Audit on the Status of Operation and Management of Long-Term Care Institutions

Disclosed on March, 2020

Ⅰ. Overview

1. Audit Background

The Long-Term Care Insurance (LTCI) program was launched in 2008 to provide long-term care services for elderly experiencing difficulties in performing daily activities due to old age or geriatric disease. The number of LTCI beneficiaries (the insured actually receiving the benefits of the insurance) increased from 210,000 (4.2% of the elderly population) in 2008 to 670,000 (8.8% of the elderly population) in 2018.

With the increased number of LTCI beneficiaries, the LTCI spending spiked by more than tenfold - from KRW 573.1 billion in 2008 to KRW 6.675 trillion in 2018. At the same time, the LTCI revenue increased from KRW 751.8 billion in 2008 to KRW 6.065 trillion in 2018. As the amount of spending is growing faster than the amount of revenue, the LTCI has faced a deficit since 2016, which raises concerns about its financial sustainability.

It has been reported that instances of fraud continue to occur in the process of paying and receiving the Long-Term Care (LTC) benefit costs due to inadequate management, resulting in financial leakages. The Board of Audit and Inspection (BAI) was requested by a non-governmental organization, “People’s Solidarity for Participatory Democracy” (PSPD), to investigate whether the heads of local

governments (Si/Gun/Gu) were imposing appropriate penalties on the LTC institutions where elder abuse was taking place, and to examine whether the Ministry of Health and Welfare (MOHW) was appropriately supervising the related organizations and facilities.

Thus, the BAI conducted an audit related to long-term care institutions, focusing its audit on the following:

a) Whether long-term care institutions get reimbursed for their operational and service costs in a reasonable way

b) Whether relevant authorities oversee the financial status of LTC facilities and review the reimbursement claims properly

c) Whether local governments supervise the operations of LTC facilities and issue administrative penalties in an appropriate way

2. Audit Focus

The purpose of the audit is to find out the factors deteriorating financial sustainability and to enhance supervision over long-term care facilities.

In 2018, the LTC benefit costs that were paid back to the LTC facilities for the elderly accounted for 42% (estimated KRW 2.95 trillion) of the entire LTC benefit costs, while the number of senior-only LTC facilities accounted for 11% (3,389 out of 33,312) of all LTC institutions. As the senior-only LTC facilities receive the highest reimbursements for incurred costs among all LTC institutions, the BAI examined whether these facilities were providing quality services and operating in an appropriate manner.

The BAI also reviewed whether the relevant authorities (including the MOHW) supervised LTC facilities and imposed administrative penalties on the facilities involved with unfair and illegal affairs, such as financial fraud and elder abuse, as requested by PSPD. The appropriateness of the medical fee schedules for the LTC services and the management of beneficiaries are also included as audit focuses.

3. Audit Process

Before the on-site audit, the BAI conducted preliminary studies based on the financial condition of the Long-Term Care Insurance, accounting reports of the LTC facilities for the elderly, research papers, news articles, etc. Auditors selected certain expenditure items to monitor by analyzing the balance sheets that the senior-only LTC facilities had submitted, and to identify areas to focus on by interviewing public officials responsible for these LTC facilities.

The on-site audit took place from July 8 to September 6, 2019, with the auditors analyzing the data and electronic documents of MOHW and the National Health Insurance Service (NHIS) to identify areas to be improved. In cooperation with the local governments authorized to supervise the LTC facilities, the auditors visited the facilities to check the status of their accounting.

4. Audit Result

A closing meeting with the auditees, including the Director of Population Policy of the MOHW, was held on October 16, 2019, to listen to the auditees' opinions regarding what was found during the audit. The audit team also sent out questionnaires to the auditees and received their written comments to proceed with the audit report. The Council of Commissioners then provided resolution to the audit report on March 19, 2019, to finalize the audit results, taking into account the written comments received from the auditees.

Ⅱ. Long-Term Care Insurance

1. Overview

1) Definition

The Welfare Services Guidelines published by the MOHW defines LTCI as a social security program that provides long-term care benefits such as aid for physical activities and household chores, money, etc., to those who have difficulties in carrying out activities of daily living due to old age or geriatric disease, thereby improving the quality of their post-retirement life, as well as relieving the burden of the family members.

2) Eligibility and Assessment

Regardless of income, those who meet the following eligibility requirements can file an application for approval for long-term care benefits.

a) The LTCI insured,* dependent(s) of the LTCI insured, or the recipient of medical benefits (*NHI insured is the same as LTCI insured)

b) People age 65 or older, or people under age 65 who have difficulties in carrying on with daily activities due to geriatric disease(s) (e.g. dementia, paralysis, and Parkinson's disease)

If an eligible person files an application for approval for long-term care benefits, the NHIS investigates the mental and physical status of the applicant, the types and details of the long-term care benefits that the applicant needs, and other matters, as deemed necessary.

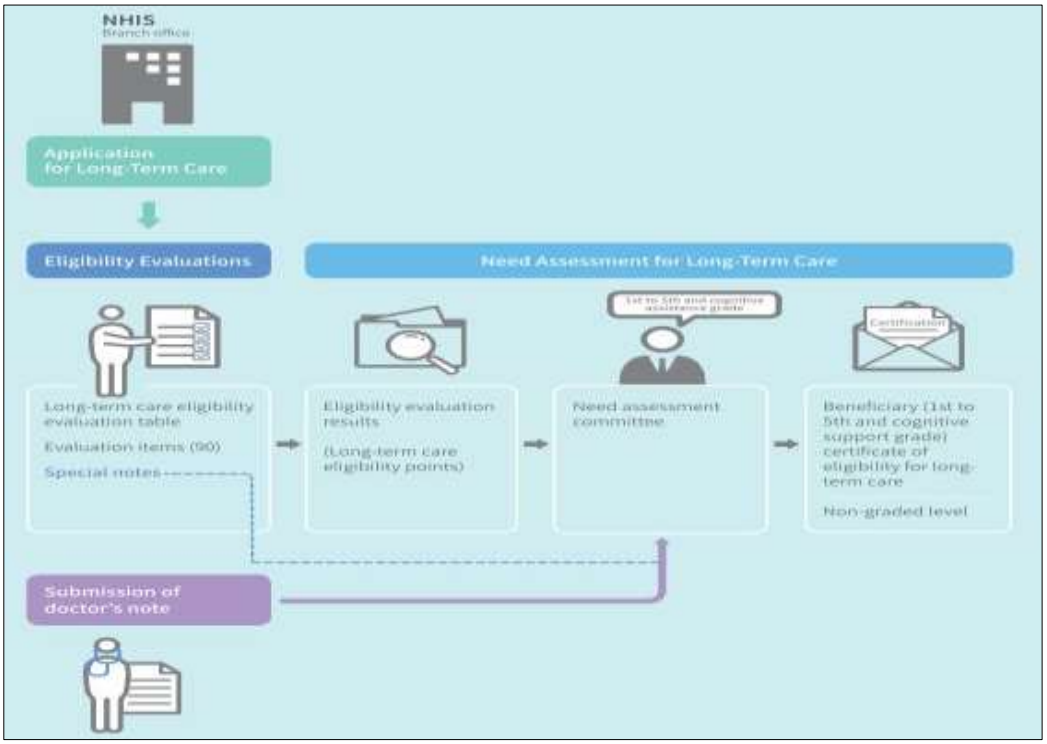
The Need Assessment Committee then assigns a grade by referring to the written examination, medical opinions, and other relevant documents. According to the grade, beneficiaries receive different types of LTC benefits. The standards for the need assessment grade is as follows.

[Table 1] Points and capacity level for approval

Grade	Conditions	Points
Grade 1	Who needs another person's help **entirely** for his/her daily life	Over 95 points
Grade 2	Who needs another person's help **substantially** for his/her daily life	Between 75and 95
Grade 3	Who needs another person's help **partially** for his/her daily life	Between 60 and 75
Grade 4	Who needs another person's help **to a certain extent** for his/her daily life	Between 51 and 60
Grade 5	A dementia patient (limited to dementia falling under the category of geriatric disease)	Between 45 and 51
Cognitive Support Grade	A dementia patient (limited to dementia falling under the category of geriatric disease)	Under 45

* Grade 1 and 2 beneficiaries can use in-home care or institutional care, but those of grades 3, 4, 5 use in-home care rather than institutional care.

[Picture 1] Application process for assessment



3) Types of long-term care benefits

Benefits for home care services (in-home service benefits): a caregiver visits the beneficiaries' home to provide care services, such as physical activity support, housekeeping, bathing, nursing, day and night care, short-term care, and equipment services.

Institutional care benefits (facility benefits): the beneficiaries reside in long-term care facilities to receive physical activity support, as well as education and training which help them maintain and improve their physical and mental conditions.

Care allowance for special cases (special cash benefits): provided for eligible people who face difficulty using a residential long-term care facilities due to geographical barriers, physical or personality issues, etc.

4) LTCI management system

LTCI is operated by MOHW, NHIS, Long-Term Care Committee, and local governments.

[Table 2] LTCI management

	Roles and Functions
Ministry of Health and Welfare	● Establishment, management and improvement of policy ● Overall responsibility and authority for the operation and management of the program
National Health Insurance Service (227 centers)	● Management of the eligibilities of the LTCI insured, their dependents, and medical benefits recipients ● Collection of LTCI contributions ● Operation of Need Assessment Committee and LTC eligibility rating determination ● Management and evaluation of long-term care benefits ● Review and payment of benefit costs, etc.
Long-Term Care Committee	● Review long-term care contribution rate and benefit costs
Local Governments	● Oversight over long-term care facilities

2. Financial Condition of Long-Term Care Insurance

1) Revenue

LTCI is financed by LTCI contributions (63.4%), state subsidies (11.8%), medical aid contributions (23.7%) and other receipts (e.g. interest 1.1%).

[Table 3] Types and percentage of LTCI revenue

(as of 2018)

Types	Percentage	Description
LTCI contributions	63.4%	NHI contributions x LTCI contribution rate
State subsidies	11.8%	According to Article 58 of the LCTI Act, the State shall annually provide the NHIS with an amount equivalent to 20/100 of the estimated revenue of LTCI contributions*
Medical aid contributions**	23.7%	Expenses incurred in relation to medical aid beneficiaries' LTCI benefits shall be borne by the State and local governments
Other receipts	1.1%	Interest, etc.

*The actual percentage is averaged at 18.4% of the estimated LTCI revenue

**Medical aid contribution is provided to the recipients of basic livelihood security program benefits, etc. and is borne by the State and local governments.

LTCI contributions, which account for the largest portion of the LTCI revenue are collected together with the NHI contributions by the National Health Insurance Service. The LTCI contributions are calculated by multiplying the LTCI contribution rate to the amount of the NHI contribution, which is calculated by multiplying the NHI contribution rate to the income of the insured. From 2010 to 2017, the LTCI contribution rate remained unchanged at 6.55% of the NHI contribution rate and increased by 0.83% to be 7.38% in 2018. It increased again in 2019 reaching at 8.51% of the NHI contribution rate.

[Table 4] LTCI contribution rate

From 2010 to 2019 (percentage)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
NHI contribution rate	5.33	5.64	5.80	5.89	5.99	6.07	6.12	6.12	6.24	6.46
LTCI contribution rate	6.55	6.55	6.55	6.55	6.55	6.55	6.55	6.55	7.38	8.51
NHI contribution rate **x** LTCI contribution rate	0.35	0.37	0.38	0.39	0.39	0.40	0.40	0.40	0.46	0.55

2) Spending

LTCI spending is comprised of long-term care benefit costs (which are reimbursed to the long-term care facilities, etc.) and operating costs. The long-term care benefit costs that account for 95.2% of the entire expenditure as of 2018 are affected by the number of people eligible for LTC benefits, medical fees, and the NHIS's co-payment rate.

[Table 5] Types of LTCI spending

(as of 2018)

Types	Percentage	Description
LTC benefit costs	95.2%	● Number of eligible people x rate of using LTC services x medical fees per person x NHIS's co-payment rate ● Costs of purchasing devices necessary for assisting beneficiaries
Other costs	4.8%	● Management and operating costs

Medical fees are one of the major factors affecting LTCI expenditure. Taking into account the inflation rate and minimum wage increase rate, medical fees have either maintained or increased between 0.65% and 11.34%.

[Table 6] Rate of increase of medical fees

(%)

	'08	'09	'10	'11	'12	'13	'14	'15	'16	'17	'18	'19
Increase rate	-	2.05	0.65	-	1.86	4.67	4.3	-	0.97	4.08	11.34	5.36

With the aging population increasing and with the introduction of the "National Responsibility Policy for Dementia Care," the number of those eligible for LTC benefits is steadily increasing. Additionally, as of 2018, it has become possible for patients who have no difficulties in carrying out physical activities to receive LTC services if they are deemed having difficulties in carrying out daily activities on their own due to dementia. As a result, the number of people eligible increased from 214 thousand in 2008 to 671 thousand in 2018.

[Table 7] Number of people eligible for LTC benefits

(thousand people, %)

	’08	’09	’10	’11	’12	’13	’14	’15	’16	’17	’18
Number of aging population (aged over 65)	5,086	5,286	5,449	5,645	5,922	6,193	6,463	6,719	6,940	7,311	7,611
Number of people eligible for LTC benefits	214	258	270	324	342	348	425	468	520	585	671
Increase in number over last year	-	44	12	54	18	36	47	43	52	65	86
Eligibility rate	4.2	4.9	5.0	5.7	5.8	6.1	3.3	7.0	7.5	8.0	8.8
Major policy	-	-	-	-	***1***	***2***	***3***	-	***4***	-	***5***

**1. The minimum score for Grade 3 was lowered from 55 to 53 in 2012*

2. The minimum score for Grade 3 was lowered from 53 to 51 in 2013

3. Grade 3 was divided into Grades 3 and 4; Grade 5 was newly created in 2014

4. Criteria for LTC benefits eligibility was eased in 2016

5. Dementia patients fell into the category of Cognitive Support Grade regardless of their physical ability (in 2018)

3) Changes in financial condition

Both the revenue and spending of the LTCI increased from 2008 to 2018, but the amount of money spent has risen faster than money received. The revenue increased from KRW 751.8 billion in 2008 to KRW 6.07 trillion in 2018 (23% annually), while the spending increased from KRW 573.1 billion in 2008 to KRW 6.07 trillion in 2018 (28% annually). In other words, the revenue in 2018 was seven times the revenue in 2008 and the spending in 2018 was an estimated eleven times more than in 2008.

Accordingly, the account balance turned into a deficit since 2016 with the deficit amount reaching KRW 610.1 billion in 2018. The amount of accumulated reserves that had steadily increased from KRW 178.7 billion in 2008 to KRW 2.35 trillion in 2015 began to decrease from 2015, falling to KRW 1.37 trillion in 2018.

[Table 8] LTCI financial status

(KRW billion)

	'08	'09	'10	'11	'12	'13	'14	'15	'16	'17	'18
Revenue	7,518	20,238	27,720	31,732	34,706	37,472	40,439	43,253	46,635	50,846	60,657
LTCI contributions	3,723	11,371	17,509	20,806	23,137	24,969	26,612	28,479	30,506	32,328	38,474
State subsidies	1,181	2,044	3,323	3,883	4,152	4,591	5,033	5,166	5,525	5,822	7,107
Medical aid contributions	2,575	6,689	6,708	6,779	7,028	7,450	8,068	8,812	9,773	12,069	14,386
Other receipts	39	134	180	264	389	462	726	796	831	627	690
Spending	5,731	18,791	25,547	27,714	29,113	32,915	37,399	42,344	47,067	54,139	66,758
LTC benefit costs	4,585	17,236	23,916	25,894	27,244	30,898	35,012	39,738	44,120	51,127	63,521
Operating costs	1,146	1,555	1,631	1,820	1,869	2,017	2,387	2,606	2,947	3,012	3,237
Account balance	**1,787**	**1,447**	**2,173**	**4,018**	**5,593**	**4,557**	**3,040**	**909**	**(432)**	**(3,292)**	**(6,101)**
Accumulated reserves	**1,787**	**3,234**	**5,407**	**9,425**	**15,018**	**19,575**	**22,615**	**23,524**	**23,092**	**19,799**	**13,698**

The financial projection report that the MOHW submitted to the Long-Term Committee on August 28, 2019, shows that without an increase in LTCI contribution rate, the accumulated reserves would be depleted by 2020. The accumulated deficit is projected to reach KRW 9.94 trillion by 2023; this is an unsustainable path.

[Table 9] LTCI financial projection

(KRW billion)

	2019	2020	2021	2022	2023
Revenue	74,844	84,014	93,070	101,954	111,623
Spending	82,374	96,437	113,310	132,292	154,217
Account balance	**(7,530)**	**(12,423)**	**(20,240)**	**(30,338)**	**(42,594)**
Accumulated reserves	**6,168**	**(6,255)**	**(26,495)**	**(26,495)**	**(99,427)**

The increase of LTC benefit costs since 2016 when the account balance turned into a deficit is attributable to the extended number of beneficiaries, increasing medical fees, and effects of policy improvements (e.g. "National Responsibility Policy for Dementia Care").

In 2018, the LTC benefit costs increased by KRW 1.24 trillion compared to the previous year. Among the increased amount, KRW 697.4 billion, KRW 550.2

billion and KRW 81.8 billion were attributable to the increase in the number of beneficiaries, increase in medical fees and the effects of policy improvements, respectively.

[Table 10] 2016-2018 LTC benefit costs

(KRW billion)

		2016	2017	2018	2019
Total		47,068	54,139	66,758	79,636
LTC benefit costs		44,120	51,127	63,521	76,000
Increased amount over the previous year	Increased number of beneficiaries	3,532	4,162	6,074	6,994
	Increase in medical fees	727	2,456	5,502	4,149
	Effects of policy improvement	122	386	818	1,336
	Subtotal	4,381	7,007	12,394	13,249
Operating costs		2,948	3,012	3,237	3,636

3. Long-Term Care Institution

1) Types of and services provided by long-term care institutions

There are three types of long-term care (LTC) facilities: (1) LTC facilities or communal living homes for the elderly where beneficiaries reside in and receive residential care, (2) facilities that provide home care benefits by having its staff (caregivers) visit the beneficiaries' homes and provide necessary services or at the facilities where beneficiaries stay for short-term care, day care, or night care, and (3) centers that provide beneficiaries with welfare equipment necessary for daily life.

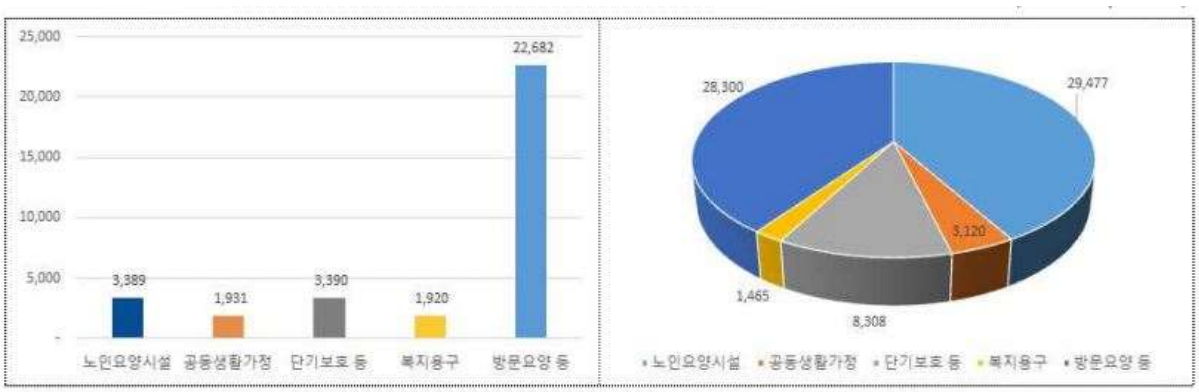
[Table 11] LTC benefits provided by LTC institutions

Category of LTC Benefits	Provided Services	Types of LTC Institutions
Institution-based benefits	◆ Beneficiaries live at the facilities for residential care	◆ LTC facilities for the elderly ◆ Communal living for the elderly

Home-based benefits	Visiting care, bathing, nursing services	◆ Caregivers regularly visit beneficiaries' homes to provide services	◆ Center for providing home care services
	Short-term care, day/night care	◆ Beneficiaries visit the facilities for short-term/day/ night care service while they reside at their home	◆ Transport provided to/from welfare facility for the elderly
	Provision of welfare equipment	◆ Beneficiaries provided with welfare equipment necessary for their daily life	◆ Center for welfare equipment service

The number of LTC institutions totaled at 33,312 as of December 31, 2018, and the LTC institutions were reimbursed an estimated KRW 7.67 trillion for LTC benefit costs.

[Picture 2] Number of LTC institutions and incurred LTC benefit costs



2) LTC facilities for the elderly

In 2018, the LTC benefit costs reimbursed to the LTC facilities for the elderly accounted for 42% (KRW 2.947 trillion) of the entire LTC benefit costs, while the number of LTC facilities for the elderly accounted for 11% (3,389 out of 33,312) of the LTC institutions. This is because the LTC facilities for the elderly involve much more operational, management and labor costs than other types of LTC institutions.

The number of LTC facilities for the elderly increased by 145% from 1,385 in 2009 to 3,389 in 2018. The small-sized facilities where the accommodation capacity is less than 29 people increased from 550 facilities in 2008 to 1,697 in 2018, accounting for 50% of the total number of LTC institutions as of 2018.

[Table 12] Number of LTC facilities for the elderly by size

(2008-2018)

Accommodation capacity	08	09	10	11	12	13	14	15	16	17	18
Total	1,385	1,694	2,408	2,489	2,588	2,498	2,713	2,935	3,185	3,289	3,389
Between 10 to 29	550	700	1,184	1,232	1,276	1,153	1,284	1,424	1,539	1,647	1,697
Between 30 to 49	233	292	386	406	434	429	460	499	585	585	594
Between 50 to 69	334	356	389	373	356	333	325	327	337	300	293
More than 70	268	346	449	478	522	583	644	685	724	757	805

3) Oversight of LTC facilities for the elderly

Since the introduction of the LTCI in 2008, the MOHW enables the private sector to operate the LTC facilities for the elderly to secure sufficient facilities and human resources. As a result, privately owned LTC facilities accounted for 97% of the total facilities as of 2018.

[Table 13] LTC facilities for the elderly by ownership

Run by	Total	Public sector	Private sector			
			Individual business owner	For-profit corporation	Social welfare corporation	Non-profit corporation
No. of facilities	3,389	100	2,120	159	779	231
Percentage	100	2.9	62.6	4.7	23.0	6.8

The LTC facilities for the elderly provide long-term care services to beneficiaries and get reimbursed the incurred service costs from the National Health Insurance Service (NHIS). The reimbursed LTC cost is financed by the LTCI contribution that the insured pay. It is necessary to ensure that the LTC facilities run by the private sector provide quality services, and that the LTC benefit cost and its reimbursement claims are appropriate.

The MOHW has the responsibility and authority over the operation and management of the Long-Term Care Program. The ministry also sets the laws, regulations and standards involved in the operation of the program including the Long-Term Care Insurance Act and the Financial Accounting Standards for

Social Welfare Institutions. The local governments (-Si, -Gun, -Gu) have the authority to supervise the LTC facilities by ordering them to submit accounting reports and issuing administrative penalties to the facilities when necessary. As the administrative and operating body of the LTCI program, the National Health Insurance Service (NHIS) is responsible for managing the eligibility of the LTCI insured, as well as for reviewing the LTC benefit costs and LTC cost reimbursement claims.

[Table 14] Oversight by the NHIS and local governments

Local governments	National Health Insurance Service
◆ Establishing, designating and cancelling LTC facilities ◆ Reviewing and endorsing financial documents and accounting reports ◆ Issuing administrative penalties, etc.	◆ Levying and collecting contributions ◆ Performing background checks on insurance applicants ◆ Reviewing and issuing benefit cost payments ◆ Levying and collecting unfairly reimbursed LTC benefit costs, etc.

The LTC facilities for the elderly get reimbursed for LTC benefit costs, but the reimbursement is different in nature from government subsidies or government funds that are subject to the BAI's financial audit. Thus, the BAI did not target the LTC facilities directly. Rather, the audit focused on whether the MOHW operates the program in an appropriate way and whether the MOHW appropriately supervises the relevant organizations.

Ⅲ. Audit Findings

The BAI recommended the MOHW and the NHIS to improve their policies and systems by identifying 19 ineffective and/or unreasonable cases. Major audit findings are as follows.

1. LTC benefit costs and LTC facilities' operating costs

(Institutional Care Benefit Cost Per Beneficiary) Based on the medical fee schedule, the MOHW calculates the institutional care benefit cost per beneficiary (hereinafter, "cost per beneficiary") every year. This benefit cost is to be calculated at an appropriate level that does not give financial burden to beneficiaries and at a level that permits LTC institutions to provide quality services. The cost per beneficiary is calculated by dividing the sum of the operating cost, labor cost (employees), and so on, by the number of beneficiaries of the LTC institutions. The number of beneficiaries and employees vary from institution to institution, and so should the cost per beneficiary. For instance, an institution accommodating 70 beneficiaries hires 41.8 employees on average, while an institution accommodating 29 beneficiaries hires an average of 15.6 workers. However, the MOHW calculated the cost per beneficiary at the same level, without regard to how many beneficiaries reside in or how many employees work at the institution. Such uniformly estimated cost per beneficiary enables certain facilities to acquire a budget surplus.

(Financial Projections) Pursuant to Article 6 of the Long-Term Care Insurance Act, the MOHW estimates short-term (for year n and n+1) and mid-long term (for the next five years) financial projections. Based on these projections, the Long-Term Care Committee annually decides the LTCI contribution rate and the medical fee schedule, as well as reviews the LTCI financial policy. When preparing a financial projection report for the next five years in 2016, the MOHW estimated that the accumulated reserves would run out by 2020. The MOWH did not, however, inform the Committee of the estimates until August 2019. The LTCI contribution rate should have steadily increased taking into account that the accumulated reserves would be depleted in 2020, but the

Committee decided on a LTCI contribution rate at a level that would cause the current account deficit. This was because the MOWH did not provide a financial projection report in a timely manner.

2. Oversight over financial and accounting status of LTC facilities

(Debt of LTC Facilities) High levels of debt of LTC facilities may contribute to the poor quality of LTC services. Some LTC facilities obtain a secured loan on the LTC benefit costs that are to be reimbursed by the NHIS. The NHIS receives a notification when a facility obtains a loan, and the NHIS pays the LTC benefit costs directly to the financial institution when the facility with the loan makes a request for reimbursement. The financial institution deducts the principal and interest from the reimbursed amount, and the remainder goes to the LTC facilities. The MOHW and the local governments are recommended to monitor whether the LTC facilities maintain appropriate levels of liabilities. Also, they need to ensure that the LTC benefit costs are properly used to provide quality services to the beneficiaries.

(Surplus Transfer) Founders and/or owners of LTC facilities are allowed to keep the surplus as long as they pay at least a certain amount of wages to their employees. According to Article 38 (6) of the LTCI Act, an LTC institution should spend some of the reimbursed LTC benefit costs for its workers (personnel expenses) at the rate determined and publicly notified by the MOHW. For instance, in the case where a LTC facility is run by a social welfare corporation, a surplus can be transferred to the account of the social welfare corporation if the facility meets the requirements stipulated in Article 38 (6) of the LTCI Act. However, there are no means to check whether a facility meets the requirements, and even if the MOHW finds that the facility did not pay a legally required amount of wages to their employees, there are no measures in place to enforce any form of disciplinary action.

(Reserve Fund) According to the MOHW's guideline for the "Social Welfare Program for the Elderly," the LTC facilities can buy a financial product on the condition that it is easily convertible to cash and that it does not bring any benefits to the owners of the facilities. The guideline also states that the LTC facilities should use the reserve fund for its original purpose. Some LTC

facilities buy variable annuity and whole life insurance for operation and maintenance. However, the variable annuity and whole life insurance are not fungible – they are hard to change into cash when the facilities need money. Also, there is the possibility of the facility owner taking advantage of the benefits generated by the variable annuity and whole life insurance, as the beneficiary of the annuity and insurance is the owner of the LTC facility. Despite these difficulties, the MOHW and the local governments did not properly conduct oversight on such practices.

(Co-payments of Beneficiaries) Certain items of the LTC benefits are not covered by the LTC insurance but are paid by the beneficiaries (e.g. meal costs, additional charges for using amenity beds, haircut costs, etc.). According to the MOHW's guideline for the "Social Welfare Program for the Elderly," the money that beneficiaries pay for uncovered benefits shall be used for only their intended purpose. However, it was discovered that some facilities use the money paid by the beneficiaries for purposes other than originally intended, such as the repayment of borrowings. Even so, the MOHW and the local governments failed to properly conduct oversight on such malpractices.

(Submission of Financial & Accounting Reports) As some LTC facilities for the elderly do not submit their budget reports and/or financial and accounting reports, it is difficult to check whether their revenues and expenditures are maintained at a sustainable level. Still, the local governments did not properly supervise such activities.

3. Management of the beneficiaries

(Special Circumstance Acceptance to Facility) Beneficiaries of grades 3, 4, and 5 may be limited to just in-home care services, but those with special circumstances are also allowed access to institutional care services. Such cases include: when family members cannot take care of the beneficiary at home, when the housing environment is not adequate, or when the physical and mental condition of the beneficiary requires the use of a facility. In such circumstances, the beneficiaries in grades 3, 4, or 5 can apply for institutional care services. The Need Assessment Committee reviews all necessary documents submitted by the beneficiary and the NHIS, and then makes a decision by majority vote.

However, the decision of whether a certain beneficiary of grades 3, 4, or 5 can be exceptionally accommodated in the facility remains an issue needing improvement. Without an objective criteria, the Need Assessment Committee's decision faces a credibility issue.

(Fraud Detection System) The NHIS established the Fraud Detection System (FDS, later changed to "Fair Detection System") which enables the NHIS to analyze certain reimbursement patterns that are likely linked to fraud or improper payments. The NHIS could have detected LTCI fraud by utilizing the FDS, but did not take advantage of it.

(Ineffective Penalties) The facilities are subject to administrative penalties such as suspension of business, fines, etc., if they violate relevant laws and regulations. If a facility owner relinquishes ownership of the facility to another person after being imposed a business suspension penalty, the existing penalty shall be transferred to the successor. Also, if a facility owner ceases to operate the facility to avoid the penalty, the suspension penalty can be replaced by a fine. The MOHW and the local governments should make sure that appropriate penalties are being imposed, but they failed to do so.

4. Penalty for elder abuse

The ***LTCI Act*** describes that the heads of local governments may impose administrative fines or penalties (e.g. suspension of operations ***for a maximum six months***) to the LTC facilities where elder abuse takes place. The ***Welfare of Older Persons Act*** also describes that the heads of local governments may order the suspension or closure of the facility ***for a maximum period of one month***, or impose administrative fines to those who commit elder abuse.

Although the relevant laws describe what kind of penalties can be enforced, the BAI found out that some local governments did not take any disciplinary measures on the facilities that violated the laws. Regarding this, some local governments state that they did not know among which of the ***two different laws*** should be preferentially applied over the other. Also, some state that the laws do not stipulate the details about the penalties.

Accordingly, in 2016, the MOHW promised that it would prepare specific standards for administrative disposition based on types of elder abuse and the

intensity and frequency of the abuse, as well as provide clarifications on the grounds for imposing penalties. However, it was found that the MOHW has failed to put their plans into action, resulting in the failure of local governments to impose appropriate penalties or fines on LTC facilities that were committing elder abuse.