then they were $630 for skilled, $560 for intermediate care No. 1 and $500 for intermediate care No. 2.

We had furnished the secretary with statistics showing that the cost of care in the State was above $650 on an average and over $700 per month in the lower east coast area.

This was disregarded and the department of health and rehabilitative services and the Governor, on their advice, recommended the legislature provide funds for payments with a cap of $630 for skilled care, $560 for intermediate care No. 1 and $500 for intermediate care No. 2.

To prove we were wrong, the department of health and rehabilitative services started a management study of 30 nursing homes. Excerpts from this survey were read by Secretary Page at a committee hearing in the Florida House of Representatives during the past session while they were deliberating the budget.

He stated that his survey showed the cost of care was only $538 per month on an average in the State.

The sample survey was of homes that were, on the average, smaller and older than the average nursing home in Florida. At least two of the facilities had been fined or threatened with fines because of low staffing, unsanitary conditions and other problems.

The average costs Secretary Page discussed in May of 1976 were costs that occurred in October of 1974. He intimated to the representatives and the press that they were present day costs.

His survey was so inaccurate that it states the cost of care in the metropolitan areas, such as Miami, was only $515 per month while in the rest of the State the costs proved to be $586 per month.

Any high school graduate, let alone an educated accountant, should be able to tell you that the reverse is true and that the cost is about $80 per month higher in the lower east coast than elsewhere in the State.

Needless to say, the legislature did not raise the payments as we had requested in the face of the information given them by the secretary.

Another part of Public Law 92–603—section 249—indicates that the State shall pay nursing homes on a cost-related basis by July 1, 1976. The Secretary of Health, Education, and Welfare has defined cost related as providing payments for care that allows a facility to meet its obligations for care for the patients and meet all rules and regulations of the State and Health, Education, and Welfare.

Our State has chosen to ignore this law and Health, Education, and Welfare regulations. Our payments of $630, $560 and $500 are not a percentage of average cost of care nor are they related to cost in any other way. They set this up as a prospective rate but ignore Health, Education, and Welfare regulations that State prospective rates must include besides inflation increase, the special increases such as Federal minimum wage increase and increases in rules and regulations.

At the present time most of the nursing homes in Florida are being paid below cost for medicaid patients. The method the State uses to pay for this care does not even follow the intent of the legislature.

We have mentioned before the contribution program and how and why it was started. We are astounded by the hypocracy of the State agency in this matter. They feel it is great for us to charge our private patients $100 more a month to make up for the below cost payment for medicaid but are now shocked if we ask for a contribution from a family of a welfare patient who, in many cases, can well afford the total cost of care. We recommended to department of health and rehabilitative services a children's responsibility act to help pay the cost but again we were ignored.

When a private patient requests admission to a nursing home and has only $700 or $800 per month which he can pay and we have to tell him our rate is $800 or $900 because we must make our private patients contribute to the care of the welfare patients, we are actually denying them the care because they are $100 short.

When I know a family of a welfare patient can dig up extra money, I would far rather ask them for some help than deny care to the other patient because he cannot pay his own way and part of a welfare patient's way too.

Part of the blame must lay with the U.S. Congress. They passed laws making certain requirements in medicaid, minimum wages, unemployment, ANSI, OSHA and many others and required the States to enforce them against the nursing homes but they did not require the States to pay for the increased cost.

Each law that Congress passes should be thoroughly costed out and any increase in cost should be accompanied by an equal increase in the Federal share of the cost of the medicaid program to the States.

We have been changed by law from a form of retirement home to a health care facility with only extra payments for some inflationary costs and none for the extra requirements for the health care.

It is time that everyone should quit blaming the nursing homes for the inadequacies of our governments, both State and Federal.

Senator CHILES. Thank you, Mr. Harris, for a fine statement.

I wonder if you could help me summarize it so I could ask you some questions.

Mr. HARRIS. I will be glad to.

The problem is so,——— complex, and I have been so close to it for the last 6 years and probably had the frustration of seeing what the costs were and seeing what had been recommended by people who did not have qualifications even to see what they were reading or what they have and this is the problem we get into.

The contribution program that we have right now was developed by the State of Florida with the full knowledge of the State. We even mentioned to the legislature that it was being done. Everybody knew it was being done because the State, as they said, didn't have the funds to pay for the full part of the program.

Senator CHILES. That is not the contribution program that we have heard from some of the witnesses——

Mr. HARRIS. Yes.

Senator CHILES [continuing]. Today as somebody was told, you either pay $600 at the front end and you pay so much a month or we are not going to let your loved one in here, or, even though they are here and they have been here and are under medicare, we are going to ship them out if you don't make this. That is not exactly a voluntary contribution.

Mr. HARRIS. No. I don't agree with part of the things that people have testified to here today.

However, we are forced to say the same thing to our private patients. The government forces us to tell the private patients that unless they can make the $100 contribution to the care of the welfare patient they can't come into our nursing home.

They condone that. I could raise my prices to the private patient $100 a month. If they don't have that $100 a month they can't come in my nursing home, but it's not right if I could tell a family who got the money, and believe me a lot of them got it, that I can't ask them for that same $100. That is not right because a lot of people are denied care in this State today because they don't have—they have too much money for medicare, but they don't have enough to pay for their own care, but because we have to make them contribute to the welfare program they can't afford to get into the nursing home.

They are the biggest majority of people.

Senator CHILES. Well, I am sure there are a lot of problems with medicaid, and there always is when you set up some program like medicaid, and there are always going to be those borderline kind of problems, but as we were saying earlier, a nursing home is not required to take that medicaid person, and if we are going to have any kind of respect for the law or the regulations on it, I think that we have to require that there be some kind of enforcement and there be some kind of honoring of that law.

And if a person is required to sign that slip, as the lady said today——

Mr. HARRIS. They are not required to sign the Federal slip. She is mistaken.

Senator CHILES. I want to check into that.

Mrs. BALL. It was the State.

Mr. HARRIS. It was a State form.

Senator CHILES. That is a requirement of the Federal law, that the State has to set up those rules and regulations so it is the same thing.

Many people equate their government, regardless of whether it is the State or the Federal Government, it is their government.

Mr. HARRIS. One of the problems gets to be, when you say that they don't have to take the patients, before we had medicaid we didn't have near as many of these problems, but when they had medicaid, about 50 percent of the private patients at that time ran and got medicaid for their families.

Yes, we do have medicaid problems.

Now, what we were told when we first started this we were told, "Look, this is a bare-bones program."

I think in the letter written to you in 1971 by Mr. Ingsley, who was then head of the division of family services, he told you that the problem was payment and the problem was that the legislature was not furnishing the funds and it was a bare bones.

They promised us it wouldn't be bare bones if we bear with them for a year or a year and a half.

Now half of our patients are medicaid, so what you are saying is, OK, refuse to take medicaid patients. This is what you said a while ago.

Many nursing homes did that last year. They were threatened. The secretary made many statements to the newspapers about these nursing homes.

They were threatened with lawsuits and everything by the State because they wouldn't accept any more medicaid patients. This just don't work. Whatever happens we always wind up as the bad guy.

Senator CHILES. Has the association taken any actions either by resolution or investigation involving the involuntary donation scheme?

Mr. HARRIS. We have written letters to all of our association members asking that they not. There is no way that I could tell a nursing home who is all welfare and they happen to be in the Miami area with a $700-a-month cost and they are getting $630 a month and say, "Look, you shouldn't do this kind of thing down here."

Of course, the other thing we have to remember is that a lot of times people go into a nursing home and offer—I have seen this happen in our facilities—many nursing homes don't take intermediate ones, and they will come over to me, to our facility, and ask me to take in that patient. We don't take intermediate ones. We take skilled and we keep them through various levels.

Well, they say, "Let us give you a donation and you take my mother in so, you know, that you could pay your staff." Many times this happens to get the patient into the nursing home and then they forget they offered to make this donation a little bit later.

That happens as often as not, too.

You know, you sit in Washington and pass laws that say that a nursing home must do certain things on staffing and you must have a medical director and you must have all these things. You must pay more than the minimum wage.

We started out in 1967 with a 75-cent-an-hour minimum wage. Now it is $2.30 an hour. This was a law from the Federal Government that required this.

We have a law that says that we have to pass the ancillary regulations.

You didn't put out the law saying that the nursing homes have to. You said all public buildings have to approve the ancillary regulations.

The only place they enforced it was in the nursing homes. I don't know why. They didn't tell the hospital that they had to do it. They didn't tell the banks or the courthouses or anything. They went to the nursing homes and said you are not in compliance because you didn't pass the ancillary regulations.

Now, you pass all these laws requiring the States to enforce these laws against the nursing homes, but you never make a law saying that the nursing home has to be paid for all these changes that they are doing. This is the problem that we run into.

Now, what we need on a Federal level is when you pass a law, cost that law out and the cost that it is going to be to the States, raise their share. We had 57 percent last year. Raise it 2 percent and make up the law that the Federal Government think that the State should pass.

The State cannot afford to keep this going. We recommended it to the State this past year but they had the children's responsibility on it. Georgia is moving toward this direction and we asked that the State of Florida do this also.

So that when the patient's family has the funds they could pass some of it to the State so that the State will not have such a burden to carry. This was ignored by the department of health and rehabilitative services. They didn't recommend it to the legislature at all.

It didn't get on the calendar and it was not passed this year at all. There has to be something done about it.

I have a packet that I will leave with you that has all the various things that we tried to do, and the testimony that was given through the years and the recommendations to improve care, recommendations for alternative care and alternative methods of caring for these people and everything is here and I will leave that with you so that you could see that the nursing home association in Florida has tried to work it out.

One thing, nationwide 4.5 percent of the people over 65 are in nursing homes. In Florida only 2 percent are in nursing homes so Florida must be doing something right. We do need to upgrade some of our nursing homes, but we need your help in doing as much as we can.

You passed a law also, 92–603, stating that the States must pay on a cost-related basis.

The Secretary of HEW has just ruled, in a new regulation, that by July 1 "cost-related basis" shall be standard payment to the nursing home to pay for the cost it takes to care for the patients plus any new costs that arise during that year from Federal laws that come in and to allow them to remain certified.

Our State ignored this. We don't have this in Florida.

I have a copy of what they sent to HEW stating that we are a cost-related State. The $630 a month is not related to any costs. The $560 is not related to any costs in any nursing home whatsoever, anyplace and they can't prove it.

So, you pass a law and the State ignores it and then we catch hell for it, and this is something that someplace, somewhere along the line, people are going to have to stop blaming the nursing home.

Senator CHILES. I thank you for your testimony. It has been helpful to us. You have made your case very well in telling us what the shortcomings are, the way that you sit, and the way that you see it and I am sure many of those are valid.

I think we still have a situation here in which the association ought to be taking some leadership and setting forth some guidelines as to what is a voluntary contribution, if that is something that the State agreed to and clearly what it is not, and making it clear that the association is opposed to that because it seems to me there has to be some way of differentiating or setting a standard for those nursing homes that want it here and want to carry out the standards regardless of whether it is abusive or not because it is a business that, like many businesses, we could elect to get in and out of or elect to take the patient or not. But, it seems to me if the association is going to be providing any kind of leadership it ought to be planting that standard that if you want to be the good guys you are going to do this and you are not going to carry out certain practices, and if you all fail to do that you are not living up to the provisions.

Mr. HARRIS. We have a very good peer committee that does get into this type of situation. Our problem is getting reports from the State when this happens. We asked the secretary and each one of the division heads to give us any complaint that he had about any nursing home.

I realize they are supposed to go in there and investigate unannounced, but we are talking about immediately after they go to their unannounced inspection so that our peer review can go in.

Unfortunately, it is almost impossible to get any information from this State agency so that our peer review can actually work on this and this is something that we really do need help in.

Senator CHILES. It seems to me that Senator Graham has told us this morning about these ombudsmen groups and you could tie into those.

Mr. HARRIS. We backed that legislation. We think that this will help. They will not get a lot of complaints. People will still mail them into the State, but we will be working on that particular thing with the ombudsmen committee.

We do have a member on each one of the ombudsmen committees so we will have that liaison on that. I think it is a seven-man committee.

Senator CHILES. Thank you.

Our next witnesses will be a panel of administrators from the following nursing homes, the Greynolds Park Manor, the Arch Creek Nursing and Convalescent Home, and the North Miami Convalescent Home. If you will all come up, please.

[Whereupon, Senator Chiles swore in Joseph Spanelli and James Reiss.]

TESTIMONY OF JOSEPH SPANELLI, PRESIDENT, LOCAL NURSING HOME ASSOCIATION, DADE COUNTY AND ADMINISTRATOR OF NORTH MIAMI CONVALESCENT HOME; AND JAMES REISS, ADMINISTRATOR OF ARCH CREEK NURSING AND CONVALESCENT HOME, AND THE NORTH MIAMI CONVALESCENT HOME

Mr. SPANELLI. My name is Joseph Spanelli. I am president of the Local Nursing Home Association here in Dade County and administrator of the North Miami Convalescent Home in North Miami, Fla.

I think whatever had to be said was said very eloquently by our State president, Dr. Harris, Arthur Harris.

It seems perfectly clear that this problem of donations is not the donations per se, but the method in which the donation is generated, and we hope that we can contact our various members of our association and tell them if they are going to solicit donations it is not a condition for admission or a condition for continued stay.

This is the advice that we give to the members of our association.

We hope they heed the advice and follow the instructions.

As Arthur Harris indicated we do have a very effective peer review committee, not only on the State level but district level and we try to keep abreast of what the problems are and look for possible solutions.

If donations in fact are a violation then Dade County is probably guilty of—guilty as to all parties. Dade County owns and operates two nursing homes, two very nice ones here, Human Resources, which was Live Oaks Nursing Home and also one in the south end of town which is Lutheran Medical Center.

Their average cost per day per patient is in excess of $30 a day. They are being reimbursed by the State approximately $20 a day which means that the taxpayers of this county of Dade have to make contributions to these facilities in order for them to continue operating in the fashion in which they are.

So, again I go back to the original statement that donations per se are not a violation, but it is the method in which the donation is generated.

Senator CHILES. What you are saying is that you try to determine or try to provide through your association that those donations are not made as a condition for admission or a condition for keeping a patient.

Mr. SPANELLI. For continued stay, yes.

Senator CHILES. Does your association or have you ever taken any action against any home that violates that provision, sanctions or expulsion or anything else?

In other words, if your association is going to have some value and some merit, for someone to stay, who is either a member of your association or not, how does the general public get some credibility of knowing that if they are going to a home that is a member of the association that there is going to be some protection or some credibility to it?

Mr. SPANELLI. To begin with, the only homes that we have any jurisdiction over are those homes that belong to the association.

When it comes to the attention of any member then it is his responsibility to report it to the State association who in turn con-

tacts the director of the peer review committee who in turn contacts the member's home and requests that he or she permit the peer review committee to come in and investigate.

It is the prerogative of that home to say "yes" or "no."

Senator CHILES. If they say no, are they still members of the association?

Mr. SPANELLI. No. Then the association has the authority to move forward and remove them from the association as a member. That is about all they could do.

Senator CHILES. Has that action ever been taken to your knowledge?

Mr. SPANELLI. To my knowledge, no, but I would have to turn to Art Harris and ask if on a State level if it's been done.

Mr. HARRIS. Yes, on two nursing homes, but not contributions per se. It is the whole operation as a whole.

Senator CHILES. For the whole operation?

Mr. HARRIS. Yes.

Senator CHILES. In your particular nursing home, the North Miami Convalescent Home, do you require a donation as a prerequisite to admission or for a patient to be able to remain there?

Mr. SPANELLI. No. We don't require it, but we do accept it. This reflects back to the Federal regulations and guidelines. It is possible for a person to have $1 million, assets of $1 million, today, give those assets to a son or a daughter tomorrow and the following day be eligible for medicaid benefits.

This, in essence, is an injustice in that you are expecting the nursing home now to take care of a patient that it costs far below what their actual costs are and yet the funds they did have were turned over to a relative or someone else and in these cases I think that the nursing home is justified to a degree in requesting the donation from this family.

Senator CHILES. All right, sir.

Mr. REISS. My name is James Reiss. I am the administrator of the Arch Creek Nursing and Convalescent Home, North Miami Beach, Fla.

I didn't prepare any statement for two reasons. I was a little confused as to the subject matter of this proceeding and second, I felt that anything I could say would be redundant to what Mr. Harris said.

I will be happy to answer any questions for you at this time that you may have.

Senator CHILES. Can you tell me whether the Arch Creek Nursing and Convalescent Home requires a donation as a prerequisite to admission or for a patient remaining in the home?

Mr. REISS. No, sir, they do not.

Senator CHILES. A medicaid patient?

Mr. REISS. No.

Senator CHILES. What is the practice or procedure of the Arch Creek Nursing Home with regard to accepting of donations?

Mr. REISS. Around the beginning of the year, the end of December of 1975 or the beginning of January of 1976, I remember speaking to one family regarding donations and I made it very clear at the time that it was not a prerequisite.

I spoke to approximately 40 families. Two of them told me, they said that they could make the contribution.

Of the 40 that I spoke to the others obviously said that they could not. They are all still in the nursing home. There was no pressure exerted.

The two donations that I got are $25 each per month.

Senator CHILES. What percentage of your home is medicaid patients?

Mr. REISS. Approximately 40 to 50 percent.

Senator CHILES. And the others are private?

Mr. REISS. Private.

Senator CHILES. Or medicare too?

Mr. REISS. Medicare too, and a handful of veterans.

Senator CHILES. You have approximately, of that 40 percent, you have two of them that are making donations of approximately $25 a month?

Mr. REISS. Yes, sir.

Senator CHILES. What charge do you get for your medicare patients?

Mr. REISS. I am sorry, I don't understand the question.

Senator CHILES. What is your daily charge or monthly charge in regard to your medicare patients?

I want to get a comparison between medicaid and medicare.

Mr. REISS. We get approximately, this changes quarterly, I think the last statement that I received was in the neighborhood of $26 to $27 per day per patient.

Senator CHILES. On medicare?

Mr. REISS. That is correct.

Senator CHILES. How about medicaid?

Mr. REISS. We get the standard, $21.

Senator CHILES. $18.66 and $16?

Mr. REISS. Yes.

Senator CHILES. So your charge for medicare is approximately $26 a day?

Mr. REISS. Yes. That is an approximate figure. I think it changed last week.

Senator CHILES. That is based on what you submit as being actual cost?

Mr. REISS. Yes.

Senator CHILES. Thank you very much.

This concludes our witnesses and we will conclude our hearing and the committee will reconvene on the call of the Chair.

I want to thank all of the witnesses for attending today and we will be issuing a report on this forthcoming. Thank you.

[Whereupon, at 12 o'clock the subcommittee hearing was concluded.]

APPENDIX

GREYNOLDS PARK MANOR,
North Miami, Beach, Fla., May 26, 1976.

To: Division of Family Services, 1350 NW., 12th Avenue, Miami, Fla.

From: Irving Glassman.

It is my intention to make a regular cash contribution to Greynolds Park Manor, Inc. which is not intended to be used by the nursing home to cover or supplement expenses relative to room, board, or laundry related to nursing care and professional nursing service for patient Dora Glassman.

It is my understanding that the states recognized cost of care is considered payment in full for these services and any attempt to otherwise cover these expenses directly or indirectly for specific patient could be considered a fraudulent act.

IRVING GLASSMAN.

GREYNOLDS PARK MANOR,
North Miami Beach, Fla., May 26, 1976.

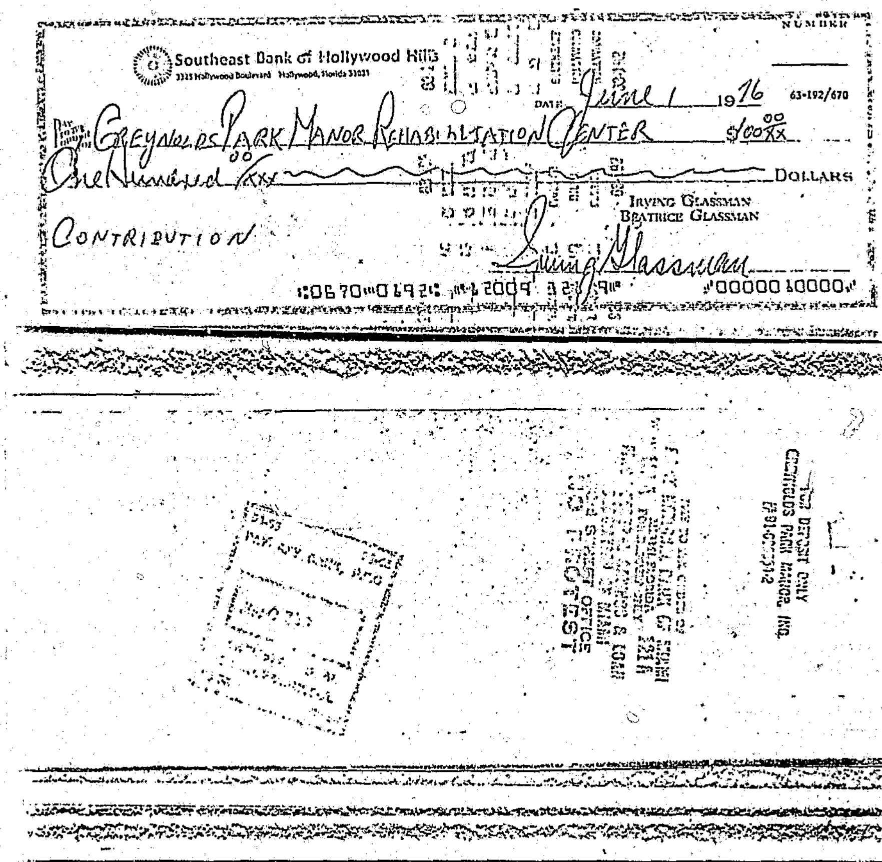
I hereby agree to donate the sum of $1.200 to Greynolds Park Manor, Inc., payable $100 per month on the 1st of each month, starting June 1, 1976.

It is understood and agreed that this donation does not have any connection with any charges for any patient at Greynolds Park Manor and is not to be applied to any such charges.

IRVING GLASSMAN.

_____,
Witness.

_____,
Witness.



Southeast Bank of Hollywood Hills

NUMBER

DATE June 1 1976 63-192/670

PAY TO THE ORDER OF Greynolds Park Manor Rehabilitation Center $100 00/xx

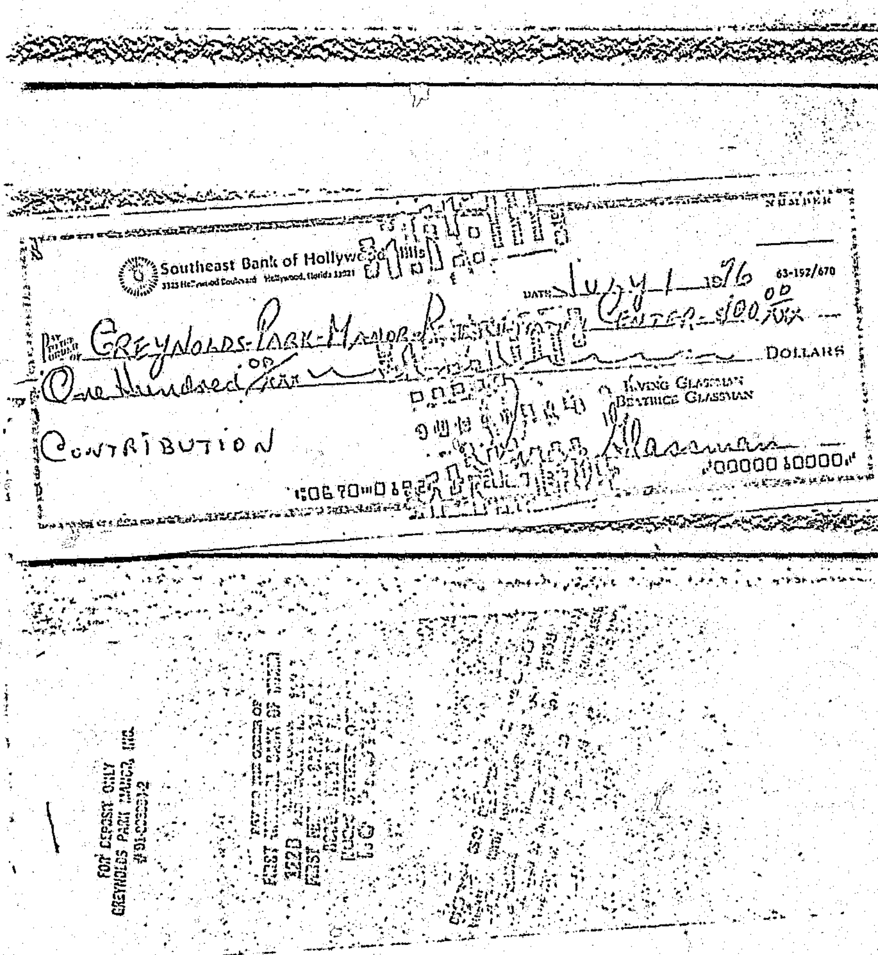
One Hundred 00/xxx DOLLARS

IRVING GLASSMAN
BEATRICE GLASSMAN

Contribution

Irving Glassman

FOR DEPOSIT ONLY
GREYNOLDS PARK MANOR, INC.


Southeast Bank of Hollywood
DATE July 1 1976
63-152/670
PAY TO THE ORDER OF Greynolds Park Manor Rehabilitation Center $100.00/xx
One Hundred 00/xx DOLLARS
Irving Glassman
Beatrice Glassman
Contribution
Irving Glassman
00000 10000
FOR DEPOSIT ONLY
GREYNOLDS PARK MANOR, INC.

No.

July 3 1976

Received of Irving Glassman

One Hundred Seven 90/100 DOLLARS

Greynolds Park Manor -

Dora Glassman

$ 107.90 C. Rodriguez

15 Armory Dora Glassman 101.40	6/3/76	Dora Glassman	Pend. Medicaid	[illegible]
BANK TRANSIT NO. / AMOUNT — CHECKS	DATE	NAME	DESCRIPTION	RECEIVED

( ) FIGURE INDICATES CASH RETURNED ACTUAL PAYMENT IS NET AMOUNT OF CASH RETURNED.

NOT VALID UNLESS SIGNED ABOVE

...IN THIS RECEIPT ...YOUR RECORDS

2325

GREYNOLDS PARK MANOR, INC.
REHABILITATION CENTER
17400 W. Dixie Highway
NORTH MIAMI BEACH, FLORIDA 33160
Telephone: 944-2361

I. Glassman 750.00	5/26/76	Dora Glassman	Pending Medicaid	[illegible]
BANK TRANSIT NO. / AMOUNT — CHECKS	DATE	NAME	DESCRIPTION	RECEIVED

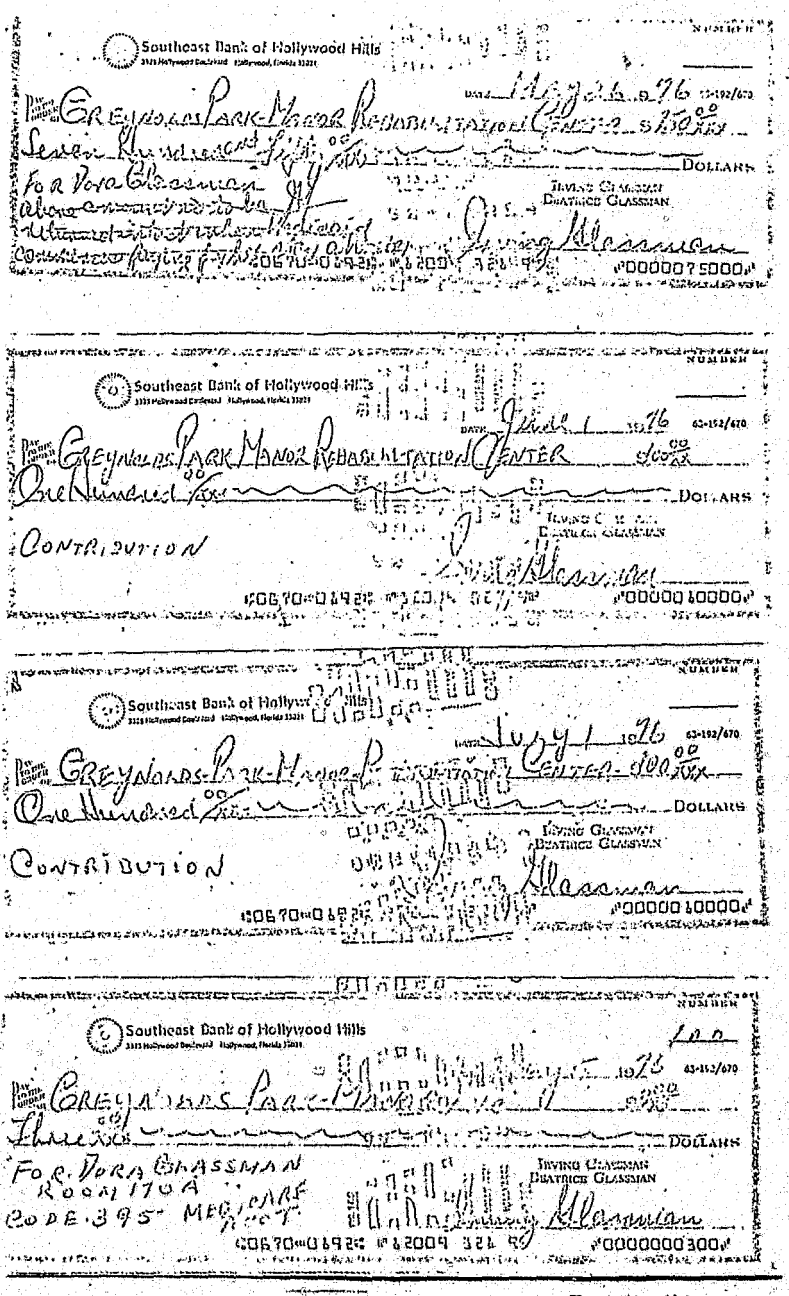
( ) FIGURE INDICATES CASH RETURNED ACTUAL PAYMENT IS NET AMOUNT OF CASH RETURNED.

NOT VALID UNLESS SIGNED ABOVE

...IN THIS RECEIPT ...YOUR RECORDS

2738

GREYNOLDS PARK MANOR, INC.
REHABILITATION CENTER
17400 W. Dixie Highway
NORTH MIAMI BEACH, FLORIDA 33160
Telephone: 944-2361



Southeast Bank of Hollywood Hills

Pay to the order of Greynolds Park Manor Rehabilitation Center $150.00

Lesser Hundred and Fifty 00/100 Dollars

For Dora Glassman

Irving Glassman
Beatrice Glassman

Irving Glassman

Southeast Bank of Hollywood Hills

Pay to the order of Greynolds Park Manor Rehabilitation Center $100.00

One Hundred 00/100 Dollars

Contribution

Irving Glassman
Beatrice Glassman

Irving Glassman

Southeast Bank of Hollywood Hills

Pay to the order of Greynolds Park Manor Rehabilitation Center $100.00

One Hundred 00/100 Dollars

Contribution

Irving Glassman
Beatrice Glassman

Irving Glassman

Southeast Bank of Hollywood Hills

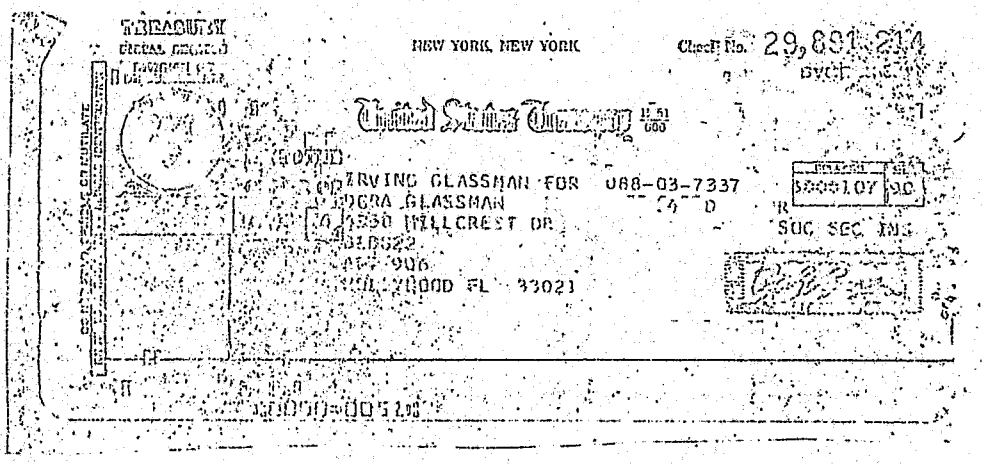
Pay to the order of Greynolds Park Manor Rehabilitation Center $100.00

Three 00/100 Dollars

For Dora Glassman
Room 170A
Code 395 Medicare

Irving Glassman
Beatrice Glassman

Irving Glassman



NEW YORK, NEW YORK

Check No. 29,691,214

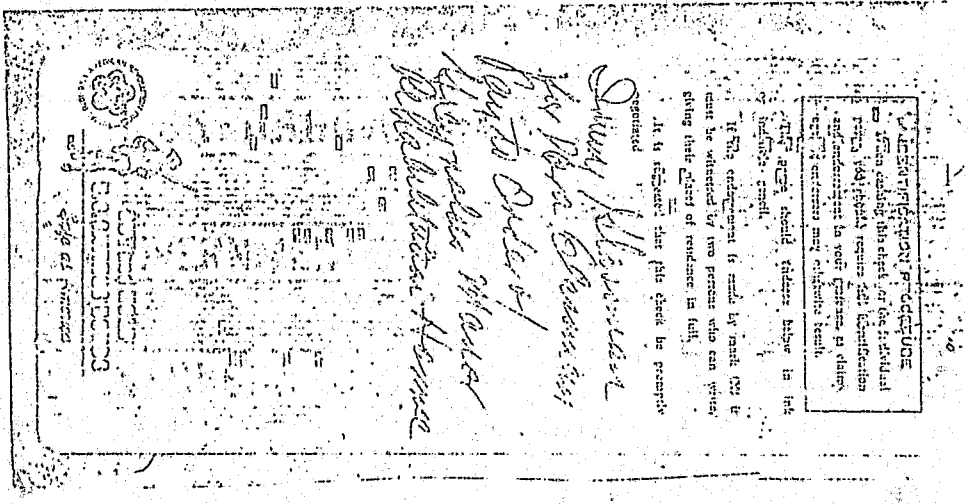
United States Treasury

PAY TO THE ORDER OF IRVING GLASSMAN FOR DEBRA GLASSMAN 3330 MILLCREST DR HOLLYWOOD FL 33021

088-03-7337

$5005.07

SOC SEC NO.



CAUTION: IMPORTANT PROCEDURE

If this endorsement is made by mark (X) it must be witnessed by two persons who can verify giving their correct place of residence in full.

It is required that this check be presented

FOR DEPOSIT ONLY
REYNOLDS PARK MANOR, INC.
#91-002964-2
FOR DEPOSIT ONLY
REYNOLDS PARK MANOR, INC.
#91-002964-2
FOR DEPOSIT ONLY
REYNOLDS PARK MANOR, INC.
#91-002964-2
FOR DEPOSIT ONLY
REYNOLDS PARK MANOR, INC.
#91-002964-2

REPORT OF

NURSING HOMES MANAGEMENT SURVEY

Office of Management Analysis and Audit
Department of Health and Rehabilitative Services
March 26, 1976

STATE OF FLORIDA

DEPARTMENT OF
Health & Rehabilitative Services

Reubin O'D Askew, Governor

1323 WINEWOOD BOULEVARD TALLAHASSEE, FLORIDA 32301

ASMA March 26, 1976

SUBJECT: Nursing Home Management Survey

TO: Robert V. Peirce, Assistant Secretary,
Administrative Services

1. The attached report is a summary of the Nursing Home Management Survey which was conducted at the request of Secretary Page.

2. The scope of the survey was, in my opinion, adequate for the purpose for which it was conducted - to determine if the Medicaid Cost Reports as submitted by the nursing homes are a reliable basis for establishing reimbursement schedules. The evidence we have collected and analyzed verifies that they are not.

3. Data are not identified with specific nursing homes included in the random sample. The analysis would not have benefited by the information, nor was it relevant to the conclusion.

Ed Tempest

Atch
Nursing Home Management Survey

ED TEMPEST
Director
Management Analysis and Audit

REPORT OF

NURSING HOMES MANAGEMENT SURVEY

I. INTRODUCTION

The Department of Health and Rehabilitative Services recently implemented a policy to reduce the monthly Medicaid reimbursement rate and also to reclassify many Medicaid patients from skilled care to intermediate care. The nursing home industry reacted strongly to these actions and the consequent accompanying expected loss of revenue, claiming that the reimbursement would not cover their costs as reported in the annual Medicaid Cost Report required of nursing homes. In order to collect data on which to base a judgement as to the probable validity of the cost reports, a management survey of a selected sample of Medicaid nursing homes was performed during the month of February 1976 by the HRS Office of Management Analysis and Audit. Because of the limited time available, the survey was not designed to determine actual cost, nor did it do so. The detailed audits necessary to determine actual cost could not be conducted within the allowable time frame.

Because of the time constraints (20 working days), the sample size was limited to 30 nursing homes of the total of 275 nursing homes participating in the Florida Medicaid program. The nursing homes to be surveyed were selected utilizing a stratified random statistical sample. Appropriate numbers of homes were selected in metropolitan areas, urban areas, and rural areas in order to get a cross-section of homes throughout the State. Homes which are members of national nursing home chains were eliminated from the sample since these homes keep their records at their corporate

offices outside the State and consequently are not available locally for survey.

II. THE SURVEY PROGRAM

A special survey program was designed for this effort. This program called for the survey teams to prepare a trial balance and cross-reference expenses to line items in the cost report; review all adjustments made by the provider; review selected revenue and expense accounts and make obvious adjustments during the survey; analyze owner's compensation, interest expenses, travel and entertainment expenses, depreciation schedules, and the calculation of return on owner's equity. Several patient's records were reviewed in each home, as well as the CPA's report (if any), the Medicare cost report, the schedule of room rates for private patients, and the patients' trust accounts. A lengthy questionnaire of 179 items was developed to assist in making a determination of the reliability of information contained in the Cost Report.

The survey teams made obvious adjustments in income accounts, expense accounts, total patient census, Medicaid patient census, and occupancy rates in order to arrive at an adjusted average monthly cost per patient for each nursing home. The adjustments consisted of changing amounts included in the cost reports which were found to be incorrect or unallowable in accordance with the Medicaid regulations of the U.S. Department of Health, Education and Welfare. Since none of the cost reports were audited by either the survey teams or an independent CPA, the resultant adjusted costs represent corrections to unverified amounts.

It was necessary to make adjustments in every nursing home in the sample, some more than others. Some adjustments were upward, particularly in the area of total Medicaid patient days

reported by the nursing home. Most of the adjustments were downward, because of unauthorized or excessive costs in certain areas. Examples of some of the types of adjustments will be presented in the next section of this report.

The adjusted average cost per month per patient for each nursing home in the sample was calculated in the following fashion. The aggregate cost of a nursing home for the fiscal year was taken from the home's cost report. Adjustments as described above were made to arrive at a survey adjusted aggregate cost. Total patient days for the year were taken from the cost report, and adjusted as necessary to arrive at an adjusted total patient days figure. This latter figure was divided into the first to obtain an adjusted average cost per patient day. This per diem rate was then multiplied by 30.4166 to arrive at the adjusted average monthly cost per patient for the home.

Within each of the three geographic strata used in the sample survey - metropolitan areas, urban areas, and rural areas - the average of all the individual adjusted average monthly cost amounts was calculated. These three averages were then consolidated using statistical weighting techniques to arrive at the statewide sample average monthly cost per patient.

III. SUMMARY OF RESULTS

Caution should be exercised in interpreting the following results due to the limited size of the sample taken. Probability considerations pertaining to the adequacy of the sample are contained in Appendix 2.

Adjusted Average Monthly Cost Per Patient

Metropolitan areas	$598.78*
Urban areas	$586.74
Rural areas	$541.42
Statewide weighted average	$582.42*

* The metropolitan areas contained three nursing homes operated by county governments. These were the only county homes in the sample. These three homes had the three highest adjusted average monthly cost per patient in the survey. These costs were $1,074.92, $981.24, and $890.29. Eliminating these three county homes from the average calculations produced the following results:

Metropolitan areas:	$515.41
Statewide weighted average:	$538.00

It can be seen that these three county operated nursing homes raised the statewide weighted average cost per month by $44.42 and the metropolitan area average per month by $83.37.

In an effort to investigate the reasons for the high costs in the county operated nursing homes, the County Comptroller of one of the counties was contacted. This County Comptroller stated that, in his opinion, there were three factors contributing to the high cost. First, the nursing home operated more as an extended care facility which had a higher than usual number of acute patients received directly from a hospital. These acute patients required more skilled and costly care than others. Second, the home operates in an environment of affluent and politically powerful groups who demand and receive excessive services. Third, bureaucratic inefficiencies affect the cost. Further, the survey team noted that this

77-853 O - 76 - 5

nursing home paid approximately $1,061,000 in salaries to operate this 119 bed home for a year, compared to some privately operated homes which might typically have total salaries of $350,000 for a 100 bed home.

MATRIX SHOWING EFFECT OF THREE COUNTY NURSING HOMES ON ADJUSTED AVERAGE MONTHLY COSTS PER PATIENT

	With County Homes	Without County Homes
Mean Monthly Costs	$582.42	$538.00
Modal Costs (most typical)	$528.50	$528.50
Median Costs	$536.49	$529.49
Standard Deviation	$160.62	$126.74
% of Homes Less Than $600	76.0%	85.0%
% of Homes Less Than Mean Cost	70.0%	56.9%
% of Homes Less Than Modal Cost	60.0%	49.2%

Rates During Year for Private Patients

	Most Recent Private Patient Monthly Rate		
	Private	Semi-Private	Ward
Statewide average of those homes responding to this question:	$846.49	$729.69	$687.42

Range of Adjusted Average Monthly Costs

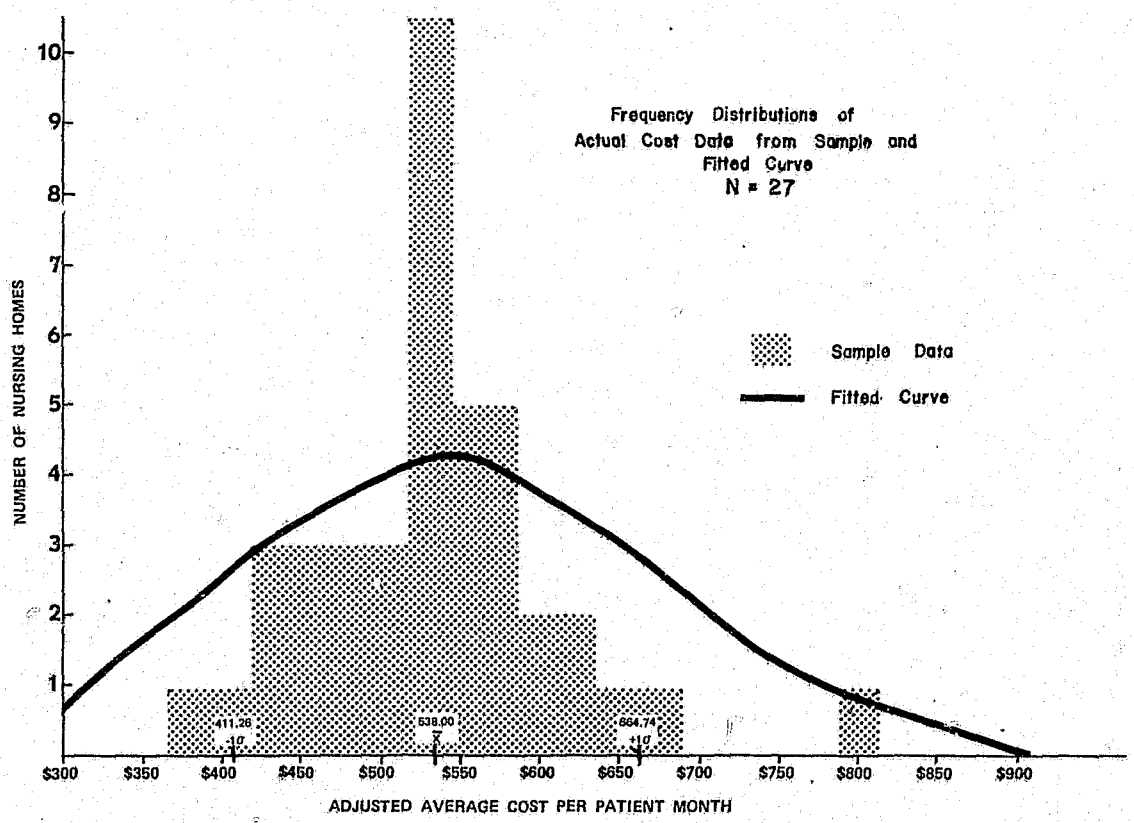
Metropolitan areas:	$396.33 to $1,074.92
Urban areas:	$506.74 to $ 834.02
Rural areas:	$466.29 to $ 587.04
Statewide:	$396.33 to $1,074.92

Frequency Distribution of Actual Data and Fitted Curve

A frequency distribution represents a sample drawn from a much larger population or universe. Even though a sample is composed of but a few items, it may be reasonably representative of the larger population from which it is drawn. Since it is virtually never impossible to measure or survey the entire population, a notion of the larger population must be formed from the sample. Therefore, the sample survey data was plotted and then a frequency distribution curve was mathematically fitted to it in order to attempt to describe the general form of the curve for the entire population.

The data from the sample survey was plotted in a frequency distribution format, and then a curve was fitted to it. The procedure for doing this is detailed in Appendix 2. It is then necessary to test the goodness of fit of the fitted curve. The method of doing this (the Chi-Square test) is given in Appendix 1. The results of the plots are shown on the next chart.

The fitted curve plotted over the histogram of actual data indicates the shape of the distribution of costs that should be expected if the sample were much larger, or if the entire population of nursing homes had been surveyed. A study of the fitted and actual data frequency curves, together with the Chi-Square


Frequency Distributions of
Actual Cost Data from Sample and
Fitted Curve
N = 27
Sample Data
Fitted Curve
NUMBER OF NURSING HOMES
10
9
8
7
6
5
4
3
2
1
411.26
-1σ
538.00
X̄
664.74
+1σ
$300
$350
$400
$450
$500
$550
$600
$650
$700
$750
$800
$850
$900
ADJUSTED AVERAGE COST PER PATIENT MONTH

Test, indicates statistically that the statewide adjusted average monthly cost per patient probably would not vary sufficiently with a larger sample to change the conclusion with regard to the reliability of the cost report.

Cumulative Distributions of Adjusted Average Monthly Cost Per Patient

The tables and curves on pages 11 through 14 present the cumulative frequency distribution of the adjusted average monthly costs per patient of the nursing homes in the survey sample. Pages 11 and 12 present this information for all 30 homes in the sample. Pages 13 and 14 show the same type information if the data of the three county operated homes are excluded.

These cumulative frequency distributions were accumulated on a "less than" basis; that is, they show the percentage of the nursing homes whose adjusted average monthly costs per patient was less than any given dollar amount. It may be readily seen, for example, that of all the nursing homes in the sample 76.7% of them had an adjusted average monthly cost per patient of less than $600. If the three county homes are eliminated, 85.2% of the homes had monthly costs of less than $600.

Statistics on Questionnaire

The following statistics give a summary of the most significant questions contained in the questionnaire developed for this survey. The figures represent the percentages of the statewide sample of nursing homes which answered yes (Y), no (N), or not applicable (N/A) to the following questions:

Questions	Y	N	N/A
1. Is interest paid to owner included in cost report?	10.3%	89.7%	--
2. Is compensation paid to administrator within HEW guidelines?	79.3%	20.7%	--
3. Is owner of administrator performing a function necessary to operate the nursing home?	100.0%	--	--
4. Does provider employ any relatives of the owner?	41.3%	58.7%	--
5. If so, do the relatives perform a function necessary to operate the nursing home?	41.3%	38.0%	20.7%
6. Does the nursing home do business with a related organization?	34.5%	65.5%	--
7. If so, are such costs competitive with cost of comparable goods, services, and facilities in the area?	31.0%	44.8%	24.2%
8. Does computation of owner's equity exclude all items not related to patient care?	34.5%	20.7%	44.8%
9. Does cost report exclude all other expenses not related to patient care?	38.0%	62.0%	--
10. Are funds derived from laundry, meals, sale of supplies, etc. used to offset costs of services or goods?	79.3%	20.7%	--
11. Was the nursing home audited by an independent CPA?	16.7%	83.3%	--
12. Was the nursing home Cost Report prepared by an independent CPA?	80.0%	20.0%	--

Typical Examples of Types of Adjustments

The following list is by no means exhaustive, nor did each of the homes experience all of these adjustments. It is presented only to give examples of the types of costs which were included in the cost reports and which the survey teams adjusted.

1. Country Club dues were included in Medicaid expenses.
2. Yacht Club dues were included in Medicaid expenses.
3. Lease cost, depreciation, and repair of expensive luxury automobiles not related to patient care were included.
4. Excessive salaries and bonuses were paid to the administrator.
5. Travel expenses not related to patient care were claimed. Several homes claimed expenses for a trip to Honolulu to attend a nursing home association meeting.
6. Expensive restaurant meals not related to patient care were included.
7. Travel which was subject to reimbursement by another state agency was included.
8. Excessive depreciation was claimed.
9. Total number of patients was understated, resulting in higher per diem cost rates.

Conclusion

Each survey team member was asked to state his judgement as to whether the Medicaid Cost Report as submitted by the nursing home was reasonably reliable. These opinions were based on the amount of adjustments to be made in each nursing home, expressed as a percentage of the aggregate cost reported by the home in its cost report. On this basis it was determined that the cost reports of 26.7% of the nursing homes were considered reasonably reliable and 73.3% were not considered reasonably reliable.

The Medicaid cost reports taken as a whole are not considered reliable as a basis for establishing nursing home reimbursement schedules for Medicaid.

CUMULATIVE DISTRIBUTION OF ADJUSTED AVERAGE
MONTHLY COSTS PER PATIENT
ENTIRE SAMPLE (N=30)

Class interval=50

COST	NO. OF HOMES	% OF TOTAL
Less than 400	1	3.3
Less than 450	4	13.3
Less than 500	7	23.3
Less than 550	18	60.0
Less than 600	23	76.7
Less than 650	25	83.3
Less than 700	26	86.7
Less than 750	26	86.7
Less than 800	26	86.7
Less than 850	27	90.0
Less than 900	28	93.3
Less than 950	28	93.3
Less than 1,000	29	96.7
Less than 1,050	29	96.7
Less than 1,100	30	100.0

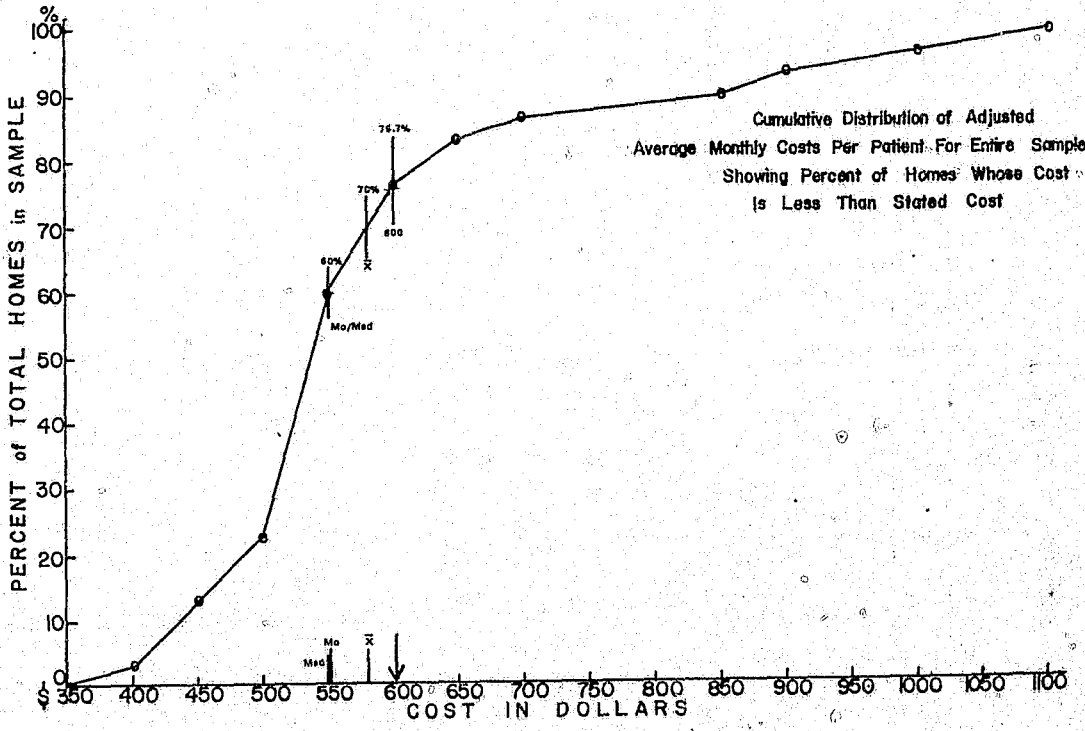
$\bar{X}_{30}$ = 582.42

Mo_{30} = 537.50

Med_{30} = 536.49

σ_{30} = 160.62

N = 30



Cumulative Distribution of Adjusted Average Monthly Costs Per Patient For Entire Sample Showing Percent of Homes Whose Cost Is Less Than Stated Cost

$\bar{X}_{30}$ = $582.42
Med_{30} = $536.49

Mo_{30} = $537.50
σ_{30} = $160.62

CUMULATIVE DISTRIBUTION OF ADJUSTED
AVERAGE MONTHLY COSTS PER PATIENT
ENTIRE SAMPLE LESS THREE COUNTY HOMES (N=27)

Class Interval=50

COST	NO. OF HOMES	% of TOTAL
Less than 400	1	3.7
Less than 450	4	14.8
Less than 500	7	25.9
Less than 550	18	66.7
Less than 600	23	85.2
Less than 650	25	92.6
Less than 700	26	96.3
Less than 750	26	96.3
Less than 800	26	96.3
Less than 850	27	100.0

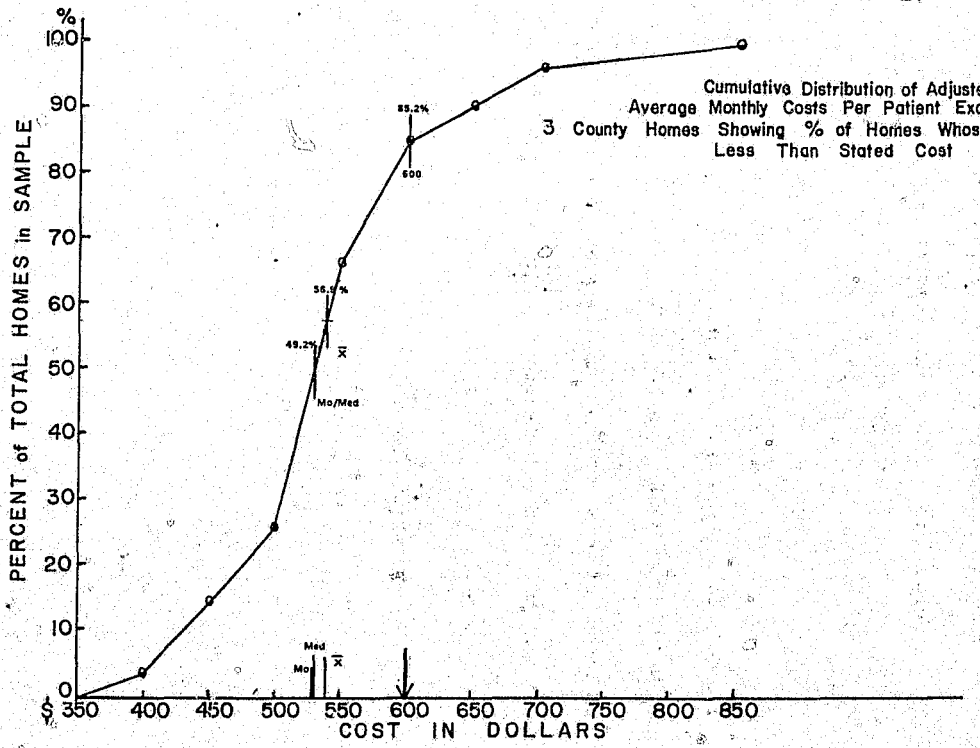
$\overline{X}_{27} = 538.00$

$Mo_{27} = 528.50$

$Med_{27} = 529.49$

$\sigma_{27} = 126.74$

N = 27



Cumulative Distribution of Adjusted Average Monthly Costs Per Patient Excluding 3 County Homes Showing % of Homes Whose Cost Is Less Than Stated Cost

$\bar{x}_{27}$ = \$538.00 $\quad$ Med_{27} = \$529.49

Mo_{27} = \$528.50 $\quad$ σ_{27} = \$126.74

A P P E N D I X

Fitting the Normal Curve to Sample Data

The principal parameters of this distribution are:

$$\overline{X}_{27} = 538.00$$

$$\sigma_{27} = 126.74$$

$$N = 27$$

$$i = 50$$

The formula for the Gaussian curve is:

$$Y_c = [N_i \, e^{(-x^2/2\sigma^2)}] \; / \; (\sigma\sqrt{2\pi}).$$

To erect the prime ordinate of the mean, Y_o: $Y_o = \frac{N_i}{\sigma\sqrt{2\pi}}$,

since $x = 0$ at the mean and therefore $e^{\frac{-x^2}{2\sigma^2}} = 1$.

For this case:

$$Y_o = \frac{27 \times 50}{126.74 \times 2.5066} = 4.2495 \simeq 4.3.$$

Appendix

Ordinates Y_c will be erected at intervals of $\frac{2}{5}\sigma$ from both sides of the mean, as follows:

X	x	$\frac{x}{\sigma}$	Proportion of Y_o	Y_c
81.70	-456.3	3.60	.00153	.01
132.40	-405.6	3.20	.00598	.02
183.10	-354.9	2.80	.01984	.1
233.80	-304.2	2.40	.05614	.3
284.50	-253.5	2.00	.13534	.6
335.20	-202.8	1.60	.27804	1.2
385.90	-152.1	1.20	.48675	2.1
436.60	-101.4	.80	.72615	3.1
487.30	- 50.7	.40	.92312	3.9
538.00	0	.0	1.00000	4.3
588.70	+ 50.7	.40	.92312	3.9
639.40	+101.4	.80	.72615	3.1
690.10	+152.1	1.20	.48675	2.1
740.80	+202.8	1.60	.27804	1.2
791.50	+253.5	2.00	.13534	.6
842.20	+304.2	2.40	.05614	.3
892.90	+354.9	2.80	.01984	.1
943.60	+405.6	3.20	.00598	.02
994.30	+456.3	3.60	.00153	.01

Conclusion As To Sample Size

The fitted curve plotted over the histogram of actual data indicates the shape of the distribution of costs that should be

expected if the sample were much larger, of if the entire population of nursing homes had been surveyed. It implies that, if a larger group had been surveyed, a few instances should be found with adjusted average monthly costs per patient that are both larger and smaller than those found in the sample.

The sample should probably have been larger, had time permitted. However, a study of the fitted and actual probability density functions indicates that the statewide average monthly cost probably would not vary sufficiently with a larger sample to change the conclusion regarding the reliability of the cost report.

Appendix

ENTRY FORM FOR ENTIRE SAMPLE

LESS THREE COUNTY HOMES (N=27)

This form was used to plot the actual cost data in the histogram contained in the body of this report. The figures herein are the actual adjusted average monthly costs per patient of the nursing homes in the sample.

$ 350.00	$ 400.00	$ 450.00	$ 500.00	$ 550.00	$ 600.00	$ 650.00	$ 700.00	$ 750.00	$ 800.00
399.99	449.99	499.99	549.99	599.99	649.99	699.99	749.99	799.99	849.99
396.33	434.35	490.32	505.22	565.44	636.32	650.61			834.02
	431.92	479.67	546.28	577.61	638.75				
	432.22	466.29	501.27	587.04					
			507.05	578.83					
			526.51	581.26					
			539.59						
			506.74						
			535.94						
			549.02						
			521.95						
			505.52						

$$Mo_{27} = l_1 + \frac{\Delta_1}{\Delta_1 + \Delta_2} \times i = 500 + \frac{8}{8 \times 6} \times 50 = 528.50$$

$$Med_{27} = 499.99 + \frac{6.5}{11} \times 50 = 529.49$$

$$\bar{X}_{27} = 538.00$$

$$\sigma_{27} = 126.74$$

Appendix

Chi-Square Test for Goodness of Fit

The goodness of fit is indicated by χ^2 when considered in conjunction with n, the number of degrees of freedom. The number of degrees of freedom is obtained by subtracting from the number of classes in the distribution the number of degrees of freedom lost in the fitting process. In this case, 3 degrees of freedom were lost because the original data and the fitted data were made to agree in respect to the number of samples (N), the mean ($\bar{X}$), and the standard deviation (σ). χ^2 and n enable P to be determined, which tells the probability that a fit as bad or worse might occur because of chance variations in sampling. For this analysis, $n = 10 - 3 = 7$.

The formula for computing χ^2 is:

$$\chi^2 = \sum \frac{(f - f_c)^2}{f_c}, \text{ where}$$

f = observed frequency in a class, and

f_c = the corresponding theoretical or expected frequency.

Before performing the actual calculations for χ^2, it is necessary first to determine the theoretical or expected frequency (f_c) in each class of the distribution. This is done as shown in the following table.

Appendix

Calculation of Expected Frequency in Each Class (f_c)

Of the Fitted Frequency Curve

Average Monthly Cost Per Patient, $'s	Limits of Classes		x	$\frac{x}{\sigma}$	% Area, $\bar{X}$ to Limit	% Area Each Class	f_c
	Lower	Upper					
200 but under 250	200		338.00	2.67	49.62	0.38	.1
250 but under 300	250		288.00	2.27	48.84	0.78	.2
300 but under 350	300		238.00	1.88	46.99	1.85	.5
350 but under 400	350		188.00	1.48	43.06	3.93	1.1
400 but under 450	400		138.00	1.09	36.21	6.85	2.0
450 but under 500	450		88.00	.69	25.49	10.72	2.9
500 but under 550	500		38.00	.30	11.79	13.70	3.7
		550	12.00	.09	3.59	15.38	4.2
550 but under 600		600	62.00	.49	18.79	15.20	4.1
600 but under 650		650	112.00	.88	31.06	12.27	3.3
650 but under 700		700	162.00	1.28	39.97	8.91	2.4
700 but under 750		750	212.00	1.67	45.25	5.28	1.4
750 but under 800		800	262.00	2.07	48.08	2.83	.8
800 but under 850		850	312.00	2.46	49.31	1.23	.3
850 but under 900		900	362.00	2.86	49.79	0.48	.1
TOTAL						99.80	27.0

$\bar{X} = 538.00, \quad \sigma = 126.74$

Now that the expected frequencies in each class of the fitted distribution have been determined, the calculations for the χ^2 test may be done. This is accomplished using the following table, in accordance with the χ^2 formula given previously.

Appendix

Calculation of the Chi-Square Test of Goodness of Fit

Average Monthly Cost Per Patient, $'s	f Observed	f_c Expected	$f - f_c$	$(f - f_c)^2$	$\frac{(f - f_c)^2}{f_c}$
350 but under 400	1	1.9	-0.9	0.81	0.43
400 but under 450	3	2.0	1.0	1.00	0.50
450 but under 500	3	2.9	0.1	0.01	0.00
500 but under 550	11	7.9	3.1	9.61	1.22
550 but under 600	5	4.1	0.9	0.81	0.20
600 but under 650	2	3.3	-1.3	1.69	0.51
650 but under 700	1	2.4	-1.4	1.96	0.82
700 but under 750	0	1.4	-1.4	1.96	1.40
750 but under 800	0	0.8	-0.8	0.64	0.80
800 but under 850	1	0.3	0.7	0.49	1.63
TOTAL	27	27.0	0.0	-	7.51

$\chi^2 = 7.51$; $n = 10 - 3 = 7$; $P = 0.39$

The results of this Chi-Square test indicate that P=0.39. The usually accepted criterion for indicating a poor fit of a fitted normal curve is P=0.05 or less. Since in this case P=0.39, it is concluded that the fitted curve, representing the entire population of nursing homes, is a reasonably good description of the entire series.

SUMMARY STATUS OF NURSING HOME

CONTRIBUTION PROBLEM IN FLORIDA

BACKGROUND:

Prior to 1976, the Department had received scattered complaints about contributions being required of relatives of Medicaid patients in nursing homes. These complaints were investigated at the local administrative level; however, it was determined at the upper administrative level that the investigations did not show sufficient evidence under the existing laws to take any affirmative action.

Towards the end of 1975 and the first part of 1976, the complaints became more numerous and the Department realized a difficult problem was in existence. The Secretary of the Department responded by mandating a more thorough investigation into the entire problem. Initial analysis of the complaints determined that the primary problem areas were the Northwest or "Panhandle" part of the State and the lower Southeast coastal area from Palm Beach County through Dade County.

INVESTIGATIVE ACTION:

The legal staff of the Department was given the lead to utilize Department resources in investigating and determining what action was available to the Department as a result of the investigations. The investigations commenced and are currently being conducted from a two-phase aspect:

First, the financial determination was to be developed through a special task force audit group from the Internal Audit staff of the Department.

Secondly, investigation was to be conducted by developing witness information from parties being allegedly required to make contributions to nursing homes on behalf of relatives who are Medicaid patients in the nursing homes.

As to the first aspect above stated, the audits were commenced and are continuing of various nursing homes in the above referred to geographical areas of the State. Although only one audit

for one fiscal year on one nursing home has been finalized into completed report form, preliminary information from other audits that have been completed or are in process have substantiated the financial aspect of the contribution problem as well as related problems involving possible overcharging for drugs and other services that are included in cost of care.

As to the second aspect of investigation, considerable difficulty has been encountered in the willingness of contributors to come forward for fear that their action may adversely affect the care or status of their relative in the nursing home. Due to staff limitations and available time, this aspect of the problem is progressing at a lesser rate than the audit aspect. It should be pointed out that a final audit report, from the time of commencement until the time the report is finalized, generally takes approximately three to five months which is due primarily to auditing standards and the necessity of sufficient review to produce an accurate report.

SPECIFIC INDICATIONS:

Both through reports to the Department by individuals and through audit procedures, it has been determined that the practice of eliciting contributions from relatives of Medicaid patients is widespread, and that the requests or demands for these contributions are generally oral and very infrequently is there any written documentation to evidence the practice. The situation arises in two general factual situations:

First, a relative determines that he or she can no longer care in the home for a Medicaid eligible client and seeks to place this client in a nursing home under Medicaid. A given nursing home will then require of the relative a contribution to the nursing home as a condition of admission.

Secondly, a person will be placed in a nursing home from a hospital under Medicare and when the

Medicare expires and prior to the nursing home being willing to sign a Medicaid agreement for the patient with the Department, they will require the relative to agree to make a contribution to the nursing home. Reports have indicated that the contributions range from $50.00 to as high as $350.00 and seem to be primarily based upon the relative's ability to contribute. The most difficult aspect of this situation is where a husband and wife maintain their primary support from Social Security Income and one of the parties is unable to be cared for at home and must be placed in a nursing home and is further eligible for Medicaid. The nursing home still requires an agreement from the spouse to pay a contribution to admit the patient.

REMEDIES: The Department feels that it has, after developing sufficient evidentiary information, several alternative recourses. It may institute a legal action for breach of contract against a nursing home. It may determine that the nursing home has breached regulations sufficient to assess an administrative fine against the nursing home. It may seek, through the appropriate branch of government, a revocation or a disciplinary action against the nursing home administrator's license. It may forward any evidentiary matter of possible criminal activities to the State Attorney's Office for further action. It may determine that sufficient evidence exists to seek revocation of the nursing home license.

CURRENT STATUS: As previously stated, with staff limitations, the Department is continuing its investigatory aspect and anticipates within two to four months of having sufficient evidentiary information to take one or more of the above described actions against several nursing homes in the State. The main concern of the Department is not to place a nursing home out of business as the service is needed for the recipients or clients, but the action that may be determined to be taken is to require the nursing home to comply with both State and Federal statutory and regulatory requirements in this situation.

PROJECTION: The Legislature of the State of Florida in its 1976 Session made considerable revisions in that part of its laws relative to that which is commonly known as "Medicaid Fraud" and particularly in dealing with the contribution aspect. This law, with certain qualifications, in effect causes contributions made as a condition of admission or continued care of a Medicaid client or patient to be designated as crimes, both misdemeanors and felonies, depending upon the amounts of the contributions. The law becomes effective October 1, 1976. The Department feels that this law will strengthen its position in being able to effectuate action in dealing with this problem. The Legislature further passed additional laws directly relating to this problem which would affect the licensure and Medicaid portions relative to nursing homes and effectively strengthen the Department's position.

PREPARED BY: DOUGLAS E. WHITNEY
Staff Attorney

August 13, 1976

DEPARTMENT OF HEALTH
AND REHABILITATIVE SERVICES

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
William J. Page, Jr., Secretary
Reubin O'D Askew, Governor
ADMINISTRATIVE SERVICES
1323 WINEWOOD BOULEVARD
TALLAHASSEE, FLORIDA 32301
3890 W. Commercial Blvd., Suite 225
Ft. Lauderdale, Fla. 33309

December 8, 1975

M's. Leah Ball
800 N.E. 175th Street
N. Miami Beach, Florida

Re: Eng. No. 76-20
Royal Glades Convalescent Home
Patient's Name: Isador Shapkin
ISADOR SHANKIN

Dear M's. Ball:

We are currently involved in the audit of Royal Glades Convalescent Home, North Miami Beach, Florida.

In connection with our audit would you furnish our office with the dates and amounts of monies paid to Royal Glades Convalescent Home?

Please describe the manner you were approached by indicating whether your contribution was:

a. Voluntary
b. Coerced
c. Condition of admission
d. Continued residence for patient

A self-addressed envelope is enclosed for your convenience.

Your reply will be held in strict confidence.

Sincerely,

Edward J. Powers

Edward J. Powers
Internal Audit Section

Enclosure

EJP:cd

December 12, 1975

Edward J. Powers
Internal Audit Section
Department of Health and Rehabilitative Services

Re: Eng. No. 76-20
Royal Glades Convalescent Home
Patient's Name: Isadore Shankin
Response to your letter dated 12/8/75

Dear Sir:

On May 1, 1974 my father was admitted as a private patient to Royal Glades at the rate of $650 per month because at the time I was told by the Miami office of HRS that a Medicaid recipient could only have $600 in assets, and at the time he had $2700. In July 1974 when I called HRS to notify them that he had only $500 left I was told that as of July 1974 a recipient could have $1500 in assets. Having already paid $650 for July I was informed that I could apply for Medicaid as of August 1974 after I made arrangements with Royal Glades to accept him. The "arrangements" were to agree to pay $175 monthly. Please place this in any of the catagories you see fit, because I honestly don't know how to describe it except to say that it was not voluntary.

As of 8/1/74 Florida Medicaid Vendor payment was $392.00 plus my father's S.S of $158 plus $175 came to $725. Rates for private patients were $650 as I had already paid that. I have just learned that including $171 from S.S., Florida Medicaid pays $600 as of 7/1/75 added to $175 brings this amount to $775. Could you please tell me why Medicaid and I should be paying more than private patient fees which are $750 as of 7/1/75. We get no special services. I visit every day and do <u>all</u> of my father's personal laundry.

Although my $175 payment is not deductable from my Federal income Tax, it is a requirement for my father's being there, and I really would like to be able to understand why.

I am available to give details of service, etc. if you want them and I do appreciate that someone is interested in inquiring. My phone # is 651-7053.

The attached is the list of dates and payments to Royal Glades as you requested.

Sincerely,

5/1/74	$650.00
6/1/74	698.30
7/1/74	653.75
8/1/74	175.00
9/1/74	175.00
10/1/74	175.00
11/1/74	175.00
12/1/74	175.00
1/1/75	175.00
2/1/75	175.00
3/1/75	175.00
4/1/75	175.00
5/1/75	175.00
6/1/75	175.00
7/1/75	175.00
8/1/75	175.00
9/1/75	175/00
10/1/75	175.00
11/1/75	175.00
12/1/75	175.00

Royal Glades

CONVALESCENT HOME
16650 WEST DIXIE HIGHWAY
NORTH MIAMI BEACH, FLORIDA
TELEPHONE WI 5-7447

December 14, 1974

Dear Mr. Porris: Re: Mary Kaufman

We have reviewed Mary Kaufman's account and wish to advise you that you owe the supplementation of $150.00 due us 2-16-74 whereby you only paid us the social security portion and had omitted the $150.00 due us. Also, there are accummulating drug charges that aren't covered under the medicaid program which are the non compensable drugs and they total $117.82 due the account to date. Therefore, we would appreciate your check for $150.00 plus $117.82 = $267.82, total.

Also, you will have to understand our position in regard to the monthly pledge due for $150.00 each month, which is very necessary as our costs are extremely high. Therefore, there is the $100.00 supplementation due for December and we would appreciate your cooperation in continuing this pledge as long as Mary Kaufman is in our facility.

We regret this imposition but we haven't any choice and must ask that you make other arrangements to have Mary Kaufman transferred out from our facility if you are unable to continue your original pledge to our torah fund.

Trusting you understand, we remain

Sincerely,

ROYAL GLADES CONVALESCENT HOME

Dr Alvin Stern

Administrator

FLORIDA STATE SENATE BILL 578

Senate Bill 578 (Chapter 76–51), the "Community Care for the Elderly Act," directs the Department of Health and Rehabilitative Services to conduct or to contract for demonstration projects in at least three areas of the state to test alternatives to institutionalization for the elderly. Such projects may include home-delivered service programs, multi-service senior center programs, and family placement programs as needed to assist elderly persons to remain living independently in their own homes and communities rather than be subjected to unnecessary or premature placement in a nursing home or other long-term care facility. Health maintenance services, homemaking and chore services, and mobile meals services would be available through home-delivered service programs. Multi-service senior center programs would provide the same services as a home-delivered service program, and in addition would provide counseling, telephone reassurance, and information and referral services. Each type of program would add additional services, such as transportation, legal, and employment services, depending on local needs and resources. Family placement programs would attack the problem of unnecessary institutionalization from a different aspect by providing for placement of an elderly person in the home of a caretaker, who would assist the elderly person in meeting the normal demands of daily living and could be reimbursed for providing such assistance. An additional aspect of the statute provides for the establishment of programs of day care for the elderly as part of a multi-service senior center program, or in a hospital or nursing home. Such programs would provide a protective daytime environment for frail elderly persons who have a regular home but who might require admission to acute or long-term health care in the absence of such programs. Day care programs would provide a sheltered physical environment, at least one meal a day, rest facilities, and social activities.

Entities desiring to contract with the Department of Health and Rehabilitative Services to conduct a community care program may become eligible to do so by providing at least 25% of project funding. Existing community resources and the use of volunteers are to be maximized in operating programs. Additionally, the Legislature in the 1976–1977 General Appropriations Act authorized the use of various funds under the Medicaid Program to pay for services provided by community care programs.

The Department of Health and Rehabilitative Services is to evaluate the effectiveness of coordinated programs of community services as a means of delaying or avoiding the placing of elderly citizens in long-term care facilities and report its findings and recommendations to the Legislature.

CHAPTER 76-51

Senate Bill No. 578

AN ACT relating to community care for the elderly; revising The Community Care for the Elderly Program Development Act of 1973 into The Community Care for the Elderly Act, by amending ss. 409.3621, 409.3622, 409.3623, 409.3624, Florida Statutes, repealing ss. 409.3625, 409.3626, 409.3627, Florida Statutes, and creating ss. 409.3628, 409.3629, 409.3630, Florida Statutes, in order to provide home-delivered service programs, multi-service senior center programs, and family placement programs for elderly persons; prescribing the powers and duties of the Department of Health and Rehabilitative Services; providing for the use of community resources and volunteers; requiring the purchase of insurance to protect volunteers from personal liability; authorizing the department to accept gifts; authorizing the department or entity developing the program to prescribe a rate schedule for contribution of money or services in payment for certain services; providing for day care for the elderly services; requiring a report; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Sections 409.3621, 409.3622, 409.3623, and 409.3624, Florida Statutes, are amended to read:

409.3621 Short title.--Sections 409.3621-409.3630 ~~409.3627~~ shall be known and may be cited as "The Community Care for the Elderly Program ~~Development Act of 1973.~~"

409.3622 Legislative intent.--The purpose of this act is to find acceptable and cost-effective ~~economically--feasible~~ ways to assist functionally impaired and other elderly persons to continue to live dignified and reasonably independent lives in their own homes or in the homes of relatives or caretakers ~~and residences~~ through the development, expansion, reorganization, and coordination of various community-based service programs. The Legislature intends that the home-delivered service program, the multi-service senior center program or the family placement ~~community--care--for-the-elderly~~ program be established in at least three districts ~~or-more-eligible-counties~~ on a trial basis ~~for-a-2-year--period~~ in order that such programs may be demonstrated, studied, and evaluated. This shall be done to determine the feasibility of such programs as a means of satisfying the unmet needs of Florida's elderly population with respect to community-delivered ~~home-delivered~~ services while conserving scarce state resources. In addition, an evaluation shall be made of the cost-effectiveness as well as the ability ~~potential-effectiveness~~ of such programs to diminish the rate of inappropriate entry and placement of functionally impaired elderly persons in institutions and the utilization of noninstitutional services and facilities ~~nursing-homes-and-related health-care-facilities.~~

409.3623 Definitions.--For the purposes of this act, the following words and phrases shall have the following meanings:

(1) "Elderly person" means any person who is 60 years of age or older.

(2) "Functionally impaired person" means any person who is unable to perform the normal tasks of daily living. More specifically, a functionally impaired person is any person who is housebound and living in the community at-home who requires help from others in order to cope with the normal demands of daily living.

CODING: Words in ~~struck-through~~ type are deletions from existing law; words in underscored type are additions.

~~(3)---"Community--care"--means-a-community-administered-and-community-coordinated-program-of-providing-coordinated-home--delivery--of--selected services-to-functionally-impaired-or-other-elderly-persons.~~

(3)~~(4)~~ "Health maintenance service services" means that those routine health service services necessary to help a confined elderly person people maintain an appropriate level standard of personal health. This service shall be ~~These-services-are~~ provided by ~~physicians--licensed to-practice-under-chapter-458-or-chapter-459,-registered-nurses,-or-other~~ qualified health service personnel who are acting within the scope of their professional or occupational licenses.

(4)~~(5)~~ "Homemaking and chore service services" means that those routine household service services necessary to help a functionally impaired elderly person ~~older-persons~~ meet the normal demands of daily living. This service may ~~These-services~~ include light housekeeping and laundering, meal preparation, personal and food shopping, check cashing and bill paying, friendly visiting, minor household repairs, and yard chores.

(5)~~(6)~~ "Mobile meal service meals" means the provision of hot or cold nourishing meals ~~prepared--under--the--supervision--of--a--dietitian--and~~ delivered on a regular schedule to a functionally impaired elderly person ~~persons-living-at-home~~. This service shall ~~should~~ include a system for determining nutritional needs of participants.

~~(7)-----"Transportation----service"---means---door-to-door---vehicular transportation-for--functionally-impaired-or-other-elderly-persons-living at-home.~~

~~(8)---"Legal--services"--means--assured--access--to--legal--counsel-by functionally-impaired-or-other-elderly-persons,-especially-those-who--are no-longer-able-to-make-decisions-effectively-for-themselves.~~

(6)~~(9)~~ "Counseling service" means the provision of information and advice by persons of professional or paraprofessional competence to enable an elderly client clients to make decisions on such personal matters as income, health, housing, transportation, and family, personal, and social relationships.

(7)~~(10)~~ "Client" means any person enrolled and participating in a community-care program who is receiving one or more of the available services.

(8)~~(11)~~ "Department" means the Department of Health and Rehabilitative Services.

(9) "Multi-service senior center program" means a program with strong outreach capabilities which provides elderly persons with medical, social, supportive, and rehabilitative services in a centralized and comprehensive manner.

(10) "District" means a service district of the department.

(11) "Local governmental unit" means a county, a district school board, a municipality, or a metropolitan or consolidated government.

(12) "Relative" means an individual who is connected by affinity or consanguinity to the client as father, mother, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, husband, wife, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half-brother, or half-sister and which individual is 18 years of age or more.

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(13) "Caretaker" means a relative, a person unrelated to the client, or the client himself, who provides a client with the type and level of care intended by this act.

(14) "Family placement program" means an alternative to institutional placement in which a caretaker provides a home for an elderly person and assists him to the extent necessary for him to participate in normal activities and to meet the demands of daily living.

(Substantial rewording of section.
See s. 409.3624, F.S., for present text.)

409.3624 Community care for the elderly programs; powers and duties of the department.--

(1) The department shall conduct or cause to be conducted a combination demonstration project and evaluation study to determine the desirability of establishing a home-delivered service program, a multi-service senior center program, or a family placement program throughout the state. In carrying out the project, the department shall establish or cause to be established programs in at least three districts.

(2) All existing community resources available to the elderly client shall be utilized to support program objectives. Additional services may be incorporated into a program as appropriate and to the extent that resources are available. The department is authorized to accept gifts and grants in order to carry out a program.

(3) The use of volunteers shall be maximized to provide a range of personal services for the client. The department shall assure appropriate coverage to protect volunteers from personal liability while acting within the scope of their volunteer assignments under a program.

(4) The department may contract for the provision of any portion or all of the services required by a program. Such purchase of service contracts shall be utilized whenever the requirements of s. 20.19(13) exist.

(5) Entities contracting with the department to conduct demonstration projects under this act shall provide a minimum of 25 percent of the funding necessary for the support of project operations. Contributions in kind, whether materials, commodities, transportation, office space, other types of facilities, or personal services, may be evaluated and counted as part or all of this required local funding.

(6) When possible, services shall be obtained under the Florida Comprehensive Annual Services Program Plan under title XX of the Social Security Act, under the Florida Plan for Medical Assistance under title XIX of the Social Security Act, under the State Plan on Aging under titles III and VII of the Older Americans Act, and under the Florida Financial Assistance for Community Services Act of 1974.

(7) If the department determines that it is necessary to help pay for services received from community care programs, a client shall contribute an amount of money or service of a specified value. The amount of money or service to be contributed shall be fixed according to a rate schedule established by the department or entity developing the program. This rate schedule shall consider expenses and resources of the client and overall ability of the client to pay for the services.

(8) The department shall submit on January 1 of each year an evaluation report to the Speaker of the House of Representatives and to the President of the Senate summarizing the progress of the project. The report shall include the information and data necessary for an accurate

analysis of the costs and benefits associated with the establishment and operation of the programs that were established.

Section 2. Sections 409.3628, 409.3629, and 409.3630, Florida Statutes, are created to read:

409.3628 Home-delivered service program.--A home-delivered service program, for the purposes of this act, shall include the following basic services:

(1) Health maintenance service;

(2) Homemaking and chore service; and

(3) Mobile meal service.

Additional services, such as transportation service, legal service, counseling service, and telephone reassurance service may be incorporated into the program as appropriate and to the extent that resources are available. Services may be furnished by public agencies or private organizations, but in each district, the total program of services shall be coordinated by means of a single, centralized management unit which is established, staffed, and equipped for such purpose.

409.3629 Multi-service senior center program.--

(1) A multi-service senior center program primarily geared to enable an elderly person to live independently outside of an institution by providing a coordinated program of services shall include:

(a) Health maintenance service;

(b) Homemaking and chore service;

(c) Mobile meal service;

(d) Counseling service;

(e) Telephone reassurance service; and

(f) Information and referral service.

Additional services, such as transportation service, legal service, and employment service, may be incorporated into the program as appropriate and to the extent that resources are available.

(2) Where feasible, such services shall be available on an emergency basis 24 hours a day.

(3) Where feasible, a multi-service senior center shall be centrally located and easily accessible to public transportation. Provision may be made for transporting persons to the center. A center shall be designed to provide ease of access and use considering the infirmities of frail and handicapped elderly persons.

(4) Services may be furnished by public agencies or private organizations, but the total program of providing service within and outside of the center shall be coordinated by means of a single, centralized management unit which operates within the center and is established, staffed, and equipped for such purpose.

409.3630 Family placement program.--

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(1) When it is determined by the department to be more cost-effective and in the best interest of an elderly person to maintain such person in the home of a caretaker in order to avoid unnecessary institutionalization, such elderly person may enroll in the family placement program.

(2) The caretaker of a person enrolled in the family placement program shall be reimbursed according to a rate schedule set by the department.

(3) While participation in the family placement program will provide the elderly person with adequate assistance to meet the normal demands of daily living, clients may also be enrolled in a home-delivered service program or a multi-service senior center program.

Section 3. (1) As part of a multi-service senior center program, nursing home or hospital, day care for the elderly services may be offered for mentally or physically impaired or frail individuals who are 60 years of age or older, who have a regular place of domicile, who do not require 24 hour-a-day care in a hospital, nursing home, or other health care institution but who may, in the absence of day care for the elderly services, require admission to an acute or long-term health care facility.

(2) Each day care for the elderly service established pursuant to this section, shall provide a protective physical environment for elderly persons, make available to all day care participants at least one meal on each day of operation, provide facilities to enable day care participants to obtain needed rest while attending the program, and provide social activities designed to stimulate interest, rekindle motivation, and provide socialization in large and small groups.

(3) Participants in day care for the elderly services in a hospital as licensed under chapter 395 Florida Statutes, or nursing home as licensed under part 1 of chapter 400 Florida Statutes shall not be counted as part of the hospital's or nursing home's general patient population in determining requirements for licensure.

(4) The Department in its 1978 annual report to the legislature as required by the 1975 Health and Rehabilitative Services Reorganization Act, shall include a report on the results of Day Care for the Elderly Services.

Section 4. Sections 409.3625, 409.3626, and 409.3627, Florida Statutes, are hereby repealed.

Section 5. This act shall take effect July 1, 1976.

Approved by the Governor June 3, 1976.

Filed in Office Secretary of State June 3, 1976.

This public document was promulgated at a base cost of $9.86 per page for 1,200 copies or $.0082 per single page for the purpose of informing the public of Acts passed by the Legislature.

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FLORIDE STATE HOUSE BILL 3140

Committee Substitute for House Bill 3140 (Chapter 76-201), the "Omnibus Nursing Home Reform Act of 1976," is an effort to upgrade the quality of nursing home care in Florida and as such is complementary in purpose to efforts to improve community care programs for the elderly. The Act touches on the operation of nursing homes in a number of areas, by prohibiting certain unfair business practices, by providing for a rating system based on quality of care standards and a reimbursement system which in part takes such ratings into account, and by providing for protection of certain rights of patients. Additional provisions of the Act relate to composition of the Board of Examiners of Nursing Home Administrators and to programs for persons with injuries to the spinal cord.

Disclosure of the names and addresses of any directors or persons owning at least 10 percent of a corporation applying for a license to operate a nursing home is required by the Act. The name and address of any business entity in which an officer, director or owner of a nursing home has an interest of 10 percent or more which will be providing goods, leases, or services to the nursing home is also required to be disclosed. Kickbacks, bribes and rebates are prohibited. Willful coercive solicitation of contributions for a nursing home, such as a contribution being made a condition for acceptance of a specific patient, is also prohibited.

The rights and welfare of patients who are residents of a facility which voluntarily closes are protected by requiring a 90-day notice of the closing in order to allow adequate time to arrange for transfer. Transfer of patients who receive assistance under the Medicaid program is made a responsibility of the Department of Health and Rehabilitative Services. The Department must have a representative in the facility at least 30 days in advance of closing and must monitor the transfer of patients to other facilities and insure that patients' rights are protected.

The Act provides that at least one unannounced inspection of each nursing home shall be made annually, and provides penalties for the giving of advance notice of such inspections. Provisions are made to insure adequate public availability of records and reports of nursing home inspections, including a requirement that a summary of the results of the last completed inspection be posted in a facility and that a copy of the full inspection report be obtainable upon request, subject to a charge for copying.

Promulgation of standards for the quality of care in nursing homes is mandated, as well as the establishment of a system of rating nursing homes. Such ratings, based on inspection results, are to be publicly posted and included in all advertising, and will in part form the basis for levels of state assistance payments for services rendered to patients, with higher rated homes receiving higher levels of payment. A system of classifying inspection deficiencies is also mandated to allow quick recognition and understanding of the severity of a deficiency.

Adoption by a nursing home of a public statement of the rights of its patients is required. Among other things, the statement must insure each patient the following: civil and religious liberties, adequate and appropriate health care, the right to present grievances, the right to manage his or her own financial affairs, privacy, freedom from mental and physical abuse and unnecessary restraints, and the right to be informed of his or her medical condition and proposed treatment.

In order to increase the skill and knowledge of health practitioners in the care and treatment of nursing home patients, the Department of Education is directed, in cooperation with the Department of Health and Rehabilitative Services, to develop appropriate educational programs. Practical education courses may be conducted in nursing homes which have received high quality ratings and which contract to provide such an educational setting.

Various other aspects of nursing home care are affected by the Omnibus Nursing Home Reform Act. Certified statements of the cost of providing care are required to be submitted by nursing homes which contract to provide services to indigent patients under the medical assistance programs. The composition of the Board of Examiners of Nursing Home Administrators is changed to provide a majority of non-administrators, and noninstitutional members of the board are required to have no direct financial interest in nursing homes. Certain home

health agencies are exempted from the requirement of obtaining a certificate of need prior to receiving a license. And, various reports to the Legislature are required in order to monitor the implementation of the Act.

Also provisions requiring the Department of Health and Rehabilitative Services to develop a plan for the establishment of a multilevel treatment program for persons with spinal cord injuries are included in the Act. The program envisioned would provide for an emergency medical evacuation system, intensive trauma care centers, rehabilitation centers, and halfway houses for victims of spinal cord injury, with appropriate treatment and rehabilitative services at each level. By insuring early identification, skilled handling, and proper treatment, such a system should aid in prevention of permanent paralysis and in restoration of injury victims to as normal a life as possible.

CHAPTER 76-201

Committee Substitute for House Bill No. 3140

AN ACT relating to nursing homes; creating the Omnibus Nursing Home Reform Act of 1976; amending s. 400.071(1) and (2)(a), Florida Statutes, and adding a new paragraph to require certain financial disclosure by applicants for licensure; amending s. 400.17, Florida Statutes, relating to the prohibition against kickbacks, bribes, and certain contributions; providing definitions; providing penalties; amending s. 400.18, Florida Statutes, relating to the rights and protection of patients being transferred from a closing facility; requiring nursing facilities to notify the Department of Health and Rehabilitative Services and the local Health Systems Agency within 90 days of discontinuance of operation; amending s. 400.19, Florida Statutes, relating to inspection by the Department of Health and Rehabilitative Services; creating s. 400.191, Florida Statutes, to provide for distribution and availability of reports and records; amending s. 400.23, Florida Statutes, to provide for patient care standards and to provide for the establishment of criteria for the evaluation of nursing home facilities; providing that state vendor payments to nursing homes be tied to ratings received; providing for classification of deficiency ratings and civil penalties therefor; creating s. 400.022, Florida Statutes, to provide for the adoption of specified patient's rights; creating s. 400.29, Florida Statutes, to provide for an annual report by the department with respect to the nursing homes in the state; providing for courses of study relating to the treatment of nursing home patients through the Department of Education; amending s. 400.504, Florida Statutes, providing that any home health agency operating and providing services prior to a specified date shall not be denied a license on the basis of not having received a certificate of need; creating s. 409.268, Florida Statutes, relating to nursing homes which provide services to the indigent; requiring annual reports to the Legislature; amending s. 468.166(2), Florida Statutes, and adding a subsection, to provide a new composition of the Florida State Board of Examiners of Nursing Home Administrators and to provide that noninstitutional members of the board shall have no direct financial interest in nursing homes; providing for a plan for rehabilitation programs for persons with injuries to the spinal cord; providing for emergency medical transportation; providing for intensive trauma care centers, rehabilitation centers and halfway houses; providing for an annual review of nursing home placements of spinal cord injured persons; creating an advisory council; providing an appropriation; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. This act shall be known and may be cited as "The Omnibus Nursing Home Reform Act of 1976."

Section 2. Subsection (1) and paragraph (a) of subsection (2) of section 400.071, Florida Statutes, are amended, paragraphs (b), (c), (d) and (e) of subsection (2) are redesignated paragraphs (c), (d), (e) and (f) respectively, and a new paragraph (b) is added to said subsection to read:

400.071 Application for license.--

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(1) Application for license as required by s. 400.062 shall be made to the department ~~(department)~~ on forms furnished by it, and shall be accompanied by the appropriate license fee.

(2) The application shall be under oath and shall contain the following:

(a) The name and address of the applicant if an individual; if the applicant is a firm, partnership, or association, the name and address of every member thereof; and if the applicant is a corporation, its name and address, the name and address of its director, officers, each person having at least a 10 percent interest in the corporation, and the name by which the facility is to be known.

(b) The name of any person whose name is required on the application under the provisions of paragraph (a) and who owns at least a 10 percent interest in any professional service, firm, association, partnership, or corporation providing goods, leases or services to the facility for which the application is made, and the name and address of the professional service, firm, association, partnership or corporation in which such interest is held.

Section 3. Section 400.17, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 400.17, F.S., for present text.)

400.17 Bribes, kickbacks, etc. prohibited.--

(1) As used in this section:

(a) "Kickback" means that part of the payment for items or services which is returned to the payor by the provider of such items or services with the intent or purpose to induce the payor to purchase the items or services from the provider.

(b) "Bribe" means any consideration corruptly given, received, promised, solicited or offered to any individual with intent or purpose to influence the performance of any act or omission.

(2) Whoever furnishes items or services directly or indirectly to a nursing home patient and solicits, offers or receives any:

(a) Kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment; or

(b) Return of part of an amount given in payment for referring any such individual to another person for the furnishing of such items or services;

shall be guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082, or by fine not exceeding $5,000, or both.

(3) No person shall, in connection with the solicitation of contributions to nursing homes, willfully misrepresent or mislead anyone, by any manner, means, practice or device whatsoever, to believe that the receipts of such solicitation will be used for charitable purposes, if such is not the fact.

(4) Solicitation of contributions of any kind in a threatening, coercive or unduly forceful manner by or on behalf of nursing homes by any agent, employee, owner or representative of a nursing home shall be grounds for denial, suspension or revocation of a license for any nursing home on behalf of which such contributions were solicited.

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(5) The admission, maintenance or treatment of a nursing home patient whose care is supported in whole or in part by state funds shall not be made conditional upon the receipt of any manner of contribution or donation from any person; however, this shall not be construed to prohibit the offer or receipt of contributions or donations to a nursing home which are not related to the care of a specific patient. Contributions solicited or received in violation of this subsection shall be grounds for denial, suspension or revocation of a license for any nursing home on behalf of which such contributions were solicited.

Section 4. Section 400.18, Florida Statutes, is amended to read:

400.18 Closing of nursing facility.--

(1) Whenever a facility voluntarily discontinues operation, and during the period when it is preparing for such discontinuance, it shall inform the department ~~{department}~~ and the local Health Systems Agency of the district wherein the facility is located, within 90 days of the discontinuance of operation. The facility also shall inform the resident or the next of kin, legal representative, or agency acting on the resident's behalf of the fact and the proposed time of such discontinuance and give at least 90 days ~~sufficient~~ notice so that suitable arrangements may be made for the transfer and care of the resident. In the event any resident has no such person to represent him, the facility shall be responsible for securing a suitable transfer of the resident prior to the discontinuance of operation. The department shall be responsible for arranging for the transfer of those patients requiring transfer who are receiving assistance under s. 409.266.

(2) A representative of the department shall be placed in a facility 30 days prior to the voluntary discontinuance of operation, or immediately upon notice from the department of involuntary discontinuance of operation of a facility to:

(a) Monitor the transfer of patients to other facilities; and

(b) Insure that the rights of patients are protected.

(3) ~~(2)~~ Immediately upon discontinuance of operation of a facility, the owner shall surrender the license therefor to the department ~~{department}~~, and the license shall be canceled.

Section 5. Section 400.19, Florida Statutes, is amended to read:

400.19 Right of entry and inspection.--

(1) The department ~~{department}~~ and any duly designated officer or employee thereof shall have the right to enter upon and into the premises of any facility licensed pursuant to this chapter at any reasonable time in order to determine the state of compliance with the provisions of this chapter and rules ~~and regulations~~ in force pursuant thereto. The right of entry and inspection shall also extend to any premises which the department ~~{department}~~ has reason to believe is being operated or maintained as a facility without a license, but no such entry or inspection of any premises shall be made without the permission of the owner or person in charge thereof, unless a warrant is first obtained from the circuit court authorizing same. Any application for a facility license or renewal thereof, made pursuant to this chapter, shall constitute permission for and complete acquiescence in any entry or inspection of the premises for which the license is sought, in order to facilitate verification of the information submitted on or in connection with the application.

(2) The department shall annually conduct at least one unannounced inspection to determine compliance by the nursing home facility with

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statutes, and with rules promulgated under the provisions of those statutes, governing minimum standards of construction, quality and adequacy of care, and rights of patients. Any employee of the department who gives or causes to be given advance notice of such unannounced inspections to any unauthorized person shall be subject to suspension of not less than 5 working days according to the provisions of s. 110.061.

Section 6. Section 400.191, Florida Statutes, is created to read:

400.191 Availability, distribution and posting of reports and records.--

(1) The department shall, within 60 days from the date of an annual inspection visit or within 30 days from the date of any interim visit, forward the results of all inspections of nursing home facilities to:

(a) The regional nursing home ombudsman committee in whose district the inspected facility is located.

(b) At least one public library or, in the absence of a public library, the county seat, in the county in which the inspected facility is located.

(c) The district administrator of the department in whose district the inspected facility is located.

(d) The Health Systems Agency in whose district the inspected facility is located.

(e) The Board of Examiners of Nursing Home Administrators.

(2) Each nursing home facility shall maintain as public information, available upon request, records of all cost and inspection reports pertaining to that facility that have been filed with or issued by any governmental agency. Copies of such reports shall be retained in said records for not less than 5 years from the date said reports are filed or issued.

(3) Any records, reports, or documents which by state or federal law or regulation are deemed confidential shall not be distributed or made available for purposes of compliance with this section unless and until such confidential status expires.

(4) Any records of a nursing home facility determined by the department to be necessary and essential to establish lawful compliance with any rules or standards shall be made available to the department on the premises of the facility.

(5) Every nursing home shall:

(a) Post in a sufficient number of prominent positions in the nursing home so as to be accessible to all residents and to the general public, a concise summary of the last inspection report pertaining to the nursing home and issued by the department, with references to the page numbers of the full reports, noting any deficiencies found by the department and the actions taken by the nursing home to rectify such deficiencies, and indicating in such summaries where the full reports may be inspected in said nursing home; and

(b) Upon request, provide to any person who has completed a written application with an intent to be admitted to, or any resident of, such nursing home, or any relative, spouse or guardian of such person a copy of the last inspection report pertaining to the nursing home and issued by the department, provided the person requesting such report agrees to pay a reasonable charge to cover copying costs.

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Section 7. Section 400.23, Florida Statutes, is amended to read:

400.23 Rules ~~and--regulations~~; minimum standards; fee for review of plans.--

(1) It is the intent of the Legislature that rules published and enforced pursuant to this chapter shall include standards by which a reasonable and consistent quality of patient care may be insured, the results of such patient care can be measured, and safe and sanitary nursing homes can be provided. It is further intended that a minimum amount of the time of professionals providing nursing home care be required to insure compliance with the reporting requirements of these rules.

(2) ~~(1)~~ Pursuant to the intention of the Legislature ~~to provide safe and sanitary homes for patients~~, the department shall publish and enforce rules ~~and regulations~~ to implement the provisions of this chapter, which shall include reasonable and fair minimum standards in relation to:

(a) The location and construction of the facility, including plumbing, heating, lighting, ventilation, and other housing conditions which will insure the health, safety, and comfort of residents and protection from fire hazard, including adequate provisions for fire alarm and other fire protection suitable to the size and type of structure and an adequate call system. Separate standards shall be provided for physical plant of new and existing facilities.

(b) The number and qualifications of all personnel, including management, medical, and nursing personnel, and aides, orderlies and support personnel, having responsibility for any part of the care given residents.

(c) All sanitary conditions within the facility and its surroundings, including water supply, sewage disposal, food handling, and general hygiene which will insure the health and comfort of residents.

(d) The equipment essential to the health and welfare of the residents.

(e) A uniform accounting system.

(f) ~~(e)~~ The care, treatment, and maintenance of residents and measurement of the quality and adequacy thereof.

(3) Not later than January 1, 1977, the department shall promulgate rules establishing uniform criteria for the evaluation of nursing home facilities with respect to their compliance with the standards set forth in this section, as indicated by inspection results. Such criteria shall include a detailed listing of the types, and degree of severity or unacceptability, of deficiencies which inspections might indicate, and shall also indicate areas of care and performance in which nursing home facilities notably and significantly exceed required minimum standards. In promulgating such criteria the department shall devise a system of rating nursing home facilities in accordance with the deficiencies and areas of significantly high care and performance which reports of inspection shall have indicated. Such a system shall include five rating categories entitled, from highest to lowest "AA," "A," "B," "C," and "F". "F" rated nursing homes shall be nursing homes whose performance is sufficiently below minimum standards to require suspension, revocation, or denial of a license to operate. The rating assigned to each nursing home facility on the basis of its immediately prior inspection shall be deemed a part of the results and findings of that inspection, and shall be required by the department to be included in all advertising and conspicuously posted within and outside of the nursing home facility to which it applies. For purposes of review and comment, ratings assigned

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to facilities shall be forwarded by the department to the regional nursing home ombudsman committee in whose district the facility is located. A nursing home facility may appeal the assignment of a particular rating to the department within 20 days after notice of its assignment.

(4) Not later than March 1, 1977, the department shall promulgate rules which relate the level of state vendor payments to nursing home facilities to the rating received by each nursing home facility under the provisions of subsection (3) so that facilities assigned higher ratings may receive higher levels of payment than those facilities assigned lower ratings after July 1, 1977. Such rules as are promulgated under this section shall be consistent with federal laws and regulations.

(5) Not later than December 1, 1976, the department shall promulgate rules to provide that where the minimum standards established under subsection (2) are not met such deficiencies shall be classified according to the nature of the deficiency, and the department shall indicate the classification on the face of the notice of deficiencies as follows:

(a) Class "I" deficiencies are those which the department determines present an imminent danger to the patients or guests of the nursing home facility or a substantial probability that death or serious physical harm would result therefrom. The condition or practice constituting a class "I" violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the department, is required for correction. Notwithstanding the provisions of section 400.121(8), a class "I" deficiency is subject to a civil penalty in an amount not less than $1,000 and not exceeding $5,000 for each and every deficiency. If the department determines that a fixed period of time is required for correction of a class "I" deficiency and the deficiency is corrected within the designated time, no civil penalty shall be imposed.

(b) Class "II" deficiencies are those which the department determines have a direct or immediate relationship to the health, safety, or security of the nursing home facility patients, other than class "I" deficiencies. A class "II" deficiency is subject to a civil penalty in an amount not less than $50 and not exceeding $250 for each and every deficiency. A citation for a class "II" deficiency shall specify the time within which the deficiency is required to be corrected. If a class "II" deficiency is corrected within the time specified, no civil penalty shall be imposed.

(c) Class "III" deficiencies are those which the department determines to have an indirect or potential relationship to the health, safety or security of the nursing home facility patients, other than class "I" or "II" deficiencies. A class "III" deficiency shall be subject to a civil penalty of not less than $20 and not exceeding $50 for each and every deficiency. A citation for a class "III" deficiency shall specify the time within which the deficiency is required to be corrected. If a class "III" deficiency is corrected within the time specified, no civil penalty shall be imposed.

(6) ~~(3)~~ The department ~~(department)~~ is authorized to charge a fee not to exceed $50 for services rendered in reviewing preliminary plans of each new project, whether an alteration or addition. Counties or municipalities shall be exempt from payment of this fee.

Section 8. Section 400.022, Florida Statutes, is created to read:

400.022 Patients' rights.--

(1) All nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the patients residing in

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such facilities and shall treat such patients in accordance with the provisions of said statement. The statement shall insure each patient the following:

(a) The right to civil and religious liberties, including knowledge of available choices and the right to independent personal decision, which will not be infringed upon, and the right to encouragement and assistance from the staff of the facility in the fullest possible exercise of these rights.

(b) The right to have private communications with any person of his or her choice.

(c) The right to present grievances on behalf of himself, herself or others to the facility's staff or administrator, to governmental officials, or to any other person, without fear of reprisal, and to join with other patients or individuals within or outside of the facility to work for improvements in patient care.

(d) The right to manage his or her own financial affairs or to have a quarterly accounting of any financial transactions made in his or her behalf, should he or she delegate such responsibility to the facility for any period of time.

(e) The right to be fully informed, in writing, prior to or at the time of admission and during his or her stay, of services not covered under Titles XVIII or XIX of the Social Security Act or not covered by the basic per diem rates.

(f) The right to be adequately informed of his or her medical condition and proposed treatment unless otherwise indicated by his or her physician, and to participate in the planning of all medical treatment, including the right to refuse medication and treatment, unless otherwise indicated by his or her physician, and to know the consequences of such actions.

(g) The right to receive adequate and appropriate health care consistent with established and recognized practice standards within the community and with rules as promulgated by the department.

(h) The right to have privacy in treatment and in caring for personal needs, confidentiality in the treatment of personal and medical records, and security in storing and using personal possessions.

(i) The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement of the services provided by the facility, including those required to be offered on an as-needed basis.

(j) The right to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency, in which case the restraint may only be applied by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of restraint, and, in the case of use of a chemical restraint, a physician shall be consulted immediately thereafter.

(k) The right to be transferred, reclassified or discharged only for medical reasons or for the welfare of other patients, or for nonpayment for his or her stay, and the right to be given reasonable advance notice of any transfer or discharge, except in the case of an emergency as determined by a licensed professional on the staff of the nursing home.

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(l) The right to freedom of choice in selecting a health care facility.

(m) The right to have copies of the facility's rules and regulations, and an explanation of his or her responsibility to obey all reasonable rules and regulations of the facility and to respect the personal rights and private property of the other patients.

(2) Each nursing home shall provide a copy of the statement required by subsection (1) to each patient or his guardian at or before the patient's admission to a facility and to each staff member of a facility. Each such facility shall prepare a written plan and provide appropriate staff training to implement the provisions of this section.

(3) Any violation of the patient's rights set forth in this section shall constitute grounds for action by the department under the provisions of s. 400.102.

Section 9. Section 400.29, Florida Statutes, is created to read:

400.29 Annual report of nursing home facilities.--On or before January 1, 1977, and annually thereafter, the department shall publish a report, available to the public, which shall include, but not be limited to, a list by name and address of all nursing home facilities in this state; whether such nursing home facilities are proprietary or nonproprietary; the rating of each nursing home facility; the name of the owner or owners; the total number of beds; the number of private and semiprivate rooms; the religious affiliation, if any, of such nursing home facility; the languages spoken by the administrator and staff of such nursing home facility; the number of full-time employees and their professions; whether or not such nursing home facility accepts medicare or medicaid patients; and recreational and other programs available.

Section 10. Section 400.504, Florida Statutes, is amended to read:

400.504 Agencies to be given reasonable time to comply with rules and standards.--Any agency as defined in this act which is in operation as of July 1, 1975, or at the time of promulgation of any applicable rules or standards adopted pursuant to this act may be given a reasonable time, not to exceed 1 year from the date of publication, within which to comply with such rules and standards and obtain a license. Further, any home health agency operating and providing services in the state and having a provider number issued by the U. S. Department of Health, Education and Welfare on or before April 30, 1976, shall not be denied a license on the basis of not having received a certificate of need.

Section 11. Courses of study in care of nursing home patients.--

(1) It is the intent of the Legislature that educational institutions in Florida shall develop and provide adequate courses of study in the health professions to enable practitioners to become skilled in the care and treatment of nursing home patients.

(2) To accomplish this purpose, the Department of Education in cooperation with the Department of Health and Rehabilitative Services is directed to develop educational programs in health occupations that are adequate and appropriate for the various services to be performed in the care and treatment of nursing home patients, and to assure such programs are available to provide an adequate supply of trained personnel for nursing homes in all areas of the state.

(3) The Board of Regents and the boards of trustees of community colleges are authorized to enter into contracts with nursing home facilities rated "AA" under the provisions of subsection (3) of section 400.23, Florida Statutes, for the purpose of providing practical

education for students in health service careers related to nursing home care.

(4) Prior to March 1, 1977, the Department of Education shall report to the President of the Senate and the Speaker of the House of Representatives on the progress of its planning for and development of adequate courses of study in the health professions, which report shall include recommendations for legislative action needed to fully carry out the legislative intent included in subsection (1) of this section.

Section 12. Section 409.268, Florida Statutes, is created to read:

409.268 Nursing home care under the medical assistance program.--

(1) Any nursing home entering into a contract to provide services to indigent patients under the provisions of s. 409.266 shall:

(a) Semiannually forward to the department a true and accurate statement of its cost of providing care. The statement shall be prepared and signed by a certified public accountant who is fully independent of the nursing home management and operations and who does not have or intend to acquire any direct financial interest or material interest in the ownership or operation of the nursing home.

(b) Fully comply with all contracts and state and federal rules and standards promulgated under the medical assistance program.

(2) The department shall audit the records of any nursing home which it has reason to believe may not be in full compliance with the provisions of this section.

Section 13. The Department of Health and Rehabilitative Services shall prepare reports for submission to the President of the Senate and the Speaker of the House of Representatives by January 1, 1977, on:

(1) Alternative systems of reimbursement by which nursing homes may be provided incentives to improve management efficiency and quality of patient care at a reasonable cost.

(2) The potential for utilization of competitive bidding for provider contracts in areas of the state having excess nursing home beds.

(3) The potential for developing total care programs for the elderly of the campus or village type which use a nursing home as a core service around which a constellation of other services are organized.

Section 14. Subsection (2) of section 468.166, Florida Statutes, is amended, and subsection (11) is added to said section, to read:

468.166 Board of Examiners.--

(2) Upon the expiration of the terms of the present board, the Governor, subject to confirmation by the Senate, shall appoint a board of examiners composed of 11 members. The board shall consist of:

~~(a) One representative of the Department of Health and Rehabilitative Services;~~

(a) ~~(b)~~ Five ~~Six~~ nursing home administrators licensed and registered in this state;

(b) ~~(c)~~ One doctor of medicine licensed in this state who has demonstrated an interest in the care of long-term patients;

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(c) ~~(d)~~ One registered nurse who has at least a baccalaureate degree and is currently employed in the field of geriatric nursing;

(d) ~~(e)~~ One hospital administrator ~~who has demonstrated an interest in the care of long-term patients and infirm aged patients~~; and

(e) ~~(f)~~ Two members ~~One member~~ from the public at large who have ~~has~~ demonstrated a concern for the chronically ill and infirm aged patients; and

(f) One pharmacist licensed and registered in this state.

(11) Noninstitutional members of the board shall have no direct financial interest in nursing homes.

Section 15. Legislative intent.--It is the intent of the Legislature to provide for the development of a coordinated rehabilitation program for those persons severely disabled by spinal cord injuries. Further it is intended that permanent paralysis be prevented whenever possible through early identification of spinal cord injuries, skilled emergency evaluation procedures, and proper medical and rehabilitative treatment. The goal of this program shall be to enable individuals severely disabled by spinal cord injury to resume the activities of daily living and reintegrate with the community with as much dignity and independence as possible. For those persons who cannot achieve complete independence, supportive services and economic assistance are needed in order for them to live as normally as possible.

Section 16. Definitions.--As used in this act:

(1) "Department" means the Department of Health and Rehabilitative Services.

(2) "Secretary" means the secretary of the Department of Health and Rehabilitative Services.

(3) "Emergency medical evacuation system" means a transportation system which provides timely skilled emergency care and movement of persons believed to have suffered spinal cord injuries.

(4) "Intensive trauma care center" means a facility which provides diagnosis and intensive treatment of persons with spinal cord injuries aimed at preventing paralysis.

(5) "Rehabilitation center" means a facility which provides intermediate care and stresses rehabilitation for persons with spinal cord injuries.

(6) "Halfway house" means a facility which provides a temporary structured residential environment for those individuals with spinal cord injuries in a training or educational program, in order to prepare such individuals to live independently.

Section 17. Establishment of a plan for a system of treatment for persons with spinal cord injuries.--The department shall develop a plan for the establishment of a multilevel treatment program for persons with spinal cord injuries and present the plan to the secretary for review by March 1, 1977. The plan shall contain at least the following components:

(1) Establishment of an emergency medical evacuation system which shall include the operation and implementation of an emergency transport system in order that persons with spinal cord injuries can be transported to an intensive trauma care center on a timely basis.

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(2) Establishment of intensive trauma care centers which will provide as a minimum:

(a) The administration of preventive treatment to persons with spinal cord injuries to prevent paralysis, save lives and stabilize the person's medical condition so that he can be transferred as soon as possible to a rehabilitation center for further rehabilitation.

(b) The appropriate number of centers to be developed according to need. Each facility shall consist of a special medical unit with appropriate professional personnel and expertise.

(3) Establishment of rehabilitation centers to provide rehabilitation services for persons transferred from the intensive trauma care center and for other spinal cord injured persons requiring rehabilitation services. Such centers shall be located according to need and shall be equipped with the appropriate staff component to meet the specialized rehabilitation needs of spinal cord injured persons.

(4) Establishment of an appropriate number of halfway houses for individuals who need attendant care, who are in adjustment periods, who require a structured environment or who are in retraining or educational programs. All residents shall use the halfway house as a temporary measure and not as a permanent home or domicile.

(5) Residents of any of the above cited facilities shall pay a monthly fee based on ability to pay.

Section 18. The department shall conduct an annual survey of nursing homes in the state to determine the number of individuals 55 years of age and under who reside in such homes due to a spinal cord injury. All individuals identified in such a survey shall be evaluated as to their rehabilitation potential, and any individual who may benefit from rehabilitation shall be given an opportunity to participate in an appropriate rehabilitation program for which he may be eligible.

Section 19. Advisory council.--

(1) There is created within the department an advisory council on spinal cord injuries composed of five appropriate professionals with expertise in areas related to the care and rehabilitation of individuals with spinal cord injuries, and six individuals with spinal cord injuries.

(2) Members of the council shall be appointed by the secretary and shall serve for terms of 4 years, except that five members of the first appointed council shall serve for 2 years.

(3) The council shall meet at least four times annually and members shall be entitled to per diem and travel expenses in accordance with the provisions of s. 112.061, Florida Statutes.

(4) The council shall provide advice and expertise to the department in the preparation, implementation, and periodic review of the coordinated rehabilitation program as set forth in this act.

Section 20. There is hereby appropriated from general revenue funds the sum of $125,000 to be matched by federal funds for purposes of implementing the provisions of this act.

Section 21. This act shall take effect October 1, 1976.

Approved by the Governor June 20, 1976.

Filed in Office Secretary of State June 21, 1976.

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