STATE OF LOUISIANA
LEGISLATIVE AUDITOR

Management and Oversight of Long-Term Care in Louisiana

April 1998

Performance Audit Division

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Legislative Auditor

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Performance Audit
Office of Legislative Auditor
State of Louisiana

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April 8, 1998

The Honorable Randy L. Ewing,
President of the Senate
The Honorable H. B. "Hunt" Downer, Jr.,
Speaker of the House of Representatives

Dear Senator Ewing and Representative Downer:

This report gives the results of our performance audit of the Management and Oversight of Long-Term Care in Louisiana. This audit was conducted as part of the National State Auditors Association's joint audit of long-term care. As with all performance audits, the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended apply.

This performance audit report contains our findings, conclusions, and recommendations. Appendix B contains the Department of Health and Hospital's response. I hope this report will benefit you in your legislative decision-making process.

Sincerely,

Daniel G. Kyle, CPA, CFE
Legislative Auditor

DGK/dl

[LTCARE]

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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Audit Initiation and Objectives

The Office of the Legislative Auditor conducted this performance audit as part of the National State Auditors Association (NSAA) joint audit on long-term care focusing on nursing homes. The NSAA joint audit coordinating team developed a set of suggested audit objectives. Ten states chose to participate in the audit. The specific objectives of our audit were to:

- 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

DHH Regulates Nursing Homes

The Louisiana Department of Health and Hospitals (DHH), through its Bureau of Health Services Financing (BHSF), is primarily responsible for regulating the 300 licensed nursing homes in Louisiana. As of December 31, 1997, there were 39,701 licensed nursing homes beds in Louisiana. According to a DHH official, the

department spent an estimated $2,988,000 regulating nursing homes in the 1997 federal fiscal year.

As part of the inspection process, DHH must ensure that nursing homes that serve Medicaid residents meet certain federal health and safety standards. Nursing homes that meet these requirements become "certified" and are allowed to serve Medicaid residents. There were 286 certified nursing homes in Louisiana at the time of our audit.

DHH's Health Standards Section ensures compliance with licensing and certification requirements by regular inspections and complaint investigations. DHH can sanction nursing homes that do not comply with licensing and certification requirements. The sanctions can range from nursing home providers submitting a plan of correction, which tells how deficiencies will be corrected, to revoking the nursing home's license.

DHH's Medicaid responsibilities also include reimbursing nursing homes for the cost of caring for Medicaid residents. Nursing homes are reimbursed through a prospective payment system based on different levels of care. A daily amount, or per diem, is paid for each resident according to his/her level of care. As of July 1, 1998, per diems range from $64.75 to $489.11. DHH spent nearly $500 million on Medicaid reimbursements for nursing homes during the 1996-1997 fiscal year.

(See pages 4-5 of the report.)

DHH Ensures Licensing and Certification Requirements Are Met

Our review of the documentation for 30 nursing homes showed that DHH followed all licensing and certification procedures. The documentation also indicates that appropriate inspections took place before granting a license or certifying a home for Medicaid residents.

However, we found two areas related to certification and licensure where DHH could make improvements. The first area involves the procedures followed on licensure inspections of private-pay facilities. The second area involves the timing of inspections.

For nursing homes that are licensed-only, DHH does not have written procedures detailing the specific activities to be followed by surveyors in conducting inspections. There is also no documentation of the specific activities that take place during an inspection. Only 14 of the 300 nursing homes (5%) in the state have no Medicaid and/or Medicare residents. The lack of written procedures and documentation makes it difficult to ensure uniformity in the conduct of these licensing inspections.

In our sample of inspection documentation, we found that a substantial number of inspections occurred almost exactly one year after the previous inspection. The law requires that inspections be unannounced; however, the close correspondence between inspection dates means that nursing homes can predict with some certainty when their next inspection will occur. As a result, the element of surprise is diminished. Inspections for 6 of the 30 sample homes (20%) took place within 2 days of the inspection in the previous year.

(See pages 14-17 of the report.)

Recommendations

2.1 DHH should develop written procedures detailing the actions to be followed during a licensing inspection. These procedures should be documented in some systematic manner to ensure consistency in the conduct of licensure inspections. These procedures should also ensure the safety and welfare of the residents.

2.2 DHH should increase the variability of the inspection dates so that nursing home administrators are less able to predict when their next inspection will occur.

No Evidence of Complaint Screening Process

Upon receipt of a complaint, DHH makes an immediate assessment of the information and prioritizes the complaint according to severity. However, there is no documentation of this process in the complaint files. Although complaint screening is a

subjective process that requires the use of professional judgment, evidence of this screening process should be apparent in the files. This documentation could act as a management control for DHH program managers in assessing the effectiveness of the screening process.

Currently, the automated complaint tracking system is used to track all complaints and ensures that all are investigated. However, DHH could use the system to look for trends in complaint numbers and types, investigation outcomes, as well as differences among inspection teams.

(See pages 25-28 and 30-31 of the report.)

Unclear and Conflicting Criteria Used to Assign Investigation Priorities

Department policies and procedures regarding assigning investigation priorities are not consistent with state and federal regulations. Because of this inconsistency, we were unable to verify which set of policies the agency was following when assigning investigation priorities. However, once a time frame for investigation was set, most investigations occurred within the time period established.

Guidelines for when complaints of immediate jeopardy should be investigated vary from two working days (federal guidelines) to five days (DHH policy). In addition, the requirements for investigating abuse/neglect can range from 24 hours (DHH policy) to 5 days (state regulations). Once the complaint desk sets the investigation priority, DHH does investigate the majority of complaints within the designated priority time frame (i.e., 24 hours, 5 days, etc.). Only 13 of the 119 complaints (11%) in our sample were not investigated within the designated time frame.

(See pages 28-30 of the report.)

Recommendations

3.1 DHH should document screening procedures used when deciding how quickly a complaint is

investigated. The department should develop standardized questions to ask at the time a complaint is taken, or design a complaint matrix illustrating how the severity of the complaint allegations is determined. This procedure will support how complaints were assigned an investigation priority relative to the seriousness *of the complaint and may help to reduce the* number of complaint investigations.

3.2 **DHH should review and clarify its policies used to assign investigation priorities to complaints. DHH should adopt policies that are consistent with federal regulations and state law. This *would further ensure uniformity in assigning* investigation priorities.**

3.3 **DHH should fully implement its automated complaint tracking system. The system could be used to compile performance data that would be useful to DHH management, surveyors, and complaint desk staff.**

Many Facilities Did Not Receive Timely Notice, But Most Revisits Were Timely

We sampled DHH's nursing home files and found that 31 of the 77 (40%) of the inspections that we examined did not meet the requirement for timely initial notice of inspection results. However, nearly all of the inspections in our sample had timely revisits, if needed. A delay of the initial notice may lengthen the time that facilities are out of compliance, and the time that residents of the nursing home may be subjected to substandard care and/or conditions.

For nursing homes not in substantial compliance during the inspection, DHH may conduct revisits to ensure that the deficiencies have been remedied. Federal guidelines stipulate the time frame within which revisits are to be conducted. Only 3 of the 34 surveys (9%) that received revisits in our sample did not adhere to the required time frame.

(See pages 36-37 of the report.)

Recommendation

4.1 DHH should produce initial notices of certification inspection results in accordance with the *State Operations Manual*.

DHH Seldom Assesses Monetary Sanctions

Few monetary sanctions are imposed on nursing homes found to have deficiencies. Because of the limited use of monetary sanctions, the enforcement process may not be as effective as it could be.

In our sample of 67 inspections conducted at 30 facilities, 27 inspections had deficiencies serious enough to warrant a revisit. Only 3 of these 27 (11%) were fined. Because DHH does not levy a monetary sanction on facilities that require revisits, it misses an opportunity to discourage nursing homes from future deficiencies.

(See pages 37-38 of the report.)

Recommendation

4.2 DHH should use its discretionary authority to fine all facilities that are found not to be in substantial compliance and that require a revisit. This practice may encourage facilities to strive to be in substantial compliance all year.

Type of Sanctions Often Conform to Regulations, But Some Fines Do Not

DHH has broad discretion over the type and severity of sanctions. We examined inspection records to see if facilities in similar situations were treated the same in the enforcement process. In general, we found that DHH was consistent in its decisions about the type of sanctions to impose. However, some fines, once imposed, were not levied as severely as the regulations require.

In 3 of the 12 fines that we examined, facilities with repeat deficiencies were fined a one-time fee instead of the per-day fee as outlined in DHH regulations. When fines are not assessed for the

repeat violations using the stricter per-day fine, the deterrent effect may be lessened or even lost.

(See pages 38-42 of the report.)

Recommendation

4.3 DHH should ensure that fines are assessed using the appropriate method. Fines that DHH determines to be repeat violations should be fined on a per-day basis in accordance with the *Standards for Payment for Nursing Facilities.*

Fines and Interest Are Not Collected by Due Date

Only 50% of the fines levied by DHH were collected by the due date. In addition, DHH did not charge any interest or penalties for these delinquent payments. With one exception, DHH did not follow its own procedures and deduct the fines from subsequent reimbursements to the facilities. As a result, the state has lost revenue, and the deterrent effect of the fines may have also been lost. Furthermore, the fines that were collected are deposited to a trust fund, but none of the money in the fund has ever been spent.

There were 12 fines in the sample of files we examined. DHH has collected nine of these, but as of November 6, 1997, three fines were still pending. Two of these three fines were under appeal by the nursing home and had, therefore, not become final. Of the ten fines that had been finalized, and, therefore, were collectable, five were not collected on time. These fines were an average of 91 days delinquent and none of them were assessed interest.

Once fines are collected, DHH forwards the money to the state treasurer's office to be deposited into the Nursing Home Residents' Trust Fund. State law specifies that the monies in this trust fund are to be used to protect the health or property of residents of nursing homes that DHH finds deficient. According to a DHH official, no claims have ever been filed against the fund. As of November 22, 1997, the fund has more than $100,000.

(See pages 42-46 of the report.)

Recommendations

4.4 **After fines become final, they should be treated as accounts receivable and collected by DHH's accounting section.**

4.5 **For those fines that are delinquent, DHH should charge interest and deduct the total amount due from the facility's Medicaid reimbursement payment.**

4.6 **DHH should inform residents and their families, through its publication *Nursing Home Care in Louisiana*, of the existence and possible uses of the Nursing Home Residents' Trust Fund, whenever applicable.**

Denial of Payments for New Admissions Has Control Weakness

The procedures used to enforce the sanction of denial of payments for new admissions lack sufficient internal controls. Facilities could still be reimbursed through the Medicaid program for new admissions during the sanction period. This weakness may lessen the effectiveness of the denial of payments sanction.

The procedures followed to enforce the denial of payments for new admissions sanction are informal. DHH notifies the staff members who process new admissions not to authorize new admissions for the sanctioned facility during a specified period. An oversight by a DHH staff member processing new admissions could lead to payment for a new admission during the sanction period. No controls, either by other staff members or by computer edits, ensure that the sanction is carried out properly.

(See page 46 of the report.)

Recommendation

4.7 **DHH should adopt formal procedures that protect against possible admission errors during the denial of payments for new admission sanction. This could include computer edits by**

the fiscal intermediary to deny payment for new admissions during the sanction period.

Case Management Regulations Are Enforced

DHH ensures proper development of resident assessments and care plans through its normal inspection process. This process appears to be carried out properly with a significant number of resident assessment and care plan deficiencies being uncovered by the surveyors. Appropriate sanctions were imposed for all deficiencies related to resident assessments and care plans for the 30 nursing homes in the sample.

We reviewed the inspection documentation for a sample of nursing homes. We found that surveyors had documented 51 resident assessment and care plan deficiencies within the 60 inspections in our sample. These data suggest that the DHH surveyors spend considerable time evaluating resident assessments and care plans.

DHH imposes sanctions for resident assessment and care plan deficiencies consistently. This serves to ensure that the health and well being of the residents is being effectively maintained.

(See pages 47-48 of the report.)

Admission and Discharge Reporting Controls Could Be Enhanced to Minimize Overpayments

DHH has some controls in place to ensure the accuracy of Medicaid recipient admission and transfer dates on payment requests. However, some of these controls involve manual processes that are susceptible to error. In addition, DHH has no controls to verify the discharge dates reported by the nursing homes. These weaknesses can allow nursing facilities to be paid for services that were not provided.

For each person applying to Medicaid for nursing home care, DHH must establish the financial and medical eligibility of the applicant. If an applicant is determined to be eligible, DHH sends a document to the facility informing them of the earliest date that Medicaid can begin reimbursing the facility for the recipient and the level of care on which the reimbursements will be based.

Each month, providers submit payment requests to the Medicaid fiscal intermediary for the previous month's nursing facility services. While DHH's reimbursement system appears to be working, it is a manual process that is susceptible to error. An oversight by staff could cause overpayments to nursing home providers.

If a nursing home resident receiving Medicaid benefits is discharged, the facility is required to notify DHH. Discharges could be to a hospital or home, or due to the death of the resident. If a facility fails to accurately notify DHH of a Medicaid resident's discharge, DHH will continue to reimburse the facility for the care of the resident.

(See pages 50-53 of the report.)

Recommendations

5.1 DHH should have Unisys install a computer edit on its payment request processing system. When Unisys data entry personnel input new admissions, this edit would require the input of some information from the new admission authorizing document (issued by DHH) that is not on the payment request. This would ensure that each new admission that is processed has the proper documentation and it would protect against errors by the staff manually screening the billing requests.

5.2 BHSF should request that the Office of Public Health's Vital Records Registry regularly provide BHSF with information about deaths in Louisiana. This information should be compared to the Medicaid eligibility roles and dates of death should be updated. In addition, BHSF should have the fiscal intermediary determine if any reimbursements were made for services provided to recipients after the date of death. If any overpayments are found, BHSF should ensure that the funds are recovered.

Level of Care Reimbursement Controls Could Be Improved

The process of changing the level of care reimbursed has no verification system in place to protect against human error. In addition, the level of care controls that DHH currently has in place do not ensure that if the level of care needed by the resident decreases, the level of care reimbursed will decrease. Because these controls are incomplete, nursing home providers can be reimbursed for services that were not provided.

As described above, DHH determines the initial level of care for each Medicaid resident. The department also authorizes any changes to the level of care reimbursed. An authorization form from DHH must accompany the first payment request that bills for the resident at the new level of care. Unisys personnel screen the payment requests to ensure that each change in level of care has the proper documentation. Like the procedure used for new admissions, this screening is vulnerable to human error and has no build-in verification procedures. Errors in the level of care reimbursed could cause payments to be made to nursing homes for services that were not provided.

Currently, the level of care controls rely on nursing facilities to report to DHH if the level of care needed by the resident decreases. DHH does not routinely compare the level of care provided with the level of care reimbursed. Certification inspections and complaint investigations may discover mismatches between the reimbursement levels and the care provided, but this is not a formal part of the inspection or investigation. Therefore, nursing facilities may be reimbursed for services not provided.

(See pages 53-55 of the report.)

Recommendations

5.3 DHH should have Unisys install a computer edit on its payment request processing system. When Unisys data entry personnel input changes in levels of care, this edit would require the input of some information from the level of care change authorization document (issued by DHH) that is not on the payment request. This would ensure that each level of care change processed has the proper authorization and it would protect against errors by the staff manually screening the payment requests.

5.4 DHH should add a procedure to the certification inspections that would have surveyors note the level of care reimbursed (from the remittance advice the facility receives along with its reimbursement from Unisys) for each of the residents in their resident sample. A comparison of the level of care reimbursed to the level actually provided could then be done for the sample of residents. If discrepancies are found, the facility would be required to complete the paper work for a change in the level of care reimbursed. DHH would have to follow up on this change to ensure that it occurs.

Post Payment Reviews Are Passive

The Surveillance and Utilization Review Subsystem (SURS) of Unisys may investigate billing irregularities by nursing facilities. These investigations, however, are usually initiated when recipients or private citizens provide the initial information. In addition, the investigations are by their nature conducted after reimbursements have occurred, thereby leaving the state to try to recover funds rather than preventing erroneous reimbursements.

In addition, the fiscal intermediary sends questionnaires to a sample of Medicaid recipients. The questionnaire asks the recipient to confirm that the reported services were received. If a recipient disagrees with the description of what services were provided, the SURS personnel may investigate. In addition to the questionnaires, private citizens or a resident's family can report alleged billing irregularities to Unisys. The SURS unit may also investigate these allegations.

Each of these methods of triggering an investigation relies on persons outside of DHH to report discrepancies. Furthermore, many nursing home residents may be too ill to tell if they got the services for which Medicaid is paying. As a result, DHH may get little or no feedback from residents who are sampled using this method.

(See pages 55-56 of the report.)

Recommendation

5.5 DHH should send the Recipient's Explanation of Medical Benefits notices to the guardians of nursing home residents rather than the residents themselves. This may generate more feedback to ensure that facilities are providing the Medicaid services that are reimbursed.

Chapter One: Introduction

Audit Initiation and Objectives

The Office of the Legislative Auditor conducted this performance audit as part of the National State Auditors Association (NSAA) joint audit on long-term care focusing on nursing homes. Each year, NSAA selects an audit topic to be addressed by any member state that wants to participate. Ten states chose to participate in this audit. The NSAA joint audit coordinating team developed a set of suggested audit objectives. The objectives focus on several aspects of nursing home regulation. Participating states had the option of modifying the NSAA objectives or developing additional objectives. We chose to complete the six suggested objectives without modification. The specific objectives of the audit were to:

- 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

Report Conclusions

The Department of Health and Hospitals (DHH) is the primary entity in Louisiana for regulating nursing homes. Our audit found that DHH conducts the necessary inspections to ensure that nursing homes in Louisiana meet all of the state licensing requirements and federal certification requirements.

For those nursing homes not subject to federal certification requirements, however, there are no written procedures for how state licensing inspections are to be conducted. There are also no standard forms to document the activities that take place during these inspections. These "license only" facilities comprise less than 5% of the total nursing homes in the state. This lack of written procedures and standard documentation makes it difficult to ensure consistency in the conduct of these inspections.

Our review of DHH inspections of 30 nursing homes indicates that the inspections took place within the time frame specified by law. However, over a third of the nursing homes in our sample had intervals between inspections of close to one year. Federal regulations state that the inspections are to be unannounced. The regularity of inspection dates diminishes the "surprise" aspect of the inspections.

Our review of the complaint system found that DHH generally investigated complaints against nursing homes within the designated time frame. However, the process for setting priorities for investigating complaints is not documented. Therefore, it is difficult to determine if investigation priorities are appropriate and consistent. Furthermore, DHH uses inconsistent and sometimes conflicting guidelines to set investigation priorities.

In addition, the Health Standards Section's automated complaint-tracking system is not being fully utilized. This system could help the department evaluate the efficiency and effectiveness of the complaint system. It could also help them to identify those nursing homes that have complaints filed on a regular basis.

After DHH surveyors complete nursing home inspections, they must report any deficiencies found to the home's administrator. More than one-third of the inspections that we examined did not meet the requirement for timely initial notice of inspection results. However, nearly all of the

nursing homes requiring a revisit, based on inspection results, received a revisit in a timely manner.

DHH rarely imposes monetary sanctions. Our sample of inspections shows that only 4.5% of the inspections resulted in monetary sanctions to the nursing homes. Nearly 40% of the inspections we reviewed, however, found the nursing homes were not in substantial compliance with state and federal regulations and required a revisit to verify their compliance. DHH is spending the state's limited resources to revisit these facilities, but it is not giving the facilities a monetary disincentive to avoid the need for revisits.

Generally, we found that DHH imposes consistent sanctions on nursing homes found to have deficiencies. However, some fines are not imposed according to regulations. Furthermore, DHH does not collect fines in accordance with its procedures. Half of the fines that were assessed against the homes in our sample were not collected until after their due dates. We also found that no interest was charged on the delinquent fines. As a result, DHH lost an opportunity to collect additional revenue. The deterrent effect of levying fines was diminished.

Our file review found that DHH is ensuring that resident assessments are conducted and care plans are developed through its normal inspection process. When deficiencies are found, DHH imposes the appropriate type of sanction on the facility.

We found that although DHH has controls in place to prevent overpayments to Medicaid nursing home providers, these controls could be strengthened. The procedures in place to control the accuracy of Medicaid nursing home billings are manual processes that are susceptible to error. In addition, some of these controls are used on only a sample of actual billings. The controls currently in place do not ensure that if the level of care actually needed by the resident decreases, the level of care reimbursed will decrease. These weaknesses can allow nursing facilities to be paid for services that were not provided.

DHH Regulates Nursing Homes

The Louisiana Department of Health and Hospitals (DHH), through its Bureau of Health Services Financing (BHSF), is primarily responsible for regulating the 300 licensed nursing homes in Louisiana. A nursing home is defined by state law as a private home, institution, building, residence or other place, serving two or more persons who by reason of illness or physical infirmity or age, are unable to properly care for themselves. State law (R.S. 40:2009.4) authorizes DHH to adopt regulations to promote safe, proper and adequate treatment of residents in nursing homes. DHH has codified these regulations in the *Minimum Standards for Nursing Homes*. Nursing homes must comply with these state regulations to obtain an operating license. Nursing homes must also pay a licensure fee. During the time period reviewed in this audit, the fee was $400 plus $3 per bed. As of January 1998, the fee was changed to $600 plus $5 per unit. The revenue from these fees goes into the state's general fund and from there back into DHH's operating budget. As of January 20, 1998, there were 38,542 licensed nursing homes beds in Louisiana.

DHH is also responsible for administering the state's Medicaid Program. As part of this responsibility, DHH must ensure that nursing homes that serve Medicaid residents meet certain federal health and safety standards. DHH must adhere to federal operating guidelines in evaluating whether these standards are followed. These guidelines are laid out in the *State Operations Manual* issued by the Health Care Financing Authority (HCFA). HCFA is part of the federal Department of Health and Human Services and is responsible for administration of Medicare and Medicaid programs. Nursing homes that meet federal health and safety requirements become "certified" and are allowed to enroll Medicaid residents. The HCFA guidelines and all state laws bearing on the Medicaid program are summarized in a BHSF publication called the *Standards for Payment for Nursing Facilities*.

DHH's Medicaid responsibilities include reimbursing nursing homes for the cost of caring for Medicaid residents. Approximately 30% of the money for reimbursements comes from state funds; the remainder comes from federal funds. Nursing homes are reimbursed through a prospective payment system based on different levels of care. A daily amount, or per diem, is paid for each resident according to his/her level of care. As of July 1, 1997, per diems range from $64.75 to $489.11. The reimbursement rates apply uniformly to all nursing homes within the state.

DHH spent nearly $500 million on Medicaid reimbursements for nursing homes during the 1996-1997 fiscal year. Of that amount, $15,767,385 was spent on state-run nursing facilities, whereas $466,669,337 was spent on private nursing facilities. Exhibit 1-1 illustrates how much BHSF spent on nursing homes for fiscal years 1994-1995, 1995-1996, and 1996-1997.

Exhibit 1-1

Department of Health and Hospitals
Nursing Home Expenditures

Nursing Homes	Fiscal Year 1994-1995	Fiscal Year 1995-1996	Fiscal Year 1996-1997
Private	$512,176,791	$503,472,410	$466,669,337
Public	21,745,125	15,863,025	15,767,385
Medicaid Total	**$533,921,916**	**$519,335,435**	**$482,436,722**

Source: Prepared by legislative auditor's staff using unaudited information provided by DHH

BHSF is organized into nine functional areas: Eligibility Operations, Eligibility Program Operations, Medicaid Management Information Systems (MMIS), Health Standards, Program Integrity, Policy and Planning, Program Operations, Institutional Reimbursement, and Financial Operations. Exhibit 1-2 on the following page shows BHSF's organization chart.

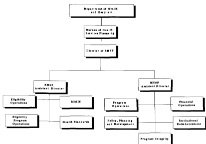
Health Standards Section Responsible for Licensure and Certification of Nursing Homes

The Health Standards Section within BHSF is responsible for enforcing licensing and certification requirements for nursing homes. The Health Standards Section ensures compliance with these requirements through a process of regular inspections and complaint investigations. The Section has 124 surveyors allocated among 9 regional offices (see Exhibit 1-3 on page 7). The surveyors operate in teams that include a variety of professionals such as nurses, dieticians, and social workers. These surveyors not only inspect nursing homes, but also inspect a wide variety of other types of facilities including group homes and mental hospitals. The Health Standards Section does not separate expenditures for

regulating nursing homes from other long-term care regulatory expenditures. However, DHH officials estimate that the Health Standards Section spent $2,988,000 regulating nursing homes in the 1997 federal fiscal year

The Health Standards Section is also responsible for enforcing sanctions against nursing homes that do not comply with licensing and certification requirements. The type of sanction chosen depends on the severity and extent of the deficiencies discovered through inspections and complaint investigations. The sanctions can range from nursing home providers submitting a plan of correction, which tells how deficiencies will be corrected, to revoking the license of the nursing home.

Exhibit 1-2
Bureau of Health Services Financing Organization Chart
(as of September 9, 1997)



Source: Prepared by legislative auditor's staff using information provided by DHH.

Exhibit 1-3
Location of BHSF Regional Offices

Source: Prepared by legislative auditor's staff using information provided by DHH.

Other Agencies and Offices Involved in the Regulation of Nursing Homes

Several state agencies and offices assist the Health Standards Section of DHH in regulating nursing homes. These include the State Fire Marshal, the Office of Public Health, the Office of Elderly Affairs, and the Department of Justice. Each of these agencies plays a significant role in ensuring the health and well-being of nursing home residents.

The State Fire Marshal's Office and the Office of Public Health are directly involved in the inspection process. The State Fire Marshal inspects all nursing homes for compliance with building and fire code regulations. These inspections generally occur simultaneously with the inspections by Health Standards Section surveyors. Inspectors from the Office of Public Health evaluate compliance with the State Sanitary Code. These inspections are done separately, but like the Health Standards Section and State Fire Marshal inspections they are done yearly for all nursing homes.

The Office of Elderly Affairs administers the state's Ombudsman Program. Ombudsmen serve as advocates of nursing home residents. They investigate some complaints and monitor the state's regulation of nursing homes. Ombudsmen also share information with DHH surveyors and often attend exit conferences of nursing home inspections. Verified allegations of abuse, neglect, financial exploitation, or Medicaid fraud are referred to the Medicaid Fraud Control Unit within the Department of Justice for investigation.

Scope and Methodology

This performance audit of long-term care in Louisiana was conducted under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. We conducted the audit in accordance with generally accepted government auditing standards as promulgated by the Comptroller General of the United States.

The scope of this audit was limited to long-term care provided within nursing homes. We did not look at adult day care, developmental disability institutions, or other types of long-term care. Specifically, we evaluated DHH's oversight of nursing homes in five areas: licensing and inspections, complaints, billing, enforcement, and case management practices. Our audit tests focussed on DHH activities in the calendar years 1996 and 1997.

We reviewed state and federal laws, DHH rules and regulations, and DHH provider files. We also interviewed DHH personnel. We assessed DHH oversight activities by reviewing the documentation in the provider files, interviewing DHH employees, and observing inspections. We then compared DHH's oversight activities with those mandated by state and federal laws and identified any differences.

Our review of the documentation in the provider files was not performed for all nursing homes in the state because of the large number of facilities. Rather, we took a random sample of 10% of the licensed nursing homes in the state. We drew this 10% sample separately for each of the nine BHSF regions to ensure geographic representation. This resulted in a sample of 30 nursing homes. We conducted separate file reviews for these 30 nursing homes in the areas of licensure/certification, complaints, and sanctions. Because few of the nursing homes in the sample had been sanctioned, we drew an additional sample of 10 nursing homes from a list of all homes that had been sanctioned in the previous two years. We included this second sample in our sanction analysis.

Report Organization

The remainder of this report is divided into the following chapters and appendixes:

- **Chapter 2** describes the licensure and inspection processes and our finding regarding the audit objectives related to licensure and inspection.
- **Chapter 3** describes the complaint processing system and our findings regarding the audit objective related to the complaint system.
- **Chapter 4** describes the enforcement and sanction process and details our findings related to sanctions. It also contains our work on the case management objective.
- **Chapter 5** describes the reimbursement process and assesses DHH's controls related to this process.
- **Appendix A** contains class violation levels and their associated fine amounts.
- **Appendix B** contains DHH's written response to the report.

Chapter Two: Licensing and Inspections

Chapter Conclusions

The Health Standards Section within DHH is ensuring that nursing homes in Louisiana meet all of the state licensing requirements and federal certification requirements. In addition, our sample file review indicates that DHH is conducting all of the necessary inspections before issuing a license and certifying a home as eligible to receive Medicaid residents.

For those nursing homes not subject to federal certification requirements (less than 5% of the Louisiana nursing home population), there is no written procedure for how state licensing inspections are to be conducted. There are also no standard forms to document the activities that take place during these inspections. The lack of written procedures and standard documentation forms makes it difficult to ensure consistency in the conduct of the inspections.

Our review of DHH inspections of 30 nursing homes indicated that the inspections took place within the time frame specified by law. However, over a third of the nursing homes in our sample had intervals between inspections of close to one year. The regularity of inspection dates diminishes the "surprise" aspect of the inspections.

Licensing and Inspection Process

DHH licenses the 300 nursing homes in the state and enforces compliance with state standards through periodic inspections. Those nursing homes that accept Medicaid recipients (286 of 300 homes, or 95%) must conform to federal certification standards in addition to the state licensing standards. DHH ensures adherence to these federal standards through periodic inspections.

State Licensing Requirements. All nursing homes in Louisiana must be licensed by DHH before operation. These licenses must be renewed yearly. Licenses must also be renewed when a nursing home expands its facilities. To obtain a license, a prospective nursing home must (1) meet the state's minimum standards; (2) fill out an application form; and (3) pay a licensure fee. The same process is followed for renewals.

The licensing standards that must be met by nursing homes are codified in the DHH publication *Minimum Standards for Nursing Homes*. This publication was last revised in 1974; however, it is currently under revision. State law stipulates that the licensing standards shall relate to:

- Location and construction of the home
- Number and qualifications of personnel
- Sanitary conditions
- Diet related to the needs of each resident
- Equipment essential to the health and well-being of the residents

The application form requests information about the ownership of the home, the number of licensed beds, the administrators of the home, the number and type of employees, and other information relevant to DHH's oversight responsibilities.

The licensing process begins with DHH's receipt of a license application. Upon receipt of the application, DHH causes an investigation to be made of the home to assess compliance with the *Minimum Standards for Nursing Homes*. The investigation consists of three distinct activities: an inspection by DHH's regional office, an inspection by the State Fire Marshal, and an inspection by the Office of Public Health.

Care is taken to ensure that the State Fire Marshal inspection does not occur before the Health Standards Section inspection. This would alert the home and eliminate the "surprise" aspect of the inspection. The Office of Public Health sanitation inspections occur separately according to its own schedule. These inspections are done yearly and the results are submitted to the Health Standards Section upon completion.

Upon determination that the home meets the requirements in the *Minimum Standards for Nursing Homes* and that the appropriate fee has been received, DHH issues a license for a 12-month period. The license is sent to the home and must be displayed in a conspicuous place. At the time of renewal, a provisional license may be issued (for a period not to exceed six months) when a home needs more time to come into full compliance with minimum standards, and there is no threat to the health and safety of the residents.

Federal Certification Requirements. Nursing homes that accept Medicaid recipients must be certified in addition to being licensed. To be certified, a home must:

- Undergo a facility need review
- Be licensed by the state
- Be in compliance with the federal requirements for participation
- Enter into a provider agreement with DHH

First, a facility need review must be conducted for the home. Facility need reviews are assessments of whether or not there is sufficient need within a community for additional Medicaid nursing home beds. These reviews are a state, not federal, requirement. Without approval from the Facility Need Review Program, a nursing home cannot have any of its beds certified as Medicaid beds even if it meets all other conditions of participation.

The second requirement is licensure. Licensure must be obtained before or in conjunction with the request for certification of beds in the Medicaid program.

Third, a home must be in compliance with the federal requirements, which are codified in 42 CFR 483.1- 483.75. These requirements relate to all aspects of nursing home care. They include resident rights, quality of care, facility services, infection control, and administration among several other areas. These requirements are more extensive and detailed than the state licensing standards. According to a DHH official, DHH conducts the certification inspection and the licensure inspection together to prevent duplication of effort.

Certification inspections are conducted to ensure compliance with the federal requirements for participation. Inspections must take place at least once every 15 months and the state average interval must be 12 months. The procedures followed during these inspections are outlined in Appendix P of the *State Operations Manual*. The inspection consists of seven tasks: offsite inspection preparation, entrance conference, initial tour, sample selection, information gathering, information analysis for deficiency determination, and the exit conference.

The surveyors use the HCFA document *Guidance to Surveyors* to help identify specific deficiencies. This document provides interpretation and clarification of all federal requirements

as stated in 42 CFR 483.1-483.75. A tag number is given for each legal requirement. Deficiencies are written on a statement of deficiencies form by reference to these tag numbers. The severity of deficiencies is assessed through use of a grid in the *State Operations Manual*. This grid categorizes deficiencies and indicates the minimum sanctions for each category. For a fuller discussion of sanctions, see Chapter 4.

Finally, there must be a provider agreement which specifies that the nursing home has met the federal requirements for participation and gives the type of service for which the nursing home has been certified. The bulk of the agreement lays out the contractual responsibilities of the nursing home and DHH in the provision of care to Medicaid residents.

DHH Ensures Licensure and Certification Requirements Are Met

Documentation in DHH files verifies that DHH followed all licensing and certification procedures for the 30 nursing homes in our sample. Also, the documentation indicates that all appropriate inspections took place before granting a license or certifying a home for Medicaid residents. As a result, DHH appears to be complying with state and federal laws regarding licensing and certification of nursing homes.

DHH stores the licensure documents in a series of individual provider files. These provider files contain an application form, a copy of the check used to pay the license fee, and the inspection reports (i.e., the Health Standards Section Report, the State Fire Marshal Report, and the Office of Public Health Report). Our file review verified the presence of this documentation for the two most recent years for the 30 nursing homes in our sample.

The certification documentation is located in the same provider files as the licensure documentation. Our file review indicated that all certification documents were present and appropriately filed for the 30 homes in our sample. Separate file reviews for the Facility Need Reviews and Provider Enrollment Agreements showed that all necessary documents were present and appropriately filed for the 30 homes in our sample.

No Written Procedure for Licensing Inspections

For nursing homes that are licensed only, DHH does not have a written inspection procedure. In addition, no standard forms are used to document the activities performed by the surveyors. The lack of written procedures and standard documentation makes it difficult to ensure uniformity in the conduct of licensing inspections.

During our observation of a state licensing inspection, we noted that there were no written procedures detailing the specific activities to be followed by DHH surveyors in conducting these inspections. There was also no formal documentation of the specific activities that took place during this inspection. A DHH official stated that surveyors simply go regulation by regulation through the DHH's *Minimum Standards for Nursing Homes* and note any deficiencies.

Only 14 of the 300 nursing homes (5%) in the state do not accept Medicaid residents. These homes are subject to state licensing inspections but not federal certification standards. Consequently, the lack of written procedures for how to conduct state licensure inspections applies only to these 14 nursing homes.

The other 286 nursing homes in the state have Medicaid residents and the surveyors must conform to the certification standards in the *State Operations Manual*. During our observation of two certification inspections, we evaluated the activities of the surveyors against the procedures outlined in the *State Operations Manual*. The surveyors followed the appropriate procedures and completed all the necessary forms to document the inspection. Our file review of the certification inspection documentation for the 30 homes in our sample also showed that the surveyors are documenting the inspections properly.

Recommendation

2.1 DHH should develop written procedures detailing the actions to be followed during a licensing inspection. These procedures should be documented in some systematic manner to ensure consistency in the conduct of licensure inspections. These procedures should also ensure the safety and welfare of the residents.

Inspection Timing Is Predictable

In our review of certification inspection documentation, we found that a substantial number of inspections occurred almost exactly one year after the previous inspection. The law requires that inspections be unannounced; however, the regularity of inspection dates means that nursing homes can predict with some certainty when their next inspection will occur. As a result, the element of surprise is diminished. Over a third of the nursing homes in our sample had inspections within 2 weeks of the date of the prior year's inspection. Inspections for 6 of the 30 sample homes (20%) took place within 2 days of the date of the prior year's inspection. The intervals between inspection dates for the sample homes ranged from 1 day to 2½ months as shown in Exhibit 2-1.

Exhibit 2-1
Intervals Between Inspections for 30 Sample Nursing Homes

Intervals Between Dates of Inspections	Number of Nursing Homes	Percentage of Total
Within 2 Days	6	20%
From 3 to 14 Days	5	17%
From 15 to 30 Days	12	40%
From 31 to 60 Days	3	10%
From 61 to 75 Days	4	13%
Total	**30**	**100%**

Source: Prepared by legislative auditor's staff using information provided by DHH.

Recommendation

2.2 DHH should increase the variability of the inspection dates so that nursing home administrators are less able to predict when their next inspection will occur.

Chapter Three: Complaint System

Chapter Conclusions

Generally, DHH investigates complaints against nursing homes within the designated time frame. However, the process for setting priorities for investigating complaints is not documented. Therefore, it is difficult to determine if investigation priorities are appropriate and consistent. Furthermore, DHH uses inconsistent and sometimes conflicting guidelines to set investigation priorities.

The Health Standards Section's automated complaint-tracking system is not being fully utilized. This system could help the department evaluate the efficiency and effectiveness of the complaint system. It could also help them to identify those nursing homes that have complaints on a regular basis.

Overview of Complaint System

In fiscal year 1996, DHH received more than 500 complaints against nursing homes. In fiscal year 1997, the number of complaints received grew to over 700. The complaint desk within the Health Standards Section is the central point of entry for all complaints against nursing homes and intermediate care/mentally retarded facilities. The complaint desk manager is responsible for intake of all information regarding the complaint from the complainant. Depending upon the nature of the complaint, DHH may send surveyors to determine whether residents' safety and well-being are jeopardized.

DHH follows both state and federal complaint procedures. At the federal level, the Health Care Financing Administration (HCFA) establishes complaint procedures for DHH. HCFA has developed regulations governing health, safety, and well-being issues pertaining to residents in nursing homes.

At the state level, the *State Operations Manual* provides the Health Standards Section complaint desk with general operating requirements for processing complaints. Other than these guidelines, DHH has discretionary authority to establish its own complaint processing control system, as long as this system ensures the timely and appropriate action on all complaint allegations. In

addition to federal requirements, DHH complies with state laws, department procedures and internal policies that it follows.

The department's nursing home complaint investigation process is outlined in Exhibit 3-1 on page 21. It can be divided into four areas:

- Intake
- Screening
- Investigation
- Results

Complaint Intake Process. DHH receives complaints from a variety of sources. R.S. 40:2009.14 requires the department to review all complaints and determine whether there is reasonable grounds for an investigation. No complaint is investigated if it is trivial, not made in good faith, or too outdated to justify a complaint investigation, or not within DHH's investigating authority. For example, if the complaint relates to a private physician's care for a nursing home resident, then DHH refers these complaints to the appropriate regulatory authority.

According to DHH officials, each complaint that is not eliminated for one of the above reasons must be investigated, and a complaint report must be received from the investigating team. DHH is required to collect the following information for every complaint allegation:

(1) the complainant's name and address (unless complainant requests anonymity);

(2) facility name and address; and

(3) a description of the problem or problems, including names, places and dates. (Each complaint can have multiple problems or allegations.)

Complaint Screening. Members of the complaint desk staff must have a baccalaureate degree or current Louisiana license and at least 5 years of experience in nursing, pharmacy, dietetics/nutrition, or medical technology. This staff screens the complaint in order to determine the severity of the allegations. Once the seriousness of the allegations is determined, the staff assigns an action code to the complaint.

Each complaint is assigned to one of the following investigation priorities: 24-hour, 5-day, or 30-day. All of these investigation priorities are assigned according to whether or not the complaint alleges immediate jeopardy to resident health and safety.

In addition to complaints, there are also allegations of non-compliance which are less serious allegations that do not receive a separate investigation by DHH. Allegations of noncompliance include next on-site visits and administrative referrals. The inspection team reviews allegations assigned "next on-site" priority, along with complaint investigations, before conducting the facility's next annual inspection, in order to be aware of any potential problems. Administrative referrals, on the other hand, are referred to the facility administrator for investigation. According to complaint desk staff, the facility has five working days to respond back to DHH with the outcome of the investigation.

Complaint Investigation. DHH forwards complaints to the regional office that oversees the facility that the complaint is against. The regional office manager receives the complaint and schedules it for investigation by an inspection team.

The surveyors are required to conduct complaint investigations in accordance with very specific investigation procedures outlined in the *State Operations Manual*. These procedures include reviewing records and observing parts of the facility's physical environment that may be relevant to the complaint. In addition, the surveyors interview the complainant, the person the complaint was about, other witnesses and staff involved.

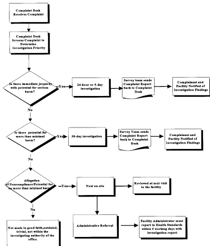
Before completion of the investigation, the inspection team is required to complete a report with a narrative description of the complaint, including the results of the investigation. If the surveyors find that the facility fails to meet one or more of the licensing or certification requirements, DHH can initiate some type of enforcement action.

Complaint Results. Once the complaint report is received from the inspection team, the complaint desk staff logs findings of the investigation into the complaint-tracking computer system. DHH then sends a letter to the nursing facility, as well as the complainant, with the results of the complaint investigation. Any complaint findings are noted in this letter. Complaint allegations can be valid, invalid, or unable to be verified.

- Valid Complaints - An on-site complaint investigation has found noncompliance with a regulation
- Invalid Complaints - An on-site complaint investigation has identified compliance with a regulation.
- Unable to verify - An on-site complaint investigation was unable to determine if there was non-compliance with a regulation

DHH keeps a pending file of all outstanding complaints against nursing homes. When the surveyor submits the complaint report, it is matched with the pending file. This procedure helps to ensure that all complaints are investigated in a timely manner.

Exhibit 3-1
DHH Nursing Home Complaint Process



Source: Prepared by the legislative auditor's staff with information provided by DHH.

Procedure Followed for Complaint Investigations

Our review of the nursing home complaint files indicated that the surveyors conducting the complaint investigations followed the defined procedure and properly documented the investigations. We reviewed complaint files for 30 nursing homes to determine two things: the adequacy of the complaint processing system and the timeliness of complaint investigations. Exhibit 3-2 below illustrates the types of allegations we reviewed in our sample, as well as definitions and an example of each type. These examples came from the files we reviewed.

Exhibit 3-2
Types of Nursing Home Complaint Allegations and Allegations of Noncompliance

Type	Definition	Examples
Care/Services	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being.	• A resident who had no bedsores (before admission to the nursing home) now has bedsores.
Dietary	Each resident must be provided with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.	• A resident is diabetic, and does not receive the proper diabetic diet.
Environment	The nursing facility is required to care for its residents in an environment that promotes maintenance or enhancement of each resident's quality of life. The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.	• The facility temperature is too cold; therefore, the residents are uncomfortable.
Resident Abuse	The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish.	• A resident has a bruise on the face, the cause of which is unknown.
Resident Neglect	The failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.	• A resident was denied food and water for several days.
Resident Rights	The resident's right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.	• A resident was denied his freedom of choice of pharmacy.
Allegations of Non-Compliance	Minor allegations that are deferred to the next on-site visit. These are used for off-site preparation activity.	• A resident's glasses were scratched and she could not see through them
Administrative Referrals	These are non-immediate concerns sent by mail or phone to the nursing home the allegation was against. The nursing home is responsible for investigating the allegation and responding back to DHH.	• A resident wants to leave the nursing home and the facility administrator will not let her leave.

Source: Prepared by legislative auditor's staff using information provided by DHH.

We reviewed all complaints on file for the last two fiscal years (1995-96, 1996-97) for the 30 nursing homes in our sample. This resulted in 119 complaints in our analysis. Some complaints had multiple allegations. The 119 complaints that we reviewed contained 398 allegations.

Over half of the allegations relate to the care of residents or the services that they should receive. Exhibit 3-3 below shows the total number of each type of allegation in our sample.

Exhibit 3-3
Types of Allegations From Sample

Type of Allegation	Total	Percentage
Care/Services	228	57%
Dietary	18	5%
Environment	24	6%
Resident Abuse	25	6%
Resident Neglect	14	4%
Resident Rights	22	6%
Other	19	5%
Combination*	14	3%
Allegations of Noncompliance	26	7%
Administrative Referrals	8	2%
Total Allegations	**398**	**100%**

*Can be a combination of any of other types of allegations.
Note: Percentages do not add up to 100% due to rounding.

Source: Prepared by legislative auditor's staff using information provided by DHH.

No Evidence of Complaint Screening Process

The complaint files we reviewed contained no evidence of how the complaint desk staff screens complaints to determine the investigation priority assigned. Not documenting this critical decision during complaint intake makes it difficult to tell whether reasonable grounds for an investigation always exist, or whether the

complaint desk is properly analyzing problems that should be investigated sooner than the assigned investigation priority.

Upon receipt of a complaint, DHH makes an immediate assessment of the information and prioritizes the complaint according to severity. In order to determine how quickly complaints should be investigated, the complaint desk staff asks the complainant a series of questions. However, there is no documentation of these screening questions in the complaint files or on correspondence sent to the regional office.

HCFA permits DHH to decide the timing, scope, duration and conduct of a complaint investigation, except when the complaint involves an allegation of immediate jeopardy to resident health and safety. Complaints that allege immediate jeopardy to a resident's health and safety, and those that allege resident abuse, or neglect are given top priority. The complaint desk staff relies on professional judgment to make an immediate assessment of the complaint. According to department officials, if a resident's life is in immediate jeopardy, or if there is a chance that other residents' lives might be jeopardized, then the complaint is investigated immediately (within 24 hours). On the other hand, if the immediate jeopardy has been removed the investigation is conducted within five days.

Half of the complaints in our sample were assigned a 30-day investigation requirement. Exhibit 3-4 on the following page shows the priority assigned to the 119 complaints in our file review.

Exhibit 3-4
Assigned Investigation Priorities of Complaints in Sample

Investigation Priority	Number Received	Percentage
24 hours	22	19%
5 days	21	18%
30 days	60	50%
Next on-site	10	8%
Administrative Referral	6	5%
Total	**119**	**100%**

Source: Prepared by legislative auditor's staff using information developed using DHH complaint files.

More than 40% of the complaint reports we reviewed had unverifiable allegations. Exhibit 3-5 on the following page illustrates the number of allegations that were unverifiable relative to the assigned investigation priority. A complaint is unverifiable when an on-site complaint investigation cannot determine if there was noncompliance with a regulation. Our review also identified 12 administrative referrals and 26 allegations of noncompliance. Because DHH does not send out surveyors specifically to investigate allegations of noncompliance, the complaint files we reviewed did not contain complaint reports categorizing these allegations as valid, invalid, or unverifiable. Therefore, these do not appear in Exhibit 3-5.

Exhibit 3-5
Total Allegations Found to Be Unverifiable

Investigation Priority	Total Allegations	Total Unable to be Verified	Percentage Unable to be Verified
24 hours	59	28	47%
5 days	65	30	46%
30 days	232	94	41%
Next on-site	4	3	75%
Total	**360**	**155**	**43%**

Source: Prepared by legislative auditor's staff using information provided by DHH.

Although complaint screening is a subjective process that requires the use of professional judgment, evidence of this screening process should be apparent in the files. This information could act as a management control for DHH program managers in assessing the effectiveness of the screening process. For example, it could be used to refine the screening process to try to minimize the number of allegations that are found to be unverifiable when investigated.

Recommendation

3.1 DHH should document screening procedures used when deciding how quickly a complaint is investigated. The department should develop standardized questions to ask at the time a complaint is taken, or design a complaint matrix illustrating how the severity of the complaint allegations is determined. This procedure will support how complaints are assigned an investigation priority relative to the seriousness of the complaint and may help to reduce the number of complaint investigations.

Unclear and Conflicting Criteria Used to Assign Investigation Priorities

Although DHH has policies and procedures for assigning investigation priorities, it is not always clear which one is followed. Furthermore, department policies and procedures are not consistent with department and federal regulations. Because of this lack of clarity, we were unable to verify which set of policies and procedures the department was following when assigning investigation priorities. However, once a time frame for investigation was set, most investigations occurred within the time period prescribed.

Federal Regulations and Department Policy and Procedures Conflict on When to Investigate Some Serious Complaints

The federal guidelines in the *State Operations Manual* permit DHH to use professional judgment when determining the conduct, urgency and disposition of a complaint except in cases of immediate jeopardy. In these exceptional cases, the *State Operations Manual* requires DHH to investigate within two working days. However, departmental policy states that complaints of immediate jeopardy should be investigated within five days.

Furthermore, the complaint procedures listed in the *Standards for Payment for Nursing Facilities* require resident abuse or neglect allegations to be investigated within five days. However, according to department policy, complaints of abuse and neglect have a 24-hour investigation requirement.

Of the 398 allegations in our sample of complaint files, 40 were allegations of resident abuse or neglect. These 40 allegations came from a total of 30 complaints. Six of the 30 complaints were assigned 30-day investigation requirements, and one was assigned to the next on-site visit (within 30 days). According to DHH officials, the process is partly subjective. For example, a complaint of abuse is usually assigned a 24-hour investigation. However, if it can be determined that immediate jeopardy has been removed, then the complaint will be assigned a 5-day investigation requirement. The following example illustrates how immediate jeopardy could be removed.

A certified nurse's aide is reported for abusing a resident. The nursing home investigates the allegation and the aide is fired. Therefore, the immediate jeopardy has been removed, as well as the risk to resident safety. This allegation would no longer have a 24-hour investigation requirement.

DHH's use of inconsistent and sometimes conflicting guidelines to set investigation priorities makes it difficult to determine if complaints are assigned an appropriate investigation priority. By having unclear and conflicting criteria, the assignment of investigation priorities could be subject to different interpretations. Given the volume of complaints DHH receives each year, priority assignment is a critical task in effectively and efficiently regulating nursing homes and assuring the health and safety of their residents.

Most Complaints Investigated Within Established Time Frame

Once the complaint desk sets the investigation priority, DHH investigates the majority of complaints within the designated priority time frame (i.e. 24 hours, 5 days, etc) Only 13 of the 119 complaints in our sample (11%) were not investigated within the designated time frame. Most of these late complaint investigations were related to allegations of care and services violations. However, 4 of the 13 late investigations contained allegations of abuse or neglect. Exhibit 3-6 illustrates the total number of late complaint investigations in our sample (by time frame).

Exhibit 3-6

Late Complaint Investigations by Time Frame

Time Frame	Late Investigations
24 hours	2
5 days	7
30 days	4
Total	**13**

Source: Prepared by legislative auditor's staff using information from DHH complaint files.

Recommendation

3.2 DHH should review and clarify its policies used to assign investigation priorities to complaints. DHH should adopt policies that are consistent with federal regulations and state law. This would further ensure uniformity in assigning investigation priorities.

Automated System Not Fully Utilized

Currently, Health Standards Section's automated complaint tracking system is not being used to its full potential. A system like this could be used to produce useful program analysis information, such as whether complaint investigations are timely and how complaints are resolved.

In May 1997, the complaint desk began using an automated complaint tracking system. This new complaint system allows complaint desk staff to input initial information about the complaint, such as the source of the complaint, facility information, who it was reported by, which regional office the complaint investigation was assigned to, a description of the allegations, and the assigned priority time frame.

According to a DHH official, the current system is used to track all complaints and ensures that all are investigated. Also, according to the same official, this type of information will provide surveyors with a quick history of the total number of complaints for a particular facility, as well as the types of complaints. However, DHH management could use the system to look for trends in complaint numbers and types, as well as differences among regional offices.

Recommendation

3.3 DHH should fully implement its automated complaint tracking system. The system could be used to compile performance data that would be useful to DHH management, regional office surveyors, and complaint desk staff.

Chapter Four: Enforcement and Sanctions

Chapter Conclusions

After the DHH surveyors complete nursing home inspections, they must report any deficiencies to the home's administrator. In the provider files that we examined, more than one-third of the inspections did not meet the requirement for timely initial notice of inspection results. However, nearly all of the inspection documents that we examined requiring a revisit received one in a timely manner.

DHH rarely imposes monetary sanctions. Our sample of inspection documents shows that only 4.5% of the inspections resulted in monetary sanctions to the nursing homes. Over 40% of the inspection documents we reviewed, however, found the nursing homes were not in substantial compliance with state and federal regulations and required a revisit to verify their compliance. Because of the limited use of monetary sanctions, the enforcement process may not be as effective as it could be.

Generally, DHH is consistent in the type of sanctions it imposes. However, some fines are not imposed according to regulations. Furthermore, DHH does not always collect fines by the time frames established in its procedures. Some fines that were assessed against the homes in our sample were not collected until well after their due dates. In addition, no interest was charged. As a result, the state has lost an opportunity to collect additional revenue, and the deterrent effect of the fines was diminished.

Enforcement of one type of sanction, the denial of payments for new admissions, has an internal control weakness. This weakness may allow nursing homes to be reimbursed for new admissions during the sanction period.

Our review showed that DHH ensures proper development of resident assessments and care plans through the normal inspection process. When case management deficiencies are found, DHH imposes the appropriate type of sanction.

Overview of Enforcement Process

Louisiana's nursing home enforcement process begins with the inspection, which is described in Chapter Two. If the inspection finds that a nursing home failed to adhere to federal or state regulations, DHH may take some type of enforcement action.

The purpose of the inspection is to identify any deficiencies or deviations from federal or state regulations. If deficiencies are found, but are not severe, the nursing home can still be considered in substantial compliance. In these circumstances, typically, the nursing home only has to submit a plan of correction, which informs DHH of how the nursing home will correct the deficiency. If the deficiencies are such that the nursing home is found not to be in substantial compliance, then a plan of correction and either a revisit or evidence review are required to ensure that the nursing home has come into substantial compliance. Exhibit 4-1 on the following page illustrates the activities of the enforcement process.

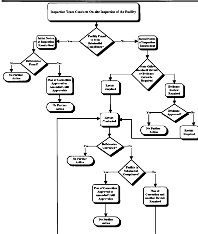
This chapter addresses the results and consequences of the inspections. These results and consequences include notification of deficiencies and revisits. They can also include monetary sanctions such as fines and the denial of payments for new admissions, where DHH denies reimbursements for any new Medicaid resident admitted into the facility for a certain period of time. Our examination of these sanctions revealed some weaknesses, which are discussed below.

File Review

As stated earlier, we randomly selected 30 licensed nursing homes and reviewed their provider files. We examined documents from 67 inspections that were conducted on the 30 facilities in our sample during the last two fiscal years. Of the 67 inspections in our sample, only three resulted in monetary sanctions. In order to review a representative sample of inspections resulting in monetary sanctions, we drew a random sample of 10 additional inspections from those that had been sanctioned by DHH. Therefore, we examined documents from a total of 77 inspections. In analyzing this information, we focused our analysis on two specific areas of the enforcement process: timeliness and consistency.

Exhibit 4-1

DHH's Enforcement Process



Source: Prepared by legislative auditor's staff from material obtained from DHH.

Many Facilities Did Not Receive Timely Notice, But Most Revisits Were Timely

In approximately 40% of the certification inspections that we examined, DHH did not meet the requirement for timely initial notice to the facility of inspection results. However, nearly all of the inspections in our sample had timely revisits, if needed. A delay of the initial notice may lengthen the time that facilities are out of compliance with state and federal regulations, and the time that residents of the nursing home may be subjected to substandard care and/or conditions.

40% of Inspections Did Not Receive Timely Initial Notice of Inspection Results

DHH did not send initial notices of inspection results within the required time frame for 31 of the 77 inspections in our sample (40%). The initial notice is a letter sent to the facilities formally notifying them of the results of the inspection. This letter gives the time frame for correcting any deficiencies, options for appealing deficiencies, as well as sanctions for noncompliance or possible sanctions if the nursing home does not correct the deficiencies.

The *State Operations Manual* states that DHH has 10 calendar days after the last day of the certification inspection to provide the nursing home with the initial notice of inspection results, if there is no immediate jeopardy. If immediate jeopardy does exist, DHH has two calendar days, one of which must be a workday, to provide the initial notice. For those inspections in our sample, the longest time period between the inspection and the initial notice was 47 days. All of the other notices were sent in less than 30 days.

While the facilities are notified of the surveyors' preliminary results at the exit conference following the inspection, there is no assurance that corrective action begins at the facility until they receive the formal notice of inspection results through the initial notice.

Most Revisits Were Done Within Required Time Frame

Nearly all of the inspections that we examined met the requirement for a timely revisit. Only 3 of the 34 inspections (9%) that received revisits in our sample did not adhere to the required time frame. Because the revisits are being conducted in a timely fashion, the nursing home has an incentive to correct deficiencies promptly.

For inspections with deficiencies that result in the nursing home not being in substantial compliance, DHH conducts a revisit after the nursing home takes corrective action to ensure that the deficiency has been remedied. According to the *State Operations Manual*, DHH has to conduct the revisit between the time that the nursing home has taken corrective action and the 70th day after the inspection is complete. The longest period of time between the inspection and the revisit was 115 days. The average time was 55 days, which is 15 days less than state regulations require.

Recommendation

4.1 DHH should produce initial notices of certification inspection results in accordance with the *State Operations Manual*.

DHH Seldom Assesses Monetary Sanctions

Few of the inspections with deficiencies serious enough to warrant a revisit by DHH (11%) resulted in monetary sanctions. Because of the limited use of monetary sanctions, the enforcement process may not be as effective as it could be.

Most Nursing Homes Given Second Chance; Few Receive Fines

DHH's enforcement process usually results in a second chance for the facility to come into substantial compliance. The system operates by conducting inspections and then allowing the nursing home to correct any deficiencies without monetary sanctions being imposed. The surveyors then revisit the nursing home to ensure that the corrections were made. Usually, monetary sanctions are only imposed at the initial inspection when immediate jeopardy exists.

In our original sample of 67 inspections conducted at 30 facilities[1], 27 inspections (40%) had deficiencies serious enough to be out of substantial compliance, and thus, to warrant a revisit.

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[1] The ten additional inspections included in our file review were excluded from this analysis. These inspections were selected from a list of inspections that all had resulted in monetary penalties. Therefore, including them in this analysis would have skewed our results.

However, only 3 of these 27 (11%) were fined. For example, one nursing home was found not to be in substantial compliance during its inspection. The home had several deficiencies cited. One of these deficiencies was more serious because the nursing home did not follow all physician orders in 5 of the 14 residents' records reviewed. The nursing home completed its Plan of Correction, specifying how it would ensure that all physician orders were followed, and DHH surveyors conducted a revisit. At the revisit, the nursing home was found to be in substantial compliance. No monetary sanctions were imposed on this nursing home.

Each Revisit Costs About $700

According to a DHH official, a standard certification inspection revisit costs an average of $718. Thus, for the 27 revisits that were required on the facilities in our sample, an estimated $19,386 was spent. Over the two-year period covered by our audit, our estimate of the cost of all nursing facilities' revisits in the state is $193,860.

DHH regulations permit the Health Standards Section to grant the facility an opportunity to correct deficiencies before assessing a fine. However, neither these regulations nor state law prohibits the practice of fining nursing homes whenever they are found out of compliance. Because DHH does not levy a monetary sanction on more facilities that are out of substantial compliance, it misses an opportunity to discourage nursing homes from future deficiencies.

Recommendation

4.2 DHH should use its discretionary authority to fine all facilities that are found not to be in substantial compliance and that require a revisit. This practice may encourage facilities to strive to be in substantial compliance all year.

Type of Sanctions Often Conform to Regulations, But Some Fines Do Not

DHH has broad discretion over the type and severity of sanctions. In general, we found that DHH was consistent in its decisions about the type of sanctions to impose. However, some fines, once imposed, were not levied as severely as the regulations require.

According to the *Standards for Payment for Nursing Facilities*, sanctions shall be imposed that will bring the nursing home into compliance in the most efficient and effective manner with the care and well-being of the residents the paramount consideration. The decision on the type and severity of the sanction shall be based on an assessment of some or all of the following factors:

1. Whether the violations pose an immediate threat to the health or safety of the residents
2. The duration of the violations
3. Whether the violation (or one that is substantially similar) has previously occurred during the last three consecutive inspections
4. The facility's history of compliance during the last three consecutive inspections
5. What sanction is most likely to cause the facility to come into compliance in the shortest amount of time
6. The severity of the violation if it does not pose an immediate threat to health or safety
7. The logistical feasibility of implementing the sanction
8. The "good faith" exercised by the facility in attempting to stay in compliance
9. The financial benefit to the facility of committing or continuing the violation
10. Such other factors as the DHH secretary deems appropriate

Nearly All Sanctions Imposed Were the Correct Type

Only one inspection that we examined showed inconsistency in the type of sanction imposed. Therefore, most nursing homes appear to have received the proper sanction. We examined 77 inspections (67 in our original sample and 10 others

with sanctions) to see if facilities in similar situations were treated the same in the enforcement process. Exhibit 4-2 below summarizes the results of this examination.

Because state laws, rules, and regulations give DHH wide latitude in imposing sanctions, we looked for obvious inconsistencies in the sanctions imposed. In one inspection, deficiencies were found, and the nursing home was not in substantial compliance. No immediate jeopardy existed. The typical remedy for this category is a plan of correction and a revisit. However, in this case, a fine was also imposed.

Exhibit 4-2
Analysis of Consistency of Sanctions Among Sample Inspections

Result of Inspection	Sanction	Number of Inspections	Percent of Total Inspections
1. No Deficiencies	None	5	6.5%
2. Deficiencies but still substantial compliance	Plan of Correction Required	39	51.9%
3. Deficiencies and not in substantial compliance	Plan of Correction and Revisit Required	31*	39.0%
4. Immediate Jeopardy	Plan of Correction, Revisit and Fine Required	2	2.6%
Total		**77**	**100%**

*Note: One inspection that falls into this category had a Plan of Correction, Revisit and a Fine.

Source: Prepared by legislative auditor's staff using data provided by DHH.

According to DHH staff, they may impose a fine when a nursing home is not in substantial compliance and, in cases like this one, where the deficiency is egregious. In this case, the

resident died. In a letter to the nursing home, DHH stated that although there was no "causal connection between the care rendered by the nursing home and this resident's demise, there were a number of care problems identified . . ."

Fines for Repeat Deficiencies Not Imposed Consistently

Some facilities with repeat deficiencies were fined a one-time fee instead of the per-day fee as outlined in the *Standards for Payment for Nursing Facilities*. When fines are not assessed for the repeat violations using the stricter per-day fine, the deterrent effect may be lessened or even lost.

There are five classes of violations listed in the *Standards for Payment for Nursing Facilities*. They range from Class A, which is the most serious, to Class E, which is the least serious. Appendix A includes a list of the violations, penalties, and the types of deficiencies associated with each class of violation.

DHH has some discretion in whether to assess certain fines. For Class B to Class E violations, the criteria states, "the Secretary . . . may elect to assess . . . civil fines or may allow a specified period of time for correction of said violation." For Class A violations, no discretion is permitted; monetary fines must be assessed. Furthermore, DHH has some discretion in the amount of the fine. The regulations state the maximum amount that can be assessed, but do not specify the exact amount that must be assessed for each class or deficiency.

In addition, according to the *Standards for Payment for Nursing Facilities*, DHH has the authority to determine whether a violation is a repeat violation and should inform the facility in its notice of that determination. Violations may be considered repeat violations by DHH if the following conditions are found to exist:

1. If it can be assumed that the violation will continue until corrective action is taken, the department may elect to treat the violation as a repeat violation subject to a fine for each day the violation exists until the violation is corrected.

2. If a similar violation has occurred within 18 months, this subsequent violation and all violations thereafter shall be considered repeat violations subject to fines and other sanctions appropriate for repeat violations.

However, the *Standards for Payment for Nursing Facilities* clearly states that if a violation is a repeat violation the fine shall be on a per-day rate. In 3 of the 12 fines (25%) that we examined, the facility was fined a one-time fee for a repeat violation instead of the per-day fee. In the letters to the facility that assess the fine, DHH refers to the violations as repeat violations.

Exhibit 4-3 on page 42 summarizes our analysis of the fines that we examined. It presents the appropriate penalty according to the *Standards for Payment for Nursing Facilities*, the actual fine assessed and our assessment of whether the fine assessed meets the standards.

The effect of not assessing the fines using the appropriate method is that the facilities that are fined on a per-day basis may correct the deficiency more quickly than a facility that is simply fined at a one-time rate.

Recommendation

4.3 DHH should ensure that fines are assessed using the appropriate method. Fines that DHH determines to be for repeat violations should be fined on a per-day basis in accordance with the *Standards for Payment for Nursing Facilities*.

Fines and Interest Are Not Collected by Due Date

Only 50% of the fines levied by DHH in our sample were collected by the due date. In addition, DHH did not charge any interest or penalties for these delinquent payments. With one exception, DHH did not follow proper procedures and deduct the fines from subsequent reimbursements to the facilities. As a result, DHH has lost an opportunity to collect additional revenue, and the deterrent effect of the fines has been diminished. Furthermore, the fines that were collected are deposited to a trust fund, but none of the money in the fund has ever been spent.

Fine Collection Process Could Be Improved

DHH internal controls for the fine collection process could be improved in order to increase accountability. DHH is responsible for assessing, recording, and collecting the monetary fines. Once it is collected, DHH's Health Standards Section sends the check to the accounting section of DHH for processing and deposit into the Residents' Trust Fund. Accounting does not receive notice of fines until they are collected.

There are risks to having the same division assess, record, and collect the money. Payments may be lost, diverted, or misused. We have found no indication that any of these problems currently exist in the Health Standards Section; however, these are potential areas of concern.

Exhibit 4-3
Analysis of Assessment of Fines

	Sanction/Category	Authorized Fine	Actual Fine	Meets Criteria?
1	First Offense, Class C Violation	Discretionary, one-time fine not to exceed $1,000	$1,000	Yes
2	**Repeat Offense, Class B Violation**	**Discretionary fine not to exceed $3,000 per-day**	**$3,000**	**No [a]**
3	1) First Offense Class D Violation [b] 2) Repeat Offense, Class D Violation	1) Discretionary, one-time fine not to exceed $100 2) Discretionary fine not to exceed $250 per-day	$100 $250/day	Yes Yes
4	Repeat Offense, Class C Violation	Discretionary fine not to exceed $2,000 per-day	$11,500	Yes
5	**Repeat Offense, Class C Violation**	**Discretionary fine not to exceed $2,000 per-day**	**$1,500**	**No [a]**
6	First Offense, Class C Violation	Discretionary, one-time fine not to exceed $1,000	$750	Yes
7	First Offense, Class C Violation	Discretionary, one-time fine not to exceed $1,000	$750	Yes
8	First Offense, Class C Violation	Discretionary, one-time fine not to exceed $1,000 per-day	$1,000	Yes
9	First Offense, Class A Violation	Mandatory, one-time fine not to exceed $2,500	$2,000	Yes
10	**Repeat Offense, Class D Violation**	**Discretionary fine not to exceed $250 per-day**	**$250**	**No [a]**
11	First Offense, Class B Violation	Discretionary fine not to exceed $1,500	$500	Yes
12	First Offense, Class A Violation	Mandatory, one-time fine not to exceed $2,500	$2,500	Yes

[a] These do not meet the criteria because the violations were assessed as repeat violations, but the fines are consistent with first offense violations.

[b] Initially, this was a first offense, one-time fine. However, it was not corrected in a timely fashion, so DHH subsequently categorized it as a repeat violation.

Source: Prepared by legislative auditor's staff from material obtained from the *Standards for Payment for Nursing Facilities* and DHH records on fine payments.

To avoid these potential problems DHH should segregate the duties between those who assess, record, and collect the fines. The department's accounting section should be responsible for recording and collecting the fines. Within the accounting section, these two duties should be segregated.

Fines Not Collected Within 10 Days

For the fines in our sample, DHH, on average, collected fines 46 days after they became final. According to the *Standards for Payment for Nursing Facilities*, fines become final when:

- No timely or proper appeal was requested.
- The facility admits the violation and agrees to pay.
- The administrative hearing is concluded with findings of violations, and time for seeking judicial review has expired.

Furthermore, when the fine becomes final, it shall be paid in full within 10 days unless the department allows a payment schedule in light of a documented financial hardship.

The *Standards for Payment for Nursing Facilities* also states that if payment is not received or security not posted within 10 days after finalization, DHH shall deduct the full amount plus interest from the nursing home's next Medicaid reimbursement. Also, according to the *Standards for Payment for Nursing Facilities*, interest should begin accruing at the current judicial rate on the day following the date on which a fine becomes due and payable.

There were 12 fines in the sample of files we examined. DHH has collected nine of these, but as of November 6, 1997, three fines were still pending. Two of these three fines were under appeal by the nursing home and had, therefore, not become final. The third pending fine for $1,500 became final in April 1997, and was over 154 days delinquent on November 6, 1997. The interest due on this fine is approximately $60 and also has not been collected.

There were ten fines in our sample that had been finalized, and, therefore, collectable. Five of the fines were not collected timely. These fines were an average of 91 days delinquent. None of the delinquent fines were assessed interest.

Revenue From Fines Has Not Been Used

The fund to which fines are deposited has not had any withdrawals since its inception. Once fines are collected, the Health Standards Section of DHH forwards the money to the accounting section of DHH, which in turn forwards the money to the state treasurer's office to be deposited into the Nursing Home Residents' Trust Fund.

According to R.S. 40:2009.11 F(2), the monies in the trust fund may only be used as specified in the federal Omnibus Budget Reconciliation Act of 1987. The relevant section of this act, codified in 42 USC § 1396r, stipulates that the money collected from fines shall be used to do the following:

- To protect the health or property of residents of nursing homes which the Department finds deficient
- To pay for the cost of relocation of residents to other facilities
- To maintain operation of a facility pending correction of deficiencies or closure
- To reimburse residents for personal funds lost

According to BHSF financial staff, no claims have ever been filed against the fund. The fund was created in 1993, and as of November 22, 1997, it has accumulated more than $100,000.

We did not identify a cause as to why claims have not been made against the fund. However, DHH should take action to inform residents and their family members of the existence and purpose of the fund.

Recommendations

4.4 After fines become final, they should be treated as accounts receivable and collected by DHH's accounting section.

4.5 For those fines that are delinquent, DHH should charge interest and deduct the total amount due from the facility's Medicaid reimbursement payment.

4.6 DHH should inform residents and their families, through its publication *Nursing Home Care in Louisiana*, of the existence and possible uses of the Nursing Home Residents' Trust Fund, whenever applicable.

Denial of Payment for New Admissions Has Control Weakness

The procedures used to enforce the sanction of denial of payment for new admissions lack sufficient internal controls. Facilities could still be reimbursed through the Medicaid program for new admissions during the sanction period. This weakness may lessen the effectiveness of the denial of payment sanction.

The denial of Medicaid payment for new admissions into the nursing home is another type of sanction available to DHH. If this sanction is imposed, DHH will deny reimbursements for any new Medicaid residents admitted to the facility. The sanction is removed when DHH determines that the nursing home is in substantial compliance with state and federal requirements. A monetary fine usually accompanies this sanction. Our review found that the procedures followed to enforce this sanction are informal. The office manager for a DHH regional office notifies the staff who processes new admissions for the nursing home under sanction not to allow any claims for payment of new admissions to be processed for the dates of the denial of payment.

In our review of a sample of cases when the sanction of denial of payment for new admissions was imposed, we found no instances where a resident had been admitted and payment had been made to the nursing home for the new admission. However, an oversight by a regional DHH staff member processing admissions could lead to payment for a new admission during the sanction period. No system, either by other staff members or by computer edits, ensures that the sanction is carried out.

This condition could result in an improper use and loss of Medicaid resources of the state and the federal government. Also, the situation could potentially diminish the deterrent effect for the sanction of denial of payment for new admissions.

Recommendation

4.7 DHH should adopt formal procedures that protect against possible errors during the denial of payment for new admissions sanction. This could include computer edits by the fiscal intermediary to deny payment for new admissions during the sanction period.

Case Management Regulations Are Enforced

Our review showed that DHH ensures proper development of resident assessments and care plans through the normal inspection process. This process appears to be carried out properly with a significant number of resident assessment and care plan deficiencies being uncovered by the surveyors. Appropriate sanctions were imposed for all deficiencies related to resident assessments and care plans for the 30 nursing homes in the sample.

Resident assessments are basic evaluations of the medical condition of new residents to nursing homes. Resident assessments evaluate a number of areas including physical and mental functional status and sensory and physical impairments. Care plans are the detailed strategies for meeting the resident needs detailed in the resident assessment. Care plans include specific goals to be met by each resident and the prescribed treatments and therapies designed to meet those goals.

The resident assessments and care plans must be conducted according to standards contained in federal regulations (42 CFR 483.20). These standards provide specific guidelines on how to complete resident assessments and care plans. Eleven deficiency tags in the *Guidance to Surveyors* relate to violations of these standards. These tags relate to the timing, content, and accuracy of the resident assessments and care plans. Violations of the standards in any of these areas are written up on a Statement of Deficiencies form.

For example, during one inspection, surveyors found that in 7 of the 24 resident records (29%) they reviewed, comprehensive care plans did not meet all of the needs identified in the corresponding resident assessments. Resident assessments identified specific problems, such as the need for physical therapy or oxygen, but the care plans did not document how these problems were being addressed. The facility responded that they

would put in place a procedure for the Director of Nursing to review all new orders on a daily basis and to meet with the therapy group weekly to ensure that care plans were updated as needed. DHH surveyors revisited the facility and found it to be in substantial compliance with all state and federal regulations.

We reviewed the Statement of Deficiencies for the two most recent inspection periods for the 30 nursing homes in our sample. The review showed that the 30 nursing homes had a total of 51 resident assessment and care plan deficiencies. Twenty-four of the 30 nursing homes (80%) had resident assessment and care plan deficiencies for at least one of the two inspections. Ten nursing homes (33%) had resident assessment and care plan deficiencies for both inspections. These data suggest that the DHH surveyors spend considerable time evaluating resident assessments and care plans.

DHH imposes sanctions for resident assessment and care plan deficiencies in a thorough and consistent manner. The sanctions imposed for these types of deficiencies are within the guidelines in the *State Operations Manual*. The thorough and consistent application of sanctions serves to ensure that the health and well-being of the residents is being effectively maintained.

Chapter Five: Reimbursement for Nursing Home Care

Chapter Conclusions

Although DHH has controls in place to prevent overpayments to Medicaid nursing home providers, these controls could be strengthened. Furthermore, these controls are not comprehensive.

The procedures in place to control the accuracy of Medicaid nursing home billings are manual processes that are susceptible to error. In addition, some of these controls are used on only a sample of actual billings. The controls currently in place do not ensure that if the level of care actually needed by the resident decreases, the level of care reimbursed will decrease. These weaknesses can allow nursing facilities to be paid for services that were not provided.

Overview of Nursing Home Reimbursement

DHH contracts with a fiscal intermediary, Unisys, to perform the claims processing and reimbursement functions of Louisiana's Medicaid program. Health care providers submit requests for reimbursement directly to Unisys, and Unisys issues checks to providers.

DHH reimburses nursing homes that serve Medicaid recipients with a daily amount or per diem. This per diem is based on the resident's level of care. The level of care depends on the services that each resident requires. Thus, a nursing home's reimbursement for a given day depends on two elements: the number of Medicaid recipients in the facility that day and each recipient's level of care. Since nursing homes are not reimbursed for each service rendered, our review of how DHH ensures that services were actually provided focused on two questions.

- How does DHH ensure that reported resident admission, transfer, and discharge dates are accurate?
- How does DHH ensure that the level of care provided in the facility matches the level of care reimbursed?

To answer these questions we reviewed the claims processing system and other related processes. We interviewed personnel in each of these areas and reviewed procedures and documentation with an emphasis on answering these questions.

Admission and Discharge Reporting Controls Could Be Enhanced to Minimize Overpayments

DHH has controls in place to ensure the accuracy of Medicaid recipient admission, transfer, and discharge dates on payment requests. However, some of these controls involve manual processes that are susceptible to error. In addition, the primary control that tests the accuracy of these dates is only conducted on a sample of the actual billings as much as a year or more after reimbursement. These weaknesses can allow nursing facilities to be paid for services that were not provided. The controls should be augmented with computer controls and analysis that would reduce errors and verify more of the billings.

Cost Report Audits Check Few Payment Requests

Procedures within the cost report audits provide a direct control for the accuracy of the admission and discharge dates reported by nursing homes on payment requests. However, these procedures are performed only on a sample of facilities and a sample of residents within these facilities. In addition, these audits are conducted, at the earliest, in the year following the reimbursement. Thus, overpayments could go completely undetected or undetected for long periods of time.

Each nursing facility enrolled as a Medicaid provider must submit annual cost reports to DHH. The cost reports include the facility's income and expenditure information for the year. They also include information about the number of residents actually in the facility during the year. DHH uses information from the cost reports to set the per diems for future nursing facility Medicaid reimbursements.

DHH contracts with an accounting firm to audit approximately one-fourth of these cost reports per year. The purpose of the audits is to obtain reasonable assurance about whether the report is free from material misstatements. In addition, the audit determines if all costs reported are allowable under Medicaid rules and if the census information on the report is

accurate. If appropriate, the audits recommend adjustments to the cost report information before it is used to set future per diems.

As part of these audits, the auditors take a sample of admissions, discharges, deaths, hospital leave days, and home leave days from the facility census records and compare them with the fiscal intermediary's reimbursement records. If overpayments are found, DHH contacts the facility to initiate recovery of the overpayment.

These audit procedures act as a control on the accuracy of nursing home admission and discharge dates reported on payment requests. It is, however, a retrospective process conducted on only a sample of the residents in a sample of the nursing facilities. If discrepancies are found, it can be a year or longer before they are discovered and rectified.

Controls for New Admissions Are Not Automated

The fiscal intermediary, Unisys, screens nursing home payment requests for the proper documentation for new Medicaid recipient admissions. While this screening system appears to be working, it is a manual process that is susceptible to error. An oversight by Unisys staff could cause overpayments to nursing home providers.

For each person applying to Medicaid for nursing home care, DHH must establish both the financial and the medical eligibility of the applicant. The financial eligibility process reviews the applicant's income and assets. If these values are below established thresholds, the applicant is declared financially eligible for Medicaid coverage. Medical eligibility is determined in the DHH regional offices. The facility submits a form that includes a doctor's certification about the level of care the applicant requires. The regional office reviews this information and makes a medical eligibility determination. This determination specifies the level of care that the resident must receive. After the applicant is declared both medically and financially eligible, the regional DHH office sends a document to the facility informing them of the earliest date that Medicaid can begin reimbursing the facility for the recipient and the level of care on which the reimbursements will be based.

Each month, nursing homes submit payment requests to Unisys for the previous month's nursing facility services. For each new admission to the facility, a copy of the authorizing documentation from the regional DHH office must accompany the

payment request. Unisys personnel review the payment requests to ensure that each new admission has the proper documentation. Unisys then processes the payment requests.

Controls on Discharge Dates Are Weak

DHH relies on self-reporting by nursing facilities to track discharge dates of Medicaid recipients. If a facility fails to notify DHH of a Medicaid resident's discharge, DHH will continue to reimburse the facility for the care of the resident.

If a nursing home resident receiving Medicaid benefits leaves the facility or if the resident crosses over to Medicare coverage, the facility is required to notify the regional DHH office. Residents could leave a facility due to transfer to another nursing facility, discharge to a hospital or home, or the death of the resident. For discharges, DHH does not use any other source to verify the information provided by the nursing facilities.

The Office of Public Health, within DHH, issues all official death certificates in Louisiana. Information about recent deaths could be shared with BHSF. This would allow BHSF to update its recipient records to reflect any recent deaths and initiate recoupment of any overpayments already made.

In contrast to new admissions and discharges, resident transfers have a self-correcting control ensuring the accuracy of the transfer dates. After a transfer, the resident's new facility will begin requesting reimbursement. If the previous facility fails to notify Unisys about the transfer, a request for reimbursement for the recipient for the same time period will come from two facilities. An edit in the Unisys computer checks for the double billing and will not pay both.

Recommendations

5.1 DHH should have Unisys install a computer edit on its payment request processing system. When Unisys data entry personnel input new admissions, this edit would require the input of some information from the new admission

authorizing document (issued by the regional DHH office) that is not on the payment request. This would ensure that each new admission that is processed has the proper documentation and it would protect against errors by the staff manually screening the billing requests.

5.2 BHSF should request that the Office of Public Health's Vital Records Registry regularly provide BHSF with information about deaths in Louisiana. This information should be compared to the Medicaid eligibility roles and dates of death should be updated. In addition, BHSF should have the fiscal intermediary determine if any reimbursements were made for services provided to recipients after the date of death. If any overpayments are found, BHSF should ensure that the funds are recovered.

Level of Care Reimbursement Controls Could Be Improved

The process of changing the level of care reimbursed has no verification system in place to protect against human error. In addition, the level of care controls that DHH currently has in place do not ensure that if the level of care needed by the resident decreases, the level of care reimbursed will decrease. Because these controls are incomplete, nursing home providers can be reimbursed for services that were not provided.

Controls for Changes in Level of Care Could Be Automated

A manual screening procedure is part of the process used by DHH to control changes to the level of care reimbursed by Medicaid. Like the procedure used for new admissions, this screening is vulnerable to human error and has no built-in verification procedures. Errors in the level of care reimbursed could cause payments to be made to nursing homes for services that were not provided.

The regional offices of DHH determine the initial level of care for each resident. They also authorize any changes to the level of care reimbursed. An authorization form from DHH must accompany the first payment request for the resident at the new level of care. Similar to the process for new residents, Unisys

personnel screen the payment requests to ensure that each change in level of care has the proper documentation. The screening process, as stated previously, is a manual process and thus has the potential for errors.

Adding a Step to Certification Inspections Could Catch Some Overpayments

According to DHH, during annual certification inspections, surveyors have occasionally discovered a facility that was being reimbursed for a resident at a level of care higher than was needed or being provided. DHH does not have controls in place to protect against this possibility. Therefore, nursing facilities may be reimbursed for services not provided.

Currently, the level of care controls that DHH has in place rely on nursing facilities to report if the level of care needed by the resident decreases. DHH does not routinely compare the level of care provided with the level of care reimbursed. Certification inspections and complaint investigations may discover mismatches between the reimbursement levels and the care provided, but this is not a formal part of the inspection or investigation. If DHH included a comparison of the level of care reimbursed to the level of care provided on a sample of Medicaid residents in certification inspections, it could lessen the possibility that nursing home providers would bill Medicaid at a level of care higher than that provided to the resident.

Recommendations

5.3 DHH should have Unisys install a computer edit on its payment request processing system. When Unisys data entry personnel input changes in levels of care, this edit would require the input of some information from the level of care change authorization document (issued by the regional DHH office) that is not on the payment request. This would ensure that each level of care change processed has the proper authorization and it would protect against errors by the staff manually screening the payment requests.

5.4 DHH should add a procedure to the certification inspection that would have surveyors note the

level of care reimbursed (from the remittance advice the facility receives along with their reimbursement from Unisys) for each of the residents in their resident sample. A comparison of the level of care reimbursed to the level actually provided could be performed for the sample of residents. If discrepancies are found, the facility would be required to complete the paperwork for a change in the level of care reimbursed. DHH would have to follow-up on this change to ensure that it occurs.

Post Payment Reviews Are Passive

The Surveillance and Utilization Review Subsystem (SURS) of Unisys may investigate billing irregularities by nursing facilities. These investigations, however, are usually initiated when recipients or private citizens provide the initial information. In addition, the investigations are by their nature conducted after reimbursements have occurred; thereby leaving DHH to try to recover funds rather than preventing erroneous reimbursements.

The Recipient's Explanation of Medical Benefits (REOMB) program sends a questionnaire to a sample of Medicaid recipients drawn from the requests for reimbursement. The questionnaire asks the recipient to confirm the reported services were received. If a recipient disagrees with the description of what services were provided, the SURS personnel may investigate. In addition to the REOMB program, private citizens or a resident's family can report alleged billing irregularities to Unisys. The SURS unit may also investigate these allegations.

If a provider is selected for review, members of the SURS staff investigate his or her billings. If overpayments are found and they appear to be mistakes by the provider, SURS contacts the provider and future reimbursements are adjusted to recover the overpayment. If the investigation reveals a pattern of overbillings, SURS refers the case to the Medicaid Fraud Control Unit within the Department of Justice.

Each of these methods of triggering an investigation relies on persons outside of DHH to report discrepancies. Furthermore, the REOMB program may not be very effective for nursing home residents because many of the residents may be too ill to be able to tell if they got the services for which Medicaid is paying. As a

result, DHH may get little or no feedback from residents who are sampled using this method. In addition, the state must try to recover funds after they have been disbursed.

Recommendation

5.5 DHH should send Recipient's Explanation of Medical Benefits notices to the guardians of nursing home residents rather than the residents themselves. This may generate more feedback to ensure that facilities are providing the Medicaid services that are reimbursed.

Appendix A

Class Violation Levels and Associated Fine Amounts

Appendix A: Criteria for Assessment of Class Violation Levels

Class Violation	Penalty	Description
Class A Violation		Violations that create a condition or occurrence relating to the operation of a facility which result in death or serious harm of a resident.
First Offense	Mandatory fine not to exceed $2,500	
Repeat Offense	Mandatory fine not to exceed $5,000 per day	
Class B Violation		Violations that create a condition or occurrence relating to the operation and maintenance of a facility that create a substantial probability that death or serious physical harm to a resident will result from the violation.
First Offense	Discretionary fine not to exceed $1,500	
Repeat Offense	Discretionary fine not to exceed $3,000 per day	
Class C Violation		Violations that do not result in death or serious physical harm to a resident or the substantial probability thereof but create a condition that creates a potential for harm by directly threatening the health, safety, rights or welfare of a resident.
First Offense	Discretionary fine not to exceed $1,000	
Repeat Offense	Discretionary fine not to exceed $2,000 per day	
Class D Violation		Violations that are related to administrative and reporting requirements that do not directly threaten the health, safety, rights or welfare of a resident.
First Offense	Discretionary fine not to exceed $100	
Repeat Offense	Discretionary fine not to exceed $250 per day	
Class E Violation		Violations that are defined as the failure of the facility to submit a statistical or financial report in a timely manner as required by regulations.
First Offense	Discretionary fine not to exceed $50	
Repeat Offense	Discretionary fine not to exceed $100 per day	

Source: Prepared by legislative auditor's staff using the *Standards for Payment for Nursing Facilities*.

Appendix B

Department of Health and Hospitals' Response

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

M. J. "Mike" Foster, Jr.
GOVERNOR

David W. Hood
SECRETARY

98 MAR 27 PM 3:08

March 27, 1998

Dr. Daniel Kyle, CPA, CFE
Legislative Auditor
1600 North Third Street
P. O. Box 94397
Baton Rouge, LA 70804-9397

Dear Dr. Kyle:

Please find attached our response to the performance audit of the *Management and Oversight of Long Term Care in Louisiana.*

Should you have any questions, please contact Thomas D. Collins, Bureau of Health Services Financing Director, at 342-3891.

Sincerely,

Charles F. Castille
Undersecretary

attachment

c: Stan Mead
Thomas D. Collins

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"AN EQUAL OPPORTUNITY EMPLOYER"

March 27, 1998

STATE OF LOUISIANA LEGISLATIVE AUDITOR
MANAGEMENT AND OVERSIGHT OF LONG TERM CARE IN LOUISIANA
PERFORMANCE AUDIT

DEPARTMENT OF HEALTH AND HOSPITALS
RESPONSE TO RECOMMENDATIONS:

Chapter Two - Licensing and Inspections.

Recommendation
2 1 DHH should develop written procedures detailing the actions to be followed during a licensing inspection. These procedures should be documented in some systematic manner to ensure consistency in the conduct of licensure inspections These procedures should also ensure the safety and welfare of the residents.

RESPONSE - HSS recently promulgated minimum standards for the licensing of nursing homes (February 20, 1998) which had not been updated or revised since 1974. With these revised regulations will be the development of written procedures outlining the process. We will develop a computer program that will provide format and reference for violations.

2 2 DHH should increase the variability of the inspection dates so that nursing home administrators are less able to predict when their next inspection will occur.

RESPONSE - HSS has attempted in previous years to restructure the survey schedule to afford the "*surprise element" for nursing home staff. We still attempt to modify the schedule* as indicated by history of poor performance. The flexibility is limited by workload and federal mandates to conduct survey within a twelve month average The annual certification inspections must be conducted within a nine to fifteen month time frame. Nursing facilities with a past history of compliance problems are generally surveyed early (months) and facilities with history of compliance are surveyed later (15 months). Federal mandates of the twelve month average are strictly enforced by the HCFA.

Chapter Three - Complaint System

3.1 DHH should document screening procedures used when deciding how quickly a complaint is investigated. The Department should develop standardized questions to ask at the time a complaint is taken, or design a complaint matrix illustrating how the severity of the complaint allegation is determined. This procedure will support how complaints are assigned an investigation priority relative to the seriousness of the complaint and may help to reduce the number of complaints investigations.

RESPONSE - A updated intake form has been developed to use for screening of the complaints. The form lists a series of questions to be asked during complaint intake. It also lists the definitions of each action code as described in the State Operations Manual and the Louisiana Complaint Law. A section on this revised form will be dedicated to the decision making process for time lines required for investigation.

3.2 DHH should review and clarify its policies used to assign investigation priorities to complaints. DHH should adopt policies that are consistent with federal regulations and state law. This would further ensure uniformity in assigning investigation priorities.

RESPONSE - The complaint protocol was updated in December, 1997 to comply with the revised complaint law, La. R.S. 40 2009 13 established by the 1997 regular legislative session

3.3 DHH should fully implement its automated complaint tracking system. The system could be used to compile performance data that would be useful to DHH management, regional office surveyors and complaint desk staff

RESPONSE - The automated complaint tracking system has been evolving since May of 1997 when it was first developed. The system is capable of providing data regarding the complaint intake and statistical data for use in trending for facility complaint history and outcome. We hope to utilize this information to enhance the survey process and assisting in the determination of "poor performers".

Chapter Four - Enforcement and Sanctions

4.1 DHH should produce initial notices of certification inspection results in accordance with the State Operations Manual.

RESPONSE - HSS is granted 10 working days by federal requirement to provide written notice of the survey findings. Each day of the survey the facility is informed of team findings so that they have an opportunity to supply additional information or response to concerns. This ongoing dialogue between facility staff and surveyors should leave few instances where the facility is unaware of deficient practices identified. The facilities are encouraged to take corrective action immediately upon notification. An exit conference is conducted by the surveyors to apprise the facility staff of the deficient practices which affords them an opportunity to begin corrective action at that time also. The facilities are also driven by HSS to develop an aggressive continuous quality improvement program so that their staff identify the deficient practices and take corrective measures before the survey is conducted.

4.2 DHH should use its discretionary authority to fine all facilities that are found not to be in substantial compliance and that require a revisit. This practice may encourage facilities to strive to be in substantial compliance all year.

RESPONSE - The HCFA have advised that the cost of certification revisits can not be charged to the providers by HSS because the cost of these revisits are included in the annual budget allotment as part of our contract to conduct the survey on behalf of the Medicare/Medicaid programs. The La. R.S. 40:2009.13(F)(2) indicates money collected via sanctions must be placed in a trust fund to be used for very limited purposes. Recoupment of the cost of revisits from sanction is not a cost allowed by this statute or by federal regulations. (42CFR 488.443(f)).

4.3 DHH should ensure that fines are assessed using the appropriate method. Fines that DHH determines to be for repeat violations should be fined on a per-day basis in accordance with the Standards for Payment for Nursing Facilities.

RESPONSE - Although there is a mechanism in place to fine a facility a "per day" fine on a repeat violation there is a maximum cap for fines. EXAMPLE, For Class C repeat violations, the facility can be fined $2000 per day but may not exceed the cap of $5000 per month. Thus HSS could impose the per day fine for 2.5 days. This limitation, combined with the fact that irrefutable repeat violations are not commonly found and that to impose a daily fine would require an "end date" be identified has caused the more expedient method to fine a set amount rather than the allowed daily fine.

4.4 After fines become final, they should be treated as accounts receivable and collected by DHH's accounting section.

RESPONSE - The Division of Fiscal Management will be working with HSS staff to develop appropriate procedures.

4.5 For those fines that are delinquent, DHH should charge interest and deduct the total amount due from the facility's Medicaid reimbursement.

RESPONSE - The Division of Fiscal Management together with the Bureau of Legal Services will research this to determine the feasibility of this recommendation and whether legislative authority is necessary.

4.6 DHH should inform residents and their families, through their publication Nursing Home Care in Louisiana, of the existence and possible uses of the Nursing Home Residents' Trust Fund, whenever applicable.

RESPONSE - HSS will develop clear criteria for use of the Residents' Trust Fund according to the federal mandates for the use of this fund.

4.7 DHH should adopt formal procedures that protect against possible errors during the denial of payment for new admissions sanction. This could include computer edits by the fiscal intermediary to deny payment for new admissions during the sanction period.

RESPONSE - DHH agreed to look at the current procedures in place. DHH has contracted for the redesign of the State Eligibility File and is incorporating special procedures and authorizations for nursing home payments which will be processed electronically to the fiscal intermediary and will control payment for new admissions and level of care.

Chapter Five: Reimbursement for Nursing Home Care

5.1 DHH should have Unisys install a computer edit on their payment request processing system. When Unisys date entry personnel input new admissions, this edit would require the input of some information from the new admission authorizing document (issued by the regional DHH office) that is not on the payment request. This would ensure that each new admission that is processed has the proper documentation and it would protect against errors by the staff manually screening the billing requests.

RESPONSE - Redesign of State Eligibility File referred to in 4.7 is anticipated to resolve this.

5.2 BHSF should request that the Office of Public Health's Vital Records Registry regularly provide BHSF with information about deaths in Louisiana. This information should be compared to the Medicaid eligibility roles and dates of death should be updated. In addition, BHSF should have the fiscal intermediary determine if any reimbursements were made for services provided to recipients after the date of death. If any overpayments are found, BHSF should ensure that the funds are recovered.

RESPONSE - The Director of the Bureau of Health Services Financing (BHSF) has contacted the Assistant Secretary for the Office of Public Health and requested that the Vital Record staff contact BHSF to study the feasibility of this recommendation.

5.3 DHH should have Unisys install a computer edit on their payment request processing system. When Unisys date entry personnel input changes in levels of care, this edit would require the input of some information from the level of care change authorization document (issued by the regional DHH office) that is not on the payment request. This would ensure that each level of care change processed has the proper authorization and it would protect against errors by the staff manually screening the payment requests.

RESPONSE - Redesign of the State Eligibility File referenced in 4.7 and 5.1 is anticipated to resolve this.

5.4 DHH should add a procedure to the certification inspection that would have surveyors note the level of care reimbursed (from the remittance advise the facility receives along with their reimbursement from Unisys) for each of the residents in their residents sample. A comparison of the level of care reimbursed to the level actually provided could be performed for the sample of residents. If discrepancies are found The facility would be required to complete the paperwork for a change in the level of care reimbursed. DHH would have to follow up on this change to ensure that it occurs.

RESPONSE - With the electronic submission of the Minimum Data Set for each resident residing in the nursing homes this problem should be better controlled. This data system will enhance our ability to detect discrepancies, to trend, and allow us to focus our survey in areas of aberrant indicators The BHSF is exploring a procedure for random sampling of nursing homes to determine if this is a problem Based upon any findings in the sample, the BHSF will take appropriate action.

5.5 DHH should send Recipient's Explanation of Medical Benefits notices to the guardians of nursing home residents rather than the residents themselves. This may generate more feedback to ensure that facilities are providing the Medicaid services that are reimbursed.

RESPONSE - The redesigned State Eligibility File will have the ability to transfer guardian name/address information to MMIS. SURS will look at the utilization of this information when it is available.