PERFORMANCE AUDIT

LONG-TERM CARE PROGRAMS
IN NORTH CAROLINA
as administered by the
DEPARTMENT OF HEALTH AND HUMAN SERVICES

APRIL 1998

STATE OF NORTH CAROLINA
Office of the State Auditor

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April 20, 1998

The Honorable James B. Hunt, Jr., Governor
Dr. H. David Bruton, Secretary
Department of Health and Human Services
Members of the North Carolina General Assembly

Ladies and Gentlemen:

We are pleased to submit this performance audit of the *North Carolina Long-Term Care Programs as administered by the Department of Health and Human Services*. This audit was undertaken as part of a multi-state audit proposed by the National State Auditors Association. As such, the results contained in this report have been forwarded to the lead state for inclusion in the multi-state summary report.

This report submitted to you today contains the results of the audit of the administration of long-term care programs in North Carolina. The objectives of the audit were to examine and evaluate the procedures for identifying, licensing, and inspecting entities providing long-term care services in the State. Additionally, we examined and evaluated procedures for receiving and reviewing complaints, making payments for services rendered, and ensuring the performance of timely case management functions.

This report consists of an executive summary, program overview, and operational findings and recommendations. Management of the Department and the various Divisions involved with administration and delivery of long-term care services have reviewed a draft copy of this report and the Secretary's written comments are included.

We wish to express our appreciation to the Secretary and staff for the courtesy, cooperation, and assistance provided us during this effort.

Respectfully submitted,

[Original signed by Ralph Campbell, Jr.]

Ralph Campbell, Jr.
State Auditor

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EXECUTIVE SUMMARY

The Office of the State Auditor undertook this performance audit of issues surrounding long-term care in North Carolina as part of a multi-state audit under the auspices of the National State Auditors Association.[1] The overall objectives for the multi-state audit were identified by the ten participating states. North Carolina's State Auditor determined that the objectives for the North Carolina long-term care programs would be to examine and evaluate procedures for identifying, licensing, and inspecting all entities providing long-term care services in the State. Additionally, the audit examined and evaluated procedures for receiving and reviewing complaints, making payments for services rendered, and ensuring the performance of timely case management functions. Lastly, we have included a segment on the future costs of long-term care in North Carolina given the growing elderly population of the State.

Because of the number and breadth of long-term care services offered in North Carolina, the scope of the audit encompassed various divisions within the North Carolina Department of Health and Human Services. These divisions included the Division of Facility Services, the Division of Medical Assistance, the Division of Aging, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, and the Division of Social Services. This report contains detailed summaries of the various long-term care programs and services for which these divisions have responsibilities, as well as identification of areas of overlap. While the Department of Health and Human Services has done a commendable job of administering the many diverse and difficult long-term care programs in the State, we have included some specific recommendations aimed at improving the operations of the programs.

The Secretary of the Department of Health and Human Services and each of the divisions involved with providing long-term care services in North Carolina have reviewed a draft copy of the report. The Secretary's response is included as Appendix C, page 51.

FINDINGS

[1] We anticipate the report containing the results of the multi-state audit will be released by the National State Auditors Association sometime in April, 1998. The results from the audit of the North Carolina long-term care programs has been forwarded to the lead state for inclusion in that summary document. Other states participating were: Louisiana, Oregon, Texas, Ohio, Pennsylvania, New York, Tennessee, Kentucky, and Connecticut.

FINDINGS (concluded)

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AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

North Carolina GS §147-64 empowers the State Auditor with authority to conduct performance audits of any state agency or program. Performance audits are reviews of activities and operations to determine whether resources are being used economically, efficiently, and effectively.

This audit was undertaken as part of a multi-state audit under the auspices of the National State Auditors Association. The Office of the State Auditor agreed to conduct a performance audit of the issues surrounding long-term care in North Carolina. This report contains the results of that audit. Additionally, the results from North Carolina were forwarded to the lead state on the multi-state audit for inclusion in a summary document. That report is anticipated to be released in April 1998.

The overall objectives of the multi-state audit were identified by the participating states. In total, ten states participated in some or all of the objectives. The State Auditor determined that for the North Carolina programs, the objectives would be to determine:

- whether the agency responsible for licensing was adequately ensuring that the providers meet all the licensing requirements and that all providers offering services are appropriately licensed;
- whether the agency responsible for inspections conducts the necessary inspections before issuing a license and whether the inspections ensure the provider is complying with the appropriate rules and regulations;
- whether the agency responsible for receiving and reviewing complaints has an adequate process and is imposing sanctions if providers are found not to be in compliance;
- whether the agency responsible for payments ensures that services billed were actually provided; and
- whether the agency responsible for case management is ensuring assessments are conducted and care plans are developed.

Additionally, we examined issues relating to the future costs of long-term care for the growing elderly population in North Carolina. Those conclusions are also included as part of this report.

The scope of the audit encompassed various divisions within the North Carolina Department of Health and Human Services, all of which have responsibilities for portions of the long-term care programs in North Carolina. These divisions included the Division of Facility Services, the Division of Medical Assistance, the Division of Aging, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, and the Division of Social Services.

To achieve the audit objectives, we employed various auditing techniques which adhere to the generally accepted auditing standards as promulgated in *Government Audit Standards* issued by the Comptroller General of the United States. These techniques included:

- review of federal and state legislation and regulations regarding long-term care;
- review of the North Carolina Administrative Code for each division involved in providing the long-term care programs;
- review of prior audit reports and other studies conducted on long-term care or portions of the programs;
- examination of the State Health Plan regarding the process, as well as the number of and type of facilities and their locations;

- interview of some 112 individuals, both within and external to the various divisions;
- on-site visits to 34 facilities and interview of staff at the facilities, as well as county level personnel involved in the processes;
- examination of policies and procedures for the various long-term care functions within the divisions;
- examination of samples of complaints, surveys, and inspections reports;
- review of the fines and penalties assessed against providers; and
- examination of the cost reimbursement process.

Because of the test nature and other inherent limitations of an audit, together with the inherent limitations of any system of internal and management controls, this audit would not necessarily disclose all weaknesses in the system or instances of noncompliance. Also, projections of any of the results contained in this report to future periods are subject to the risk that procedures may become inadequate because of changes in conditions and/or personnel, or that the effectiveness of the design and operation of policies and procedures may deteriorate.

LONG-TERM CARE - THE FUTURE

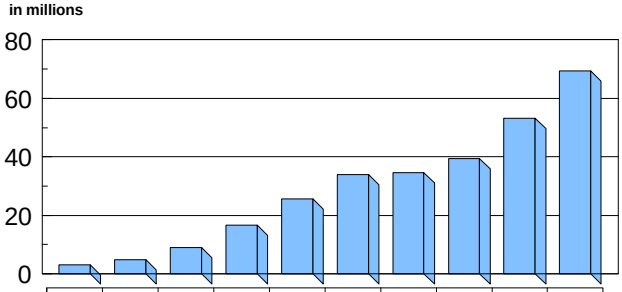
The New England Journal of Medicine says that if you live past the age of 65 there is a 43% chance you will require long-term care. The US Department of Commerce reports that more than 8.8 million individuals over the age of 65 receive long-term care: 1.3 million are nursing home residents, and 7.5 million require some form of home care. Studies have shown nursing home care can cost $36,000 or more annually. Although older adults are the age group most likely to need long-term services, long-term care also impacts other populations such as disabled adults.

The Social Security Act of 1935 was targeted at the aged and poor. Payments through this Act were meant to supplement pensions and savings to assure support of the elderly (those over the age of 65). However, since the Social Security Act was passed, conditions have changed considerably: the nuclear family has disappeared; Social Security payments barely meet the older persons' minimum living expenses; and the cost of medical care has sky rocketed. The cost of nursing homes is often more than three times the Social Security entitlement for an individual.

According to US Census Bureau data, persons 65 years or older number 33.9 million in 1996, representing 12.8% of the US population. That is about one in every eight Americans. Within 20 years, the number of retirees will grow dramatically. At the beginning of the next century, older adults will constitute 18% of the total population. Exhibit 1 depicts the expected increase in persons 65+. Many elderly people choose to move to a setting with other retirees, into centers referred to as “retirement,” “rest,” or “domiciliary” homes. These centers are considered to be independent living arrangements. However, elderly living in them may not qualify for Medicaid because they may not require skilled nursing care on a daily basis or be eligible to receive in-home services through Medicaid due to income/resource levels. Regardless of whether older adults are living in their own home, or some type of congregate housing arrangement, given current Medicaid eligibility criteria, the vast majority of frail older adults living in the community in need of supportive services will not be Medicaid eligible.

EXHIBIT 1

NUMBER OF PERSONS AGE 65+: 1900 to 2030



1900	1920	1940	1960	1980	1996	2000	2010	2020	2030
3.1	4.9	9.0	16.7	25.7	33.9	34.7	39.4	53.2	69.4

Source: US Bureau of the Census

In its 1997 report to the General Assembly, the North Carolina Study Commission on Aging said that there are dramatic changes expected in the demographic profile of North Carolina.

> These changes will have a direct impact on our health and human services systems. Between 1980 and 2010, the population age 65 and older will have doubled to 1. 2 million. Older adults now comprise the fastest growing segment of our population. Between 1980 and 1990, North Carolina experienced a growth rate of 33% for individuals 65 and over compared to a growth rate of 12.8% for the State as a whole. This ranked North Carolina tenth in the United States in the growth of the older adult population. By the beginning of the next

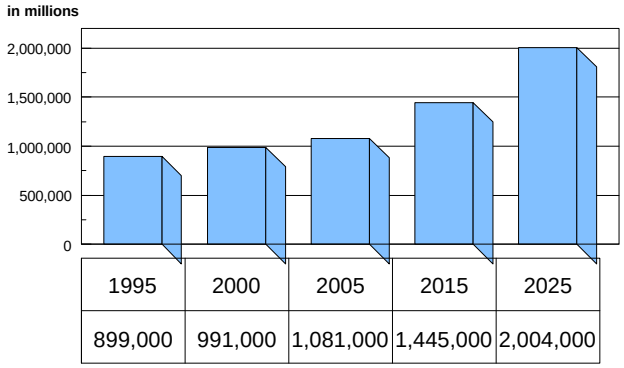
century, our 65+ population will constitute 13% of the total population. This will increase to more than 14% by the year 2010. [2]

Another factor which North Carolina must take into account is the increase in the number of persons retiring to our State. Between the years 1985 and 1990, it is estimated that up to 40,000 retirees relocated to North Carolina. This ranked North Carolina fifth nationally in attracting out-of-state retirees. While people retiring to North Carolina are generally younger and better off financially, poverty is a striking characteristic of older native North Carolinians. The 1990 census found that 19.5% of those 65 and older, and 30% of those 85+, lived at or below the federal poverty level.[3] This means many older adults in North Carolina who need health and supportive services lack financial resources needed to pay for their own care. Long-term care expenditures for older adults have grown from $486 million in 1990 to $1.08 billion in 1996, an increase of 122%.

The Study Commission found further that despite popular conceptions, most older adults in North Carolina live in independent living arrangements, not a group setting like a nursing home or adult care home. In fact, in 1990 over 94% of the 65+ population lived independently, with just over 5% living in a group setting. More than half (58%) live with their spouse; almost 29% live alone. This means that there will be a tremendous need to identify and fund services which are targeted at those older citizens living independently. Currently, North Carolina spends at least five times more on institutional care for the elderly than on community-based care. As reported by the Commission, ". . . there is a need to better coordinate and use existing resources to assure optimal responses to expected increases in demands."[4]

Statistics show that the most dramatic increase will be with the 85+ population in North Carolina. Here we can expect an increase of 62.3% between 1990 and 2000, from about 69,000 to about 112,000 individuals. This is the age population that experiences the highest rates of physical and health impairments. These impairments result in the need for health, personal care, and other supportive services. Currently, the 85+ age group is the largest group using both in-home and community based care.

EXHIBIT 2
NUMBER OF NORTH CAROLINAS CITIZENS 65+
1995 to 2025



1995	2000	2005	2015	2025
899,000	991,000	1,081,000	1,445,000	2,004,000

Source: US Bureau of the Census

Estimates are that the overall percentage of North Carolinians 65 and older will increase from 12.7% in 1997 to 21.4% in 2025. Exhibit 2 depicts the expected changes in number of 65+ North

[2] *Report to the Governor and the 1997 General Assembly of North Carolina, 1997 Session*, January, 1997, North Carolina Study Commission on Aging.
[3] There is some evidence of a decline in the poverty rate among seniors since the 1990 census. The federal poverty level for an individual in 1997 was $7,890 and $10,610 for a couple.
[4] Ibid., North Carolina Study Commission on Aging.

Carolinians. Table 1 shows the number and percentage of older adults in North Carolina by county. This projected increase means there will be an increasing need for hospitals, health care, group care, housing, in–home care, and community based services--the whole continuum of long-term care options. Until recently the trend in North Carolina has been to fund institutional care first and then fund in-home and community services if funds are available. In January 1996, there were approximately 15,500 older adults on waiting lists for non-Medicaid funded in-home and community based services for older adults. However, the General Assembly, realizing the magnitude of the problem, appropriated $5 million for FY96-97 and $5 million for FY97-98 to the Division of Aging to provide in-home and community services to persons on a waiting list to receive services. According to the Division of Aging, the number of older adults on waiting lists as of June 30, 1997 was 11,868, with 7,188 projected to remain on the list at June 30, 1998.

TABLE 1
OLDER ADULTS IN NORTH CAROLINA
IN 1997

COUNTY	NUMBER	% OF TOTAL CO. POPULATION	COUNTY	NUMBER	% OF TOTAL CO. POPULATION
ALAMANCE	18,624	15.7	JOHNSTON	12,699	12.5
ALEXANDER	3,860	12.3	JONES	1,434	15.0
ALLEGHANY	1,957	20.6	LEE	6,855	14.3
ANSON	3,827	16.0	LENOIR	8,848	14.8
ASHE	4,389	18.8	LINCOLN	7,105	12.3
AVERY	2,444	16.0	MACON	6,456	23.7
BEAUFORT	6,876	15.7	MADISON	3,178	17.5
BERTIE	3,125	15.0	MARTIN	3,947	15.2
BLADEN	4,623	15.3	MCDOWELL	5,947	15.6
BRUNSWICK	10,887	16.8	MECKLENBURG	57,703	9.5
BUNCOMBE	32,532	16.7	MITCHELL	2,890	19.3
BURKE	11,978	14.2	MONTGOMERY	3,264	13.5
CABARRUS	15,074	13.1	MOORE	15,989	22.7
CALDWELL	10,088	13.5	NASH	11,045	12.7
CAMDEN	936	14.3	NEW HANOVER	19,724	13.3
CARTERET	9,367	15.8	NORTHAMPTON	3,722	18.0
CASWELL	3,395	15.8	ONSLOW	8,365	5.5
CATAWBA	13,608	12.8	ORANGE	9,711	8.8
CHATHAM	6,906	15.5	PAMLICO	2,288	18.9
CHEROKEE	4,572	20.2	PASQUOTANK	4,830	14.3
CHOWAN	2,641	18.6	PENDER	5,481	14.8
CLAY	1,733	21.6	PERQUIMANS	2,059	19.1
CLEVELAND	13,163	14.5	PERSON	4,825	14.6
COLUMBUS	7,502	14.5	PITT	12,020	9.9
CRAVEN	11,071	12.7	POLK	4,112	25.5
CUMBERLAND	22,938	7.6	RANDOLPH	15,248	12.8
CURRITUCK	2,164	13.0	RICHMOND	6,600	14.4
DARE	3,362	12.3	ROBESON	12,312	10.9
DAVIDSON	18,073	12.9	ROCKINGHAM	13,605	15.1
DAVIE	4,655	15.2	ROWAN	18,973	15.4
DURHAM	19,825	10.1	SAMPSON	7,728	14.9
EDGECOMBE	7,233	12.7	SCOTLAND	3,987	11.4
FORSYTH	37,673	13.1	STANLY	8,110	14.8
FRANKLIN	5,527	12.7	STOKES	5,216	12.1
GASTON	22,714	12.7	SURRY	10,644	15.9
GATES	1,429	14.4	SWAIN	1,919	16.3
GRAHAM	1,325	17.4	TRANSYLVANIA	5,926	21.3
GRANVILLE	5,208	12.4	TYRRELL	677	18.2
GREENE	2,352	13.5	UNION	10,191	9.8
GUILFORD	49,036	12.8	VANCE	5,296	13.1
HALIFAX	8,596	14.8	WAKE	44,461	8.0
HARNETT	9,741	12.0	WARREN	3,603	19.5
HAYWOOD	10,421	20.5	WASHINGTON	2,068	15.2
HENDERSON	18,193	23.1	WATAUGA	4,775	11.6
HERTFORD	3,436	15.4	WAYNE	12,648	11.2
HOKE	2,903	9.8	WILKES	9,101	14.5
HYDE	851	16.9	WILSON	9,263	13.4
IREDELL	14,765	13.7	YADKIN	5,496	15.7
JACKSON	4,462	15.1	YANCEY	3,029	18.5
			STATE	**946,305**	**12.7**

Source: Office of State Planning

The Commission and other experts in long-term care have noted the growing need for a continuum of long-term care services. The General Assembly has taken heed of these warnings and has begun to address the issue through funding to the Division of Aging for a comprehensive system of in-home aide services. It is also important to note that during the early 1980's, the State declared a moratorium on nursing home beds. This led to the rapid expansion of "rest homes" in North Carolina. While the General Assembly has attempted to clarify the role of rest homes, implementation of reforms has been hampered by the lack of an explicit overarching long-term care policy. According to Dr. George Maddox, Program Director of the Duke Long-Term Care Resources Program, "The challenge to long-term care policy development in North Carolina has been, and remains, how to develop a comprehensive system of care which has as its cornerstone the home and community-based care older adults most often prefer."[5] As reported by the Study Commission,

> . . .*Long-term care lurks as the sleeping giant of the health-care system and the stakes are high unless steps are carefully taken to forge a long-term care system in this decade that is accessible to all the citizens of this State.*[6]

RECOMMENDATION

> **The Office of the State Auditor agrees with the findings and recommendations contained in the 1997 report of the North Carolina Study Commission on Aging. The General Assembly, with input from the Department of Health and Human Services, should develop an explicit overarching policy on long-term care. The Department of Health and Human Services should continue its efforts to develop a comprehensive long-term care system for North Carolinians encompassing the continuum of long-term care options. This system should expand the number and kinds of options available to elderly citizens and should place more emphasis on the less expensive and more preferred in-home and community based options. Once the plan is developed, DHHS should present it to the General Assembly for its consideration.**

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The rest of the report details the current systems and programs in place for delivery of long-term care to North Carolinians. Overall, the Department of Health and Human Services is doing a commendable job in delivery of services through the various long-term care programs. However, we have noted areas where we believe improvements can be made.

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[5] Dr. George Maddox, Program Director of the Duke Long-Term Care Resources Program in a speech to the North Carolina Study Commission on Aging.

[6] Ibid., North Carolina Study Commission on Aging.

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

The North Carolina Department of Health and Human Services (DHHS) (formerly Department of Human Resources) sets policy and coordinates program activities for the many federal and State social and health programs. One of its goals is to enable older adults to secure and maintain maximum independence and dignity. DHHS administers State and federal funds for human service programs. Within DHHS are the Divisions of Facility Services; Medical Assistance; Social Services; Mental Health, Developmentally Disabled Adults, and Substance Abuse Services; and Aging. Exhibit 3 depicts the current organizational structure of DHHS. All divisions are charged with some segment of delivery of services to the elderly. As shown in Table 2, there were 3,848 licensed long-term care facilities in North Carolina as of May 1997.

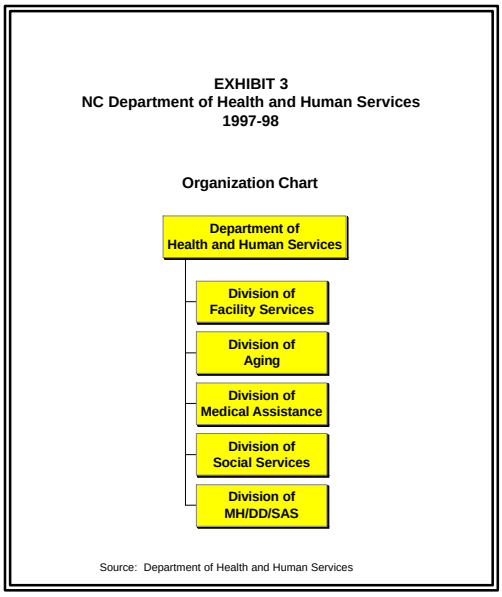


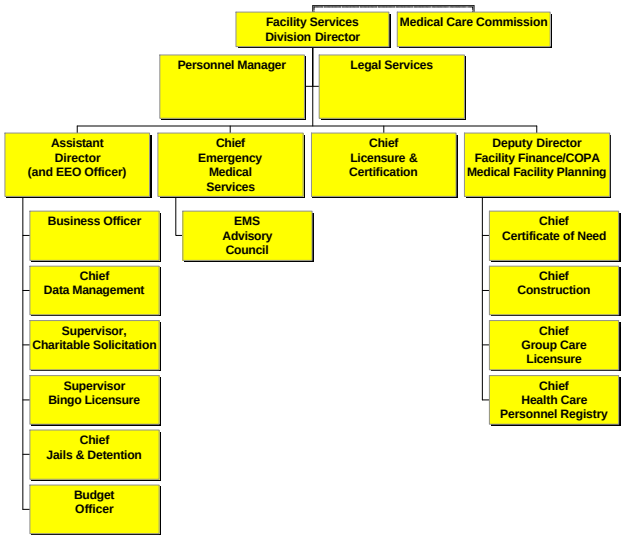
TABLE 2
NUMBER OF LONG-TERM CARE FACILITIES BY TYPE
AS OF MAY 1997

Facility Type	Number Licensed	Number of Beds
Certified Nursing Facilities(includes 54 hospitals with nursing beds)	358	42,795
Adult Care Homes (under GS §131D)		
• Homes for the Aged	487	23,642
• Family Care Homes	755	4,037
• Developmentally Disabled Adult Group Homes	212	1,096
Subtotal Adult Care Homes	1,454	28,775
Mental Health Facilities (under GS §122C)		
• ICF/MR Group Homes (listed under other programs types below)	3	
• MH Residential Treatment	226	1,032
• MH specialized Community Residential Centers ICF	32	836
• MH Medical Detoxification	19	423
• MH Social Detoxification	9	228
• MH Residential Treatment/Rehabilitation	19	589
• MH Residential Acute Treatment	14	215
• MH Community Respite Services	112	385
• MH Residential Therapeutic (Habilitative) Camps	6	254
• MH Therapeutic Homes	684	999
• Mental Health Supervised Living	177	876
• MN DD/BD Supervised Living	129	471
• MH DD Supervised Living	434	2,340
• MH DD Supervised Living ICF	43	359
• MH SAS Supervised Living	54	831
• MH MD Supervised Living	75	184
Subtotal for Mental Health Facilities	2.036	10,022
TOTAL ALL FACILITIES LICENSED	**3,848**	**81,592**
Source: Division of Facilities Services		

DIVISION OF FACILITY SERVICES

The Division of Facility Services (DFS) has primary responsibility for planning, licensing, and inspection of long-term care facilities. DFS determines the need for health care facilities and services across the State and develops a plan to meet that need. DFS is responsible for licensing of all health care facilities (except for State and federal health care facilities) and for certifying facilities that are otherwise eligible for Medicare/Medicaid funding. DFS is also responsible for the oversight of compliance with regulations by those facilities and services. Exhibit 4 depicts the organizational structure of DFS as of May 1997. Total staffing for DFS was 297.5 positions.

EXHIBIT 4
NC DEPARTMENT OF HEALTH AND HUMAN RESOURCES
DIVISION OF FACILITY SERVICES
ORGANIZATION CHART--MAY 1997



Source: Division of Facility Services

The Division's overall budget for 1996-97 amounted to $21,664,847, with $9,571,894 from State appropriations. The amount budgeted for personal services was $13,974,032. Table 3 contains the Division's financial information applicable to the area of facilities and health service regulation.

TABLE 3
DIVISION OF FACILITY SERVICES
FACILITIES AND HEALTH SERVICE REGULATION
FISCAL YEAR 1996-97 BUDGET

Description	Authorized Budget	State Appropriations	Personal Services
Group Care	$2,108,979	$1,374,541	$1,262,346
Domiciliary Care	111,385	27,890	101,633
Office of Residential Care	89,506	89,506	69,622
Administration--Licensure & Certification	589,787	121,054	547,548
Health Licensure	707,436	604,874	618,891
Complaint Investigation (July-September)	205,732	96,954	178,055
Complaint Investigation (October-June)	762,284	191,280	697,356
Certification	1,447,195	(29,983)	1,218,371
CLIA	225,006	40	189,510
Acute & Home Care License/Cert.	586,255	153,696	526,066
Construction (State)	840,662	840,662	750,033
Construction (Federal--July-September)	147,221	(2,046)	122,088
Construction (HCFA--Federal)	93,434	00	93,434
Construction (Federal--October-June)	399,130	(36,172)	349,988
Nurse Aide Registry (July-September)	78,336	7	64,571
Nurse Aide Registry (October-June)	381,488	(31,811)	286,206
Certificate of Need	756,930	756,930	619,203
Medical Facilities Planning	253,921	242,921	193,774
Complaint Abuse & Neglect (Oct-June)	358,175	250,370	318,960
Complaint Abuse & Neglect (July-Sept)	52,746	00	46,951
Nursing Home Certification	2,271,488	313,413	2,032,440
ICF/MR Licensure & Certification	892,549	(9,926)	801,618
MDS Automation	133,403	21,579	122,287
TOTALS	**13,493,048**	**4,975,779**	**11,210,951**

Source: Division of Facility Services Budget Report

DFS works in cooperation with other divisions within DHHS, including the Division of Mental Health, the Division of Social Services, the Division of Aging, and the Division of Medical Assistance, as well as with local Division of Social Services (DSS) agencies.

The State Health Coordinating Council:

The State Health Coordinating Council consists of 27 members who are appointed by the Governor for three year terms. The Council, established in June 1985 by Executive Order, is supervised by the Deputy Director. GS §133E-177 directs the Council and DFS to ". . . develop policy, criteria, and standards, for health service facilities planning, conduct statewide inventories of and make determinations of need for health services facilities and develop an annual State Medical Facilities Plan." The Council has three working committees: the Acute Care Committee; the Long-term Care Committee; and the Mental Health Committee. The Long-term Care Committee's primary charge is to provide planning for the nursing homes. The overall objective of the Plan is to provide individuals, institutions, State and local government agencies, and community leadership with policies and projections of need to guide local planning for specific health care facilities and services. The Plan projects the State's need for:

- acute care hospitals;
- ambulatory surgery facilities;
- inpatient rehabilitation facilities;
- technology services;
- nursing care facilities;
- home health agencies;
- end-stage renal disease dialysis facilities;
- hospice home care and hospice inpatient beds;
- psychiatric hospital units and specialty hospitals;
- substance abuse hospital units, specialty hospitals, and residential facilities; and
- intermediate care facilities for mentally retarded persons.

Each annual projection is for a three year period with the exception of adult care homes and developmentally disabled homes (DDA)[7]. The Governor must approve the Plan before it becomes the official planning document for health care facilities. The importance of the Plan as it relates to long-term care is that the need for nursing homes is quantified by the Plan. Table 4 shows the facilities, beds and services from the 1997 Plan.

TABLE 4
STATE MEDICAL FACILITIES PLAN
1997 STATISTICS

FACILITY TYPE	# OF FACILITIES	# OF BEDS
Acute Care Hospital	120	21,420
Inpatient Rehabilitation	23	954
Ambulatory Surgical	51	167
Technology Services *		
Nursing Care Facilities	425	39,753
Home Health Services	230	140,726**
End Stage Renal Disease Dialysis	91	1,759
Hospice	112	15,078**
Psychiatric Inpatient Services	65	2,390
Substance Abuse Services	60	1,294
ICF/MR	237	2,592

* Services include various medical services and procedures.
** Number of Patients served.
Source: DFS 1997 State Medical Facilities Plan.

Medical Facilities Planning Section:

The Medical Facilities Planning Section of DFS serves as staff to the State Health Coordinating Council. The section is headed by a Deputy Director and consists of three

[7] The General Assembly passed legislation in 1997 prohibiting DHHS from approving the addition of any acute care home beds for the 12 month period beginning August 28, 1997.

evaluators, with a budget for 1996-97 of $253,921. Revenues from the sale of the annual Plan were budgeted at $11,000.

Certificate Of Need Section:

GS §131E-175 through 190 require any person or entity wishing to establish a health care facility to first make application for a *certificate of need* (CON) to DHHS. As the designated State Health Planning and Development Agency, DHHS is empowered to establish the standards and criteria for the CON process. It also has the power to grant, deny, or withdraw a CON and to impose necessary sanctions. DHHS also establishes and collects fees for CON programs. General Statutes direct that fees may not be higher than $17,500 or lower than $2,000 for application filings.

The Certificate of Need Section within DFS accepts applications from providers and approves facilities after applying statutory criteria for new institutional health services within the State. That is, the applications are subject to review and evaluation as to need, cost of services, accessibility to services, quality of care, feasibility, and other criteria prior to the services being offered or developed. The CON Section reviews the applicants' finances, the architectural plans, potential staffing within the area, local training programs available for staff, and availability of medical services in the area. This review and evaluation is an effort to assure the public that only appropriate and needed institutional health services are made available in the area to be served.

The Certificate of Need Section received 131 applications for FY94-95, 187 in FY95-96, and 235 in FY 96-97. Of these applications, 23 of the FY94-95 applications were for nursing homes, 46 were nursing home applications in FY95-96, and 98 were nursing home applications in FY96-97. These applications may be for new homes, replacement facilities, or additional beds in an existing home. See Table 5.

TABLE 5
CERTIFICATE OF NEED APPLICATIONS

FY	NURSING FACILITIES	CONTINUING CARE RETIREMENT COMMUNITY	HOME FOR THE AGED	HOSPITAL	OTHER*	TOTAL
94-95	23	2	2	2	102	131
95-96	46	6	0	10	125	187
96-97	98	8	4	8	117	235

*Note: Psychiatric Facilities, ICF/MR, Home Health Agencies, Ambulatory Surgical Centers, Hospices, Chemical Dependency Treatment Centers, Oncology Treatment Facilities, Kidney Disease Treatment Centers, Diagnostic Centers.

Source: Division of Facility Services

New nursing home beds, or increases in the number of beds in an existing nursing home, cannot be developed without the owner and lessee of the home first obtaining a Certificate of Need. Applications for a CON are accepted only if there is already a review scheduled for the county in which the beds are proposed to be located. Within 30 days of the beginning of the review period, written comments may be filed by any person, including the applicant, regarding the proposals under review.

A public hearing is conducted by the CON Section within 30 to 50 days from the beginning of the review period. At that time the applicant is given the opportunity to respond to written comments submitted to the CON Section and inquiries made at the hearing. A decision to approve or disapprove an application is made by the CON Section within 150 days of the beginning of the review period. A certificate of need is issued 35 days after the date of approval if a petition for a contested case hearing is not filed.

After a CON is issued, it is the responsibility of the owner/lessee to contact the Construction Section, the Nursing Home Licensure Branch, and the Nursing Home Certification Branch about their respective requirements for the development of nursing home beds. Prior to certification, the facilities must be licensed by the State. This is the responsibility of the Certification and Licensure Section of DFS.

The CON Section, headed by a chief, consists of 13 staff, including 10 professionals. The budget for the Section during 1996-97 was $756,930. Revenue from application fees amounted to $1,670,846. The CON Section provides information to the Medical Facilities Planning Section to refine the process of determining the need and placement of medical facilities within the State. For purposes of long-term care, the CON Section is responsible for approving the establishment of new nursing homes, and additions to beds at existing homes; replacement facilities; and relocated facilities.

Health Care Personnel Registry Section:

The purpose of the Health Care Personnel Registry Section is to provide a registry of all individuals who have met the federal and State training and competency requirements to perform Nurse Aide I functions. Additionally, the Registry Section is to provide a listing of unlicensed assistive personnel who have been accused of harming, or been found to have harmed, a resident of a facility. The Section also has responsibility for reviewing and determining federal and State compliance of all nurse aide training and competency evaluation programs submitted to it. Lastly, the Section is responsible for the investigation of all allegations of patient abuse, neglect, misappropriation of patient or facility property, fraud against a patient or facility, and diversion of patient or facility drugs.

The **Nurse Aide Registry** was created by federal law 42 U.S.C. 1395i-3(e) and 42 U.S.C. 1396(r). The purpose of the Registry is to maintain a listing of all nurse aides who have successfully completed a state-approved Nurse Aide Training/Competency Evaluation Program or CEP and to review all Nurse Aide Training/Competency Evaluation Program proposals submitted for state approval. The registry is also intended to protect residents from nurse aides who have been found guilty of patient abuse, neglect, or misappropriation of resident's properties. Under federal law, nursing home administrators are not allowed to hire or continue to employ nurse aides against whom an allegation has been substantiated. Administrators are required to report immediately all allegations of abuse, neglect, or misappropriations to the local DSS offices. Further, they are required to report allegations to the Health Care Personnel Investigations Program (within DFS) within 24 hours of the event. The administrators further have to provide a written, typed report of their own internal investigation to DFS within five working days of the allegation.

The **Health Care Registry** was created in 1996 by GS §131-256. This North Carolina law expands the existing Nurse Aide Registry to include a second registry to list all unlicensed aides who provide hands-on care to residents in health care facilities (adult care homes, hospitals, home care agencies, nursing pools, hospices, and nursing facilities). The Registry contains the names of all health care personnel against whom the following types of allegations have been substantiated:

- neglect or abuse of a resident in a health care facility or a person to whom home care services or hospice services are being provided;
- misappropriation of the property of a health care facility;
- diversion of drugs belonging to a health care facility or to a patient or client; or
- fraud against a health care facility or against a patient or client to whom the employee is providing services.

The law also requires DHHS to list all pending state investigations against these aides.[8]

"Health care personnel" are nurse aides; in-home aides who provide hands-on paraprofessional services; and personal aides in adult care homes who perform, or directly supervise others who perform, tasks in activities of daily living. These include personal functions essential for the health and well-being of residents such as bathing, dressing, personal hygiene, ambulating or locomotion, transferring, toileting, and eating. Whether the employees are monitored for Registry purposes is directly related to the definition above.

The **Health Care Personnel Investigation Program** is a two-part program within the Health Care Personnel Registry Section with responsibility for:

- receipt, review, and investigation of allegations of resident abuse, resident neglect, and misappropriation of resident property occurring in nursing homes to determine whether permanent findings should be placed on the Nurse Aide I Registry, and
- receipt, review, and investigation of allegations of resident abuse, resident neglect, and misappropriation of resident or facility property, diversion of resident or facility drugs, and fraud against a resident or facility committed by health care personnel and occurring in either hospitals, adult care homes, home care agencies, nursing pools, hospices, or nursing homes, to determine whether temporary placement of allegations to be investigated or permanent findings should be placed on the Health Care Personnel Registry.

The law also provides some limited immunity for providers in using the information from the Health Care Personnel Registry or the Nurse Aide Registry in making hiring decisions or in conducting employee evaluations so long as the information is used in good faith.

TABLE 6
NURSE AIDE AND HEALTH CARE PERSONNEL COMPLAINTS
FY93-94 THROUGH FY96-97

Action	FY 93-94	FY 94-95	FY 95-96	FY 96-97
Total Intakes Received	470	644	764	938
Total Intakes Screened	425	494	742	900
# Requiring CIB Investigations	145	180	259	395
# Investigations Completed*	138	129	284	411
# Substantiated	59	42	98	211
% Substantiated	43%	32%	34%	51%

*Included investigations started in prior year(s).
Source: Division of Facility Services

The Health Care Personnel Registry Section has a staff of twenty; eight (including clerical staff) are assigned to investigating allegations of nurse aids and other health care personnel. During 1996-97, 395 allegations were investigated. The Section reports that 211 (51%) of the allegations investigated during FY96-97 were substantiated. See Table 6. These allegations come to the

[8] The North Carolina Medical Care Commission was charged with monitoring the implementation of the Health Care Personnel Registry and for reporting to the General Assembly in 1998 any amendments needed to implement the purposes of the act. No report had been prepared at the time of the audit.

Section from facility administrators, local DSS, police, and/or resident's families. The 1996-97 budget for the Section was $459,824 with State appropriations of $45,986. Medicare, Medicaid, and other federal funds provide 90% of the Section's budget.

Licensure And Certification Section:

The primary purpose of the Licensure and Certification Section is to provide for the health, safety, and well-being of individuals receiving services in facilities licensed by the State and certified by the federal government to receive federal Medicare and Medicaid. The Section is also responsible for effective regulatory and remedial activities including appropriate consultation and training opportunities. Staff conduct inspections and complaint investigations of health care facilities to track compliance with federal regulations governing those facilities. The types of facilities for which the Licensure and Certification Section has oversight include nursing home licensure, certification and re-certification, intermediate care facilities for the mentally retarded, acute care/home care, and certified laboratories (CLIA).

The Certification staff performs periodic reviews, or surveys, as mandated by the federal program. Deficiencies are discovered during the survey process and through complaint investigations. Approximately 90% of the survey staff in the Section are registered nurses with skilled care backgrounds. Survey teams are generally composed of three nurses, a dietitian, and a pharmacist. Normally the team is at each site for a three day period. During that time, the annual survey is conducted and complaints which have come into the Section are investigated.

For the FY96-97, the Licensure and Certification Section conducted 405 standard and initial surveys; 525 complaints investigation surveys; and 55 surveys/complaint investigations combined. Table 7 contains a breakdown of the types of complaints received and investigated.

TABLE 7
COMPLAINTS RECEIVED AGAINST CERTIFIED FACILITIES

	1996					1997				
Facility Type	Total Complaints	Unsubstantiated		Substantiated		Total Complaints	Unsubstantiated		Substantiated	
		#	%	#	%		#	%	#	%
Certified Hospitals (may include NH beds	25	17	68%	8	32%	40	39	98%	1	2%
Skilled Nursing receiving Medicare	1	0	0%	1	100%	2	2	100%	0	0%
Nursing Facility receiving Medicare/Medicaid	442	309	70%	133	30%	593	441	74%	152	26%
Nursing Facility Medicaid	1	1	100%	0	0%	1	1	100%	0	0%
Intermediate Care/Mentally Retarded	58	30	52%	28	48%	61	20	33%	41	67%
Home Health Agency	13	12	92%	1	8%	16	9	56%	7	44%
Renal Dialysis Facility Comprehensive Outpatient Rehab Facility	10	5	50%	5	50%	18	8	44%	10	56%
Hospice	0	0	0%	0	0%	5	5	100%	0	0%
Clinical Laboratories	3	0	0%	3	100%	1	1	100%	0	0%
TOTALS	**553**	**374**	**67.6%**	**179**	**32.4%**	**737**	**526**	**71.4%**	**211**	**28.6%**

Source: Division of Facility Services

Construction Section:

The Construction Section is responsible for reviewing building plans and specifications for those applicants wishing to be licensed and/or certified by DFS. The review is to assure that there is a safe and proper environment for patients and residents using facilities regulated by DFS. Additionally, the Section conducts physical plant inspections deemed necessary for facilities seeking licensure, certification for Medicare/Medicaid, financial assistance, and/or Joint Commission Accreditation of Health Care Organizations (JCAHO). These physical plant inspections are to insure that newly completed construction and ongoing construction is in accordance with approved plans and specifications, to provide consultation to applicants, and improve and maintain awareness of regulations and codes that govern those facilities wanting to be licensed or certified.

The Section also inspects institutional installations and construction, inspects facilities for construction related complaints, and conducts inspections after "significant" fires. The State laws require that new construction plans and renovations for most programs be reviewed and federal law requires an inspection be made annually at nursing homes.

The Section offers training for architects, engineers, and contractors involved in the construction of medical facilities. The Section reviews approximately 1,200 plans and 700 projects each year. The federally-funded engineers do periodic inspections of the certified facilities on a regular basis. A Life Safety Code Survey is performed on nursing homes annually. The Section also investigates construction related complaints at the facilities.

The following sites are under the Construction Section's jurisdiction for reviews and inspections:

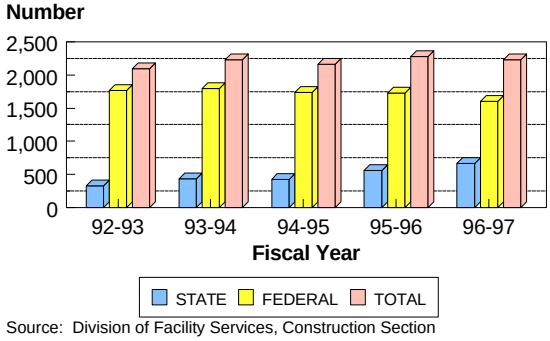
- **Hospitals.** Federal regulations require that acute care hospitals be included in the oversight activities, and many of the requirements contained in the regulations are pertinent to Medicaid and Medicare certification.
- **Nursing Homes**. Also inspect annually for Life Safety Code violations if certified by the federal government to receive Medicare/Medicaid funds.
- **Adult Care Homes.** 7 or More Residents.
- **Adult Care Homes With 2-6 Residents and Homes for Developmentally Disabled Adults for 2-9 Residents.** Most projects are approved for these residential facilities after review and receipt of documentation of compliance from local building and fire officials.
- **Mental Health Licensure program projects.** Most projects are residential and are approved after review and documentation of compliance from local building and fire officials. Inspect for construction related complaints and significant fires.
- **Jails, Ambulatory Surgery Facilities, Hospices, Abortion Clinics.**
- **Child Caring Institutions and Maternity Homes (for DSS).** Most projects at these residential facilities are approved after review and receipt of documentation of compliance from local building inspectors and fire officials.

JCAHO also inspects hospitals; however, those inspections are more confined to the medical service areas of the hospital, and limited physical plant review is performed. Hospitals with "swing" beds (beds which rotate between inpatient hospital and nursing home usage rates) and those with nursing home beds fall under Certification regulations, and are inspected annually for that distinct type of beds.

Local building inspectors and fire marshals are involved in the inspection process during the construction and subsequent inspections. The Department of Environment and Natural Resources is involved in the sanitation aspects of new institutional projects. The Office of State Construction conducts some reviews and inspections on State-owned projects only. The North Carolina Building Code does not have specifics on health care facilities, but does have safety rules. The Department of Insurance's Engineering Division reviews plans for projects larger than 10,000 square feet for general building code compliance, structural, and handicap accessibility requirements.

State-owned and federal-owned health care facilities, such as the VA hospital, are not required to have licensure inspections. State-owned hospitals that are not licensed, such as Dorothea Dix Hospital and Cherry Hospital, may be inspected if required to validate JCAHO accreditation. State-owned psychiatric hospitals are only required to be inspected if they must meet State licensure requirements. Existing adult care facilities are not inspected at all except for construction related complaints.

EXHIBIT 5
INSPECTIONS PERFORMED BY CONSTRUCTION SECTION
FY92-93 through FY96-97



Source: Division of Facility Services, Construction Section

The budget for the Section during 1996-97 was $1,333,226, with $492,564 from federal funding. There are 19 architects and engineers, including the section chief, employed in the Construction Section. Seven and one-half of the engineering positions are funded by the federal government to regulate and enforce compliance with the federal regulations for certification and re-certification of health care facilities receiving Medicare and/or Medicaid federal reimbursement. The remaining 11.5 state funded architects and engineers, including the section chief, are responsible for state licensure regulations of all facilities licensed by the Division that have a construction based regulatory component. The section is responsible for regulating approximately 5,000 facilities of all types for compliance with state licensure requirements related to construction and fire safety. Reductions in staffing in 1988 and the increasing numbers of new facilities has hampered the section's ability to conduct inspections at all facilities. In 1996-97, the Construction Section conducted approximately 2,200 site inspections. See Exhibit 5.

North Carolina Medical Care Commission:

The North Carolina Medical Care Commission was authorized by GS §1143B-165 to administer the Health Care Facilities Finance Act. The Commission issues tax-exempt bonds to finance and refinance construction, equipment, etc., of health care facilities and continuing care centers. The Commission also promulgates rules for regulating health care or related facilities such as nursing homes, hospitals, home care agencies, and emergency medical services.

The Commission, composed of seventeen members serving four-year terms, is appointed by the Governor as follows:

- Three nominated by the North Carolina Medical Society;
- One nominated by the North Carolina Nurses Association;
- One nominated by the North Carolina Pharmaceutical Association;
- One nominated by the Duke Foundation;
- One nominated by the North Carolina Hospital Association and;
- Ten selected to represent agriculture, industry, labor, and other interest groups in North Carolina.

Acute And Home Care:

The Acute and Home Care Section, headed by a branch manager, is responsible for oversight of home care agencies. The Section is staffed by 10 professionals (including 9 Registered Nurses) and 4 administrative/clerical. The FY96-97 budget for the Section was $586,255. The majority of the funding for this Section is from Medicare.

The Medical Care Commission establishes the rules for home care agency compliance. GS §131E-140 requires DHHS to accept applications for licensing of home care agencies. Each county is required to assure that the services are provided. The license to operate a facility is separate from the practitioner's license issued by an occupational licensing board. The facility license allows the service providers to operate under the State's health care agency laws. Any agency licensed by DHHS is subject to inspections at any time as a condition of holding such license. Table 8 contains a breakdown of the number and type of licensed home care agencies in North Carolina. Licensed facilities include:

TABLE 8
NUMBER OF LICENSED AND CERTIFIED FACILITIES
AS OF JUNE 1997

Facility Type	Licensed	Certified
Home Care Agencies	836	
Medicare Certified Home Care Agencies		*238*
Nursing Pool Agencies	72	
Hospice Agencies	54	
Home Care Agencies Providing Hospice Services		*68*
Medicare Certified Hospices		*103*
Home Health Agencies	159	
End Stage Renal Disease Providers	98	
Ambulatory Surgical Centers	53	
Comprehensive Outpatient Rehabilitation Facilities	4	
Psychiatric Hospitals	15	
Total	**1,291**	**409**

Source: Division of Facility Services, Acute and Home Care

- **Home Care**--the providers must be licensed. Payment is usually private money, but can also be paid by Medicaid through the Community Alternatives (CAP) program. These services are provided at the client's place of residence.
- **Hospice Agencies**--regulated by statutes as home care agencies; now in nursing homes.
- **Medicaid Home Health**--the providers must be both licensed and certified. They provide skilled nursing services to those who are disabled or age 65 or over. Medicare money pays for the services in many cases.
- **End Stage Renal Disease Program**--the providers are free standing dialysis facilities and the service is outpatient. Medicare money may be used to pay for the services so certification is required; however, no State license is required for the facility. Users include those in both certified facilities and adult care homes.

In addition to licensing home care agencies, the Section investigates complaints involving providers. During FY96-97, of the 138 complaints received and investigated, 50 (36.2%) were substantiated.

Organizations which are not licensed but hold themselves out to the public as home health agencies are also subject to inspections. GS §131-141.1 provides that a fine of $500 may be levied for conviction of operating without a license for the first conviction and for each subsequent offense. Inspections are conducted every 3-6 years. Currently, most inspections conducted by the Section are primarily complaint driven surveys due to the lack of staff in the Section. A review of Section record shows that 99% of the complaints come from the patients.

Group Care Licensure Section:

The Group Care Licensure Section is responsible for the licensing of all adult care, developmentally disabled adult, and mental health facilities in the State. These facilities are not certified for Medicaid/Medicare funding; therefore, they are not subject to federal regulations for operation or sanctions. The safety and health oversight of the facilities is dependent on the laws of North Carolina and the procedures used by DHHS. Table 9 contains a breakdown of the number and type of licensed group care homes in North Carolina.

TABLE 9
NUMBER AND TYPE OF LICENSED GROUP CARE HOMES IN NORTH CAROLINA AS OF MARCH 1997

Type	Number Licensed	Number of Beds
Homes for the Aged	487	23,642
Family Care Homes	755	4,037
Developmentally Disabled Adult Group Homes	212	1,096
Mental Health Facilities	2,036	10,022
Total	3,490	38,797

Source: Division of Facility Services

The monitoring process for nursing homes is carried out by the survey teams from the Licensure and Certification Section, staffed as required by the regulations--registered nurses, pharmacists, dietitians, etc. Group care homes are subject to oversight through the Group Care Licensure laws of the State, but there are few enforced standards like those required of nursing homes. Most of the group care homes receive State and county funds, along with some federal funds. They are monitored by several groups including the Division of Social Services Adult Home Specialists at the local level, the Group Care Consultants, and the local Ombudsmen program.

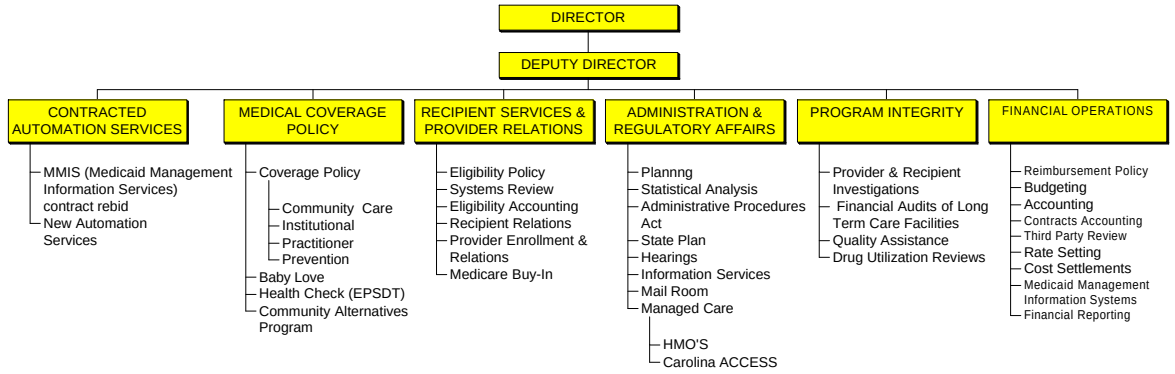
DIVISION OF MEDICAL ASSISTANCE

Congress created the Medicaid program in 1965. It was designed to be a medical safety net for two categories of low income people receiving cash assistance: 1) mothers and children, and 2) elderly, blind, and disabled persons. Medicaid is jointly financed by the federal and state governments. All states, the District of Columbia, and some U. S. territories have Medicaid programs. Medicaid programs are governed by federal guidelines, but vary in eligibility criteria and covered services. In North Carolina, each of the 100 counties contribute to the non-federal share of costs, with each county determining its own eligibility for Medicaid benefits.

North Carolina's program began in 1970 under the North Carolina Department of Social Services, later made a division within DHHS. A separate Division of Medical Assistance (DMA) was created within DHHS in 1978. Exhibit 6, page 20, depicts the organizational

structure of DMA at the time of the audit. DMA has responsibility for the State's Medicaid program which ensures that eligible low income people have access to appropriate and adequate medical care. DMA develops policies and procedures to ensure these individuals are properly determined eligible for medical assistance and reimburses health care providers for services given to eligible persons.

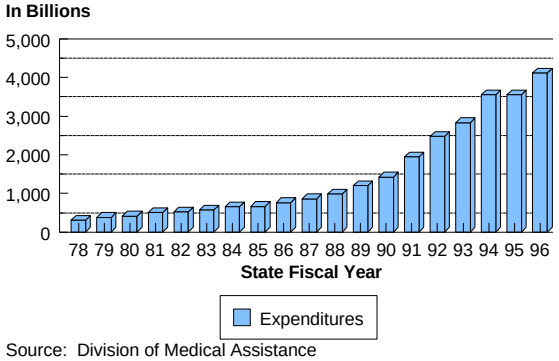
EXHIBIT 6
N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
OFFICE OF THE DIRECTOR



Source: Division of Medical Assistance

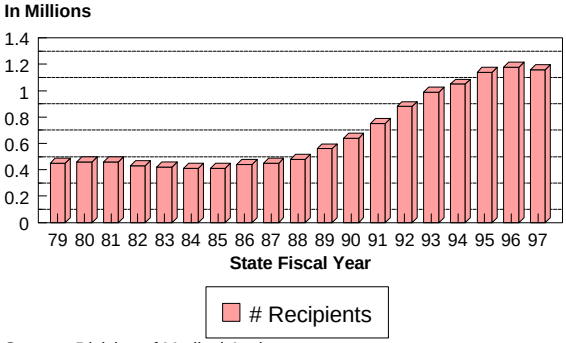
From 1978 to 1996, total Medicaid expenditures in North Carolina grew from $307 million to $4.1 billion, and the number of people eligible for Medicaid increased from 453,174 to 1,155,422. During this time, DMA staff increased from 121 to 299 people. Exhibit 7 and 8 graphically depicts this growth.

EXHIBIT 7
NORTH CAROLINA MEDICAID
CHANGES IN MEDICAID COSTS



Source: Division of Medical Assistance

EXHIBIT 8
NORTH CAROLINA MEDICAID
HISTORY OF MEDICAID ELIGIBLE PEOPLE



Source: Division of Medical Assistance

The largest share of Medicaid costs is paid by the federal government. Federal matching rates for services are established by the federal Health Care Financing Administration (HCFA). HCFA uses the most recent three year average per capita income for each state and

national per capita income in establishing this rate. As North Carolina's per capita income rises, the federal match for Medicaid declines, requiring the State and counties to increase their proportionate shares of Medicaid costs. Table 10 shows the rate by state for the fiscal years 1989 through 1996. Nationwide, in state fiscal year (SFY) 1996, the federal match rate varied from a low of 50% to a high of 78.02%. Additionally, states may require localities to participate in the non-federal share of expenditures. In North Carolina, each county contributes 15% of the non-federal share. During SFY 1996, North Carolina's federal, State, and county shares of total expenditures were approximately 65%, 30%, and 5%, respectively.

TABLE 10
SCHEDULE OF FEDERAL MEDICAID ASSISTANCE PERCENTAGES (for Fiscal Years 1989-1996)

STATE:	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996
Alabama	73.10	73.21	72.73	72.93	71.45	71.22	70.45	69.83
Alaska	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Arizona	62.04	60.99	61.72	62.61	65.89	62.11	66.40	63.83
Arkansas	74.14	74.58	75.12	75.66	74.41	65.00	73.75	73.61
California	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Colorado	50.00	52.11	53.59	54.79	54.42	50.00	53.10	52.44
Connecticut	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Delaware	52.60	50.00	50.00	50.12	50.00	50.00	50.00	50.33
Dist of Columbia	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Florida	55.18	54.70	54.46	54.69	55.03	54.78	56.28	55.76
Georgia	62.28	62.09	61.34	61.78	62.08	62.47	62.23	61.90
Hawaii	53.00	54.30	54.14	52.57	50.00	50.00	50.00	50.00
Idaho	72.71	73.32	73.65	73.24	71.20	70.92	70.14	68.78
Illinois	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Indiana	63.71	63.76	63.24	63.85	63.21	63.49	63.03	62.57
Iowa	62.93	62.92	63.41	65.04	62.74	62.33	62.62	64.22
Kansas	54.93	56.07	57.35	59.23	58.18	59.52	58.90	59.04
Kentucky	72.89	72.95	72.96	72.82	71.69	70.91	69.38	70.30
Louisiana	71.07	73.12	74.48	73.44	73.71	73.49	72.65	71.89
Maine	66.68	65.20	63.49	62.40	61.81	61.96	63.30	63.32
Maryland	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Massachusetts	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Michigan	54.75	54.54	54.17	55.41	55.84	56.37	56.84	56.77
Minnesota	53.07	52.74	53.43	54.43	54.93	54.65	54.27	53.93
Mississippi	79.80	80.18	79.93	79.99	79.01	78.85	78.58	78.02
Missouri	59.96	59.18	59.82	60.84	60.26	60.64	59.85	60.06
Montana	70.62	71.35	71.73	71.10	70.92	71.05	70.81	69.38
Nebraska	60.37	61.12	62.71	64.50	61.32	61.08	60.40	59.49
Nevada	50.00	50.00	50.00	50.00	52.28	50.31	50.00	50.00
New Hampshire	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
New Jersey	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
New Mexico	71.54	72.25	73.38	74.33	73.85	74.17	73.31	72.87
New York	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
North Carolina	**68.01**	**62.46**	**66.60**	**66.52**	**65.92**	**65.14**	**64.71**	**64.39**
North Dakota	66.53	67.52	70.00	72.75	72.21	71.13	68.73	69.06
Ohio	58.98	59.37	59.93	60.63	60.75	60.83	60.69	60.17
Oklahoma	66.06	68.29	69.65	70.74	69.67	70.39	70.03	69.89
Oregon	62.44	62.95	63.30	63.55	62.39	62.12	62.36	61.01
Pennsylvania	57.42	56.86	56.64	56.84	55.48	54.61	54.27	52.93
Rhode Island	55.88	55.15	53.74	53.29	53.64	53.87	53.49	53.84
South Carolina	73.08	73.07	72.38	72.66	71.28	71.08	70.71	70.77
South Dakota	71.02	70.90	71.69	72.59	70.27	69.50	68.06	66.66
Tennessee	70.17	69.64	68.57	68.41	67.52	67.15	66.52	65.64
Texas	59.04	61.23	63.53	64.18	64.44	64.18	63.31	62.30
Utah	73.80	74.70	74.89	75.11	75.29	74.35	73.48	73.21
Vermont	63.92	62.27	61.97	61.37	59.88	59.55	60.83	60.87
Virginia	51.20	50.00	50.00	50.00	50.00	50.00	50.00	51.37
Washington	53.00	53.88	54.21	54.98	54.24	54.24	51.97	50.19
West Virginia	76.14	76.61	77.00	77.68	76.29	75.72	74.60	73.26
Wisconsin	59.31	59.28	59.02	60.38	60.42	60.47	59.81	59.67
Wyoming	62.61	65.95	68.11	69.10	67.11	65.63	62.87	59.69

Source: Division of Medical Assistance

Long-term care comprises the most costly piece of the Medicaid budget, consuming 20% of the State's total service expenditures. In SFY 1997, the total cost of long-term care in North Carolina nursing facilities was $767,308,290. Table 11 shows the portion of the Medicaid budget for FY1996 and 1997.

TABLE 11
North Carolina Medicaid
State Fiscal Year 1996 and 1997
Uses of Medicaid Funds

Type of Service	1996 Total Expenditures	1996 Percent of Total Dollars	1997 Total Expenditures	1997 Percent of Total Dollars
Inpatient Hospital	$ 691,202,501	16.8%	717,611,668	15.5%
Outpatient Hospital	214,340,262	5.2%	232,400,142	5.0%
Mental Hospital (> 65)	13,718,463	.3%	12,439,983	.2%
Psychiatric Hospital (< 21)	17,295,394	.4%	17,282,825	.4%
Physician	337,282,703	8.2%	369,994,473	8.0%
Clinics	223,886,598	5.4%	270,204,038	5.8%
Nursing Facility:				
Skilled Level	386,294,858	9.4%	428,046,638	9.2%
Intermediate Level	336,159,174	8.2%	339,261,652	7.3%
(Mentally Retarded)	355,172,014	8.6%	359,316,958	7.7%
Dental	42,318,146	1%	42,476,178	.9%
Prescription Drugs	324,331,335	7.9%	391,239,143	8.4%
Home Health	96,070,494	2.3%	94,980,247	2.0%
CAP/Disabled Adult	86,997,985	2.1%	110,768,008	2.4%
CAP/Mentally Retarded	56,651,628	1.4%	105,656,284	2.3%
CAP/Children	3,121,489	.1%	5,938,897	.1%
Personal Care	58,075,382	1.4%	68,644,173	1.5%
Hospice	10,588,771	.3%	10,245,714	.2%
EPSDT (Health Check)	28,219,077	.7%	30,115,812	.7%
Lab & X-Ray	25,632,155	.6%	18,806,500	.4%
Adult Care Home	**48,503,112**	**1.2%**	**64,660,069**	1.4%
Other Services	96,909,566	2.4%	128,140,410	**2.8%**
Part A Premium Medicare	38,236,137	.9%	41,718,153	.9%
Part B Premium	105,968,092	2.6%	108,516,420	2.3%
HMO Premium	6,021,954	.1%	20,426,299	.4%
Subtotal Services	**$ 3,596,975,336**	**87.5%**	**3,981,890,683**	85.8%
Adjustments & Cost Settlements	103,166,771	2.5%	185,958,582	**4.0%**
Disproportionate Share Payments	280,842,697	6.8%	333,760,618	7.2%
Subtotal Services & Other	**$ 3,980,984,804**	**96.8%**	**4,501,609,883**	97%
Administration (State & County)	**132,359,973**	**3.2%**	**138,812,034**	**3.0%**
(State)	61,073,915	1.5%	63,354,988	**1.4%**
(County)	71,286,058	1.7%	75,457,046	1.6%
Grand Total Expenditures	**$ 4,113,344,777**	**100%**	**4,640,421,917**	**100%**

Source: Division of Medical Assistance

DMA contracts with EDS Corporation to perform many of the Medicaid administrative functions. Currently, EDS pays claims, serves as a focal point for provider questions and problems, trains new providers, operates the prior approval system for most Medicaid services and operates the North Carolina Medicaid Management Information System (MMIS). Expenditures for EDS services were $16.6 million in SFY 1996. The current contract with EDS expires June 30, 1998.

Program Integrity Section:

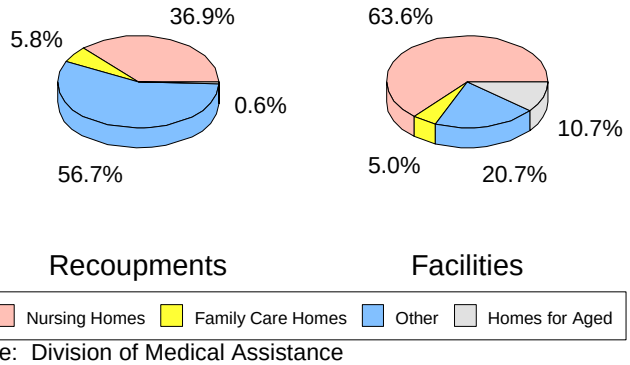
The Program Integrity Section of DMA is devoted to accounting for public expenditures for Medicaid services in the State. The Program Integrity efforts include:

- conducting claim and program reviews to identify areas of error, incorrect payments, possible fraud, or the need for corrective action;
- identifying and assisting in the development of claim payment system audits and edits to ensure proper payment;
- conducting reviews directly with the providers and recipients of services to validate medical need and delivery of the service; and
- identifying and recovering provider and recipient overpayments.

Since January 1994, Program Integrity has identified and recouped $992,030 from nursing homes and adult care homes for improper Medicaid payments. See Exhibit 9.

EXHIBIT 9

MEDICAID REFUNDS AND NUMBER OF FACILITIES
for FY96-97



Source: Division of Medical Assistance
Note: "Other" includes mental health institutions, developmentally disabled adult group homes, and hospitals.

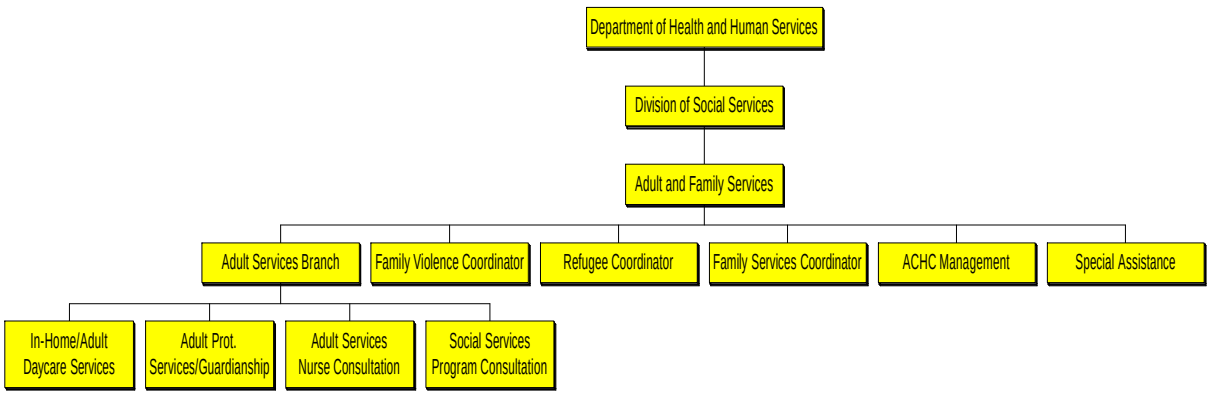
DIVISION OF SOCIAL SERVICES

The Division of Social Services (DSS) provides services to older and disabled adults through social service departments in all 100 counties in the State. Exhibit 10, page 24, depicts the organizational structure of the State level DSS at the time of the audit. Some of the services mandated by State statutes or mandated under the Social Services Block Grant Plan and used by older and disabled adults are described below.

- **In-Home Services** -- includes in-home aides who assist persons with activities of daily living such as personal hygiene, ambulation, meal preparation, and home management. It also includes adult day care. The service must be authorized by a physician and provided by aides under the supervision of a registered nurse. In-Home Services are funded as part of the regular Medicaid Program.
- **Case Management Services** -- plans and directs the provision of social services to an individual who is receiving, or who is applying to receive, services. Activities include initial and on-going eligibility determination and assessment of the extent of the individual's current service needs, as well as establishment of ways and means to tackle the individual's problem. This means assuming the role of prime agent to assure a dependable and coordinated flow of services to the client as he or she moves through the service delivery systems.

- **Protective Services for Adults --** are available to adults who are incapacitated due to physical or mental disability and who are in need of protection because they are abused, neglected, or exploited. Services include receiving and evaluating reports of a need for protection; planning and counseling with disabled adults and their families to identify and address those problems which precipitate abuse, neglect, or exploitation; assistance in arranging for needed services such as medical care, support services in the home, appropriate living arrangements, and others.
- **State/County Special Assistance for Adults Program --** authorized by GS §108A-40, this is a program of financial assistance for eligible residents of adult care homes and helps to pay for their care in the homes. It is administered by the county departments of social services under rules and regulations of the Social Services Commission.
- **Adult Placement Services** - are provided to aging and disabled adults and their families in finding an adult care home, or nursing home, or other substitute home or residential health care facility when they are unable to continue living at home. Activities include screening, assessment, counseling, assisting in completing financial applications and medical evaluations, locating and securing placement, and support in the transition and in maintaining the placement. It also includes assisting in relocating from one facility to another or in returning to more independent settings. County DSSs work jointly with hospital discharge planners, area mental health programs, and state psychiatric hospitals in providing the service.
- **Adult Care Home Case Management** - is provided to heavy care residents living in adult care homes who need extensive or total assistance with toileting or feeding or both. Case mangers determine which residents meet the heavy care criteria and authorize additional Medicaid payments to the adult care homes for additional hours of personal care services, verify that this care is provided, and assure that the care is meeting the personal care needs of these residents. They also assess the broader health care and social service needs of these residents and arrange for care and services from local providers to help meet these needs.
- **Adult Guardianship Services** - are provided when a determination is made by the court that an individual is mentally incompetent and a guardian is needed. The director of the county department of social services is appointed to serve as guardian by the court, in which case the director is authorized as a substitute decision-maker for the incompetent adult. Services may include making decisions about where the individual will live, authorizing medical treatment, arranging for other necessary services, and managing the adult's finances.

Exhibit 10
Department of Health and Human Services
Division of Social Services
Adult and Family Services



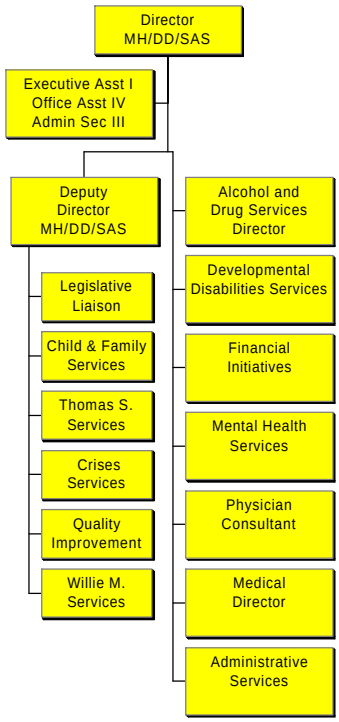
Source: Division of Social Services

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES (DMH/DD/SA)

DMH/DD/SA provides services to persons of all ages who have mental illnesses, developmental disabilities, or substance abuse problems. Exhibit 11 shows the organizational structure at the time of the audit. Services are provided through 13 institutions and 41 area mental health, developmental disabilities, and substance abuse programs. (Exhibit 12, page 26) Services are directed toward elimination, reduction, and prevention of the disabling effects of mental illness, developmental disabilities, and substance abuse. The institutions operated by DMH/DD/SA provide residential services for the disability groups it is mandated to serve. Area mental health programs are required to provide the following services to all age groups as applicable:

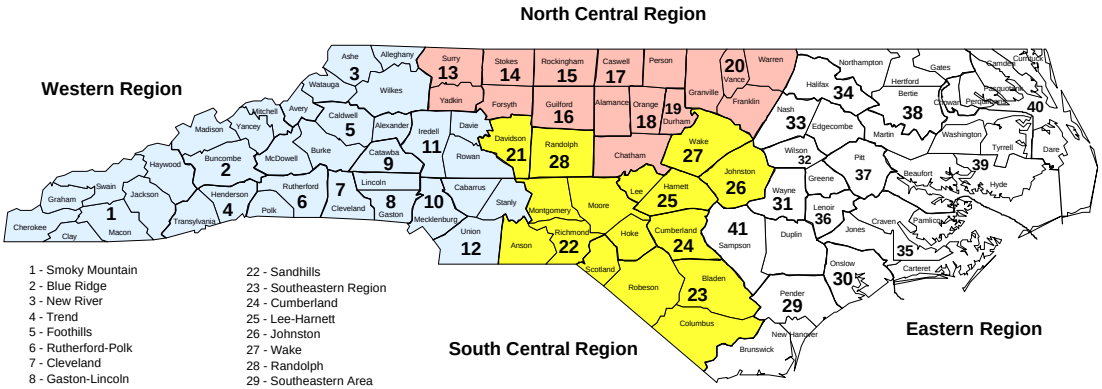
- outpatient, emergency, consultation and education, and case management for all disability groups;
- inpatient psychiatric services;
- psychosocial rehabilitation or partial hospitalization;
- developmental day services for preschool children with developmental disabilities;
- adult developmental activity programs; alcohol and drug education traffic schools;
- drug education schools;
- detoxification services; and
- forensic services.

EXHIBIT 11
NC Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services



Source: Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

EXHIBIT 12
DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE
REGIONS AND AREA PROGRAMS



1 - Smoky Mountain
2 - Blue Ridge
3 - New River
4 - Trend
5 - Foothills
6 - Rutherford-Polk
7 - Cleveland
8 - Gaston-Lincoln
9 - Catawba
10 - Mecklenburg
11 - Tri-County
12 - Piedmont
13 - Surry-Yadkin
14 - Forsyth-Stokes
15 - Rockingham
16 - Guilford
17 - Alamance-Caswell
18 - Orange-Person-Chatham
19 - Durham
20 - Vance-Warren-Granville-Franklin
21 - Davidson
22 - Sandhills
23 - Southeastern Region
24 - Cumberland
25 - Lee-Harnett
26 - Johnston
27 - Wake
28 - Randolph
29 - Southeastern Area
30 - Onslow
31 - Wayne
32 - Wilson-Greene
33 - Edgecombe-Nash
34 - Halifax
35 - Neuse
36 - Lenoir
37 - Pitt
38 - Roanoke-Chowan
39 - Tideland
40 - Albemarle
41 - Duplin-Sampson

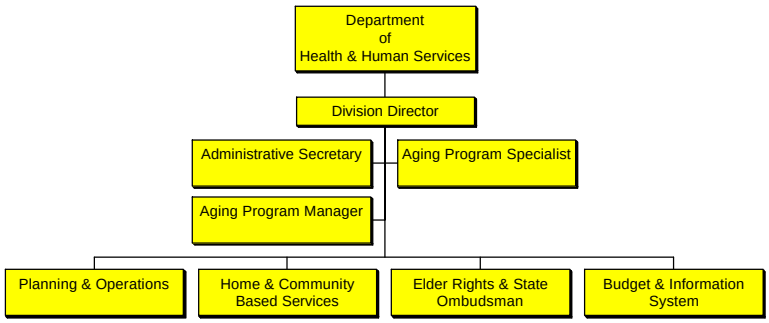
Source: Division of Mental Health, Dvelopmental Disabilities and Substance Abuse

DIVISION OF AGING

The Division of Aging (Division), established by State Law in 1977, is responsible for planning, administering, coordinating, and evaluating the activities developed under the federal Older Americans Act and the programs for older adults funded by the North Carolina General Assembly. Exhibit 13 depicts the organizational structure in place at the time of the audit. The Division has the responsibility of developing, administering, and monitoring the activities of the *State Plan on Aging* required by the federal Administration on Aging, as well as the *State Aging Services Plan* required by the State legislation. Additionally, the Division is primarily responsible for the coordination of all statewide activities related to the purposes of the Older Americans Act. To accomplish these duties; the Division has divided the State into district planning and service areas, as shown in Exhibit 14. Each area has an Area Agency on Aging which is responsible for developing an area plan. These plans must be reviewed and approved by the State Division of Aging. The Division also monitors, assesses, and evaluates the objectives set forth in each new plan; and carries out all other appropriate functions and responsibilities as prescribed under the Older Americans Act; federal regulations; the State Plans on Aging; and North Carolina laws, rules, and regulations. The Division works to achieve successful aging for North Carolina's older population by providing a system of services, opportunities, and protective supports that include:

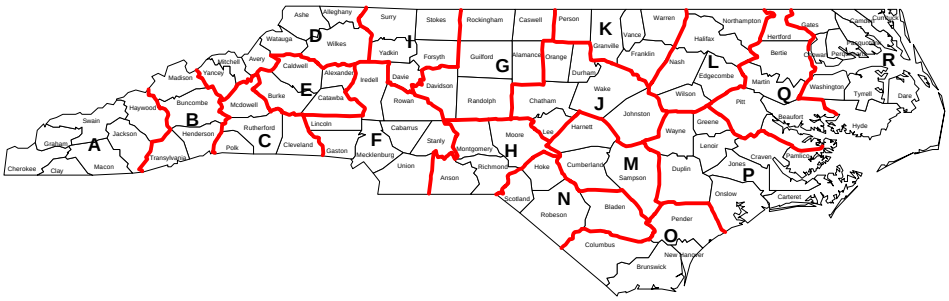
- supporting home and community services to promote independence and self-sufficiency;
- promoting opportunities for citizen involvement to allow seniors to contribute in civic affairs and public policy making, and through volunteerism;
- ensuring the rights and protections of older people for their social, health, and economic well-being; and
- preparing younger generations to enjoy meaningful lives in their later years.

EXHIBIT 13
Department of Health and Human Services
Division of Aging



Source: Division of Aging

EXHIBIT 14
DIVISION OF AGING
DISTRICT PLANNING AND SERVICE AREAS



Source: Division of Aging

The federal Older Americans Act requires that each state establish and maintain a **Long-Term Care Ombudsman Program** to advocate on behalf of residents in nursing and adult care homes. The major responsibilities of this program include:

- receiving and resolving complaints made by or on behalf of residents in long-term care facilities;
- providing information to the general public on long-term care issues;
- promoting community involvement with long-term care facilities and residents;
- working with long-term care providers to resolve issues impacting on the welfare of residents;
- assisting long-term care providers with staff training (particularly on resident's rights);
- training and assisting community advisory committees;
- providing information to public agencies, legislators, and others on problems impacting the rights of residents; and
- making recommendations for resolution of problem issues identified.

The Ombudsman Program has been in existence in North Carolina since 1978. In 1989, the North Carolina General Assembly enacted GS §143B-181.15-.25 establishing the Long-Term Care Ombudsman Program. This program incorporates federal mandates from the Older Americans Act and clearly defined the roles and responsibilities of the State and regional long-term care ombudsmen. The State Long-Term Care Ombudsman Program is located in DHHS, Division of Aging. The regional Long-Term Care Ombudsman Programs are housed in the 18 Area Agencies of Aging.

There are also volunteer advocates in each county who are appointed by the county commissioners to serve on the nursing and adult care home community advisory committees, as required by GS §131D-31, 32 and 131E-128. There are over 1200 volunteers state-wide. These committees focus on ensuring that the intent of the *Residents' Bill of Rights* is maintained and promoting community involvement in long-term care facilities. These volunteers are trained and assisted by the regional ombudsmen.

The *Residents' Bill of Rights* was established by the General Assembly to promote the interests and well being of the patients and residents in nursing homes, homes for the aged and disabled, and adult care homes. Rules developed in response to the bill of rights will provide the following:

- diverse and innovative housing models that provide choices of different lifestyles that are acceptable, cost effective, and accessible to all consumers regardless of age, disability, or financial statue;
- a residential environment free from abuse, neglect, and exploitation;
- available, affordable personal services models and individualized plans of care that are mutually agreed upon by the resident, family, and providers and that include measurable goals and outcomes;
- client assessment, evaluation, and independent case management that enhances quality of life by allowing individual risk-taking and responsibility by the resident for decisions affecting daily living to the greatest degree possible based on the individual's ability and;
- oversight, monitoring, and supervision by State and county governments to ensure every resident's safety and dignity and to assure that every resident's needs, including nursing and medical care needs, are being met.

The Declaration of Residents' Rights pursuant to GS §131D-21 and GS §131E-117 is included in Appendix A, 45.

In order to address the objectives identified for the audit, we visited 34 sites in 30 counties. We conducted interviews with 112 personnel at the State and local levels, as well as reviewed licensure files, complaint files, reimbursement records, and case management files. Our findings are presented below along with our conclusions as to whether the Department of Health and Human Services and its various divisions are adequately providing oversight and management for the long-term care programs in North Carolina.

OBJECTIVE 1: *To determine whether the agency responsible for licensing was adequately ensuring that the providers meet all the licensing requirements and that all providers offering services are appropriately licensed.*

Conclusion: ***DHHS has established procedures that ensure that providers meet the licensing requirements. Further, DHHS is overseeing and monitoring all providers as required by State statutes. However, statutes do not currently cover all types of 24-hour residential facilities.***

THE *STATE MEDICAL FACILITIES PLAN* DOES NOT INCLUDE ALL TYPES OF LONG-TERM CARE FACILITIES.

The *State Medical Facilities Plan (Plan)* is a component of the *State Health Plan*. Its major objective is to provide individuals, institutions, State and local government agencies, and community leadership with policies and projections of need for the different types of facilities. The *Plan* is used to guide local planning for specific health care facilities and services to assure equitable geographical distribution and equal access to all population groups for health services. Currently, the *Plan* provides projections of need for the types of facilities and services listed in Table 4, page 11. We learned during the audit that there are, however, a number of other types of 24-hour residential facilities that are not included in the *Plan*. Specifically, homes for the aged, family care homes, developmentally disabled adult group homes, and continuing care facilities are not included. Historically, these types of facilities were not considered "health care" facilities; however, with the increasing number of group care homes and the increasing needs of these residents, these services should be identified in the Plan. Since the Commission on Aging has forecast that the population aged 65 and older will double to 1.2 million by the year 2012, we believe that the State Health Coordinating Council needs to include all types of long-term care facilities in its planning process. We're suggesting that this data be included for informational purposes and not necessarily go through the certificate of need process.

RECOMMENDATION

The General Assembly should expand the definitions contained in GS §131E to require the *State Medical Facilities Plan* to include all types of licensed health care service facilities and to address the needs of those facilities. Including all types of long-term care facilities in the Plan will provide a more accurate picture of the State's needs for long-term care beds. Providing data concerning these 24-hour residential facilities would

be informative but would not necessitate including them in the certificate of need process.

OBJECTIVE 2: *To determine whether the agency responsible for inspections conducts the necessary inspections before issuing a license and whether the inspections ensure the provider is complying with the appropriate rules and regulations.*

Conclusion: ***DHHS is conducting the pre-licensing inspections as required. Procedures are in place for conducting regular monitoring inspections. However, based on our review, we believe there are some changes needed to make procedures more effective. Additionally, due to the increase in the number of long-term care facilities, the level of staffing needs to be re-examined to assure adequate coverage.***

CURRENT PROCEDURES DO NOT ADEQUATELY IDENTIFY OR ADDRESS POTENTIAL CONFLICTS OF INTEREST AND INDEPENDENCE IMPAIRMENTS.

Some State and local regulatory staff who have oversight authority and monitoring responsibilities for group care facilities may not be independent. DFS does have a division directive that states that it is the policy of DFS ". . . to avoid any possible conflicts of interest between regulatory staff and regulated entities." However, we were unable to find any specific documentation completed by the regulatory staff attesting to their independence. During one site visit with a complaint investigation team, the administrator of the facility was a former employee of the local regulatory unit for that county and a former colleague of the State-level investigatory team. The local regulatory staff had not substantiated the original complaint. The State-level review of the report filed by the local staff showed that standard procedures for investigation of abuse cases were not followed. Therefore, staff from the Group Care Licensure Unit conducted an investigation of the allegation of abuse during a subsequent visit. The State regulatory staff's report of the complaint investigation also found the allegation to be unsubstantiated. However, neither the local staff nor the State-level staff adequately addressed the issue of independence impairments.

RECOMMENDATION

All State and local regulators should be required to attest to their independence annually. These forms should be kept on file at the respective agencies. When regulatory supervisors make assignments of staff to monitor and/or investigate specific long-term care facilities, the supervisors should first determine the staff's independence. Each staff person should further be responsible for notifying his/her supervisor in writing of any potential conflicts of interest or independence impairments. This is in keeping with DFS's current procedures to ensure that an independent survey or investigation can be properly conducted according to the standards and policies established.

ADULT CARE BEDS LICENSED AS PART OF A NURSING HOME ARE NOT INSPECTED.

Currently, no routine inspections are performed of adult care home beds that are licensed as part of a nursing home (commonly referred to as combination facilities). As of March 1997, there are 361 nursing homes with 5,484 licensed adult care beds that are not inspected by monitors at the local level or by the Licensure and Certification Section or the Group Care Section of DFS. See Table 12, page 31. The Licensure and Certification Section is responsible for performing routine annual inspections of nursing homes. However, it does not have inspection procedures designed to ensure compliance with applicable laws, rules, and regulations pertaining to the adult care beds. GS §131 E-104.(b) states that the North Carolina Medical Care Commission ". . . shall adopt rules for the operation of the adult care portion of a combination home that are equal to the rules adopted by the Social Services Commission for the operation of freestanding adult care homes." Further, GS §131 E-105.(a) states DHHS ". . . shall inspect any nursing home and any adult care home operated as a part of a nursing home in accordance with rules adopted by the Commission."

RECOMMENDATION

The Division of Facility Services should immediately establish procedures for assuring oversight of adult care beds that are licensed as part of a nursing home. This oversight should ensure compliance with applicable laws, rules, and regulations pertaining to adult care beds. This was recommended by a March 1997 DHHS Internal Audit and had not been acted upon at the time of this audit.

NF = NURSING FACILITY
HA = HOMES FOR THE AGED

TABLE 12
DIVISION OF FACILITY SERVICES
ADULT CARE BEDS IN NURSING FACILITIES
As of March 1997

County	# of Nursing Facilities	# of NF Beds	# of HA Beds	County	# of Nursing Facilities	# of NF Beds	# of HA Beds
Alamance	5	650	4	Jones	1	60	30
Alexander	1	143	0	Lee	2	234	0
Alleghany	1	90	22	Lenoir	2	306	0
Anson	1	66	53	Lincoln	3	250	63
Ashe	1	120	30	Macon	1	190	10
Avery	1	120	0	Madison	2	180	20
Beaufort	2	290	10	Martin	1	154	0
Bertie	2	142	38	McDowell	2	220	15
Bladen	2	184	30	Mecklenburg	25	2,983	478
Brunswick	3	314	92	Mitchell	1	127	10
Buncombe	19	1,651	315	Montgomery	1	102	10
Burke	5	456	60	Moore	5	494	74
Cabarrus	5	597	54	Nash	4	419	149
Caldwell	3	340	20	New Hanover	6	709	50
Carteret	3	246	13	Northampton	2	149	0
Caswell	1	137	0	Onslow	2	319	7
Catawba	5	652	74	Orange	5	443	127
Chatham	3	340	50	Pamlico	1	96	8
Cherokee	1	60	20	Pasquotank	2	266	0
Chowan	1	130	30	Pender	2	140	23
Clay	1	80	20	Perquimans	1	78	0
Cleveland	4	504	0	Person	1	127	5
Columbus	3	293	25	Pitt	5	488	50
Craven	4	396	33	Polk	3	221	74
Cumberland	9	747	194	Randolph	5	560	68
Currituck	1	90	10	Richmond	2	225	10

NF = NURSING FACILITY
HA = HOMES FOR THE AGED

TABLE 12 (concluded)

County	# of Nursing Facilities	# of NF Beds	# of HA Beds	County	# of Nursing Facilities	# of NF Beds	# of HA Beds
Dare	1	126	18	Robeson	5	413	47
Davidson	9	694	198	Rockingham	3	382	26
Davie	3	198	64	Rowan	8	795	207
Duplin	3	222	62	Rutherford	4	230	100
Durham	11	1,258	142	Sampson	2	282	60
Edgecombe	3	307	65	Scotland	2	149	20
Forsyth	15	1,847	253	Stanly	4	406	52
Franklin	2	258	10	Stokes	3	282	58
Gaston	11	972	214	Surry	3	310	30
Gates	1	70	10	Swain	1	120	0
Graham	1	60	23	Transylvania	2	227	30
Granville	1	160	20	Union	3	287	67
Greene	1	85	17	Vance	3	232	77
Guilford	19	2,045	419	Wake	15	1,668	209
Halifax	4	285	25	Warren	1	140	20
Harnett	4	381	114	Washington	1	114	9
Haywood	5	405	30	Watauga	1	104	0
Henderson	7	692	40	Wayne	4	473	48
Hertford	1	151	0	Wilkes	3	407	19
Hoke	1	92	8	Wilson	4	375	69
Hyde	1	80	0	Yadkin	2	207	20
Iredell	4	502	76	Yancey	1	120	0
Jackson	1	94	0				
Johnston	3	450	30				
Totals					361	37,535	5,484

Source: Division of Facility Services

SOME FACILITY OPERATORS ARE NOT PROVIDING THE REQUIRED TRAINING FOR STAFF.

Federal and State regulations currently require facility operators to provide specified training for staff. Nurse aides working in nursing facilities are required to receive a minimum of 75 hours of training or have completed a state-approved Nurse Aide Training Competency Evaluation Program. Nurse aides in family care homes are required to receive a minimum of 20 hours of training. Nurse aides in homes for the aged are required to receive a minimum of 40 hours of training. Seventy-five hours of training is required of staff in any adult care home who perform or supervise special health-related personal care tasks. The purpose of the training is to assure these health care providers know how to perform and supervise basic personal care tasks. The Division of Facility Services worked with the Department of Community Colleges to establish a 75-hour curriculum with 20 and 40 hour modules and competency evaluation guidelines for the adult care homes. A 1996 survey conducted by DFS showed that only 75% of staff had completed, were participating in, or had scheduled the required training. See Table 13. Currently, Adult Home Specialists in each county verify facility personnel files for training certificates. Statewide information for 1997 of adult care home staff training was not available for analysis. Approximately 700 programs across the State, offered through the Community College System, high schools, home health care agencies, hospitals, nursing facilities and school of nursing, can provide the 75-hour training for special health-related personal care tasks. The community colleges also provide the opportunity to receive the adult care home training required by the State.

TABLE 13
DIVISION OF FACILITY SERVICES
FACILITY STAFF TRAINING STATISTICS - 1996

COUNTY	FACILITIES RESPONDING PER COUNTY	# OF AIDES/SUPS REQUIRING TRAINING/ COMPETENCY TEST	# WHO HAVE COMPLETED, ARE PARTICIPATING IN, OR ARE SCHEDULED FOR TEST	% WHO HAVE COMPLETED, ARE PARTICIPATING IN, OR ARE SCHEDULED
Alamance	79	284	223	79%
Beaufort	10	69	63	91%
Buncombe	84	226	191	85%
Cabarrus	16	175	137	78%
Caldwell	1	17	17	100%
Carteret	13	90	90	100%
Caswell	31	114	102	89%
Chatham	7	66	58	88%
Cherokee	6	0	NA	NA
Craven	8	121	114	94%
Cumberland	52	285	107	38%
Davidson	1	25	25	100%
Davie	4	30	16	53%
Edgecombe	5	61	51	84%
Forsyth	49	343	316	92%
Franklin	10	90	61	68%
Guilford	53	284	197	69%
Halifax	5	35	35	100%
Haywood	12	55	45	82%
Henderson	15	80	62	78%
Hertford	9	18	12	67%
Iredell	9	90	49	54%
Lenoir	24	120	104	87%
Lincoln	5	15	7	47%
Macon	1	11	10	91%
Martin	3	56	56	100%
McDowell	18	115	114	99%
Mecklenburg	24	140	62	44%
Montgomery	8	31	23	74%
Nash	8	25	15	60%
New Hanover	14	72	72	100%
Orange	4	42	31	74%
Pasquotank	2	64	64	100%
Perquimans	5	20	20	100%
Polk	5	21	16	76%
Rowan	22	95	49	52%
Sampson	9	46	38	83%
Stanly	6	39	15	38%
Stokes	7	40	6	15%
Surry	11	123	113	92%
Transylvania	7	39	23	59%
Union	16	73	14	19%
Vance	12	101	91	90%
Wake	30	207	131	63%
Watauga	3	19	15	79%
Wayne	11	84	58	69%
Wilkes	7	40	27	68%
Yadkin	3	26	25	96%
State Total	744	4222	3170	75%

Source: Division of Facility Services

RECOMMENDATION

The Division should accumulate the latest data available on staff training from the providers and/or local Adult Home Specialists across the State to determine if individuals responsible for the caring of Adult Care Home residents are properly trained. State and local inspection staff should routinely cite administrators who have not provided the required staff training, as required by current regulations. Failure by the facility

administrator to correct the training deficiencies or to comply with the regulations should result in sanctions as contained in the regulations.

FORMER RESIDENTS' TRUST ACCOUNTS HAVE NOT BEEN PROPERLY REFUNDED.

Federal regulations address proper handling of residents' trust fund balances, including the processing of refunds to former residents, their families, or their estates. DFS consultants examine the accounts of a sample of current residents to assure compliance with regulations. However, these procedures do not require the consultants to examine a sample of trust fund balances for former residents who have either passed away or who have moved out of the facility for whatever reason. Unless a specific complaint is made regarding residents' or former residents' trust funds, there is no on-going review of the trust fund accounts. During the audit, we noted former residents' accounts with balances of up to $2,500. Most of these residents were deceased, yet the balances, which should have been paid to the resident's estate or next of kin within 30 days, had been in the nursing home's account for as much as a year.

RECOMMENDATION

DFS should expand its procedures to routinely include an examination of residents' trust funds. The procedures should include an examination of a sample of trust funds for former residents, as well as current residents. Specifically, DFS personnel should determine whether the fund balances of former residents were properly processed as required by federal and State regulations. Issues of non-compliance with these regulations should be identified and cited as deficiencies for that facility.

THE CONSTRUCTION SECTION HAS NOT CONDUCTED ROUTINE INSPECTIONS ON ADULT CARE HOMES SINCE 1988.

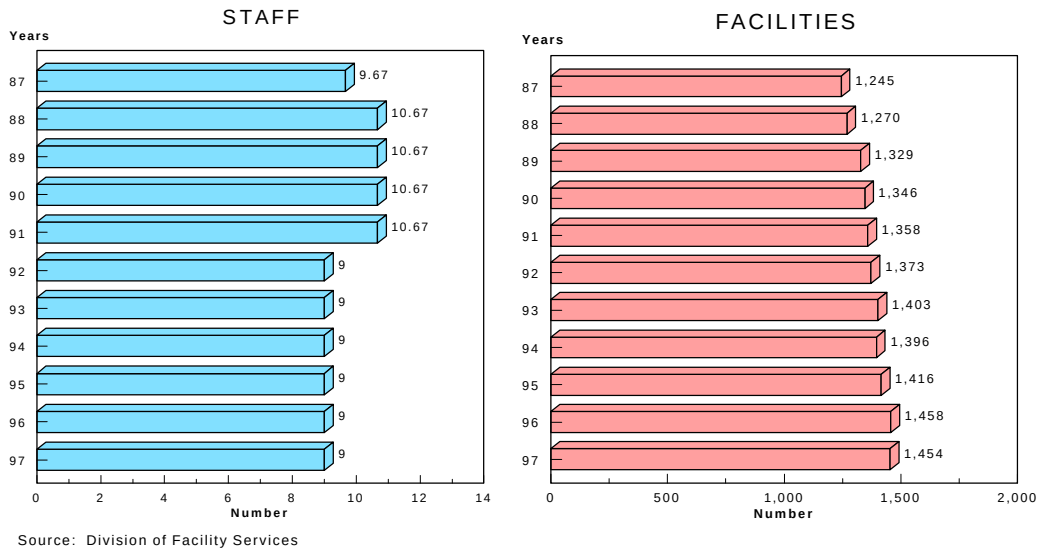
Currently, the Construction Section only inspects adult care homes when complaints are received regarding construction-related issues. Further, State and local survey staff only look at limited physical aspects of the facility during a regular survey. Due to the growth in new health care construction and renovation projects beginning in 1989, the Construction Section staff was forced to halt routine inspections of existing homes for the aged. For 1987, the nine and two-thirds state-funded Construction Section staff inspected 621 of the 1,245 Adult Care Homes operating at that time. Currently, there are 1,454 Adult Care Homes with 9 state-funded staff to conduct inspections, both regular and complaint related. Exhibit 15 depicts the changes in the number of adult care homes and the number of staff for the period 1987 through 1997.[9] During site visits, the audit team noted construction problems, which we believe would have been addressed during regular inspections. Problems noted included: structural damages to outdoor canopy, exposed electrical wiring, and significant damages to ceilings. These problems were not reported by the inspection team for follow-up.

[9] The Construction Section staff is responsible for administering licensure and certification requirements for approximately 5,000 facilities, 1,454 of which are adult care homes.

RECOMMENDATION

DHHS and DFS management should evaluate the proper level of staffing needed in the Construction Section to adequately provide regular construction inspections of adult care facilities. Once a determination is made as to the number of additional staff needed, DHHS should request funding from the General Assembly to hire the necessary number of inspectors. Further, procedures should be modified to require that all construction related violations be reported to the Construction Section for follow-up.

EXHIBIT 15
CHANGES IN THE NUMBER OF STAFF AND ADULT CARE HOMES: 1987-1997



Source: Division of Facility Services

THE MONITORING OF ADULT CARE FACILITIES IS NOT CONSISTENT FROM COUNTY TO COUNTY.

Currently, the monitoring process for adult care facilities allows each county's Adult Home Specialists (AHS) to determine the areas, extent, and frequency of licensure requirements to be examined at adult care homes. The State Division of Facility Services (DFS) has overall responsibility for the licensing of adult care facilities. To this end, DFS has developed and distributed procedures to be used for licensure inspections. However, we learned that the procedures have not been updated since 1991. During interviews with State and local staff, we learned that the Domiciliary Home Procedures Manual in not used at all during monitoring

TABLE 14
DIVISION OF FACILITY SERVICES
EMPLOYMENT STATISTICS OF ADULT HOME SPECIALISTS - 1997

# AHS for State	# Full-Time AHS	# Part-Time AHS	% Time Spent As AHS	Initial Employ-ment Between 7/96-7/97 As AHS	Initial Employ-ment After 7/97 As AHS
135	51	84	48%	28	17

% of AHS initially employed between 7/96-7/97	20.7%
% of AHS initially employed after 7/97	12.6%
% of AHS employed between 7/96 and 12/97	33.3%

Source: Division of Facility Services, Group Care Licensure Section

visits. Site visitations, examination of monitoring documents, and interviews with county Adult Home Specialists and Group Care Consultants confirmed the fact the monitoring activities are not performed consistently from county to county. Compounding this problem is the number of Adult Home Specialists who work full-time in that position (51), the percentage of time spent performing the duties of an AHS (48%), and the percentage of staff employed between July 1996 and December 1997 (33%). See Table 14 for statewide figures. Interviews indicated some confusion on the part of both State and local staff as to their respective responsibilities in the licensure process. The lack of a consistent monitoring process, coupled with the apparent confusion of responsibilities, sets up a situation whereby an adult care facility could be in significant non-compliance with State regulations. Yet, this non-compliance might not be detected and corrected given the current inconsistencies in the process.

RECOMMENDATION

DHHS and DFS management should review the statutes concerning the oversight responsibilities for adult care facilities. Recommendations for needed changes to the statutes should be made to the General Assembly for its consideration. Clear definition of responsibility would ensure that all homes across the State are being monitored effectively and consistently. Additionally, DFS should immediately update all licensure and monitoring procedures and distribute those to the affected personnel at the State and local level. At a minimum, standard procedures for licensure monitoring visits should be developed and enforced. Once developed, DFS should conduct training for local inspection staff so that they will understand the required procedures.

NON-MEDICAL STAFF ADMINISTER MEDICATION AT ADULT CARE FACILITIES.

Currently, State regulations require staff charged with administering medication for adult care homes to be specifically designated and trained. Review of inspection reports and observations during inspection visits showed that medication errors were often noted at both nursing and adult care homes. These errors could include: not administering medication at all, not administering medication at the correct intervals, failing to replenish a depleted medicine timely, and/or incorrectly administering the proper doses of medication. This situation is of concern since many residents of adult care facilities are prescribed several medications per day, including strong anti-psychotic drugs. In one home visited by the audit team and DFS inspectors, we noted one resident, who was not supposed to have medicine on the days he underwent dialysis, receiving medication on those days. This inspection visit took place after a provisional license was issued citing that same deficiency.[10] In 1996, the Governor's Ad Hoc Committee on Rest Homes and Nursing Homes recommended a trained medication technician per every 35 residents be added as a minimum requirement.

[10] This home had been cited on three previous occasions for this same deficiency. DFS used one of the options allowed under current procedures (i.e., issuing a provisional license) to try to correct the problem.

RECOMMENDATION

DHHS and DFS management should review the current staffing requirements for adult care homes for sufficiency. If it is determined that a licensed health care professional should be responsible for administering medication in long-term care facilities of all kinds, then recommendations for statutory modification should be made to the General Assembly for consideration.

THE GROUP CARE LICENSURE SECTION MAY NOT BE ADEQUATELY STAFFED.

The Group Care Licensure Section is responsible for the licensing of all adult care, developmentally disabled adult, and mental health facilities in the State, approximately 3,500 facilities. See Table 9, page 19. At the time of the audit, the Section had nine group care consultants, five mental health consultants, two pharmacy consultants, two dietary consultants, and one nurse consultant. These staff are responsible for conducting the required license surveys, as well as investigation of complaints. Historically, the clientele of the adult care homes have been individuals who did not have significant physical or mental problems. However, recent years have seen a marked change in the needs of these residents.[11] Yet, the composition of the staff for the Group Care Licensure Section has not changed to reflect the increased medical needs of these adult care home residents. Other sections within DFS such as Licensure and Certification do have health care professionals who participate on every survey team. Because of the limited number of health care professionals in the Group Care Licensure Section and the large number of facilities for which the Section is responsible, it is impossible for the one nurse consultant to actively participate on all surveys.

RECOMMENDATION

DFS should review the staffing levels of health care professionals in each section given the responsibilities of the section. Specific attention should be given to the composition of the staff in the Group Care Licensure Section. If it is determined that any area is understaffed, this information should be used as the basis for a request to the General Assembly for additional staff. Additional training should be provided to all consultants to keep them informed of the health care conditions they will encounter in the various types of long-term care facilities.

Auditor's Note: *Since the completion of the audit fieldwork, DFS has completed the Oversight Plan for the Adult Care Home Monitoring Program, dated March 5, 1998.*

[11] "Study of North Carolina Domiciliary Care Home Residents," 1995, Research Triangle Institute.

OBJECTIVE 3: *To determine whether the agency responsible for receiving and reviewing complaints has an adequate process and is imposing sanctions if providers are found not to be in compliance.*

Conclusion: ***DHHS has multiple avenues for filing a complaint which serves to make the system easier to access for residents and/or their families. While each entity has established procedures, we did find the need for better coordination of services and communication between these entities. Further, we confirmed that North Carolina has established processes for imposing sanctions for non-compliance as part of that process. Providers have the opportunity for appeal.***

THE COMPLAINT PROCESS AT DHHS IS FRAGMENTED AND LACKS ADEQUATE COORDINATION OF SERVICES AND INFORMATION.

Complaints are received and investigated in various sections of the Division of Facility Services, the Division of Aging, the Division of Social Services, the Division of Mental Health, Developmental Disabilities and Substance Abuse, the Division of Medical Assistance, as well as at the local Division of Social Services offices. The current system, with multiple avenue of access, provides residents and the general public with means to register complaints and seek assistance. Observations of operating procedures and interviews with staff at each division receiving complaints revealed inconsistent procedures and practices for handling, referring, and investigating incidents. Currently, DHHS does not have a central database for all long-term care facilities where historical, statistical, financial information, survey results, investigation results, and complaint information can be retrieved. Each division within DHHS and various sections within these divisions have separate information systems designed to meet the particular objectives of that division or section. Some of these systems are manually kept, not interlinked, thereby making specific information retrieval difficult. Additionally, we found little sharing of information from division to division or within the sections of a given division. These communication issues were also noted in the 1996-97 report on the Department of Human Resources reorganization given by the external auditors[12] to the General Assembly. We noted no significant improvement in this area during our audit.

RECOMMENDATION

DHHS should develop a central database into which all complaints are logged. Referral procedures should be established and followed to ensure that timely and appropriate referrals are made to the relevant regulatory personnel to conduct the investigation. The investigative staff should be qualified health care specialists or other professional specialists who can work within the parameters of the complaint investigation for all facilities. DHHS and the Division of Information Resource Management should continue in their efforts to develop a central database that could provide all information relating to long-term care facilities. This will improve

[12] KPMG Peat Marwick, L.L.P. March 20, 1997, Report to the General Assembly. "A Culture of Collaboration: Reorganizing the North Carolina Department of Human Resources".

coordination of services such as licensing and monitoring of homes and the communications between sections and divisions.

CURRENT PROCEDURES REGARDING REPORTING OF ALLEGATIONS CONCERNING RESIDENTS' CARE ARE NOT BEING FOLLOWED.

Currently, federal certification regulations and State licensure rules require long-term care facility operators to investigate all allegations of residential abuse or neglect of residents or misappropriation of residents' or facility assets. Additionally, the facility operator is required to notify both the local DSS Adult Protective Services and the State Health Care Personnel Registry Section about allegations of abuse, neglect, or misappropriation concerning nurse aides and for reporting all substantiated allegations against health care personnel. Either the Licensure and Certification Section, the Group Care Section, or the local DSS staff can investigate these allegations against nurse aides and health care personnel. DHHS procedures require investigators to notify the Registry Section of the allegations and results of the investigation. During the audit, we learned that facility administrators may not be properly investigating allegations or consistently notifying local and State investigators as required since it may be detrimental to the facility to do so. Further, we noted that the investigators do not routinely notify the Registry Section when they receive allegations. Therefore, staff in the Registry Section may have no knowledge that the allegations have been reported unless the facility operator has complied with the regulation for reporting.

RECOMMENDATION

All allegations of abuse, neglect, or misappropriation should be investigated and reported by the facility administrator in accordance with the established State and federal regulations. Failure by facility administrators to report allegations should result in a citation for deficiencies and non-compliance. Sanctions and penalties allowed by State licensure and federal certification laws applicable to these non-compliance issues should imposed accordingly. Further, investigatory staff at all levels should adhere to DHHS procedures for referral of allegations to the Health Care Personnel Registry Section.

THE HEALTH CARE PERSONNEL REGISTRY DOES NOT INCLUDE INFORMATION FOR ALL HEALTH CARE PERSONNEL.

The purpose of the health care personnel registry is to establish and maintain a listing of all names of health care personnel working in health care facilities who have been subject to findings by DHHS. However, individuals employed by health care facilities in administrative, maintenance, custodial, and dietary positions are not include in the Registry, even though persons in these positions have contact with residents and access to the residents' possessions. While allegations of resident abuse, neglect, or misappropriation by any member of a facility's staff should be investigated under the general licensure and certification laws, the names of non-health care personnel found guilty would not be added to any departmental registry. By

not including all facility personnel in the Registry, the State is not providing as much protection of residents as possible.

RECOMMENDATION

The General Assembly should amend GS §131E-256 to include the names of all health care facility personnel, even those not working directly in a health-related field. Substantiated allegations against any long-term care facility staff member should be noted.

ALLEGATIONS OF RESIDENT ABUSE, NEGLECT, OR MISAPPROPRIATION ARE NOT AVAILABLE BY FACILITY.

The number of allegations of abuse, neglect, or misappropriation is not readily available by provider or facility through the Health Care Personnel Registry. Currently, the Registry Section can only retrieve information by the name and social security number of the individual health care technician. Information of all substantiated allegations at a given facility is needed to provide the general public enough facts to determine that the facility is a safe and suitable environment for the residents. Additionally, knowledge of allegations by facility could be use by the survey teams in determining whether patterns of violations are occurring which should be considered when the facility is scheduled to be re-licensed.

RECOMMENDATION

DHHS should modify the Health Care Personnel Registry database to allow reporting by facility. This information should be available to the general public, as well as used by the licensure survey teams during inspection visits.

OBJECTIVE 4: *To determine whether the agency responsible for payments ensures that services billed were actually provided.*

Conclusion: ***The Department of Health and Human Services (DHHS) has assigned the responsibilities for payment of services to the Division of Medical Assistance (DMA). DHHS and DMA have established procedures for ensuring services billed are actually provided. The procedures were established in accordance with the Federal Health Care Financial Administration (HCFA) requirements. HCFA conducts routine reviews of DMA's procedures and records. Our examination of these reviews and of DMA's internal controls show that the agency's procedures are adequate.***

DFS DOES NOT ROUTINELY NOTIFY DMA OF CHANGES IN NURSING FACILITY OWNERSHIP.

Current procedures require owners of nursing facilities to notify DFS of a change in ownership. DFS issues a new license once all the proper forms are completed by the new owner. Upon granting the new license, DFS forwards an authorization letter to the nursing facility. Additionally, DFS officially notifies DMA of the change in ownership by forwarding a copy of the authorization letter. DFS' procedures for processing a change in ownership do not require it to determine whether the previous owners owe the State money for unauthorized or inappropriate reimbursement of Medicaid or State funds. Such checking would have to be completed by DMA. Therefore, a current owner of a nursing facility who owed the State a reimbursement of funds could sell his assets to another owner without the knowledge of DMA, thereby lessening the State's chances of receiving reimbursement.

RECOMMENDATION

DHHS, DFS, and DMA management should examine the current procedures for processing of a change in ownership for nursing facilities. All appropriate units within DHHS should be notified of a change request. DMA should have the opportunity to examine its records to determine if the facility requesting the changes has any financial obligations to the State. No changes in ownership should be processed by DFS until that determination is made. This would ensure that appropriate steps can be taken to recoup any funds that may be owed from the facility.

THE EFFICIENCY OF THE AUDIT SERVICES SECTION IS HAMPERED BY THE LACK OF A COMPUTERIZED DATABASE.

The Audit Services Section of DMA lacks a computerized system to coordinate all information related to cost reports and field audits. The Section receives annual cost reports from all certified Medicaid providers and 517 nursing facilities. Nursing facilities submit cost reports on diskette to the Section. All cost reports received are desk audited. In addition to the desk audits, 120 field audits are conducted each year. These field audits are currently contracted out to two private CPA firms, each performing 60 audits. The audit program used by each firm was developed by the Audit Services Section and includes variance analysis, detailed review of expenditure classifications, statistical sampling, and examination of medical records to verify services were provided. However, information obtained from these cost reports and field audits are not currently integrated into a computer database. This limits staff's ability to perform any detailed analytical examination of provider cost reports. DMA is in the process of enhancing computer services through a LAN for the Section.

RECOMMENDATION

DMA should continue its efforts to implement a comprehensive automation and information system within its Audit Services Section. Any additional funds necessary to complete the upgrade should be determined and requested from the General Assembly. Computerization

of data from costs reports and field audits would provide the Audit Services Section the ability to perform extensive analytical reviews of Medicaid providers.

OBJECTIVE 5: *To determine whether the agency responsible for case management is ensuring assessments are conducted and care plans are developed.*

Conclusion: ***We examined 280 case files during the site visits to the various types of long-term care facilities. Documented plans of care were current and properly authorized. Assessments by local, State and facility personnel were adequately documented. Therefore, we conclude that DHHS is ensuring assessments are conducted and care plans are developed as required in the federal and State regulations.***

APPENDICES

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APPENDIX A

GS §131D-21. Declaration of residents' rights. (Adult Care Home)

Each facility shall treat its residents in accordance with the provisions of this Article. Every resident shall have the following rights:

(1) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.
(2) To receive care and services which are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations.
(3) To receive upon admission and during his or her stay a written statement of the services provided by the facility and the charges for these services.
(4) To be free of mental and physical abuse, neglect, and exploitation.
(5) Except in emergencies, to be free from chemical and physical restraint unless authorized for a specified period of time by a physician according to clear and indicated medical need.
(6) To have his or her personal and medical records kept confidential and not disclosed without the written consent of the individual or guardian, which consent shall specify to whom the disclosure may be made, except as required by applicable State or federal statute or regulation or by third party contract. It is not the intent of this section to prohibit access to medical records by the treating physician except when the individual objects in writing. Records may also be disclosed without the written consent of the individual to agencies, institutions or individuals which are providing emergency medical services to the individual. Disclosure of information shall be limited to that which is necessary to meet the emergency.
(7) To receive a reasonable response to his or her requests from the facility administrator and staff.
(8) To associate and communicate privately and without restriction with people and groups of his or her own choice on his or her own or their initiative at any reasonable hour.
(9) To have access at any reasonable hour to a telephone where he or she may speak privately.
(10) To send and receive mail promptly and unopened, unless the resident requests that someone open and read mail, and to have access at his or her expense to writing instruments, stationery, and postage.
(11) To be encouraged to exercise his or her rights as a resident and citizen, and to be permitted to make complaints and suggestions without fear of coercion or retaliation.
(12) To have and use his or her own possessions where reasonable and have an accessible, lockable space provided for security of personal valuables. This space shall be accessible only to the resident, the administrator, or supervisor-in-charge.
(13) To manage his or her personal needs funds unless such authority has been delegated to another. If authority to manage personal needs funds has been delegated to the facility, the resident has the right to examine the account at any time.
(14) To be notified when the facility is issued a provisional license or notice of revocation of license by the North Carolina Department of Human Resources and the basis on which the provisional license or notice of revocation of license was issued. The resident's responsible family member or guardian shall also be notified.
(15) To have freedom to participate by choice in accessible community activities and in social, political, medical, and religious resources and to have freedom to refuse such participation.
(16) To receive upon admission to the facility a copy of this section.

GS §131E-116. Definitions.

As used in this Part, unless otherwise specified:

(1) "Administrator" means an administrator of a facility.
(1a) "Commission" means the North Carolina Medical Care Commission.
(2) "Facility" means a nursing home and a home for the aged or disabled licensed pursuant to G.S. 131E-102, and also means a nursing home operated by a hospital which is licensed under Article 5 of G.S. Chapter 131E.

(3) "Patient" means a person who has been admitted to a facility.

(4) "Representative payee" means a person certified by the federal government to receive and disburse benefits for a recipient of governmental assistance.

GS §131E-117. Declaration of patient's rights. (Nursing Homes)

All facilities shall treat their patients in accordance with the provisions of this Part. Every patient shall have the following rights:

(1) To be treated with consideration, respect, and full recognition of personal dignity and individuality;
(2) To receive care, treatment and services which are adequate, appropriate, and in compliance with relevant federal and State statutes and rules;
(3) To receive at the time of admission and during the stay, a written statement of the services provided by the facility, including those required to be offered on an as-needed basis, and of related charges. Charges for services not covered under Medicare or Medicaid shall be specified. Upon receiving this statement, the patient shall sign a written receipt which must be on file in the facility and available for inspection;
(4) To have on file in the patient's record a written or verbal order of the attending physician containing any information as the attending physician deems appropriate or necessary, together with the proposed schedule of medical treatment. The patient shall give prior informed consent to participation in experimental research. Written evidence of compliance with this subdivision, including signed acknowledgements by the patient, shall be retained by the facility in the patient's file;
(5) To receive respect and privacy in the patient's medical care program. Case discussion, consultation, examination, and treatment shall remain confidential and shall be conducted discreetly. Personal and medical records shall be confidential and the written consent of the patient shall be obtained for their release to any individual, other than family members, except as needed in case of the patient's transfer to another health care institution or as required by law or third party payment contract;
(6) To be free from mental and physical abuse and, except in emergencies, to be free from chemical and physical restraints unless authorized for a specified period of time by a physician according to clear and indicated medical need;
(7) To receive from the administrator or staff of the facility a reasonable response to all requests;
(8) To associate and communicate privately and without restriction with persons and groups of the patient's choice on the patient's initiative or that of the persons or groups at any reasonable hour; to send and receive mail promptly and unopened, unless the patient is unable to open and read personal mail; to have access at any reasonable hour to a telephone where the patient may speak privately; and to have access to writing instruments, stationery, and postage;
(9) To manage the patient's financial affairs unless authority has been delegated to another pursuant to a power of attorney, or written agreement, or some other person or agency has been appointed for this purpose pursuant to law. Nothing shall prevent the patient and facility from entering a written agreement for the facility to manage the patient's financial affairs. In the event that the facility manages the patient's financial affairs, it shall have an accounting available for inspection and shall furnish the patient with a quarterly statement of the patient's account. The patient shall have reasonable access to this account at reasonable hours; the patient or facility may terminate the agreement for the facility to manage the patient's financial affairs at any time upon five days' notice.
(10) To enjoy privacy in visits by the patient's spouse, and, if both are inpatients of the facility, they shall be afforded the opportunity where feasible to share a room;
(11) To enjoy privacy in the patient's room;

(12) To present grievances and recommend changes in policies and services, personally or through other persons or in combination with others, on the patient's personal behalf or that of others to the facility's staff, the community advisory committee, the administrator, the Department, or other persons or groups without fear of reprisal, restraint, interference, coercion, or discrimination;
(13) To not be required to perform services for the facility without personal consent and the written approval of the attending physician;
(14) To retain, to secure storage for, and to use personal clothing and possessions, where reasonable;
(15) To not be transferred or discharged from a facility except for medical reasons, the patient's own or other patients' welfare, nonpayment for the stay, or when the transfer or discharge is mandated under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act. The patient shall be given at least five days' advance notice to ensure orderly transfer or discharge, unless the attending physician orders immediate transfer, and these actions, and the reasons for them, shall be documented in the patient's medical record;
(16) To be notified within 10 days after the facility has been issued a provisional license because of violation of licensure regulations or received notice of revocation of license by the North Carolina Department of Human Resources and the basis on which the provisional license or notice of revocation of license was issued. The patient's responsible family member or guardian shall also be notified.

GS §131E-118. Transfer of management responsibilities.

The patient's representative who has been given the power in writing by the patient to manage the patient's financial affairs or the patient's legal guardian as appointed by a court or the patient's attorney-in-fact as specified in the power of attorney agreement may sign any documents required by the provisions of this Part, may perform any other act, and may receive or furnish any information required by this Part.

GS §131E-119. No waiver of rights.

No facility may require a patient to waive the rights specified in this Part.

GS §131E-120. Notice to patient.

(a) A copy of G.S. 131E-115 through G.S. 131E-127 shall be posted conspicuously in a public place in all facilities. Copies of G.S. 131E-115 through G.S. 131E-127 shall be furnished to the patient upon admittance to the facility, to all patients currently residing in the facility, to the sponsoring agency, to a representative payee of the patient, or to any person designated in G.S. 131E-118, and to the patient's next of kin, if requested. Receipts for the statement signed by these persons shall be retained in the facility's files.

(b). The address and telephone number of the section in the Department responsible for the enforcement of the provisions of this Part shall be posted and distributed with copies of the Part. The address and telephone number of the county social services department shall also be posted and distributed.

APPENDICES

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APPENDICES

APPENDIX B
LONG-TERM CARE FACILITIES

County	Nursing Homes		Developmentally Disabled Adults		Homes for the Aged		Family Care Homes		County	Nursing Homes		Developmentally Disabled Adults		Homes for the Aged		Family Care Homes	
	Number of Facilities	Total Number of Beds	Number of Facilities	Total Number of Beds	Number of Facilities	Total Number of Beds	Number of Facilities	Total Number of Beds		Number of Facilities	Total Number of Beds	Number of Facilities	Total Number of Beds	Number of Facilities	Total Number of Beds	Number of Facilities	Total Number of Beds
Alamance	5	654	19	11	15	464	48	261	Jones	1	90	0	0	0	0	1	6
Alexander	1	143	0	0	2	66	0	0	Lee	2	234	3	18	6	293	3	17
Alleghany	1	112	0	0	1	98	1	6	Lenoir	2	306	6	37	4	184	16	92
Anson	1	119	0	0	0	0	0	0	Lincoln	3	313	0	0	4	136	1	4
Ashe	1	150	2	12	2	76	0	0	Macon	1	299	0	0	1	52	0	0
Avery	1	120	0	0	1	40	0	0	Madison	2	200	1	6	0	0	9	54
Beaufort	2	300	3	19	5	157	2	12	Martin	1	154	0	0	2	152	3	17
Bertie	2	180	0	0	1	25	9	50	McDowell	2	235	3	27	6	341	9	54
Bladen	2	214	0	0	3	191	13	62	Mecklenburg	25	3,461	4	23	15	874	9	54
Brunswick	3	406	0	0	1	80	1	6	Mitchell	1	137	1	6	0	0	6	35
Buncombe	19	1,966	3	17	20	693	64	371	Montgomery	1	112	0	0	3	126	7	41
Burke	5	516	0	0	6	288	16	92	Moore	5	568	4	21	4	240	6	35
Cabarrus	5	651	4	20	8	513	4	23	Nash	4	568	2	13	5	212	6	34
Caldwell	3	360	0	0	5	284	4	19	New Hanover	6	759	0	0	13	550	7	39
Camden	0	0	0	0	0	0	1	6	Northhampton	2	149	0	0	5	200	2	11
Carteret	3	259	0	0	3	186	9	50	Onslow	2	326	0	0	4	312	9	43
Caswell	1	137	2	12	6	107	25	145	Orange	5	595	6	33	3	152	10	55
Catawba	5	726	0	0	7	296	2	12	Pamlico	1	104	1	4	0	0	0	0
Chatham	3	390	3	17	6	174	1	6	Pasquotank	2	266	0	0	2	190	0	0
Cherokee	1	80	0	0	2	24	24	4	Pender	2	163	0	0	2	79	4	24
Chowan	1	160	0	0	1	60	1	6	Perquimans	1	78	0	0	2	48	3	16
Clay	1	100	0	0	1	12	0	0	Person	1	133	4	4	1	34	7	39
Cleveland	4	504	2	12	8	339	18	99	Pitt	5	538	0	0	5	354	16	83
Columbus	3	318	0	0	2	160	4	23	Polk	3	295	0	0	2	26	1	6
Craven	4	429	0	0	6	434	2	12	Randolph	5	628	2	12	3	271	9	50
Cumberland	9	941	22	133	14	643	18	85	Richmond	2	220	2	11	6	263	3	16
Currituck	1	60	0	0	0	0	0	0	Robeson	3	240	0	0	14	543	16	92
Dare	1	144	0	0	0	0	0	0	Rockingham	3	408	0	0	4	181	31	178
Davidson	9	892	0	0	4	306	2	12	Rowan	8	1,002	6	33	9	470	7	40
Davie	3	262	1	6	2	92	0	0	Rutherford	4	330	1	9	9	355	27	158
Duplin	3	284	8	30	7	276	8	45	Sampson	2	342	2	10	4	147	5	26
Durham	11	1,400	10	54	12	737	40	201	Scotland	2	169	2	12	1	80	3	18
Edgecombe	3	372	0	0	2	156	3	17	Stanly	4	382	3	18	2	42	1	6
Forsyth	15	2,100	7	39	20	1,196	26	130	Stokes	3	340	2	14	4	114	1	6
Franklin	2	268	2	10	5	259	2	11	Surry	3	340	3	16	7	416	0	0
Gaston	11	1,188	0	0	8	503	5	28	Swain	1	120	0	0	1	50	0	0
Gates	1	80	0	0	0	0	0	0	Transylvania	2	257	2	14	0	0	5	30
Graham	1	83	0	0	1	12	3	18	Tyrrell	0	0	1	6	0	0	0	0
Granville	1	180	1	6	3	173	6	26	Union	3	354	3	19	4	144	9	50
Greene	1	102	1	6	1	40	1	6	Vance	3	309	3	15	3	173	5	25
Guilford	19	2,464	16	91	16	946	27	144	Wake	15	1,877	11	62	18	1,384	43	233
Halifax	4	310	1	6	3	160	2	12	Warren	1	160	1	5	3	150	7	39
Harnett	4	495	0	0	11	455	5	28	Washington	1	123	2	11	0	0	0	0
Haywood	5	435	3	18	14	294	3	15	Watauga	1	104	0	0	2	96	1	6
Henderson	7	732	3	17	11	326	4	23	Wayne	4	521	1	9	9	456	12	72
Hertford	1	151	0	0	2	121	11	62	Wilkes	3	426	3	16	2	149	2	12
Hoke	1	100	0	0	1	75	0	0	Wilson	4	444	7	36	5	541	9	44
Hyde	1	80	1	6	0	0	0	0	Yadkin	2	227	1	5	3	169	0	0
Iredell	4	578	1	6	9	513	2	10	Yancey	1	120	1	5	1	29	0	0
Jackson	1	94	0	0	7	187	0	0									
Johnston	3	480	3	18	19	627	7	39	**TOTAL**	**517**	**41,506**	**278**	**1,321**	**503**	**23,642**	**755**	**4,037**

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APPENDIX C

North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733-4534 • Courier 56-20-00

James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

April 2, 1998

The Honorable Ralph Campbell, Jr.
State Auditor
Office the State Auditor
300 N. Salisbury Street
Raleigh, North Carolina 27603-5903

Dear Mr. Campbell:

Enclosed is the Department of Health and Humans Services' response to the draft performance audit on *Long Term Care Programs in North Carolina as administered by the Department of Health and Human Services.*

Thank you for the opportunity to review and respond to the performance audit. If you have any questions, please do not hesitate to contact me or James B. Edgerton.

Sincerely,

H. David Bruton, MD

Enclosures

North Carolina: Host of the 1999 Special Olympics World Summer Games

The response from the Department of Health and Human Services has been reformatted to conform with the style and format of the rest of the audit report. However, no data has been changed.

APPENDICES

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APPENDIX C

PERFORMANCE AUDIT ON *LONG TERM CARE PROGRAMS IN NORTH CAROLINA*: RESPONSE TO RECOMMENDATIONS

Response to Recommendation that the Department Continue Efforts to Develop a Comprehensive Long-term Care System that Expands Options, Places More Emphasis on In-home and Community Based Options.

The Department is developing a plan for publicly-funded long-term care that is responsive both to increasing demand, consumer preferences and choices, and the simultaneous need to moderate the growth in Medicaid spending. Reforming long-term care depends as much upon restructuring service delivery systems as it does on the ability to combine diverse funding streams. The Department is in the second year of a three year Medicaid demonstration project funded by a foundation to revamp long-term care services in the state. The model will restructure home and community based care to make it more affordable, easier to access, and more fully integrated with both primary and acute health care. The model is being tested in a five county area in the Albemarle region (Pasquotank, Perquimans, Chowan, Camden, and Currituck) of northeastern North Carolina and will be tested in the Unifour area (Alexander, Burke, Caldwell, and Catawba counties). Other sites are under consideration. A new long-term care research and development unit has been created in the Office of Rural Health and Resource Development to manage the demonstration. An Office of Long-term Care Policy has been put in place in the Office of the Secretary to coordinate efforts across the Department. The Department has made the Study Commission on Aging aware of these efforts and plans to keep this body apprised of development and progress.

Response to Recommendation that Adult Care Home Beds Be Included in the State Medical Facilities Plan:

The Division of Facility Services disagrees with the recommendation. The State Medical Facilities Plan currently includes only facilities and services that are subject to the Certificate of Need statute. To include adult care home beds in the Plan without subjecting them to Certificate of Need would be confusing. In addition there would be little purpose in determining a limited need for beds if providers are free to build as many as they want wherever they want.

The Department is currently maintaining an inventory of licensed beds, those that have approved plans but are not yet licensed and those that are exempt from the moratorium imposed by the General Assembly. It will continue to do this so long as the moratorium remains in effect. The moratorium is scheduled to expire on August 25, 1998, but the Department has recommended that it be extended for at least an additional year.

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Response to Recommendation Regarding Identifying or Addressing Potential Conflicts of Interest and Independence Impairments:

The Division of Facility Services agrees that addressing potential conflicts of interest is necessary and is already doing this in most areas. Federal regulations for nursing homes (42

CFR 488.314 (a)(4)) describe certain situations that constitute conflicts of interest and prevent surveyors from surveying specific facilities. In addition the State Operations Manual, section 7202, recommends that State Agencies require employees to make declarations of any outside interests, with updates, whenever needed. The Licensure and Certification section requires that all employees declare potential conflicts of interests. This form has been shared with all other sections within the Division for use in other programs and will be included as a requirement in the Adult Care Homes Policies and Procedures Manual, which is in the process of being revised. Group Care Licensure staff are currently asked to report any potential conflict of interest situations to their supervisors.

Response to Recommendation Regarding Inspection of Adult Care Beds Licensed as Part of a Nursing Home:

The Division of Facility Services agrees that adult care beds licensed as part of a nursing home should be routinely inspected. However, the decline in resources coupled with increases in workload and inflationary increases have made it necessary to prioritize work within the Licensure and Certification Section. From 1991 to 1997 North Carolina's Medicare allocation was reduced by 14 percent overall, (from $3,409,701 to $2,997,369). In addition, in 1996, ten state funded positions were eliminated as part of the Department's cost cutting efforts. During the last six years there has been a 16 percent increase in the number of nursing homes and a 38 percent increase in the number of intermediate care facilities for the mentally retarded. Other factors which have contributed to the increase in workload include increased administrative responsibilities related to nursing home enforcement, required state agency quality improvement programs and responsibilities related to the nursing home assessment instrument (MDS).

In prioritizing work it was felt that adult care beds that were housed in nursing homes could not be prioritized as high as some other regulatory needs because of the intense scrutiny already given to nursing homes through the regulatory process. The Division of Facility Services is required to survey nursing homes at least every 15 months with an average of 12 months. Most other provider groups are surveyed much less often with the exception of intermediate care facilities for the mentally retarded which must be surveyed annually. For example, home health agencies are surveyed every three years and most other acute care programs (non accredited hospitals, rural health clinics, end stage renal dialysis facilities, hospices and others) are only surveyed at the rate of 10 percent a year. In addition, state law requires that all nursing home complaints be investigated within 60 days. Of all complaints received and investigated about 95 percent are in nursing homes. This includes complaints in adult care beds in nursing homes which are presently investigated. Finally the federal survey process which we use to survey nursing homes is very detailed and thorough and through the

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process we can look at the systems in the nursing home. It has been our experience that adult care beds in nursing homes are treated as a part of the overall system and when problems are identified in the nursing home and systems are put in place to fix these problems, these systems should fix the problems that exist in the adult care beds as well.

The routine oversight of the substantial number of adult care home beds in nursing homes would require additional staff or would require diversion of staff from activities that are mandated while this function is not. It is estimated that 12 additional Facility Survey Consultant I's and one Processing Assistant III would be required at an annual cost of $736,000. There are 6,245 adult care home beds in 217 nursing homes and hospitals. It is estimated that one additional surveyor would be needed on each of the twelve nursing home survey teams.

Response to Recommendation Regarding Assuring Staff Training:

The Division of Facility Services agrees that staff training should be assured. In its role of overseeing the monitoring of adult care homes by the county departments of social services, the Division of Facility Services staff are conducting on-site monitoring of adult homes specialists in addition to providing training and consultation in which the monitoring of adult care home staff training is being addressed. The Division of Facility Services' surveys of facilities involve the monitoring of staff training and citing of homes that are not in compliance. Adult homes specialists are being encouraged and trained to do the same.

Response to Recommendation Regarding Refunding of Former Residents' Trust Accounts:

The Division of Facility Services disagrees that additional monitoring of former residents' trust accounts should be done. Federal regulations (42 CFR 483.10(c)(6)) require that "upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate." The procedures in the interpretive guidelines for this regulation indicate "as part of closed records review, determine if within 30 days of death, the facility conveyed the deceased resident's personal funds and a final accounting to the individual or probate jurisdiction administering the individual's estate as provided by state law."

Additional procedures for the closed record review indicate that closed records should be selected on residents who have been identified through the use of offsite information concerning a particular care issue. Surveyors are instructed to focus the review on the appropriateness of care and treatment surrounding the resident's discharge or transfer.

The sample size dictates the number of closed record reviews to be done. Facilities from 5 to 48 residents get one closed record review, facilities from 49 to 75 get two and facilities larger than 75 beds get three. These closed record reviews may or may not involve residents who are deceased. If the resident is deceased then procedures instruct us to check to see if the facility

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conveyed the residents funds. Resources are not available to do more than what is dictated through the federal process. Neither state law nor rules require that this be done.

In addition, families of deceased patients can pursue civil legal remedies if they believe nursing homes have improperly accounted for residents' funds. This is also the case for patients or families who believe they have been billed improperly.

> ***Auditor's Note:*** *We agree that DFS is currently complying with Federal regulations, however, our review of a small random sample of trust account balances revealed some accounts with significant balances. These funds are being held by the facility in violation of Federal regulations.*

Response to Recommendation Regarding Construction Staff :

The Division of Facility Services agrees that additional staff are needed in the Construction Section. The Division and Section have requested additional staff each year beginning in 1992 with no increases in staff. The division estimates that 16 additional professional staff plus one additional clerical position would enable the Section to review projects in a timely manner (now at approximately 16 weeks lag); to conduct field inspections for most licensure programs; to include a combination of interim construction inspections, final inspections for new construction projects; and licensure inspections of most existing facilities on some regular timetable. The annual cost is estimated to be $1,214,327.

Response to Recommendation Regarding Assuring Consistency of Monitoring from County to County:

The Division of Facility Services agrees that monitoring should be consistent and was already taking a number of steps to accomplish that before the performance audit. The Adult Care Home Procedures Manual is in the last stages of revision and is expected to be completed by early April. It will be distributed to all county departments of social services and training on its use will be provided for all adult homes specialists. Survey visits to specialists by the Division of Facility Services staff and a greater emphasis on training will promote statewide consistency in the monitoring of adult care homes. The Division of Facility Services has developed an oversight plan for the adult care home monitoring program which has been submitted to the Study Commission on Aging.

Response to Recommendation Regarding Dispensing of Medications by Non-Medical Staff in Adult Care Homes:

The Nurse Practice Act exempts adult care homes from having a licensed health professional to administer medications. Additional staff for medication administration would create a substantial financial impact. A cost analysis prepared for the Governor's Ad Hoc Committee on Rest Homes and Nursing Homes (April, 1996) showed that the addition of one aide to one

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8-hour shift in adult care homes statewide would cost $7,382,000 for a 12-month period. If the additional staff person were a licensed health professional this cost would increase drastically. Requiring a medication technician to administer medications would significantly increase the cost due to both additional training needed and higher wages.

DFS has two pharmacists on staff who do extensive consultation and training in medication management. Also, there are stronger sanctions for non-compliance with medication administration rules than a provisional license. There are administrative penalties and license revocation or even suspension depending on the seriousness or extent of the violation(s).

Response to Recommendation Regarding Sufficiency of Group Care Licensure Staffing:

Because the Division of Facility Services is changing its role in the relationship with county departments of social services, the sufficiency of staffing is uncertain. Group Care Licensure staff are focusing on training, consultation and evaluating the counties' adult homes specialists' monitoring role through survey visits to county department of social services in fulfilling its oversight responsibilities. Staff survey of adult care homes are limited to a sample of facilities used to determine compliance in monitoring procedures by county adult home specialists. Complaint investigations are the responsibility of adult homes specialists who are employees of the county departments of social services. Attention has shifted to assuring accountability of county departments of social services in their monitoring role through quarterly oversight visits and enabling consistent and effective monitoring through training of adult homes specialists. This shift is allowing more effective use of staff time and resources as outlined in the Oversight Plan for the Adult Care Monitoring Program. After the oversight plan has been fully implemented the division will be better able to assess sufficiency of staffing.

Response to Recommendation Regarding the Complaint Process at the Department of Health and Human Services:

The Division of Facility Services agrees that the complaint process needs to be strengthened. The Licensure and Certification Section has recently asked a consultant with the Office of State Budget and Management to look at the complaint process and make recommendations and that report has just been received. The Division is in the process of developing an action plan and schedule to implement most, if not all, of those recommendations. Also, the Division of Information Resource Management installed a new complaint tracking system in early March that will be made available to all sections of the Division of Facility Services. The Division has also installed a toll-free Complaints Hotline that receives complaints about allegations of noncompliance by any facility. Complaints are routed to the appropriate office for investigation. The division has estimated that an additional 16 staff, at an annual cost of $864,010 the first year, are needed to reduce the timeframe for investigating complaints and ensuring follow up of facilities that provide substandard care.

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Response to Recommendation Regarding Current Procedures for Reporting Allegations Concerning Residents' Care:

The Division of Facility Services agrees that adult care home providers are not reporting at the same rate as others. This may be a result of the lack of understanding of the new law. While the Division has conducted over thirty workshops on the law and its requirements, additional training sessions are scheduled with the North Carolina Assisted Living Association and the North Carolina Association, Long Term Care Facilities, who represent the majority of adult care homes in the state.

With relation to the communication between investigators there is good communication between survey staff in the Division. If Licensure and Certification receives a report of resident abuse, neglect, etc. that information is reported to the Health Care Personnel Registry and likewise if the Health Care Personnel Registry identifies that a provider has not reported as required by regulation then that is reported to the Licensure and Certification Section. To further enhance the communication between the Registry and county departments of social services, the Division has been working with the Division of Social Services to update the Memorandum of Understanding between the Division of Facility Services and the Division of Social Services concerning reporting procedures as well as other issues.

Response to Recommendation Regarding The Health Care Personnel Registry Not Including Information For All Health Care Personnel:

The Division of Facility Services agrees that the Registry should be expanded. Based upon input from the division and an advisory group, the Medical Care Commission has unanimously voted to recommend to the General Assembly that the Registry program be expanded to include direct care staff in all mental health facilities licensed or operated by the State. The addition of the mental health programs will require additional staff and resources which the Commission has also recommended. If mental health facilities were added, an additional four consultants and an attorney (through a contract with the Attorney General's Office) would be required at an annual cost of $311,157. The division has estimated that it needs $227,538 annually for an additional four positions to eliminate the current backlog and keep up with the present volume of cases. As far as expanding the program to include non-direct care personnel working in health care facilities this would also require additional resources and staff to implement. While it may be a good idea to include all staff employed in health care settings, providing the resources to support the current volume of cases and to include all direct care personnel in mental health facilities should be top priorities.

Response to Recommendation Regarding Allegations of Resident Abuse, Neglect, or Misappropriation Not Being Available By Facility:

The Division of Facility Services disagrees that this information be available by facility. While the Registry database contains facility information it is not capable, at this time, of generating a specific report as suggested in the recommendation. The Division is concerned that the

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inclusion of specific facility information may discourage providers from reporting allegations. This program is designed to be a cooperative effort between the Registry and the provider community, with the common goal being to prohibit the employment of individuals who may abuse residents. The inclusion of specific provider information for use as specified in the report will only serve to discourage the accomplishment of this goal.

Response to Recommendation Regarding the Division of Facility Services Notification of the Division of Medical Assistance of Changes in Nursing Facility Ownership:

The Division of Facility Services agrees that a notification process would be helpful. However, there is presently a clearance process in place that is required by the Health Care Financing Administration to keep individuals who have been involved in fraudulent activities out of the Medicare program. Nursing homes must go through this program. Initially this clearance process was required before the ownership took place but was changed because the legal complexities of changing ownership made the process unworkable. The Department believes, at this time, that it does not have the regulatory authority to impose this recommendation without a change in either statute or rule. While the Department is not opposed to the concept, there are no plans to propose a statutory change.

Response to Recommendation Regarding Computerized Database:

The Division of Medical Assistance is in the process of installing a Division wide LAN system. That will be accomplished in mid-1998. Once staff have access to this equipment, we understand we will have separate areas per unit assigned for internal Section use. The Division will evaluate if that will meet the needs identified by the State Audit.

While the Audit Section uses a FoxPro database software package with the providers, it may be possible to upload "read-only files" and reliably access the data using Microsoft Access. That may meet the need stated by the Audit without additional cost to the agency.

Therefore, the Division of Medical Assistance will assess what can be done when the LAN arrives. The Division will attempt to use it for the purposes described. If it does not work, Program Integrity and DMA Information Services will assess the next steps.

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Estimated Costs of Recommendations:

The performance audit includes a number of recommendations to strengthen the functions and responsibilities of the Division of Facility Services. The costs of these recommendations are summarized below. (Note that the table does not include the cost to adult care homes of adding licensed health professionals to dispense medications.) While these recommendations are with merit, these needs must be weighed against other needs of the Department.

Recommendation	Total Cost	No. Staff
Inspect Adult Care Home Beds in Nursing Facilities	$ 736,000	12
Review Construction Plans/Inspect Sites	1,214,327	16
Increase Health Personnel Registry Staff to Meet Current Volume	227,538	4
*Add Mental Health Facilities to Health Care Personnel Registry Program	311,157	4
Total Estimated Cost of Recommendations	**$ 2,489,022**	**36**

***Auditor's Note:** The audit did not address the issue of including staff from mental health facilities in the Registry.*

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Mr. Marvin K. Dorman, Jr.	State Budget Officer
Mr. Edward Renfrow	State Controller
Dr. H. David Bruton	Secretary, Department of Health and Human Services

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April 20, 1998

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