REPORT BY THE STATE AUDITOR

OF CALIFORNIA

THE VETERANS HOME OF CALIFORNIA HAS NOT MAXIMIZED REVENUE FROM RESIDENTS AND REIMBURSEMENTS FROM THE FEDERAL GOVERNMENT

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California State Auditor
Bureau of State Audits

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Summary

Results in Brief

The 1993-94 Budget Act (Chapter 55, Statutes of 1993) required the Bureau of State Audits to review the policies and procedures of the state Department of Veterans Affairs (department) to maximize fees paid by residents of the Veterans Home of California (home). The Budget Act also required that the review evaluate the department's efforts to exhaust all sources of reimbursements from both the residents and the federal government. During our review, we noted the following:

- By not implementing adequate procedures and adopting policies to recover all possible fees, the home has not maximized revenue from residents. For example, the home can collect up to $1.15 million more from residents if it assesses an estimated $150,000 annually in fees on some social security income received by residents and charges residents an additional $1.0 million annually by raising fees to the maximum allowed by the Budget Act, while assuring that residents do not pay more than the state-funded cost of their care.

- The home does not have the authority to collect the state-funded cost of care provided to residents who leave the home to live somewhere else. For example, the state-funded cost of care provided to the approximately 100 residents who left the home in 1993 would have been approximately $787,000 if they had resided in the home for only one year and had received domiciliary care, the least costly level of care. The amount the home might have recovered depends on the income and assets of the residents who left the home.

- By not implementing adequate procedures to recover all possible reimbursements, the home has not maximized reimbursements from the federal government. We reviewed the home's reimbursements in fiscal year 1992-93 and found that the home received $260,000 less in Medicare reimbursements for hospital care than it would have if it had been reimbursed at rates similar to comparable institutions. In addition, the home received $200,000 less in reimbursements for outpatient clinic visits than it would have if it had received reimbursements for the percentage

of residents who were eligible for Medicare. Also, the home received approximately $293,000 less in reimbursements than possible for certain therapy services.

The home received less in these reimbursements because its manual procedures and automated systems do not adequately accumulate all the possible charges to Medicare, do not properly classify all the charges by complexity, and do not properly price all the charges. Factors outside the home's control, such as differences in facility size, complexity of cases, and patient demographics between the home and the comparable institutions, explain in part why the home received less in reimbursements. In addition, according to its reimbursements officer, the home provides residents with all medical services, including services which are not covered by Medicare. Other institutions may not provide these additional services. Moreover, according to the home's administrator, the lack of staff resources is a major factor in preventing the home from maximizing reimbursements.

- The home could have received up to approximately $446,000 annually in aid and attendance allowances if the federal Department of Veterans Affairs determines that 95 residents had been eligible to receive the allowances and if the home had obtained the statutory authority to receive the allowance for all veterans, including those with dependents.

Because the information is not available, we could not quantify the total lost revenue the home could have collected from residents if it had consistently verified income information on which fees were calculated. We also could not determine the total lost reimbursements the home could have received from Medicare and Medi-Cal if it had adequate manual billing procedures and automated systems. Because the home did not maximize revenue from residents and reimbursements from the federal government, support from the State's General Fund is higher than it needs to be. In addition, the cost of care to be recovered from residents is higher than it needs to be.

The home has implemented some corrective action to address these issues. For example, on February 1, 1994, it implemented new fees which we estimate will increase revenue annually by $1.1 million of the $2.1 million in possible additional revenue based on the maximum allowed by the Budget Act. In addition, on March 1, 1994, it began

assessing fees for February 1994 on the social security income not previously assessed. Further, the home is presently analyzing and implementing ways to improve its billing information system.

Background

The home at Yountville provides long-term residential care for aged and/or disabled war-time veterans. To offset costs, the California Military and Veterans Code allows the home to collect revenue from residents, which the home generally assesses as fees based on a percentage of the residents' income. The Budget Act for fiscal year 1993-94 allowed the home to collect fees of up to 70 percent of the residents' income and limited the total amount collected from residents to 40 percent of the State's general fund costs of the home for fiscal year 1993-94, approximately $9 million. The home is also eligible to receive reimbursements from the federal government and other third parties. For example, it may receive reimbursements from Medicare, Medi-Cal, the federal Department of Veterans Affairs, and third-party insurance companies. These fees and reimbursements reduce the home's costs that are supported by the General Fund.

The Home Has Not Maximized Revenue From Residents

The home's procedures, policies, and statutory limitations have prevented the home from maximizing revenue from residents. By not implementing adequate procedures and adopting policies to recover all possible fees, the home has not maximized revenue from residents, and support from the State's General Fund may be higher than it needs to be. For example, the home can collect up to $1.15 million more from residents if it assesses an estimated $150,000 annually in fees on some social security income received by residents and if it charges residents an additional $1.0 million annually by raising fees to the maximum allowed by the Budget Act.

In addition, the home does not have the authority to collect the state-funded cost of care provided to residents who leave the home to live somewhere else. For example, the state-funded cost of care provided to the approximately 100 residents who left the home in 1993 would have been approximately $787,000 if they had resided in the home for only one year and had received domiciliary care, the least costly level of care. The amount that the home might have recovered depends on the income and assets of the residents who left the home.

Further, because the information to determine all lost revenue is not available, we could not quantify the total lost fees the home could have collected from residents if it had consistently verified income information on which fees were calculated. The home has implemented some corrective action to address these issues. For

example, on February 1, 1994, it implemented new fees which we estimate will increase revenue annually by $1.1 million of the $2.1 million in possible additional revenue based on the maximum allowed by the Budget Act. In addition, on March 1, 1994, it began assessing fees for February 1994 on the social security income not previously assessed.

The Home Has Not Maximized Reimbursements From the Federal Government

By not implementing adequate procedures to recover all possible reimbursements, the home has not maximized reimbursements from the federal government. To determine how effective the home was in maximizing Medicare reimbursements, we compared the home's reimbursements with the reimbursements that comparable institutions received, with the reimbursements available based on its population of residents eligible for Medicare, and with its possible reimbursements for certain therapy services.

We reviewed the home's reimbursements in fiscal year 1992-93 and found that the home received $260,000 less in Medicare reimbursements for hospital care than it would have if it had been reimbursed at rates similar to comparable institutions. In addition, the home received $200,000 less in reimbursements for outpatient clinic visits than it would have if it had received reimbursements for the percentage of residents who were eligible for Medicare. Finally, the home received approximately $293,000 less in reimbursements than possible for certain therapy services.

The home received less in Medicare reimbursements because its manual procedures and automated systems do not adequately accumulate all the possible charges to Medicare, do not properly classify all the charges by complexity, and do not properly price all the charges. In addition, because the information to determine all lost reimbursements is not available, we could not determine the total lost reimbursements the home could have received from Medicare and Medi-Cal if it had adequate manual billing procedures and automated systems. Factors outside the home's control, such as differences in facility size, complexity of cases, and patient demographics between the home and the comparable institutions, explain in part why the home received less in reimbursements. Also, the home may have received less because, according to its reimbursements officer, the home provides residents with all medical services, including services which are not covered by Medicare. Other institutions may not provide these additional services. Moreover, according to the home's administrator, the lack of staff resources is a major factor in preventing the home from maximizing reimbursements.

Finally, the home could have received up to approximately $446,000 annually in aid and attendance allowances if the federal Department of Veterans Affairs determines that 95 residents had been eligible to receive the allowances and if the home had obtained the statutory authority to receive the allowance for all veterans, including those with dependents. Because the home did not maximize reimbursements, the cost of care to be recovered from residents and the State's General Fund is higher than it needs to be. The home has implemented some corrective action to address these issues. For example, the home is presently analyzing and implementing ways to improve its billing information system.

Recommendations

To further its efforts in maximizing revenue from residents and reimbursements from the federal government, the home should take the following actions:

- Continue to assess and collect fees on the social security income it reimburses the residents;
- Raise fees to residents to the maximum allowed by the Budget Act, while assuring that residents do not pay more than the state-funded cost of their care;
- Seek statutory authority to collect the state-funded cost of care from residents who leave the home to live somewhere else;
- Consistently verify income information from the residents;
- Develop an action plan for improving manual procedures that will capture all patient care charges;
- Continue analyzing and procuring a cost-effective management information system capable of supporting all aspects of the home's activities, including patient care, reimbursements, and general management information beneficial to the overall cost-efficient management of the home;
- Continue to develop procedures to ensure that aid and attendance allowances are received for all eligible residents; and
- Seek legislation to allow the home to receive aid and attendance allowances for residents with dependents who do not provide regular assistance to the residents.

Agency Comments

The Department of Veterans Affairs responded that it believes that the findings and recommendations contained in the report will help the home be more effective in providing services to California's aged and disabled veteran population. However, the department is concerned that raising fees to the maximum allowed by the Budget Act while assuring that residents do not pay more than their cost of care will have a negative impact on the quality of residents' lives. The department also notes that some amounts in our report, which we included for illustrative purposes, do not necessarily represent revenue or reimbursements that are attainable by the home. In addition, the department believes that the home will incur some costs to increase reimbursements.

Introduction

The Veterans Home of California (home) at Yountville, established in 1884, provides long-term residential care for aged and/or disabled war-time veterans. The home's mission is to provide an environment for veterans that improves overall health, reduces the incidence and severity of disabilities, increases social interaction, and promotes self-reliance and self-worth.

The home has a budgeted staff of approximately 860 employees and has 1,419 beds available in five levels of care. According to the home, some of the beds are currently vacant because some buildings are under construction. The levels of care provided at the home are domiciliary, licensed residential, intermediate, skilled nursing, and acute care. Residents in domiciliary care are self-sufficient and able to adequately perform all the activities of daily living. Residents in licensed residential care are self-sufficient and able to adequately perform daily living activities with minimal assistance. Residents in intermediate care receive some nursing care and supervision. Residents in skilled nursing care receive 24-hour inpatient care including medical, nursing, dietary, and pharmaceutical services. Residents in acute care receive hospital services, such as medical, psychiatric, or surgical services.

Residents of the home are honorably discharged war-time veterans, California residents, and over 62 years old or disabled. In addition, if space is available, spouses of eligible veterans who meet certain requirements may also live at the home.

The home is organized under the state Department of Veterans Affairs (department). The department estimates that during fiscal year 1993-94, the home will provide care for 1,125 residents at a cost of $45.6 million. Appendix A shows the population of residents by age and level of care as of June 30, 1993, and Appendix B shows the population of residents by time of admission to the home. In addition to the $45.6 million, the home also draws from the post fund to provide for the general welfare of its residents. The post fund pays the salaries of residents in a therapeutic employment program who provide services such as residential and restorative care. It also pays for other expenses, such as recreational activities for the residents. The home estimates that during fiscal year 1993-94, costs of $1.7 million will be paid from the post fund, which is not part of the State's budget.

Historically, the State's General Fund has paid for about one half of the home's costs. Residents' fees and charges (fees) as well as reimbursements from Medicare, Medi-Cal, the federal Department of Veterans Affairs (VA), and other third parties reduce the share of costs paid by the General Fund. Appendix C shows the current residents' fees, and Appendix D shows the average cost that would be paid by the General Fund by level of care based on fees at the maximum allowed by the 1993-94 Budget Act. In fiscal year 1992-93, the home reported $5.5 million in residents' fees, $4.7 million in Medicare reimbursements, $2.4 million in Medi-Cal reimbursements, $7.0 million in VA per diem reimbursements, $3.8 million in funds for construction, and $1.0 million in miscellaneous revenues. In fiscal year 1992-93, the State's general fund support was approximately $22.8 million, 48 percent of the home's $47.1 million operating cost.

The department plans to open a new veterans home in Barstow, California in fiscal year 1995-96. The new home is planned to accommodate a total of 400 residents, consisting of 220 residents in domiciliary care, 120 residents in intermediate care, and 60 residents in skilled nursing care. As a long-term goal, the department also hopes to open three more new homes in Southern California, each accommodating 400 residents. The information in this report should help the department maximize revenue from residents and reimbursements from the federal government in future veterans homes.

Scope and Methodology

The 1993-94 Budget Act (Chapter 55, Statutes of 1993) required the Bureau of State Audits to review the policies and procedures of the department for maximizing fees paid by residents of the home. The Budget Act required that the review evaluate the department's efforts to exhaust all sources of reimbursements from both the residents and the federal government. In addition, in August 1993, the Joint Legislative Audit Committee asked the Bureau of State Audits to include in the audit a review of the internal controls over the purchases of goods and services.

Revenue From Residents

To determine whether the home's policies and procedures maximized revenue from the residents, we reviewed the policies and procedures related to fees and interviewed staff at the home. Because the home assesses fees based on residents' income, we reviewed a sample of residents' files to determine whether the home verified the income information when the resident first provided it. We also determined whether the home assessed fees in accordance with its policies and whether it properly collected and deposited selected payments in fiscal year 1993-94. In addition, we estimated the increased revenue from

residents because of new fees implemented by the home as a result of the 1993-94 Budget Act provisions. We also estimated the increased revenue from residents if the home raises fees to the maximum allowed by the Budget Act.

Reimbursements From the Federal Government

To ascertain whether the home's policies and procedures maximized reimbursements from Medicare, we analyzed statistics, based on information from the Office of Statewide Health Planning and Development, for hospitals, and the home's Medicare cost reports. In addition, we focused on Medicare reimbursements for hospital care, outpatient clinic visits, and certain therapy services. We also reviewed internal documents and interviewed staff about the home's efforts to maximize reimbursements.

We reviewed reimbursements from the VA by analyzing significant fluctuations in the monthly claims for reimbursement in fiscal year 1993-94 and by ascertaining whether the home maximized reimbursements with certain waivers for veterans with large incomes.

Reimbursements From Other Third Parties

The fiscal year 1993-94 Budget Act did not require that we evaluate the home's efforts to maximize reimbursements from other third parties. However, we obtained some information on reimbursements from third-party insurance companies which is discussed in Appendix E.

Internal Controls Over Cash Receipts and Purchases of Goods and Services

Our review of internal controls over cash receipts focused on the areas observed during our testing of residents' fees. To determine whether the home has adequate internal controls over the purchases of goods and services, we reviewed internal controls including the separation of duties, the proper authorization for purchases and payments, the safekeeping of assets, and the reasonableness of expenditures from the State's General Fund. We tested some expenses for food, pharmaceuticals, minor equipment, and other operating expenses.

The results of our review are shown in Appendix F. Most of the issues related to the purchases of goods and services were brought to our attention by the home.

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Chapter 1 The Veterans Home of California Has Not Maximized Revenue From Residents

Chapter Summary

The procedures, policies, and statutory limitations of the Veterans Home of California (home) have prevented it from maximizing revenue from residents. By not implementing adequate procedures and adopting policies to recover all possible fees, the home has not maximized revenue from residents, and the State's general fund support may be higher than it needs to be. For example, the home can collect up to $1.15 million more from residents if it assesses an estimated $150,000 annually in fees on some social security income received by residents and if it charges residents an additional $1.0 million annually by raising fees to the maximum allowed by the Budget Act.

In addition, the home does not have the authority to collect the state-funded cost of care provided to residents who leave the home to live somewhere else. For example, the state-funded cost of care provided to the approximately 100 residents who left the home in 1993 would have been approximately $787,000 if they had resided in the home for only one year and had received domiciliary care, the least costly level of care. The amount the home might have recovered depends on the income and assets of the residents who left the home.

Further, because the information to determine all lost revenue is not available, we could not quantify the total lost fees the home could have collected from residents if it had consistently verified income information on which fees were calculated. The home has implemented some corrective action to address these issues. For example, on February 1, 1994, it implemented new fees which we estimate will increase revenue annually by $1.1 million of the $2.1 million in possible additional revenue based on the maximum allowed by the Budget Act. In addition, on March 1, 1994, it began assessing fees for February 1994 on the social security income not previously assessed.

Background

The California Military and Veterans Code allows the home to collect fees from residents, which the home generally assesses as a percentage of residents' income. In calculating fees, the home considers all of a resident's income except income used to support dependents, earnings from an employment program at the home, and interest income on money deposited at the home. The home does not assess fees on employment program earnings to encourage residents to participate in

the therapeutic program, nor does it assess fees on interest income paid by the home on deposits to encourage residents to maintain funds at the home. When residents deposit money at the home, the home is able to assist residents in paying fees when they are no longer able to function independently, gain immediate access to the residents' money when they die, and monitor the residents' eligibility for Medi-Cal.

The Budget Act for fiscal year 1993-94 allowed the home to collect fees of up to 70 percent of the residents' income and limited the total amount collected from residents to 40 percent of the State's general fund costs for the home for fiscal year 1993-94, approximately $9 million.

The Home Has Not Consistently Verified Income Information From the Residents

The home cannot be certain it has maximized revenue from residents because it has not consistently verified residents' income information on which fees were calculated. During fiscal year 1992-93, the home reported revenue of $5.5 million in fees. Instead of consistently verifying the residents' income information, the home has used the "honor system" and, generally, has verified income by requesting information from the Social Security Administration and by sending confirmation letters to the federal Department of Veterans Affairs (VA) only when it had questions regarding the income reported by residents.

We reviewed a judgmental sample of residents' files, regardless of when the residents were admitted to the home. According to the home's administrator, residents' income has been a factor in determining fees since the early 1970's. For 12 of the 45 residents' files reviewed, we found no evidence that the home verified income information when the resident first provided it, as early as 1978. The home verified some income information for some of the residents in subsequent years. However, it did not consistently verify income information, and we did not find evidence that any income information was ever verified for 3 of the 12 residents. According to the home's reimbursements officer, although the home has always requested documentation from residents to support their income, the home has no legal ability to obtain income information from outside sources when residents do not have documentation available. Although the home may not have the legal authority to obtain income information from outside sources, the California Military and Veterans Code, Section 1044, allows the home's administrator to prescribe conditions upon which residents remain with the home, which could include requiring that residents provide documentation of income.

Without consistent verification of income information, the home cannot be assured that it is assessing residents' fees on the proper amount of

income. For example, in November 1993, the former reimbursements officer identified 142 residents who, based on their low incomes, may be eligible to receive pensions from the VA. It is possible that these residents already receive pensions they did not report to the home. Thus, the home may have lost fees on the unreported income or on income that residents could have been receiving. The home is in the process of developing new procedures for tracking residents' applications for veterans' pensions. The discussion in Chapter 2 on aid and attendance allowances was part of the same review by the former reimbursements officer in November 1993.

It is not unusual for the government to verify income information. For example, the federal Housing and Urban Development Department provides housing assistance to individuals based on their income, requiring documentation which may include income tax returns and bank statements to support their alleged incomes. In addition, county welfare offices ensure individuals report all income by reviewing information from the Social Security Administration and tax, welfare, employment, and other agencies.

The Home Has Not Correctly Assessed Fees on Social Security Income

The home has not assessed fees on some social security income received by residents. By statute, the home pays for the insurance premiums for Medicare Part B, supplementary medical insurance coverage, on behalf of all residents. For residents who receive social security income, the insurance premiums are initially deducted from the benefit checks. The home subsequently reimburses the residents by crediting their trust accounts maintained at the home. However, the home has not assessed fees on the premiums reimbursed to the residents. Based on our analysis of the home's data from July through December 1993, the home has not assessed and collected estimated fees of $150,000 annually from residents.

According to the reimbursements officer, the home did not previously identify its repayment of the Medicare premiums to residents as income for fee purposes. On March 1, 1994, the home began assessing fees for February 1994 on the social security income not previously assessed.

The Home Has Not Raised Fees to the Maximum Allowed by the Budget Act

Instead of raising fees to the maximum allowed by the Budget Act, effective February 1, 1994, the home implemented new fees that increased residents' fees based on the level of care received. As shown in Appendix C, the new fees are generally 55 percent of income for residents in domiciliary and residential care, 65 percent of income for residents in intermediate care, and 70 percent of income for residents in

skilled nursing care. The new fees allow most residents to have remaining income of at least $165 monthly, which may be used as spending money. Spending money may be used for items besides room, board, and medical care, which are provided by the home. Residents with monthly incomes less than $165 are not assessed fees. The previous fees were generally 50 percent of income for all levels of care.

According to a memorandum dated December 28, 1993, the director of the department indicated that the new fees were based on the different levels of care so that no resident would pay more than the home's cost for providing care for the resident, which is paid by the State's General Fund. Appendix D displays the general fund support by level of care based on fees at the maximum allowed by the 1993-94 Budget Act. Based on the home's income information for December 1993 and average cost information for July through December 1993, if the home charges fees at 70 percent of income, as provided for in the Budget Act, only some 14 residents in domiciliary care, one resident in residential care, and 2 residents in intermediate care would be in a position to pay more than the home's average cost of care that is not reimbursed by the federal government.

Based on the home's records, we estimate that with the fees implemented on February 1, 1994, revenue will increase by approximately $1.1 million, from $6.1 million to $7.2 million annually. The home estimated that the new fees would increase revenue by $1.4 million annually. However, it overstated the increase because it did not include in the estimate the effect of income used for purposes such as alimony or dependent support, which the home exempts from fees. Because the new fees will be in place only 5 months during the year, we estimate that revenue will increase by approximately $460,000 for fiscal year 1993-94. These estimates are based on the population of residents at the different levels of care and their incomes as of December 1993. Any substantial changes in the levels of care received by the residents or their incomes may affect the increase in revenue.

In contrast, if the home had raised fees to the maximum allowed by the Budget Act for fiscal year 1993-94 while assuring that residents did not pay more than the state-funded cost of their care, we estimate that revenue would have increased by approximately $2.1 million, to $8.2 million annually. The state-funded cost of care is the home's cost not covered by residents' fees and reimbursements from the federal government or other third parties. By not increasing fees to the maximum allowed by the Budget Act, the home is losing approximately $1.0 million annually in revenue from residents.

In addition, if fees had been raised to the maximum, the average monthly income remaining for residents to use as spending money would have been at least $240. Currently, the average monthly income remaining for residents is at least $336. Because the average monthly income amounts do not include earnings from an employment program at the home and interest income on money deposited at the home, some residents have even more spending money available to them. For example, in fiscal year 1992-93, approximately 180 residents in the employment program earned approximately $400 monthly.

According to the home's administrator, historically some residents have responded to fee increases by leaving the home. However, residents leave the home for many reasons other than increased fees. For example, in 1993, approximately 100 residents left the home for reasons including the home discharging them for disciplinary problems or nonpayment of fees. Other residents found alternative living arrangements. The estimated increase of $2.1 million does not consider the potential decline in fees due to residents leaving the home. However, based on the home's records, we estimate that if the home raises fees to 70 percent of residents' income, regardless of the level of care, the average monthly fee would be approximately $600. Further, according to a survey of outside nursing facilities by the former reimbursements officer, monthly fees for residents receiving licensed residential, intermediate, and skilled nursing care ranged from $1,100 to $3,400 and did not include services provided by the home, such as physicians' services, acute medical care, therapy services, pharmacy, medical supplies, and transportation. Based on the survey results, we believe that it would not be economical for residents to leave the home instead of paying the increased fees.

The Home Does Not Have the Authority To Collect the State-Funded Cost of Care From Residents Who Leave the Home

The home has not collected the state-funded cost of care from residents who leave the home to live somewhere else. For example, we estimate that if the approximately 100 residents who left the home in 1993 had resided in the home for only one year and had received domiciliary care, the least costly level of care, the state-funded cost of care of residents who left the home to live somewhere else would have been approximately $787,000. The amount that the home might have recovered for the state-funded cost of care depends on the income and assets of the residents who left the home.

According to its administrator, if the home's policy was to recover the state-funded cost of care from residents who leave the home, some veterans may not enter the home because they would not want to be

responsible for the state-funded cost of care if they decided to leave, and others who could leave and resume their previous lives would be unable to leave without incurring a significant liability. Currently, the home is responsible for this liability because it is not able to collect the state-funded cost of care, not covered by residents' fees or federal reimbursements, unless residents remain at the home until their death. The home has the statutory authority to collect the state-funded cost of care from the estates of residents who remain at the home until their death. By statute, these collections are deposited in the post fund, which supplements the cost of care provided by the General Fund. The post fund pays the salaries of residents in a therapeutic employment program who provide services such as residential and restorative care. It also pays for other expenses, such as recreational activities for the residents. Although the home has the statutory authority to collect from the estates of residents who remain at the home until their death, it does not have the authority to collect the state-funded cost of care from residents who leave the home to live somewhere else. Because of this inconsistency in statutory authority, the estates of residents who remain at the home until their death may pay more for the residents' cost of care than residents who leave the home to live somewhere else. In a memorandum dated September 9, 1992, the administrator indicated that in Connecticut, residents at the veterans home retain $65 monthly for personal use, and the home bills either the resident or the resident's estate the full cost of care when the resident dies or leaves the home.

Conclusion

Because the home has not assessed fees on some social security income received by residents until recently and has not raised fees to the maximum allowed by the Budget Act, the State's general fund support may be up to $1.15 million higher than it needs to be. In addition, because the home has not had the authority to collect the state-funded cost of care provided to residents who leave the home to live somewhere else, the general fund support may be higher than it needs to be. For example, the state-funded cost of care provided to the approximately 100 residents who left the home in 1993 would have been approximately $787,000 if they had resided in the home for only one year and had received domiciliary care, the least costly level of care. The amount that the home might have recovered depends on the income and assets of the residents who left the home to live somewhere else. Further, because the information to determine all lost revenue is not available, we could not quantify the total lost fees the home could have collected from residents if it had consistently verified income information on which fees were calculated. The home has implemented some corrective action to address these issues. For example, on February 1, 1994, it implemented new fees which we

estimate will increase revenue annually by $1.1 million of the $2.1 million in possible additional revenue based on the maximum allowed by the Budget Act. In addition, on March 1, 1994, it began assessing fees for February 1994 on the social security income not previously assessed.

Recommendations

To further its efforts in maximizing revenue from residents, the home should take the following actions:

- Consistently verify income information from the residents;
- Continue to assess and collect fees on the social security income it reimburses residents for Medicare premiums;
- Raise residents' fees to the maximum allowed by the Budget Act, assuring that residents do not pay more than the state-funded cost of their care; and
- Seek statutory authority to collect the state-funded cost of care from residents who leave the home to live somewhere else.

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Chapter 2 The Veterans Home of California Has Not Maximized Reimbursements From the Federal Government

Chapter Summary

By not implementing adequate procedures to recover all possible reimbursements, the Veterans Home of California (home) has not maximized reimbursements from the federal government. To determine how effective the home has been in maximizing Medicare reimbursements, we compared the home's reimbursements with the reimbursements that comparable institutions received, with the reimbursements available based on its population of residents eligible for Medicare, and with its possible reimbursements for certain therapy services.

We reviewed the home's reimbursements in fiscal year 1992-93 and found that the home received $260,000 less in Medicare reimbursements for hospital care than it would have if it had been reimbursed at rates similar to comparable institutions. In addition, the home received $200,000 less in reimbursements for outpatient clinic visits than it would have if it had received reimbursements for the percentage of residents who were eligible for Medicare. Also, the home received approximately $293,000 less in reimbursements than possible for certain therapy services.

The home has received less in Medicare reimbursements because its manual procedures and automated systems do not adequately accumulate all the possible charges to Medicare, do not properly classify all the charges by complexity, and do not properly price all the charges. In addition, because the information to determine all lost reimbursements is not available, we could not determine the total lost reimbursements the home could have received from Medicare and Medi-Cal if it had adequate manual billing procedures and automated systems. Factors outside the home's control, such as differences in facility size, complexity of cases, and patient demographics between the home and the comparable institutions, explain in part why the home has received less in reimbursements. In addition, the home may have received less in Medicare reimbursements because, according to the home's reimbursements officer, the home provides residents with all medical services, including services that are not covered by Medicare. Other institutions may not provide these additional services. Moreover, according to the home's administrator, the lack of staff resources is a major factor in preventing the home from maximizing reimbursements.

Further, the home could have received up to approximately $446,000 annually in aid and attendance allowances if the federal Department of Veterans Affairs (VA) determines that 95 residents had been eligible to receive the allowances and if the home had obtained the statutory authority to receive the allowance for all veterans, including those with dependents. Because the home has not maximized reimbursements, the cost of care to be recovered from residents and the State's General Fund is higher than it needs to be. The home has implemented some corrective action to address these issues. For example, it is presently analyzing and implementing ways to improve its billing information system.

Background

The home receives reimbursements from Medicare for its eligible residents. Medicare insurance consists of Part A, hospital insurance, and Part B, supplementary medical insurance. Medicare Part A, hospital insurance, reimburses some costs of hospitalization and certain inpatient care, skilled nursing care related to short-term rehabilitation, and home health services. Medicare provides higher reimbursements for complex or difficult hospital procedures than for routine hospital procedures. Medicare Part B, supplementary medical insurance, reimburses the costs for most outpatient hospital services including clinic visits, certain therapy services, and physicians' services. Medicare reimburses the home for most of the cost of services. The remaining cost is the co-payment, which is normally the responsibility of the patient. However, the home does not collect the Medicare co-payments from residents. Instead, the co-payments are included in the cost of care, which is paid by the State's General Fund. Some of this state-funded cost of care is collected from some estates of residents, as discussed in Chapter 1.

The home also receives reimbursements from Medi-Cal for its eligible residents. The State of California's Medi-Cal program is funded 50 percent by the State's General Fund and 50 percent by the federal government. Medi-Cal reimburses the costs for both long-term and short-term skilled nursing care and generally the costs for hospital care, including inpatient care and outpatient care.

The Home Has Not Maximized Reimbursements From Medicare

The home has not maximized reimbursements from Medicare. To determine whether it was effective in maximizing Medicare reimbursements, we compared the home's reimbursements in fiscal year 1992-93 for hospital care with the reimbursements that comparable institutions received for fiscal years ending between June 30, 1991, and June 29, 1992. In addition, we compared the home's reimbursements with the reimbursements available for outpatient clinic visits based on its population of residents eligible for Medicare and with its potential reimbursements for certain therapy services. Finally, we identified conditions that demonstrate the home's inadequate manual billing procedures and automated systems.

The home was reimbursed $1.54 million for hospital care related to 350 patient discharges for an average reimbursement per discharge of $4,400. We compared these reimbursements for hospital care with reimbursements received by comparable institutions on a discharge basis when a patient is released from the hospital. Comparable institutions include co-payments in the reimbursements they report, so we increased the home's average per discharge reimbursement to $4,789 to include the co-payment. If the home had been reimbursed at the rate that comparable institutions were reimbursed, $5,532 per patient discharge, it would have received an additional $260,000 in Medicare reimbursements. The home may have received less in reimbursements for hospital care than comparable institutions because, according to its health record technician, it determines the complexity of hospital procedures billed to Medicare manually and by accessing Medicare's computer system. According to the department's chief of information technology services, in November 1993, the home installed a computer program that enhanced its determination of the complexity of hospital procedures billed to Medicare. The home may also have received less in reimbursements than comparable institutions because it does not perform complex hospital procedures.

In addition to the home's determination of the complexity of procedures, according to its reimbursement analyst, its computer system can record only one level of care per patient day, based on a 12:01 a.m. census. The different levels of care are discussed in the introduction. For example, according to the reimbursement analyst, if a patient uses a special room in the acute hospital for a specific procedure but is transferred back to skilled nursing the same day, the current patient day is recorded as a skilled nursing day, and the hospital room charges are not billed to Medicare. Although the home may not be billing all hospital room charges, it may be billing other charges to Medicare.

The home was reimbursed $1.49 million for outpatient care, including $990,000 for 15,096 outpatient clinic visits. In estimating the home's potential reimbursements for outpatient clinic visits, we included the effect of the average percentage of costs disallowed by Medicare for comparable institutions. If it had received reimbursements for outpatient clinic visits for the percentage of residents who were eligible for Medicare, the home would have received an additional $200,000. It may have received less in reimbursements because, according to the reimbursement analyst, its procedures do not ensure that it bills Medicare for the highest reimbursement possible based on the complexity of clinic visits and procedures performed. For example, according to the reimbursement analyst, the home may bill for an examination for heart problems but not increase the billing for complications related to an existing diabetes condition. Further, the home may have received less in reimbursements because, according to the home's reimbursements officer, it provides residents with all medical services, including services which are not covered by Medicare, such as necessary therapy maintenance, annual physicals, and trimming residents' nails. Other institutions may not provide these additional services.

Another reason the home received less in reimbursements is its procedures do not ensure that it bills Medicare for all reimbursable therapy visits and procedures. According to the home's chief of rehabilitation services, 50 to 75 percent of physical therapy treatments and 25 percent of both occupational and speech therapy treatments provided to residents are not reimbursable by Medicare, but are necessary to maintain the residents' current level of health. The following table compares the home's actual Medicare reimbursements with the potential reimbursements which have been reduced for the estimated treatments not reimbursable by Medicare. Note that the home's potential Medicare reimbursements for therapy services exceed the actual Medicare reimbursements by approximately $293,000.

	Potential Medicare Reimbursements	**Actual Medicare Reimbursements**
Physical therapy	$ 69,000	$4,246
Occupational therapy	175,000	1,735
Speech therapy	56,000	631
Total	**$ 300,000**	**$6,612**

The difference results, at least in part, from the home's inadequate procedures for billing therapy services. For example, based on a

memorandum dated November 22, 1993, from the former reimbursements officer, the home has not billed all therapy visits because it has not implemented procedures to ensure that the required documentation, such as entries in the residents' medical records, is completed by both the therapists and the referring physicians.

Although the home was reimbursed $700,000 for physician services, related to 15,096 patient visits, its procedures do not ensure that all physicians' services are billed. If the home would analyze the patient visits compared with reimbursements for each physician, it would have some assurance that all physicians' services are being billed. However, the home prepares statistics on physicians' services only for activity and related charges. These limited statistics do not provide the home with information on the effectiveness of the physician and medical staff to properly document the complexity of the patient's diagnosis and report all charges in order to recover the highest possible reimbursement. In addition, according to the department's chief of information technology services, because the home does not use all procedure codes and related prices allowed by Medicare, it sometimes underbills Medicare for physicians' services. The chief of information technology services further stated that the home has updated most of the prices for physicians' services; however, many procedure codes for services provided to residents are not entered into the home's billing system.

The home has not maximized reimbursements from Medicare because its manual procedures and automated systems do not adequately accumulate all the possible charges to Medicare, do not properly classify all the charges by complexity, and do not properly price all the charges. In addition, according to the chief of information technology services, procedure changes critical for correct billing that have been recommended both internally and by outside consultants have not been adequately and completely implemented, and although many changes have been made to the automated systems, the home has not fully implemented manual procedures to effectively use the modified systems. Moreover, the home did not develop an action plan to improve its manual billing procedures as discussed in a 1988 report by Deloitte, Haskins and Sells. Also, the home has only recently adapted procedures to bill certain therapy and restorative care services. According to the reimbursements officer, before 1993, the staff focused its efforts on the most recent Medicare billing changes imposed in 1990, which were required by 1993. According to the home's administrator, the lack of staff resources is a major factor in preventing the home from maximizing reimbursements. The administrator further stated that before fiscal year 1993-94, some employees at the home felt they had relatively little incentive to improve its reimbursements

because the home did not fully benefit from any increase in reimbursements.

In addition to the home's not implementing adequate manual and automated procedures, its computer system cannot process the information necessary to maximize revenues. According to the chief of information technology services, the present system lacks the capacity to provide complete billing information for all services provided.

The home has taken numerous steps to maximize the federal reimbursements it receives from Medicare. For example, the home contracted with Deloitte, Haskins and Sells for a review of its billing procedures. In addition, because it lacks the in-house expertise, beginning in 1991, the home contracted with an outside certified public accountant to analyze and prepare the annual Medicare cost reports. The accountant also provides recommendations for improving the home's procedures for billing Medicare. Moreover, in June 1993, the home established a part-time task force to discuss ways to increase reimbursements. However, the staff members who comprise the task force have other duties and are not able to focus all of their efforts on increasing reimbursements. The home is also presently analyzing and implementing ways to improve its billing information system. For example, it has analyzed the possibility of procuring a new management information system that would provide hospital, billing, and general management information.

In the home's Feasibility Study Review submitted to the Department of Finance in 1991, the home estimated that the proposed management information system would increase all reimbursements by $900,000. According to the chief of information technology services, patient care would also be improved with the new system. For example, according to the chief of information technology services, the system would allow a doctor to enter information on a computer related to the procedures performed on a patient, and the data would be automatically recorded in both the patient's medical file and the hospital's billing system. The chief of information technology services further stated that presently, the doctor records information on one document for the patient file and a second document for the billing system. Thus, the doctor's time is diverted away from providing patient care.

The Department of Finance approved the proposed system under the condition that the system be paid for with increased reimbursements. However, according to the chief of information technology services, additional analyses by the home determined that the projected reimbursements of the proposed system were not achievable. As an

alternative plan, the home is also considering the purchase of an information system that would cost less than a complete management information system. According to the chief of information technology services, the home is planning to seek approval for this alternative system without the condition that the system be paid for with increased reimbursements.

The Home Has Not Maximized Reimbursements From Medi-Cal

The home's inadequate manual billing procedures and automated systems that affect Medicare reimbursements also affect reimbursements from Medi-Cal, resulting in unmaximized reimbursements from Medi-Cal. For example, the home's procedures have not ensured that all possible outpatient charges are billed to Medi-Cal. However, the home has implemented procedures for billing inpatient charges to Medi-Cal and has also increased the number of residents enrolled in Medi-Cal by identifying residents who qualify for the program.

The Home Has Not Maximized Reimbursements From VA Aid and Attendance Allowances

The home has not maximized reimbursements received indirectly from the VA for aid and attendance allowances because it has not implemented adequate procedures to ensure that it assists all eligible residents in applying for the allowances and it has not monitored the status of the applications. The VA provides an aid and attendance allowance of $391 per month to residents who require the regular assistance of another person. In fiscal year 1992-93, the home reported approximately $746,000 from residents for aid and attendance allowances. In accordance with the Military and Veterans Code, Section 1012.2, the home collects the amount of the allowance from residents, although it can only collect from those without dependents. The amount collected is in addition to the fees. In November 1993, the home's former reimbursements officer identified 95 residents who may have been eligible to receive aid and attendance allowances from the federal Department of Veterans Affairs. The home could have received up to approximately $446,000 a year if those 95 residents had qualified for aid and attendance allowances and if the home had obtained the statutory authority to receive the allowance for all veterans, including those with dependents.

In a letter dated November 10, 1993, the home's administrator indicated that problems occur when residents do not report awards for aid and attendance allowances to the home. Sometimes, residents do not inform the home of large retroactive awards received. The administrator believes that federal legislation is necessary before the VA can pay the aid and attendance allowances directly to the home.

Until the home has the authority to directly receive aid and attendance allowances, the administrator has requested that the VA send the home copies of the award letters that are sent to residents. Then, the home would receive early notification of aid and attendance awards. The home is also working with the VA to determine whether the 95 residents not reporting aid and attendance allowances already receive these benefits. In addition, the home is in the process of developing new procedures for tracking residents' applications for aid and attendance allowances. Finally, the home is developing proposed legislation to revise the Military and Veterans Code so it will allow the home to collect all aid and attendance allowances regardless of whether a resident has dependents.

Another issue related to aid and attendance allowances concerns the instances in which the VA pays aid and attendance allowances to residents who are not eligible for the awards. According to the home's internal memoranda in September 1993, the home did not have a policy to address instances in which the home collected money from residents who were not eligible to receive aid and attendance allowances. According to the memoranda, when the VA realizes that the residents are not eligible for aid and attendance allowances, it holds them liable for repaying allowances even though the home collects the funds from residents. According to the home's reimbursements officer, when residents receive overpayment notices from the VA, the home must gather missing information on aid and attendance allowances from the resident or the VA to determine who is responsible for repayment.

VA Per Diem Reimbursements

The home also receives per diem reimbursements from the VA for care provided to residents who are eligible to receive care in a federal facility. These reimbursements are limited to $13.25 per day for each veteran receiving domiciliary care and $31.03 per day for each veteran receiving nursing home or hospital care.

To review per diem reimbursements from the VA, we analyzed significant fluctuations in the monthly claims for reimbursements in fiscal year 1993-94. In addition, we reviewed a sample of residents with incomes exceeding a certain amount to determine if the home received or requested a waiver for these residents. The VA does not

allow reimbursements for veterans with incomes exceeding a certain amount unless it approves a waiver based on the resident being temporarily unable to earn a living and having no adequate means of support. Based on our review, the home appears to be maximizing per diem reimbursements from the VA.

Conclusion

Because the home has not maximized reimbursements from the federal government, the State's general fund support may be higher than it needs to be. To determine how effective the home has been in maximizing Medicare reimbursements, we compared the home's reimbursements with the reimbursements that comparable institutions received, with the reimbursements available based on its population of residents eligible for Medicare, and with its possible reimbursements for certain therapy services. We reviewed the home's reimbursements in fiscal year 1992-93 and found that the home received $260,000 less in Medicare reimbursements for hospital care than it would have if it were reimbursed at rates similar to comparable institutions. In addition, the home received $200,000 less in reimbursements for outpatient clinic visits than it would have if it had received reimbursements for the percentage of residents who were eligible for Medicare. Also, the home received approximately $293,000 less in reimbursements than possible for certain therapy services. The general fund support may be even higher for the areas where we could not determine the total lost reimbursements. In addition, the home could have received up to approximately $446,000 annually in aid and attendance allowances if the VA determines that 95 residents had been eligible to receive the allowances and if the home had obtained the statutory authority to receive the allowance for all veterans, including those with dependents. Further, the effect of not maximizing reimbursements is that the cost of care to be recovered from residents is higher than it needs to be. The home has implemented some corrective action to address these issues. For example, the home is presently analyzing and implementing ways to improve its billing information system.

Recommendations

To further its efforts in maximizing reimbursements from the federal government, the home should take the following actions:

- Develop an action plan for improving manual procedures designed to capture all patient care charges. This effort should address the internal problems identified by the department as well as analyze benefits that may result from implementing the systems and procedures in the Deloitte, Haskins and Sells report and the

recommendations for improving the home's procedures for billing Medicare made by the certified public accountant who prepares the Medicare cost reports;

- Continue analyzing and procuring a cost-effective management information system capable of supporting all aspects of the home's activities, including patient care, reimbursements, and general management information beneficial to the overall cost-efficient management of the home;

- Seek the authority to receive aid and attendance allowances directly from the VA. In addition, the home should collect unreported aid and attendance allowances from residents;

- Continue to develop procedures to ensure that aid and attendance allowances are received for all eligible residents; and

- Seek legislation allowing the home to receive aid and attendance allowances for residents with dependents who do not provide regular assistance to the residents.

We conducted this review under the authority vested in the state auditor by Section 8543 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope of this report.

Respectfully submitted,

KURT R. SJOBERG
State Auditor

Date: April 19, 1994

Staff: Philip Jelicich, CPA, Audit Principal
Lisa Foo, CPA

Appendix A Veterans Home of California Population by Age and Level of Care As of June 30, 1993

Age	Domiciliary	Residential	Intermediate	Skilled Nursing	Acute	Total
+100			1	4		5
95-99	2	1	10	24		37
90-94	5	7	10	20		42
85-89	28	9	12	27	1	77
80-84	39	12	13	58	1	123
75-79	95	22	33	34	1	185
70-74	169	18	26	65	1	279
65-69	129	15	35	22	2	203
60-64	74	13	8	26		121
55-59	23	2	1	1		27
50-54	9		1	2		12
45-49	14	1	1			16
40-44	2					2
Total	**589**	**100**	**151**	**283**	**6**	**1,129**

Source: Veterans Home of California

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Appendix B Veterans Home of California Residents by Time of Admission to the Home As of June 30, 1993

Year of Admission	Number of Residents
1952 to 1959	7
1960 to 1969	23
1970 to 1979	109
1980 to 1989	606
1990	131
1991	113
1992	31
1993	109
Total	**1,129**

Source: Veterans Home of California

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Appendix C Residents' Monthly Fees Effective February 1, 1994

Residents With Monthly Incomes of $165 or Less - No fees are assessed.

Domiciliary and Residential Care - Fees are 55 percent of monthly income up to a maximum fee of $1,200. For those residents with monthly incomes between $166 and $367, fees are the amount in excess of $165.

Intermediate Care - Fees are 65 percent of monthly income up to a maximum fee of $2,300. For those residents with monthly incomes between $166 and $471, fees are the amount in excess of $165.

Skilled Nursing Care - Fees are 70 percent of monthly income up to a maximum fee of $2,500. For those residents with monthly incomes between $166 and $550, fees are the amount in excess of $165.

Acute Care - Fees are based on the level of care to which the residents return after the hospital stay. For those residents who return to skilled nursing care, there is a 60-day period for which the home does not charge the resident fees based on 70 percent of the monthly income. The home provides this grace period because Medicare reimburses the home for the first 60 days after an acute hospital stay.

Married Couples - Fees are based on the current fee schedule with income defined as 50 percent of the couple's combined income with a minimum monthly fee of $600 for nonveteran spouses. If a resident is survived by a nonveteran spouse, the fees for the nonveteran spouse are based on the current fee schedule.

Income - All income a resident receives except income used to support dependents, earnings from an employment program at the home, and interest income earned on money deposited at the home.

Source: Veterans Home of California

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Appendix D Average Monthly General Fund Support Per Resident for Different Levels of Care[a] If Fees Were Charged at the Maximum Allowed by the 1993-94 Budget Act

Level of Care	Average Monthly Cost of Care[b]	Average Monthly Federal Reimbursements[b,c]	Average Monthly Fees At 70 Percent of Income	Average Monthly General Fund Support
Domiciliary	$1,851	$ 610	$565	$ 676
Residential	1,987	610	612	765
Intermediate	3,825	1,349	753	1,723
Skilled Nursing	4,766	1,956	784	2,026

[a] Does not include the acute level of care because it is not a residential level of care.

[b] Based on information from July through December 1993 from the Veterans Home of California.

[c] Reimbursements from Medicare, Medi-Cal, and the federal Department of Veterans Affairs.

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Appendix E Third-Party Insurance Reimbursements

The Veterans Home of California (home) does not bill third-party insurance companies because it does not have the manual billing procedures or automated systems to bill them. In addition, according to the home's reimbursements officer, the home receives reimbursements from insurance companies for charges which Medicare automatically forwards to insurance companies.

The home does not know whether implementing manual and automated procedures for billing third-party insurance companies will be cost-effective. According to the reimbursements officer, although the home is currently analyzing the potential increased reimbursements from insurance companies, it is concentrating available resources in areas in which there may be higher reimbursements.

Moreover, the reimbursements officer believes that many residents do not maintain their insurance because the home provides medical care and because there is no financial incentive, such as reducing the monthly fees of residents who maintain insurance coverage. Further, residents who retain health insurance are generally limited to residents who have retirement plan coverage, residents who travel, or residents who feel they may leave the home because most residents do not want to pay monthly insurance premiums when the home provides the care regardless of coverage.

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Appendix F Noncompliance With the State's System of Internal Controls

The Veterans Home of California Did Not Always Deposit Cash Receipts From Residents' Fees in Total for Each Day

The State Administrative Manual, Section 8030.1, states that agencies will not withhold receipts for the purpose of establishing or augmenting change funds but will deposit all funds received intact. However, the Veterans Home of California (home) sometimes deposited the cash receipts from residents' fees over a period of two to three days instead of depositing the receipts in total for each day. Not depositing receipts in total for each day makes the cash receipts vulnerable to misuse. According to the home's reimbursements officer, the home began depositing cash receipts from residents' fees in total for each day after March 1, 1994.

The Home Did Not Always Comply With the Law in Establishing and Maintaining Contracts With Vendors

The California Public Contract Code, Section 10295, states that all contracts, unless otherwise exempt, entered into by any state agency for the purchase of equipment, supplies, materials, services, or construction are void unless or until approved by the Department of General Services (DGS). The State Administrative Manual, Section 1215, requires that contracts exceeding $15,000 and interagency agreements exceeding $35,000 be approved by the DGS. In addition, the State Administrative Manual, Section 1254, requires that evidence of insurance for hazardous activities be approved by the DGS, the Office of Insurance and Risk Management, and the Office of Legal Services. Further, the State Administrative Manual, Section 1216, states that any contracts in which the State holds another party harmless must be approved by the DGS.

However, the home entered into contracts for goods and services from two state agencies and one pharmaceutical supplier of medical equipment before the contracts, for the period in which the goods and services were to be received, were signed and approved by the DGS. Each interagency agreement exceeded $35,000, and the contract with the supplier exceeded $15,000.

In addition, the home entered into agreements for services from 14 physicians and physician groups and 5 institutions that provided special care to residents without contracts including the required DGS approval. The home did not obtain the required DGS approval for malpractice insurance and hold-harmless clauses indemnifying the contractor against any legal action by the State. The home has begun converting the agreements to standard contracts approved by the DGS.

As part of the conversion, the home requested that the internal law office at the state Department of Veterans Affairs review whether the home inappropriately required the physicians to waive Medicare co-payments.

The Home Has Exchanged Goods for Services and Equipment

The California Government Code, Section 12410, requires that the state controller audit all claims against the State and gives it the authority to audit the disbursement of any state money for correctness, legality, and sufficient provisions of law for payment. However, the home has not allowed the state controller to audit claims against the State for certain services and medical equipment worth more than $15,000 from a pharmaceutical vendor. The home has circumvented the State's internal controls over payments to vendors by exchanging bulk dietary supplements for services and medical equipment. The home has begun working on proposals for requests for bids for a new contract that does not provide for the exchange of goods for services and equipment.

The Home Is Not Properly Recording and Safeguarding All Inventory

The State Administrative Manual, Section 10860.1, requires that the accounting office maintain the official inventory records. In addition, Section 10860 describes the procedures for taking physical inventories and reconciling the differences between the actual physical inventories and the inventory records. However, the accounting office does not maintain the inventory records for the central and maintenance warehouses. In addition, the accounting office does not verify the results of physical inventories taken by the central and maintenance warehouses.