BOARD AND CARE

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this inspection is to assess existing State board and care regulations and enforcement activity.

BACKGROUND

Board and care refers to nonmedical community-based living arrangements providing shelter, food, and protective oversight to a dependent elderly and disabled population. Over one million elderly and disabled individuals reside in board and care facilities nationwide, and their numbers are increasing.

As an outgrowth of abuses in board and care facilities, the Congress enacted the Keys Amendment [Section 1616 (e) of the Social Security Act] in 1976. It requires States to set standards that assure that Supplemental Security Income (SSI) recipients do not reside in substandard facilities. The Office of Human Development Services (OHDS) has the Federal responsibility for administering the Keys Amendment and assuring that States have these standards in place.

The American Bar Association (ABA) developed "A Model Act Regulating Board and Care Homes: Guidelines for States" under an OHDS grant to help States develop standards to improve conditions in the homes.

METHODOLOGY

This inspection included the following activities: interviews with Federal officials involved with board and care; discussions with 70 State officials in 50 States and the District of Columbia (DC) representing 72 State programs involved with licensing and/or certifying board and care facilities; analysis of current standards for each of the 72 programs; and onsite visits to seven locations involving interviews with 26 providers, 15 provider or resident advocates and several State officials.

FINDINGS

Although State Standards Adequately Address Certain Basic Safety And Service Requirements, Weaknesses Exist In Other Important Areas.

Almost all State standards address personal care services, fire safety, physical structure, sanitation and licensing. Only limited attention is given to level of care needs of residents, training, dealing with unlicensed facilities, complaints and coordination among responsible agencies, providers and consumers.

Almost three-quarters of State respondents and more than three-quarters (80 percent) of providers and advocates recommend a common set of national minimum standards. These should include basic safety and service requirements, ways to deal with unlicensed facilities, staff training, requirements for different levels of care and coordination among responsible agencies, providers and consumers. They feel that such standards would create greater uniformity and effectiveness in regulation and enforcement.

While States Conduct Basic Enforcement Activities, Serious Weaknesses Exist.

Almost all States conduct inspections and issue corrective action plans. Only about one-third of State standards provide intermediate sanctions such as assessing civil monetary penalties and prohibiting admission of new residents to homes under citation. According to some respondents, the absence of these sanctions restricts States' enforcement capacity.

While most States have the ability to revoke or deny licenses, less than half actually did so in 1988. More than one-third of State standards provide for closing homes and removing residents, but only 11 States actually took these actions or imposed any penalties or sanctions.

There are a number of enforcement concerns which exist with regard to board and care. Unlicensed homes are one such enforcement concern. Ambivalence exists as to how these homes should be penalized. Over three-quarters of State respondents cited constraints to effective enforcement. These include limited staff, a lengthy legal process, insufficient financial resources, the absence of legal authority for sanctions and the lack of alternative placement. Close to half felt their States assigned board and care a low priority. A majority felt the Keys Amendment could not be enforced.

The DHHS Plays A Limited Role In Board And Care And Limited Coordination Exists.

Activities affecting board and care facilities and residents are limited within HHS. The Office of Human Development Services is responsible for administering the Keys Amendment. The States must notify the Social Security Administration (SSA) of violations of the Keys Amendment and SSA provides information to States to assist in identifying unlicensed homes. The Administration of Developmental Disabilities (ADD) and the National Institute of Mental Health (NIMH) both have protection and advocacy programs administered by State agencies or organizations which may include residents of board and care facilities. The Administration on Aging (AoA) has an Ombudsman Program which advocates the rights of the institutionalized elderly including residents in board and care facilities. The Health Care Financing Administration (HCFA) has a home and community based waiver program which gives States the option to broaden the definition of "medical assistance" under Medicaid if States certify compliance with Keys Amendment requirements. These waivers may include services to board and care residents. The Assistant Secretary for Planning and Evaluation (ASPE) has several board and care initiatives currently underway.

There is limited contact between these various agencies within HHS involved with board and care; each unit functions independently and has little awareness of relevant activities occurring elsewhere in the Department.

RECOMMENDATIONS

States should

- Re-evaluate their board and care standards especially in the areas of level of care, training, coordination and unlicensed facilities.

- Improve their ability to identify and deal with unlicensed facilities and provide incentives for facilities to become licensed.

- Use such sanctions as civil monetary penalties, restrictions on new admissions and closing of homes.

- Assure that existing procedures for resolving complaints are sufficiently publicized so that complaints are brought to the attention of the proper authorities.

To support States' efforts in implementing the above recommendations, OHDS should designate a unit for board and care which will

- Disseminate information on such matters as operational efficiencies, effective enforcement techniques, research and States' best practices.

- Promote more effective use of the Model Act.

- Provide technical assistance to States, particularly to support the standards and enforcement concerns highlighted in this report.

- Coordinate departmental activities relative to board and care.

COMMENTS

Comments on the draft report were received from HCFA, ASPE, AoA, PHS, SSA and OHDS and were generally supportive of our findings and recommendations. While support was expressed for our recommendation that there be a Departmental coordinating unit, the question of funding was raised by OHDS (See Appendix B). We continue to believe the problems addressed in this report are sufficiently important to warrant the relatively small expenditure necessary to support a coordinating unit.

INTRODUCTION

PURPOSE

The purpose of this inspection is to assess existing State board and care regulations and enforcement activity.

BACKGROUND

History

Board and care refers to nonmedical community-based living arrangements providing shelter, food and protective oversight to a dependent population of elderly and disabled. These facilities vary widely in definition, size, resident populations, funding sources and services provided. The terminology for board and care facilities encompasses a broad range of titles such as residential care, personal care, adult foster care, sheltered care, domiciliary care, family homes, adult homes, group homes and assisted living. Board and care residents have a wide range of demographic characteristics and needs; they include the elderly, developmentally disabled and mentally impaired.

All States have regulations relating to board and care. However, States use a variety of definitions and a wide range of size criteria to identify these homes for licensing. The definition is usually based on the services provided rather than the anticipated needs of the residents. A board and care home may be defined by a State as "a publicly or privately operated residence that provides meals, lodging and personal assistance to two or more adults who are unrelated to the licensee or administrator." In contrast, a nursing home provides 24-hour medical care.

State regulations require that all facilities which fit their definition of a board and care home be licensed or certified. The license is issued to a specific licensee for a specific facility and cannot be transferred to a different licensee or facility. The licensee is the person(s) who holds the license to operate the facility and is responsible for seeing that the licensing requirements for the facility are met. The licensee may operate and maintain the home or delegate those functions to an administrator or manager.

Oversight and enforcement also vary. Within some States more than one agency has responsibility for board and care, differing usually with the type of resident, size of the facility and kinds of services provided to the residents. The most prevalent agencies involved are the Department of Social Services, Department of Public Health and Department of Mental Health and Retardation.

According to the House Subcommittee on Health and Long-term Care report, over one million elderly and disabled individuals reside in board and care facilities nationwide. Their numbers are increasing due primarily to three factors. The first is the deinstitutionalization of the

mentally ill in the 1960s which resulted in many of these people being placed in board and care homes because they continued to require a sheltered environment. Second, the enactment of the Supplemental Security Income (SSI) program in 1972 created a guarantee of payment for owners and operators of these facilities. Lastly, a shortage of nursing home beds and other long-term care services has resulted in more admissions to board and care homes.

Legislative Highlights

The Keys Amendment was enacted in 1976 (Section 1616 (e) of the Social Security Act) as an outgrowth of abuses in board and care facilities in the mid-1970's. It requires States to "establish, maintain and insure the enforcement of standards" for residences where "a significant number" of SSI recipients reside or are likely to reside. It also has a penalty provision which reduces a recipient's SSI payments if he or she resides in a facility not meeting State standards. This reduction is applied to that portion of the payment that is a State supplement and only by the amount of the supplement that is used for medical or remedial care. The legislative history reflects the concern of Congress that Federal SSI benefits not be used to support substandard living facilities.

The Omnibus Budget Reconciliation Act of 1987 is likely to impact on board and care. It eliminates (by October 1, 1990) the Medicaid distinction between skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) and combines them into a single level, called "nursing facility," under Medicaid. Some ICFs that cannot meet the more stringent requirements for nursing facilities will be downgraded to a lower level such as board and care. As a result, residents presently in ICFs may no longer be eligible for nursing facility care and may become board and care residents.

HHS Role

A number of HHS components have responsibility for board and care homes or their residents. The Office of Human Development Services (OHDS) has the Federal responsibility for managing the Keys Amendment and seeing that it is implemented at the State level. The Administration on Developmental Disabilities (ADD), the Administration on Aging (AoA) and the National Institute of Mental Health (NIMH) each provide grants to States to operate an Ombudsman or a protection and advocacy program for their respective client groups. To help States locate board and care facilities, the Social Security Administration (SSA) provides State Data Exchange (SDX) tapes which identify addresses where three or more SSI recipients reside. The Health Care Financing Administration (HCFA) issues waivers to broaden the definition of "medical assistance" under the Medicaid program if the Keys statute and regulations are met.

Prior Activities

Concerns about the quality and services in board and care homes were highlighted in a prior Office of Inspector General (OIG) study (1982) and, more recently, in both a General

Accounting Office (GAO) study and a report issued by the House Select Committee on Aging's Subcommittee on Health and Long-term Care (March 1989).

The American Bar Association (ABA) developed "A Model Act Regulating Board and Care Homes: Guidelines for States" under an OHDS grant in 1984. This was intended as a resource document to help States develop and revise standards to improve conditions in the homes. Fire and safety guidelines were also developed by an HHS interagency task force and shared with the States. These guidelines were the result of a ten year effort and have been incorporated in the Life Safety Code by the National Fire Protection Association. Currently, there is a large evaluation being conducted of this system which is being jointly funded by six Federal agencies.

METHODOLOGY

This inspection was conducted in three parts. First, Federal officials with some responsibility for board and care were interviewed to determine the level of activity within HHS.

Second, 70 discussions with State officials were conducted in 50 States and the District of Columbia (DC). They represented 72 State programs involved with licensing and/or certifying board and care facilities (one person in 33 States, two each in 15 States and three each in 3 States; in 2 States one respondent spoke for two programs). An effort was made to identify all agencies in each State with responsibility for this function. Information was obtained regarding licensing, certification and enforcement activities, and perceptions were gathered regarding board and care regulations and their enforcement. Copies of current standards and licensing requirements for each of the 50 States and DC were obtained and analyzed against the Model Act, each other and exemplary State standards for commonalities and variations.

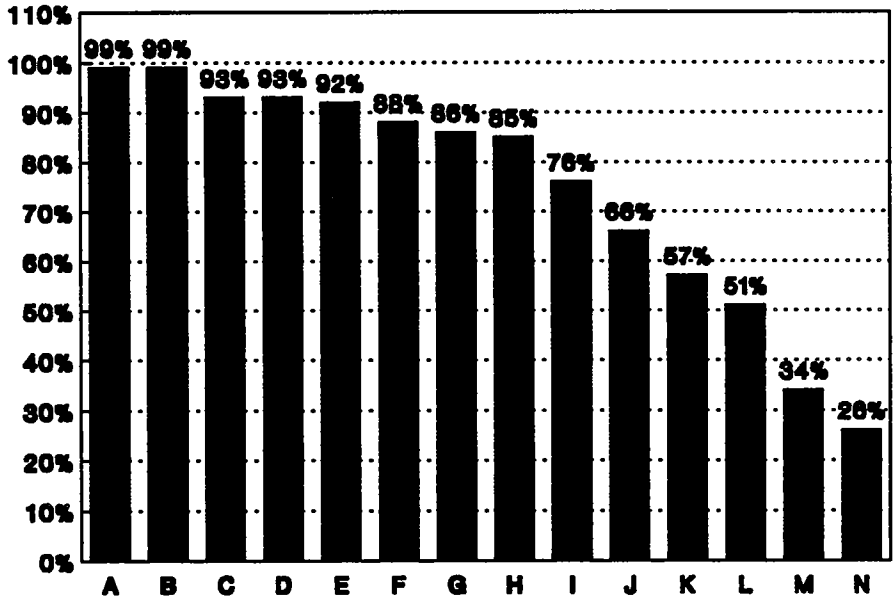
During the third part, onsite visits were made to seven locations (California, DC, Georgia, Michigan, Missouri, New Jersey, and New York) selected on the basis of geographical distribution, recommendations from State and industry respondents and prior analyses. Members of the team included a physical therapist and a registered nurse. Interviews were held at 26 homes selected for several reasons, including whether they cared for SSI recipients or participated in demonstration programs. The 26 homes represent a mix of different sizes, services and types of residents served. Also interviewed were 15 advocates of providers or residents and several State officials involved with board and care. The interviews included discussions of State standards, enforcement and problems in the industry.

FINDINGS

ALTHOUGH STATE STANDARDS ADEQUATELY ADDRESS CERTAIN BASIC SAFETY AND SERVICE REQUIREMENTS, WEAKNESSES EXIST IN OTHER IMPORTANT AREAS.

States have made progress in carrying out their responsibilities in board and care facilities over the past few years. Almost all State standards include basic safety and service requirements such as personal care services, fire safety, physical structure, sanitation and licensing. However, only limited attention is given to the level of care needs of residents; training; dealing with unlicensed facilities; a complaints procedure requirement; and coordination among responsible agencies, providers and consumers. State standards were compared to the Model Act to determine States' conformity to key areas in the Act (Figure I). See a State by State comparison to the Model Act in Appendix A.

FIGURE I
State Conformance With Model Act Provisions



A - Definition of Board & Care
B - Physical Structure
C - Admissions Criteria
D - Administrator /Staff Qualifications
E - Licensing Requirements
F - Enforcement Programs
G - Sanctions
H - Residents' Rights
I - Size Criteria
J - Training Requirements for Staff
K - Variance and Waivers
L - Complaints Procedures
M - Board & Care Plan
N - Unlicsed Facilities

Almost all State standards (over 95 percent) include personal care services, fire safety, physical structure, sanitation and licensing.

- Virtually all State standards presently require the provision of minimal personal care services. Most commonly, these include assistance with daily living activities (94 percent), help with medications (96 percent), diet (96 percent), and supportive services (86 percent). All the standards address sanitation, including food handling, laundry, water and sewerage. Almost all address the physical structure of the building, including the architectural plans and fire safety. Most also deal with residents' rights (85 percent) and record-keeping (92 percent), although usually in a limited way.

State standards do not adequately address residents' needs.

- According to almost half of the respondents, standards do not clearly distinguish the level of care needed. They cited this problem most frequently. Respondents report that while the original "Mom and Pop" facilities served a fairly self-sufficient population, the medical and health needs of many residents are increasing. One respondent stated, "The standards are not responsive to the change in residents' needs." Another said, "We need to be more realistic with regard to who lives in the homes. Homes with SSI and developmentally disabled residents are very different than those with private-pay elderly." While most respondents cited this need for increased level of care, many mentioned difficulty in providing these additional services due to the limited financial resources of board and care residents who have only SSI benefits as income.

- State standards do not meet the needs of the changing population in board and care homes. Most standards (68 percent) restrict the admission of residents to homes if they are physically or mentally unable to evacuate the premises independently. However, respondents report that some current residents do not meet this criterion. Additionally, team onsite visits to homes showed residents who were wheelchair-or bed-bound and others who cognitively would not be able to leave the home independently. Also, almost half of the State standards do not restrict admitting residents to homes without adequate resources to care for them. Thus, residents with greater care needs may potentially be placed in facilities where their needs cannot be met.

- Almost two-thirds of the State standards do not specifically mention a board and care plan, although three-quarters require physician certification upon admission. Such a plan is one way of planning and providing for different levels of care. Of those standards which do address care plans, the great majority do not specify how often the plan should be updated.

- Similarly, case management (someone monitoring the needs of each resident) is noted in only 38 percent of the standards, generally with the developmentally disabled and mentally impaired as opposed to the aged. The Model Act provides that each resident should have a board and care plan which is reviewed quarterly and which describes the ability of residents to function in the home. One provider stated: "We need regulations which watch for the changing condition of the elderly patients and not just nitpicking of easy environmental issues."

- Over one-third of State standards do not address nursing services. Of those that do, over half prohibit them. One respondent, representing a view often heard, said, "There is no flexibility for residents that require acute care to remain in the home." In contrast, some felt that nursing services were inappropriate for this level of care. One State is instituting a demonstration project that will enable residents who require ongoing nursing care, such as catheter and colostomy care or insulin therapy, to live in board and care facilities.

- Resident level of care needs are rarely specified in State definitions. A board and care facility is usually defined based on the services provided rather than the anticipated needs of the residents. Some State officials suggested that the definition should include *both* the needs of the resident and the services provided.

Limited attention is given to staff training.

- According to State respondents, staff training is the second most frequently cited problem. Both State and provider respondents often mentioned the changing needs of residents as a reason training is essential. According to one State respondent, the lack of control of staff training is a "vulnerable area." Many also noted that limited resources and insufficient staff at the State level often constrain implementing existing training requirements.

- One-third of State standards do not address training. The Model Act provides for specific areas of training for both administrators and staff and suggests that the operator have training before being issued a license (which three States currently require). It also suggests that if a facility is found to be out of compliance, the operator and staff should be given training in the areas where violations exist.

- Of the two-thirds of State standards which do address training, three-quarters do not specify the type or hours of training required. Generally, training requirements are specified as being "in-service" or "on-the-job." Much of the training is limited to first aid courses, general orientation, fire safety and food handling.

- Although most States give limited attention to training, six States reported innovative training programs. These include medication aide training, special

programs for working with the mentally retarded, seminars in different aspects of care by experts in relevant fields, and special training prior to being issued a license. One State uses the money derived from licensing to hold training programs.

- Almost all States (93 percent) address qualifications and requirements of the administrator and staff. However, the requirements for both are extremely limited and were cited as a problem area by numerous respondents. In many cases, the operator is required to be at least 18 years of age, have a high school diploma and be of "good moral character." A few States, however, are beginning to require a bachelor's degree for the administrator and nurse's aide training for staff. Many say it is difficult to require adequate qualifications for board and care staff since the pay is low and it is difficult to recruit and keep employees.

State standards do not usually address unlicensed facilities and complaints.

- Seventy-four percent of State standards do not mention unlicensed facilities so they do not include a penalty provision for failure to comply with licensing requirements. Some respondents volunteered failure to address these homes as a problem with their standards.

- Only 51 percent of State standards require a complaints procedure, although almost all States report having such a procedure in place.

[The above two areas are discussed in more detail in the enforcement section of this report.]

Coordination rarely occurs.

- According to State respondents, coordination was the third most frequently cited problem area. Although almost two-thirds of State respondents felt coordination between State agencies was adequate, only one-third of providers agreed. Some providers said duplication of effort often occurs, with several agencies doing the same thing, such as investigating complaints. One provider said, "People are coming in all the time." Both State and provider respondents recommended the establishing coordination units and strengthening communication.

- No State standards address coordination among responsible agencies, providers and consumers. The Model Act suggests a coordinating council, to include advocates, residents and providers, as a mechanism to assure coordination among the multiple State agencies responsible for regulating facilities and providing services to residents of these facilities. An analysis of State regulations conducted by Boston University in 1980 identified 77 agencies nationally that were monitoring board and care facilities. Our study revealed 72 agencies; 10 States had

reduced their number of agencies and two States are combining two monitoring agencies into one. Five States have added agencies.

- A majority of States, providers and advocates felt coordination between States and the Federal government was lacking. Most stated that coordination did not exist.

Most respondents advocate a common set of minimum standards for every State.

- According to almost three-quarters (72 percent) of State respondents, a common set of minimum standards should be federally mandated. Some felt that since some States were less active in board and care than others, minimum standards would create greater uniformity in regulation and enforcement. Others mentioned that minimum standards would allow for common expectations of safety and care in the board and care industry. One respondent said that "every disabled and frail elderly person in this country has a right to minimum standards, despite where they live." Numerous respondents, including those in favor of minimum standards, said that were minimum standards to be developed, States should be given the flexibility to adapt and add to the standards to meet their particular needs.

- Twenty-eight percent of State respondents did not favor a mandatory set of minimum standards for States. Most felt that States should be allowed to establish their own regulations to allow for regional and local differences. One argued that since most State standards have already been tried and found to work, only guidelines and suggestions concerning possible new topics and ideas should be provided. Some felt that minimum standards would only add another level of unnecessary government bureaucracy to the board and care industry; one stated that "people are monitored enough without someone else coming in." Another felt that minimum standards would not assure quality of care in these homes any more than State standards would.

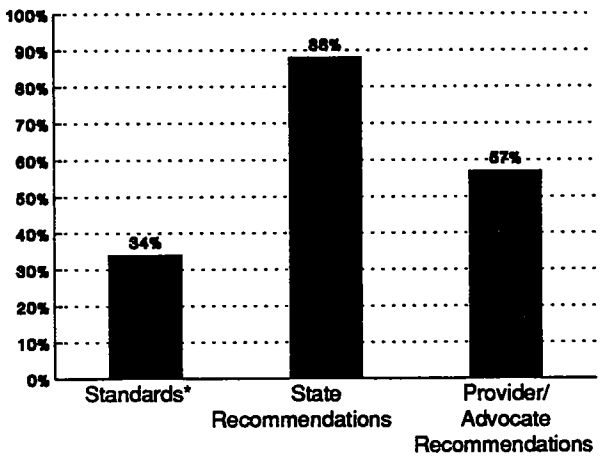
- Eighty percent of providers and advocates agreed that minimum standards should be mandated for every State for many of the same reasons given by State officials. They mentioned that national standards might serve to professionalize the industry and provide helpful guidelines to operators when setting up homes. A number expressed concern that minimum standards might become maximum standards in that States might choose not to elaborate upon them. Minimum standards might thus "give permission" to States to do only the minimum required.

- The majority of all respondents also felt that common definitions should be used in every State. Many believed it would be an important prerequisite to the development of minimum standards.

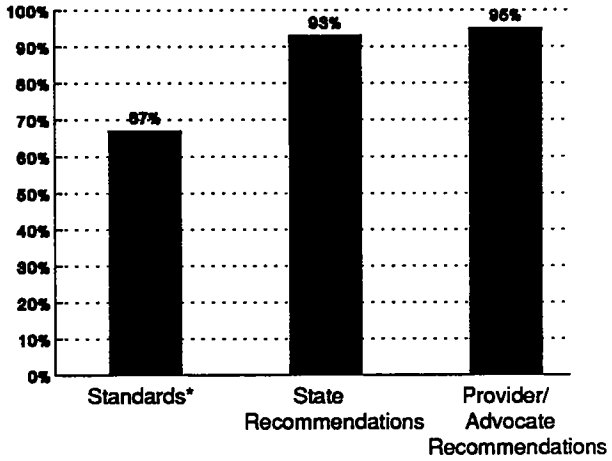
- Respondents generally agree on key areas where minimum standards should be developed. These include basic safety and service areas and some areas not presently addressed, such as unlicensed facilities, training and board and care plans (Figure II). However, the manner in which they are addressed varies from State to State. Supporting this was the respondents' frequently cited concern about failure to address certain key areas in greater depth and with more clarity.

FIGURE II
THREE KEY AREAS NOT SUFFICIENTLY ADDRESSED ARE RECOMMENDED FOR INCLUSION IN NATIONAL MINIMUM STANDARDS

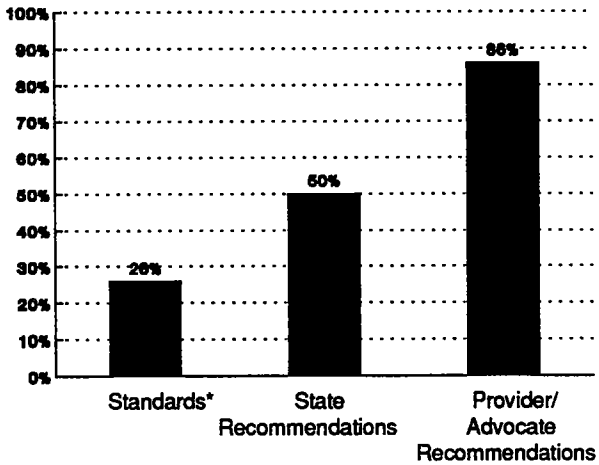
Board and Care Plan



Training



Unlicensed Facilities



** Percentage of current State standards which address each area.*

Model Act discusses key areas not addressed in State standards.

- The Model Act provides alternatives to States in those areas which respondents identify as being a problem with their standards, such as level of care, training, unlicensed facilities and coordination.

- A majority of State respondents (51 percent) were unaware of the Model Act. A few respondents expressed keen interest when informed of it and asked where to obtain a copy.

- Of those who heard of the Model Act, 35 percent used portions of it as a guide when preparing or updating their individual State standards; 24 percent continue to use it as a reference tool.

WHILE STATES CONDUCT BASIC ENFORCEMENT ACTIVITIES, SERIOUS WEAKNESSES EXIST.

Almost all State standards address inspections and corrective action plans and States are implementing these standards. However, problems exist in enforcement, both with unlicensed facilities and facilities found out of compliance.

Almost all State standards address inspections (94 percent) and corrective action plans (82 percent).

- As part of their licensing process, three-quarters of States inspect all homes at least once a year, some even more frequently. The frequency is often determined by the availability of staff and resources.

- A majority of States report at least some unannounced inspections. In half these States all inspections are unannounced, while in others they are conducted only when deemed necessary. However, just over half require that licensing inspections be unannounced. Many are doing more than their standards mandate, thus indicating that they perceive unannounced inspections as an effective enforcement tool. Most States (80 percent) also use spot checks as part of their enforcement activity. An analysis showed that unannounced inspections were conducted by States that have both strengths and weaknesses in enforcement.

- Almost all States with standards for corrective action plans actually required such plans for the majority of their licensed homes in 1988. Many reported that few homes were ever without any deficiency. In most cases, the operators came into compliance after successfully implementing the plan. The violations ranged from the minimal, such as improperly storing a head of lettuce or missing a light bulb, to the more serious, such as lacking a sprinkler system. However, the deficiencies

noted in most of the corrective action plans were primarily non-life-threatening. In a few States, deficiencies are graded for their degree of seriousness, thus facilitating close monitoring of homes with more significant problems.

- Almost all States report having a complaints procedure in effect, although State standards do not always address the requirement for such a procedure. In most cases the licensing agency itself receives complaints; only one-quarter of States report that the Ombudsman also receives them. Most States conduct onsite investigations in response to complaints; they investigate the more serious allegations almost immediately. As part of their procedures for resolving complaints, almost one-half (47 percent) report having a resident hotline. The types of complaints cover a wide range, from poor food and an unsanitary physical environment to inadequate care and abuse or neglect. A number of providers asserted that their State's complaint procedure was always biased in favor of the consumer and offered the operators no recourse for their own grievances against residents.

Enforcement activity is limited.

- Respondents cited three major factors to explain why constraints to enforcement exist. First, lack of State resources inhibit the States' ability to actively enforce their current standards. Second, no statutory authority exists in many States to impose both intermediate and severe sanctions. Finally, the lack of alternative placement for board and care residents makes it difficult to close homes and penalize unlicensed homes even when those sanctions are available.

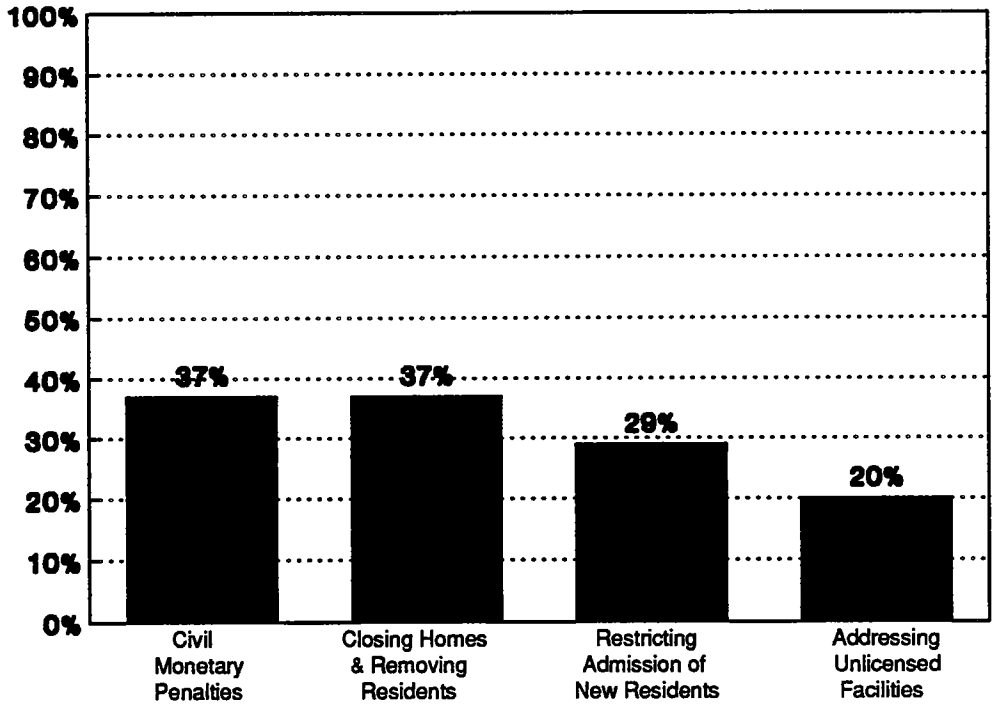
- While most States (86 percent) are able to revoke or deny licenses, under half actually did so in 1988. The average number of revocations or denials was 20. The problem was seen as not being with the availability of the sanction but with its use; one provider voiced a common concern that "States are reluctant to use what is available."

- Forty percent of States imposed no penalties or sanctions on board and care homes in 1988. Of those which did, 15 imposed fines, 7 issued provisional licenses, 4 issued citations, 4 limited or suspended admission to homes, 2 used receiverships, 1 initiated criminal charges against a provider and 1 cancelled a service contract. Closing homes and removing residents, the most severe penalty, was reported by only 11 States. One of these States with a separate enforcement unit reported closing 53 homes. However, the remaining 10 States closed from one to eight. A number of respondents mentioned that they were often complacent in their enforcement activities and would wait for a situation to significantly deteriorate before taking action.

Enforcement options are limited.

- Slightly more than one-third of State standards allow for the intermediate sanction of civil monetary penalties, while less than one-third prohibit admitting new residents to homes under citation. Just over one-third of State standards allow for the more severe sanction of closing homes and removing residents (Figure III). Most States which do allow civil monetary penalties consider them very instrumental in minimizing substandard facilities and essential to the success of their enforcement efforts. Fines usually go into the general treasury, although a few States use them for board and care activities.

FIGURE III
ENFORCEMENT OPTIONS ARE LIMITED



- Many respondents stated that the legal process required to revoke licenses was often lengthy and cumbersome. Thus, the absence of intermediate sanctions such as civil monetary penalties was seen as restricting the enforcement capabilities of some States. Some respondents believed that prohibiting the admission of new residents into homes while the legal process is occurring would prevent placing more individuals into homes where conditions are questionable. Only 17 percent of State standards require a criminal check for providers as part of their licensing procedure; even fewer require such a check for staff members.

- Over three-quarters of State respondents felt that constraints limited effective enforcement. Most frequently cited were limited staff, insufficient financial resources, a lengthy legal process, and the absence of legal authority for intermediate sanctions. Since in most States board and care is not a separate budget item, it is not possible to determine the level of resources devoted to enforcement. Two States report having separate enforcement units. Drastic measures are rarely used because inadequate funds frequently preclude expensive actions. A number of respondents mentioned that enforcement efforts were often hampered by political considerations. For example, local judges and law enforcement officers might be reluctant to act against neighborhood providers.

- Respondents did not agree on the most effective enforcement techniques. Recommendations included imposing civil monetary penalties, increasing State resources, improving the strength of legal options and categorizing different levels of violations. Some see fines as a deterrent to non-compliance; others see them as a means of taking funds away from where they are most needed—to improve the home. Some provider responses reflect this dilemma. One stated, "it hurts when the pocketbook is hit." Others complained that fines were too excessive for minor problems which caused no direct harm to the resident. When a license is revoked in some States, the home is allowed to continue operating as a boarding home and the residents may remain in the facility. In other States, the home is closed and the residents always removed to other licensed locations. However, the lack of alternative facilities for placement is a problem as there is sometimes no other available licensed home for residents to move to. Respondents mention residents' rights as a consideration: residents may wish to stay in the home, even if it is determined to be unsafe and becomes unlicensed.

Unlicensed homes are a key enforcement concern.

- State efforts to deal with unlicensed facilities are restricted by lack of resources and difficulty in locating the homes. Most State officials felt that their resources were not sufficient to deal with unlicensed as well as licensed homes. Respondents also had difficulty in estimating the number of unlicensed facilities in their States which should be licensed according to their definition of a board and care home.

- Ambivalence exists among respondents as to whether and how unlicensed facilities should be penalized. Some States feel they should be immediately penalized while others feel the operators of these homes should first be given the opportunity to acquire a license. However, a majority of providers and advocates favored penalizing these operators. Some States are reluctant to take action against unlicensed facilities because of a lack of alternative placement for the residents in these homes.

- Available SSA tapes are seldom used and are not found useful. Only 41 percent of State respondents knew of the tapes, and very few (17 percent) reported using them to locate unlicensed facilities. Respondents generally felt that the tapes were of limited use and did not warrant additional allocation of staff and resources.

- An analysis of existing enforcement techniques and how they are implemented showed no direct correlation between the enforcement technique and the presence or absence of unlicensed facilities.

Concerns were expressed about the adequacy of enforcement.

- Two-thirds of providers and advocates felt that some problem with enforcement existed in their State. The majority felt enforcement was slow, inadequate, inconsistent and ignored. One provider, expressing a prevailing view, said he would "like to see more emphasis on education and less on mechanical enforcement of standards—education should be used in addition to fines." A number felt their State was not stringent enough with unlicensed facilities and that operators of these facilities should always be fined. Some providers and advocates complained that the lengthy process for penalizing providers could potentially put residents at risk. Most agreed, nevertheless, that such a process was essential.

- Half of the providers and advocates felt that the inspection process does not adequately ensure that standards are maintained. They often called it a paper process in which evaluation was limited to checking off items on a list. A few State respondents mentioned a recent requirement for a resident interview during the inspection. However, one provider said that in practice this means that residents are asked over a loudspeaker to come and speak to the inspector if they want to. Many providers and advocates voiced concern about the inconsistency of how different inspectors interpreted regulations. State respondents also mentioned this as being a problem when inspections were delegated to county authorities.

- Close to half of the State respondents felt that their States assign board and care a low priority in terms of overall health care. An even greater number of providers and advocates (two-thirds) agreed. Most argued that other programs in the long-term care continuum, such as nursing homes, were regarded as more important. As a result, resources allocated were not always adequate.

- A majority of State respondents felt the Keys Amendment could not be enforced. Only 17 percent claim to have reported substandard facilities to the Federal government as the Keys Amendment requires. Most felt that the penalty clause which reduces the benefits of SSI recipients was unenforceable. Some suggestions included: "Junk it and start over again," "penalize the owners—not the residents,"

and "[require] mandatory registration of SSI recipients residing in board and care facilities."

THE DHHS CURRENTLY PLAYS A LIMITED ROLE IN BOARD AND CARE AND LITTLE COORDINATION EXISTS.

Activities affecting board and care facilities and residents are limited within HHS in OHDS, SSA, AoA, NIMH and HCFA, with little coordination among these agencies.

Board and care activities are limited within HHS components.

- Within OHDS only one person is responsible for managing the Keys Amendment and collecting the required information from the States. A yearly OHDS memorandum reminds States that they must certify annually that they comply with the Keys Amendment and includes information on the Model Act and SSA/SDX tapes. Approximately 30 States responded in 1988 with brief letters saying, in effect: "This is to inform you that [State's name] is in compliance with the Keys Amendment."

- No SSA procedures are in place to implement the penalty provision of the Keys Amendment. While the Keys Amendment has a penalty provision which reduces a recipient's SSI payments if he or she resides in a substandard facility, the prevailing opinion among people in the field is that deducting money from the SSI recipient's payment does not assure that conditions will improve in the facility.

- Due to lack of resources, the Administration on Developmental Disabilities (ADD) does not systematically monitor all developmentally disabled individuals who reside in board and care homes. However, ADD does have a protection and advocacy program for the developmentally disabled which may extend in part to residents of board and care homes.

- Although board and care is now included in the AoA Ombudsman Program, no additional funds have been appropriated for this additional responsibility. The extent to which local and State Ombudsmen become involved in board and care varies from State to State. The AoA has been directed to study the impact of the Ombudsman Program on residents of board and care facilities, to develop recommendations for expanding and improving Ombudsman services, and to study the effectiveness of recruiting, supervising and retaining volunteer Ombudsmen. This report will be available by December 31, 1989.

- The major part of the NIMH protection and advocacy program is to advocate for residents of public 24-hour care facilities. In 1988 only 6 percent of the program's

clients were in facilities outside of public institutions. Some of these were board and care homes.

- Few States have taken advantage of the available SSA State data exchange tapes and many were not even aware that such tapes existed. A number of respondents requested information on how to obtain these tapes after learning about them.

- As of August 1989, HCFA had approved 125 waiver programs in 47 States. HCFA is unable to identify how many of these waivers include services for board and care residents. However, they do claim to ensure that each program which indicates that it serves such recipients makes explicit provision for the welfare of these clients. HCFA also reports to have investigated and taken necessary action where there has been any indication brought to their attention that health and welfare has been compromised.

- On the positive side The Assistant Secretary for Planning and Evaluation (ASPE) is currently funding a study entitled "Analysis and Comparison of State Board and Care Regulations and Their Effect on the Quality of Care in Board and Care Homes." This study will attempt to determine the extent to which care in unlicensed homes differs from the care provided in licensed homes. They also anticipate doing a board and care census in the future.

Little coordination exists within HHS among the agencies involved with board and care.

- There appears to be limited contact between the various agencies within HHS involved with board and care; each unit functions independently and has little awareness of relevant activities occurring elsewhere in the Department.

- While the Keys Amendment specifies that the State must notify the SSA of any violations in board and care homes, it is not required that OHDS be so notified, and the SSA does not share any such information with OHDS.

- No unit is designated within HHS for coordinating the activities of different agencies and disseminating information between them. Such a unit previously existed in the Department but has since been disbanded.

- Some coordination does exist, however, between the different agencies involved with protection and advocacy programs for the mentally ill, developmentally disabled and aged residing in board and care homes. These agencies will be meeting regularly to inform each other of their activities and to coordinate their efforts.

RECOMMENDATIONS

States should

- Re-evaluate their board and care standards (using the Model Act as a reference) to assure they include and adequately address
  - level of care,
  - training,
  - coordination, and
  - unlicensed facilities.
- Improve their ability to deal with unlicensed facilities such as
  - targeting ways to identify them and
  - providing incentives for facilities to become licensed.
- Use such sanctions as
  - civil monetary penalties,
  - restrictions on new admissions, and
  - closing of homes.
- Assure that existing procedures for resolving complaints are sufficiently publicized so that complaints are brought to the attention of the proper authorities.

To support States' efforts in implementing the above recommendations, OHDS should designate a unit for board and care which will

- Disseminate information on such matters as
  - operational efficiencies
  - effective enforcement techniques
  - research and
  - States' best practices.
- Promote more effective use of the Model Act.

- Provide technical assistance to States, particularly to support the concerns relating to the standards and enforcement highlighted in this report. This might include convening a workgroup of States and other parties to discuss developing minimum standards.

- Coordinate departmental activities relative to board and care.

COMMENTS

Comments of the draft report were received from HCFA, ASPE, AOA, PHS, SSA and OHDS and were generally supportive of our findings and recommendations. While support was expressed for our recommendation that there be a Departmental coordinating unit, the question of funding was raised by OHDS. (See Appendix B). We continue to believe the problems addressed in this report are sufficiently important to warrant the relatively small expenditure necessary to support a coordinating unit.

APPENDIX A

BIBLIOGRAPHY

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APPENDIX B

COMMENTS ON THE DRAFT REPORT

Comments received from HCFA, ASPE, AoA, PHS, SSA and OHDS were generally supportive of our findings and recommendations. Suggestions for changes in the wording and clarifications in the text have for the most part been incorporated into the final report.

Among the comments that were supportive of our recommendation that a Departmental coordinating unit for board and care be designated were the following: The Assistant Secretary for Health noted that: "Through technical assistance and dissemination activities, this unit would have the potential to greatly improve the quality of care and life of individuals ..." Similarly, the Assistant Secretary for Human Development Services stated "that the functions might be timely, appropriate, and supportive of State actions given the real advances in State performance over the past several years and the Federal government's new federalism relationship with States." The OHDS added that "such a unit might help meet Congressional concern that the Department address identified abuses."

The ASPE specifically recommended that OHDS be designated as the Departmental coordinating unit for board and care activities. We concur and have modified our report by specifically addressing our recommendation to OHDS.

While as noted above OHDS expressed concerns about inadequate current staffing and funding, OHDS supports the idea of a coordinating unit. We recognize that a coordinating unit would require reallocation of very scarce resources. However, in view of the importance of this area we feel that such reallocation is necessary.

In addition, OHDS noted that the Department funds very little research, has little information to disseminate and possesses no particular expertise to offer technical assistance to the States. We might offer, in response, that this coordinating unit would be expected to disseminate not only the Department's research but also research conducted by other sources; would gather and share ideas and best practices from the States; and would hopefully utilize the knowledge of experts in the field in offering technical assistance.

The OHDS had some question about the substance of the proposed coordination role. Our vision is that this unit would be the focal point for board and care activities within the Department. In doing so, it would serve as a referral source for outside requests, periodically evaluate the effectiveness of Departmental programs and make recommendations to improve them.

In conclusion, we strongly encourage having a Departmental coordinating unit as essential to supporting and encouraging the States' efforts to assure the safety and well-being of the board and care population. We believe OHDS should be given this role.

The actual comments received are on the following pages.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of
Human Development Services

Assistant Secretary
Washington DC 20201

FEB 1 1990

TO: Richard P. Kusserow
Inspector General

FROM: Assistant Secretary
for Human Development Services

SUBJECT: Office of Inspector General Draft Report: "Board and Care," OAI-89-1860

Thank you for the opportunity to review and comment on the draft Office of Inspector General (OIG) report on "Board and Care." Overall, the report is timely, and we believe its findings will inform future discussion on this issue. It contains information that will be helpful to this office in carrying out its responsibilities under the Keys Amendment. In addition, we appreciate the briefing and the additional views and information provided by OIG staff on January 4. However, we do have serious concerns regarding the recommendation that the Secretary designate a unit for board and care in the Department. We also have some general suggestions for strengthening the report.

1. Additional contextual information should be added to the report

We suggest that the report include the positive observations and other excellent points made by OIG staff at the January 4 briefing, e.g., that care being provided is much better than the public's perception of such care and that States are trying and, for the most part, are succeeding in carrying out their responsibilities in this area, particularly given the changing needs of the board and care population.

Also, as additional background, we suggest that a brief description of the range and types of homes and facilities included under the category of board and care be added, as well as a brief description of the various types of persons being served in these homes. We believe it is particularly important to emphasize that there is no common definition or description of a board and care facility and that board and care residents have a wide range of demographic characteristics and a wide range of needs.

2. Recommendations for State action

Generally, we support the four recommendations for State action. We believe OIG has identified areas that would benefit board and care residents and allow for better State oversight and enforcement.

3. Recommendation that the Secretary should designate a unit in the Department for board and care

We agree that the functions recommended to be carried out by a designated board and care unit might be timely, appropriate, and supportive of State actions given the real advances in State performance over the past several years and the Federal government's new federalism relationship with States. Also, such a unit might help meet Congressional concern that the Department address identified abuses. However, it is unclear how the specific recommendations for Federal research, technical assistance, and other activities could be implemented given the current lack of staff and funding for such activities in the Department. Our specific comments are as follows:

a. The report stated that one function of the unit would be to disseminate information on matters such as operational efficiencies, effective enforcement techniques, research, and States' best practices. In fact, the Department funds very little research and has almost no information to disseminate on the other objectives.

b. A second function of the board and care unit would be to "promote more effective use of the Model Act." Although the report used the Model Act exclusively against which to measure State standards, there are other model standards and regulations which could or should be considered by States, e.g., model regulations developed by Boston University and a Model Act on Zoning for board and care residences developed by the Administration on Developmental Disabilities.

c. A third function of the board and care unit would be to "provide technical assistance to States." As noted earlier, the Department has no particular expertise in this area and the Office of Human Development Services (HDS), for example, would need additional staff and funding to carry out such activities.

d. The fourth function of the board and care unit would be to coordinate Departmental board and care activities. In reality, however, the Department carries out few meaningful activities in this area. Three agencies make grants to States to carry out advocacy and ombudsman services on behalf of board and care residents and others. The Social Security Administration is rarely involved as States chose to deal with facilities that do not meet standards by enforcement methods other than reduction of an individual's Supplemental Security Income (SSI) payment. The Health Care Financing Administration, by statute, must verify that Keys Amendment and other standards are met in order to grant State "community based" waivers. We administer compliance with Section 1616(e) of the Social Security Act. The Office of the Assistant Secretary for Planning and Evaluation has been involved in various long term care research and evaluation efforts and recently has funded a project to further study board and care issues. It is unclear what the substance of the coordination is or should be.

Finally, we agree it is important for the Department to respond to Congressional concern on the board and care issue. As opposed to recommendations that would require additional staff and funding resources, we suggest that the OIG consider existing mechanisms, such as current Departmental long term care and health promotion work groups, as a way to carry out some of these functions.

3. Other points of clarification

In addition to the marked-up copy (attached), we have the following suggestions:

a. Clarify that the report uses the term "unlicensed" to refer to homes that fall under a State's standard for licensure, not those that are exempt. (See page 13.)

b. Clarify that, while respondents recommended "national minimum standards," they also recommended State flexibility in meeting or developing such standards. (See page 8.)

c. It is stated that "A majority felt the Keys Amendment could not be enforced." It would be preferable to say that standards developed under the Keys Amendment could not be enforced. (See page ii.)

d. It is stated that "State regulations require that all board and care homes be licensed or certified." This is incorrect. (See page 1.)

e. Clarify that although the Keys Amendment also included statutory amendments to the Social Security and SSI programs, historical usage and this report refer to Section 1616(e) of the Social Security Act as the Keys Amendment.

f. It is stated that "Fire and safety guidelines were also developed by an HHS interagency task force and shared with the States." This needs further explanation. The fire and safety guidelines were the result of a ten year effort. A "Fire-Safety Evaluation System for Board and Care Homes" was incorporated in the Life Safety Code by the National Fire Protection Association. It represents a major development in the technology of providing board and care services. Currently, there is a large evaluation being conducted of this system which is being jointly funded by six Federal agencies. (See page 3.)

We believe the marginal notes and edits on the attached copy of the draft report are self explanatory. If you have any questions, please call Janet Hartnett on 245-7027.

Mary Sheila Gall

Attachment

Reagan/Grob
HOD
Brown/PIO file
Region 2
Bobbel

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JAN 9 1990

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MEMORANDUM

TO : Richard P. Kusserow
Inspector General

FROM : Arnold R. Tompkins
Acting Assistant Secretary for Planning and Evaluation

SUBJECT: OIG Draft Report: "Board and Care", OAI-02-89-01860

We have reviewed the above report and conditionally concur based on consideration of the following observations:

1. Although ASPE worked closely with the OIG during this study, no mention is made of the board and care initiatives currently underway in ASPE. The report should cite the ASPE board and care initiatives which include the current quality of care study and the design work for a board and care census. These activities demonstrate that the Department is more than just a passive observer of board and care issues.

2. The report points out, and rightly so, that very little coordination exists within HHS among the agencies involved with board and care. However, as a result of the ASPE initiatives cited above, information sharing and coordination among agencies has improved.

3. The tone of the report implies that all unlicensed board and care homes are operating outside of the law and that if licensing was required of them, the system would somehow be much better. First, it should be made clear that not all unlicensed homes are operating illegally (some States have very limited licensing requirements). Second, although the quality of care provided in some unlicensed homes is suspect, there are many unlicensed homes that provide care equal too or better than that found in licensed homes. In some communities, unlicensed homes are an important part of the community-based care system. The issue is to determine the extent to which care in unlicensed homes differs from the care provided in licensed homes. The ASPE quality study will attempt to address this issue.

4. References to the Keys Amendment of the Social Security Act should be clarified to explain that reductions to an SSI recipient's payment can only be applied to that portion of the payment that is a State supplement and only by the amount of the supplement that is used for medical or remedial care. This adds to the intractable nature of employing the penalty provision of Keys.

5. Several references are made to the SDX tapes and the feasibility of having States use them to locate unlicensed homes. These references need to be placed in a context that informs the casual reader of what the SDX tapes are, what their potential is for addressing the unlicensed homes issue and what problems are associated with use of the tapes. Again, the ASPE quality of care study will test the feasibility of using the tapes to locate unlicensed homes.

6. One of the major recommendations of the study is that the Secretary designate a unit for board and care. We concur with this recommendation. The next step, if others also concur, is to choose the location of such a unit. It occurs to us that SSA's involvement is essentially as a check writing agency, HCFA's interest is centered around the 2176 Waivers, and ASPE is not a program office. On the other hand, OHDS includes AoA, which has responsibility for the ombudsman program and the aged constituency, which makes up the bulk of board and care residents, and ADD which administers programs for the developmentally disabled. Hence, our initial reaction is that the unit be located in OHDS. We would be interested in exploring this issue further.

7. On page 1, in the third paragraph under History, it is implied that all State regulations require the licensing of board and care homes. This is not true.

8. On page 2, under HHS Role. The first sentence should be modified by adding "or their residents" to the end of the sentence.

9. On page 15, the ADD means the Administration on Developmental Disabilities.

Mangano/Grob Region 2
Cameron/MOD Baebel
Brown/PD file

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Administration on Aging

Washington, D.C. 20201

RECEIVED
OFFICE OF INSPECTOR GENERAL
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JAN 8 1990

TO: Richard P. Kusserow
Inspector General

FROM: Acting Commissioner on Aging

SUBJECT: Comments on Draft Inspection Report Entitled "Board and Care"

This is in response to your December 8, 1989 memorandum to Mary Sheila Gall, Assistant Secretary for Human Development Services, requesting review and comment on the draft inspection report entitled "Board and Care."

We have reviewed the draft report and concur with its findings and recommendations. We suggest only the following changes and additions:

- p. ii, 7th line from the bottom, should be changed to read "...Ombudsman Program which advocates the rights of the institutionalized elderly including...." (The Older Americans Act requires the State Office of the Ombudsman to investigate complaints made by or on behalf of residents of long term care facilities, not all elderly.)
- page 2, line 5 under HHS Role, should be changed to read "...(AoA)...(NIMH) have programs administered by State agencies or organizations which...." (Neither, ADD, AoA, nor NIMH directly operate their respective protection and advocacy programs.)
- The report should mention a study funded by the Assistant Secretary for Planning and Evaluation (ASPE) entitled "Analysis and Comparison of State Board and Care Regulations and Their Effect on the Quality of Care in Board and Care Homes," which is currently being conducted by Research Triangle Institute. This is a major Department initiative involving board and care regulation. ASPE should be mentioned on page 15

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and elsewhere, and reference to the study should be made at appropriate places in the report.

We appreciate the opportunity to review and comment on the draft report.

Joyce T. Berry, Ph.D.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date JAN 26 1990

From Louis B. Hays
Acting Administrator

Subject OIG Draft Report - Board and Care, OAI-02-89-01860

To The Inspector General
Office of the Secretary

Thank you for the opportunity to review your draft report which assesses existing State board and care regulations and enforcement activities.

The report states that HCFA is unable to identify how many of the approved waiver programs include services for board and care residents. While this is true, HCFA does ensure that each program which indicates that it serves such recipients makes explicit provision for the welfare of these clients. HCFA has also investigated and taken necessary action where there has been any indication that health and welfare has been compromised. We want to ensure that OIG is aware of the following HCFA initiatives that help accomplish these aims.

- Since the inception of the waiver program in 1981, States have been required to provide assurances that the health and welfare of clients will be protected during their participation in the program. The States are also required to back up these assurances with copies of written provider standards and annual reports on the satisfaction of these requirements.

- In our 1985 final regulations, we specifically required that States providing waiver services to individuals who were residents of board and care facilities ensure compliance with section 1616(e) of the Social Security Act (Keys Amendment) and supply a copy of the required standards to us for review. In addition, our regulations authorized the withholding of Federal matching funds for waiver services during periods of noncompliance with the Keys Amendment or other health and safety standards.

- HCFA has conducted intensive regional office investigations of several programs in which allegations were made that recipient health and welfare were being compromised while in residential waiver providers. In West Virginia, HCFA used the results of this inquiry to deny the State's application for renewal of its waiver program. In Pennsylvania and Oregon, corrective action was promptly initiated by the States.

I would also note that on page 2 of the report, "nursing facility" applies only to Medicaid, not Medicare.

Thank you for the opportunity to review the above draft report.

Mangano/Grob Region 2
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DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Memorandum

Date JAN 22 1990

From Assistant Secretary for Health
and Acting Surgeon General

Subject OIG Analysis and Inspections Draft Report "Board and Care"
OAI-02-89-01860

To Inspector General, OS

We are in agreement with the overall content of the subject OIG draft report and concur with the report's recommendation that the Secretary, HHS, should designate a board and care unit to support the States' efforts in implementing the recommended improvements. Through technical assistance and dissemination activities, this unit would have the potential to greatly improve the quality of care and life of individuals residing at boarding homes.

James O. Mason

James O. Mason, M.D., Dr.P.H.

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DATE SENT 1/24

DEPARTMENT OF HEALTH & HUMAN SERVICES

Ramagano/Grob Cameron Brown

Region 2 Bichel

Social Security Administration

Refer to:

Memorandum

Date: FEB 28 1990

From: Gwendolyn S. King
Commissioner of Social Security

Subject: Office of Inspector General Draft Report, "Board and Care" (OAI-02-89-01860)--INFORMATION

To: Mr. Richard P. Kusserow
Inspector General

Attached is our response to the draft report. If we can be of further assistance, please let us know.

Attachment:
Tab I - SSA response

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How to use these separators

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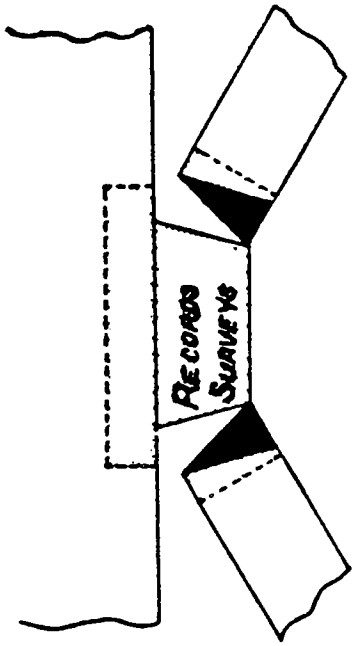

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FOURTH		94	87	80	73	66	59	52	45	38	31	24	17	10	3
FIFTH		95	88	81	74	67	60	53	46	39	32	25	18	11	4
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TABBED SEPARATOR SHEET
Form SSA-69 (10-79)

COMMENTS OF THE SOCIAL SECURITY ADMINISTRATION ON THE OFFICE OF INSPECTOR GENERAL DRAFT REPORT, "BOARD AND CARE" OAI-02-8901860

In this inspection, the Office of Inspector General (OIG) assessed existing State board and care regulations and enforcement activities. The inspectors found serious weaknesses in existing State standards and enforcement practices and found support for the establishment of national minimum standards. They also found that the Department of Health and Human Services plays a limited role in board and care.

OIG's recommendations were directed to the States and to the Secretary. Among those for the States were: that States reevaluate their board and care standards, and improve their ability to identify and deal with unlicensed facilities. The inspectors recommended that the Secretary should designate a unit for board and care which will disseminate information and provide technical assistance to States, promote more effective use of the Model Act for Regulating Board and Care Homes and coordinate Departmental activities relative to board and care.

Although none of OIG's recommendations are directed toward the Social Security Administration (SSA), we appreciate the opportunity to review the report.

Technical Comments

We have the following general comments to offer concerning certain sections of the report dealing with Social Security:

-- First, on Page 15 of the report OIG notes that "No SSA procedures are in place to implement the Keys Amendment". This statement is inaccurate since procedures have been promulgated to implement the Keys Amendment and may be found in our Program Operations Manual System, GN 00502.120. These procedures provide that substandard facilities be reported to SSA's Regional Offices. The Regional Offices are responsible for disseminating the lists of substandard facilities to SSA field offices to be screened as part of the representative payee selection process to ensure benefits are not inappropriately directed to these facilities.

   We assume that the statement in the report that SSA has no procedures to implement the Keys Amendment is related to the lack of SSA procedures to implement the penalty provision of the Keys Amendment, contained in section 1616(e)(4) of the Social Security Act. This is true, primarily because the penalty provision is basically inoperable because of a flaw in its construction. The law states that when a Supplemental Security Income (SSI) recipient resides in a substandard facility the individual's title XVI payments should be

reduced by an amount equal to the amount of any State supplementary payment or other State or local payment which is made for or on account of any medical or remedial care provided by the facility. States do not include money for medical or remedial care in their supplementary payments or, as we understand it, in other payments. In addition, board and care homes ordinarily are not involved in the provision of the type of care specified in section 1616(e)(4). Thus, it seems fair to say that it is virtually impossible to implement this sanction.

Furthermore, the provision is not workable because it hurts the recipient directly and the operator only indirectly at best. Conceivably, if SSA reduced the SSI benefit, the operator could get less, or could evict the recipient and get a new resident. Chances are it would do the latter.

-- Our second observation is a minor technical point found on Page 1 of the executive summary. Paragraph 2, line 3 under "Background" should read "Supplemental Security Income (SSI)...".

Other miscellaneous technical comments and observations have been made on a mark-up copy of the report and provided to OIG staff under separate cover.

APPENDIX C

CHARTS

ENFORCEMENT OPTIONS

STATE	CORRECTIVE ACTION		INSPECTED HOMES		REVOKE/DENY LICENSE		CIVIL MONETARY PENALTY		CLOSE HOMES		RESTRICT ADMISSION		UNLICENSED HOMES ADDRESSED	CRIMINAL CHECK
Alabama/1	S	E	S	E	S	E	S		S	E	S			
Alabama/2		E		E		E				E				
Alaska	S	E	S	E	S				S		S			Y
Arizona		E		E		E								
Arkansas	S	E	S	E	S		S	E	S		S			Y
California		E	S	E	S	E	S	E	S				S	
Colorado/1		E	S	E	S	E		E						
Colorado/2		E	S	E	S				S		S			
Connecticut	S	E	S	E	S	E	S	E					S	
Delaware	S	E	S	E	S		S							
District of Columbia	S	E	S	E										Y
Florida	S	E	S	E	S	E	S		S	E	S		S	
Georgia	S	E	S	E	S	E			S	E				
Hawaii	S	E	S	E	S	E	S	E	S	E	S		S	
Idaho	S	E	S	E	S	E	S		S	E				
Illinois	S	E	S	E	S	E	S	E	S					
Indiana/1	S	E	S	E	S	E	S				S			
Indiana/2	S	E	S	E										
Iowa/1		E	S	E										
Iowa/2	S	E	S	E										
Iowa/3	S	E	S	E	S			E						
Kansas/1	S	E	S	E	S	E	S	E						
Kansas/2	S	E	S	E	S	E								Y
Kentucky/1		E	S	E	S	E								
Kentucky/2		E		E				E						
Louisiana	S	E	S	E	S	E	S						S	
Maine	S	E	S	E	S								S	Y
Maryland/1	S	E	S	E	S		S		S	E	S			
Maryland/2	S	E	S	E										
Maryland/3	S	E	S	E	S	E	S						S	
Massachusetts	S	E	S	E	S		S		S		S	E	S	
Michigan/1	S	E	S	E	S	E								
Michigan/2	E		S	E	S									
Minnesota	S	E	S	E	S		S				S			

S= IN STANDARDS
E= ENFORCED

Y= YES

Enforcement Options

STATE	CORRECTIVE ACTION	INSPECTED HOMES	REVOKE/DENY LICENSE	CIVIL MONETARY PENALTY	CLOSE HOMES	RESTRICT ADMISSION	UNLICENSED HOMES ADDRESSED	CRIMINAL CHECK
Mississippi	S E	S E	S E		E		S	
Missouri	S E	S E	S				S	
Montana	S E	S E	S				S	
Nebraska	S E	S E	S E			E		
Nevada	S E	S E	S E					
New Hampshire	S E	S E	S			S		
New Jersey/1	S E	S E	S E	S	S E		S	
New Jersey/2	S	S E	E					
New Mexico	S E	S E	S E					
New York	S E	S E	S E	S E	S	S	S	
North Carolina	S E	S E	S E	S	S	S E		
North Dakota	S E	S E	S					
Ohio/1	S E	S E	S E					Y
Ohio/2	S E	S E	S E	S E	S	S	S	
Oklahoma	S E	S E	S	S	S			
Oregon/1	S E	S E	S	S E	S	S		
Oregon/2	S E	S	S E	S E	S	S E		
Pennsylvania	S E	S E	S E		S	S	S	
Rhode Island	S	S E	S		S	S	S	
South Carolina	S E	S E	S E	S				
South Dakota/1		E						
South Dakota/2		S E	S	S E				
Tennessee/1	S E	S E	S		S			
Tennessee/2	S E	S E	S E		S			
Texas	S E	S E						Y
Utah/1	E	S E	S					
Utah/2	S E	S E	S					
Utah/3	S E	S E	S		S	S		Y
Vermont/1	S E	S E	S	S	S	S	S	Y
Vermont/2	S E	S E	S E	S E	S	S	S	
Virginia/1	S E	S E	S E					
Virginia/2	S E	S E	S					
Washington/1	E	S E	S E					Y
Washington/2	S E	S E	S E				S	Y
West Virginia/1	S E	S	S		S E			
West Virginia/2	S	S E	S		E			
Wisconsin	E	S E	S		E			
Wyoming	S E	S E	S E					

* The above information is based on analyzing existing State standards & discussions with State officials. States may have other statutory authority to take.

State Conformance With Model Act Standards

State	Definition	Size	Board & Care Plan	Admissions	Resident Rights	Qualifications	Structure	Health	Fire	Training	Licensing	Unlicensed Homes	Variance	Inspections	Complaints	Sanctions
Alabama/1	◆	◆		◆		◆	◆	◆	◆		◆			◆		◆
Alabama/2	◆	◆					◆	◆	◆							
Alaska	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆		◆	◆		◆
Arizona	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆					
Arkansas	◆	◆		◆	◆	◆	◆	◆	◆		◆			◆	◆	◆
California	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Colorado/1	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆			◆	◆	
Colorado/2	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆			◆		◆
Connecticut	◆	◆		◆	◆	◆	◆	◆	◆		◆	◆		◆		◆
Delaware	◆	◆		◆	◆		◆	◆	◆		◆			◆	◆	◆
D.C.	◆	◆		◆	◆	◆	◆	◆	◆		◆		◆	◆		◆
Florida	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Georgia	◆	◆		◆	◆	◆	◆	◆	◆		◆		◆	◆		◆
Hawaii	◆		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆
Idaho	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆			◆		◆
Illinois	◆			◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆	◆
Indiana/1	◆		◆	◆	◆	◆	◆	◆	◆	◆	◆			◆		◆
Indiana/2	◆	◆		◆		◆	◆	◆			◆			◆		
Iowa/1	◆	◆		◆		◆	◆	◆	◆		◆			◆		
Iowa/2	◆		◆	◆	◆	◆	◆	◆	◆	◆	◆			◆	◆	◆
Iowa/3	◆	◆		◆	◆	◆	◆	◆	◆		◆		◆	◆	◆	◆
Kansas/1	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆	◆		◆
Kansas/2	◆	◆	◆		◆	◆	◆	◆	◆		◆		◆	◆		◆
Kentucky/1	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆			◆		◆
Kentucky/2	◆			◆	◆	◆	◆	◆	◆	◆	◆					
Louisiana	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆
Maine	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆	◆	◆	◆
Maryland/1	◆	◆	◆	◆		◆	◆	◆	◆	◆	◆			◆		◆
Maryland/2	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆		◆	◆		
Maryland/3	◆	◆		◆	◆	◆	◆	◆	◆		◆	◆		◆		◆
Massachusetts	◆	◆		◆		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Michigan/1	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆	◆
Michigan/2	◆			◆	◆	◆	◆	◆	◆	◆	◆			◆	◆	◆
Minnesota	◆			◆		◆	◆	◆	◆	◆	◆		◆	◆	◆	◆

◆ = yes
empty box = no

State Agency Conformance with Model Act Standards

State	Definition	Size	Board & Care Plan	Admissions	Resident Rights	Qualifications	Structure	Health	Fire	Training	Licensing	Unlicensed Homes	Variance	Inspections	Complaints	Sanctions
Mississippi	◆			◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆
Missouri	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Montana				◆		◆	◆	◆	◆		◆	◆		◆		◆
Nebraska	◆	◆			◆	◆	◆	◆	◆	◆	◆			◆	◆	◆
Nevada	◆			◆	◆	◆	◆	◆	◆		◆			◆		◆
New Hampshire	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆		◆	◆	◆	◆
New Jersey/1	◆			◆	◆	◆	◆	◆	◆		◆	◆	◆	◆		◆
New Jersey/2	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆			◆		
New Mexico	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆	◆
New York	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
North Carolina	◆	◆		◆	◆	◆	◆	◆	◆		◆			◆	◆	◆
North Dakota	◆		◆			◆	◆	◆	◆		◆		◆	◆	◆	◆
Ohio/1	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆			◆		◆
Ohio/2	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Oklahoma	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆			◆	◆	◆
Oregon/1	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆	◆
Oregon/2	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆	◆
Pennsylvania	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Rhode Island	◆	◆		◆	◆		◆	◆	◆		◆	◆	◆	◆		◆
South Carolina	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆			◆		◆
S. Dakota/1	◆			◆	◆		◆	◆	◆	◆	◆		◆			
S. Dakota/2	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆			◆		
Tennessee/1	◆	◆	◆	◆	◆		◆	◆	◆	◆	◆		◆	◆	◆	◆
Tennessee/2	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆			◆	◆	◆
Texas	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆	
Utah/1	◆		◆	◆		◆	◆	◆		◆	◆		◆	◆		
Utah/2	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆		◆	◆		◆
Utah/3	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆	◆
Vermont/1	◆			◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Vermont/2	◆			◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Virginia/1	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆	◆
Virginia/2	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆	◆
Washington/1	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆			◆		
Washington/2	◆	◆			◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆
W. Virginia/1	◆	◆	◆	◆		◆	◆	◆	◆	◆	◆		◆	◆	◆	◆
W. Virginia/2	◆	◆		◆	◆	◆	◆	◆	◆		◆			◆		◆
Wisconsin	◆	◆		◆	◆	◆	◆	◆	◆		◆		◆	◆	◆	◆
Wyoming	◆			◆	◆	◆	◆	◆	◆		◆		◆	◆	◆	◆

◆ = yes
empty box = no

KEY OF MULTIPLE LICENSING AGENCIES

Alabama/1	Dept. of Health
Alabama/2	Dept. of Mental Retardation
Colorado/1	Dept. of Health
Colorado/2	Dept. of Social Services
Indiana/1	Dept. of Health
Indiana/2	Dept. of Mental Health
Iowa/1	Dept. of Human Services
Iowa/2	Dept. of Human Services
Iowa/3	Dept. of Inspections and Appeals
Kansas/1	Dept. of Health and Environment
Kansas/2	Dept. of Social Services and Rehabilitation
Kentucky/1	Cabinet for Human Resources
Kentucky/2	Cabinet for Human Resources
Maryland/1	Dept. of Human Resources
Maryland/2	Office on Aging
Maryland/3	Dept. of Health
Michigan/1	Dept. of Social Services
Michigan/2	Dept. of Public Health
New Jersey/1	Dept. of Community Affairs
New Jersey/2	Dept. of Health
Ohio/1	Dept. of Human Services
Ohio/2	Dept. of Housing
Oregon/1	Dept. of Human Resources, Senior Services Div.
Oregon/2	Dept. of Human Resources, Mental Health Div.
Tennessee/1	Dept. of Mental Health and Mental Retardation
Tennessee/2	Dept. of Health and Environment
Utah/1	Dept. of Social Services
Utah/2	Dept. of Social Services, Div. of Aging & Adult Serv.
Utah/3	Dept. of Health
Vermont/1	Dept. of Health
Vermont/2	Dept. of Human Services
Virginia/1	Dept. of Social Services, 4 or more Residents
Virginia/2	Dept. of Social Services, 1-3 Residents
Washington/1	Dept. of Social and Health Services
Washington/2	Dept. of Health
West Virginia/1	Dept. of Social Services
West Virginia/2	Dept. of Health