National State Auditors Association
Joint Performance Audit
Long-Term Care

May 1998

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New York
North Carolina
Ohio
Oregon
Pennsylvania
Tennessee
Texas

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May 1, 1998

Mr. R. Thomas Wagner, Jr.
Auditor of Accounts
401 Federal Street, Suite 1
Dover, Delaware 19901

Dear Mr. Wagner:

This report combines the results of audits by several state audit organizations that participated in the National State Auditors Association's (NSAA) 1998 Joint Audit on Long-Term Care. Appendix A of this report lists those state audit organizations and the contact persons.

Nine audit organizations participated in this joint audit project: Connecticut, Louisiana, New York, North Carolina, Ohio, Oregon, Pennsylvania, Tennessee, and Texas. Each audit organization conducted a performance audit of the regulation and management of long-term care in its state. Oregon coordinated the audit planning phase. Louisiana coordinated the audit efforts and compiled the joint report based on the reports issued by the other participating states. Appendix B contains the executive summaries of each state's report.

NSAA sponsors joint audit projects to improve audit efforts through the sharing of information and expertise. I hope that this project will provide assistance to our nation's leaders who are struggling to provide safe and effective health care for our aging citizens.

We appreciate the privilege of serving as the lead state.

Sincerely,

Daniel G. Kyle, CPA, CFE
Legislative Auditor

DGK/ss

[NSAA]

National State Auditors Association 1997 Joint Audit
Long-Term Care
Executive Summary

For the 1997 National State Auditors Association's (NSAA) joint performance audit project, member states selected long-term care as the audit topic. The general findings are:

- Long-term care providers are generally meeting licensing and certification requirements.
- In general, agencies perform the necessary inspections to ensure that providers comply with state and federal regulations. However, some states found that routine inspections are either not conducted or not properly completed for community-based long-term care facilities. In addition, inspection timing is somewhat predictable in some states, diminishing the unannounced aspect of the inspections.
- Fines are not aggressively imposed or collected in some states and, therefore, may not be effective as a deterrent. In addition, the money collected from fines may not be needed for its designated purpose. Furthermore, some sanctions were not consistently imposed and the consistency of others could not be determined because of poor documentation of the decision-making process.
- The procedures used to set complaint investigation priorities could be improved. The priority-setting decision was not always documented and quality controls were not present to ensure that investigations were not assigned the wrong priority. In addition, there are instances where procedures for investigating complaints either have not been written or are not being followed.
- Many complaints were not investigated in a timely manner. Some complaints were never investigated and others were not investigated within the time frames set by the regulatory agency.
- Deaths of nursing home residents or other changes in their status are self-reported by facilities and not verified by the regulatory agencies. In addition, controls were not always sufficient to prevent direct payments to ancillary service providers in nursing homes. These practices may result in overpayments of Medicaid reimbursements to nursing facilities.
- A change in federal regulations could reduce Medicaid program costs without any impact on the quality of care at long-term care facilities. In addition, the auditors found many areas where payments were made for services that were not provided.
- Facilities appear to be properly developing resident assessments and care plans.

Introduction

According to a publication by the Centers for Disease Control, the nursing home industry is a major segment of the long-term care system with a mission to provide residential care for the aged and infirm. Long-term care in nursing homes, the subject of this national performance audit, is regulated by agencies within each state. A large part of the funding for long-term care comes from Medicaid (Title XIX of the Social Security Act). A 1997 publication by the Urban Institute titled *Medicaid and Long-Term Care* stated that long-term health care is one of the costliest and fastest growing needs of the elderly. It further states that long-term care expenditures are expected to multiply as the elderly population grows an estimated 73 percent in the next 30 years.

The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) implemented nursing home reform legislation. This act provided national standards for nursing homes to follow. The legislation streamlined the process for making nursing homes eligible (or certified) to serve Medicaid recipients, as well as helped ensure that nationwide long-term care facilities complied with these federal standards. According to the act, "a nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident."

Nursing homes, which provide long-term care for elderly residents, must meet these standards to be certified as eligible to participate in the Medicaid program. Each state's survey agency (entity responsible for administering long-term care) conducts periodic inspections to ensure compliance with the federal certification requirements for participation. The federal Health Care Financing Administration (HCFA) contracts with state agencies to conduct these inspections.

Long-term care can include community-based care or institutional care. Community-based care is usually associated with services provided in a client's own home or in a substitute home. This type of care includes adult foster homes and adult care homes. Institutional care can include nursing homes, facilities for the developmentally disabled, and adult care beds within a larger institution.

Scope and Methodology

For the 1997 National State Auditors Association's (NSAA) joint audit project, member states selected "Long-Term Care" as the audit topic. Initially, ten states chose to participate in the audit: Connecticut, Kentucky, Louisiana, New York, North Carolina, Ohio, Oregon, Pennsylvania, Tennessee, and Texas. The state of Louisiana served as the lead state in planning and coordinating the audit and in compiling and reporting the overall audit conclusions.

Auditors from six member states met in Denver, Colorado, on January 9 and 10, 1997, to determine the audit objectives and draft the audit program. They selected six objectives to pursue. States were allowed to modify the audit program, if desired, to better address issues relevant to their state. The audit objectives established for the 1997 NSAA Joint Audit of Long-Term Care were as follows:

- Determine whether the agency responsible for licensing providers is adequately ensuring that the providers meet all of the licensing requirements and that all providers offering services are appropriately licensed

- Determine whether the agency conducts the necessary inspections before issuing a license and whether the inspections ensure the provider is complying with the appropriate rules and regulations

- Determine whether the agency is imposing sanctions if providers are found not to be in compliance with the appropriate rules and regulations and determine whether the agency is consistently imposing sanctions for providers who are not in compliance (including follow-up to ensure violations are corrected)

- Determine whether the agency's process of receiving complaints is adequate and whether the agency reviews all complaints alleging violations of rules or regulations in a timely manner

- Determine whether the agency ensures that services that were billed were actually provided
- Determine whether the agency is ensuring assessments are conducted and care plans developed to ensure each resident receives appropriate services

In general, the audit covered the fiscal years 1994 through 1996. Texas completed its fieldwork in 1996 while the remaining states conducted their fieldwork during 1997. The scope of the audit was tailored to meet the needs of the different participating states. Oregon chose to focus most of its audit work on adult foster homes rather than nursing homes. These homes care for five or fewer residents in a private residence. Connecticut, North Carolina, Ohio, Tennessee, and Texas included not only nursing homes, but all types of long-term care facilities in their audits. Rather than duplicate recent work by committees of its state legislature, Kentucky's work included a review of the state's billing procedures for nursing facilities and an analysis of program reviews and task force reports, which addressed the remaining audit objectives. Since the resulting survey report did not entail a full audit, we did not include its findings in the cumulative report.[1] The audit work reported herein was conducted in accordance with generally accepted government auditing standards.

The following sections describe the findings and conclusions for each of the six joint audit objectives. Some states covered additional objectives. These were excluded from this summary report but can be found in the individual state reports.

Licensing

Determine whether the agency responsible for licensing providers is adequately ensuring that the providers meet all of the licensing requirements and that all providers offering services are appropriately licensed

[1] A copy of Kentucky's report can be obtained from the contact person listed in Appendix A.

LICENSING AND CERTIFICATION REQUIREMENTS ARE GENERALLY BEING MET

With one exception, the agencies responsible for licensing providers performed their oversight responsibility of ensuring that the providers met the requirements to receive and maintain their licenses. In Oregon, evidence of national and state criminal record checks was not available for all providers, employees, and non-client residents of adult foster homes as required by law. Eight states (Louisiana, New York, North Carolina, Ohio, Oregon, Pennsylvania, Tennessee, and Texas) addressed the first part of this objective.

To protect senior and disabled clients living in adult foster homes from individuals engaged in certain criminal activities, Oregon law requires state and national criminal records checks be performed on certain individuals associated with these homes before issuing or renewing a license. Auditors found no evidence of state criminal records checks for 13 percent of the individuals in a sample of adult foster care records. For those individuals in their sample that required a national criminal background check, no documentation of the check was found for 28 percent of the individuals. The auditors conducted criminal record checks on a sample of those without documentation and found one individual with a disqualifying criminal history. The report recommendations include establishing a procedure and training staff to routinely confirm current criminal record checks on all individuals associated with adult foster homes, as required by law.

Only one state, Tennessee, had a finding specifically related to the second part of the audit objective regarding appropriately licensing all providers offering services. According to Tennessee's report, the same agency responsible for licensing nursing homes does not have the authority to investigate potentially unlicensed nursing homes. Tennessee recommends that the agency be given the statutory authority to investigate these homes.

Recommendation

The long-term care licensing agencies should be commended for ensuring that providers meet licensing requirements. All states should consider the implications of criminal history checks by their licensing agencies. The Oregon example raises the question of risk associated with not ensuring that

individuals do not have a criminal history that may endanger the long-term care residents of state licensed facilities. In addition, all states should consider the authority given to licensing agencies based on the Tennessee example. One of the purposes of licensing is to ensure that all residents of long-term care facilities receive an appropriate level of care from qualified providers. If a licensing agency has no authority to investigate unlicensed facilities, the recipients of services provided by these facilities may not receive the appropriate level of care.

Inspections

Determine whether the agency conducts the necessary inspections before issuing a license and whether the inspections ensure the provider is complying with the appropriate rules and regulations

In general, states found that the licensing agencies conduct the necessary inspections of nursing homes and that these inspections ensure that providers are complying with the appropriate rules and regulations. However, North Carolina found that adult care beds that are licensed as part of nursing homes are not routinely inspected. In addition, inspections of adult care homes are not consistent from county to county. North Carolina, along with Texas, found that current procedures do not adequately address potential conflicts of interest and independence impairments of inspectors. Oregon found that follow-up on deficiencies identified during inspections of adult foster homes was not always timely or complete. In addition, two states (Louisiana and Texas) found that the timing of inspections was somewhat predictable and diminished the "unannounced" character of these inspections. Seven states (Louisiana, New York, North Carolina, Ohio, Pennsylvania, Tennessee, and Texas) conducted audit work on inspections of long-term care facilities including nursing homes. Oregon limited its scope to adult foster homes for this objective.

GENERALLY, INSPECTIONS ARE CONDUCTED

Based on the reports of the seven states that reviewed nursing home inspections, agencies are performing inspections to ensure that providers are in compliance with state and federal regulations. Only three states (Louisiana, North Carolina, and Pennsylvania) specifically stated in their reports that the necessary

inspections were performed before issuing a license. Four other states (New York, Ohio, Tennessee, and Texas) made general observations that the state and federal regulations pertaining to inspections were followed. New York found some minor problems with the documentation of inspection results.

North Carolina found that no routine inspections are performed on adult care beds that are licensed as part of a nursing home. Inspections are conducted on nursing homes and adult care homes. However, no procedures are in place to monitor compliance of rules and regulations of adult care beds within nursing facilities. In addition, the current inspection process for adult care homes in North Carolina allows a county agency to determine the areas, extent, and frequency of licensure requirements to be examined. The state agency that has oversight of these facilities has developed inspection procedures, but these are not current and are not used. The auditors found that monitoring activities are not performed consistently from county to county.

Louisiana found that the regulatory agency inspected all nursing homes, including those that do not accept Medicaid or Medicare reimbursements (i.e., private pay facilities). However, the auditors found that the inspectors did not have written procedures for the inspection of private pay facilities. The lack of written procedures makes it difficult to ensure uniformity in the conduct of these inspections.

Oregon laws and administrative rules require the relevant agency to perform adult foster home inspections, note deficiencies, establish timelines for corrective actions, and ensure deficiencies are corrected before license issuance or renewal. Auditors found that while most inspections were conducted in a timely manner, 21 percent of the homes with deficiencies were not given a time frame for corrections, 69 percent with deficiencies were issued a license before follow-up, and 29 percent of those deficiencies were never confirmed as corrected. Recommendations included providing training that emphasizes deficiency follow-up procedures and documentation.

Two states (Texas and North Carolina) found that the regulatory staff who have oversight authority and monitoring responsibilities for group care facilities might not be independent of the facilities they regulate. Specifically, Texas found no written policy precluding inspectors from facilities where a potential conflict of interest exists and it found no evidence of any decisions by the management of the regulatory agency related to assigning

employees to avoid conflicts of interest. North Carolina was unable to find any specific documentation completed by the regulatory staff attesting to its independence. The administrator of one facility was a former employee of the local regulatory unit and a former colleague of the state-level investigation team. North Carolina recommends that all regulators be required to attest their independence annually.

INSPECTION TIMING SOMEWHAT PREDICTABLE IN SOME STATES, DIMINISHING THE UNANNOUNCED ASPECT OF THE INSPECTIONS

Federal regulations require that inspections be unannounced. The states of Louisiana and Texas found that while inspections were unannounced, the timing of inspections was somewhat predictable. The predictability of inspections diminishes the regulatory agency's ability to ensure that providers are complying with the appropriate rules and regulations year round. Both Louisiana and Texas recommend that the variability of the inspections be increased so that nursing home administrators are less able to predict when inspections will occur. Pennsylvania reviewed the timing of inspections and found that the relevant department staggered the inspection dates.

Recommendation

Most states found that the long-term care licensing agencies conduct the necessary inspections. The audit findings, however, suggest three areas that states should consider:

(1) the procedures for inspecting long-term care facilities other than nursing homes that accept Medicaid or Medicare reimbursements;

(2) the independence of inspectors relative to the facilities they inspect; and

(3) the timing of inspections.

Relevant agencies should consider reviewing their procedures for inspecting long-term care facilities that are not under the federal certification process for nursing facilities. The findings from Louisiana, Oregon, and North Carolina relate to the

frequency, consistency, and thoroughness of inspections of these types of facilities. These findings indicate that the appropriate state agencies may not be ensuring that the residents of these types of facilities are sufficiently protected from conditions that may negatively affect their health, safety, and welfare.

States should consider how their long-term care regulatory agencies ensure that their staffs are independent of the facilities they regulate. Inspectors typically cover a particular area or region; therefore, impairments to independence may exist. Procedures should be in place to identify and address potential conflicts of interest and independence impairments.

States may wish to review the procedures followed by their long-term care regulatory agencies to vary the timing of inspections. Inspections are a more effective means to ensure the safety and well-being of long-term care facility residents when their timing is less predictable.

Sanctions

Determine whether the agency is imposing sanctions if providers are found not to be in compliance with the appropriate rules and regulations and determine whether the agency is consistently imposing sanctions for providers who are not in compliance (includes follow-up to ensure violations are corrected)

Several states found that regulatory agencies are not as aggressive as they could be regarding the imposition of sanctions on long-term care facilities found to have deficiencies. In 1995, the Health Care Financing Administration established optional remedies that states could use to enforce compliance by nursing home providers. These remedies include monetary fines and non-monetary enforcement actions such as required in-service training, state monitoring, and plans of correction. The severity of the deficiency determines what category of sanctions the regulatory agency can choose to impose. Because there are other options, some states may be reluctant to impose monetary penalties and may opt to impose non-monetary ones.

Two states (Louisiana and Ohio) found that fines were not collected in a timely manner and they questioned the way the money collected through fines was used. Six states reported on this

objective or a part of it (Louisiana, North Carolina, Ohio, Pennsylvania, Tennessee, and Texas). Only two states (Louisiana and Pennsylvania) specifically addressed whether sanctions were consistently imposed. The other states generally reviewed the sanctions process used by their respective long-term care regulatory agencies.

FINES NOT AGGRESSIVELY USED IN SOME STATES AND MAY NOT BE EFFECTIVE AS A DETERRENT

Four states (Louisiana, Pennsylvania, Tennessee, and Texas) found that some remedies are not being fully utilized. The level of sanction imposed by a regulatory agency sends a signal to facilities about the importance the agency places on ensuring the health and safety of long-term care residents. While other factors play a role in determining the type and size of sanctions, the deterrent aspect of sanctions is important.

Louisiana found that only about 11 percent of the inspections of nursing homes that were not in substantial compliance resulted in civil monetary penalties (fines). Louisiana recommended that the state agency fine all facilities that are found not to be in substantial compliance with the idea of encouraging facilities to be in substantial compliance year round.

Pennsylvania found that while the number of nursing facilities has increased over the last three years, the number of sanctions imposed has declined. Officials at the regulatory agency in Pennsylvania were unable to explain this reduction. The perception that the regulatory agency has relaxed its imposition of sanctions on nursing facilities could result in a reduction in the level of quality care by nursing facilities. Pennsylvania recommended that the regulatory agency should analyze its system of imposing sanctions to determine the reasons for the reduction in the number of sanctions imposed.

Tennessee's report states that although statutory authority for the imposition of state penalties against deficient nursing homes exists, this authority is not used. Because federal penalties are more severe, the regulatory agency in Tennessee has simply decided to forego the imposition of state penalties. Tennessee recommended several changes in policy to the regulatory agency.

Texas' report states that nursing homes are generally allowed to correct deficiencies and return to compliance to avoid

license denial or revocation. Texas specifically stated in its report that license denial or revocation has been recommended 309 times since 1994; however, a license has been denied only once and none have ever been revoked. In addition, Texas found that a nursing facility's history of noncompliance is not fully used as a factor in the assessment of whether sanctions will be imposed. Texas recommends that management evaluate its current use of state licensing remedies and administrative penalties as enforcement tools. It also recommends that the regulatory agency should implement procedures to verify and use ownership information submitted on license applications and use an owner's history of noncompliance as a basis for imposing remedies.

FINES NOT COLLECTED WHEN DUE - FINE REVENUE NOT BEING USED

Louisiana and Ohio found that fines were not collected when due. Louisiana recommends that for delinquent fines, interest should be charged and the amount should be deducted from the facility's Medicaid reimbursement payment, if applicable. Ohio recommends that the regulatory agency account for and report on all fines collected.

Louisiana and Ohio also found problems with the use of money from fines levied against deficient nursing homes. The Omnibus Budget Reconciliation Act of 1987 mandates that this money be placed in a special fund. The money in this fund is only to be spent to protect the health or property of residents in nursing homes that are found to be deficient. Louisiana found that no claims have ever been filed against its state's fund. Louisiana recommends that the regulatory agency inform residents and their families of the existence and possible uses of the fund, whenever applicable.

Ohio also found that the money in its Resident Protection Fund might never be needed for the purposes for which it was established. Ohio's report pointed out that a draft proposal has been submitted to the Health Care Financing Administration recommending alternative ways to use the money in the Resident Protection Fund. These alternatives include:

- Helping defray increased costs associated with more frequent monitoring of poor performing nursing facilities

- Helping defray the costs of complaint monitoring units
- Funding printing costs for literature outlining patient rights
- Funding future relocation activity

SOME SANCTIONS NOT CONSISTENTLY IMPOSED

Louisiana reviewed a sample of sanctions imposed on nursing homes and found that most sanctions were imposed consistently. However, auditors found that a subset of fines, those for repeat deficiencies, was not imposed consistently. Specifically, some facilities with repeat deficiencies were fined a one-time fee rather than the per-day fee required by state law. This lack of consistency has the potential to become a problem for the agency during the appeals process. Louisiana recommends that all fines for repeat deficiencies be assessed using the appropriate method.

Pennsylvania tried to ascertain how its regulatory agency arrives at its decision to impose sanctions. Pennsylvania found two facilities with a similar number and level of deficiencies but with different sanction amounts. In reviewing the documentation related to these sanctions, Pennsylvania found no evidence to support the decision to impose sanctions in either case. Therefore, the audit agency was unable to determine if sanctions were imposed consistently.

Recommendations

States regulatory agencies should evaluate how aggressively they are imposing state sanctions on long-term care facilities with deficiencies. They should also evaluate the effectiveness of the sanctions that are imposed. The findings from Louisiana, Pennsylvania, Tennessee, and Texas show that these agencies are not as aggressive as they could be when penalizing non-compliant long-term care facilities. To encourage compliance by facilities, sanctions must have a deterrent effect.

States should consider the way that money collected from fines is used (or not used). Federal regulations restrict its use to protect the health or property of residents in nursing homes found

to be deficient. However, as the Ohio finding suggests, states may interpret the federal regulations in different ways. If states find that these funds are not being used, they should work with the Health Care Financing Administration to decide how these funds could best be used.

States should review the procedures followed by regulatory agencies regarding documenting the decision to impose sanctions on long-term care facilities with deficiencies and the consistent application of these sanctions. The Pennsylvania and Louisiana examples raise the issue of overturning sanctions through appeals based on their inconsistent application by regulatory agencies. For the sanctions to be effective, they must be assessed and collected. The sanctions must also be sustainable through the appeal process.

Complaints

Determine whether the agency's process of receiving complaints is adequate and whether the agency reviews all complaints alleging violations of rules or regulations in a timely manner

Most states found areas that need improvement in their long-term care complaint processing systems. These improvements would help to further ensure that residents' health and safety are protected. First, three states (Louisiana, Ohio, and Texas) found the procedures for setting priorities for investigating complaints should be improved. Second, three other states (New York, North Carolina, and Pennsylvania) found instances where procedures either had not been written or were not being followed. Finally, three states (New York, Pennsylvania, and Oregon) found that complaints were not investigated in a timely manner. A total of eight states (Louisiana, New York, North Carolina, Ohio, Oregon, Pennsylvania, Tennessee, and Texas) addressed this objective in their audit.

Priority Setting Controls Should Be Improved

Louisiana's report stated that auditors found no evidence documenting the decision-making process used by regulators when assigning investigation priorities to complaints. Furthermore, the agency used inconsistent and conflicting guidelines to set investigative priorities. Complaint prioritization requires

professional judgment, and documenting the decision would help the regulatory agency assess the effectiveness of its priority setting process. Louisiana recommends that formal procedures be developed for assigning investigative priorities and that decisions on investigative priorities be documented.

Ohio found problems with the deferment of complaint investigations. In Ohio, intake personnel screen complaints that potentially pose a threat to the health and safety of recipients and investigate them immediately. All other complaints are deferred for future investigation. This process of deferring complaints means that the investigation of potentially serious complaints may be delayed. Ohio recommends that the responsible agency conduct a desk audit on a sample of deferred complaints to determine whether the initial assessments were accurate.

The Texas report noted that in one of the 33 cases that the auditors reviewed, a higher priority should have been assigned to a complaint. This situation was also noted in a review of two other files. Texas recommended that a quality assurance program be implemented to review priority assignments.

PROCEDURES ARE INADEQUATE OR NOT FOLLOWED

New York's report stated that one of the three area offices it reviewed lacked written procedures for complaint investigations and a system to monitor complaints. The office could not locate several complaint investigation files requested by the auditors. New York recommends that the office draft written complaint procedures, provide more training for investigators, and develop a system to track the status of complaints.

In North Carolina, auditors found that current procedures regarding reporting of allegations concerning residents' care are not being followed. When allegations of resident abuse or neglect or misappropriation of resident assets are reported, the facility is required to investigate the allegations and notify both a local and a state agency. The auditors found that facilities may not consistently notify the authorities of these allegations. North Carolina's report recommends that facilities follow the established procedures and that failure to follow them should be cited as a deficiency. The facility should also be sanctioned by the appropriate agency for noncompliance.

Pennsylvania found that some of the regulatory agency's field offices had no written procedures to address complaints of a life-threatening nature. In addition, the agency's system to record and receive complaints only operates during normal business hours. Pennsylvania's report recommended ways that the regulatory agency could improve its system.

MANY COMPLAINTS ARE NOT INVESTIGATED IN A TIMELY MANNER

New York found one of the three area offices it reviewed did not investigate all of the complaints received. For example, three complaints alleging physical abuse or neglect that were received in 1996 had not been investigated as of September 1997.

Pennsylvania found that 69 percent of all the complaints reviewed by the audit team and 70 percent of these with the highest priority were not investigated within the time frame set by the agency's priority system. The agency personnel interviewed maintained that they had insufficient staff to follow up on complaints and complete inspections. The report recommends that the agency investigate complaints within the assigned priority with an emphasis given to the higher priority complaints where residents are at higher risk or in immediate jeopardy. It also recommends that the agency determine if staffing is adequate to investigate all complaints in a timely manner.

Oregon found that 18 percent of the facility abuse complaint investigations in its sample were started late, 28 percent of the investigation reports were completed after required time frames, and 47 percent were not mailed promptly to the regulatory agency's state office. The state office reviews the reports to determine if sanctions or corrective actions are to be taken against perpetrators. The report recommended that the regulatory agency:

- Provide additional training to staff emphasizing the timelines
- Obtain a tracking and monitoring system to alert staff of impending timeliness
- Review the procedures used to prioritize investigations

- Set specific time requirements for sending reports to the state office

Recommendations

When considering the prioritization of complaint investigations, states should consider the inherent risk of delaying investigations that need immediate action. Delays may jeopardize the health and safety of long-term care residents. States should evaluate the procedures they have in place to control these risks.

The complaint system is one of the principal methods regulatory agencies have of ensuring the safety and well-being of long-term care residents. States should verify that complaint-tracking systems are in place and effectively working. These systems ensure that complaints are investigated and that they are investigated in a timely manner. The findings in New York, Oregon, and Pennsylvania show that some long-term care complaints are not investigated and that many of the complaints are investigated late. In Pennsylvania, as a result of the audit findings presented on its original report and a subsequent follow-up audit, a complete overhaul of the nursing home complaint system is under way.

Reimbursement

Determine whether the agency ensures that services that were billed were actually provided

Five states found that the regulatory agencies are not adequately ensuring that services billed were actually provided. As a result, states and the federal government are paying for long-term care services that were not provided.

Four states (Connecticut, Louisiana, Ohio, and Pennsylvania) found control weaknesses and some states found subsequent overpayments relating to the reporting of resident deaths. Connecticut found that nursing home providers misunderstood that state's bed reservations policies. In addition, the auditors found that the regulatory agency did not check payment requests to ensure that this policy is accurately applied. Under certain conditions in Connecticut, nursing homes may be paid for up to 15 days when a resident is discharged to a hospital and is expected to return. As a result of this misunderstanding and

lack of monitoring, Connecticut found that, for the seven instances reviewed, $67,594 in overpayments occurred. New York found overpayments related to ancillary service providers. A total of six states (Connecticut, Louisiana, New York, North Carolina, Ohio, and Pennsylvania) included this objective in their audits. In addition, Connecticut found that a change in federal regulations might allow states to save some money on Medicaid reimbursements.

FOUR STATES CALL FOR THE USE OF DEATH RECORDS TO VERIFY DATES OF DEATH OF MEDICAID NURSING HOME RESIDENTS

Connecticut reviewed the payment records for a sample of Medicaid recipients in long-term care facilities and found one case where a payment was made to a facility for services provided after the death of the resident. While the amount of the overpayment was small, it highlighted a weakness in the reimbursement system's controls. Connecticut recommended that the regulatory agency implement policies and procedures to ensure that, when dates of death are received, a retroactive review of payment records be conducted and any overpayments be recovered.

Like Connecticut, both Louisiana and Pennsylvania found that controls governing the reporting of deaths were weak. Deaths are largely self-reported by facilities and unverified by the regulatory agency. Given these weaknesses, nursing homes could possibly be reimbursed for residents who were no longer in their care. Recommendations from both states include comparing death records with Medicaid eligibility roles periodically for updating. In addition, payment records should be reviewed to recover any overpayments related to delayed death notifications.

Ohio specifically stated that controls were not adequate to prevent payment on behalf of deceased Medicaid recipients and that these overpayments were not collected in a timely manner. Payments on behalf of deceased Medicaid recipients totaled $54.5 million between January 1994 and June 1996. Ohio made several recommendations to the regulatory agency that could help to lower the number and amount of overpayments.

Although Oregon did not audit the reimbursement system for long-term care providers, it did have a finding that was similar to other states that reviewed the reimbursement system. Oregon found that the regulatory agency does not have a process in place to identify all deaths of public assistance (Medicaid) clients in

nursing homes. The agency relies primarily on providers or clients' families to report these deaths. The report recommended that the agency:

- Provide training to staff emphasizing the importance of reporting deaths to the appropriate agency division
- Determine the feasibility of obtaining death records from the Vital Statistics Section to be used to identify deceased public assistance clients

OVERPAYMENTS FOR ANCILLARY SERVICES

New York found problems with the payments made to ancillary service providers. Ancillary services, such as pharmacy, dental and restorative therapy services, are generally included in a nursing home's reimbursement rate. Nursing homes either deliver these services directly or contract with ancillary service providers to render them to residents. If Medicaid pays separately for a resident's ancillary services, it may be paying twice for the same service. New York found that for the three-year period ending in December 1996, as much as $1.3 million in potential Medicaid overpayments were made to ancillary service providers. New York recommends that an evaluation be made of the Medicaid Management Information System (MMIS) to identify why controls were not sufficient to prevent overpayment to ancillary service providers.

POSSIBLE REDUCTION IN COSTS WITHOUT ANY IMPACT ON THE QUALITY OF CARE

Connecticut found that a change in federal regulations could reduce program costs without any impact on the quality of care. According to federal regulations, most Medicaid nursing home residents keep a fixed amount of their income and contribute the rest to offset the cost of their care. Under certain conditions, Medicaid residents who also qualify for Medicare are allowed to keep all of their income. Without a change to federal regulations, Connecticut (and other states) pays substantially more in Medicaid dollars for some residents than for others with similar income. Connecticut recommended seeking a waiver from the federal government or working with other states to have regulations changed to allow all Medicaid clients who are in need of Medicare

to have the same responsibility concerning the use of their income to help pay for their care.

Recommendations

States should consider the controls regulatory agencies have related to the reporting of resident deaths in long-term care facilities and the recovery of related overpayments. The findings from four states in this joint audit suggest that some states do not have mechanisms in place to accurately verify dates of death. In addition, once deaths are confirmed, some states do not have adequate controls to recover any overpayments that may have occurred.

The New York audit work on ancillary service providers may indicate a need for states to review controls for preventing and recouping overpayments to these providers. This type of overpayment should be a concern of all states. The Connecticut finding on recipients of both Medicare and Medicaid offers an opportunity for states to work together to change the federal regulations and thereby save all states money.

Case Management

Determine whether the agency is ensuring that assessments are conducted and care plans developed to ensure that each resident receives appropriate services

RESIDENT ASSESSMENTS AND CARE PLANS APPEAR TO BE PROPERLY DEVELOPED

Only three states (Louisiana, North Carolina, and Pennsylvania) addressed this objective. Each state found that the relevant agency does ensure proper development of resident assessments and care plans through the normal inspection process.

Appendix A

List of Participating States and Contact Persons

NSAA 1998 Performance Audit
Long-Term Care
Participating States and Contact Persons

Auditors of Public Accounts
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(860) 566-3648 ext. 305
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Office of Legislative Auditor
Post Office Box 94397
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Contact Person: Ms. Sharon Robinson

Office of the State Comptroller
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Contact Person: Mr. Lee Eggleston

Office of State Auditor
Performance Audit Division
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Raleigh, **North Carolina** 27603-5903
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Contact Person: Mr. Spencer Phillips

Auditor of State
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Oregon Audits Division
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(503) 986-2255
Contact Person: Mr. Craig Stroud

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Contact Person: Ms. Mary Detweiler

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State Auditor's Office
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Austin, **Texas** 78711-2067
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Contact Person: Mr. Jon Nelson

Appendix B

Executive Summaries of the Participating States' Reports

Executive Summary

Connecticut Report

Executive Summary

In accordance with Section 2-90 of the Connecticut General Statutes, we have conducted a performance audit of some aspects of government-financed long-term care in Connecticut. The Department of Social Services determines eligibility of the clients who receive this care, as well as providing for the payment to the facilities which provide the care. Funding for the program comes from the Federal Medical Assistance Program (Medicaid) and from the State General Fund. Medicaid expenditures incurred by the State of Connecticut are reimbursed at about 50 percent by the Federal government. This audit was done as part of a 1997 National State Auditors Association (NSAA) joint audit. In all, ten states participated in that effort. Although the plan for that audit had a number of objectives, the State of Connecticut's audit efforts focused on determining whether the services billed for long-term care were actually provided. The conditions noted during this audit, along with our recommendations are summarized below.

Backlog of $21, 676,494

Patient income is not always applied in a timely manner to the cost of nursing home care.

An estimated $21,676,494 that is owed either to the State or to clients was being held without any interest costs by nursing homes, which have no claim to it. This money is not applied toward the cost of care nor given to the clients immediately because a manual process must be completed by the Department of Social Services before the money can be distributed. The resulting backlog of cases goes back to 1995 and beyond. None of the cases originating in 1996 and 1997 had been worked on as of November 1997. We have been told that the work is being processed at such a rate that the completion of the old cases corresponds to the number of new cases coming in, thus keeping the backlog from increasing, but not reducing it.

The Department of Social Services should take some action that would eliminate this backlog and recoup the money due to the State and have any moneys owed to the patients returned to them. Such action could include making improvements to the computer system to eliminate the need for the manual process, giving the nursing homes some responsibility for distributing the money, and/or increasing staff effort. (See Item No. 1)

Potential Savings of $610,389 **A change in Federal regulations could reduce program costs without any impact on the quality of care.**

When a person who is institutionalized under Medicaid is also eligible for a particular type of Medicare coverage, called Qualified Medicare Beneficiary (QMB), money that otherwise could go toward the cost of the person's care goes to the client. To qualify for the QMB status, an individual's income must fall below the poverty limits established for Connecticut, and her/his stay in the nursing home has to have been preceded by a three-day hospital stay that was covered by Medicare. The client's income cannot be used to offset the Medicaid cost for long-term care for a 100-day period following the hospital stay. Two patients with identical long-term care, with both Medicaid and Medicare coverage, could have their incomes treated differently. If one person's income qualifies her/him for QMB, that person keeps her/his income while the other has to use it to help pay for the cost of the long-term care. By allowing this special benefit to some clients, Medicaid costs in Connecticut are annually greater by a projected $610,389.

We understand from officials of the Department of Social Services that Federal regulations may not allow residents in nursing homes to be treated differently from those living in the community. The Department of Social Services should seek a waiver from the Federal government or work with other States to seek a change to these regulations. (See Item No. 2)

Overpayments of $293,721 **Mass adjustments were applied twice to the same claim, resulting in overpayments of $293,721 to the provider.**

Mass adjustments, which are changes in the daily rates paid to the service providers, are usually done as the result of Federal audits or audits of the providers' cost reports. When a special rate adjustment was processed after a delay and after a mass adjustment, it resulted in duplicate transactions and overpayments.

The Department of Social Services should take steps to prevent mass adjustments from being applied twice. (See Item No. 3)

Bed Reservations

Four facilities were overpaid $67,594 for improperly billed bed reservation days.

When a census requirement is met, a long-term care facility is paid for up to 15 days when a client is discharged temporarily to a hospital. Reliance is placed on the facility to bill for these bed reservations only when the census requirement is met. Currently, there is no review of the accuracy of these billings either at the time they occur or when audits of the homes are performed. Twenty percent of the facilities we contacted did not have an accurate understanding of the bed reservation policy, and 18 percent of the facilities we tested were overpaid for improperly billed bed reservation days.

Procedures should be developed to review census records and bed reservations as part of the audits of the long-term care facilities. (See Item No. 4)

Inaccurate Payment

Patient liability was not correctly applied due to a change in eligibility.

The management information system that processes the payments to the long-term care facilities relies on information that is obtained from the system that determines the eligibility of the clients. Our testing revealed that, when eligibility information is changed after the payment system does its updates, payments could be inaccurate.

Procedures should be implemented to ensure that the billing system receives the correct data. (See Item No. 5)

Rate Changes

Mid month rate change adjustments appear to have been overlooked.

Commonly, rate adjustments are done in mass adjustment transactions with the effective date the beginning of the month. When rate changes are made that are not effective at the beginning of the month, a manual adjustment is needed.

We noted one case where a change in ownership required a rate change in the middle of the month and where the vendor for the billing system was notified to make the adjustment, but failed to do so. An incorrect rate was paid for this period.

Procedures should be implemented to confirm that requested interim rate changes are made by the vendor. (See Item No. 6)

Patient Funds

It appears that patient funds were improperly retained by a facility after the death of a resident.

Although there was no authority for it, funds remaining in a patient account, which was administered by a long-term care facility, were kept by that facility after the patient died.

The Department of Social Services should consider including a review of the patient fund account balances of deceased residents as part of its nursing home audits. (See Item No. 7)

Payment after Death

A payment was made to a facility for services that were not rendered.

A payment was made to a facility for a day when the patient was deceased. Although the payment was insignificant, it pointed out a problem in the system that would allow such a payment. This error occurred when a correction was made to the date of death, and the appropriate manual adjustment was not made.

The Department of Social Services should implement policies and procedures to ensure that, when dates of death are received, a review is done to verify that payments were not made for services after that date. (See Item No. 8)

Executive Summary

Louisiana Report

Office of Legislative Auditor

Executive Summary

Performance Audit
Management and Oversight of Long-Term Care in Louisiana

The Department of Health and Hospitals (DHH) is the primary entity for regulating nursing homes in Louisiana. Our performance audit found that:

- DHH conducts the necessary inspections to ensure that nursing homes meet all of the state licensing and federal certification requirements. However, there is no written protocol for state licensing inspections and no formal documentation of the activities that take place during these inspections. Furthermore, the timing of inspections is predictable.
- Generally, DHH investigates complaints against nursing homes within the designated time frame. However, the process of setting priorities for investigating complaints is not documented. Therefore, it is difficult to determine if investigation priorities are set appropriately and consistently. Furthermore, DHH uses inconsistent and sometimes conflicting guidelines to set investigation priorities.
- Few inspections with deficiencies serious enough to warrant a revisit by DHH result in monetary sanctions. Therefore, DHH misses an opportunity to discourage nursing homes from future deficiencies.
- In general, DHH was consistent in its decisions about the type of sanctions to impose. However, monetary sanctions for repeat deficiencies were not levied as severely as regulations require. In addition, half of the fines levied by DHH in our sample were not collected by the due date and DHH did not charge any interest or penalties for these delinquent payments.
- DHH ensures proper development of resident assessments and care plans through its normal inspection process. The surveyors are uncovering a significant number of resident assessment and care plan deficiencies.
- The controls that prevent overpayments to Medicaid nursing home providers are weak and should be strengthened.

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Executive Summary
New York Report

Department Of Health
Monitoring Nursing Home Compliance With Medicaid Participation Requirements And Controlling Provider Payments

Scope of Audit

The Department of Health (Department) supervises and certifies the State's nursing homes under Article 28 of the Public Health Law. The Department's Bureau of Long Term Care Services (Bureau) is responsible for licensing nursing homes and for certifying that they comply with Federal standards for safety and quality care. The Bureau has six area offices (Buffalo, Rochester, Syracuse, Northeast, New Rochelle and New York City) which monitor nursing homes' compliance by means of regular certification surveys and investigation of complaints that residents or other parties bring against nursing homes. The Department also administers the State's Medicaid program. For each Medicaid-eligible resident, nursing homes receive a per diem reimbursement rate that includes the provision of basic care, as well as many ancillary services, such as pharmacy services. The Department uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to reimburse providers. During the three years ended December 31, 1996, Medicaid reimbursed New York State nursing home providers $13 billion.

Our audit addressed these questions about the monitoring of nursing home compliance with participation requirements and the payment of selected ancillary service providers for the period January 1, 1994 through December 31, 1996:

- Does the Bureau timely investigate and adequately track the complaints it receives?
- Does the Bureau perform nursing home certification surveys on a timely basis?
- Are MMIS controls adequate to prevent inappropriate payments for ancillary services?

Audit Observations and Conclusions

In our audit of three area offices, we found that the Syracuse and Northeast offices adequately handled complaint investigations. However, we determined that the New York City office needs to improve its complaint tracking system and investigate complaints more timely to ensure this patient protection mechanism serves its purpose. While all area offices performed certification surveys that were in general compliance with Federal regula-

tions, improvements could be made in documenting survey results and in completing follow-up activities. We also determined that the Department needs to investigate about $1.3 million in potential overpayments to ancillary care providers, and develop programming changes to the MMIS to prevent future overpayments.

Federal regulations require the Bureau to establish written procedures and implement a control system to receive, investigate and resolve complaints. Such systems should ensure that area offices properly investigate all complaints timely, collect sufficient evidence and ensure that facilities correct all substantiated complaints. We found that the New York City area office does not always investigate all the complaints received or gather sufficient evidence to substantiate them. For example, three complaints that were received in 1996, and which alleged physical abuse or neglect, had not been investigated as of September 26, 1997. We also determined that this office lacked written procedures and a system to monitor complaint investigations. To ensure that nursing home residents are adequately protected, we recommend that the Bureau resolve the outstanding complaints, draft written procedures, provide training and develop a system to track the status of complaints. (See pp. 5-7)

The Federal Health Care Financing Administration, which is responsible for implementing Federal quality assurance standards among health care providers, contracts with states to conduct periodic certification surveys to ensure that Federal standards are met. While the three area offices we visited generally conduct timely surveys to ensure compliance, some surveys were missing documentation of required components, like resident interviews. Further, some Statements of Deficiency, which the Bureau sends nursing homes to identify compliance problems, and Plans of Correction, which facilities send the Bureau to propose solutions, are not issued timely. We recommend that the Bureau develop a uniform process for documenting survey results, and controls to ensure compliance follow-up is timely. (See pp. 7-10)

New York's Medicaid payment rate includes reimbursement for numerous ancillary services, such as pharmacy services. Since such services are included in the standard rate, the service provider should not separately bill Medicaid for providing them. However, during the three years ended December 31, 1996, we found that MMIS did not detect as much as $1.3 million in potential Medicaid overpayments to ancillary service providers. We recommend that the Department investigate these potential overpayments and seek recoveries where appropriate. (See pp. 11-13)

Comments of Department Officials

Department of Health officials generally agreed with our recommendations.

Executive Summary

North Carolina Report

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

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

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

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

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Executive Summary

Ohio Report

EXECUTIVE SUMMARY

As a whole, Ohio long-term care providers met applicable licensing requirements. The cognizant state agency, the Ohio Department of Health, also conducted required inspections of facilities, received and processed health care related complaints, and imposed sanctions for provider noncompliance in conjunction with the U.S. Health Care Financing Administration. However, we found that Ohio Department of Health had an outstanding backlog of unprocessed patient complaints due in part to a decision to defer processing of the less serious complaints until the next scheduled survey.

Within the State of Ohio, the Ohio Department of Human Services (ODHS) has responsibility for reimbursing nursing homes for services provided, for collecting sanctions imposed by Health, and for overall management of the State's Medicaid Program. We found that Human Services not only routinely overpaid providers on behalf of deceased recipients but also paid the providers for expenditures that either should have been paid by the federal Medicare program or not at all since the claims, in some cases, were duplicates of others that had already been paid. Consequently, we concluded that this agency needs to substantially improve its controls to ensure that the services billed for (resident care for Medicaid recipients) are actually provided.

Specifically, between 1994 and 1996 (through June), ODHS overpaid providers $54.5 million for deceased Medicaid recipients including $12.4 million (23 percent) that was still outstanding as of June 30, 1996. Between January 1994 and June 1996, this agency also paid more than $50 million that was identified by its claims payment system as inpatient or outpatient Medicare charges. Ohio Administrative Code 5101:3-1-05 states that Medicare will be the primary payer where services are dually covered by both Medicaid and Medicare.

Although Ohio Department of Human Services is working with a contractor to identify and to recover tens of millions in overpayments, providers are receiving interest-free use of funds for extended periods of time. These overpayments and related contractor costs could have been used to fund other necessary projects. Also, the collectibility of millions in overpayments is uncertain. First, a nursing home association has challenged Human Service's right to recover those involving years where "final" per diem rates have been set (1994 and 1995). Second, untimely reporting of other overpayments by the nursing facilities and/or adjustment efforts by ODHS may preclude the voluntary return by providers of these overpayments before final per diem rates are negotiated for subsequent years.

To better ensure that the delayed investigation of complaints by Department of Health does not adversely affect the health, safety, and well-being of Ohio's nursing facility recipients, it is recommended that this agency periodically perform limited desk audits on a sample of unprocessed complaints to confirm that more immediate corrective action is not required. Because of the systemic nature of the issues identified at Human Services, it is recommended that this agency immediately (1) take action to withhold future payments or to collect the overpayments identified in other ways, (2) initiate revisions to the Ohio Administrative Code to

overpayments identified in other ways, (2) initiate revisions to the Ohio Administrative Code to allow it to impose a deadline for provider notification of changes impacting Medicaid reimbursements and associated penalties, (3) suspend payments on claims identified as potentially erroneous until researched to ensure payment is proper, and (4) expand its audit efforts by periodically verifying the existence of Medicaid recipients for which payments are being made. It is also recommended that Human Services periodically match its payment records with official death records maintained by Ohio Department of Health to eliminate or at least minimize payments on behalf of deceased recipients.

Ohio Departments of Health and Human Services generally agreed with the contents of this reports. Their comments are included in appendixes to this report.

Executive Summary

Oregon Report

SUMMARY

PURPOSE

The purpose of this review was to determine whether the Department of Human Resources Senior and Disabled Services Division (division) complied with laws and administrative rules governing the Adult Foster Home (AFH) licensing and inspection process and the facility abuse complaint investigation process. We reviewed whether the division could improve fund recoveries from the estates of deceased public assistance clients and the Division of State Lands — Abandoned Property Section. Finally, we determined whether the division effectively stops payments made to non-medical community-based care providers when public assistance clients die.

BACKGROUND

The division delivers services to seniors and disabled people through a network of offices located in all areas of the state. The division is responsible for oversight of the long-term care program and ensuring compliance with certain laws and regulations when inspecting and licensing AFHs and performing facility abuse complaint investigations. For certain public assistance programs, the division recovers funds from deceased client bank and nursing home accounts for assistance paid on the client's behalf. The division can also collect abandoned assets up to the amount of assistance paid on a deceased client's behalf from the Division of State Lands — Abandoned Property Section.

RESULTS IN BRIEF

We found that the division can improve its processes to ensure that local offices comply with the laws and administrative rules for performing AFH inspections and issuing AFH licenses. We determined Oregon criminal records checks were correctly performed for 87 percent of sampled AFH providers, resident managers, and non-client residents. Our results indicate the division could improve its performance of national records checks. Although only 7 percent of the individuals in our sample required a national records check, 28 percent of those were not evidenced as being performed. We identified one individual in our sample with a disqualifying criminal history currently living in an AFH. Further, while most sampled AFH inspections were conducted in a timely manner, 21 percent of the homes with noted deficiencies were not given a timeframe for correction, 69 percent with deficiencies were issued a license prior to follow up, and 29 percent of those deficiencies were never confirmed as corrected. Finally, we found that the

division generally ensures AFH providers and resident managers complete a basic training course prior to licensing. The division did not ensure provider and resident manager training requirements were met for nine percent of the individuals sampled.

In the area of facility abuse complaint investigations, we found that the division does not always ensure that critical timelines are met. We determined that 18 percent of the facility abuse complaint investigations in our sample were started late, 14 percent had no evidence that an initial status report was issued, and we confirmed that 6 percent of the initial status reports were issued late.[1] We also found that local offices completed 28 percent of the sampled investigation reports outside of required timeframes and remitted 47 percent to the division more than 7 days after completion. Finally, the division did not issue 23 percent of required nursing facility letters of determination in our sample or determine corrective actions for 10 percent of the sampled investigations relating to AFHs within time requirements.[2]

We also determined that the division could increase recoveries of cash funds from the bank and nursing home accounts of deceased public assistance recipients by $400,000 annually if the division received timely notification of client deaths. In addition, we identified more than $255,000 of abandoned funds recoverable by the division from the Division of State Lands — Abandoned Property section.

Finally, we determined the division effectively stops payments to non-medical community-based care providers when public assistance clients die.

AGENCY'S RESPONSE The division agrees with the audit findings and is currently in the process of implementing many of our recommendations.

1 Initial status reports communicate to a facility, the division, and the complainant that a local office has received a complaint and reiterates the local office's understanding of allegations received.
2 Letters of determination state the division's conclusions regarding complaint allegations.

Executive Summary
Pennsylvania Report

The following executive summary presents the audit's objectives and conclusions, as well as a brief synopsis of our results. Additional detail about our methodologies, conclusions, and recommendations can be found in the body of the report.

Chapter I - Licensing and Inspections

Objectives: We elected to determine whether the Department of Health is adequately ensuring that the providers meet all of the licensing requirements, and that all providers offering services are appropriately licensed. Additionally, our objectives included determining whether the Department of Health conducts the necessary inspections before issuing a license and whether the inspections ensure the providers are complying with the appropriate laws, regulations, and rules.

Conclusions	Summary
♦ **I-A) The Department of Health has an effective program to ensure that nursing facilities are properly licensed and inspected.**	We determined that procedures had been implemented and adequately ensured that the 25 nursing facilities we toured were appropriately licensed and inspected prior to receiving their license. In addition, we found that procedures ensured that the providers we sampled complied with appropriate regulations. *(Refer to page I-3.)* During the planning of our audit we became aware that certain stakeholders of the Long-Term Care Program were concerned that the Department of Health focused equal attention on all nursing facilities. They suggested that the Department of Health's effectiveness could be improved by concentrating efforts on poorer performing facilities, and relaxing the requirements for inspections of facilities with consistent records of compliance. However, we concluded that the Department of Health is already ensuring its effectiveness by spending additional time at poorer performing facilities. Additionally, we found that many factors prevent the likelihood that nursing facilities will maintain consistent records of compliance. *(Refer to pages I-4 and I-5.)*
♦ **I-B) The annual report on the effectiveness of the Department of Health provides limited information to the General Assembly.**	Although Section 804(d) of the Health Care Facilities Act of 1979 requires the Department of Health to provide annual reports on its effectiveness to the General Assembly, the only available report was the *Report of the Quality Assurance Program*, which was prepared in January 1997 for the 1995-96 fiscal year. The report provided very limited information about the Department of Health and did not include statistics about the performance of the department. *(Refer to page I-6.)* We recommend that the General Assembly require the Department of Health to consistently provide the information required by Section 804(d) of the Health Care Facilities Act of 1979. In addition, it should consider requesting additional information about the Department of Health's performance to assist its decision-making processes. *(Refer to page I-7.)*

Chapter II - Complaints and Investigations

Objectives: Our objectives included determining whether the Department of Health's process of receiving complaints is adequate, and whether the Department of Health reviews all complaints alleging violations of laws, regulations, or rules in a timely manner.

Conclusions	Summary
♦ **II-A) The system to receive and record complaints on behalf of nursing home residents is insufficient.**	We determined that the Department of Health has implemented a system to record and receive the complaints filed on behalf of nursing home residents. Nevertheless, we discovered that at least three of the Department of Health's eight field offices had no written procedures to address complaints of a life-threatening nature which require immediate attention. In addition, the Department of Health has only established a system to record and receive complaints during normal business hours. *(Refer to pages II-3 and II-4.)* We recommend that the Department of Health (1) ensure that all eight field offices have written procedures to address complaints which require immediate attention and (2) establish a system to record and receive complaints after normal business hours. *(Refer to page II-4.)*
♦ **II-B) The health and security of Pennsylvania long-term care residents has been placed at risk because the Department of Health failed to investigate complaints in a timely manner.**	Our review of 52 complaints filed at one of the Department of Health's eight field offices disclosed that 36 complaints (69 percent) were investigated late according to the Department of Health's own timetables. In addition, five of the other seven field offices acknowledged that they were unable to follow up complaints on a timely basis. *(Refer to page II-6.)* The inability of the Department of Health to resolve complaints in a timely manner affected the quality of care and services provided to nursing home residents in Pennsylvania. For example, the Department of Health investigated an allegation about a resident suffering from dehydration 13 working days late and 10 days after the resident had died. *(Refer to page II-7.)* The personnel we interviewed maintained that they had insufficient staff to follow up on complaints, in addition to completing inspections and surveys. Therefore, they had assigned a greater priority to their completion of the increasing number of inspections and surveys resulting from the growing number of nursing facilities in Pennsylvania. *(Refer to page II-8.)* We recommend that the Department of Health investigate complaints in a timely manner consistent with the priority code assigned. Additionally, the Department of Health should take immediate action to utilize its tracking system to determine if staffing is adequate to investigate all complaints promptly. *(Refer to page II-8.)*

Conclusions	*Summary*
◆ **II-C) The Department of Health has adequately maintained the Nurse Aide Registry; however, additional safeguards are needed to protect older Pennsylvanians.**	Our testing of 25 nursing facilities disclosed that those facilities used the Nurse Aide Registry to verify the qualifications of individuals seeking employment as nurse aides, and no barred nurse aides were employed at those facilities during the three calendar years ended December 31, 1996. *(Refer to page II-9.)* However, our examination of hiring policies and procedures disclosed that nursing homes had no procedures to detect barred nurse aides applying for other positions involving contact with residents. In addition, information from other states about nurse aides barred from employment has not been incorporated into the Commonwealth's registry. *(Refer to page II-10.)* Therefore, the Department of Health should require nursing facilities to use the Nurse Aide Registry to investigate the backgrounds of individuals applying for positions requiring direct or indirect contact with the residents of their facility. In addition, the Department of Health should incorporate barred nurse aide information from other states into its Nurse Aide Registry. *(Refer to page II-10.)*

Chapter III - Violations

Objectives: We elected to determine whether the Department of Health is imposing sanctions if providers are found not to be in compliance with the appropriate laws, regulations, and rules, and to determine whether the Department of Health is consistently imposing sanctions for providers who are not in compliance.

Conclusions	*Summary*
♦ **III-A) The Department of Health should be more aggressive in imposing sanctions against nursing facilities.**	The Department of Health is imposing sanctions on providers who are not in compliance with appropriate laws and regulations. However, the number of those sanctions has consistently decreased during the three years ended December 31, 1996, while the number of nursing facilities has steadily increased. *(Refer to pages III-3 and III-4.)* To ensure that nursing facilities continually provide quality care to their residents, the Department of Health should analyze its system of imposing sanctions to determine the reasons for the reduction in the number of sanctions imposed. *(Refer to page III-4.)*
♦ **III-B) The consistency of the Department of Health's sanction process cannot be determined because the decision-making process has not been documented.**	The Department of Health considers the circumstances encompassing each facility's deficiencies in making its determinations to impose sanctions. Checklists and narratives prepared by the survey teams itemize any applicable factors to be used in determining the sanctions to be imposed. However, because the agency's decision-making process has not been documented, we were unable to complete our objective and conclude whether the Department of Health consistently imposes sanctions for providers who are not in compliance with laws and regulations. *(Refer to page III-5.)*
♦ **III-C) The Department of Health should establish and adhere to policies and procedures for the amendment of sanctions.**	Sanctions were amended after they had been imposed on nursing facilities without the approval of those individuals who initially authorized them. We also determined that sanction amendments were completed before appeals were filed by the nursing facilities to the Health Policy Board. Representatives of the Department of Health and the Health Policy Board confirmed that policies and procedures had not been established to amend sanction orders. *(Refer to page III-6.)* To ensure compliance with the Health Care Facilities Act, and provide for appropriate and authorized amendments to sanctions imposed on nursing facilities, the Department of Health should establish and adhere to policies and procedures for the amendment of sanctions. *(Refer to page III-7.)*

Chapter IV - Reimbursement System

Objectives: Our objectives included determining whether the Department of Public Welfare ensured services billed by long-term care facilities for Medical Assistance residents were actually provided. In addition, we elected to determine if the reimbursement rate was accurately calculated and used in determining the payment for the long-term care facilities in our sample.

Conclusions	*Summary*
♦ **IV-A) The case-mix system is accurately calculating and applying the correct long-term care providers' reimbursement rates.**	Our testing and inquiries revealed that the case-mix system calculates applicable reimbursement rate information accurately, and applies the correct parameters for peer group and individual long-term care facility rate calculations. *(Refer to page IV-3.)* In addition, we noted no exceptions between the rates calculated by the case-mix system and the rates used in the Medical Assistance Management Information System used to disburse payments. *(Refer to page IV-3.)*
♦ **IV-B) Long-term care facilities appropriately bill for the services they provide.**	We verified the calculations, rates, and dates of service for 10 invoices at each of the 25 nursing facilities we visited. The results of our testing provided reasonable assurance that the long-term care facilities provided the services that were billed. *(Refer to page IV-3.)*
♦ **IV-C) The Department of Public Welfare needs to strengthen the controls within the Nursing Home Information System.**	We identified errors in the picture date data submitted by nursing facilities to the Department of Public Welfare for the calculations of reimbursement rates. These errors could have been corrected prior to the reimbursement rate calculations if additional edit checks and controls had been implemented in the Nursing Home Information System. We recommend that the Department of Public Welfare implement safeguards to detect and prevent input errors. *(Refer to pages IV-4 and IV-5.)* In addition, we reviewed the responsibilities of the Utilization Management Review teams and determined that they have chosen to prevent future errors from occurring through education, rather than functioning in a capacity to make adjustments to previous payments to nursing facilities. However, the Utilization Management Review team is the only mechanism in place to assure that appropriate payments are made. *(Refer to page IV-6.)* Consequently, we recommend that the Department of Public Welfare determine the impact of errors in picture date data transmitted for the calculation of reimbursement rates and adjust the facility's reimbursement amounts. *(Refer to page IV-7.)*

Chapter IV – Reimbursement System (Continued)

Conclusions	Summary
♦ **IV-D) The Department of Public Welfare needs to strengthen the controls within the Medical Assistance Management Information System to recover payments for services claimed for deceased residents.**	Our testing revealed that nursing facilities are able to receive payments for residents who have died. Although the Department of Public Welfare verifies a resident's eligibility by checking the Client Information System updated by county assistance offices before processing payments, this system does not always contain the current status of a resident because the system relies on information provided by nursing facilities. *(Refer to page IV-8.)* Therefore, in order to recover payments for services claimed for deceased residents, the Department of Public Welfare should establish a routine procedure to match the active records in the Client Information System with the death records filed with the Department of Health. *(Refer to page IV-9.)*
♦ **IV-E) The number of residents requiring higher levels of care has increased.**	Our review of the Resource Utilization Groups III index scores showed that the number of Medical Assistance and non-Medical Assistance residents who have received lower levels of care has decreased 18 percent and 22 percent, respectively, from February 1994 to February 1997. *(Refer to page IV-10.)* We recommend that the Department of Public Welfare monitor the shifts to the categories of higher scores to determine if the case-mix system is providing the necessary incentive to long-term care facilities to admit Medical Assistance recipients that need higher levels of care. *(Refer to page IV-11.)*
♦ **IV-F) Case-mix reimbursement rates for Alzheimer's residents may be too low.**	Although representatives of the nursing facilities favored the present case-mix system to the previous reimbursement system because it more accurately matched cost reimbursement with levels of care, our inquiries revealed that residents suffering from Alzheimer's disease may be improperly classified. The cost of additional non-medical personnel who function as chaperones for the affected residents was not considered in the low index score applied by the Resource Utilization Groups III system. *(Refer to page IV-12.)* We recommend the Department of Public Welfare monitor the level of care to Alzheimer's residents, and consider revising the index scores for residents with this infirmity. *(Refer to page IV-12.)*

Chapter V – Case Management Practices and Quality of Care

Objectives: We elected to determine whether the Departments of Health and Public Welfare are ensuring assessments are conducted and care plans are developed to ensure each resident receives appropriate services. In addition, we attempted to evaluate the quality of care being provided to Pennsylvania nursing home residents.

Conclusions	*Summary*
♦ **V-A) Adequate procedures are performed to ensure that assessments and care plans were developed and implemented for residents.**	We determined that the Departments of Health and Public Welfare review resident assessments and care plans as part of their routine inspection processes. Problems identified during these inspections are documented and remedied in plans of correction and corrective action plans prepared by the nursing facilities. *(Refer to page V-3.)* The results of our testing at the nursing facilities we visited confirmed that care plans were developed in accordance with the assessments conducted, and the plans of correction resulting from agency surveys were implemented. *(Refer to page V-3.)*
♦ **V-B) Pennsylvania residents are not provided with sufficient information to select a nursing facility.**	Although inspection reports resulting from Department of Health surveys are public information and provide Pennsylvania residents with the most current information about the quality of care at each facility, those reports are not presently useful for the selection of a nursing facility. In addition to being difficult to read, the reports do not include the total number of deficiencies at each facility, comparative information from other surveys or other facilities, or an explanation of the seriousness of the facility's instances of noncompliance. *(Refer to page V-5.)* Therefore, we recommend that the Governor designate a council, agency, or board to provide Pennsylvania residents with the additional information necessary for them to make decisions regarding the placement of their family members and friends in nursing facilities. *(Refer to page V-6.)*

Chapter VI - Medical Assistance Approval Process

Objectives: Our objective was to determine whether there are delays in the Medical Assistance approval process and, if they exist, whether they can be prevented.

Conclusions	*Summary*
♦ **VI-A) The Department of Public Welfare has initiated plans to improve the timeliness of the Medical Assistance approval process.**	Survey results revealed that less than 75 percent of Medical Assistance approvals are received within 90 days of the date of application. Although the most prevalent reason cited for delays established that families and responsible parties fail to provide necessary documentation to county assistance offices, the second and third most frequently cited reasons included county assistance office staffing problems and processing procedures. *(Refer to pages VI-3 and VI-4.)* However, we determined that the Department of Public Welfare has already taken appropriate steps to facilitate the timeliness of the Medical Assistance approval process. Those steps included the identification of county assistance offices with problems, the implementation of a corrective action plan for those offices, and streamlining the Medical Assistance application to ask the "right" questions. *(Refer to page VI-4.)* We recommend that after the Department of Public Welfare has completed its training program and introduced the revised Medical Assistance application, it should poll the participants to monitor the timeliness of the approval process. *(Refer to page VI-5.)*

Executive Summary

Tennessee Report

State of Tennessee

Audit Highlights.

Comptroller of the Treasury Division of State Audit

1997 National State Auditors Association Joint Audit on
Long-Term Care
December 1997

AUDIT OBJECTIVES

The objectives of the audit were to review the *Board for Licensing Health Care Facilities'* and the Health Care Facilities Division of the Department of Health's legislative mandate concerning the certification, licensing, inspecting, complaint handling and sanctioning of long-term care providers in Tennessee, and the extent to which the board and the division have carried out that mandate efficiently and effectively, and to make recommendations that might result in more efficient and effective regulation of long-term care providers

FINDING

The Division Does Not Use State Civil Penalties Against Deficient Nursing Homes
Tennessee statute gives the Commissioner of Health the authority to assess state civil penalties against deficient nursing homes Because federal penalties are more severe than state penalties, the department decided to forego state penalties and simply recommend federal penalties be imposed Also, state law does not currently allow the department to impose civil penalties against deficient residential homes for the aged Division management noted that this type of enforcement provision would hold the operators of these facilities more accountable for conditions at their facilities (page 10)

Executive Summary

Texas Report

The Department of Human Services (Department) has generally complied with federal and state regulations in the conduct of surveys and complaint investigations. However, compliance with the inspection protocol does not ensure effective regulation, and more importantly, quality care in nursing facilities. Many factors have hindered the Department's ability to be effective in its regulatory role over nursing facilities, which has allowed substandard providers to exist.

The State Auditor's Office reported on a review of nursing home regulation in December 1993 (*A Review of Nursing Home Regulation in Texas*, SAO Report No. 94-015). While the Department has made a good-faith effort to address prior findings and recommendations, opportunities still exist to improve the regulatory function. In consideration of the prior audit and this current audit, the Department should continue to focus on the processes by which policies and procedures are developed, reviewed, and distributed; the quality control process; and training. On April 15, 1997, the Department's Acting Commissioner issued a directive to reengineer the long-term care regulatory process, demonstrating a commitment to improve.

The Department Has Generally Complied With Federal and State Protocol in the Conduct of Inspections

Long-term care facility surveyors generally complied with federal and state regulations in the survey and certification of nursing facilities and in the conduct of complaint investigations during fiscal year 1996. A review of survey and investigative files showed that surveyors followed the defined protocol and used the correct forms. Observation of two surveys and two complaint investigations resulted in the same conclusion.

Inspection Criteria and Performance Standards Should Be Specified

While the Department generally follows federal and state protocol in the conduct of inspections, breakdowns have occurred which can be traced to a lack of specific criteria, unclear policies and procedures, and a focus on compliance versus performance.

Concerns about the development of deficiencies were noted during this review. The development of deficiencies is the means by which the Department determines a facility's compliance with laws and regulations, and if necessary, the need for further enforcement action. Documented criteria and procedures exist, but they are not always clear. For example, the Department has no specific ratios by which to evaluate the adequacy of staffing at nursing facilities, except for licensed nurses. In one case, a facility had a history of problems associated with adequacy of staffing. Sometimes, surveyors would cite the facility, and other times they would not. Ultimately, legal proceedings concluded that inadequate staffing contributed to a resident's injuries and subsequent death.

The Department has not defined measurable performance standards for nursing facilities, nor does it require facilities to report performance measures on a regular basis. The Department contracts with nursing facilities for services as defined for the Medicaid program, but the contracts do not contain specific outcome measures requiring nursing facilities to perform at a certain level of success. This is a statutory requirement that arose from the State Auditor's review of contract monitoring of purchased services in 1994 (*A Review of Contract Monitoring of Purchased Services*, SAO Report No. 95-007).

The Department Should Improve the Use of Available Remedies in the Enforcement Function

The Department has not effectively used available remedies to regulate nursing facilities. A wide range of remedies are available under federal and state law; yet, the Department has primarily focused on the imposition of federal remedies related to the Medicaid program. State licensing remedies have been used very little. Additionally, the Department has not used a history of noncompliance at a facility as a basis for imposing remedies.

Since January 1, 1994, Department records show that license denial or revocation for nursing facilities and intermediate care facilities for the mentally retarded has been recommended at least 309 times as a result of a survey, but a license has only been denied once (in 1994), and none have ever been revoked. The Department has generally allowed facilities to correct deficiencies and return to compliance to avoid license denial or revocation, regardless of the facility's history of noncompliance. Additionally, the Department has not fully used its authority in the imposition of administrative penalties, which is one of three types of monetary penalties that can be assessed.

Communication and Coordination Between the Department and the Office of the Attorney General Should Be Improved

The referral of cases from the Department to the Office of the Attorney General for trustee appointments has generally been handled effectively. However, the assessment of civil penalties against nursing facilities has not been effectively used as an enforcement tool due to breakdowns in communication between the Department and the Office of the Attorney General. Out of 119 case referrals between September 1, 1993, and December 31, 1996, 18 cases have resulted in a monetary settlement or judgment totaling $418,500, according to the Office of the Attorney General.

Some of the breakdowns were caused by the lack of a clear definition of violations that constitute a threat to resident health and safety. Others were due to a lack of timely response from the Department to requests from the Office of the Attorney General for additional information. Management and staff of the Department and the Office of the Attorney General have recently held frequent meetings to address past problems and to develop solutions.

Management Should Continue to Evaluate Methods for Minimizing the Risk of Disclosure of Unannounced Inspections

Evidence of disclosure of unannounced inspections was not found during this audit. However, management should continue to evaluate its approach to the scheduling of standard surveys. Even without disclosure of unannounced inspections, inspection schedules can be predicted with some degree of accuracy, given the limited time frame in which they are conducted.

Procedures should be improved to manage potential conflicts of interest identified by employees. As of April 1997, 136 regional employees had affirmatively identified a potential conflict of interest with a long-term care facility, such as a relative who is an employee or resident of a facility. During fiscal years 1995 and 1996, 38 of those employees participated in 147 visits to a facility identified on disclosure forms.

Procedures Should Be Improved for Referrals to Other Regulatory Agencies

Procedures should be improved for referrals to the Board of Nurse Examiners, the Health and Human Services Commission for Medicaid fraud, and the Board of Nursing Facility Administrators. With the many referrals that the Department makes, procedures should be in place to review adherence to established policies and procedures. For example, in three cases at three different facilities, circumstances warranted the referral of nurses to the Board of Nurse Examiners, but no referrals were made.

Information Systems Should Be Improved

The approach to automation within the Long-Term Care Regulatory Program (Program) has not been well-coordinated. For example, the sections of Licensure, Certification, and Provider Enrollment have been unified within the Long-Term Care Regulatory Division since September 1, 1993, and have not yet coordinated their work. Each section has a separate information system and there is duplication in the data collected. Also, a wide variety of personal computer architectures, network topologies, and software exist in the regions, which is caused by decentralized management of automation resources and a lack of standardized procedures for purchasing.

The Program's primary automated system is not designed to provide necessary and useful reports for management and staff. Management at the Department's State Office does not have a formal tracking and reporting system to assist in the monitoring and evaluation of the Long-Term Care Regulatory Program. A thorough analysis and assessment of the current system was completed in January 1997, and discussions are underway to address the recommendations.

Summary of Management's Response

Based on the recommendations contained in this report the Department will evaluate each of the areas identified. The Department has already initiated a reengineering project for Long Term Care-Regulatory. The purpose of this project is to evaluate the long term care survey process and support operations in order to improve the effectiveness of long term care regulation in Texas. The Department will include each of the Auditor's recommendations as part of the evaluation of this program through the reengineering effort. The Department has also initiated a comprehensive review of the data automation needs of this program. The purpose of this project is to provide automation support sufficient to provide accurate and readily available information for the purposes of program operations and management oversight.

Summary of Objective and Scope

The objective of this audit was to evaluate the Department's effectiveness and its compliance with statutory duties and responsibilities in the regulation of long-term care facilities. The scope of this audit included the duties and responsibilities of the Department of Human Services' Long-Term Care Regulatory Division. The primary focus of review and testing was nursing facilities and skilled nursing facilities. However, the control systems over inspections, licensing, and the enforcement function apply to licensed personal care homes and intermediate care facilities for the mentally retarded. Some review and testing was conducted of these facilities.

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Executive Director