

An Audit Report on

Administration of Nursing Facility Contracts at the Department of Aging and Disability Services and the Health and Human Services Commission

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Administration of Nursing Facility Contracts at the Department of Aging and Disability Services and the Health and Human Services Commission

Overall Conclusion

To ensure that residents in Medicaid-certified nursing facilities are adequately protected and receive quality services, the Department of Aging and Disability Services (Department) should:

- More promptly investigate high-priority complaints and incident reports as required by state and federal law.
- Ensure that its nursing facility inspectors consistently cite and sanction nursing facilities when they identify deficiencies.
- Strengthen its monitoring of nursing facilities' financial stability and registered nurse staffing levels.

The Health and Human Services Commission (Commission) recouped \$13.5 million in fiscal year 2003 from nursing facilities that incorrectly reported the level of effort necessary to meet residents' actual needs.

(The Medicaid payments that nursing facilities receive are based on the level of effort they report for each Medicaid resident.) However, the Commission could recoup more by focusing its resources on the **highest-risk nursing facilities**. The Commission also could reduce facilities' reporting errors in this area by more frequently imposing sanctions on facilities that systematically overstate the level of effort necessary to meet residents' needs. In addition, the process the Commission uses to review nursing facilities' annual cost reports (which provide the data used to calculate base payment rates for nursing facilities) is adequate.

Both the Department and the Commission should better secure access to the primary automated system used to record and track information regarding nursing facilities. However, nothing came to our attention to indicate that there had been any instances of unauthorized access to this system.

In conducting this audit, we also identified other significant issues for consideration (see Chapter 6 of this report for additional details). Although there

Background Information

At the end of fiscal year 2004, there were approximately 1,050 Medicaid-certified nursing facilities in Texas. According to the Automated Budget and Evaluation System of Texas (ABEST), those nursing facilities served about 60,000 Medicaid residents. The Department of Aging and Disability Services reports that Medicaid payments to these facilities totaled almost \$1.7 billion in fiscal year 2004.

Multiple agencies are responsible for overseeing nursing facilities in Texas. This audit focused on the following:

- The Department of Aging and Disability Services' monitoring of nursing facility care through complaint investigations and annual inspections
- The Health and Human Services Commission's responsibility to ensure that nursing facilities correctly specify the level of effort necessary to meet each resident's actual needs and submit accurate cost reports



are no state or federal requirements in the following areas, measurements in these areas could be important indicators of the quality of care that nursing facility residents receive:

- Approximately 62 percent of Medicaid-certified nursing facilities in Texas do not meet the lowest minimum certified nurse aide staffing level suggested by the U.S. Centers for Medicare and Medicaid Services (CMS).¹ According to CMS, its suggested minimum certified nurse aide staffing level is the level that would be necessary to reduce the risk of diminished quality of care.
- In their 2003 cost reports, Medicaid-certified nursing facilities in Texas reported that their overall staff turnover rates exceeded 100 percent. Studies have noted that high turnover can adversely affect nursing facilities' quality of care and financial stability.

Key Points

The Department should correct specific issues to improve its quality-of-care monitoring in nursing facilities.

In fiscal years 2002 through 2004, the Department did not always comply with requirements to promptly investigate the highest-priority complaints and incident reports it received regarding nursing facilities. During that time period, it did not investigate approximately 36 percent of the highest-priority complaints and incident reports within required time frames. The Department also did not always cite deficiencies during nursing facility inspections, or it understated the deficiencies it did cite. In fiscal years 2003 and 2004, the Department's inspectors did not cite or cited at a lower scope and severity 303 (18 percent) of the 1,716 nursing facility deficiencies that federal inspectors had identified.

While the timing of the Department's annual nursing facility inspections is not overly predictable, the timing of its resident trust fund monitoring visits should be improved. In addition, the Department should improve its monitoring of nursing facilities' financial stability and registered nurse staffing levels.

The Commission should strengthen its efforts to ensure that nursing facilities do not overstate residents' needs in order to receive higher Medicaid payments.

The Commission's utilization review function reports that it recouped a net \$13.5 million from nursing facilities that had incorrectly reported the level of effort necessary to meet residents' needs in fiscal year 2003. However, the potential exists that as much as \$19 million in additional payments were made in

¹ The U.S. Centers for Medicare and Medicaid Services is the federal oversight agency for Medicaid-certified nursing facilities.

error due to nursing facilities' incorrectly reporting the level of effort necessary to meet residents' needs.

To increase recoupments, the Commission should change its current methodology to focus its utilization review resources where the greatest risks of overstated levels of effort exist. To reduce the frequency with which facilities systematically overstate the level of effort necessary to meet residents' needs (and, therefore, ultimately reduce the amount it needs to recoup), the Commission should apply existing sanctions more frequently on facilities with the highest error rates.

The Commission has established an adequate process to review nursing facilities' cost reports.

The process the Commission uses to review the annual cost reports that nursing facilities are required to submit is adequate. We did not identify any material errors in the sample of nine cost reports we audited at nine different nursing facilities. However, to further ensure that it identifies unallowable costs, the Commission should better analyze (1) corporate overhead expenditures allocated to nursing facilities' cost reports and (2) trends in cost report accuracy that are associated with particular preparers of cost reports.

The Department and Commission should strengthen access to the Compliance, Assessment, Regulation, and Enforcement System (CARES) and the local area network through which that system can be accessed.

To reduce the risk that unauthorized users could view or alter data in CARES, the Department should (1) promptly remove CARES user access for individuals whose employment has been terminated, (2) strengthen CARES password requirements, and (3) lock out users who make multiple unsuccessful CARES log-in attempts.

The Commission should improve the physical security of its computer room (which houses CARES equipment) and strengthen access controls for the local area network through which CARES can be accessed.

The Department's contracts with nursing facilities contain provisions to hold contractors accountable.

By incorporating the state and federal requirements for participating in the Medicaid program by reference, the Department's boilerplate contract with Medicaid-certified nursing facilities contains provisions sufficient to hold facilities accountable for delivery of quality services. However, the Department should strengthen its contracts with nursing facilities by adding a provision that permits it to audit the financial records of corporations that own Medicaid-certified nursing facilities.

Other significant issues for further consideration were noted.

Information already collected by the Department and Commission could be used to track additional risk factors such as facilities' direct care worker turnover and staffing levels, as well as service and expenditures patterns that are specific to certain ownership types.

Summary of Managements' Responses

The Department and Commission agree with our recommendations.

Summary of Information Technology Review

The information technology component of this audit focused on controls associated with the primary automated system used to record and track information regarding nursing facilities (CARES), as well as the local area network through which CARES can be accessed. As discussed above, we identified certain issues that should be corrected to reduce the risk of unauthorized access to CARES. The audit team also assessed controls associated with the Automated Cost Report Evaluation System (ACRES), which is used to collect and analyze expenditure, staffing, and facility demographic information that Medicaid-certified nursing facilities submit each year in annual cost reports. This audit did not include reviewing financial systems that are involved in the nursing home payment process.

Summary of Objective, Scope, and Methodology

Our objective was to determine whether the Department and the Commission have adequate contract administration processes for nursing facilities, including:

- Sufficient contractor oversight to ensure that contractors consistently provide quality services and that public funds are spent effectively and efficiently.
- Methods used to establish contractor reimbursement that are sufficient to ensure that the State pays a fair and reasonable price for services.
- Contract provisions that are sufficient to hold contractors accountable for delivery of quality services and prevent the inappropriate or inefficient use of public funds.

Our scope covered the Department's and the Commission's contract administration activities related to the 1,055 contracts with Medicaid-certified nursing facilities in Texas that were in place at the end of fiscal year 2004.

Our methodology included interviewing Department and Commission staff and reviewing information compiled from annual nursing facility inspections, complaint

and incident report investigations, nursing facility cost reports, and utilization review data. We conducted site visits to 15 Medicaid-certified nursing facilities. We also reviewed the Department’s boilerplate contract for Medicaid-certified nursing facilities.

Recent SAO Work		
Number	Product Name	Release Date
05-028	A Follow-Up Audit Report on Managed Care Contract Administration at the Health and Human Services Commission	February 2005
04-042	An Audit Report on the Health and Human Services Commission's Administration of the CHIP Exclusive Provider Organization Contract	July 2004
04-011	An Audit Report on the Health and Human Services Commission's Monitoring of Managed Care Contracts	November 2003
02-052	An Audit of Community Service Contracts at Selected Health and Human Service Agencies	June 2002
02-018	An Audit Report on Medicaid Long-Term Care Claims Data at the Department of Human Services	January 2002

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Detailed Results

Chapter 1

The Department Should Correct Specific Issues to Improve Its Quality-of-Care Monitoring in Nursing Facilities

The Department of Aging and Disability Services (Department) should improve its monitoring of the quality of care that Medicaid-certified nursing facilities provide by consistently complying with requirements to promptly investigate the high-priority complaints and incident reports it receives regarding these facilities. The Department also should conduct a secondary review when its investigators substantiate a serious allegation made through a complaint or incident report but do not cite the nursing facility. Additionally, the Department should develop an adequate system to ensure that all complaints about its nursing facility inspectors² are appropriately entered into its tracking system so that these complaints can be investigated.

The Department should ensure that its inspectors consistently cite nursing facility deficiencies at the appropriate level of scope and severity. Many of the deficiencies that the Department's inspectors have not cited in a consistent manner relate to nursing facilities' noncompliance with requirements to routinely assess residents' needs and appropriately develop care plans for residents. In addition, the Department should enforce the federal requirement for physician involvement in the development of residents' care plans. Results of audit tests indicated that physicians are not routinely involved in planning resident care.

While the overall timing of the Department's annual nursing facility inspections is less predictable than the national average, the Department should reduce the predictability of the timing of annual inspections within 2 of its 11 regions. To decrease the risk that nursing facilities could mismanage or abuse resident trust funds, the Department also should reduce the predictability of both the timing and the sampling methodology it uses for its resident trust fund monitoring visits.

In addition, the Department should better track two quality-of-care risk indicators: nursing facility financial stability and registered nurse staffing levels at nursing facilities.

² For the purposes of this report, the terms "inspectors" and "inspections" are synonymous with the industry terms "surveyors" and "surveys," respectively.

The Department Should Promptly Investigate High-Priority Complaints and Incident Reports Regarding Nursing Facilities, as Required by State and Federal Law

Complaints and Incident Reports

Complaints and incident reports are filed to allege deficient care, abuse, or neglect. Complaints can originate from any source, while incidents are self-reported by nursing facilities. Serious complaints and incident reports are investigated in the same manner.

As Table 1 shows, the Department did not always comply with requirements to promptly investigate the highest-priority complaints and incident reports it received regarding nursing facilities in fiscal years 2002 through 2004.³ During that time period, it did not promptly investigate approximately 36 percent of the highest-priority complaints and incident reports filed regarding nursing facilities.

Table 1

Summary of High-Priority (1-3) Complaints and Incident Reports						
Priority	Severity of Allegation	Required Response Time	Legal Basis for Required Response Time	Fiscal Years 2002-2004		
				Total Number of Complaints and Incident Reports	Number of Complaints and Incident Reports Investigated On Time	Number of Complaints and Incident Reports Investigated Late
1	Immediate jeopardy to health and safety of residents	Within 24 hours	Texas Health and Safety Code, Section 126(c)(1) ^a	1,819	1,635 (90%)	184 (10%)
2	Actual harm or potential for more than minimal harm	Within 10 business days	U.S. Centers for Medicare and Medicaid Services, State Operations Manual	20,305	10,252 (50%)	10,053 (50%)
3	Potential for minimal harm	Within 45 calendar days	Department policy	12,246	10,113 (83%)	2,133 (17%)
Totals				34,370	22,000 (64%)	12,370 (36%)

^a The federal government allows two days after receipt of the complaint or incident report for the highest-priority investigation to begin, but Texas statute requires this investigation to begin within 24 hours.

Source: State Auditor's Office analysis of information in the Department's Compliance, Assessment, Regulation, and Enforcement System (CARES)

Priority 1 Complaints and Incident Reports. The Department prioritizes complaints and incident reports according to how crucial the timeliness of investigation is to the health and safety of residents. The top priority—Priority 1—is reserved for complaints and incidents alleging immediate jeopardy to the health and safety of a nursing facility's residents. In these cases, it is important that the Department conduct an on-site investigation as quickly as possible to mitigate risks to residents.

³ The Department assigns complaints and incident reports to nine different priority levels. We limited our analysis to the top three levels.

The Texas Health and Safety Code, Section 126(c)(1), requires the Department to make an on-site visit to the nursing facility within 24 hours of receiving a Priority 1 complaint or incident report. As Table 1 shows, the Department responded within 24 hours to approximately 90 percent of Priority 1 complaints and incident reports in fiscal years 2002 through 2004. During this period, the Department received 1,819 Priority 1 complaints and incident reports and did not investigate 184 (10 percent) of them promptly.

Priority 2 Complaints and Incident Reports. Priority 2 is the most frequently assigned priority level for complaints and incident reports. The Department assigns this priority when a complaint or incident report alleges that residents have been harmed or that there is some risk that residents may be harmed but the danger to the residents does not reach the level of immediate jeopardy required for Priority 1 investigations. The Department has 10 business days (14 calendar days) to conduct an on-site visit of a nursing facility for which it has received a Priority 2 complaint or incident report.

The Department received 20,305 Priority 2 complaints and incident reports in fiscal years 2002 through 2004. As Table 1 shows, the Department responded to Priority 2 complaints in a timely manner approximately half of the time.

Priority 3 Complaints and Incident Reports. Priority 3 complaints and incident reports allege that there is the potential for minimal harm to nursing facility residents. The Department's policy for Priority 3 complaints and incident reports is to make an on-site visit within 45 days of receiving the complaint or incident report. As Table 1 shows, the Department complied with this requirement approximately 83 percent of the time in fiscal years 2002 through 2004.

Investigation timeliness varies significantly among regions, and there are vacant nursing facility inspector positions in some regions.

Audit tests identified significant differences in investigation response times for all high-priority (Priorities 1–3) complaints and incident reports among the Department's 11 regions. For example, while Region 5 (Beaumont) responded to 98 percent of all high-priority complaints and incident reports on time, Region 11 (Corpus Christi) responded on time to only 34 percent of high-priority complaints and incident reports. (See Appendix 2 for more information on regional differences in investigation timeliness for high-priority complaints and incident reports.)

In general, regions with large urban populations are less likely to investigate complaints and incident reports on time than the less urbanized regions. Exacerbating this problem, the more urbanized regions currently have a number of vacant inspector positions. According to the Department, about 26 (9 percent) of the 298 full-time nursing facility inspector positions were vacant at the end of fiscal year 2004. Most of these vacancies were in regions

with large urban populations and included the four largest metropolitan areas of Dallas/Fort Worth, Houston, San Antonio, and Austin.⁴ These regions collectively investigate about 60 percent of high-priority complaints and incident reports on time, compared with 79 percent collectively investigated on time by the other five regions.

Audit tests identified 23 cases in which the Department substantiated serious allegations but did not cite the nursing facilities.

Auditors reviewed 23 serious allegations⁵ from fiscal year 2002 through fiscal year 2004 for which the Department substantiated the allegation but did not cite the nursing facility. In all cases but one, the decision to not cite the nursing facility was supported by the narrative of case details.⁶ However, in one case, the Department substantiated an allegation of sexual abuse but did not cite the nursing facility even though the facility appears to warrant some blame, according to the case documentation. This suggests that it could be beneficial for the Department to conduct additional reviews of cases involving serious allegations that are substantiated but for which the nursing facility is not cited.

The Department should better track complaints that are made about its nursing facility inspectors.

The Department thoroughly investigates complaints filed against its inspectors after such complaints have been entered into the Department's tracking system. However, the Department does not currently have a process to ensure that all complaints that are filed against its inspectors are entered into its tracking system. The regions have the primary responsibility for reporting complaints against inspectors to the Department's central office, but there is currently no process for ensuring that the regions are consistently doing this.

Recommendations

The Department should:

- Ensure that it responds to the highest-priority complaints and incident reports promptly in accordance with all requirements.
- Implement an additional review of investigations of serious allegations that are substantiated but for which the nursing facility is not cited. The

⁴ Regions with vacant nursing facility inspector positions include Region 3 – Arlington; Region 4 – Tyler; Region 6 – Houston; Region 7 – Austin; Region 8 – San Antonio; and Region 11 – Corpus Christi.

⁵ The 23 allegations fell into the following categories: death by other than natural causes (17 allegations), physical abuse (1 allegation), sexual abuse (2 allegations), and verbal abuse (3 allegations).

⁶ For 22 of 23 cases, the investigations concluded that the facilities were not at fault or had appropriately handled incidents involving employees or residents.

additional review should focus on determining whether the investigation was sufficient.

- Consider using existing complaint-intake procedures to process all complaints about inspectors to ensure that they are entered into the Department's tracking system.
- Consider hiring contractors to fill vacant inspector positions.

Management's Response

We agree with this finding.

Corrective Action(s) Planned or Taken:

Regulatory Services Survey Operations has developed and implemented a weekly workload tracking report to measure both pending and completed work by program area in each regional office. Temporary resource shifting is occurring statewide to assist specific regional offices experiencing greater backlogs in pending work. Regulatory Services Survey Operations will conduct an in-depth monthly analysis of complaint and incident investigations by priority level and take necessary action to shift resources, either on a temporary or permanent basis, to address significant identified delays.

Implementation: 05/31/05, Director of Survey Operations

Regulatory Services Survey Operations will develop a sampling and evaluation procedure to identify and review serious incident/complaint investigations conducted by regional survey staff including allegations that are substantiated and not cited. Areas of noted concern will be identified both individually and in aggregate and used for training and follow-up with survey staff throughout the state.

Implementation: 05/31/05, Director of Survey Operations

Regulatory Services Survey Operations and Enforcement staff will work jointly on development of tracking, investigation and follow-up procedures to address all complaints received regarding surveyor performance.

Implementation: 05/31/05, Director of Survey Operations and Director of Enforcement

Regulatory Services Survey Operations is working aggressively to develop and implement successful practices to improve both recruitment and retention of survey staff. We are considering use of contract survey staff for certain areas of the operation, but current efforts to secure qualified contract workers have not been successful. Due to the lack of success to date, it is not believed

that use of contract workers will have a significant positive impact on meeting required timeframes for completion of investigations.

Implementation: On-going, Director of Survey Operations

Chapter 1-B

The Department Should Consistently Cite Nursing Facility Deficiencies at the Appropriate Level of Scope and Severity

In fiscal years 2003 and 2004, when federal inspectors conducted inspections of 101 nursing facilities alongside inspectors from the Department, the Department’s inspectors did not cite or cited at a lower scope and severity 303 (18 percent) of the 1,716 deficiencies that the federal inspectors identified. These deficiencies directly affect the quality of care that nursing home residents receive. Among the most common deficiencies that Department inspectors did not cite or did not cite at the appropriate level were problems with infection control, nurse aide proficiency, and the development of resident care plans.

Table 2 depicts the ranges of severity and scope that the federal government assigns to nursing facility deficiencies. Severity depends on the potential for harm, while scope depends on the number of residents affected or potentially affected. A deficiency assigned to Category A is the least severe and affects the smallest number of residents, while a deficiency assigned to Category L is the most severe and affects the largest number of residents. The results of the side-by-side inspections with Department and federal inspectors indicate that Department inspectors sometimes understate the severity of nursing facility deficiencies and the number of residents affected or potentially affected by the deficiencies.

Table 2

Categories of Nursing Facility Deficiency Severity and Scope			
Severity	Scope		
	Isolated	Pattern	Widespread
Potential for minimal harm	A	B	C
Potential for more than minimal harm	D	E	F
Actual harm	G	H	I
Immediate jeopardy	J	K	L

Source: U.S. Centers for Medicare and Medicaid Services.

The categorization of deficiencies using this scale determines the magnitude of sanctions imposed against a nursing facility. Therefore, differences in the categorization of deficiencies can be crucial in determining whether the nursing facility should be sanctioned and to what extent.

On average, when the Department inspectors and the federal inspectors did not agree on the categorization of deficiencies, the federal inspectors categorized the deficiency as one level higher in severity than the Department inspectors categorized it. For example, the Department inspectors might record a deficiency in Category E, concluding that the problem is part of a pattern at the nursing facility but that the problem presents only the potential for harm. However, while the federal inspectors might agree that the deficiency is part of a pattern, they would conclude that the deficiency has already caused actual harm to residents and, therefore, would record the deficiency in Category H.

In addition, while the differences between federal and Department inspectors' categorizations of deficiencies averaged almost three letters, in many cases the differences were greater than three letters. For example, federal inspectors identified deficiencies causing actual harm that Department inspectors either did not cite or cited below the "actual harm" level 30 times during the side-by-side inspections.

Federal inspectors gave Department inspectors good assessment scores.

Despite the differences in deficiency categorization discussed above, federal inspectors gave Department inspectors good assessment scores in fiscal years 2003 and 2004. The federal inspectors graded the Department inspectors on six functional areas within the inspection process, assigning scores ranging from 1 ("much less than satisfactory") to 5 ("extremely effective"). As Table 3 shows, Department inspectors' average scores for all but one function exceeded the "very effective" level.

However, the lowest score Department inspectors received was in the area of deficiency determination, which is the final task of deciding whether to cite deficiencies and determining the appropriate scope and severity. This is consistent with the deficiency categorization differences discussed above.

Table 3

Federal Scoring of Department Nursing Facility Inspectors Fiscal Years 2003-2004						
	Measure 1: Concern Identification	Measure 2: Sample Selection	Measure 3: General Investigation	Measure 4: Food Investigation	Measure 5: Medication Investigation	Measure 6: Deficiency Determination
Statewide Average Score	4.66	4.81	3.77	4.63	4.40	3.59
Federal Inspectors' Grading Scale: 1 - Much less than satisfactory; 2 - Less than satisfactory; 3 - Satisfactory; 4 - Very effective; 5 - Extremely effective						

Source: State Auditor's Office analysis of Federal Oversight Support Survey (FOSS) reports for fiscal years 2003 and 2004.

Results of audit tests at 15 nursing facilities identified other areas for improvement.

Resident Assessments. Results of audit tests at 15 Medicaid-certified facilities in five regions indicated that all 15 facilities were inconsistent in the

Resident Assessments

The Code of Federal Regulations, Title 42, Section 483.20, requires initial, quarterly, annual, and change-of-condition assessments for all residents as a condition for each nursing facility's participation in the Medicaid program.

timeliness with which they conducted required resident assessments. Specifically, 31 percent of initial resident assessments, 54 percent of annual resident assessments, and 39 percent of quarterly resident assessments were either not completed on time or could not be located by the nursing facility. However, only 6 (40 percent) of the 15 nursing facilities had been cited by Department inspectors

for deficiencies involving resident assessments during their last inspections.

Resident assessments are the basis for all care planning for Medicaid residents. This information is required by the federal government for all Medicaid residents, and it is used to determine patterns of clinical problems across facilities. The nursing facilities enter information for each resident directly into a system that is used jointly by the federal government and the Department. This information also is reported in the Quality Reporting System available to the public on the Department's Web site. However, the Department does not monitor this information to ensure that nursing facilities are regularly assessing residents as federal regulations require.

Resident Care Plans. All 15 facilities audited also were inconsistent in

Resident Care Plans

The Code of Federal Regulations, Title 42, Section 483.20(k)(2), requires nursing facilities to develop a comprehensive care plan within seven days of completing the comprehensive assessment.

Care plans must be prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs. To the extent practicable, the resident, the resident's family, or the resident's legal representative should also participate in the preparation of the care plan. The care plan also must be periodically reviewed and revised by a team of qualified persons after each assessment.

developing care plans for residents. Specifically, 55 percent of initial care plans, 37 percent of annual care plans, and 20 percent of quarterly care plans were incomplete. Care plans are the basis for all the nursing facility services a resident receives. They address residents' medical and pharmaceutical needs, as well as how much assistance residents need in performing activities of daily living.

Only 7 (47 percent) of the 15 facilities had been cited by Department inspectors for care plan deficiencies during their last inspections. It is also important to note that for 36 of the 101 inspections conducted jointly by federal inspectors and Department inspectors, the federal inspectors documented assessment and care plan deficiencies that the Department inspectors either failed to

cite or cited at a lower scope and severity.

Physician Involvement in Developing Care Plans. Although care plans must be developed by an interdisciplinary team including at least a physician and a nurse, audit tests found no evidence of physician involvement in developing care plans at the 15 facilities audited. None of the 639 care plans audited showed documentation of a physician regularly attending care plan meetings

as required by federal regulations. This federal requirement is included in the guidelines that the Department's inspectors use during the annual inspection process.

Recommendations

The Department should:

- Ensure that its inspectors consistently categorize nursing facility deficiencies at the appropriate scope and severity.
- Enforce the requirement that nursing facilities conduct regular assessments of Medicaid residents and develop resident assessments and care plans that are appropriate to each resident's needs.
- Enforce the requirement for physician involvement in the development of resident care plans.

Management's Response

We agree with this finding.

Corrective Action(s) Planned or Taken:

Results from the Federal Oversight Support Survey and Comparative surveys conducted by the Centers for Medicare & Medicaid Services (CMS) will be analyzed with monthly reporting of identified trends and patterns. These results will be used to target training of survey and enforcement staff regarding appropriate determination of scope and severity of deficiencies.

Implementation: 06/30/05, Director of Survey Operations

Compliance & Oversight staff will conduct monthly audits of scope and severity determinations to identify variations from accepted procedures with follow-up back to managers at the State Office and Regional Office levels. Additionally, Medical Quality Assurance staff currently evaluate facility performance in assessing client care needs in specific focus areas recognized as improving the quality of care.

Implementation: 06/30/05, Director of Survey Operations

The area of care planning and physician involvement in care planning will be addressed through joint surveyor/provider training focusing on the standards requirements in these areas and the specific surveyor protocols used to measure compliance.

Implementation: 07/31/05, Director of Survey Operations

The Timing of the Department’s Annual Nursing Facility Inspections Is Not Overly Predictable, but the Department Should Reduce the Predictability of Its Trust Fund Monitoring Visits

The Department does a good job of avoiding predictable timing for its annual inspections of Medicaid-certified nursing facilities. An analysis of Department data for inspections conducted between July 2001 and September 2004 indicates that only about 28 percent of the Department’s annual inspections were predictably timed, according to the criteria used by the Government Accountability Office (GAO) in recent studies of state processes for inspecting nursing facilities.

Annual Inspection Timing
 According to the Government Accountability Office, an annual inspection is considered predictable if:

- The nursing facility is inspected within 15 days of the one-year anniversary of its prior annual inspection.
- The nursing facility is inspected within 1 month of the maximum allowable interval between annual inspections (15 months).

Using its own criteria for predictability of inspections, the GAO found that, on average, 34 percent of nursing facility inspections nationwide were predictable.⁷ The GAO also reported that the Department’s inspections in fiscal years 2001 and 2002 were predictable about 27 percent of the time, which is similar to the predictability rate we calculated for the period between July 2001 and September 2004.

However, there are important regional differences in inspection predictability within Texas. As Table 4 shows, inspections in two Texas regions—Region 7 (Austin) and Region 8 (San Antonio)—were significantly more predictable than those in the remaining regions. (See Appendix 3 for a map of the Department’s 11 regions.)

Table 4

Summary of Inspection Timing by Region		
Region Number	Region Name, Location	Percent with Predictable Timing
1	High Plains, Lubbock	21.5%
2	Northwest Texas, Abilene	21.6%
3	Metroplex, Arlington	27.8%
4	Upper East Texas, Tyler	15.9%
5	Southeast Texas, Beaumont	9.8%
6	Gulf Coast, Houston	24.0%
7	Central Texas, Austin	46.8%
8	Upper South Texas, San Antonio	43.5%
9	West Texas, Midland	16.3%
10	Upper Rio Grande, El Paso	11.5%
11	Lower South Texas, Corpus Christi	31.6%

Source: State Auditor’s Office analysis of information in the Department’s Compliance, Assessment, Regulation, and Enforcement System (CARES)

⁷ *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*, Government Accountability Office, Report No. 03-561, July 2003.

It is important to avoid predictable timing for the annual inspection process because the element of surprise is crucial for Department inspectors to get an accurate picture of a nursing facility's operations.

The Department should improve the timing of its trust fund monitoring.

The Department's procedures for monitoring nursing facilities' management of residents' trust funds are adequate to detect facility mismanagement. However, the Department's timing of trust fund reviews is predictable, and Department monitors tend to select samples of trust funds for review in a predictable manner. The predictability of both the timing of site visits and the sampling methodology makes it possible for facilities to know in advance the period of trust fund activity the Department will review and, therefore, present a misleading picture of routine management practices.

It is important to note that our review of trust fund management at 15 nursing facilities did not identify any facilities that were abusing resident trust funds. We found only minor problems with trust fund documentation and approval signatures for certain routine trust fund transactions.

Recommendations

The Department should:

- Develop action plans to make the timing of nursing facility inspections in Region 7 and Region 8 less predictable.
- Establish procedures to make the timing and account sampling methodology of trust fund monitoring less predictable.

Management's Response

We agree with this finding.

Corrective Action(s) Planned or Taken:

By May 31, 2005, an assessment protocol will be developed to measure predictability of survey schedules in each region and a monthly analysis of surveys using this protocol will be initiated with reporting back to the regional offices. Upon implementation of the assessment protocol specific targets will be established in Regions 7 & 8 to improve the variability of their annual survey schedules.

Implementation: 06/30/05, Director of Survey Operations

Procedures will be established to ensure the timing and account sampling methodology of trust fund monitoring is less predictable.

Implementation: 06/01/05, Section Director, Institutional Services

The Department Should Improve Its Monitoring of Two Quality-of-Care Risk Indicators: Nursing Facility Financial Stability and Registered Nurse Staffing Levels

Monitoring Financial Stability. Beginning June 15, 2001, statute required the

Monitoring Financial Stability

The 77th Legislature enacted Texas Health and Safety Code, Section 255.002, which requires the Department to “establish an early warning system to detect conditions that could be detrimental to the health, safety, and welfare of residents. The early warning system shall include analysis of financial and quality-of-care indicators that would predict the need for the department to take action.”

Department to monitor the financial stability of nursing facilities (see text box for additional details). However, the Department has not yet complied with that requirement. Residents in financially unstable facilities may be at greater risk of receiving substandard quality of care because these facilities may not be able to meet all the quality-of-care requirements for state licensure or participation in the Medicaid program. Additionally, if a facility closes suddenly due to a financial crisis, resident care may be hindered or interrupted. The Department reports that 53 Texas nursing facilities filed for bankruptcy in fiscal years 2003 and 2004.⁸

Registered Nurse Staffing. Data analysis of staff time that nursing facilities reported in their 2003 cost reports shows that most Texas Medicaid-certified

Minimum Registered Nurse Staffing

The Code of Federal Regulations, Title 42, Section 483.30(b)(1), requires nursing facilities participating in the Medicaid program to “use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.”

nursing facilities have at least the minimum number of registered nurses required by federal regulations. However, according to the Department, 59 nursing facilities (approximately 6 percent of Medicaid-certified nursing facilities) reported that they did not comply with this requirement. These 59 facilities’ cost reports indicated that they did not have an average 8 hours of registered nurse time during each day of fiscal year 2003. Additionally, 22 of these 59 facilities showed insufficient registered nurse time in their 2002 cost reports, which could indicate that this is a recurring problem.

The Health and Human Services Commission’s (Commission) Rate Analysis Division runs queries on the cost report data to identify nursing facilities that do not meet the federal minimum registered nurse staffing level. However, the Commission does not notify the Department of the results of these queries, and the Department does not attempt to identify facilities with insufficient registered nurse staffing by using other methods. As a result, the Department has not used existing sanctions to penalize nursing facilities for noncompliance with the registered nurse requirement.

⁸ Facilities that file for bankruptcy do not necessarily close.

Recommendations

The Department should:

- Use nursing facilities' cost reports and other available financial information to monitor the financial stability of nursing facilities.
- Monitor registered nurse staffing levels at all nursing facilities to ensure that all facilities comply with federal requirements.
- Use enforcement tools to penalize nursing facilities that do not comply with federal requirements for minimum registered nurse staffing.

Management's Response

We agree with this finding.

Corrective Action(s) Planned or Taken:

Regulatory Services will continue to consider the HHSC, Office of Inspector General, Audit Department's reviews of cost reports in determining whether additional or continued monitoring of a facility's financial stability is warranted. Regulatory Services is currently working jointly with HHSC on a comprehensive financial viability analysis project for nursing facilities in the state. It is believed that the implementation of project recommendations will address concerns noted regarding increased monitoring of financial stability of nursing facilities operated in Texas.

Implementation: Ongoing with full implementation in 2007, Assistant Commissioner for Regulatory Services

Regulatory Services will work with staff at HHSC and staff in the Quality Monitoring Section at DADS to evaluate currently available information from cost reports related to nurse staffing levels and determine, from that evaluation, which elements of available data may be appropriate for inclusion in existing regulatory and/or quality oversight activities.

Implementation: 08/31/05, Director of Survey Operations

Regulatory Services will review and provide additional training regarding federal requirements for minimum registered nursing staffing and provide additional training to regional and state office enforcement staff regarding these requirements and the enforcement tools available to address violations as they are identified.

Implementation: 08/31/05, Director of Survey Operations and Director of Enforcement

The Commission Should Strengthen Its Efforts to Ensure that Nursing Facilities Do Not Overstate Residents' Needs in Order to Receive Higher Medicaid Payments

Operating with a budget of approximately \$3 million, the Commission's utilization review function reported that it recouped a net \$13.5 million in fiscal year 2003 from nursing facilities that had incorrectly reported the level of effort necessary to meet residents' needs. The utilization review function is important because the Medicaid payments that nursing facilities receive are based on the level of effort they report for each Medicaid resident. By systematically overstating the level of effort necessary to meet residents' needs, a nursing facility can receive significantly higher payments.

The Commission's Utilization Reviews

A utilization review verifies whether a nursing facility correctly specified the level of effort necessary to meet residents' needs in the appropriate TILEs (Texas Index for Level of Effort).

When a utilization review finds errors in a nursing facility's assignment of TILEs, the Commission recoups any Medicaid overpayments (and refunds any underpayments), and future Medicaid payments to that nursing facility are adjusted accordingly.

The Commission's policy is to conduct utilization reviews at each nursing facility at least once every 16 months, depending on the error rate identified during a nursing facility's last utilization review.

Despite the Commission's efforts, the potential exists that as much as \$19 million in additional payments were made in error in fiscal year 2003 due to nursing facilities' incorrectly reporting the level of effort necessary to meet residents' needs.⁹ To increase recoupments, the Commission should change its current methodology to focus its utilization review resources where the greatest risks of overstated levels of effort exist.

In addition, the Commission could reduce the frequency with which facilities overstate the level of effort necessary to meet residents' needs (and, therefore, ultimately reduce the amount it needs to recoup) by applying existing sanctions more frequently on facilities with the highest error rates.

Refining the utilization review sampling methodology to use more of a risk-based approach could help to better focus utilization review resources.

As Table 5 shows, the Department recognizes 11 levels of effort (known as TILEs, which are categories in the Texas Index for Level of Effort) that correspond to the wide range of resident needs. Texas nursing facilities assign each Medicaid resident to a TILE according to the resident's clinical condition and the level of assistance the resident needs in routine daily activities.¹⁰

⁹ This estimate is based on data from fiscal year 2003 utilization reviews.

¹⁰ Routine daily activities are also known as activities of daily living (ADL).

Table 5

Texas Index for Level of Effort (TILE) Per Diem Base Payment Structure Fiscal Years 2004-2005			
TILE	Resident's Clinical Condition	Resident's Assistance Needs	Per Diem Base Payment
201	Heavy Care	Very High	\$146.92
202	Rehabilitation	All Levels	\$131.13
203	Heavy Care	Moderate to High	\$124.11
204	Clinically Complex	High	\$103.88
205	Clinically Stable	High	\$ 96.50
206	Clinically Complex	Moderate	\$ 97.58
207	Clinically Stable	Moderate	\$ 88.70
208	Clinically Complex	Low	\$ 85.71
209	Clinically Stable	Low/Moderate	\$ 80.00
210 ^a	Clinically Stable	Low	\$ 69.78
211	Clinically Stable	Low	\$ 67.28

^a TILE 210 is reserved for residents who have mental challenges but are otherwise clinically stable and need only minimal assistance with daily activities.

Source: Health and Human Services Commission

The utilization review function's current methodology evaluates a large sample of Medicaid residents at each nursing facility to determine whether nursing facilities have assigned appropriate TILES to those residents. The utilization review function primarily reviews residents assigned to TILES that have relatively higher payment rates. If the same evaluation methodology had been applied to the entire population of Medicaid nursing facility residents and their TILES, the potential exists that as much as \$19 million in additional payments were made in error in fiscal year 2003. While this suggests that a 100 percent review of residents and their TILES could lead to greater recoupment amounts, we identified alternatives that the Commission could pursue to increase the amounts identified for recoupment. Using its existing resources, the Commission could better focus its efforts by:

- Refining its sampling methodology to use more of a risk-based approach that focuses on nursing facilities that have a history of overstating the level of effort necessary to meet residents' actual needs.
- Analyzing TILE assignments to identify nursing facilities with unusual concentrations of residents assigned to TILES that have higher payment rates.
- Developing a module in its Medicaid Fraud and Abuse Detection System that is specifically designed to identify fraud and abuse in nursing facilities' assignment of residents to TILES.

- Analyzing the timing of changes that nursing facilities make to residents' TILEs to identify nursing facilities that may change residents' TILEs to avoid the Commission's review.
- Increasing its coverage of nursing facilities that have a pattern of systematically overstating levels of effort.

Applying existing sanctions could help to deter nursing facilities from systematically overstating the level of effort necessary to meet residents' needs.

An analysis of the TILE errors that the utilization review function has identified indicates that certain nursing facilities are systematically overstating the level of effort necessary to meet residents' needs. As discussed above, nursing facilities have an incentive to overstate the level of effort because Medicaid payments are higher for residents requiring higher levels of care.

In fiscal years 2003 and 2004, the utilization review function found that nursing facilities assigned incorrect TILEs to approximately 12.5 percent of the residents included in the sample. If these errors were random, approximately half of them would be errors that overstated the level of effort necessary to meet residents' needs, while the other half would understate the necessary level of effort. However, 87 percent of the errors overstated residents' needs and, therefore, resulted in the nursing facilities' receiving higher payments than they should have received. This indicates that many errors are likely to be the result of systematic overstatement. Moreover, our review of error rates for fiscal years 2003 and 2004 indicates that the Commission's efforts are not significantly reducing the overall rate at which the population of facilities incorrectly reports the level of effort necessary to meet residents' needs.

The Commission could reduce nursing facilities' systematic overstatement of the level of effort necessary to meet residents' needs by applying existing sanctions to deter this type of activity. Historically, vendor-hold sanctions (through which payments are withheld from a nursing facility until corrections are made) have been applied infrequently. For the period of our review, the Commission imposed a vendor hold on only 1 of the 42 nursing facilities whose TILE errors made them eligible for vendor holds under the Commission's current policies. The Commission's current policy makes facilities subject to possible vendor hold when they have an error rate of 25 percent or higher on an initial utilization review and an error rate of 20 percent or higher on the subsequent review (see Appendix 4 for this policy). The Commission imposed three additional vendor holds in fiscal year 2003 on nursing facilities for TILE errors identified in the period that preceded our analysis.

Recommendations

The Commission should:

- Refine its utilization review sampling methodology by:
 - ♦ Analyzing resident characteristics at nursing facilities to identify unusual concentrations of residents assigned to TILES that have relatively higher payment rates.
 - ♦ Analyzing the timing of changes that nursing facilities make to residents' TILES to identify nursing facilities that may change residents' TILES to avoid the Commission's review.
 - ♦ Increasing utilization review coverage of nursing facilities owned by corporations that have a pattern of systematically overstating levels of effort.
 - ♦ Developing a module in the Medicaid Fraud and Abuse Detection System that is specifically designed to identify fraud and abuse in nursing facilities' assignments of residents to TILES.
- Deter nursing facilities from systematically overstating residents' needs by applying the existing vendor-hold sanction more frequently.

Management's Response

SAO Recommendation: *The Commission should refine its utilization review sampling methodology by analyzing resident characteristics at nursing facilities to identify unusual concentrations of residents assigned to TILES that have relatively higher payment rates.*

Management Response: *The Health and Human Services Commission (HHSC) agrees that the utilization review process could be improved through enhanced views of Texas Index for Level of Effort (TILE) payment data. It is HHSC's intention to develop Medicaid Fraud and Abuse Detection System (MFADS) modules to examine trends in high paying TILES, the timing of payment changes, and fraudulent TILE billing practices. It is not anticipated that these modules would result in changes to routine sampling criteria, as the current sampling methodology includes all high paying TILES that have potential for billing errors. The Utilization Review (UR) Section does not routinely review all claims in the TILE 201 category, as it is not cost effective. After an initial review to confirm that a condition exists, UR staff do not routinely review level of care provided for conditions that rarely change, e.g. quadriplegia.*

Action Planned: HHSC will develop MFADS modules to examine trends in high paying TILES. Actions resulting from queries that indicate problematic billing patterns could result in a more comprehensive review, a referral for criminal or civil investigation, or a referral for sanctions in the form of civil monetary penalties. HHSC will also develop an MFADS model utilizing long term care data.

Estimated Completion Date: The development of a long-term care data model is included in the expanded scope of work for the first year of the optional term of the MFADS contract. The optional term begins September 1, 2005. Approval from the Centers for Medicare and Medicaid Services (CMS) is required for the additional funding that is being requested to expand the scope of work. If the funding approval is received, it is estimated that the model could be deployed by May 31, 2006.

The development of MFADS queries to look at specific information, such as the ratio of high paying TILES to patient load, can be developed and implemented by October 2005.

Title of Responsible Persons: Utilization Review Nursing Facility Manager, and Director, Technology Analysis & Development Support.

SAO Recommendation: The Commission should refine its utilization review sampling methodology by analyzing the timing of changes that nursing facilities make to residents' TILES to identify nursing facilities that may change residents' TILES to avoid the Commission's review.

Management Response: HHSC agrees that the utilization review process could be improved through enhanced views of TILE payment data. It is HHSC's intention to develop MFADS modules to examine trends in high paying TILES, the timing of payment changes, and fraudulent TILE billing practices. It is not anticipated that these modules would result in changes to routine sampling criteria, as the current sampling methodology includes all high paying TILES that have potential for billing errors. UR does not routinely review all claims in the TILE 201 category, as it is not cost effective. After an initial review to confirm that a condition exists, UR staff do not routinely review level of care provided for conditions that rarely change, e.g. quadriplegia.

Additionally, changes to the sampling methodology incorporated this fiscal year require inclusion of higher risk claims that have expired and those for patients that have been discharged or are deceased. The review of expired forms greatly reduces the opportunity for nursing facilities to benefit from TILE changes that occur between reviews.

Action Planned: HHSC will develop MFADS modules to examine the timing of payment changes. Actions resulting from queries that indicate problematic billing patterns could result in a more comprehensive review, a referral for

criminal or civil investigation, or a referral for sanctions in the form of civil monetary penalties.

Estimated Completion Date: *The development of a long-term care data model is included in the expanded scope of work for the first year of the optional term of the MFADS contract. The optional term begins September 1, 2005. Approval from the Centers for Medicare and Medicaid Services (CMS) is required for the additional funding that is being requested to expand the scope of work. If the funding approval is received, it is estimated that the model could be deployed by May 31, 2006.*

The development of MFADS queries to look at specific information, such as the ratio of high paying TILES to patient load, can be developed and implemented by October 2005.

Title of Responsible Persons: *Utilization Review Nursing Facility Manager, and Director, Technology Analysis & Development Support*

SAO Recommendation: *The Commission should refine its utilization review sampling methodology by increasing utilization review coverage of nursing facilities owned by corporations that have a pattern of systematically overstating levels of effort.*

Management Response: *Procedures implemented this fiscal year increase utilization review coverage of all facilities that have patterns of overstating TILES. Specifically, the frequency of the second and all future sets of reviews conducted after September 15, 2004 are now determined by a facility's error rate at the previous review. For example, a low error rate, between zero and seven percent, would result in a review being scheduled within the next 16 months. A high error rate, defined as over 24 percent, would result in a review in seven months.*

Action Planned: *HHSC will work with DADS to collect and incorporate data for corporate ownership of nursing facilities.*

Estimated Completion Date: *September 1, 2005*

Title of Responsible Person: *Utilization Review Nursing Facility Manager*

SAO Recommendation: *The Commission should refine its utilization review sampling methodology by developing a module in the Medicaid Fraud and Abuse Detection System that is specifically designed to identify fraud and abuse in nursing facilities' assignments of residents to TILES.*

Management Response: *HHSC agrees that the utilization review process could be improved through enhanced views of TILE payment data. It is HHSC's intention to develop MFADS modules to examine trends in high paying TILES, the timing of payment changes, and fraudulent TILE billing*

practices. Actions resulting from queries that indicate problematic billing patterns could result in a more comprehensive review, a referral for criminal or civil investigation, or a referral for sanctions in the form of civil monetary penalties. It is not anticipated that these modules would result in changes to routine sampling criteria, as the current sampling methodology includes all high paying TILES that have potential for billing errors.

Action Planned: *HHSC will develop MFADS modules to examine fraudulent TILE billing practices. Actions resulting from queries that indicate problematic billing patterns could result in a more comprehensive review, a referral for criminal or civil investigation, or a referral for sanctions in the form of civil monetary penalties.*

Estimated Completion Date: *The development of a long-term care data model is included in the expanded scope of work for the first year of the optional term of the MFADS contract. The optional term begins September 1, 2005. Approval from the Centers for Medicare and Medicaid Services (CMS) is required for the additional funding that is being requested to expand the scope of work. If the funding approval is received, it is estimated that the model could be deployed by May 31, 2006.*

The development of MFADS queries to look at specific information, such as the ratio of high paying TILES to patient load, can be developed and implemented by October 2005.

Title of Responsible Persons: *Utilization Review Nursing Facility Manager, and Director, Technology Analysis & Development Support.*

SAO Recommendation: *The Commission should deter nursing facilities from systematically overstating residents' needs by applying the existing vendor-hold sanction more frequently.*

Management Response: *While HHSC agrees that vendor hold procedures would have been applied more frequently in the past if current policies were in effect, we would also like to assure the State Auditor's Office that the vendor hold policies that were in place for the time period reviewed were consistently applied. Since the rules and resultant policies implemented this fiscal year allow the vendor hold sanction to be applied more quickly than in the past, it is anticipated that this sanction will be applied more frequently in the future.*

Action Planned: *Implement process to monitor frequency of vendor hold sanction.*

Estimated Completion Date: *September 1, 2005*

Title of Responsible Person: *Utilization Review Nursing Facility Manager*

The Commission Has Established an Adequate Process to Review Nursing Facilities' Cost Reports

The Purpose of Nursing Facility Cost Reports

Nursing facilities that participate in the Medicaid program are required to submit annual cost reports. The Commission uses these reports as a basis for calculating the amount of Medicaid payments that nursing facilities will receive.

The process that the Commission uses to review the annual cost reports that nursing facilities are required to submit is adequate. We did not identify any material errors in the sample of nine cost reports we audited at nine different nursing facilities. Ensuring that cost reports are accurate is important because these reports are the basis for calculating the amounts of state payments to nursing facilities.

Examples of the Commission's efforts to ensure accurate cost reports include the following:

- **Cost Report Desk Reviews and Field Audits.** In fiscal year 2004, the Commission conducted desk reviews of 917 (90 percent) of the 1,022 cost reports that nursing facilities submitted for fiscal year 2003 activities; it conducted more thorough field audits of the remaining 105 cost reports.
- **Cost Report Training for Nursing Facilities.** Nursing facility staff are required to attend training that the Commission provides regarding the preparation of cost reports. When nursing facilities submit their cost reports, they must also submit a copy of the preparer's certificate indicating that the preparer completed the mandatory training.
- **Cost Report Automated System.** Starting with the 2001 cost reports, the Commission implemented the Automated Cost Reporting and Evaluation System. The implementation of this system has made it possible for nursing facilities to submit cost reports electronically and for the Commission to analyze cost report data more efficiently.
- **Sanction for Failure to Submit Cost Reports.** The Texas Administrative Code permits the Commission to sanction nursing facilities that do not submit required cost reports.

To further ensure that it identifies unallowable costs, the Commission should better analyze corporate overhead expenditures and trends in cost report accuracy that are associated with particular preparers of cost reports.

Corporate Ownership of Nursing Facilities

In fiscal year 2003, approximately 78 percent (817 of 1,050) of the Medicaid-certified nursing facilities in Texas were owned by corporations that own multiple nursing facilities.

Although we did not identify any material errors in the sample of cost reports we audited, we identified questionable costs allocated by one corporation to multiple nursing facilities it owned in Texas. Specifically, six of the nine cost reports we audited were associated with nursing facilities owned by a single corporation, and we noted that those six facilities' cost reports had higher-than-average corporate overhead expenditures. Because of this, we tested a judgmental sample of

the corporate overhead costs that the corporation had allocated to each individual facility it owned. Through that testing, we identified \$600,083 in unsupported and unallowable corporate overhead expenditures on the cost reports. (These expenditures were primarily for depreciation, travel, and meals.) In addition, although the owners of this corporation also own facilities in other states, all of the owners' salaries were allocated to its Texas nursing facilities. This suggests that the Commission should better scrutinize the allocation of corporate overhead expenditures when it performs desk reviews and field audits of cost reports.

We also noted that one cost report that contained errors had been prepared by an individual who had also prepared at least one other cost report that the Commission had determined to be unreliable. This problem may be compounded in instances in which a corporation owns multiple nursing facilities and uses the same preparer to prepare cost reports for all of its facilities. This suggests that the Commission should enhance its procedures by examining trends in cost report accuracy that are directly associated with specific cost report preparers.

Recommendations

The Commission should:

- Incorporate additional procedures for cost report desk reviews and field audits to scrutinize corporate overhead expenditures that are allocated to individual facilities.
- Examine trends in the accuracy of cost reports prepared by specific cost report preparers. If specific preparers make errors in multiple cost reports, the Commission could require them to undergo additional cost report preparation training.

Management's Response

SAO Recommendation: Incorporate additional procedures for cost report desk reviews and field audits to scrutinize corporate overhead expenditures that are allocated to individual facilities.

Management Response: HHSC will incorporate additional procedures for cost report desk reviews and field audits to better scrutinize corporate overhead expenditures that are allocated to individual facilities. HHSC's current desk review process removed a total of \$902,749 from the Administrative Cost Area of the cost reports of the six corporate facilities audited. HHSC agrees that additional procedures in this complex area would help to reduce the risk of unsupported and unallowable expenditures on cost reports.

Action Planned: *The HHSC Office of Inspector General (OIG) Audit Section will make enhancements to cost report desk review processes and work with HHSC Rate Analysis to determine if any system enhancements can be made in this area.*

Estimated Completion Date: *August 31, 2005*

Title of Responsible Person: *OIG Director of Audit*

SAO Recommendation: *Examine trends in the accuracy of cost reports prepared by specific cost report preparers. If specific preparers make errors in multiple cost reports, the Commission could require them to undergo additional cost report preparation training.*

Management Response: *HHSC will develop procedures to examine those cost report preparers that prepared unauditible cost reports to determine if there are any discernable trends in poor preparation in certain preparers. HHSC can review what options are available to address these problem preparers.*

Action Planned: *HHSC Rate Analysis will implement a plan to review preparers that prepare unauditible reports and determine possible actions to address the situation.*

Estimated Completion Date: *December 31, 2005*

Title of Responsible Person: *Manager of Rate Analysis*

The Department and Commission Should Strengthen Access to and Edit Checks within the Primary Automated System for Long-Term Care and the Network through Which That System Can Be Accessed

Compliance, Assessment, Regulation, and Enforcement System (CARES)

CARES is the Department's comprehensive information system. CARES enables the Department to track, manage, and report information about nursing facilities, complaints, investigations, and enforcement actions.

The Department should better secure access to the Compliance, Assessment, Regulation, and Enforcement System (CARES), the primary automated system it uses to record and track information regarding nursing facilities. Although CARES has a number of input controls, the Department also should add edit checks to the CARES enforcement action module to increase the reliability of CARES data. In addition, the Commission—which oversees the computer room that houses CARES computer equipment and operates the local area network through which CARES can be accessed—should strengthen the physical security of its computer room and local area network access.

Despite the specific weaknesses discussed below, nothing came to our attention to indicate that there had been any instances of unauthorized access to CARES.

Chapter 4-A

The Department Should Better Secure Access to CARES

To reduce the risk that unauthorized users could view or alter data in CARES, the Department should (1) promptly remove CARES user access for individuals whose employment has been terminated, (2) strengthen CARES password requirements, and (3) lock out users who make multiple unsuccessful CARES log-in attempts. Audit tests found the following:

- Ninety-four (approximately 9 percent) of the 1,003 active CARES user accounts were assigned to individuals whose employment had been terminated. The Department deactivated 91 of these user accounts after we brought this matter to its attention and planned to deactivate the 3 remaining accounts. The Department was unable to confirm whether an additional five active CARES user accounts were assigned to individuals who were actually state employees.
- The minimum length required for CARES passwords is six characters, which is not a sufficient length to ensure adequate protection. (Industry best practices suggest that passwords should be at least eight characters in length, include both upper- and lowercase letters, and also include special characters, like numbers and symbols.) In addition, while users must change their passwords every 90 days, CARES maintains a history of only one previous password. This allows users to reuse older passwords.
- Although CARES does not allow more than three consecutive unsuccessful log-in attempts, it does not lock the user out permanently.

The user can return to the log-in screen and continue attempting to access the system. Locking the user out of the system altogether would prevent the user from making multiple access attempts using multiple user IDs and passwords.

CARES is accessible via the Internet or through the Commission's local area network, and additional CARES access control issues related to the local area network are discussed in Chapter 4-C.

Recommendations

The Department should:

- Ensure that it deactivates CARES user accounts that are assigned to individuals whose employment has been terminated.
- Require CARES passwords to be at least eight characters in length.
- Ensure that CARES maintains a history of each user's last six passwords and prevents users from reusing those passwords.
- Ensure that CARES locks out users after three consecutive unsuccessful log-in attempts and verify the identity of individuals seeking access to CARES.

Management's Response

We agree with this finding.

Corrective Action(s) Planned or Taken:

IT management will work with appropriate DADS management to ensure timely and accurate termination notification is both submitted and processed. Management will also ensure the HR Health and Human Service Administrative System (HHSAS) termination notice currently sent to the HHSC Security Administrators is also sent to the CARES application administrator. Upon receipt of the HR notice the CARES application administrator will be responsible for inactivating those terminated employees. In addition, DADS management will send an agency-wide broadcast to remind program supervisors and managers to follow appropriate procedures when an employee is terminated or transferring to another agency or division. The above actions will be addressed and implemented by August 31, 2005. Finally, System Change Request 856 (SCR) will have functionality built-in to inactivate a CARES user if they have maintained non-log-in status during a 90-day period. This change request will be implemented 04/22/2005.

DADS agrees the CARES application should be protected by strong password requirements. The current 6-character password length was deployed according to legacy DHS security standards. DADS intends to partner with the Department of Information Resources (DIR) Messaging and Collaboration Initiative, which will implement Identity Management and resultant 8 character passwords. This DIR project is slated for contract award July 2005.

Insertion of password tracking of the last six passwords will be implemented as part of the Nursing Facility Ownership and Financial Viability project. This solution is targeted for release in March 2007.

The CARES application changes scheduled for 4/22/2005 will lock out the user after five consecutive unsuccessful login attempts. We will address locking out the user after 3 unsuccessful attempts in the next interim release of the CARES application targeted for 8/31/05.

Implementation: Please see the above target dates for implementation, DADS Information Resource Manager.

Chapter 4-B

The Department Should Add Edit Checks to the CARES Enforcement Action Module

Although CARES has a number of input controls, the Department should add edit checks to the CARES enforcement action module to increase the reliability of CARES data. Ensuring the reliability of the data entered through the enforcement action module is important because this data includes specific information regarding each enforcement action taken against a nursing facility, including the nature of the enforcement action, the date on which a penalty was imposed, and the date on which a payment was received from the facility. Without accurate enforcement data, the Department could fail to collect penalties and could be forced to settle cases for less than the amounts assessed.

When we requested CARES enforcement action data, the Department needed to make several corrections to the data before providing it to us. In addition, a review of that data and the enforcement action module itself demonstrated that edit checks could strengthen the reliability of the data. For example:

- Because the module lacks reasonableness edit checks on several date fields, it allowed the entry of inaccurate dates. For example, the module allowed the entry of (1) interest accrual start dates that were after interest accrual stop dates, (2) enforcement action imposition dates such as 1919, and (3) payment dates such as 2033.

- Certain enforcement action records had enforcement action imposition dates that were blank, which indicates the absence of an edit check requiring the user to enter this date.
- Certain enforcement action records had payment dates that were blank, even when payment had actually been made. This indicates the absence of an edit check requiring the user to enter this date.
- Certain enforcement action records showed that the nursing facility had not made a payment related to an enforcement action but, at the same time, the record's payment status specified "Paid in Full." This indicates the absence of an edit check for internal consistency.

After we brought this matter to the Department's attention, it began an analysis to determine where edit checks could be added to the module and how to improve the quality of data for situations in which edit checks may not be feasible.

Recommendation

The Department should continue its analysis to determine where edit checks could be added to the CARES enforcement action module and how to improve the quality of data for situations in which edit checks may not be feasible.

Management's Response

We agree with this finding.

Corrective Action(s) Planned or Taken:

The DADS Integrated Product Team will conduct an in-depth analysis of the CARES application with a specific intent to identify data elements in need of additional or stronger edit checks. Implementation of all edits approved by the CARES project change control board, will occur with each future interim release of the application.

Implementation: The next interim release of the CARES application is targeted for 8/31/2005, DADS Information Resource Manager

Chapter 4-C

The Commission Should Improve the Physical Security of Its Computer Room

The Commission has issued 597 access cards (to 531 individual accounts) that enable individuals to enter its computer room. The computer room houses computer equipment for multiple health and human services systems (including CARES) and multiple agencies.

Because the Commission's computer room is used by multiple agencies for multiple systems, the number of access cards that have been issued may not be

Requirement for Security of Information Resources

Texas Administrative Code, Section 202.20(1), requires that:

Information resources residing in the various state agencies of state government are strategic and vital assets belonging to the people of Texas. These assets must be available and protected commensurate with the value of the assets. Measures shall be taken to protect these assets against unauthorized access, disclosure, modification or destruction, whether accidental or deliberate, as well as to assure the availability, integrity, utility, authenticity, and confidentiality of information. Access to state information resources must be appropriately managed.

excessive. However, the fact that hundreds of access cards have been issued increases the importance of monitoring to ensure that access cards are issued only to authorized individuals who need access to this room. Currently, the Commission does not have a process to ensure that this is the case. For example, the list of active access cardholders included 13 individuals whose employment has been terminated.

In addition, the halon fire-suppression system in the Commission's computer room was overdue for an inspection at the time of our audit. Inspecting this

system regularly and on time helps to ensure that the room is adequately protected.

Recommendations

The Commission should:

- Consider programming the access cards for its computer room to expire every 60 days.
- Restrict access to its computer room to essential personnel.
- Ensure that individuals whose employment has been terminated promptly relinquish their access cards to the computer room.
- Ensure that the halon fire-suppression system for its computer room is routinely inspected on time.

Management's Response

SAO Recommendation: *The Commission should:*

- *Consider programming the access cards for its computer room to expire every 60 days.*
- *Restrict access to its computer room to essential personnel.*
- *Ensure that individuals whose employment has been terminated promptly relinquish their access cards to the computer room.*

Action Planned: *The Texas Building and Procurement Commission (TBPC) is charged with maintaining the Winters Facility security system. The HHSC*

Enterprise IT Infrastructure Management (EIT) department is responsible for authorizing access to the computer room.

Access to secured areas requires approval by EIT personnel who manage those areas. A report will be produced every quarter and presented to the approvers for review and recommendation of actions to staff access. This procedure mitigates the risk related to the recommendation to expire access cards every 60 days, while minimizing disruption to employees who need access to perform their job duties. Also, the access system will be programmed to provide the names of staff who have failed to use their access cards for a 60 day period. Based upon follow up with identified staff, access will be removed and access cards collected for those individuals who no longer need access to fulfill job responsibilities.

The new TBPC Facilities Manager for the Winters Complex had begun an audit of the entire security access levels and staff list prior to this audit finding. The findings from the TBPC audit will be reviewed with the EIT Infrastructure Management Director, and TBPC and EIT will coordinate appropriate responses. In addition, EIT will provide a daily Health and Human Services (HHS) Human Resources (HR) report of terminated staff to TBPC Security and ensure access to the computer room is removed within 24 hours of notification. EIT will also coordinate with HHS HR to require the return of access cards in all cases.

Estimated Completion Date: May 31, 2005

Title of Responsible Person: HHSC IT Move Coordinator

SAO Recommendation: The Commission should ensure that the halon fire-suppression system for its computer room is routinely inspected on time.

Action Planned: The halon fire-suppression system is scheduled to be inspected annually. However, this fiscal year the annual inspection was delayed from March 31, 2004, to December 15, 2004, because of required maintenance on the system and organization changes resulting from the HHSC consolidation. Future inspections will occur on schedule.

Estimated Completion Date: June 30, 2005

Title of Responsible Person: Computer Operations Manager, EIT Infrastructure Management and Operations

The Commission Should Strengthen Access Controls for the Local Area Network through Which CARES Can Be Accessed

Weaknesses in access to the Commission's local area network through which CARES can be accessed¹¹ increase the risk that unauthorized users could access CARES.

The Commission does not have uniform password policies for this local area network; therefore, the security of passwords for this network varies. The Commission does not have uniform password policies because, in order to synchronize the log-in for this local area network with access to legacy systems, the Commission must use the level of access controls that the legacy systems allow. These controls vary across legacy systems. Although some of the legacy systems have their own security, access controls at the local area network level provide an additional level of security and protection for all the applications and data on the network.

Results of audit tests conducted in January 2005 found that for 11,485 user accounts on the local area network through which CARES can be accessed:

- 11,153 required a minimum password length of only four characters, which is not a sufficient length to ensure adequate protection.
- 173 were not required to have passwords.
- 11,474 did not have a limitation on the number of unsuccessful access attempts; therefore, individuals using these accounts could continue attempting to access the local area network.
- 11,038 were not required to change their passwords. For 446 user accounts, passwords were required to be changed every 30 to 365 days. One required the user to change the password only after 2,592 days.

In addition, servers attached to this local area network have a total of 477 guest accounts that should be better monitored. Some of these guest accounts are on older legacy systems and, according to Commission staff, it may be difficult to predict the effect of removing the guest accounts. Guest accounts that enable a user to do anything more than read data can make individual user accountability difficult to ensure.

¹¹ The Commission operates multiple local area networks; however, audit work focused on the local area network through which CARES can be accessed.

Recommendations

The Commission should:

- Ensure that access controls for the local area network through which CARES can be accessed comply with Commission policies and industry standards.
- Review the guest accounts for servers attached to the local area network through which CARES can be accessed and remove as many of these accounts as possible. For the guest accounts that cannot be removed, the Commission should ensure that these accounts enable the users to only read data.

Management's Response

SAO Recommendation: *The Commission should ensure that access controls for the local area network through which CARES can be accessed comply with Commission policies and industry standards.*

Management Action Planned: *HHSC will ensure that authentication controls in the new technical environment comply with HHS policies and national standards for passwords and access management.*

Estimated Completion Date: *January 1, 2006*

Title of Responsible Persons: *HHSC-IT Director, and Chief Information Officer.*

SAO Recommendation: *The Commission should review the guest accounts for servers attached to the local area network through which CARES can be accessed and remove as many of these accounts as possible. For the guest accounts that cannot be removed, the Commission should ensure that these accounts enable the users to only read data.*

Management Action Planned: *Though guest accounts currently have only limited functionality, a review will be conducted on all "guest" accounts to verify the business need. Review results will be documented. The review will eliminate unnecessary "guest" accounts and verify account functionality is appropriate for their approved use. Any "guest" account that cannot be eliminated at this time will be cross-checked against the mainframe migration schedule for a suggested timeframe for elimination. HHSC's current practice is that all new system development will allow only unique password accounts. Security policies, standards, and procedures will be updated to reflect current practice.*

Estimated Completion Date: *August 31, 2005*

Title of Responsible Person: *HHSC-IT Director*

The Department's Contracts with Nursing Facilities Contain Provisions to Hold Contractors Accountable

By incorporating the state and federal requirements for participating in the Medicaid program by reference, the Department's boilerplate contract with Medicaid-certified nursing facilities contains provisions sufficient to hold facilities accountable for delivery of quality services. For example, the contract contains provisions specifying the following:

- The nursing facility will provide nursing care services as defined by (1) Title XIX of the Social Security Act (the federal Medicaid program) and (2) Department rules specified in the Texas Administrative Code.
- The Department can terminate the contract if the facility fails to comply with the terms of the contract.
- The Department can assess monetary penalties for contract violations.
- The nursing facility will disclose information regarding past criminal activities and persons convicted of crimes in accordance with federal regulations.
- The nursing facility will comply with federal requirements to notify the Department when residents enter or leave the facility.
- Department personnel, as well as personnel from the Office of the Attorney General and the U.S. Department of Health and Human Services, can interview nursing facility residents.

The contract also contains provisions to prevent the inappropriate or inefficient use of public funds. For example, the contract contains provisions specifying the following:

- The Department can withhold payments or portions of payments because of "irregularity(ies) or difference(s) from whatever cause until such irregularity(ies) or difference(s) can be adjusted."
- The nursing facility agrees to accept the Department's payment as payment in full and assign all rights of recovery from third parties and any other source of payment to the Department as required by federal regulations and state statute.
- The nursing facility will disclose certain information regarding ownership and business transactions.
- The nursing facility will maintain financial and supporting documents for which claims are submitted and medical records for at least five years after the termination of the contract.

- The nursing facility will maintain separate trust funds for each resident who entrusts personal funds to the nursing facility.
- The nursing facility will certify that information submitted regarding claims for payment is true, accurate, and complete and that such information can be verified by source documents.
- The nursing facility will notify the Department 30 days in advance if it files for bankruptcy, dissolves, or ceases to operate.

While the contract provisions are sufficient to hold nursing facilities accountable, we noted that the contract does not include a provision that specifically permits the Department to audit the financial records of corporations that own Medicaid-certified nursing facilities. Adding such a provision could help ensure that the Department has access to the records it needs in order to hold nursing facilities accountable.

Recommendation

The Department should strengthen its contracts with nursing facilities by adding a provision that permits it to audit the financial records of corporations that own Medicaid-certified nursing facilities.

Management's Response

We agree with this finding.

Corrective Action(s) Planned or Taken:

DADS Provider Services will confirm which rights to audit are currently included in the nursing facility contracts. If the language is not adequate, DADS will add verbiage in the contract specifically addressing DADS and HHSC audit rights of entities that own or control Medicaid-certified nursing facilities.

Implementation: FY06 nursing facility contracts, 08/31/05, Section Director, Institutional Services

The Department and Commission Should Consider Using Available Information to Enhance Monitoring of Quality of Care

Although the Department is not specifically required to do so, it could use the information that it and the Commission already collect to track additional risk factors such as facilities' direct care worker turnover and staffing levels. Additionally, cost report and inspection information indicates that service delivery models vary depending on facility owner and ownership type.

Chapter 6-A

The Department Should Consider More Closely Monitoring Direct Care Worker Turnover and Staffing Levels at Medicaid-Certified Facilities

Medicaid-certified nursing facilities have relatively high turnover among direct care staff.

Direct Care Staff

Direct care staff includes the following positions:

- Registered nurses
- Licensed vocational nurses
- Certified nurse aides

Direct care staff turnover in the State's Medicaid-certified nursing facilities is more than 100 percent overall¹² according to information included in the 2003 cost reports. One in seven facilities has turnover in excess of 200 percent. Turnover, as reported by the facilities, is consistently high across all of the Department's regions. Although there are some regional differences in turnover, it is important to note that the lowest regional turnover (in Region 8, San Antonio) was still almost 100 percent. While turnover information is available in the cost reports the Commission requires Medicaid-certified nursing homes to submit annually for purposes of rate-setting¹³ (see Chapter 3), the Department is not currently using this available information to track turnover at the facilities.

Certified Nurse Aides

Certified nurse aides most frequently serve as the caregivers in nursing facilities. They have the most frequent contact with residents and provide critical services such as feeding, dressing, bathing, and routine communicating.

There are no state or federal requirements in the area of turnover, but high turnover can adversely affect nursing facilities' quality of care and financial stability. The National Citizens' Coalition for Nursing Home Reform cited relationships with immediate caregivers as an important factor in nursing home residents' quality of life.¹⁴ According to a 2003 study,¹⁵ high turnover among direct care staff has a detrimental effect on the quality of care that nursing home residents receive. Another study focused on the financial cost

¹² This includes all direct care staff positions (registered nurses, licensed vocational nurses, and certified nurse aides) for all Medicaid-certified facilities that submitted cost reports for their fiscal year 2003 activities.

¹³ The Commission does not currently audit the turnover information in the cost reports. Nursing facilities self-report this information.

¹⁴ National Citizens' Coalition for Nursing Home Reform (NCCNHR). 1985. "Consumer Perspectives on Quality Care." Washington DC: NCCNHR.

¹⁵ *Caring about Caregivers: Reducing Turnover of Frontline Health Care Workers in South Central Wisconsin*. Center on Wisconsin Strategy, University of Wisconsin-Madison. October 2003.

of high turnover and estimated that the cost of training new certified nurse aides is between \$2,000 and \$4,000 each.¹⁶

Extremely high turnover (as in the one in seven Texas Medicaid-certified facilities reporting more than 200 percent turnover) also may be an indicator of serious management problems.

Issues surrounding turnover indicate that the Department should consider more closely monitoring facilities with high turnover, initiating discussions about best practices with facilities to lower turnover, and including nursing facility turnover information on its facility ratings Web site.

Medicaid-certified nursing facilities have relatively low nurse aide staffing levels.

Other than the required minimum level for registered nurse staffing discussed in Chapter 1-D, Texas Medicaid-certified nursing facilities have no state or federal requirements for direct care staffing levels. Nevertheless, recognized industry best practices and minimum safe staffing levels do exist.

According to a recent report by the U.S. Centers for Medicare and Medicaid Services (CMS),¹⁷ the minimum certified nurse aide (CNA) staffing level necessary to reduce the risk of diminished quality of care is either 2.0 or 2.9 hours per resident day (hprd), depending on the methodology.¹⁸ For example, using the lower standard of 2.0 hprd, a facility with 100 residents would require at least 200 hours of CNA labor a day, or about 25 full-time nurse aides, to meet the minimum standard. According to information that facilities reported in annual cost reports, about 62 percent of Texas Medicaid-certified nursing facilities do not have CNA hprd staffing levels above 2.0; only about 2 percent report CNA hprd staffing levels above 2.9.

Additionally, staffing patterns differ according to ownership. While the average CNA hprd for all Medicaid-certified nursing facilities in Texas is close to the 2.0 CNA hprd staffing level discussed above, on average the 280 facilities owned by the six largest nursing home corporations in Texas have only 1.6 CNA hprd (see Table 6). This is equivalent to five fewer CNAs available to a population of 100 residents, and it is well below the minimum level discussed in the CMS report.

¹⁶ *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, Centers for Medicare and Medicaid Studies (CMS), Phase I-2000, Phase II-2001

¹⁷ *Ibid.*

¹⁸ The 2.0 hprd minimum was the result of a multivariate analysis of data from a few states. The 2.9 hprd minimum was the result of a time-motion study.

Table 6

Certified Nurse Aide Staffing Levels by Ownership Type		
	Average CNA Staffing (hprd)	Approximate Resident-to-Staff Ratio
Texas Medicaid-certified nursing facilities owned by the top six corporations	1.63	4.9
All other Texas Medicaid-certified nursing facilities	2.04	3.9

Source: State Auditor's Office analysis of fiscal year 2003 cost report information in the Commission's Automated Cost Report and Evaluation System

Enhanced staffing payments are being made to nursing facilities whose staffing levels are below industry-recognized minimums.

The Commission reports that in fiscal year 2003 it paid 948 nursing facilities an extra \$75 million (on top of the regular per diem rates) as part of enhanced staffing agreements with those facilities. The Commission currently pays 27 different levels of enhanced staffing supplements based on increasing staffing levels at each participating facility rather than on recognized standards of sufficient staffing. This means that the State is paying additional funds to some nursing facilities that continue to staff below industry-recognized minimum safe staffing levels.

Low staffing levels may contribute to high turnover.

The problems of turnover and low staffing levels are closely related, and recent studies link job satisfaction among certified nurse aides with staffing levels.¹⁹ One of the primary reasons for nurse aide dissatisfaction is insufficient staffing, which results in low staff morale.

Table 7 shows that there are also differences in staffing levels and turnover rates among Texas Medicaid-certified nursing facilities by ownership type. For-profit nursing facilities tend to have lower staffing and higher turnover. The highest direct care staffing levels and the lowest turnover are found in government-run nursing facilities.

¹⁹ *What Makes for a Good Working Condition for Nursing Home Staff: What Do Direct Care Workers Have to Say?*, Nursing Home Coalition of New York State (NHCC), June 2003.

Table 7

Fiscal Year 2003 Certified Nurse Aide Staffing and Turnover by Ownership Category		
Ownership Type	Nurse Aide Staffing Level (HPRD)	Turnover Rates
For-Profit	1.89	119.2%
Nonprofit	2.14	99.0%
Government-Run	2.44	74.9%

Source: State Auditor's Office analysis of cost report information in the Commission's Automated Cost Report and Evaluation System

Recommendations

The Department should consider:

- Monitoring direct care worker turnover and staffing levels reported by the nursing facilities.
- Including direct care worker turnover and staffing level statistics for all Medicaid-certified facilities in its Quality Reporting System.
- Exploring ways to reduce nursing facility staff turnover through focused Quality Monitoring Program facility consultation.

Management's Response from the Department

We agree with this observation.

Corrective Action(s) Planned or Taken:

CMS currently maintains the Nursing Home Compare website including reports on nursing facility staffing. The Department will work with HHSC to examine the feasibility of employing additional methods of monitoring direct care worker turnover and staffing levels in nursing facilities.

Work on examining the feasibility of additional methods of monitoring will be completed by June 30, 2005, Director, Center for Policy and Innovation

The Department will also undertake efforts to study ways to reduce nursing facility staff turnover, such as a systematic review of professional literature regarding successful turnover reduction interventions, to provide the basis for future technical assistance and consultation.

The literature review concerning reduction of nursing facility staff turnover will be completed by June 1, 2006, Director, Center for Policy and Innovation

Management's Response from the Commission

It is unclear if the SAO considered adjustments for facilities' average case mix or recoupments of enhancement funds from facilities failing to meet their staffing and /or spending requirements in its analyses. As well, the enhanced staffing program is not designed to reward facilities for exceeding staffing levels suggested by CMS but rather is aimed at improving staffing in Texas from where it currently stands. As such, enhancements are paid to facilities committing to staff above the average statewide staffing levels for facilities with a similar case mix. If a facility fails to meet its staffing and/or spending requirements, the enhanced funds are recouped. To improve direct care staffing in Texas facilities to the levels recommended by CMS would require significant additional appropriated funds.

Chapter 6-B

The Department and Commission Should Be Aware of Differences among Medicaid-Certified Nursing Facilities Depending on Ownership Type

Direct care expenditures and administrative costs vary by ownership type.

Our analysis of nursing facilities' fiscal year 2003 cost reports showed significant differences in expenditure patterns between nursing facilities that are owned and operated by for-profit corporations and nursing facilities that are owned and operated by nonprofit and government organizations.

As Table 8 shows, nursing facilities that are owned by for-profit corporations have lower average expenditures on direct care for residents and higher administrative costs. In contrast, while nursing facilities that are operated by government organizations (state, counties, municipal governments, and special districts) constitute less than 3 percent of all Medicaid-certified nursing facilities in Texas, they have the lowest administrative costs and the highest percentage of funding dedicated to direct care.

Table 8

Direct and Dietary Costs as a Percentage of All Costs for Medicaid-Certified Facilities by Ownership Type	
Ownership Type	Direct Care and Dietary Cost as a Percentage of All Costs
For-Profit	62.3%
Nonprofit	65.1%
Government-Run	70.0%

Source: State Auditor's Office analysis of fiscal year 2003 cost report information in the Commission's Automated Cost Report and Evaluation System

It is also important to note that there are significant differences among for-profit owners. We analyzed nursing facilities owned by the six corporations

that own the most Medicaid-certified nursing facilities in Texas and found that the nursing facilities that are owned by three of these corporations reported administrative costs that were at or below the state average for all Medicaid-certified facilities (approximately 15 percent of all expenditures). However, the nursing facilities owned by the other three corporations reported administrative costs that ranged from 22 to 24 percent of all expenditures.

Quality-of-care indicators vary by ownership type.

The Department gives overall ratings to nursing facilities based on the results of annual inspections, complaint and incident report investigations, and resident outcomes reported by the facilities.²⁰ Our analysis of these ratings showed that, on average, nursing facilities that are owned by for-profit organizations score lower than nursing facilities that are operated by nonprofit and government organizations. The average overall ratings for each ownership type are shown in Table 9.

Table 9

Medicaid-Certified Facilities' Overall Ratings by Ownership Type	
Facility Ownership Type	Average Overall Rating
For-Profit	58.6
Nonprofit	65.1
Government-Run	73.2

Source: State Auditor's Office analysis of the Department's Quality Reporting System data as of August 31, 2004

It is important to note that for-profit organizations own more than 80 percent of Medicaid-certified nursing facilities in Texas.

Recommendation

The Department and Commission should further analyze the relationship between direct care expenditures and quality of care and consider establishing limits on allowable administrative costs.

²⁰ Overall scores for Texas nursing facilities are available on the Quality Reporting System Web site at http://facilityquality.dhs.state.tx.us/lcqr_public/nq1/jsp3/qrsHome1en.jsp?MODE=P&LANGCD=en

Management's Response from the Department

We agree with this observation.

Corrective Action(s) Planned or Taken:

Regulatory Services will work with HHSC Rate Analysis to evaluate currently available information from cost reports related to direct care expenditures and its relationship to quality of care. HHSC will evaluate administrative costs to determine the appropriateness of establishing limits on allowable administrative costs for nursing facility providers.

Evaluation will be complete by 12/31/05, Assistant Commissioner, Regulatory Services.

Management's Response from the Commission

Action Planned: *Regulatory Services will work with staff at HHSC to evaluate currently available information from cost reports related to direct care expenditures and its relationship to quality of care. HHSC will evaluate administrative costs to determine the appropriateness of establishing limits on allowable administrative costs for nursing facility providers.*

Estimated Completion Date: *December 31, 2005*

Title of Responsible Person: *Assistant Commissioner for Regulatory Services, and HHSC Manager of Rate Analysis.*

Appendices

Appendix 1

Objective, Scope, and Methodology

Objective

Our objective was to determine whether the Department of Aging and Disability Services (Department) and the Health and Human Services Commission (Commission) have adequate contract administration processes for nursing facilities, including:

- Sufficient contractor oversight to ensure that contractors consistently provide quality services and that public funds are spent effectively and efficiently.
- Methods used to establish contractor reimbursement that are sufficient to ensure that the State pays a fair and reasonable price for services.
- Contract provisions that are sufficient to hold contractors accountable for delivery of quality services and prevent the inappropriate or inefficient use of public funds.

Scope

Our scope covered (1) the Department's monitoring of nursing facility care through complaint investigations and annual inspections and (2) the Commission's responsibility to ensure that nursing facilities correctly specify the level of effort necessary to meet each resident's actual needs and submit accurate cost reports.

Our scope included the Department's and Commission's contract administration activities related to the 1,055 contracts with Medicaid-certified nursing facilities in Texas that were in place at the end of fiscal year 2004. We analyzed nursing facility complaints and incident reports for fiscal years 2002 through 2004. Our audit of the utilization review function focused on fiscal years 2003 and 2004. We audited nine nursing facility cost reports for fiscal year 2003.

Methodology

The audit methodology consisted of collecting information and documentation, performing selected tests and other procedures, analyzing and evaluating the results of the tests, and conducting interviews with Department and Commission management and staff.

To quantify the extent of nursing facilities' systematic overstatement of residents' TILES (categories in the Texas Index for Level of Effort), we projected the overall dollars in error (from the Commission's 2003 utilization review sample) to the dollars in the population. This was done using three methods: (1) the ratio of dollars in error to the total dollars sampled (ratio method); (2) the average difference between the actual and criterion claim payment (difference method); and (3) the correlation between dollars in error and dollars paid (correlation method). These three methods produced very consistent estimates of the dollars in error in the population.

We then made adjustments to account for the fact that recoupment is less likely for the higher-numbered TILES. We excluded TILES 209–211 from this analysis because these TILES are less susceptible to overstatement and because review coverage of these TILES was minimal. Excluding them had no material effect on the projection of dollars in error. The result of this analysis should be viewed as an estimate because the TILE forms reviewed were not selected randomly. However, the sample of more than 25,000 TILE forms was large enough, particularly in the lower-numbered TILES, to suggest generalization to the population.

Information collected and reviewed included the following:

- The Department's standard contract with nursing facilities
- The TILE per diem base payment structure for fiscal years 2004–2005
- Commission information regarding the rate-setting process for nursing facilities
- Commission procedures for desk audits and field audits of nursing facilities' cost reports
- Nursing facility cost report information in the Automated Cost Reporting and Evaluation System (ACRES)
- Long-term care information in the Compliance, Assessment, Regulation, and Enforcement System (CARES)
- Department procedures for conducting nursing facility inspections and investigating complaints and incident reports
- Commission procedures for utilization reviews
- Utilization review data
- Nursing facility complaint and incident report data
- *Federal Oversight Support Survey* for fiscal years 2003 and 2004

- *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*, Government Accountability Office, Report No. 03-561, July 2003
- *What Makes for a Good Working Conditions for Nursing Home Staff: What Do Direct Care Workers Have to Say?*, Nursing Home Coalition of New York State (NHCC), June 2003
- National Citizens' Coalition for Nursing Home Reform (NCCNHR). 1985. "Consumer Perspectives on Quality Care." Washington DC: NCCNHR.
- *Caring about Caregivers: Reducing Turnover of Frontline Health Care Workers in South Central Wisconsin*. Center on Wisconsin Strategy, University of Wisconsin-Madison. October 2003.
- *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios In Nursing Homes*, Centers for Medicare and Medicaid Studies (CMS), Phase I-2000, Phase II-2001.

Procedures and tests conducted included the following:

- Field visits to 15 nursing facilities to audit the timeliness and completeness of resident assessments and care plans, trust fund management, and compliance with other criteria required for participation in the Medicaid program
- Data analysis of cost report information and verification of supporting documentation for expenditures reported on fiscal year 2003 cost reports
- Data analysis and statistical projection using utilization review data
- Data analysis of annual inspection timing
- Data analysis using nursing facility complaint and incident report data
- Technical network vulnerability scans
- Review of CARES and ACRES information technology controls
- Interviews and walk-throughs with Department and Commission staff
- Data analysis of facility staffing, turnover, and ownership information reported in facility cost reports for fiscal years 2003 and 2004

Criteria used included the following:

- U.S. Centers for Medicare and Medicaid State Operations Manual
- Texas Health and Safety Code, Chapters 242 and 255

- Code of Federal Regulations, Title 42, Chapter 483
- Texas Administrative Code, Title 40, Chapter 19
- Texas Administrative Code, Title 1, Chapter 202
- The Department's *Long-Term Care Investigation Handbook*
- The Department's *Long-Term Care Regulatory Facility Enforcement Handbook*

Other Information

We conducted fieldwork from October 2004 through February 2005. This audit was conducted in accordance with generally accepted government auditing standards. The following members of the State Auditor's staff performed this audit:

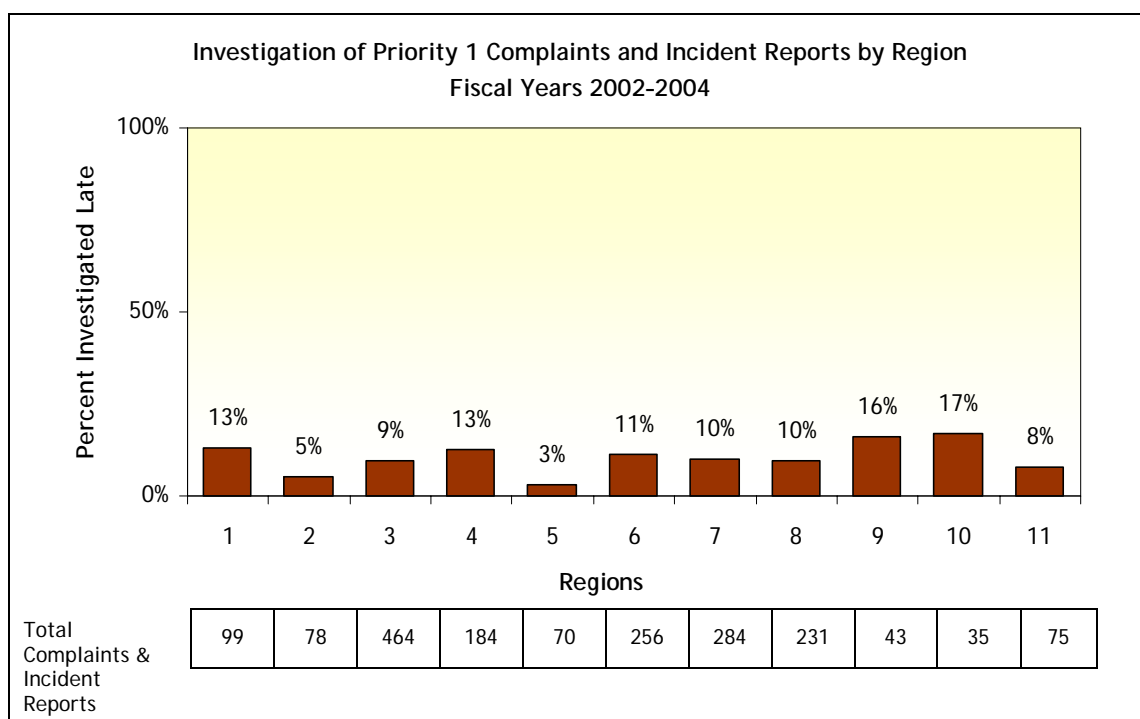
- Scott Boston, MPAff (Project Manager)
- Sherry Sewell, CGAP (Assistant Project Manager)
- Brianna Lehman
- Joseph K. Mungai, CIA
- Jon Nelson, MBA, CISA
- Stephanie Sherrill
- John Swinton, MPAff, CGFM
- Serra Tamur, MPAff, CISA, CIA
- Wei Wang, CIA, CPA
- Robert W. Woodward
- Leslie Ashton, CPA (Quality Control Reviewer)
- John Young, MPAff (Audit Manager)

Timeliness of Regional Investigations of High-Priority Complaints and Incidents

The following graphs illustrate regional compliance with investigation timeliness requirements for high-priority complaints and incident reports that the Department received in fiscal years 2002 through 2004.

Priority 1 (Immediate Jeopardy) Complaints and Incident Reports (see Figure 1). The Department's regions varied least in the timeliness of their investigations of the highest-priority complaints and incident reports. Region 5 was most consistently prompt in investigating Priority 1 complaints and incident reports, with about 97 percent of investigations conducted on time. Region 10 was least consistent in the timeliness of investigations, responding to about 83 percent of Priority 1 complaints and incident reports on time.

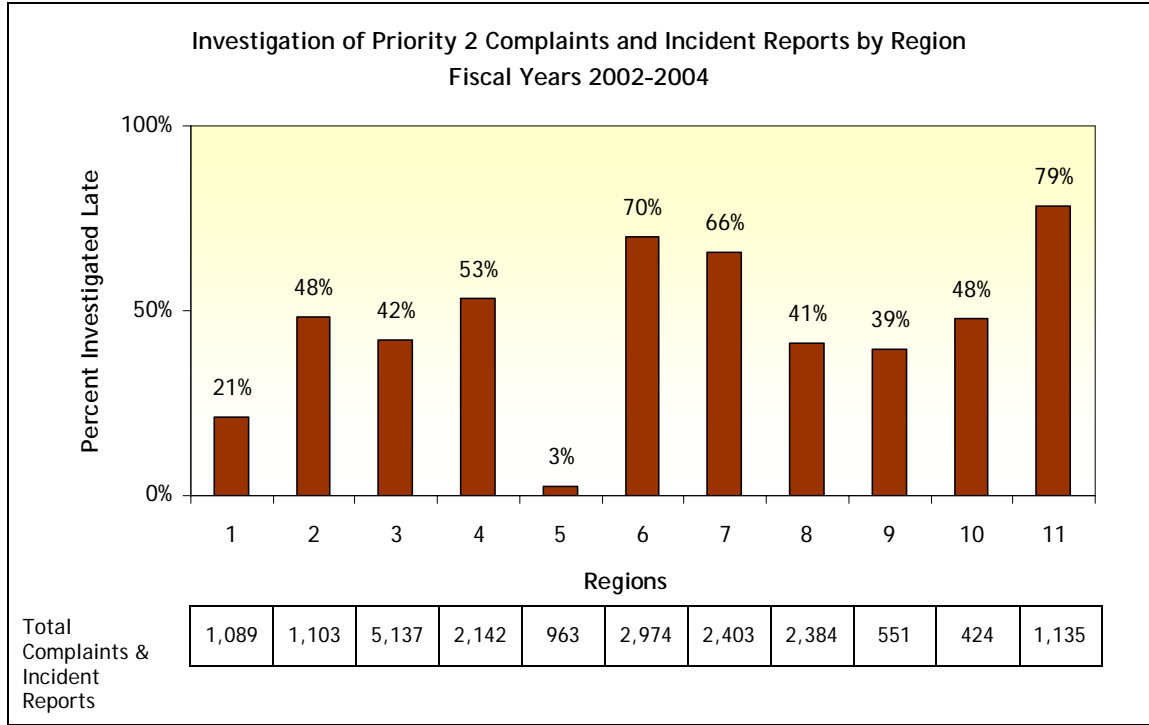
Figure 1



Source: State Auditor's Office analysis of CARES data

Priority 2 (Actual Harm/Potential Actual Harm) Complaints and Incident Reports (see Figure 2). The timeliness of regional investigations of Priority 2 complaints and incident reports varied significantly. As with Priority 1 complaints and incident reports, Region 5 investigated more than 97 percent of Priority 2 complaints and incident reports in a timely manner. On the other hand, Region 11 and Region 6 investigated only about 21 percent and 30 percent of Priority 2 complaints and incident reports, respectively, in a timely manner.

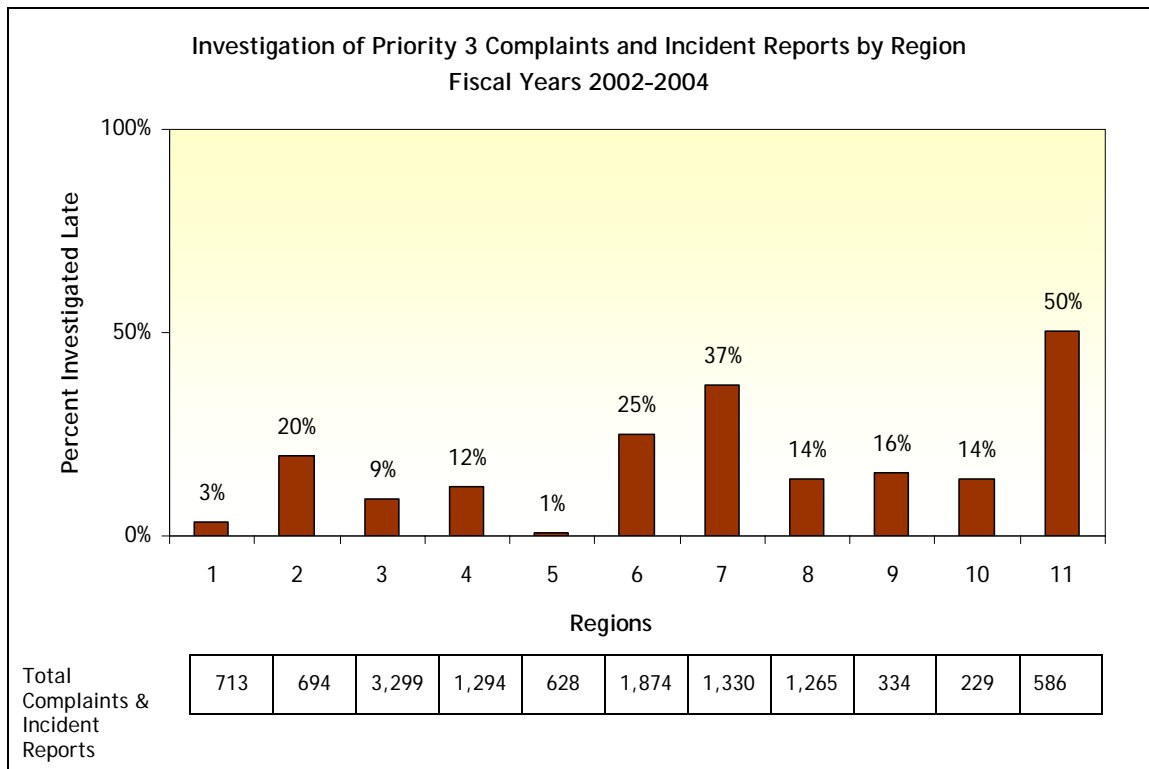
Figure 2



Source: State Auditor's Office analysis of CARES data

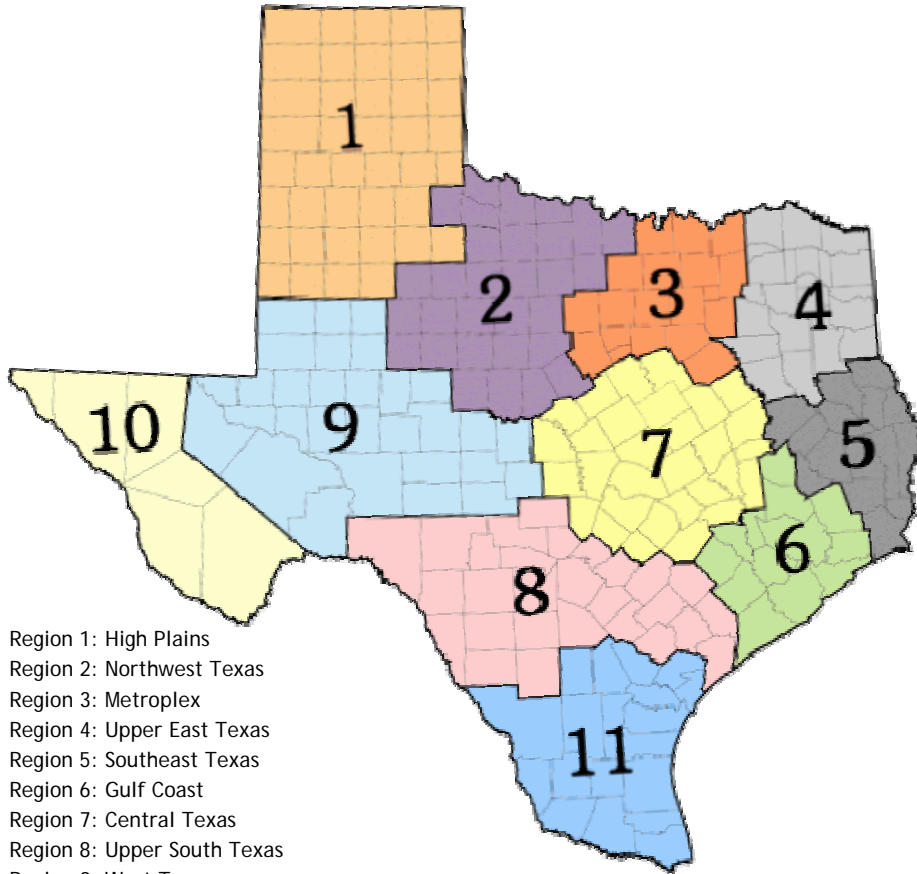
Priority 3 (Minimal Harm/Potential for Minimal Harm) Complaints and Incident Reports (see Figure 3). The timeliness of regional investigations of Priority 3 complaints and incident reports also varied significantly. Region 5 investigated more than 99 percent of Priority 3 complaints and incident reports in a timely manner. However, Region 11 and Region 7 investigated only about 50 percent and 63 percent of Priority 3 complaints and incident reports, respectively, in a timely manner.

Figure 3



Source: State Auditor's Office analysis of CARES data

Department of Aging and Disability Services Regions



- Region 1: High Plains
- Region 2: Northwest Texas
- Region 3: Metroplex
- Region 4: Upper East Texas
- Region 5: Southeast Texas
- Region 6: Gulf Coast
- Region 7: Central Texas
- Region 8: Upper South Texas
- Region 9: West Texas
- Region 10: Upper Rio Grande
- Region 11: Lower South Texas

Utilization Review Sanction Policy



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

July 15, 2004

To: All Nursing Facilities

Re: Implementation of new Case Mix Rules

The purpose of this letter is to provide a final notification to Nursing Facility (NF) Providers of the new Case Mix Rules in the Texas Administrative Code (TAC), Title 1, Part 15, Subchapter C, §371.212 – 371.214. These rules became effective May 12, 2004. **The Utilization Review (UR) Department will fully implement the new rules effective August 2, 2004.** Again, the major changes to the rules include:

- Missing documentation and signatures:
 - At the first visit after the new rules became effective, NRs will check for required signatures. If signatures are missing or 3652 CARE forms cannot be located, the assessment will be considered invalid and will be included in the overall error rate.
 - At the subsequent visit to facilities that had missing forms or signatures at the first visit, any required signatures missing on 3652 CARE forms or missing forms may result in a 212 TILE for those forms for the time they were invalid.
- New error rate requirements and outcomes:
 - For the first visit after the new rules became effective, if error rate is 25% or greater, facilities will receive a warning letter, and may have a return visit within the next seven months.
 - At the subsequent visit to facilities with an error rate greater than 25% at the first visit, if the error rate is 20% or higher, the facility may be placed on Vendor Hold.
- Changes to the following qualifying conditions or treatments: rehabilitation therapy, restorative nursing, dehydration, UTI, oxygen administration, respiratory administration, wound dressings, and eating training programs.

Additionally, the TILE certification will now be effective for a two-year period, and currently certified TILE nurses will be granted a one-year grace period from the effective date of the rule.

If you have any questions, please feel free to contact Sandra Brown, RN, BSN, Nursing Facility Manager, at (512) 482-3298.

Sincerely,

A handwritten signature in cursive script that reads "Jessica Allison".

Jessica Allison, RN, MSN
Utilization Review Manager
Office of Inspector General

JA/sb

C: Sandra Brown

Copies of this report have been distributed to the following:

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The Honorable Tom Craddick, Speaker of the House, Joint Chair
The Honorable Steve Ogden, Senate Finance Committee
The Honorable Thomas “Tommy” Williams, Member, Texas Senate
The Honorable Jim Pitts, House Appropriations Committee
The Honorable Jim Keffer, House Ways and Means Committee

Office of the Governor

The Honorable Rick Perry, Governor

Health and Human Services Commission

Mr. Albert Hawkins, Executive Commissioner

Department of Aging and Disability Services

Mr. James R. Hine, Commissioner



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