# Adult Homes Serving Residents with Mental Illness

## *A Study on Layering of Services*

New York State Commission on Quality of Care
for the Mentally Disabled

August 2002

# EXECUTIVE SUMMARY

In its 1990 study of adult homes,[1] the Commission on Quality of Care for the Mentally Disabled concluded that "adult homes are a valuable resource in meeting the needs of persons with mental illness for low-cost supervised housing." The study, which evaluated the performance of some 47 homes housing mostly individuals with mental illness, identified the "cost of care" solely by reviewing the cost to operate the home. It did not consider the cost of "on-site" direct health or mental health services to residents by outside providers because, except for the occasional physician's visit or on-site mental health clinic, in-house services to residents appeared fairly limited. Moreover, to avoid the isolation inherent in living with persons sharing the same disability, residents were expected to take advantage of community-based medical and habilitation supports.

More than a decade later, the picture is quite different. It is not uncommon to see multiple practitioners and providers -- primary care and specialty physicians, medical and mental health clinics, private psychiatrists, nursing services and home health care aides - - located on-site in adult homes and acting independently of each other. This present open-ended expansion of services, rendered to a captive adult home population, invites an intensity of care which is expensive, uncoordinated and, in some cases, unnecessary. Medicaid billings of over $27,000 per year per resident at the 11 largest homes in the New York City area, when added to the approximate $10,000 a year paid by residents from their Supplemental Security Income (SSI) benefit checks to the adult home for room, board and assistance, point to the need for the more coordinated use of existing funding streams to support a better system of care and treatment.

The Commission recognizes that many operators effectively provide safe and comfortable housing and reliable access to medical and health care services. However, after examining the complex services for 2,100 residents with mental disabilities at the largest homes in the New York City area, it seems obvious that resources need to be redirected to promote quality care. Absent reform, residents will continue to receive medical care under a system in which services are often not sought by the recipient, but initiated by the practitioner; in which providers fail to communicate with one another on treatments and medications, even on such matters as the need for surgery; and, in which the primary care physician plays no role in assuring that necessary services are coordinated effectively.

One of the key elements to the success of any reform initiative will be to ensure that residents of adult homes who are in need of a different level of care are identified and assisted in making the transition to appropriate settings. Those remaining should be afforded access to mental health facilities/programs focused on habilitation and recovery, not just maintenance.

Fundamental to a discussion of significant change in adult homes is an understanding of the "IMD exclusion." Federal law and regulations prohibit federal financial participation for *all* services, including medical and ancillary services, provided to residents of institutions for mental diseases (IMDs) who are between the ages of 21 and 65. Thus, direct medical assistance (i.e., Medicaid) payments to an adult home to provide psychiatric/psychological care and treatment would place at risk the main source of public financing of health care services (including hospital services and medications)

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[1] *Adult Homes Serving Residents with Mental Illness: A Study of Conditions, Services, and Regulation*, New York State Commission on Quality of Care for the Mentally Disabled, October 1990.

for this population. This exclusion reflects both a Congressional belief that the funding of long-term care in such settings has traditionally been the principal responsibility of the states, and federal concerns about the economic and therapeutic efficiency of large institutions. Largely for this reason, adult homes do not directly provide nursing or medical services, and the laws and regulations governing and establishing them presume that residents are not bedfast or in need of total assistance.

Nevertheless, given the critical role Medicaid plays, there is a need to explore home and community-based approaches to assure that adult home residents receive a package of services that better and more appropriately address their needs. Consideration may also be given to supplementing those services which adult homes are required to provide, perhaps by exploring long-term managed care demonstration projects.

At the same time, there must be a frank acknowledgment that there are actions by some homes and service providers which reflect poorly on the entire provider community, including, unfortunately, those providers committed to providing quality services. There must, therefore, be a continuing regulatory effort to identify these providers, get them up to standard or get them out of the system.

In May 2002, the Commissioner of Health established an Adult Home Workgroup. The Workgroup includes, in addition to the Commissioner, the Commissioner of the Office of Mental Health, the Director of the State Office for the Aging, the Chairman of the Commission on Quality of Care for the Mentally Disabled, representatives of the Attorney General's Office, an adult home resident, adult home operators and a range of advocates and other experts in providing services to the individuals served by adult homes.

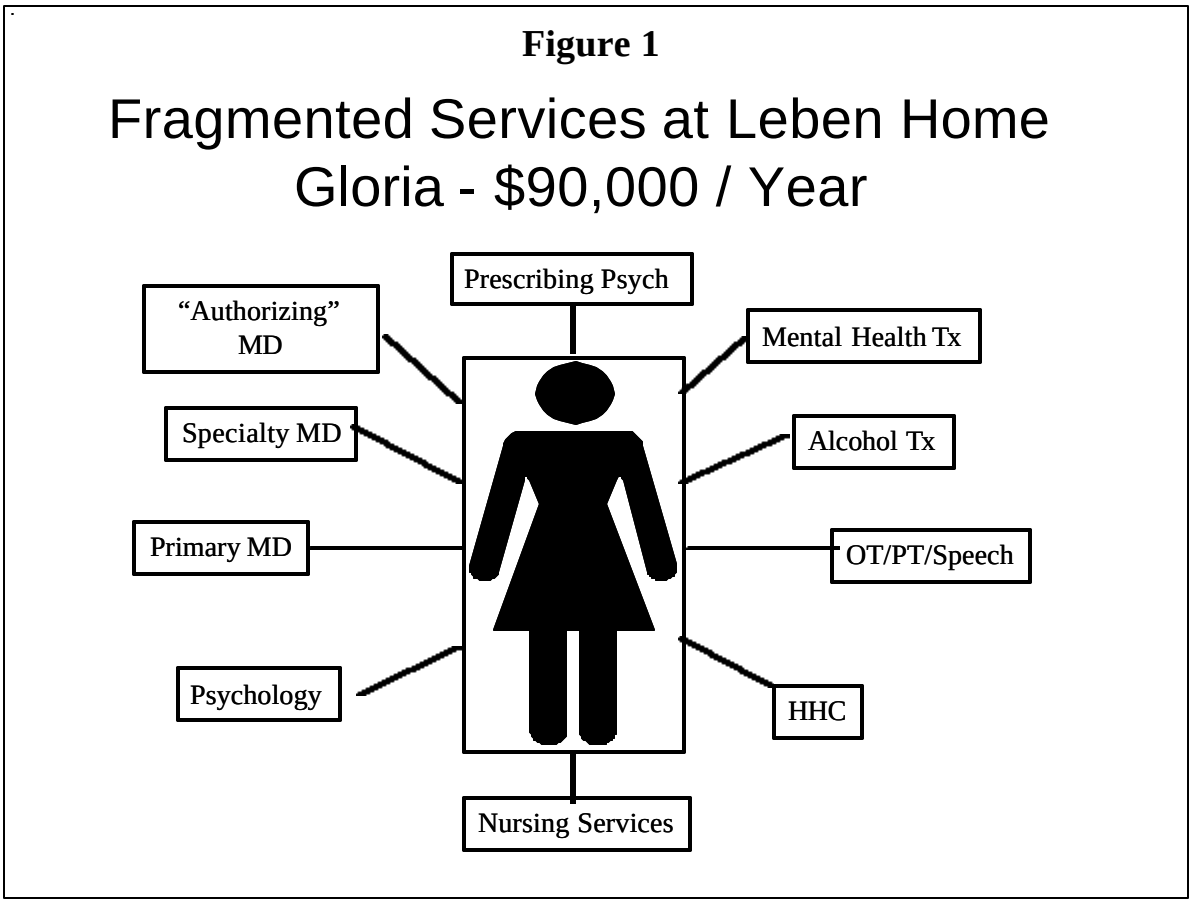
The Commissioner charged the Workgroup with developing recommendations to improve the coordination of necessary medical and mental health care services for adult home residents and restructure payment systems to support a coordinated service delivery system, and to explore new models or methods to meet the housing, medical and mental health needs of adult home residents.

This is a year of opportunity to address many of the structural problems that have plagued the adult home industry for more than 25 years. This study provides background information regarding the current layering of publicly-funded services which will assist the members of the Workgroup in formulating specific recommendations to respond to the Commissioner's charge and improve the quality of life for adult home residents.

# INTRODUCTION

The Commission's 1999 visits to Ocean House Center, Inc. and the Leben Home for Adults, both adult homes in Queens, where nearly all of the residents have a history of mental illness, raised questions not only about the substandard conditions in the homes[2] but also about the types and quality of the medical, nursing, habilitation and mental health services provided to the residents and paid for through the medical assistance program (i.e., Medicaid). One resident, "Gloria" (a pseudonym), illustrated the problems in their extremes. Gloria was seen by five different physicians, with no one coordinating her care. She received speech therapy, occupational therapy and physical therapy authorized not by her primary care physician, but by another physician who saw her only for the purpose of authorizing those services. The psychiatrist who prescribed her psychotropic medication was not the same psychiatrist who approved her mental health service plan. Her alcoholism counselor did not talk to her mental health counselor who did not talk to the psychologist she was seeing. Her annual physical did not mention that she was diabetic, so it appears that the physician did not talk to the nurses who gave her insulin injections every day. Medicaid paid $90,000 for this patchwork of services, which did little to improve Gloria's quality of life or ability to function independently.

**Figure 1**




[2] On June 27, 2002, the operators of Ocean House were arrested and charged with stealing more than $2 million of the facility's funds and turning this not-for-profit home into an instrument for personal gain. According to the charges, more than $135,000 from a $1.4 million loan, which was supposed to have been used to renovate the home, was also stolen to make improvements at the personal residence of one of the operators. See also, *Exploiting Not-for-Profit Care in an Adult Home, The Story Behind Ocean House Center, Inc.,* December 2001.

On May 3, 2001, the Department of Health ordered the suspension of the Leben Home's operating license and installed a temporary operator. The home, now known as the Queens Adult Care Center, is being run by new operators.

In addition, observation of on-site mental health services at Ocean House, provided by St. John's Episcopal Hospital, revealed that sessions which were little more than early grade-school coloring exercises were billed to Medicaid at the rate of $141.45 for each person attending this group activity.[3]

With these excesses in mind, along with the common question of whether the SSI rate of $28/day is adequate compensation for providing room, board and personal care at adult homes, the Commission initiated a study to determine the true cost of providing services to adult home residents. The Commission sought to determine whether what it had seen were practices characteristic of only a few homes where case management was seriously deficient, or whether there was a pattern of unsolicited, revenue-driven services at many adult homes caring for persons with mental illness.

# SCOPE OF REVIEW

To conduct a study of the cost and quality of the Medicaid-funded services provided to residents of adult homes under its jurisdiction,[4] the Commission chose the 11 largest adult homes in the greater New York City area. In these homes, some 90 percent of the residents are persons with histories of mental illness. Each of these homes had a census of at least 200, and one home had a census over 300 (Figure 2). Together, they cared for about one-fifth of the total population of "impacted adult homes."[5] The Commission analyzed the cost of care for the residents who had continuously resided in these homes for at least the one-year period October 1999 to September 2000, by reviewing Medicaid cost data provided by the Department of Health (DOH), Office of Medicaid Management. It also audited a sample of Medicaid claims to ensure that the billings were supported by proper documentation. In addition, Commission staff visited the homes, reviewed the available medical and mental health records of 60 residents, and interviewed providers and adult home administrators. Finally, the study concluded with a review of each home's finances.[6]

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[3] Following the Commission's findings, the state Office of Mental Health has required a new menu of groups; including, medication management, independent living skills, relationships and others.

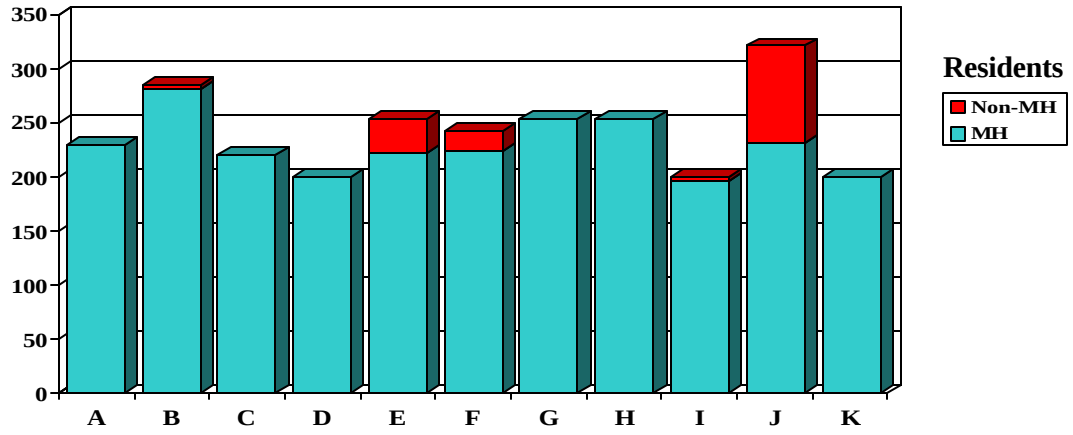
[4] Effective August 12, 1994, the Commission was provided oversight authority under N.Y. Mental Hygiene Law §45.10 for adult homes in which 25 percent or more of the residents receive or have received services from a mental hygiene provider.

[5] As of March 2002, there were 221 facilities housing 25 percent or more residents with mental disabilities which are designated "impacted homes."

[6] One home closed during the report period. Hence, it was not visited and its finances were not reviewed.

**Figure 2**

## Census Data




Department of Health
Adult Care Facility
Statistical Report 6/98

## LAYERING OF SERVICES

The Commission's current study concludes that the multiplicity of services seen at both Leben Home and Ocean House were not aberrations. The study of the services provided at the sampled adult homes revealed that many residents received multiple layers of services from different providers that were costly, fragmented, sometimes unnecessary, and often appeared to be revenue-driven, rather than based on medical necessity. These services were often characterized by their lack of individualization. The breadth of services-- from home health aides helping residents bathe and doing laundry to occupational therapists teaching numbers by having residents play solitaire on a computer; as well as the volume of services -- with residents seeing primary care, specialty physicians and other practitioners for services of questionable medical necessity -- can be attributed to easy accessibility and the absence of a gate-keeper or service coordinator.

Although considered a "community-setting," some homes appear to be more institutional in nature, with residents treated as a "class" rather than in accord with their capacities and characteristics as individuals. Instead of a normalizing experience arising out of residents availing themselves of services in the community, practitioners were renting space from the adult home operators and regularly providing services on-site. In most instances, the home had no arrangements in place to coordinate services, and the responsibility for coordinating medical services was left, by default, to residents' private physicians who often did not know all of the services the resident was receiving.

## Services are Costly

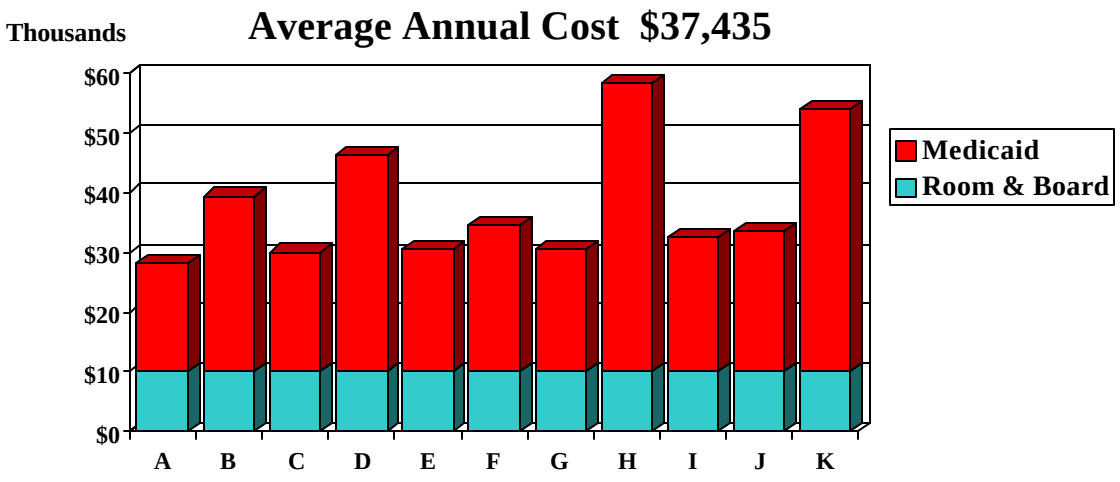
The large majority of adult home residents with mental disabilities pay for their care with Supplemental Security Income (SSI) benefits. As of January 1, 2002, in the New York City area, this amounts to $980 per month, with the state contributing $435 and the federal government $545. From these benefit payments, the adult home receives $858 per month ($10,296 yearly) for room, board and the services of attendants to assure the safety and comfort of the residents, and to help residents bathe, dress and move about. The residents are entitled to retain a $122 per month personal needs allowance for clothing, hygiene supplies, and other amenities.

Since adult homes are not health care facilities and do not provide medical care to their residents, the cost of these services is borne by Medicaid and/or Medicare through direct payments to hospitals, clinics, physicians, pharmacies and other service providers.

The Commission found that when Medicaid costs are added to the room and board costs, the average annual total cost was approximately $37,000 per resident.[7] Projected to the 7,000 residents with mental illness living in the New York City area adult homes, this equates to more than one-quarter of a billion dollars each year.[8] Figure 3 shows the average annual cost per resident in each of the adult homes studied.

**Figure 3**

# Average Cost of Services Per Resident



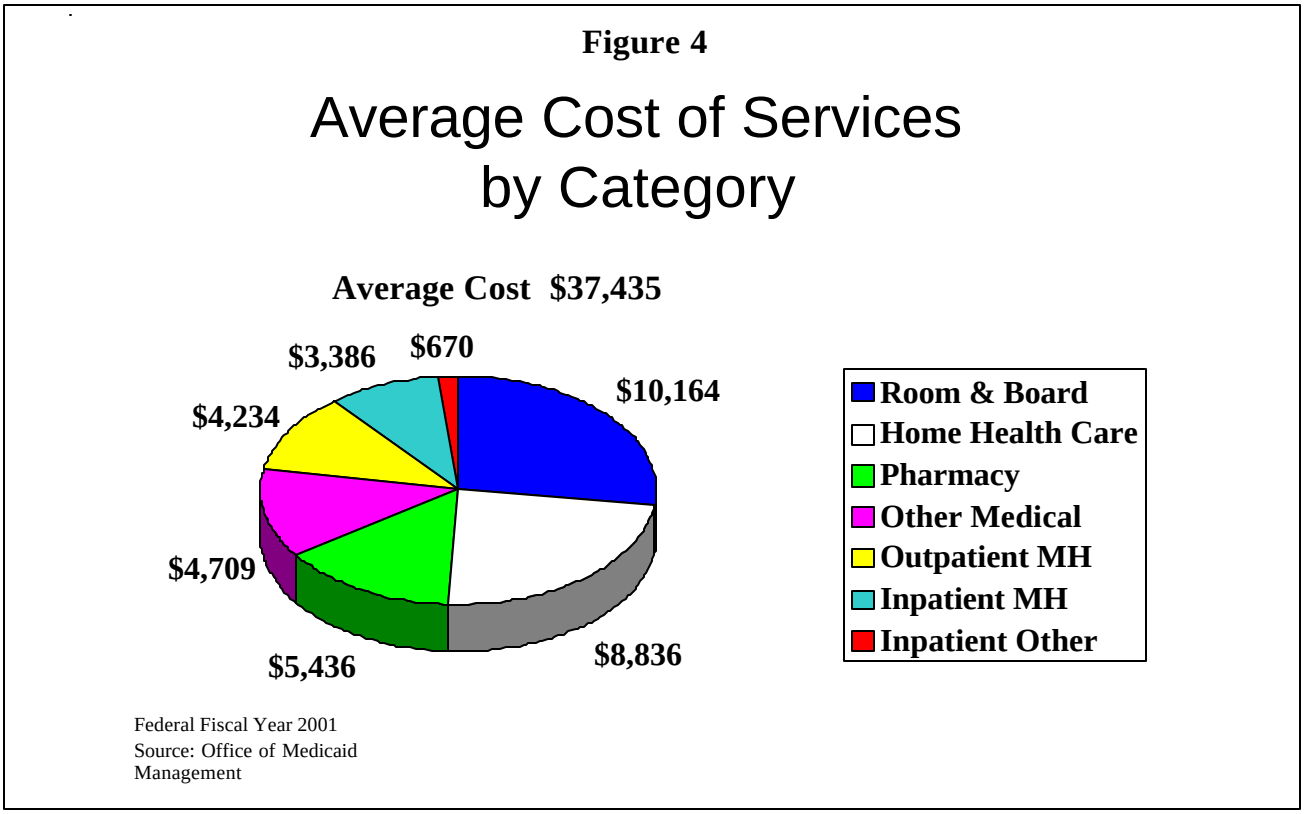

Federal Fiscal Year 2001
Source: Office of Medicaid Management

[7]This figure is based on a detailed analysis of all Medicaid expenditures for 100 residents in our sample.
[8]Upstate Medicaid expenditures are considerably less, averaging about $8,000 per year for mentally-ill adult home residents.

The total cost of care was divided into seven cost categories: room and board, home health care, pharmacy costs, outpatient mental health costs, other medical costs (including nursing home, emergency room, transportation and laboratory services), hospital inpatient mental health, and inpatient costs for other than mental health services. As indicated in Figure 4, expenses for room and board account for slightly over $10,000 a year, or about $28 a day. Nearly as costly as room and board were the costs associated with home health care. Home health care includes skilled nursing services, home health aide services and other services, such as physical therapy, occupational therapy and speech therapy. Pharmacy services were the next most costly at about $5,400 per resident, followed by "other" medical services at $4,700 per resident.

Because nearly everyone in the sample received mental health services, it was surprising that outpatient mental health services were only about half the cost of home health care. Interestingly, inpatient services for both mental health and other reasons were the least costly services at the homes studied.

**Figure 4**




Federal Fiscal Year 2001
Source: Office of Medicaid Management

## The Case of Cheryl

Although this study did not find another "Gloria," with total cost for room and board, and services coming to nearly $90,000 a year, the study did identify a resident, "Cheryl" (a pseudonym), whose services (and their costs) illustrate its principal findings. Cheryl is a middle-aged woman with schizophrenia. She also has diagnoses of asthma and hypertension that do not require medication. As shown in the daily schedule below, Cheryl begins her day with the assistance of a home health aide helping her bathe and dress. Because a nurse must supervise the home health aide, the nurse sees Cheryl twice a month. Cheryl attends an OMH-certified continuing day treatment program. Her schedule there is like many others reviewed in this study, with much of the five-hour day devoted to socializing and eating. Similar to Gloria, Cheryl's psychotropic medication is prescribed by a private psychiatrist on-site at the home rather than a psychiatrist affiliated with her day program.

**Figure 5**

# A Day in the Life of Cheryl

| | | |
|---|---|---|
| 7:00 a.m. | HHA assists to bathe, dress and groom | $15.77 |
| 7:30 a.m. | Nursing visit - short assessment and supervision of HHA | $80.54 |
| 8:30 a.m. | Van ride to CDT program | $23.00 |
| 9:30 a.m. | CDT program | $106.02 |
| 2:30 p.m. | Van ride back to adult home | $23.00 |
| 3:30 p.m. | Private psychiatrist visit for management of meds | $22.50 |
| | Total: | $270.83 |

## Home Health Care Services

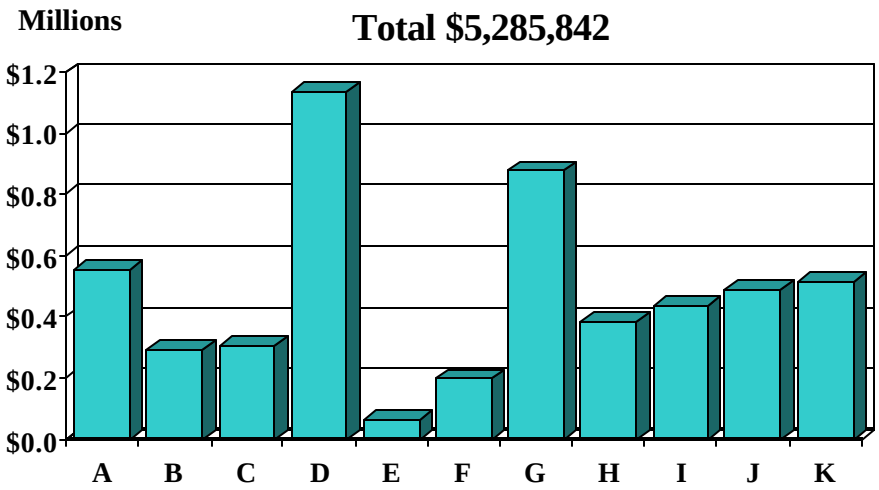
As illustrated by Cheryl, home health care services are costly for two reasons: nursing services are reimbursed at a high fee-for-service rate and because home health aides are performing housekeeping services that, by regulation, should be provided by the adult home. In fact, a review of the five most costly residents in the sample revealed findings similar to the cost patterns reported above. For three of the five most costly residents, home health care costs ranged from $48,000 to $58,000 a year.

## Fee-for-Service Payments for Nursing Services

Skilled nursing services were particularly expensive. Nursing services are reimbursed on a fee-for-service basis, which in this study averaged $71 per service. As indicated in Figure 6, nursing costs in the 11 homes reviewed ranged from a low of $61,000 a year to a high of more than $1.1 million or about $6,000 per recipient. In all of the homes studied, fewer than half of the residents were receiving nursing services. For example, at the home where total nursing services cost over $1.1 million a year, only 48 percent of the 200 residents were receiving this service. And, particularly important, in the homes that serve predominantly persons with mental illness, the nurses were not responsible for supervising the administration of oral medications. Instead, this responsibility was left to unlicensed adult home staff, who distribute hundreds of doses of oral medications each day.

**Figure 6**

## Total Nursing Costs by Home




Federal Fiscal Year 2000
Source: Office of Medicaid Management

The majority of nursing services studied (56 percent) were for insulin injections for diabetic residents. Other typical services included assistance with eye and nose drops and skin creams (23 percent), and supervision of home health aides (15 percent of all services). Six percent of the services were for wound care. Examples of common nursing services convincingly illustrate the high cost of fee-for-service billing. If a diabetic resident needs insulin twice a day, Medicaid is billed (on average) $142 a day. If a person recovering from cataract surgery requires eye drops twice daily, again $142 is billed to Medicaid. In each of these instances, the Medicaid payment was buying approximately 15 minutes of a nurse's time at a rate of almost $10 a minute.

According to federal guidelines, nursing services are a "covered service" for someone with an illness or injury. Home health aide services are services that support any services that a nurse provides and are part of the home care plan. Therefore, home health aide services are not "covered" unless the resident is also getting skilled care, such as nursing or other therapy. In other words, personal care, like bathing, assistance using the toilet, or help in getting dressed, should not be a Medicaid billable service when this is the *only* care needed. Yet, in Cheryl's case, she had no medical condition that required nursing attention twice a month. Instead, she only needed help with housekeeping and personal care, both of which are responsibilities of the adult home. Even though no nursing services were needed, Cheryl received these services at a cost of approximately $160 a month, not because of an illness or an injury, but because a nurse was needed to supervise the home health care aide.

Having skilled nurses supervise housekeeping services that are the responsibility of the adult home is barred by law and regulation. Moreover, Medicaid funds could be used more effectively and more residents served if the current fee-for-service billing approach for skilled nursing services was revised. The same $1.1 million that was billed for the services of seven full-time-equivalent nurses in the adult

home described previously could support 17 nurses at an annual cost of $65,000 each -- more than enough nurses to care for all of the residents of the home. Additionally, these nurses could assume responsibility for supervision of medications, an area of deficiency often cited by both DOH and the Commission during their inspections.

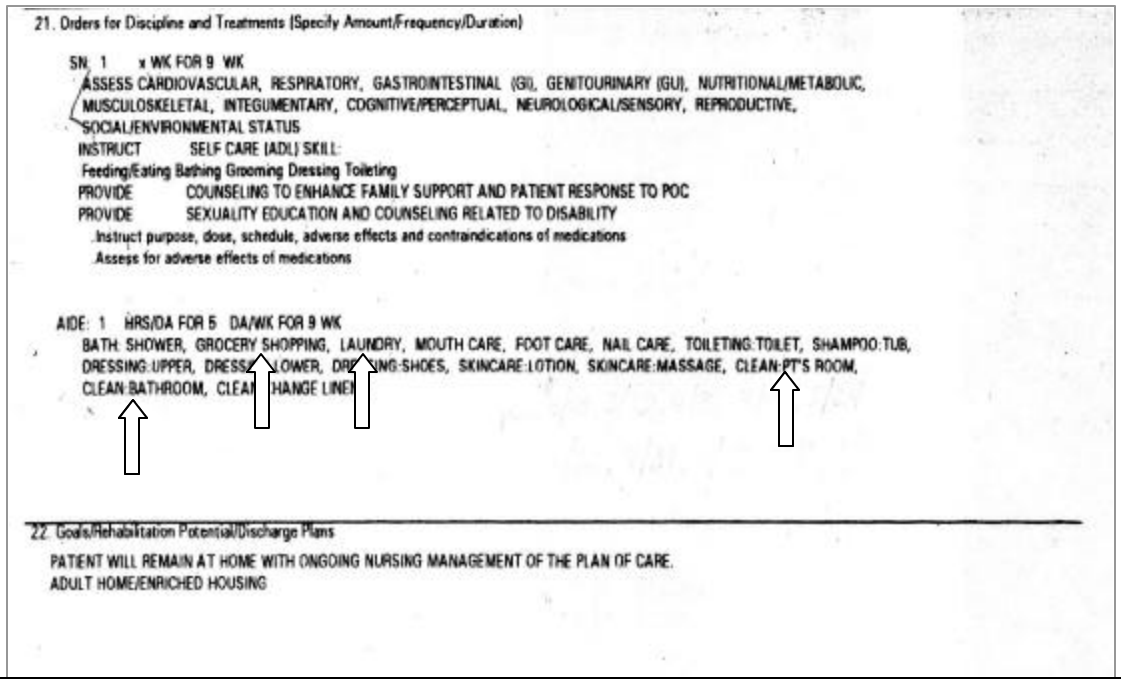
## Financing Home Health Care Aides

In addition to the expense associated with the current system for providing nursing care, the high cost of home health care is also attributable to the use of home health aides who assist residents with personal care and do light housekeeping and laundry for them. In many instances, the services provided supplant the services that by regulation should be provided by the adult home. To erase any confusion about the appropriate use of home health aides in an adult home, the Department of Social Services reissued guidelines to the industry in March 1992. These guidelines limit home health aide assistance to those residents who need "total assistance" with grooming and bathing and/or who need assistance with simple tests to monitor a medical condition. According to the guidelines, personal care services for persons needing some (not total) assistance are the responsibility of the adult home. Specifically, making and changing the bed, light cleaning of the bedroom and bath, and doing the resident's laundry are all the responsibility of the adult home. In this study, the Commission found that these guidelines were largely ignored by adult homes, certified home health care agencies and the authorizing physicians.

The Commission estimates that over 87 percent of the home health aide services provided during the study period did not comply with the state guidelines and should not have been billed to Medicaid. Looking back to Cheryl helps to illustrate this finding. Cheryl's home health care plan was a boiler-plate plan designed for persons who live in their own home and have an aide come in for several hours a day.

**Figure 7**

### Home Health Care Physician Order



21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

SN 1 x WK FOR 9 WK
ASSESS CARDIOVASCULAR, RESPIRATORY, GASTROINTESTINAL (GI), GENITOURINARY (GU), NUTRITIONAL/METABOLIC, MUSCULOSKELETAL, INTEGUMENTARY, COGNITIVE/PERCEPTUAL, NEUROLOGICAL/SENSORY, REPRODUCTIVE, SOCIAL/ENVIRONMENTAL STATUS
INSTRUCT SELF CARE (ADL) SKILL:
Feeding/Eating Bathing Grooming Dressing Toileting
PROVIDE COUNSELING TO ENHANCE FAMILY SUPPORT AND PATIENT RESPONSE TO POC
PROVIDE SEXUALITY EDUCATION AND COUNSELING RELATED TO DISABILITY
Instruct purpose, dose, schedule, adverse effects and contraindications of medications
Assess for adverse effects of medications

AIDE: 1 HRS/DA FOR 5 DA/WK FOR 9 WK
BATH SHOWER, GROCERY SHOPPING, LAUNDRY, MOUTH CARE, FOOT CARE, NAIL CARE, TOILETING:TOILET, SHAMPOO:TUB, DRESSING:UPPER, DRESS[illegible]LOWER, DR[illegible]NG:SHOES, SKINCARE:LOTION, SKINCARE:MASSAGE, CLEAN:PT'S ROOM, CLEAN:BATHROOM, CLEA[illegible]HANGE LINE

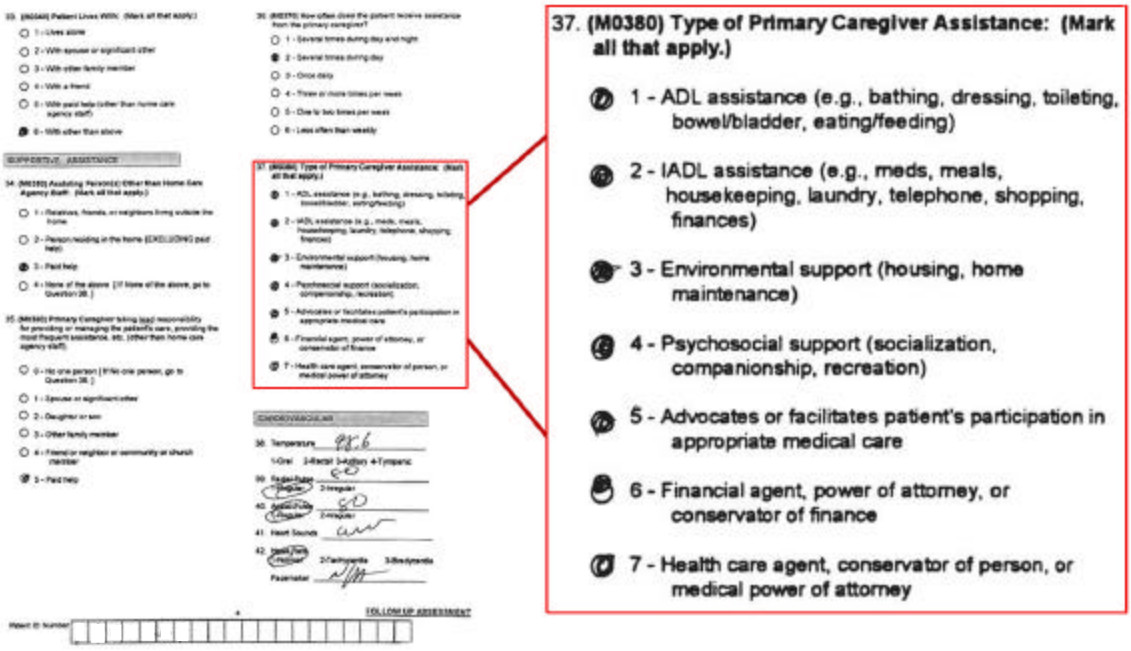
22. Goals/Rehabilitation Potential/Discharge Plans
PATIENT WILL REMAIN AT HOME WITH ONGOING NURSING MANAGEMENT OF THE PLAN OF CARE.
ADULT HOME/ENRICHED HOUSING

It included, for example, grocery shopping, laundry and cleaning the bedroom and bathroom; tasks which are specifically the responsibility of the adult home.

The excerpted section of a client assessment form reproduced below indicates that even the home health care agency recognized that assistance in bathing, toileting, dressing and eating and assistance in housekeeping and laundry was being provided by the primary care giver -- in this instance, the adult home. Yet, the aide performed these services and Medicaid was billed accordingly.

**Figure 8**

## CHHA Client Assessment Form




When the Commission questioned the home health care agencies about the apparent disregard for the guidelines, some replied that they were not supplanting the services of the home, but rather were supplementing the home's services because, in addition to actually performing the specific service (making the bed, for example), they were teaching residents, so that in time they could take care of themselves. However, when the Commission evaluated the number of persons discharged from home health aide services, it found that the caseloads remained quite steady over the one-year period, with only ten percent of the residents being discharged for*any* reason other than that they no longer needed wound care. This low rate of discharge calls into question the efficacy of the training component that is reportedly a distinctive feature of home health care at adult homes.

Three groups profit financially when home health aides do the work that is supposed to be done by aides and housekeepers employed by the adult home: the Certified Home Health Care Agency (CHHA), which supervises the aides and contracts for their services with a licensed home health care agency or employs them directly; the home health care agency which employs the aides; and the adult home which can improve its "bottom-line" by not hiring housekeeping staff and by collecting rent from the on-site

provider. To illustrate, the Commission found the following payment process at one home: the licensed home health care agency paid the aide $7/hr. It then billed the CHHA $12/hr for this service, which, in turn, billed Medicaid $17/hr for the service. The adult home, meanwhile, saved $7 for every hour of work that the licensed home health aide performed, which would otherwise be the responsibility of adult home staff, and received rental income from one or both of the agencies. When projected to the sample study of 2,100 persons, close to $3 million in savings annually could be achieved if this system of providing personal care were reformed.

## Services and Cost of Mental Health Care

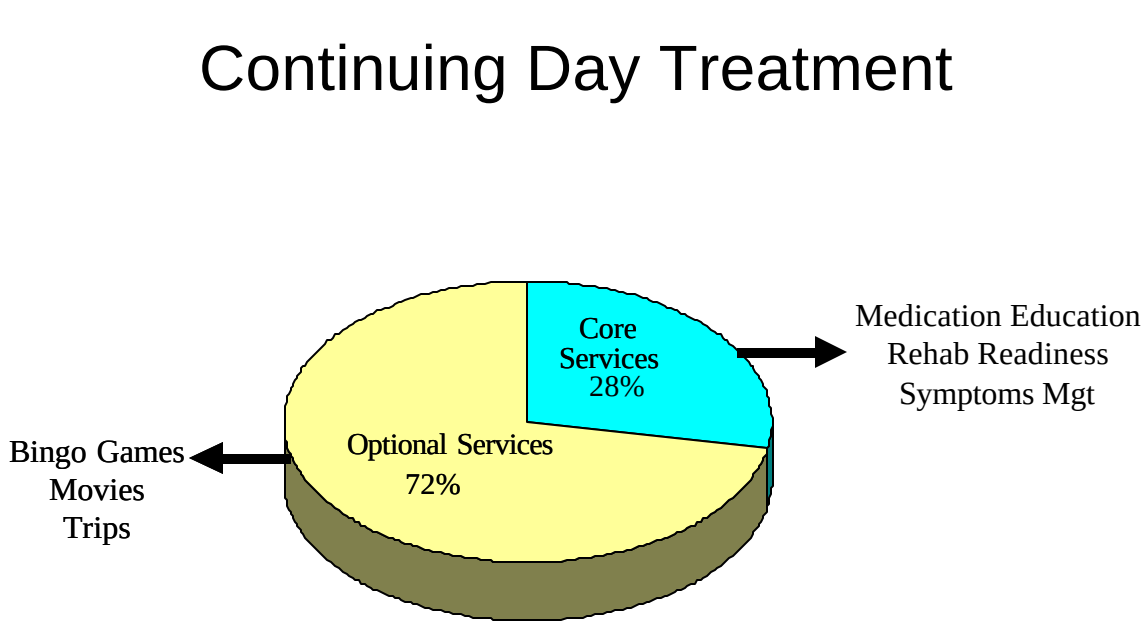
Cheryl attended a Continuing Day Treatment (CDT) program, typically for five hours each weekday. Although her activities varied each day, she usually arrived at about 9:30 a.m. and left at 2:30 p.m. The intervening hours (on one particular day of the week) were spent in the following group sessions:

**Figure 9**

| Time | Service Provided |
|---|---|
| 9:30 a.m. - 10:30 a.m. | Current events, coffee, donuts |
| 10:45 a.m. - 11:45 a.m. | Movie |
| 12:00 p.m. - 1:00 p.m. | Lunch |
| 1:00 p.m. - 1:45 p.m. | Pet therapy |

Cheryl's activities at this program were not significantly different from those in many of the programs which Commission studied. Rather than emphasizing core services - - defined in Office of Mental Health regulation (14 NYCRR 587.10) as medication therapy, medication education, rehabilitation readiness assessment and development, case management and symptoms management - - many programs offered only about one out of four sessions devoted to these core activities (Figure 10). The majority of the remaining time was spent in social activities, breaks and meals. Cheryl and others at OMH-certified day programs need and benefit from the social activities that break their isolation and encourage interaction and communication; but rehabilitation is equally important, raising the question of proportionality. According to the weekly schedule, Cheryl's program contained only three 45-minute sessions devoted to core services, contrasted with 17 "optional" sessions.

**Figure 10**




In addition to the questionable mix of services at the continuing day treatment programs, the Commission's study raises concerns about the systemic practice of billing for more hours of therapeutic activity than were actually provided. Typically, lunch was counted as a billable hour of service even though, in a number of programs visited, many people ate lunch somewhere else--at the corner pizza shop, for instance. In some programs, the first hour of the day was spent with donuts and coffee. These programs, however, billed for five hours of service. Based on a subset of 100 randomly chosen individuals (from the 2,100 persons in the study), it is estimated that one-third of the continuing/day treatment Medicaid billings were for hours of service that were actually spent at lunch or in unstructured social activities, such as shooting pool. The Commission estimates as much as $2 million is being improperly billed because programs do not adhere to regulatory standards.

## Unnecessary Services

The proliferation of on-site services at the adult homes has not, in many instances, improved the quality of the care provided to residents. A review of medical records and interviews with physicians and patients revealed treatment practices characteristic of a system in which the primary care physician plays no gate-keeper role and no other person coordinates services. In some homes visited, where all residents saw their primary care physician every month, up to 30 people an hour were called over a loud speaker system to come to the doctor's office. Review of the medical charts of some of these residents revealed no evidence of medical necessity for the visit, and the residents were provided basic assessments that could have been performed by a nurse. As discussed earlier, if the current fee-for-service billing structure was reformed, routine nursing services and the "triaging" of residents in need of more expert evaluation could be provided more efficiently to all residents of an adult home at a much lower cost.

To illustrate how nursing services might have been rendered in lieu of treatment by a physician, consider "Joseph" (a pseudonym). In February 2000, he saw a physician who documented that he was "feeling well." Other documentation included his blood pressure and weight, and a note that his lungs were clear and there were no problems with his heart. One month later, he was seen and again was "feeling well." In April and again in May, Joseph's physician wrote the same note, "feeling well." In June, Joseph was treated for a cold.

A review of the treatment practices of two specialty physicians raised particular concerns regarding the necessity of services. In two homes, an allergist saw, on average, one out of every three residents. The administrator of one of these homes reported that many residents did not know why they were receiving allergy injections every week. In total, this physician provided care in 23 adult homes in the greater New York City area, and for the period January 2000 to October 2001, billed Medicaid and Medicare slightly more than $1 million.

A close review of a podiatrist's billings revealed similar patterns of apparent over-utilization and, in this case, raised the question of what, if any, service was actually provided. During 102 half-days on site, the podiatrist saw 55 percent of the residents at one sample home and submitted over 1,300 claims to Medicaid and/or Medicare in the 19-month period from January 2000 through July 2001. Strikingly, of the 133 residents for whom payment was claimed, three-quarters were billed for having one or more nails removed at a cost of about $120 per procedure. However, none of the patients' billing records show any follow-up care after these surgical procedures, and the podiatrist never left instructions with the home regarding foot soaks or changing bandages. When Commission staff interviewed 13 residents who were reported to have had one or more nails removed, one person recalled treatment for an ingrown toenail; the remainder said that the podiatrist cut their nails, but never removed nails.[9]

## Fragmented Services and Lack of Communication

Effective systems for communicating important information among providers of medical, habilitation and mental health services and relevant adult home staff were absent in many of the homes visited. While each party could describe procedures for relaying important information to others caring for a resident, those persons reportedly receiving the messages often told a different story. Far more common than regularly scheduled meetings reviewing the status of residents, were calls for help (and finger-pointing, assigning blame) when someone was in crisis. Particularly glaring was the nearly total absence of communication between private psychiatrists who prescribed medications and the resident's other mental health provider who furnished counseling and developed the comprehensive service plan.

While on-site, Commission staff witnessed inattention to residents who exhibited clear signs of decompensation and fragmented services that resulted from the absence of clear and timely communication. "Ray" (a pseudonym) is a case in point. Prior to a two-week hospitalization, Ray was taking ten medications for a cardiac condition, arthritis, gastric reflux and schizophrenia. Upon discharge, none of his cardiac and arthritis medications were reordered. The untrained medication assistance staff at the home had not recognized the significance of what had happened. Upon questioning the primary care physician, Commission staff learned that he was not aware of the problem. Ray was concurrently refusing to take his psychotropic medication, but the mental health provider "had not gotten around to" addressing the issue. Meanwhile, Ray had not been out of bed for three days,

[9]The Commission conducted an in-depth review of this podiatrist's billings and has made referrals to appropriate regulatory and enforcement agencies for whatever action they deem necessary.

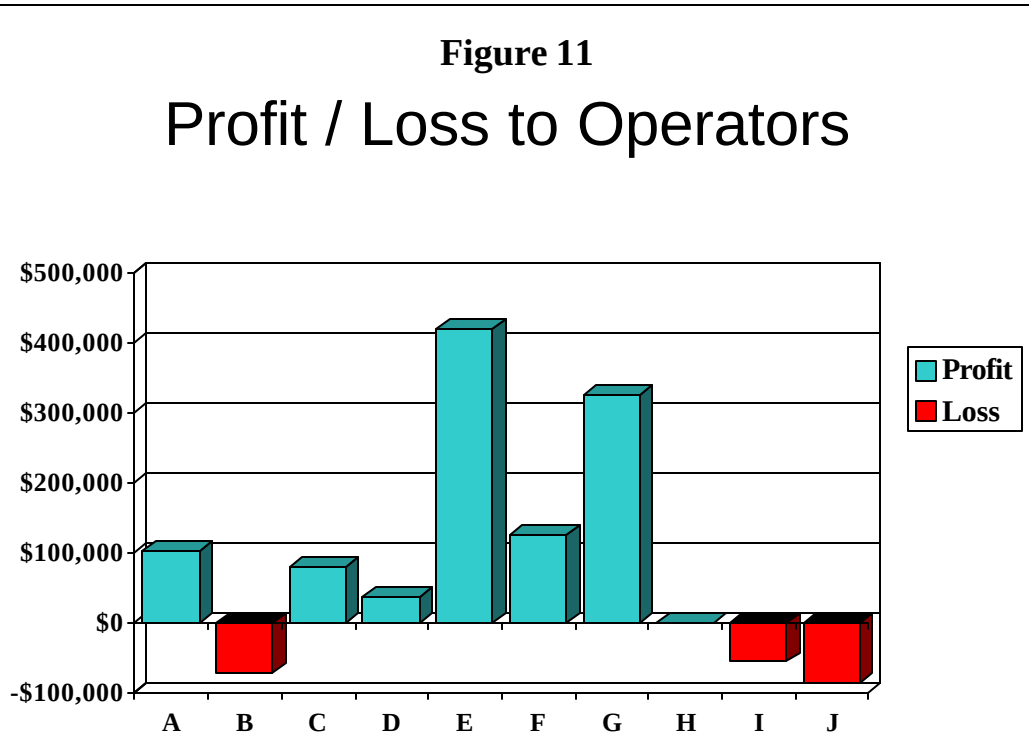
except for an occasional meal. He was rehospitalized the evening of the Commission's visit when he took himself to the emergency room.

## Profitability of Adult Homes

The Commission also reviewed the annual financial reports for 1999 submitted to DOH by the adult homes in the sample. These reports summarize the financial position and the operating results of the home for the fiscal period. The Commission's review found instances where operating profits were hidden through false or misleading financial statements, which included non-arm's length payments to the operator. Non-arm's length transactions often create "costs" which in reality are "off-the-book" profits to the operators.

The Commission's review of the annual submissions to DOH revealed wide variability in reported profits as seen in Figure 11. These reports, which are required to be audited by an independent accountant and certified by the adult home operator as containing "true, correct and complete" figures, reported operating results ranging from a loss of $86,000 to a profit of $421,000.

**Figure 11**




Source: Department of Health
Annual Cost Reports 1999

A "look-behind" the numbers, however, raised questions about some of the figures and consequently about the adequacy of the cost reports themselves. One home provides an example of how actual profitability can be disguised because of inadequacies in the cost report, which does not require full disclosure of related-party transactions. The home, which reported a loss on its annual cost report, paid $1.1 million for rent to a company which the owner of the adult home controls.

While this relationship (control of both the adult home and the rental company) is disclosed on the cost report, what is not disclosed is how much of the rental payment is actual profit to the adult home operator, i.e., what portion of the $1.1 million in rent is not committed to payment of legitimate operating expenses of the building, such as mortgage interest, real estate taxes, and maintenance.

The operators of this home also run an Assisted Living Program (ALP), which provided nursing and home health aide services under a capitated fee structure to 98 residents who need more extensive care. (See pp. 16-17 for a further discussion of the ALP program.) The home collected $2 million (primarily from Medicaid) for these services and paid this amount to a home care agency that provided the services. The home care agency is also controlled by the adult home operator. Again, while this relationship is disclosed on the cost reporting form, what is not disclosed, as in the case of the realty company, is the actual cost of the services provided. In this case, the cost of staff, equipment and other necessary expenses is not disclosed and hence the profit from this activity is not discernible.

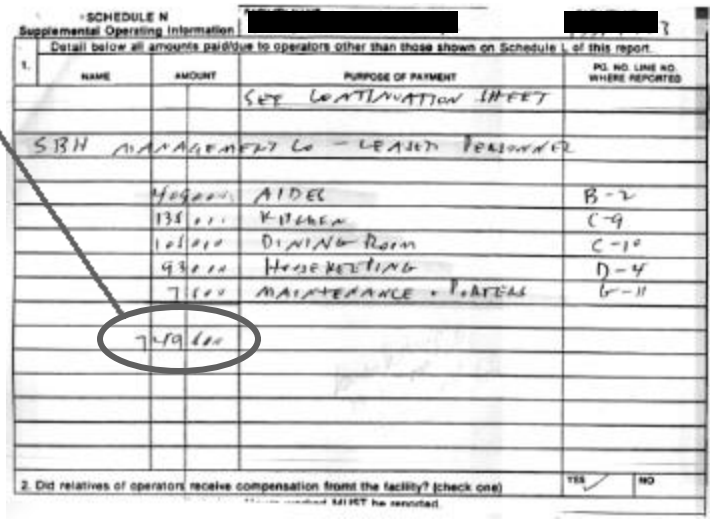
At another home, the Commission undertook an expanded review of its finances by obtaining access to the financial records of the home and its related-party company. What emerged was a considerably different picture than the one presented on the annual cost report (Figure 12).

**Figure 12**

# Hidden Profits to Operators

| | |
|---|---|
| **Payroll Costs Reported** | **$749,500** |
| **Payroll Costs Incurred** | **325,226** |
| **Hidden Profits to Operators** | **$424,274** |

**Annual Cost Report**




Source: Department of Health
Annual Cost Reports 1999

In this instance, the owners had set up a related "employee leasing company" to pay the salary of adult home staff. The home did not directly employ its cooks, aides and housekeepers, but rather paid the employee leasing company for their services. According to the 1999 cost report, the home reported a profit. However, in its "look-behind" review, the Commission found that the operator actually made

a profit five times the amount reported. Although the home's cost report shows that $749,500 was paid to the employee leasing company, the leasing company's records revealed that the actual cost for employees was only $325,226, with the remaining $424,274 profit going to the operators.

As mentioned earlier, in the background of much of the discussion about the quality of care of residents and conditions of adult homes is the question of whether the current SSI rate of $28 per day is adequate. A full understanding of this industry cannot be obtained without a complete picture of a home's "profitability." Unless full disclosure of related-party transactions is required, it is not possible to discern whether a home's operating costs are a true reflection of the cost of care. In the absence of this information, a fair discussion of the adequacy of the SSI rate is not possible.

## Adult Home Rental Income

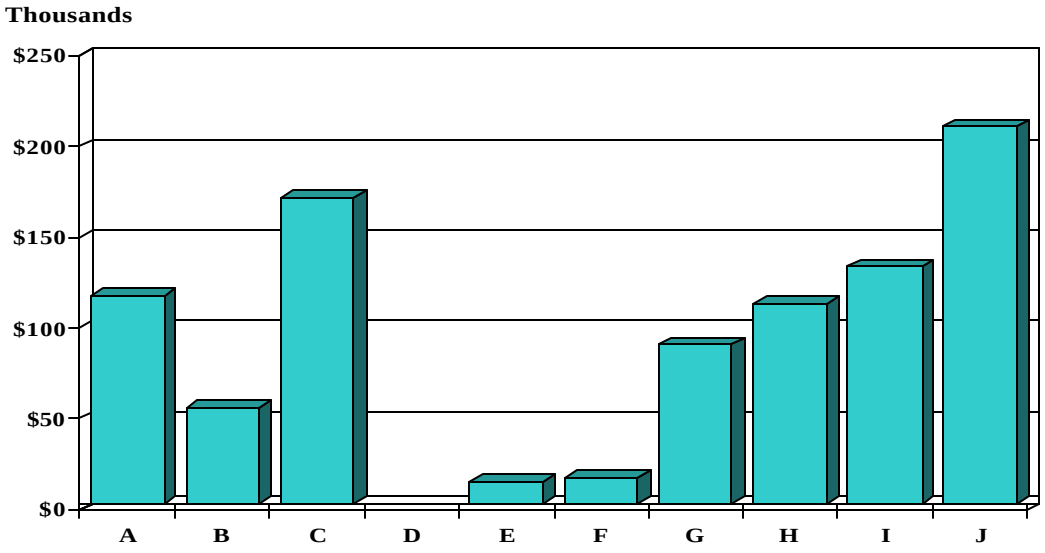
The Commission's financial review also examined rental agreements which existed between the homes and outside service providers, which included private practitioners and medical and mental health clinics. The review revealed some homes where space was rented at prices above fair-market value. This raised questions as to whether the payments were a form of remuneration to induce access to the homes' residents.

Although regulations [18 NYCRR 487.7(i)(5)] state that adult homes shall "provide, without charge, space for residents to meet in privacy with service providers," the Commission found that nine of the ten homes visited collected rent ranging from $15,000 to $200,000 annually. Leases provided to the Commission by the homes identified space leased to private physicians; other private practitioners, such as psychologists; medical clinics; mental health clinics and CSS programs; rehabilitation service providers (occupational, physical and speech therapy); and nursing and home health care agencies.

The Commission's experience in reviewing the operations of Ocean House and Leben Home alerted it to the necessity of gaining access to information about rental income to the adult home from outside providers of service in order to understand a home's financial condition. Rental income is both a significant source of income at some homes and, more importantly, it buys access to the home's residents. Exceptionally high rents, the renting of the same space to several providers, the renting of common space (lounges, portions of the dining room), the renting of non-existent office space and inflated "service agreements" (for telephone and parking spaces, for example) are practices which point to these arrangements as a hidden form of remuneration in return for access to the home's residents. For example, at one home reviewed in the study, an OMH-certified clinic rented space for $16.50 per square foot, but across the hall, in similar space, a private provider was paying $37 per square foot.

**Figure 13**

# Rental Income



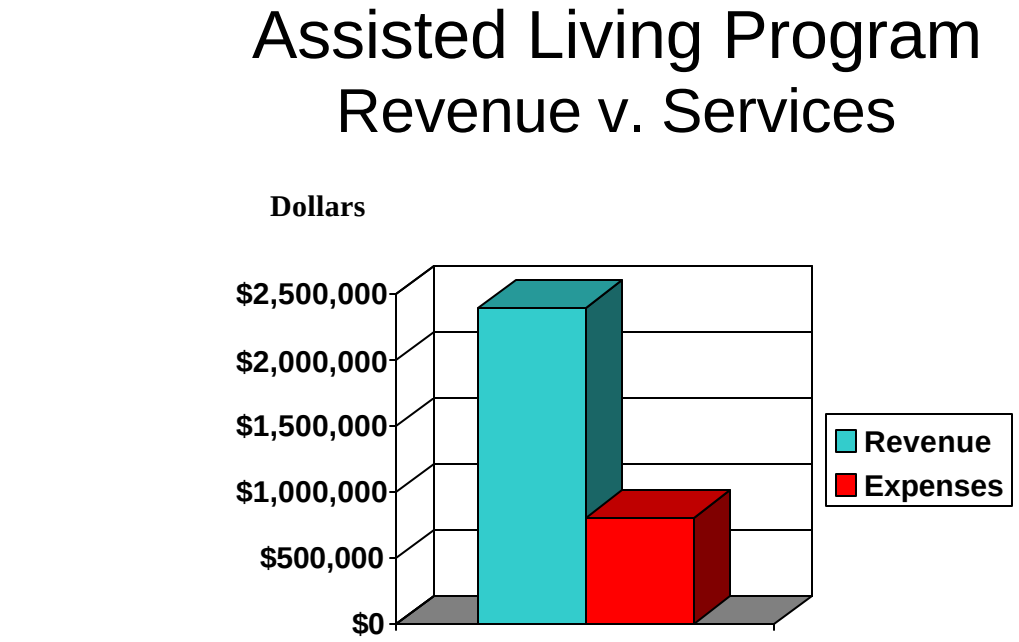

Amounts Based Upon An Analysis of Lease Agreements

## Other Care Models and their Financing

Some discussions about how to "fix" adult homes have focused on the Assisted Living Program (ALP) as a possible model to better address the needs of persons with histories of mental illness. This program was enacted as part of Chapter 165 of the Laws of 1991 in response to the need for a cost-effective option for Medicaid recipients needing home care and supportive housing to avoid placement in a skilled nursing facility. Participants in the ALP are provided long-term residential care, room and board, housekeeping, personal care, supervision and home health services. In 1993, DOH determined that 4,200 ALP beds were needed for people who would otherwise be admitted to nursing facilities for reasons primarily unrelated to their need for skilled medical care and services. Payment for the home care services component is determined by the local social services district at 50 percent of the rate paid for nursing home care for a person with the same level of disability.

One home in the Commission's sample provided services from an ALP to approximately one-third of its residents (maximum enrollment is 40 percent of the adult home census). Medicaid payment for this ALP program for 1999 totaled over $1.6 million or about $16,000 per person, two times the average home health care cost at other adult homes. At another home reviewed, after being certified as an ALP program, the total revenues of the home increased by $2.4 million, while the home's expenses for the ALP services only increased by one-third that amount (Figure 14).

**Figure 14**




Source: IRS Form 990 1997 -1999

The Commission believes that there is sufficient reason to study the appropriateness of this model for persons with a primary diagnosis of mental illness to answer such questions as whether residents have a medical need for the services, what services are actually being provided, the benefits to the recipients, and the costs associated with them.

## CONCLUSION

In this study, the Commission found that the physical and mental health needs of residents of adult homes are addressed by a disjointed patchwork of publicly-funded services. Residents are often poorly served, and resources are not utilized cost-effectively.

The commonly held view is that only $28 per day in public funds is expended to support a resident of an adult home. However, this study finds that, when SSI and Medicaid expenditures are combined, almost three and one-half times this amount, or about $37,000 a year per resident is being spent overall. Indeed, public funds are being spent on services with few strings attached; i.e., services are costly, fragmented, sometimes unnecessary and appear, in many instances, to be revenue-driven.

In summary, the Commission found a fundamentally flawed service system that addresses separate aspects of a resident's life. But the whole, which is greater than the parts, is never addressed. Despite the investment of substantial public money, residents are being short-changed when the reality of their living conditions and services is examined.

# DISCUSSION POINTS

Many ideas for reforming adult homes have surfaced as a result of the creation of an Adult Home Work Group by the Commissioner of Health. These include studying the structure and funding of alternative housing models with wrap-around services and the utilization of independent service coordinators to work with residents to ensure that they receive residential, health, mental health, habilitation and recovery services that are necessary and appropriate to their needs, as determined by professional care providers, and consistent with their wishes and desires.

Based upon this study, other issues which the Work Group may wish to discuss include:

First and foremost, exploring ways in which the $37,000 currently being spent could be better utilized, including creating demonstration projects with the funding currently available to develop alternatives to adult homes that promote responsibility and independence;

Examining the roles of Continuing Day Treatment Programs to better align their programmatic offerings to the real need of adult home residents for habilitation and recovery services;

Exploring the possibility of a single point-of-accountability or gatekeeper approach to the provision of services to adult home residents to ensure that medical services are delivered in a cost-effective manner and only when necessary; and

Increasing the utilization of the Limited Licensed Home Health Care Services Agency (LLHCSA), which provides a more cost-effective approach to services and ensures tighter control over utilization of medically necessary services through the involvement of local social service districts. With regard to nursing services alone, utilization of LLHCSAs could provide a far less costly approach to meeting this basic need, and allow for homes to have on-site professional nursing staff to monitor medication administration systems, train unlicensed staff to assist in medication distribution, provide direct nursing services and monitor residents' well-being.

Finally, based on its review, the Commission notes that increased utilization of the Assisted Living Program, as a model for adult homes serving individuals with mental illness, may require further study.

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