Report Highlights

Department of Health and Hospitals' Administration of Medicaid Long-Term Care Services

March 2005

Louisiana Legislative Auditor

Steve J. Theriot, CPA

Legislative Auditor

The Department of Health and Hospitals (DHH) is responsible for administering Medicaid-funded long-term care services for the elderly and individuals with disabilities. Medicaid long-term care in Louisiana includes institutional services provided in over 300 state and private nursing facilities and almost 500 state and private intermediate care facilities for the mentally retarded (ICFs/MR), as well as home and community-based services provided through waivers.

Audit Results

ACCESS TO LONG-TERM CARE SERVICES

- A uniform assessment process would help DHH ensure that individuals receive appropriate, cost-effective placements in long-term care settings. Approximately 5,945 individuals residing in nursing facilities and ICFs/MR could potentially be served in less costly settings, resulting in a cost difference of between approximately $35 million and $53 million.
- DHH's definition of nursing facility level of care is too broad.
- Inequitable funding has resulted in long waiting lists for home and community-based services. Individuals on the waiting list for the New Opportunities Waiver (NOW) on June 9, 2004, will have to wait over nine years for services. However, institutional facilities with low occupancy and/or utilization have generally received funding increases each year.
- DHH's Facility Need Review Program should be modified or eliminated because it restricts market entry and creates an advantage for existing nursing facility and ICF/MR providers.

MAJOR COSTS OF LONG-TERM CARE SERVICES

- Some provisions of the private nursing facility reimbursement system appear generous as compared to other states. Louisiana could have potentially saved over $44 million in state fiscal year 2005 if it had adopted provisions similar to other states.
- The NOW waiver needs a cost control mechanism. The average annual direct cost per person for the waiver in state fiscal year 2004 was only $251 less than the average cost of private ICF/MR care.

QUALITY OF LONG-TERM CARE SERVICES

- DHH has various processes to help ensure quality in institutional settings. However, the processes could be improved by increasing the minimum staffing requirement from 1.5 to 3.0 hours per resident per day in nursing facilities; assigning investigation priorities for nursing facility complaints in a timely manner; consistently imposing penalties for repeat deficiencies in ICFs/MR; and removing or increasing the cap on civil money penalties.
- The Bureau of Community Supports and Services' (BCSS') oversight over regulatory processes is insufficient to ensure that waiver recipients receive quality services.

How Can DHH Improve Access to Medicaid Long-Term Care Services in Louisiana?

What We Found

- DHH is developing single points of entry for the elderly and individuals with physical disabilities but has not developed single points of entry for individuals with developmental disabilities.
- DHH's definition of nursing facility level of care is too broad.
- Using assessment data on individuals residing in nursing facilities and ICFs/MR, we estimated that approximately 5,945 individuals could be served in less costly settings, resulting in a potential cost difference of between approximately $35 million and $53 million.
- Inequitable funding has resulted in long waiting lists for home and community-based waiver services. As of December 31, 2003, over 11,000 individuals were waiting for waiver services. Individuals on the waiting list for the NOW waiver as of June 9, 2004, will have to wait over nine years for services.
- Private nursing facilities and state developmental centers have generally received increased funding each year. However, the number of individuals residing in the facilities has decreased. The average occupancy rate for private nursing facilities in state fiscal year 2004 was 76.6%. The average daily census for the developmental centers decreased 8.3% from state fiscal year 2000 to state fiscal year 2004.
- DHH should improve the allocation of waiver slots. The "first-come first-served" method does not take into consideration applicants' needs for waiver services.
- DHH's Facility Need Review Program limits nursing facility and ICF/MR participation in the Medicaid long-term care market and gives existing providers an advantage.
- DHH does not have sufficient oversight over the alternate use of empty nursing facility beds. The department did not know how 91.0% of the 1,529 beds in alternate use on October 20, 2004, were being used.

Summary of Major Recommendations

DHH should:

- ✓ Continue developing single points of entry for all populations in need of long-term care services
- ✓ Develop a specific definition of nursing facility level of care
- ✓ Implement a standard assessment process for entry into the long-term care system
- ✓ Develop a funding plan that includes closing and/or downsizing state facilities
- ✓ Improve the waiting list process for waiver services
- ✓ Modify the Facility Need Review Rule if the legislature does not repeal the Facility Need Review Law and improve oversight over alternate use beds

Summary of Matters for Legislative Consideration

The legislature should consider:

- ✓ DHH's plan for equitable funding of a full array of long-term care services
- ✓ Repealing the Facility Need Review Law or amending it to eliminate problems and allow for open market competition among Medicaid long-term care providers

What Are the Major Costs of Medicaid Long-Term Care Institutional Services?

What We Found

- The largest costs incurred by state and private nursing facilities for state fiscal year 2003 were for direct nursing salaries and related supplies.
  - For state nursing facilities, these costs totaled over $7 million and averaged over $3.6 million per facility, or $67.50 per resident day.
  - For private nursing facilities, these costs totaled over $280 million and averaged over $1 million per facility, or $28.01 per resident day.

- The largest costs incurred by state developmental centers for state fiscal year 2002 were for therapeutic and training services. These costs totaled almost $71 million and averaged almost $8 million per facility, or $115.80 per resident day.

- Therapeutic and training services also comprised the largest costs for private ICFs/MR. These costs totaled almost $84 million and averaged over $189,000 per facility, or $62.65 per resident day.

- Some provisions of Louisiana's Medicaid reimbursement rate methodology for private nursing facilities appear generous when compared to other states. Louisiana could have potentially saved over $44 million in state fiscal year 2005 if the following three provisions were changed:

  - Louisiana includes all residents in the acuity ("case mix") calculation, whereas most other states include only Medicaid residents.

  - Louisiana requires a 9.25% minimum floor for the rental rate calculation, whereas other states range from 6.73% to 9.0%.

  - Louisiana uses a 70% minimum occupancy for calculating the capital component of the rate, whereas other states use at least 90%.

Summary of Major Recommendations

- ✓ DHH should amend the rules that govern reimbursement rates for private nursing facilities to make the methodology more consistent with other states.

How Does DHH Ensure the Accuracy of Institutional Costs?

What We Found

- DHH needs to strengthen its process for ensuring that costs submitted by private nursing facilities and ICFs/MR are accurate. For example,

  - DHH has not sanctioned facilities that report disallowed costs or receive disclaimers on their cost reports. Auditors disallowed over $57 million in state fiscal years 2001 through 2003.

  - Case mix data used to calculate private nursing facility reimbursement rates are often inaccurate. DHH contractors found over $900,000 in case mix errors in state fiscal year 2004.

  - DHH has not always followed its criteria for selecting facilities to be audited.

Summary of Major Recommendations

DHH should:

- ✓ Amend the Standards for Payment for Nursing Facilities and ICFs/MRs to include sanctions for disclaimers and disallowed costs

- ✓ Develop an electronic database to track audit findings, disallowed costs, and other cost report data

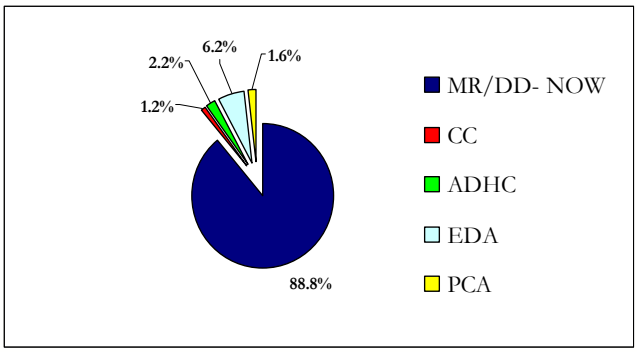
- ✓ Require its audit contractor to audit all private nursing facilities each year or each rebase year

What Are the Major Costs of Medicaid Long-Term Care Home and Community-Based (Waiver) Services?

What We Found

- From state fiscal year 2000 through state fiscal year 2004, DHH expenditures for home and community-based services increased 139% from over $103 million to over $247 million.

- The NOW waiver (formerly the MR/DD waiver) received almost 89% of total waiver expenditures during this five-year period, as shown below.



- The NOW waiver needs a cost control mechanism.

  - Annual budgets for NOW waiver recipients ranged from $600 to $177,098 in state fiscal year 2004.

- If DHH capped the NOW waiver at the average annual cost of a private ICF/MR ($49,267), it could have served an additional 1,507 individuals who were waiting for NOW waiver slots in state fiscal year 2004.

Summary of Major Recommendations

✓ DHH should implement a control mechanism for the NOW waiver.

How Does DHH Ensure the Accuracy of Waiver Costs?

What We Found

◈ DHH has developed some electronic systems and processes that help ensure that providers bill correctly. However, provider monitoring could be improved.

Summary of Major Recommendations

✓ DHH should target problem providers in its monitoring process.

What Regulatory Processes Does DHH Use to Ensure the Quality of Long-Term Care Services in Nursing Facilities and ICFs/MR, and How Can Those Processes Be Improved?

What We Found

◈ The minimum staffing requirement for nursing facilities is too low. The Centers for Medicare and Medicaid Services (CMS) recommends 3.0 hours of nursing care per resident per day as the preferred minimum level to avoid harm, but state regulation only requires a minimum of 1.5 hours.

◈ CMS found that Health Standards is "very effective" in surveying nursing facilities.

◈ The predictability of standard surveys of nursing facilities has declined. However, the timing of ICF/MR surveys is predictable. We found that 42.9% of ICF/MR surveys in our sample were conducted within two weeks of the date of the previous year's survey.

◈ DHH has not assigned investigation priorities to nursing facility complaints timely. On average, it took Health Standards 7.1 working days to return complaint calls and obtain the information needed to assign investigation priorities from August through October of 2004.

◈ Although DHH allows nursing facilities and ICFs/MR to dispute survey deficiencies and sanctions, few were disputed and even fewer were overturned in calendar year 2003.

◈ Health Standards lacks policies and procedures to ensure that residents of nursing facilities and ICFs/MR are notified of sex offenders living in the facilities. We identified 11 registered sex offenders residing in 11 different nursing facilities and two residing in an ICF/MR.

◈ State civil money penalties may not be high enough to deter noncompliance by facilities.

◈ In calendar year 2003, DHH consistently imposed penalties on nursing facilities for repeat deficiencies but not on ICFs/MR.

◈ Revenue from penalties could be used to improve quality in facilities.

Summary of Major Recommendations

DHH should:

✓ Increase the minimum staffing requirement for nursing facilities to at least 3.0 hours per resident per day

✓ Vary the dates on which it surveys ICFs/MR

✓ Ensure that nursing facility complaint calls are returned and complaint investigations are assigned in a timely manner

✓ Consistently sanction non-compliant facilities

Summary of Matters for Legislative Consideration

The legislature should consider:

✓ Amending the law to increase or remove the cap on sanctions for violations of nursing facility and ICF/MR regulations

✓ Allowing DHH to use civil money penalties collected from sanctions to improve quality in nursing facilities and ICFs/MR

What Regulatory Processes Does DHH Use to Ensure the Quality of Long-Term Care Services Provided Through Waivers, and How Can Those Processes Be Improved?

What We Found

◈ The BCSS' oversight over regulatory processes is insufficient to ensure that waiver recipients receive quality services.

◈ BCSS lacks easily accessible, centralized electronic data.

- The BCSS state office does not track or compile data on provider deficiencies and has not provided sufficient guidance to regional offices on how to consistently cite instances of noncompliance.
- We were not able to evaluate the effectiveness of BCSS' enforcement activities because of the lack of data on enforcement actions.

◈ Regulatory processes for ensuring the quality of waiver services need improvement. For example,

- Licensing, enrollment, and monitoring processes lack coordination and standardization.
- Licensing regulations governing waiver providers are outdated.
- Critical incidents (i.e., incidents involving abuse, neglect, extortion, etc.) were not always resolved within required time frames.
- Complaint data are incomplete and unreliable.
- The BCSS state office does not monitor the timeliness or appropriateness of the regions' investigations of complaints and critical incidents.
- BCSS is not notified of the resolution of all abuse and neglect cases.
- BCSS does not require case management agencies to routinely report quality information derived from their home visits of waiver recipients.

Summary of Major Recommendations

DHH should:

✓ Improve its oversight over the regulatory processes in the waiver programs

✓ Develop an integrated database to consistently collect data from its regulatory activities

Summary of Matter for Legislative Consideration

✓ The legislature should consider transferring the licensing authority for all waiver providers from DSS to DHH.

What Additional Initiatives Can DHH Use to Ensure the Quality of Long-Term Care Services?

What We Found

◈ We identified several other initiatives that could help DHH ensure quality in Medicaid long-term care services. They are as follows:

- Encouraging culture change in nursing facilities
- Disseminating quality and compliance information to the public
- Developing an online abuse registry for waiver and ICF/MR providers
- Measuring consumer satisfaction
- Ensuring attainment of personal outcomes for waiver recipients
- Partnering with nonprofit organizations to provide the Program of All-Inclusive Care for the Elderly (PACE)

Summary of Major Recommendations

DHH should:

- ✓ Post provider quality and compliance information on its Web site
- ✓ Periodically measure consumer satisfaction in all long-term care settings
- ✓ Expand its efforts to partner with nonprofit agencies to provide PACE programs throughout the state

Summary of Matter for Legislative Consideration

- ✓ The legislature should consider requiring DHH to develop an online abuse registry for ICF/MR and waiver providers.

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Questions? Call Steve J. Theriot at 225-339-3800

DEPARTMENT OF HEALTH AND HOSPITALS' ADMINISTRATION OF MEDICAID LONG-TERM CARE SERVICES

PERFORMANCE AUDIT

ISSUED MARCH 9, 2005

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March 9, 2005

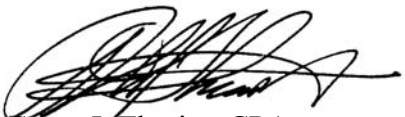
The Honorable Donald E. Hines,
President of the Senate
The Honorable Joe R. Salter,
Speaker of the House of Representatives

Dear Senator Hines and Representative Salter:

This report provides the results of our performance audit of the Department of Health and Hospitals' administration of Medicaid long-term care services for the elderly and individuals with disabilities. The audit was conducted under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended.

The report contains our findings, conclusions, and recommendations. Appendix B contains management's response. I hope this report will benefit you in your legislative decision-making process.

Sincerely,



Steve J. Theriot, CPA
Legislative Auditor

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EXECUTIVE SUMMARY

The Department of Health and Hospitals (DHH) is responsible for administering Medicaid-funded long-term care services in Louisiana. During this audit, we focused on ways that DHH could improve access to Medicaid long-term care services, the major costs associated with long-term care services, and the regulatory processes DHH uses to ensure the quality of long-term care services in nursing facilities, ICFs/MR, and the waiver programs. We also identified additional initiatives DHH can use to ensure the quality of long-term care services across all settings. See list of Acronyms on page 13.

Performance Audit Findings

Access to Long-Term Care Services

- DHH is developing single points of entry for the elderly and individuals with physical disabilities but has not developed any for individuals with developmental disabilities *(see pages 25-26)*.
- DHH's definition for nursing facility level of care is too broad *(see pages 27-29)*.
- Using assessment data on individuals in nursing facilities and private ICFs/MR, we estimated that approximately 5,945 individuals residing in those facilities could potentially be served in less costly home and community-based settings or assisted living facilities at a cost difference of approximately $35 million to $53 million *(see pages 29-33)*.
- Inequitable long-term care funding has resulted in long waiting lists for home and community-based services. As of June 2004, the average wait time for an EDA waiver slot was over a year and the average wait time for a NOW waiver slot was over nine years. However, nursing facilities and state developmental centers have generally received increased funding each year even though the number of individuals residing in those facilities has decreased. In state fiscal year 2004, the average occupancy rate in private nursing facilities was 76.6%. The average daily census of state developmental centers decreased 8.3% from state fiscal year 2000 to state fiscal year 2004 *(see pages 33-38)*.
- DHH's Facility Need Review Program should be modified or eliminated because it restricts market entry and creates an advantage for existing nursing facility providers *(see pages 41-44)*.

Major Costs of Long-Term Care Services

- Some provisions of the Medicaid reimbursement system for private nursing facilities appear generous compared to other states. Louisiana could have potentially saved over $44 million in state fiscal year 2005 if DHH amended certain provisions of the reimbursement rate methodology rule to be more consistent with other states *(see pages 51-54)*.
- DHH needs to strengthen the processes it uses to ensure the accuracy of costs reported by private nursing facilities and private ICFs/MR. For example,
  - DHH has not sanctioned facilities that report disallowed costs or receive disclaimers on their cost reports from the auditors *(see pages 56-57)*.
  - Cost report and case mix data used to calculate private nursing facility reimbursement rates are often inaccurate and incomplete *(see pages 57-59)*.
  - DHH has not always followed its criteria for selecting facilities to be audited *(see pages 59-60)*.

- The average annual direct cost per person for the NOW waiver in state fiscal year 2004 was only $251 less than the average cost per private ICF/MR resident. If the NOW waiver had been capped at the average cost of a private ICF/MR, DHH would have incurred over $74 million less in costs for the waiver. DHH could have used those funds to serve approximately 1,507 additional individuals who were waiting for NOW services *(see pages 64-66)*.
- The Bureau of Community Supports and Services (BCSS) has some electronic capabilities to help ensure that providers do not bill for more services than they were approved to provide. However, the provider monitoring process that BCSS uses to ensure that providers actually provide the services for which they bill could be improved by targeting problem providers and increasing sample sizes *(see pages 67-69)*.

Quality of Long-Term Care Services

Nursing Facilities and ICFs/MR

- DHH's minimum staffing requirement for nursing facilities is too low. CMS recommends 3.0 hours of nursing care per resident per day to avoid harm, but Louisiana state regulations only require a minimum of 1.5 hours per resident per day *(see pages 72-73)*.
- According to CMS, Health Standards is "very effective" in surveying nursing facilities *(see pages 74-75)*.
- The predictability of standard surveys of nursing facilities has declined. However, the timing of ICF/MR surveys is predictable *(see pages 75-77)*.
- DHH has not assigned investigation priorities to complaints filed against nursing facilities timely. It took Health Standards an average of 7.1 working days to return complaint calls and obtain the information needed to assign investigation priorities from August through October of 2004 *(see pages 79-80)*.
- DHH allows nursing facilities and ICFs/MR to dispute survey deficiencies and sanctions. However, few deficiencies and sanctions were disputed and fewer were overturned in calendar year 2003 **(***see pages 80-81)*.
- Health Standards lacks policies and procedures to ensure that residents of nursing facilities and ICFs/MR are notified of sex offenders living in the facilities. We identified 11 registered sex offenders residing in 11 different nursing facilities and two residing in an ICF/MR *(see pages 82-83)*.
- State civil money penalties may not be high enough to deter noncompliance by nursing facilities and ICFs/MR *(see pages 85-87)*.
- In calendar year 2003, DHH consistently imposed penalties on nursing facilities for repeat deficiencies but not on ICFs/MR *(see pages 87-89)*.
- Revenue from civil money penalties could be used to improve quality of care in nursing facilities and ICFs/*MR (see pages 90-91)*.

Home and Community-Based Services

- BCSS' oversight over regulatory processes has been insufficient to ensure that waiver recipients receive quality services *(see pages 92-95)*.
- BCSS lacks easily accessible, centralized electronic data, which makes it difficult to evaluate the quality of waiver services. The BCSS state office does not track or compile data on provider deficiencies and has not provided sufficient guidance to the regions on how to consistently cite instances of noncompliance. We were unable to evaluate the effectiveness of BCSS' enforcement activities because of the lack of data on enforcement actions *(see pages 95-99)*.
- Regulatory processes for ensuring quality need improvement.
  - Licensing, enrollment, and monitoring processes lack coordination and standardization *(see pages 101-102)*.
  - Some DSS licensing regulations governing waiver providers are outdated *(see page 102)*.
  - Critical incidents were not always resolved within the required time frame in state fiscal year 2004 *(see pages 103-105)*.
  - Complaint data are incomplete and unreliable *(see page 105)*.
  - The BCSS state office does not monitor the timeliness or appropriateness of regions' investigations of critical incidents and is not notified of the resolution of all abuse and neglect cases *(see pages 106-107)*.
  - Case management agencies did not always provide required services from January 1, 2002, through December 31, 2004 *(see page 107)*.
  - BCSS does not require case management agencies to routinely report quality information derived from their home visits to waiver recipients *(see pages 107-108)*.

Additional Initiatives to Help Ensure the Quality of Long-Term Care Services

We identified several additional initiatives that could help DHH ensure quality in Medicaid long-term care services.

- Encouraging culture change in nursing facilities *(see pages 109-110.)*
- Disseminating quality and compliance information to the public *(see pages 110-111.)*
- Developing an abuse registry for ICFs/MR and waiver providers *(see page 111.)*
- Measuring consumer satisfaction *(see pages 111-112.)*
- Ensuring attainment of personal outcomes for waiver recipients *(see page 112.)*
- Partnering with nonprofit organizations to provide the Program of All-Inclusive Care for the Elderly (PACE) *(see pages 112-113.)*

ACRONYMS

ACS Affiliated Computer Systems

ADHC Adult day health care

ADLs Activities of daily living

BCSS Bureau of Community Supports and Services

BHSF Bureau of Health Services Financing

CC Children's Choice (Waiver)

CMS Centers for Medicare and Medicaid Services

CPOC Comprehensive plan of care

DHH Department of Health and Hospitals

DSS Department of Social Services

EDA Elderly Disabled Adult (Waiver)

FOSS Federal Oversight and Support Surveys

HCBS Home and community-based services

HPRD Hours per resident day

ICAP Inventory for Client and Agency Planning

ICFs/MR Intermediate care facilities for the mentally retarded. The state's ICFs/MR are also called developmental centers.

IDR Informal dispute resolution

LPN Licensed practical nurse

M&S Myers and Stauffer, LC

MDS Minimum data set

MOU Memorandum of understanding

MR/DD Mentally retarded/developmentally disabled

NF Nursing facility

NOW New Opportunities Waiver

OCDD Office for Citizens with Developmental Disabilities

P&N Postlethwaite and Netterville

PCA Personal care attendant

PLI Patient Liability Insurance

RN Registered nurse

SPOE Single point of entry

SRI Statistical Resources, Inc.

UPL Upper payment limit

AUDIT INITIATION AND BACKGROUND

Audit Initiation and Objectives

Louisiana Revised Statute 24:522 requires, in part, that the legislative auditor establish a schedule of performance audits to ensure that at least one performance audit is completed and published for each executive department within a seven-year period beginning with the 1997-98 fiscal year. In accordance with this requirement, the Office of Legislative Auditor scheduled a performance audit of the Department of Health and Hospitals (DHH) for the 2004-2005 fiscal year. The scheduling of this audit was approved by the Legislative Audit Advisory Council on July 30, 2003. After researching the major health care issues facing DHH, we decided to focus the audit on Medicaid-funded long-term care for the elderly and individuals with disabilities. Appendix A contains our audit scope and methodology.

The objectives of this audit were to determine the following:

- How can DHH improve access to Medicaid long-term care services in Louisiana?
- What are the major costs of Medicaid institutional long-term care services in Louisiana, and how does DHH ensure that the costs are accurate?
- What are the major costs of Medicaid home and community-based (i.e., waiver) long-term care services in Louisiana, and how does DHH ensure that the costs are accurate?
- What processes has DHH developed to ensure the quality of long-term care services in nursing facilities and intermediate care facilities for the mentally retarded, and how can those processes be improved?
- What processes has DHH developed to ensure the quality of long-term care services in the home and community, and how can those processes be improved?
- What additional initiatives could help DHH ensure the quality of long-term care services?

Overview of Long-Term Care

Long-term care is the term used for a variety of supportive and rehabilitative services provided to individuals who need assistance to function in their daily lives. Long-term care services can include nursing care, case management, assisted living, adult day health care, social services, and home health care. These services can be provided in two different types of settings:

1. **Institutions**, such as nursing facilities (i.e., nursing homes) and intermediate care facilities for the mentally retarded (ICFs/MR)

2. **Home and community-based services**, such as waivers, assisted living, home health services, and personal care services

The elderly and individuals with physical and developmental disabilities are the primary recipients of long-term care services. According to the most recent census, almost 35 million people in the United States (12.4% of the nation's population) are elderly, and almost 4 million (1.2% of the nation's population) are developmentally disabled.[1] In calendar year 2002, 25% of Medicaid enrollees in the country were elderly, physically disabled, or developmentally disabled.

According to the American Association of Retired Persons, growth in the number of elderly is projected to rise over the next several decades because of the aging baby boom population. Between 2000 and 2020, the percentage of persons age 65 and older is expected to rise from 12.4% to 16.3%.

Overview of Medicaid Program

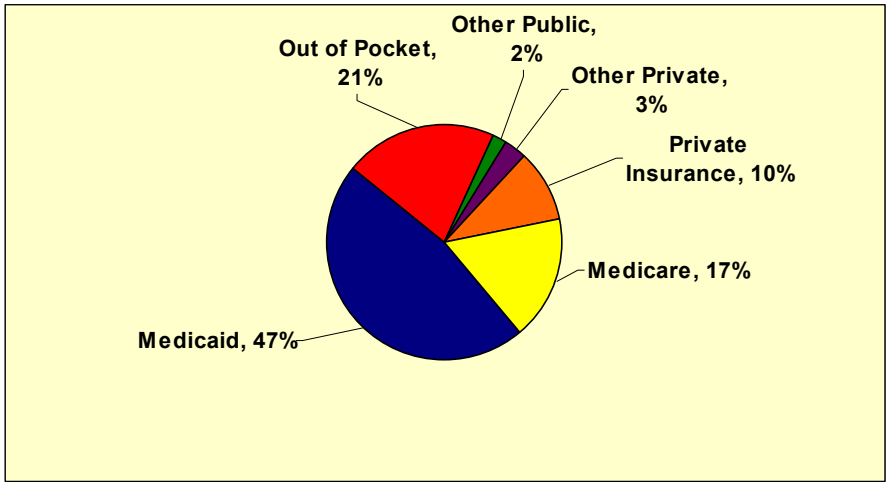
Title XIX of the federal Social Security Act established the Medicaid program in 1965. Through the program, the federal government partners with states to provide medical assistance for eligible individuals and families. Although the federal government provides financial assistance to states to carry out the Medicaid program, states are free to establish the following program components:

- Eligibility standards
- Type, amount, duration, and scope of services
- Rates of payment for services
- Administration of the program

Medicaid is the nation's largest source of long-term care financing. In calendar year 2002, Medicaid accounted for 47% of national long-term care spending. The second largest source was out-of-pocket payments by people who receive long-term care services (21%). The other 22% was divided among various other sources. Exhibit 1 on the following page shows the sources of national long-term care financing in calendar year 2002.

[1] This number is based on a national estimate that 1.2% to 1.6% of the population has developmental disabilities. The figure does not include physical disabilities. We were unable to obtain data on the number of people with physical disabilities.

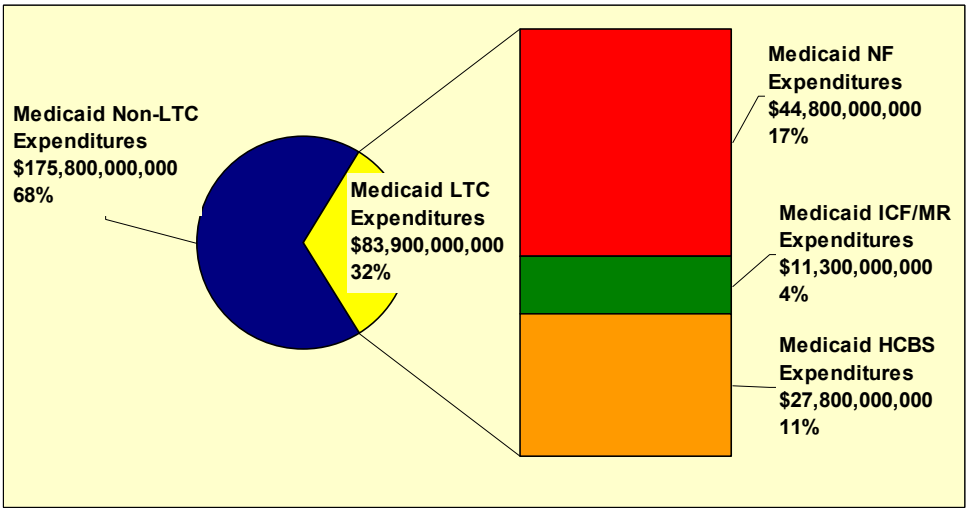
Exhibit 1
Sources of National Financing for Long-Term Care
Calendar Year 2002



Source: Prepared by legislative auditor's staff using information obtained from Georgetown University's Long-Term Care Financing Project.

Medicaid long-term care expenditures were 32%, or $83.9 billion, of total Medicaid expenditures ($259.6 billion) in federal fiscal year 2003. Approximately two-thirds, or $56.1 billion, of all Medicaid long-term care expenditures ($83.9 billion) were for institutional services (i.e., nursing facilities and ICFs/MR). Exhibit 2 illustrates total Medicaid spending for federal fiscal year 2003.

Exhibit 2
Total Medicaid Spending
Federal Fiscal Year 2003



Source: Prepared by legislative auditor's staff using information obtained from Medstat (May 25, 2004 memo).

Medicaid Long-Term Care Services in Louisiana

Institutional Services

Source: Photo of Veteran's Celebration courtesy of St. Clare Manor.

Louisiana has historically served the elderly and individuals with disabilities through institutional care provided in nursing facilities and ICFs/MR. In calendar year 2004, Louisiana licensed approximately 318 nursing facilities (including two state facilities) and 487 ICFs/MR (including nine state developmental centers). Nursing facility services for people age 21 and above are mandated under the federal Medicaid law. ICF/MR services are considered optional under the law. Exhibit 3 shows average occupancy rates of state and private nursing facilities and ICFs/MR and Medicaid expenditures to those facilities in state fiscal year 2004.

Exhibit 3
Average Occupancy Rates and Medicaid Expenditures
Paid to Nursing Facilities and ICFs/MR
State Fiscal Year 2004

Institution Type	Average Occupancy Rate	Medicaid Expenditures Paid to Facilities	Percent of Total Expenditures
Private Nursing Facilities	75.8%	$561,137,457	56.5%
State Nursing Facilities*		$19,106,002	1.9%
Private ICFs/MR (1-15 beds)	97.2%	$183,208,375	18.4%
Private ICFs/MR (16+ beds)	99.3%		
State Developmental Centers*	94.6%	$229,854,603	23.1%
Total		**$993,306,437**	**100.0%**

* Expenditures include UPL. See footnote on page 49 for more information on UPL.
Source: Prepared by legislative auditor's staff using information provided by DHH.

Home and Community-Based Services

Louisiana currently administers four Medicaid waiver programs that allow the elderly and people with disabilities to receive services outside of institutions. DHH began phasing out a fifth waiver in state fiscal year 2004. Waivers provide a variety of services including personal care attendant services, transportation, 24-hour supervision, homemaker services, environmental modifications, and respite services. The waivers are authorized under 1915(c) of the Social Security Act and enable states to provide home and community-based services to individuals who would otherwise require admission to institutions. Federal law requires that the average cost of waiver services be less than or equal to the average cost of institutional services. Home and community-based services are considered an optional Medicaid service under federal law. Exhibit 4 on the following page shows examples of services offered, the number of funded

waiver slots in state fiscal year 2004, and the number of people waiting for Medicaid home and community-based services as of December 31, 2003, which was the most recent data available when we conducted our review.

Exhibit 4
Waiver Services Offered, Number of Funded Slots (State Fiscal Year 2004), and Number of People Waiting for Slots (as of December 31, 2003)

Name of Waiver	Examples of Services Offered	Number of Funded Slots[1] (FY 2004)	Number of People Waiting for Waiver Services (As of 12/31/03)
Elderly Disabled Adult (EDA)	• Case Management • Personal Care Attendant • Household Supports • Personal Supervision (day and night) • Environmental Modifications	1,779	3,248
Adult Day Health Care (ADHC)	• Direct Care Services • Health Services • Social Services • Nutrition • Transportation	638	50
Personal Care Attendant (PCA)*	• Personal Care Services	362	108
New Opportunities Waiver (NOW)**	• Support Services (day and night) • Specialized Medical Equipment and Supplies • Environmental Modifications • Transportation • Skilled Nursing	4,576	7,932
Children's Choice (CC)	• Case Management • Family Support • Center-Based Respite • Environmental Accessibility Adaptations • Family Training, Diapers	800	
Total		**8,155**	**11,338**

[1] The number of funded slots does not equal the number of people served because one slot may be filled by more than one recipient during a single year.
*DHH began phasing out this waiver during state fiscal year 2004. Most of the recipients of the services offered under the PCA waiver will transition into the EDA waiver and may also receive personal care services under the Personal Care Services program, a Medicaid State Plan amendment.
**Previously called the MR/DD Waiver.
Source: Prepared by legislative auditor's staff using information provided by DHH.

National and State Long-Term Care Litigation

Recent litigation has expanded access to home and community-based long-term care services. Two recent cases are described below.

Tommy Olmstead, Commissioner, Georgia Department of Human Resources, et al., Petitioners v. L.C., by Jonathan Zimring, Guardian Ad Litem and Next Friend, et al.

In this case, the U.S. Supreme Court held that mentally-disabled patients were qualified for community-based treatment, but the state could take into account available resources in determining whether patients were entitled to immediate community placement.

Lee Barthelemy, Aaron Liller, Claude Callagan, Carolyn Netterville, Richard Nagle, and Darlene Williamson, on behalf of themselves and all others similarly situated, and Resources for Independent Living v. Louisiana Department of Health and Hospitals and David Hood Secretary, Louisiana Department of Health and Hospitals

After the United States District Court, E.D., Louisiana certified a class in October 2000, the parties to this suit entered into a settlement agreement whereby the defendants will expand the community-based Medicaid services available to class members subject to the reasonable allocation of resources among the competing demands for services in the area of activity that are the responsibility of the defendants. The court defined the class as all persons with disabilities who are receiving Medicaid-funded services in nursing facilities, or who are at imminent risk of being admitted to a nursing facility to receive such services, who have applied for Medicaid-funded services in the community through one or more of the Medicaid-funded home and community-based waivers administered by DHH, who have not been determined ineligible for such community-based services, and who have not received such Medicaid-funded community-based services. A modification to the settlement agreement was approved in March 2003 by the same court. As a result of the settlement agreement and amendment, DHH is required to do, among other things, the following:

- Add personal care services to the State Medicaid Plan, which will allow all Medicaid recipients to access those services
- Develop and use assessment processes and procedures
- Experiment with a single point of entry system
- Raise rates for personal care attendants and case management fees
- Remove the cap on services in the waivers
- Promote the principles of consumer direction

DHH's Administration of Medicaid Long-Term Care Services

As illustrated in Exhibit 5, Louisiana's Medicaid-funded long-term care services are administered primarily by the following three DHH entities: [2]

1. Bureau of Health Services Financing - Medicaid (BHSF)
2. Office for Citizens with Developmental Disabilities (OCDD)
3. Bureau of Community Supports and Services (BCSS)

Bureau of Health Services Financing (BHSF)

BHSF administers the Medicaid program in Louisiana. As shown in Exhibit 5, different sections within the bureau have various responsibilities related to Medicaid long-term care services.

Exhibit 5
BHSF Sections and Responsibilities
Related to Medicaid Long-Term Care Services

Section	Responsibilities
Eligibility Field Operations	• Certifies financial eligibility for long-term care services
Health Standards	• Creates and regulates licensing and certification standards for nursing facilities and ICFs/MR • Performs provider licensing and certification surveys for nursing facilities and ICFs/MR • Investigates complaints against nursing facilities and ICFs/MR • Certifies medical eligibility for nursing facilities and ICFs/MR • Manages resident assessment instruments for nursing facilities and ICFs/MR
Rate and Audit Review	• Administers reimbursement methodology for nursing facilities and ICFs/MR • Administers contracts for audits and desk reviews of nursing facility and ICF/MR cost reports • Administers contracts for nursing facility case mix reimbursement (including Medicare Minimum Data Set audits)

Source: Created by legislative auditor's staff using DHH's Manual of Programs and Services.

[2] It should be noted that the draft of *Louisiana's Plan for Immediate Action: Providing Long-Term Care Choices for the Elderly and People with Disabilities* dated December 17, 2004, calls for an administrative restructuring of DHH offices.

BHSF operates regional and parish Medicaid offices and Medical Assistance Program units throughout the state. The Health Standards section operates six regional offices in the New Orleans/Houma-Thibodaux, Baton Rouge/Mandeville, Lafayette/Lake Charles, Alexandria, Monroe, and Shreveport areas.

Office for Citizens with Developmental Disabilities (OCDD)

OCDD operates the nine state-owned ICFs/MR called state developmental centers. The developmental centers provide 24-hour care and active treatment to people with developmental disabilities in a residential setting. The developmental centers are located in areas throughout the state, as shown in Exhibit 6.

Exhibit 6
Locations of State ICFs/MR (Developmental Centers)

Developmental Center	Location
Columbia Developmental Center	Columbia
Hammond Developmental Center	Hammond
Leesville Developmental Center	Leesville
Metropolitan Developmental Center	Belle Chasse
Northwest Louisiana Developmental Center	Bossier City
Pinecrest Developmental Center	Pineville
Peltier-Lawless Developmental Center	Thibodaux
Ruston Developmental Center	Ruston
Southwest Developmental Center	Iota
Source: Created by legislative auditor's staff using information from DHH's Web site.	

In addition to providing long-term care services to people with disabilities, OCDD also offers other state-funded services to this population. Other state-funded services include case management; support coordination; diagnosis and evaluation; early intervention/infant habilitation; individual and family support; vocational and habilitative services; and supported living services.

Individuals with developmental disabilities may apply for OCDD services, including developmental center services, through the Community Services Regional Offices. The offices are located in New Orleans, Thibodaux, Lafayette, Lake Charles, Pineville, Shreveport, Monroe, and Mandeville. The Capital Area Human Services District in Baton Rouge and the Jefferson Parish Human Services Authority in Metairie offer services through Memoranda of Understanding with DHH.

Bureau of Community Supports and Services (BCSS)

BCSS manages the Medicaid waiver program by performing the following functions:

- Maintaining the Request for Services Registry, where potential Medicaid waiver recipients apply for future waiver slots on a first-come, first-served basis

- Certifying medical eligibility for applicants who may be offered waiver slots
- Licensing all case management agencies and adult day health care facilities providing waiver services
- Investigating complaints against waiver providers
- Monitoring 5% of waiver recipients (and their providers) yearly through visits and file reviews

BCSS operates nine regional offices throughout the state. The offices are located in New Orleans, Baton Rouge, Thibodaux, Lafayette, Lake Charles, Alexandria, Shreveport, Monroe, and Mandeville.

Waiver services may also be provided by adult day care centers, supported independent living providers, respite care centers, and personal care attendants. The providers of these services are licensed by the Department of Social Services, not BCSS.

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HOW CAN DHH IMPROVE ACCESS TO MEDICAID LONG-TERM CARE SERVICES IN LOUISIANA?

We identified five areas in which DHH could improve access to Medicaid long-term care services in Louisiana. They are as follows:

- Area 1: Reducing Fragmentation
- Area 2: Improving Admissions Review and Assessment
- Area 3: Addressing Inequitable Funding
- Area 4: Improving Allocation of Waiver Slots
- Area 5: Modifying or Eliminating Facility Need Review

Issues related to each of these areas are discussed in the following sections.

Area 1: Reducing Fragmentation

DHH Is Developing Single Points of Entry for the Elderly and Individuals With Physical Disabilities

DHH has identified fragmentation of administration, funding, and services as a critical challenge to improving Louisiana's long-term care system. Because long-term care functions are dispersed among eight offices or divisions within two state agencies and the Governor's Office, many consumers have expressed confusion over how and where to access long-term care services. To address this issue, DHH is developing single points of entry (SPOEs) for the elderly and individuals with physical disabilities. A SPOE is defined as a system that enables consumers to access long-term care services through one agency. The agency may manage access to one or more funding sources and perform a range of activities that may include information and assistance, screening, assessment of service needs, care planning, and monitoring. Current DHH initiatives related to SPOE are as follows:

- DHH and the Governor's Office of Elderly Affairs are developing an Aging/Disability Resource Center in the Lafayette region at the Cajun Area on Aging using a grant from the Centers for Medicare and Medicaid Services (CMS). The center that will serve as an information one-stop and pilot for a SPOE for all long-term care services to older adults and individuals with physical disabilities.
- DHH has contracted with Affiliated Computer Systems (ACS) to develop a SPOE for nursing facility and home and community-based services. According to the contract, ACS will maintain a toll-free hotline that explains long-term care options, schedules eligibility interviews, and makes referrals to other agencies.

While DHH has developed these initiatives for the elderly and individuals with physical disabilities, it has not developed similar entry points for the MR/DD population. In November 2004, DHH established OCDD as the single point of access for the developmental centers and the MR/DD registry for the NOW and CC waivers. However, individuals seeking private ICFs/MR can be directly admitted to facilities without going through OCDD. Legislation in the 2004 Regular Legislative Session that would have made OCDD the SPOE failed.

Some providers have expressed concerns about the SPOEs, noting that they may be biased against certain settings and that individuals may not be able to access services timely. Therefore, it is important for DHH to ensure that the SPOEs allow consumers to quickly access a wide array of services. One way to ensure timely access is to implement a Fast Track system similar to the one in Colorado. With Fast Track, a three-person team establishes Medicaid eligibility, conducts assessments, and develops care plans for individuals at risk of entering a nursing facility. Between July 2000 and July 2001, the average length of time to determine eligibility in Colorado was nine days.

Most states have some kind of SPOE. According to a 2003 survey conducted by the Rutgers Center for State Health Policy and funded by CMS, 32 states and the District of Columbia operate 43 SPOEs for long-term care services. A SPOE system for both the elderly and individuals with physical and developmental disabilities has the potential to streamline access to an array of services and reduce confusion over where to go for services. It also has the ability, when combined with uniform assessment practices, to ensure that individuals receive appropriate and cost-effective services.

Recommendation 1: DHH should continue working toward single points of entry for the elderly and individuals with physical disabilities. The single point of entry system should truly be a "one-stop-shop" that allows individuals to contact local offices to obtain information and/or referrals, undergo assessment and eligibility determination, and apply for appropriate services. DHH should require that all individuals needing long-term care use the local single points of entry before accessing services.

Summary of Management's Response: DHH agrees with this recommendation and has implemented a SPOE that has an end-goal of becoming a 'one stop' regionally based entry point (see Appendix B for management's full response).

Recommendation 2: DHH should ensure that individuals can access long-term care services timely through its single point of entry system. One possibility may be to implement a Fast Track system similar to Colorado's.

Summary of Management's Response: DHH agrees with this recommendation and is developing plans to include 'fast track' access in its SPOE similar to Colorado's (see Appendix B for management's full response).

Area 2: Improving Admissions Review and Assessment

DHH's Definition for Nursing Facility Level of Care Is Too Broad

DHH's definition of nursing facility level of care is not specific or measurable. DHH uses the level of care descriptions in the Nursing Facility Standards for Payment, which are promulgated by DHH regulation and approved by CMS, to determine if individuals medically qualify for nursing home admission. However, the standards do not specify how many services (e.g., assistance with activities of daily living (ADLs), tube feedings, medication administration, etc.) applicants must need to qualify for admission to a nursing facility.

Applicants for nursing facility admission must submit a medical eligibility form (called the "90-L") to DHH, which must be signed by a physician. The form provides the physician's evaluation of the applicant's health status including mental status, degree of dependence with ADLs, and any special care or procedures required (i.e., dialysis, restraints, etc.). The form also includes the physician's determination of the level of care the individual requires. Admission review nurses at DHH use the level of care descriptions in the Standards for Payment to review the form and approve or deny admission to a nursing facility. No specific or measurable criteria are used for this review. According to DHH officials, if an individual needs any of the services described in the level of care description, DHH will approve admission to a nursing facility. Exhibit 7 lists examples of the level of care descriptions.

Exhibit 7
Examples of Nursing Facility Level of Care Services

Level of Care	Examples of Services
Intermediate Care I **(minimum care required)**	• Administration of oral medications and eye drops • Frequent periods of agitation, requiring physical or chemical restraints • Incontinence (bladder and/or bowel) • Dependence on staff for a number of personal care needs
Intermediate Care II **(medium care required)**	• Supervision or assistance with personal care needs • Assistance in eating • Administration of medication, eye drops, topical applications • Mild confusion
Skilled Nursing Facility **(maximum care required)**	• Intravenous, intramuscular, or subcutaneous injections • Treatment of pressure sores • Tube feedings • Physical, speech, or occupational therapy

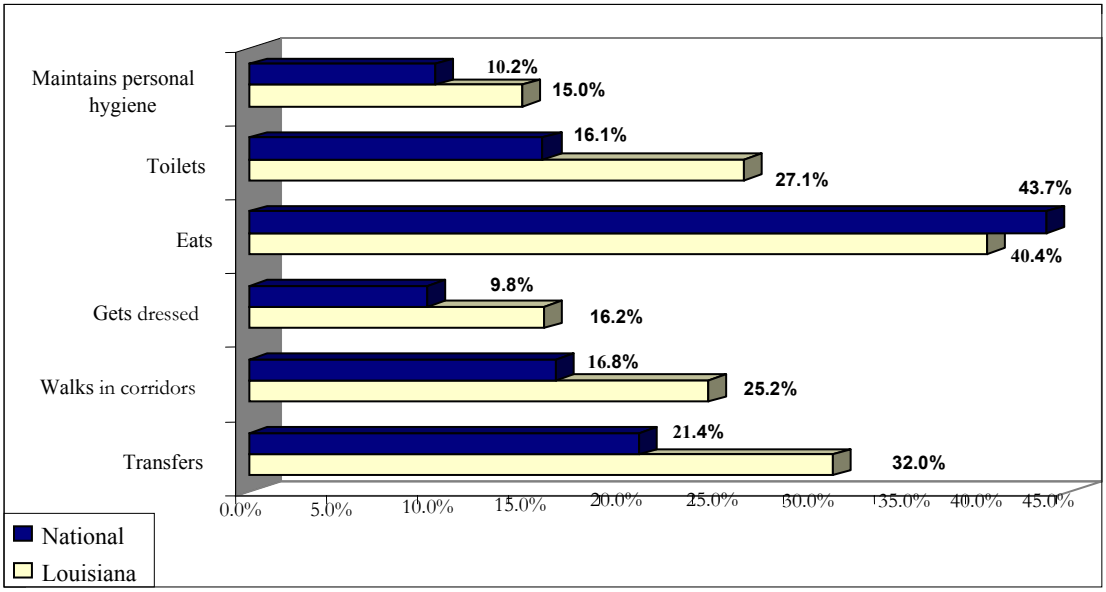
Source: Prepared by legislative auditor's staff using information provided by DHH.

Because of the lack of specific, measurable criteria, individuals who are relatively independent and may not require 24-hour care may be admitted to nursing facilities. For instance, as Exhibit 7 illustrates, an elderly person who only needs assistance to take medicine or

administer eye drops could qualify for admission. The lack of specific criteria may also result in DHH approving admissions to nursing facilities inconsistently among regions.

To determine the degree of independence of Louisiana nursing facility residents, we analyzed assessment data that was self-reported by nursing facilities to CMS (called Minimum Data Set or MDS) as of June 30, 2004. The data show the functional levels and abilities of nursing facility residents. Our analysis shows that Louisiana ranks above the national average in the percentage of nursing facility residents who can independently perform certain ADLs. For example, Louisiana ranks 3rd in the percentage of residents who can toilet independently -- 27.1% of Louisiana nursing facility residents can toilet independently as opposed to the national average of 16.1%. Louisiana ranks 4th in the percentage of residents who can dress themselves -- 16.2% of Louisiana nursing facility residents can get dressed independently as opposed to the national average of 9.8%. Exhibit 8 summarizes how Louisiana compares to the national average in the percentage of nursing facility residents who independently perform certain ADLs.

Exhibit 8
Percentage of Nursing Facility Residents Who Independently Perform Activities of Daily Living As of June 30, 2004



Source: Prepared by legislative auditor's staff using MDS data as of June 30, 2004.

The lack of measurable and specific criteria to evaluate whether applicants medically qualify for nursing facility admission may be one reason why Louisiana nursing facilities have a large percentage of residents who can perform certain ADLs independently. Other states have developed standard definitions of eligibility for nursing facilities. Arkansas' admission criteria require that individuals be impaired in a specific number of ADLs. Texas and Oklahoma use assessment instruments whereby individuals' scores on the assessments determine whether they qualify for admission. If DHH adopted a standard definition of nursing facility level of care, it would help ensure that the department makes objective and consistent determinations of nursing facility admission.

Recommendation 3: DHH should develop a specific, measurable assessment-based definition of nursing facility level of care.

Summary of Management's Response: DHH agrees with this recommendation and is in the process of revising the definition and basing it on an assessment instrument (see Appendix B for management's full response).

Uniform Assessment Process Would Help Ensure Cost Effective Placements

DHH does not have a uniform or standardized assessment process that is conducted before individuals enter the long-term care system. Assessment of individuals' needs, functional limitations, and preferences are generally conducted after they have been admitted to institutions or offered waiver slots. Conducting assessments before entering the long-term care system would help ensure that individuals are placed in appropriate and cost-effective settings and that they access relevant services. DHH's current assessment methods are summarized in Exhibit 9.

Exhibit 9
DHH Assessment Processes

Type of Facility	Assessment Instrument Used	When Assessed?	By Whom?	Reason for Assessment
State/Private Nursing Facilities	Resident Assessment Instrument - Minimum Data Set (RAI-MDS)	Within 14 days of admission	Nurses	To develop care plan and/or document acuity for reimbursement rates
Private ICFs/MR	Inventory for Client and Agency Planning (ICAP)	Within 30 days of admission	Interdisciplinary team at facility	To develop care plan and document support needs for eventual reimbursement system
State Developmental Centers	No standardized instrument used, but comprehensive functional assessment required	Within 30 days of admission	Interdisciplinary team at facility	To develop care plan
EDA and ADHC Waivers	Resident Assessment Instrument - Minimum Data Set Home Care (RAI-MDS-HC)	Once a waiver slot is issued	Case managers	To develop care plan
NOW and CC Waivers	None required, but Special Needs Assessment Profile and Health Risk Screening Tool administered in certain cases	Once a waiver slot is issued	Contracted case managers	To identify special needs

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

CMS recognizes that successful and balanced long-term care systems establish consistent assessment processes for institutional and community services so that individuals have equal access to services. Other states have developed comprehensive assessment processes that help ensure appropriate access to the system. According to the 2003 Rutgers survey funded by CMS, of the 43 SPOEs operated by 32 states and the District of Columbia, 41 (95.3%) conduct initial assessments and subsequent reassessments at the single entry point.

In Oregon, all applicants receive identical comprehensive assessments that are conducted by case managers employed by a SPOE. The case managers electronically enter the assessment information into a database that calculates whether the applicants meet the state's nursing facility level of care criteria. Once an assessment is complete, the database calculates the individuals' priority for receiving services according to a 17-level scale based on the degree of assistance the individuals require for their specific ADLs.

Recommendation 4: DHH should develop a standardized assessment process that is conducted for each applicant before entry into the long-term care system. Ideally, the assessment should be conducted at the designated single point of entry and should include cost and individual choice as factors in determining where individuals will be placed and what services they will receive.

Summary of Management's Response: DHH agrees with this recommendation and is currently developing an assessment process (see Appendix B for management's full response).

Recommendation 5: DHH should develop a similar assessment process and entry point for the MR/DD population.

Summary of Management's Response: DHH agrees with this recommendation and is in the process of implementing ICAP and rewriting the MR/DD law (see Appendix B for management's full response).

Some individuals may not be served in the most cost-effective settings. Assessment data from state fiscal year 2004[3] show that some individuals residing in private ICFs/MR and public and private nursing facilities could possibly be served in less costly alternate settings, assuming that proper supports and services, as well as controls that ensure the health and safety of the individuals, are available in those settings. The average annual direct costs per recipient for facilities and waivers are summarized in Exhibit 10 on the following page.

[3] The assessment data are for FY 2004 except for private ICF's/MR, which are as of October 18, 2004. Assessment data are compiled and reported by individual facilities. We examined assessment scores only and did not evaluate the accuracy of the assessments.

Exhibit 10
Average Annual Direct Costs Per Recipient or Resident
Institutional Settings and Waivers
State Fiscal Year 2004

Type of Setting	Average Annual Direct Cost
State Nursing Facilities*	$59,987
Private Nursing Facilities	$23,735
State ICFs/MR (Developmental Centers)*	$114,135
Private ICFs/MR	$49,267
Medicaid Assisted Living**	$12,593
NOW	$49,016
CC	$10,081
EDA	$16,595
ADHC	$11,756
*Adjusted for UPL. **Medicaid assisted living amount was calculated using DHH's estimate of a daily Medicaid per resident rate of $34.50.	
Source: Prepared by legislative auditor's staff using information provided by DHH.	

We analyzed assessment data from the ICAP for private ICFs/MR obtained from DHH and the MDS data analyzed and reported in DHH contractor reports for residents of public and private nursing facilities. Using the average cost data in Exhibit 10, we identified 5,945 individuals whose assessment scores show that they require only minimal or limited support. These individuals could potentially be served in less costly alternate settings.

Using average annual cost per capita data provided to us by DHH, we estimated that providing services to these 5,945 individuals through waivers or in assisted living placements would cost approximately $35 million to $53 million less than the cost of their current placements. These funds could potentially be used to provide services for between 2,132 and 4,206 other individuals who are either listed on the waiver registries or reside in developmental centers or nursing facilities and want to transition to alternate settings. In addition, reducing the number of individuals on registries would help Louisiana meet the requirements of the Barthelemy Settlement Agreement. Exhibit 11 on the following page summarizes our analysis of individuals residing in private ICFs/MR and state and private nursing facilities who could potentially transition to alternative settings.

Exhibit 11
Analysis of Individuals Transitioning From Private ICFs/MR and State and Private Nursing Facilities to Alternate Settings
State Fiscal Year 2004 (except as noted)

Current Setting	Waiver (Alternate Setting)	Number That Could Transition	Difference in Cost Between Current and Alternate Setting	Number of Additional People Who Could Be Served Based on Cost Difference	Percent Reduction in Registry as of 12/31/03
Private ICF/MR*	CC	31	$1,214,766	121	1.52%
Private ICF/MR	NOW	1,337	$335,587	7	0.09%
State Nursing Facility	EDA	16	$692,970	42	1.29%
Private Nursing Facility	EDA	4,561	$32,565,040	1,962	60.42%
	Medicaid Assisted Living		$50,820,943	4,036	N/A
Total		**5,945**	**Between $34,808,363 and $53,064,266**	**Between 2,132 and 4,206**	

*Private ICF/MR data are as of October 18, 2004.
N/A = No reduction in the registry because these people would move from a nursing facility to Medicaid assisted living.
Note: This analysis assumes that appropriate waiver services are available and effective controls are in place to ensure client safety.
Source: Prepared by legislative auditor's staff using information obtained from DHH.

Because the state developmental centers do not have quantifiable assessment data on residents, we were unable to conduct an analysis based on assessment information for the centers. However, DHH has a 5-year plan to downsize the developmental centers, so we were able to use census data to estimate the differences in costs between retaining current residents (as of state fiscal year 2004) in the developmental centers and transitioning them to private ICF/MR facilities that also provide 24-hour care. Using the average annual direct cost of private ICF/MR care, we estimated that if all developmental center residents were transitioned to private ICFs/MR, the difference in cost would be $101,129,212. These funds could be used to serve an additional 884 individuals who are awaiting services through the NOW waiver. Exhibit 12 on the following page summarizes our analysis of individuals residing in the developmental centers who could potentially transition to private ICFs/MR.

Exhibit 12
Cost Differences if Individuals in State ICFs/MR (Developmental Centers) Transitioned to Private ICFs/MR
State Fiscal Year End 2004

Developmental Center	SFY 2004 Census	SFY 2004 Average Developmental Center Cost	SFY 2004 Average Private ICF/MR Cost	Difference in Cost
Columbia	14	$1,597,890	$689,738	$908,152
Leesville	20	$2,282,700	$985,340	$1,297,360
Metropolitan	245	$27,963,075	$12,070,415	$15,892,660
Northwest	169	$19,288,815	$8,326,123	$10,962,692
Peltier-Lawless	41	$4,679,535	$2,019,947	$2,659,588
Ruston	90	$10,272,150	$4,434,030	$5,838,120
Southwest	89	$10,158,015	$4,384,763	$5,773,252
Hammond	305	$34,811,175	$15,026,435	$19,784,740
Pinecrest	586	$66,883,110	$28,870,462	$38,012,648
Total	**1,559**	**$177,936,465**	**$76,807,253**	**$101,129,212**

Note: This analysis assumes that appropriate private ICF/MR services are available.
Source: Prepared by legislative auditor's staff using information obtained from DHH.

According to DHH, approximately 25% (390 individuals) of individuals currently living in developmental centers could move to a waiver. However, since many of the individuals in developmental centers require 24-hour care, little difference in cost would result if they required 24-hour care in the NOW waiver. The average annual budgeted cost of individuals transitioning from developmental centers to the NOW waiver in state fiscal year 2004 was $100,656, whereas the average annual direct cost of remaining in the developmental centers was $114,135. A standardized assessment process would help ensure that individuals are served in the most appropriate and cost-effective settings.

Area 3: Addressing Inequitable Funding

Facilities With Low Utilization Have Received Increased Funding While Individuals Requesting Home and Community-Based Services Must Wait for Services

Inequitable funding of home and community based services has resulted in long waits for individuals seeking waiver services. As of December 31, 2003, a total of 11,338 individuals were waiting for waiver services, 3,406 of whom were waiting for services for the elderly and adults with physical disabilities provided through the EDA waiver. As of June 2004, the average wait time for the EDA waiver was over a year. In contrast, in fiscal year 2003, the overall occupancy rate for state and private nursing facilities was 77.4%. Of 35,561 Medicaid beds in the facilities, only 27,524 were occupied; 8,037 were unoccupied. In addition, the

average daily census at the two state nursing facilities decreased from 405 in state fiscal year 2000 to 315 in state fiscal year 2004.

In addition, expenditures for state developmental centers have steadily increased since state fiscal year 2001, but the census of residents residing in the centers has decreased from 1,729 in state fiscal year 2000 to 1,585 in state fiscal year 2004 (8.3%). However, funding for additional waiver slots for individuals with MR/DD has not increased significantly, despite the fact that 7,932 individuals were waiting for MR/DD services as of December 31, 2003. Individuals on the registry as of June 2004 will have to wait over 9 years for a NOW waiver.

The demand for home and community-based services outweighs the availability of services. In state fiscal year 2003, a total of 8,155 waiver slots were funded. However, as previously stated, on December 31, 2003, a total of 11,338 individuals were waiting for waiver slots. Exhibit 13 shows the number of funded slots versus the number of individuals waiting for slots.

Exhibit 13
Funded Waiver Slots (State Fiscal Years 2001-2005) vs.
Number of People Waiting for Slots (Calendar Years 2001-2003)
All Waivers

	2001		2002		2003		2004		2005	
Waiver	**Funded Slots (SFY)**	**People Waiting (CY)**	**Funded Slots (SFY)**	**People Waiting (CY)**	**Funded Slots (SFY)**	**People Waiting (CY)**	**Funded Slots (SFY)**	**People Waiting (CY)****	**Funded Slots (SFY)**	**People Waiting (CY)****
NOW	4,251	8,465*	4,251	7,527	4,576	7,932	4,576		4,576	
CC	500		800		800		800		800	
EDA	679	3,116	979	1,987	1,779	3,248	2,179		2,329	
ADHC	500	72	525	140	638	50	663		688	
PCA	124	641	149	162	362	108	387		412	
Total	**6,054**	**12,294**	**6,704**	**9,816**	**8,155**	**11,338**	**8,605**		**8,805**	

* Individuals requesting the NOW and CC waivers are included on one registry.
** Data not available at time of analysis.
Note: PCA waiver recipients are currently being transitioned to the EDA waiver.
Source: Prepared by legislative auditor's staff using data provided by DHH.

As Exhibit 13 shows, the number of funded waiver slots for individuals with MR/DD (i.e., the NOW and CC waivers) have remained about the same since state fiscal year 2001 while the number of funded waiver slots for the elderly and physically disabled (i.e., the EDA, ADHC, and PCA waivers) have steadily increased. The increase in the number of slots for the elderly and physically disabled is driven primarily by the Barthelemy lawsuit, which resulted in the legislature funding more slots to avoid noncompliance with the settlement agreement.

The lack of funded waiver slots also affects individuals who reside in institutions. Many individuals in nursing facilities and ICFs/MR would like home and community-based services but are forced to wait for them. According to registry data as of September 2004, a total of 851 individuals in nursing facilities and 916 in ICFs/MR had placed their names on the waiver registries.

Some states are pursuing initiatives that help individuals leave institutions and move back to the community. In 2002, Louisiana received a Nursing Facility Transition Grant. One of the goals of the grant is to transition individuals from nursing facilities back to their local communities. DHH says it has thus far transitioned 44 individuals from nursing facilities to community settings. Another initiative being pursued in other states is to allow money to follow each individual's choice of service. For example, if a person in a nursing facility chooses to leave and go to the community, the funding for that person's care will follow the person into the community. An attempt was made to pass money-follows-the-person legislation in Louisiana during the 2004 Regular Legislative Session, but the legislation was converted into a study.

Some institutions with low utilization have received funding increases. Private nursing facilities and state developmental centers have received increased funding in recent years despite decreasing utilization. Likewise, state nursing facilities received increased funding in state fiscal years 2003 and 2004 despite having a lower number of residents in those years. On the contrary, private ICFs/MR have experienced relatively constant funding and occupancy rates over the past several years.

State Nursing Facilities

Unlike the private nursing facilities and state developmental centers, DHH expenditures for the two state nursing facilities (Villa Feliciana Medical Complex and New Orleans Home and Rehabilitation Center) have steadily decreased from state fiscal years 2000 through 2003. However, expenditures increased significantly from state fiscal year 2003 to state fiscal year 2004. According to DHH, the increase was due to a change in the reimbursement rate methodology, which allowed the facilities to be reimbursed using Medicare upper payment limits. However, the facilities have also seen a decrease in the number of residents over the past five years. The average number of residents at Villa Feliciana decreased from 238 to 183 from state fiscal years 2000 to 2004. The number of residents at the New Orleans Home has decreased from 167 to 132 during the same time period. Exhibit 14 on the following page summarizes reimbursement rates, average daily census, and expenditures for the state nursing facilities for state fiscal year 2000 through state fiscal year 2004.

Exhibit 14
State Nursing Facilities
Reimbursement Rates, Average Daily Census, and Expenditures
State Fiscal Years 2000 Through 2004

SFY	Weighted-Average Per Diem Reimbursement Rate	Average Daily Census Villa Feliciana	Average Daily Census New Orleans Home	DHH Expenditures
2000	$138.19	238	167	$20,664,397
2001	$137.12	223	153	$16,226,952
2002	$137.07	195	141	$15,238,769
2003	$138.25	185	127	$13,663,420
2004	$156.47	183	132	$19,106,002*

*This amount includes the UPL.
Note: Expenditures to nursing facilities do not include PLI.
Source: Prepared by legislative auditor's staff using information provided by DHH.

Private Nursing Facilities

Private nursing facilities have experienced decreasing occupancy rates in each of the last five years. However, their reimbursement rates have risen each year. The facilities had a 76.6% average occupancy rate in state fiscal year 2004. Their average reimbursement rate rose to $86.52 per person per day in state fiscal year 2004. This rate was further increased to $99.42 in state fiscal year 2005. In addition, DHH expenditures for the facilities have risen from about $492 million in state fiscal year 2000 to over $561 million in state fiscal year 2004. Exhibit 15 summarizes reimbursement rates, occupancy rates, and expenditures for private nursing facilities for state fiscal years 2000 through 2004.

Exhibit 15
Private Nursing Facility Reimbursement Rates,
Occupancy Rates, and DHH Expenditures
State Fiscal Years 2000 Through 2004 (except where noted)

SFY	Weighted Average Per Diem Reimbursement Rate	Average Occupancy Rate	DHH Expenditures
2000	$69.34	79.3**	$491,959,788
2001	$78.08	78.4**	$526,719,492
2002	$82.91	78.3**	$560,309,956
2003*	$86.02/85.72	78.2	$570,847,533
2004	$86.52	76.6	$561,137,457

*State fiscal year 2003 has two rates because case mix began January 1, 2003.
**These occupancy rates are for calendar years because fiscal year information was not available.
Note: Expenditures to nursing facilities do not include PLI. Private nursing facilities receive PLI of approximately 20% to 25% in addition to DHH expenditures.
Source: Prepared by legislative auditor's staff using information provided by DHH.

State ICFs/MR (Developmental Centers)

DHH expenditures for state developmental centers have also increased each year since state fiscal year 2000. The largest increase was from state fiscal year 2003 to 2004. According to DHH, the increase was due to a change in the reimbursement rate methodology, which allowed the developmental centers to be reimbursed at 112% of their costs. However, as previously stated, the number of individuals at developmental centers has decreased from 1,729 in state fiscal year 2000 to 1,585 (8.3%) in state fiscal year 2004. Exhibit 16 summarizes census figures and expenditures for the developmental centers for state fiscal years 2000 through 2004.

Exhibit 16
State ICFs/MR (Developmental Centers)
Average Daily Census and Expenditures
State Fiscal Years 2000 Through 2004

SFY	Average Daily Census	DHH Expenditures
2000	1,729	$172,412,219
2001	1,704	$174,772,209
2002	1,684	$176,086,778
2003	1,648	$184,930,420
2004	1,585	$229,854,603*

* State fiscal year 2004 expenditures include the UPL.
Source: Prepared by legislative auditor's staff using information provided by DHH.

Private ICFs/MR

Unlike private and public nursing facilities and the state developmental centers, private ICFs/MR have had a relatively consistent occupancy rate of 95% or above since state fiscal year 2000. However, private ICF/MR reimbursement rates have not increased since state fiscal year 2002 when they were increased from $121.40 per person per day to $122.98 per person per day. According to DHH, the reason the reimbursement rates have not been increased regularly over the years is that the legislature has not appropriated funds for rate or inflationary increases. Exhibit 17 on the following page shows reimbursement rates and expenditures for state fiscal years 2000 through 2004. Because the occupancy rate has remained relatively consistent over the past five years, we did not include it in the exhibit.

Exhibit 17
Private ICFs/MR
Reimbursement Rates and Expenditures
State Fiscal Years 2000 Through 2004

SFY	Average Per Diem Reimbursement Rate	DHH Expenditures
2000	$116.34	$169,953,904
2001	$121.40	$175,097,706
2002	$122.98	$181,012,675
2003	$122.98	$184,050,120
2004	$121.97	$183,208,375

Note: Occupancy rate has remained relatively constant at approximately 95%.
Source: Prepared by legislative auditor's staff using information provided by DHH.

Matter for Legislative Consideration 1: The legislature should consider the funding plan developed by DHH to equitably fund a full array of long-term care services (see Recommendation 6).

Recommendation 6: DHH should work with legislative staff to develop a funding plan for a full array of long-term care services. The plan should include closing one or both state nursing facilities and should consider options for closing and/or downsizing more state developmental centers.

Summary of Management's Response: DHH partially agrees with this recommendation and acknowledges that the Governor's Health Care Reform Panel may assist with developing a funding plan (see Appendix B for management's full response).

Area 4: Improving Allocation of Waiver Slots

DHH Should Improve Allocation of Waiver Slots

As noted previously, Louisiana does not have enough waiver slots available to meet the demand for Medicaid waiver services. As a result, when individuals apply for waiver services, their names are placed on the appropriate "registry" (i.e., waiting list) until a waiver slot becomes available. We identified two problems with the registries and the allocation of waiver slots. These problems are discussed in the following paragraphs.

DHH allocates most slots on a "first-come first-served" basis. The EDA, ADHC, and CC waivers are all allocated on a first-come first-served basis. Several stakeholders we interviewed said that this system of offering waiver waiting slots is problematic because requestors' need for services are not taken into account when distributing the slots. That is, it is important for people with critical needs to receive services as quickly as possible, as their

conditions could further deteriorate while they wait for services. Exhibit 18 shows how long individuals on the registry as of June 9, 2004, must wait for waiver services. Other stakeholders recommended that BCSS allow for a right of first refusal when offering waiver slots, as some individuals accept services they do not currently need for fear of losing their slots.

Exhibit 18
Approximate Wait Times For Waiver Services
As of June 9, 2004

Waiver	Approximate Wait Time for Services
EDA	One year, five months
ADHC	Two months
NOW	Nine years, four months
CC	Four years, ten months
Source: Prepared by legislative auditor's staff using information provided by DHH.	

BCSS does allow individuals listed on the NOW registry to go inactive. Going inactive means that requestors who are offered waiver slots may choose to go on "inactive" status if services are not required at that time. The requestors will be offered the next available waiver slots when services are desired. Allowing individuals on all of the registries to go on inactive status would enable requestors with higher levels of need to access waiver services before requestors who currently do not need services.

The NOW waiver does provide for exceptions to the first-come first-served methodology. The exceptions are as follows:

- A minimum of 90 waiver slots are reserved for foster children in the custody of the Office of Community Services.
- Ten waiver slots are reserved for clients of the Developmental Neuropsychiatric Program.
- Sixty-six waiver slots are reserved for individuals who require emergency waiver services.
- A minimum of 160 waiver slots are reserved for residents of Pinecrest and Hammond Developmental Centers or their alternates.
- When waiver slots become available that are not already reserved as described above, they are first offered to residents of developmental centers. If not filled within 120 days, half of those slots will be offered to private ICF/MR residents listed on the registry and the other half will be offered to community residents listed on the registry.

Other states allocate waiver slots based on need or risk of institutionalization. Two states' methods of allocating slots are as follows:

- **New Hampshire**'s Developmental Disabilities System prioritizes requestors on waiting lists (for both waiver and state-funded services) according to three priority levels. The "first priority" level is used for requestors who currently need services or will need services within one year. The "second priority" level is used for requestors who will need services within one to two years. The "third priority" level is used for requestors who either currently need services or will need services within two years, but whose needs are not as critical as requestors given higher priority. Otherwise, requestors are placed on a projected service need list and are contacted regularly to determine if their needs have changed.

- **Vermont** prioritizes its waiver waiting list for the elderly and people with physical disabilities by offering services on a priority basis for requestors in four different groups: current nursing home residents, current hospital patients, at-risk community residents, and requestors at risk of moving to a more restrictive setting.

Recommendation 7: DHH should determine whether individuals listed on all registries, not just the NOW registry, can go on "inactive" status when waiver slots are offered and the individuals do not currently want waiver services.

Summary of Management's Response: DHH partially agrees with this recommendation and is moving toward implementation of a needs-based access system through the SPOE for individuals who are disabled and the elderly (see Appendix B for management's full response).

Improved communication is needed when offering waiver slots and validating registry information. Some stakeholders suggested that BCSS should rely more on personal contact with individuals requesting waiver services when offering waiver slots to them and validating registry information. Currently, BCSS makes two attempts to contact potential waiver recipients by mail. BCSS also attempts to locate those individuals with invalid addresses listed on the registries. If an individual does not respond to BCSS' second mail request, his/her name is removed from the registry. However, stakeholders stated at an October 2004 meeting that the letters sent by BCSS are hard to understand. They also said that potential recipients often interact with OCDD employees for state-funded services and that OCDD employees may be able to explain the content of the BCSS letters to them. Helping individuals understand communications to them from BCSS would help ensure that the individuals make informed decisions on whether to accept waiver slots when they become available and help ensure that their registry information is valid.

Recommendation 8: DHH should use multiple means of contacting requestors for waiver services when offering waiver slots and validating registry information. For instance, DHH should follow up its offer letters with personal phone calls. DHH should also use OCDD regional office staff to assist when DHH does not receive responses from individuals since regional staff are often in contact with many of those individuals.

Summary of Management's Response: DHH agrees with this recommendation and will enhance its process through the implementation of the SPOE (see Appendix B for management's full response).

Area 5: Modifying or Eliminating Facility Need Review

DHH's Facility Need Review Program Should Be Modified or Eliminated

DHH's Facility Need Review Program limits nursing facility and ICF/MR provider participation in the Medicaid long-term care market. As a result, Medicaid consumers have limited choice in selecting long-term care facilities in which to reside. In addition, the lack of competition resulting from the program creates a loss of incentive for providers to provide quality care. We identified the following concerns with the Facility Need Review Program.

The Facility Need Review Program restricts market entry. DHH's Facility Need Review Program was authorized by R.S. 40:2116 in July 1990 and established by rule in January 1991, approximately three years after the U.S. Department of Health and Human Services and the State of Louisiana terminated the contract establishing the Section 1122 program. Section 1122 of the federal Social Security Act was enacted by Congress in 1972 to assure that federal Medicaid funds were not used to support unnecessary capital expenditures made by or on behalf of health care facilities reimbursed by Medicaid. Health care facilities approved under Section 1122 were issued "certificates of need." The intent of Section 1122 legislation was to control federal Medicaid spending. Section 1122 does not mention preventing providers from entering the market and providing Medicaid services.

Louisiana's Facility Need Review Program differs in scope and intent from the Section 1122 program. With the Facility Need Review Program, the department limits providers' participation in the Medicaid program by refusing to issue provider agreements in cases where it determines that a sufficient number of Medicaid beds are already available in the area. Thus, the program provides approved nursing facilities and ICFs/MR with an advantage over other facilities in the Medicaid nursing facility and ICF/MR markets. Limiting provider market entry ultimately affects consumer choice. The lack of choice creates a barrier to accessing institutional Medicaid long-term care services for consumers who want to enter certain facilities but those facilities have no Medicaid beds available. In addition, as long as minimum staffing levels are met in facilities, the need to limit the number of beds in facilities is questionable.

Some states have eliminated their certificate of need programs. According to the February 2004 National Directory of Health Planning, Policy, and Regulatory Agencies, 14 states have repealed their certificate of need programs, although 36 states and the District of Columbia still maintain them. The federal government, in a recent report, has called for the reconsideration of certificate of need programs in the United States. The Federal Trade Commission and U.S. Department of Justice conclude in their July 2004 report *Improving Health Care: A Dose of Competition* that states should reconsider the necessity of these programs, noting that their anticompetitive aspects outweigh their economic value. In addition, the agencies note that the programs are generally unsuccessful at controlling costs.

DHH's bed moratorium also restricts market entry and provides an advantage for existing providers. The current bed moratorium provisions of the Facility Need Review Program also provide approved nursing facilities and ICFs/MR with an advantage over other facilities in the Medicaid nursing facility and ICF/MR markets. The bed moratorium in R.S. 40:2116 prevents new nursing facility beds (or facilities) from participating in the Medicaid nursing facility market by withholding Facility Need Review approval through July 1, 2008. In addition, an August 1995 rule prevents new ICF/MR beds (or facilities) from participating in the Medicaid ICF/MR market by stating that there is no current need for additional ICF/MR beds. Thus, entry into these markets is further restricted, which has created a provider oligopoly (i.e., a market controlled by a small number of providers) in the Medicaid nursing facility and ICF/MR markets.

To illustrate the problem, we visited a nursing facility that has recently added 96 beds through new construction. According to the facility administrator, on December 2004, the facility had a waiting list of approximately 75 people, 70 of whom were Medicaid eligible. However, the bed moratorium prevents the facility from applying for additional Medicaid beds. As a result, the facility cannot receive Medicaid reimbursement for any of the new beds, even if the beds are filled.

Facility Need Review may also give approved nursing facilities an advantage over providers in the assisted living market. Act 184 of the 2004 Regular Legislative Session, which amended R.S. 40:2116, will provide approved nursing facilities with an advantage over assisted living providers if the legislature funds assisted living under Medicaid. The act requires assisted living facilities to obtain Facility Need Review approval to enter the Medicaid market. However, nursing facilities that convert beds to assisted living beds or construct assisted living facilities are not required to obtain Facility Need Review approval. When the Facility Need Review Program was created, Section 1122-approved nursing facilities were grandfathered into the program. However, Act 184 does not specify that assisted living providers will be grandfathered into the program. As a result, nursing facilities with Facility Need Review approval are not required to obtain additional approval before entering the assisted living market, while assisted living providers are required to obtain Facility Need Review approval before entering the Medicaid assisted living market. Grandfathering assisted living facilities into the program would remove the barrier to entering the Medicaid assisted living market that was imposed by the act.

Matter for Legislative Consideration 2: The legislature should consider repealing the Facility Need Review Law (R.S. 40:2116) or amending it in such a way as to eliminate the problems discussed in this section and to allow for appropriate competition among providers (provided that minimum staffing requirements are met) in the Medicaid nursing facility, ICF/MR, and assisted living markets.

Recommendation 9: If the legislature does not repeal or modify the Facility Need Review Law, DHH should modify the rule to enable the department to legally revoke the approval of a certain percentage of empty beds that were previously approved under the Facility Need Review Program and allocate them on an as-needed basis using a combination of the following criteria:

- Quality performance indicators published by CMS
- Survey deficiencies
- Existence of waiting lists
- Consumer choice
- Others as deemed appropriate by the department

Summary of Management's Response: DHH agrees with this recommendation and states that the recommendation is reasonable given the current low level of occupancy (see Appendix B for management's full response).

DHH should improve its oversight over alternate use of empty nursing facility beds. A provision of the Facility Need Review Rule allows private and public nursing facilities with low occupancy rates to temporarily convert vacant beds to alternate uses without losing Medicaid approval for those beds. As of October 20, 2004, a total of 56 private nursing facilities had 1,529 beds in alternate use. However, DHH does not keep track of the types of alternate use into which facilities convert their beds. Of the 1,529 beds in alternate use, DHH was unaware of how 1,392 (91.04%) of them were being used.

The rule applies to nursing facilities located in service areas with an average annual occupancy rate of less than 93%. While the rule does not specifically define acceptable types of alternate use, it does cite adult day care as an example. Placing beds in alternate use increases the occupancy rates of the facilities becasue the empty beds are no longer included in occupancy rate calculations. The facilities are allowed to keep the beds in alternate use until the annual occupancy rate in the service area exceeds 93%. At that time, the facilities have one year to re-enroll the beds as Medicaid nursing facility beds or the approval for such beds expires.

Because the rule does not define acceptable types of alternate use and DHH does not monitor alternate uses, it may be possible for facilities to use their alternate use beds for purposes other than health-related services, such as storage and administrative space. In addition, because beds in alternate use are not included in occupancy rate calculations, the average annual occupancy rate of facilities with alternate use beds may actually be lower than the one reported by DHH. For example, the reported occupancy rate for state fiscal year 2004 was 75.8% for all nursing facilities. However, if the beds in alternate were included in the calculation, the average annual occupancy rate would be only 72.7%.

Recommendation 10: DHH should revise the Facility Need Review Rule to specify acceptable types of alternate use.

Summary of Management's Response: DHH agrees with this recommendation and is in the process of amending its rules to clarify that alternate use must be for a medical purpose (see Appendix B for management's full response).

Recommendation 11: DHH should monitor the types of alternate use into which nursing facility beds are placed to ensure compliance with the amended rule.

Summary of Management's Response: DHH agrees with this recommendation and will monitor facilities for compliance (see Appendix B for management's full response).

WHAT ARE THE MAJOR COSTS OF MEDICAID LONG-TERM CARE INSTITUTIONAL SERVICES?

According to cost reports prepared for state and private nursing facilities for state fiscal year 2003, the largest costs incurred were for skilled nursing facility and nursing facility services (i.e., direct nursing salaries and related supplies). For the state nursing facilities, these costs totaled over $7 million and averaged over $3.6 million per facility, which translates to an average of $67.50 per resident day. For the private nursing facilities, skilled nursing facility/nursing facility costs totaled over $280 million and averaged over $1 million per facility, or $28.01 per resident day. Per resident day amounts were calculated by dividing total costs for all facilities by total resident days for all facilities. The per resident day figures show the average amounts spent per resident per day.

According to audited cost reports prepared for state and private ICFs/MR for state fiscal year 2002, the largest costs for state developmental centers were for therapeutic and training services. These costs totaled almost $71 million and averaged almost $8 million per facility, for a per resident day average of $115.80. Therapeutic and training services also comprised the largest costs for private ICFs/MR. These costs totaled almost $84 million and averaged over $189,000 per facility, or $62.65 per resident per day.

Major costs from the cost reports and a description of the reimbursement methodologies are discussed in the following sections. Many of the costs are self-reported by the facilities and, for the private facilities, are subject to audit. However, as described on page 56, not all private facilities receive full scope audits each year. In addition, state facilities' cost reports are no longer audited. Also, the costs discussed in the following sections do not comprise all cost categories, nor do they include costs for all facilities because some facilities did not submit cost reports, some submitted partial year cost reports, and some received disclaimers from auditors on their cost reports. Furthermore, although we made our exhibits of costs as comparable as possible, full comparability was not possible because of differences in the way different types of facilities report costs. The information in the following sections should be viewed with these limitations in mind. See Appendixes D and E for descriptions of the cost categories in the exhibits.

We also identified several issues related to private nursing facility reimbursement rates that result in generous reimbursement for those facilities as compared to other states that have similar reimbursement methodologies. These issues are summarized on pages 51 through 54.

STATE NURSING FACILITIES

Major Costs

Exhibit 19 summarizes major costs, average major costs per facility, and average major costs per resident day for the two state nursing facilities.

Exhibit 19
Major Costs, Average Major Costs Per Facility, and Average Major Costs Per Resident Day
Two State Nursing Facilities
State Fiscal Year 2003

Major Costs	Total	Average Per Facility	Average Per Resident Day
Direct Nursing Salaries and Related Supplies	$7,238,430	$3,619,215	$67.50
Employee Benefits	$3,674,841	$1,837,421	$34.27
Administrative and General	$2,072,929	$1,036,464	$19.33
Dietary (Includes Food)	$1,340,397	$670,198	$12.50
Nursing Administration	$1,226,737	$613,369	$11.44
Total Maintenance, Repair, and Plant Operation	$1,182,889	$591,445	$11.03
Housekeeping	$907,503	$453,751	$8.46
Provider Fees	$672,961	$336,480	$6.27
Respiratory Therapy	$413,207	$206,603	$3.85
Property Tax and Insurance	$411,427	$205,714	$3.84
Capital*	$291,343	$145,672	$2.72
Social Service	$261,165	$130,582	$2.44
Pharmacy	$255,628	$127,814	$2.38
Occupational Therapy	$177,675	$88,837	$1.66
Laboratory	$175,817	$87,908	$1.64
Central Services and Supply	$130,248	$65,124	$1.21
Laundry	$103,125	$51,563	$0.96
Physical Therapy	$96,913	$48,456	$0.90
Speech Pathology	$44,376	$22,188	$0.41
Activities	$35,135	$17,568	$0.33
Radiology	$23,927	$11,963	$0.22

*Includes Capital Building and Fixtures and Capital Movable Equipment.

Note: The figures in this exhibit reflect indirect costs reported by DHH.
Note: Cost reports are prepared by DHH's consultant (Public Consulting Group or PCG) and have not been audited.
Note: We chose these cost categories to display because they reflect major dollar costs and costs that are associated with quality of facilities.
Note: Figures have been adjusted to remove expenditures associated with Villa Feliciana hospital services.
Source: Prepared by legislative auditor's staff using cost report data provided by DHH and PCG.

Reimbursement Methodology

State-owned or operated nursing facilities are paid prospective Medicaid reimbursement rates, which means that future reimbursement rates are based on historical costs. The reimbursement rate for each facility is equal to the facility's allowable costs from its most recent cost report trended forward (i.e., adjusted for inflation) to the midpoint of the rate year.

PRIVATE NURSING FACILITIES

Major Costs

Exhibit 20 shows major costs, average major costs per facility, and average major costs per resident day reported for state fiscal year 2003 by the 277 private nursing facilities whose costs were included in the database used to calculate Medicaid reimbursement rates. See pages 57 through 58 for more information on this database.

Exhibit 20
Major Costs, Average Major Costs Per Facility, and Average Major Costs Per Resident Day
277 Private Nursing Facilities
State Fiscal Year 2003

Major Costs	Total	Average Per Facility	Average Per Resident Day
Routine Service Cost Centers			
Direct Nursing Salaries and Related Supplies	$280,481,803	$1,012,570	$28.01
General Service Cost Centers			
Administrative and General	$136,212,492	$491,742	$13.60
Capital*	$85,529,502	$308,771	$8.54
Employee Benefits	$64,592,824	$233,187	$6.45
Provider Fees	$60,084,005	$216,910	$6.27
Maintenance, Repair, and Plant Operation	$56,799,045	$205,051	$5.67
Dietary	$47,241,678	$170,548	$4.72
Food	$39,386,943	$142,191	$3.93
Nursing Administration	$35,149,872	$126,895	$3.51
Housekeeping	$31,501,946	$113,725	$3.15
Laundry	$15,941,481	$57,550	$1.59
Property Taxes and Insurance	$12,726,402	$45,944	$1.27
Social Service	$10,732,350	$38,745	$1.07
Central Services and Supply	$4,187,094	$15,116	$0.42
Pharmacy	$3,412,506	$12,320	$0.34
Activities	$2,529,316	$9,131	$0.25
Ancillary Service Cost Centers			
Physical Therapy	$23,696,621	$85,547	$2.37
Occupational Therapy	$17,726,325	$63,994	$1.77
Drugs Charged to Patients	$16,698,734	$60,284	$1.67
Speech Pathology	$8,379,049	$30,249	$0.84
Medical Supplies Charged to Patients	$6,885,086	$24,856	$0.69
Laboratory	$4,218,242	$15,228	$0.42
Radiology	$3,987,051	$14,394	$0.40
Respiratory Therapy	$3,139,090	$11,332	$0.31

*Includes Capital Building and Fixtures and Capital Movable Equipment.

Note: Costs are self-reported by facilities. Not all cost reports have been audited.

Note: We chose these cost categories to display because they reflect major dollar costs and costs that are associated with quality of facilities.

Source: Created by legislative auditor's staff using information provided by Myers and Stauffer, LC.

Reimbursement Methodology

As of January 1, 2003, private nursing facilities are reimbursed for Medicaid expenditures using a case-mix price-based system. Like the state nursing facilities, this system is a prospective payment system. Private nursing facilities are paid daily facility-specific rates (per diem) for each resident that are based on the acuity of all residents in each facility. The rates consist of the following four components:

1. Direct care and care-related component
2. Administrative and operating component
3. Capital component
4. Pass-through component

Detailed information on how each of the components is calculated is included in Appendix C.

Nursing facility reimbursement rates are rebased every two years. For rate periods between rebasing years, an index factor is applied to the median costs and prices. Effective January 1, 2004, the per diem reimbursement rates for all private nursing facilities were reduced by $0.67 because of a budget shortfall. However, the rates were increased significantly in August 2004 when the legislature approved an $89,297,525 budget adjustment to rebase the rates. The increase resulted in an average of $12.20 being added to each facility's per diem rate.

STATE ICFs/MR (DEVELOPMENTAL CENTERS)

Major Costs

Exhibit 21 on the following page summarizes major costs, average major costs per facility, and average major costs per resident day reported for the nine state developmental centers for state fiscal year 2002.

Exhibit 21
Major Costs, Average Major Costs Per Facility,
and Average Major Costs Per Resident Day
Nine State ICFs/MR (Developmental Centers)
State Fiscal Year 2002

Major Costs	Total	Average Per Facility	Average Per Resident Day
Therapeutic and Training	$70,940,922	$7,882,325	$115.80
Administrative and General (Includes $7,353,462 in Provider Fees)	$32,804,723	$3,644,969	$53.55
Medical and Nursing	$20,734,182	$2,303,798	$33.84
Plant Operation and Maintenance	$13,529,457	$1,503,273	$22.08
Dietary (Includes $3,531,239 in Food)	$8,065,928	$896,214	$13.17
Consultants	$5,146,677	$571,853	$8.40
Capital	$4,564,116	$507,124	$7.45
Housekeeping	$3,721,306	$413,478	$6.07
Recreational	$1,455,935	$161,771	$2.38
Laundry and Linen	$1,195,620	$132,847	$1.95

Note: Analysis does not include state-operated community homes. Analysis uses indirect costs reported by DHH.
Note: Costs are self-reported by facilities. Not all cost reports have been audited.
Note: We chose these cost categories to display because they reflect major dollar costs and costs that are associated with quality of facilities.
Source: Prepared by legislative auditor's staff using cost reports provided by DHH.

Reimbursement Methodology

For dates of services on or after February 9, 2003, developmental centers and other state ICFs/MR are reimbursed using a formula. Like other facilities, state ICFs/MR are required to submit cost reports, which are subject to audit. Payments are made at the Medicare UPL[4] using the following calculations:

1. Per diem routine costs are calculated for each facility and then averaged.

2. 112% of the average per diem routine costs is calculated.

3. The per diem routine costs are inflated using the skilled nursing facility market basket index of inflation.

[4] The UPL sets the ceiling on what the federal government will pay as its share of the Medicaid costs for the different classes of covered services and often exceeds what states actually pay providers for Medicaid covered services. According to the U.S. General Accounting Office, states have been able to exploit the UPL by paying facilities much more than the established Medicaid rate and requiring the facilities to return the excess payments to the states.

Capital and ancillary costs are paid on a "pass-through" basis. The per diem rate for each facility is the sum of the routine service cost calculations, capital costs, and ancillary costs.

PRIVATE ICFs/MR

Major Costs

Exhibit 22 summarizes major costs, average major costs per facility, and average major costs per resident day reported for the 443 private ICFs/MR that were included in the P&N audit database for state fiscal year 2002.

Exhibit 22
Major Costs, Average Major Costs Per Facility,
and Average Major Costs Per Resident Day
443 Private ICFs/MR
State Fiscal Year 2002

Major Costs	Total	Average Per Facility	Average Per Resident Day
Therapeutic and Training	$83,877,358	$189,339	$62.65
Administrative and General (Includes $14,631,579 in Provider Fees)	$46,316,713	$104,552	$34.59
Dietary (Includes $6,439,847 in Food)	$8,493,276	$19,172	$6.34
Medical and Nursing	$7,542,562	$17,026	$5.63
Plant Operation and Maintenance	$7,272,638	$16,417	$5.43
Consultants	$2,971,562	$6,708	$2.22
Housekeeping	$1,859,668	$4,198	$1.39
Laundry and Linen	$819,270	$1,849	$0.61
Recreational	$767,694	$1,733	$0.57
Property Taxes	$210,941	$476	$0.16

Note: We chose these cost categories to display because they reflect major dollar costs and costs that are associated with quality of facilities.
Note: Costs are self reported by facilities. Not all cost reports have been audited.
Source: Prepared by legislative auditor's staff using cost report data provided by P&N.

Reimbursement Methodology

Private ICFs/MR are reimbursed using a prospective payment system according to the size and level of care classification of each facility. As with the private nursing facilities, the reimbursement system is a prospective payment system. DHH's audit contractor compiles a database from costs reported in the private ICF/MR cost reports. Within each size and level of care category in the database, the following amounts are calculated:

- All costs, other than fixed
- Fixed costs

- Average per diem cost for each size and level

These amounts are then trended forward (i.e., adjusted for inflation) in accordance with the Medicaid State Plan and a base rate is calculated for each level of care. This rate is recalculated periodically for each level of care. Facilities are paid a monthly per diem rate based on the daily rate multiplied by 365 days and then divided by 12 months.

According to a DHH official, in the future, private ICFs/MR will be reimbursed based on a resident-specific acuity-based methodology, similar to private nursing facilities, using the ICAP assessment instrument.

Recommendation 12: DHH should periodically review all cost report data in the aggregate and assess whether certain costs are unreasonable and then use the information to help guide management and policy decisions.

Summary of Management's Response: DHH partially agrees with this recommendation and will explore the feasibility of annual audits of all cost reports and/or strong sanctions to deter abuse (see Appendix B for management's full response).

Some Provisions of Private Nursing Facility Medicaid Reimbursement Methodology Appear Generous Compared to Other States

Act 694 of the 2001 Regular Legislative Session directed DHH to develop a case mix reimbursement system to ensure that nursing facilities are paid a reasonable and adequate Medicaid reimbursement rate. In conjunction with industry representatives, DHH developed a rule that was finalized on August 20, 2002. DHH began reimbursing private nursing facilities under the new methodology on January 1, 2003. Under the new methodology, facilities with sicker (i.e., higher acuity) residents receive higher rates. Appendix C provides an overview of the methodology and includes an example of how rates are calculated.

Several provisions in Louisiana's rule governing the calculation of reimbursement rates for private nursing facilities differ from those of other states that have case mix reimbursement systems. Some of Louisiana's provisions result in more generous payments to nursing facilities. Myers and Stauffer, LC (M&S) is the firm that rebases rates for Louisiana and several other states. M&S compiled data on 21 states (including Louisiana) with case mix reimbursement systems and calculated that Louisiana could have saved almost $45 million in state fiscal year 2005 if it included less generous provisions in its rate calculations. Those provisions, and the associated cost savings if the provisions were amended, are summarized in the following sections.

Louisiana includes all residents instead of just Medicaid residents in its acuity (i.e., case mix) calculation of the direct care component of the Medicaid reimbursement rates. Louisiana's reimbursement rule dictates which nursing facility residents are included in the direct care component of the reimbursement rates. Louisiana is the only state of the 21 states

included in M&S' review that has a price-based system that includes all nursing facility residents (e.g., Medicaid, Medicare, and private pay residents) in the calculation of the direct care and care-related component of the reimbursement rate. The other four states that use a price-based system include only Medicaid residents. Furthermore, 81.0% of all 21 states (including both price-based and cost-based) include only Medicaid residents in their rate acuity calculations. Exhibit 23 summarizes the results of M&S' review.

Exhibit 23
Results of Myers and Stauffer's Review of Case Mix States
Types of Residents Included in Rate Acuity

Type of Reimbursement System	Number of States That Include All Residents	Names of States That Include All Residents (e.g., Medicaid, Medicare, and Private Pay)	Number of States That Include Only Medicaid Residents	Names of States That Include Only Medicaid Residents
Price-based	1	Louisiana	4	Kentucky Montana Nevada Texas
Cost-based	3	Mississippi Nebraska North Dakota	13	Colorado Georgia Idaho Indiana Iowa Kansas Maine New Hampshire North Carolina Ohio Pennsylvania South Dakota Washington
Total (%)	**4 (19.0%)**		**17 (81.0%)**	

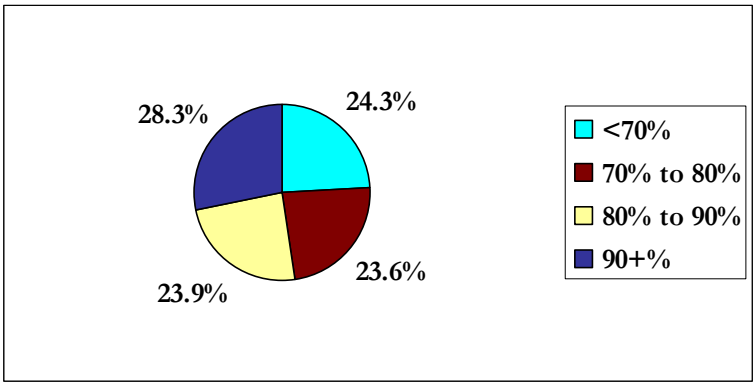
Source: Prepared by legislative auditor's office using data provided by M&S.

According to M&S, DHH could have potentially saved over $18 million in state fiscal year 2005 if it included only Medicaid nursing facility residents in the case mix calculations. In addition, if nursing facilities include in their calculations residents who require specialized services, they are not in compliance with R.S. 46:2743, which states that specialty services (i.e., infectious disease, neuro-rehabilitation treatment, and technology dependent care) must be excluded from case mix provisions.

Louisiana uses a higher rental rate than several other states to calculate the capital component of the reimbursement rates. Louisiana uses a minimum floor of 9.25% as the rental rate used to calculate the fair rental value of the capital component of the reimbursement rates. However, Indiana, Kentucky, Nevada, and Pennsylvania all use lower rates ranging from 6.73% to 9.0%. According to M&S, if Louisiana required the use of the actual 20-year Treasury Bond rate (which is currently about 4.96%) plus a risk factor of 2.5% instead of a minimum floor of 9.25%, DHH could have potentially saved almost $17 million in state fiscal year 2005.

Louisiana uses the lowest minimum occupancy rate compared to other states to calculate the capital component of the reimbursement rates. The reimbursement rule also provides that Louisiana uses a minimum occupancy rate of 70% in its rate calculations, which means that facilities with occupancy rates lower than 70% are automatically raised to 70% for the purpose of calculating the capital component of their reimbursement rates. As a result, facilities are reimbursed for 30% of their excess capacity. Five other states use at least 90% as their minimum occupancy rate. According to M&S, DHH could have potentially saved over $9 million in state fiscal year 2005 if the rule were amended to include a 90% minimum occupancy rate instead of 70%, as facilities would only be reimbursed for 10% of their excess capacity. Using data from M&S on occupancy rates, we determined that 28.3% of private nursing facilities in Louisiana have occupancy rates over 90%. Exhibit 24 summarizes the percentage of private nursing facilities by occupancy rate category.

Exhibit 24
Percentage of Louisiana Private Nursing Facilities
Within Occupancy Rate Categories
State Fiscal Year 2003



Source: Prepared by legislative auditor's staff using information on occupancy rates provided M&S.

In summary, these three provisions in the reimbursement rate methodology rule result in more generous payments to private nursing facilities. As DHH is facing a budget crisis this year and in coming years, the department should make as many changes to the rule as are practical. Exhibit 25 on the following page shows the total savings that could have been achieved in state fiscal year 2005 if these three provisions of the rule were amended.

Exhibit 25
Potential Cost Savings Resulting From Proposed Changes to Private Nursing Facility Reimbursement Rate Rule

Current Provision	Proposed Amendment	Potential Cost Savings
All residents are included in calculation of acuity (case mix).	Only Medicaid residents are included in calculation of acuity.	$18,275,107
Rental rate is 9.25% minimum and 10.75% maximum.	Rental rate is actual 20-year Treasury Bond rate plus a 2.5% risk factor.	$16,886,424
Minimum occupancy rate is 70%.	Minimum occupancy rate is 90%.	$9,403,429
Total Potential Savings		**$44,564,960**

Source: Prepared by legislative auditor's staff using M&S calculations.

Recommendation 13: DHH should amend the rule governing Medicaid reimbursement rate calculations to include only Medicaid residents in acuity (case mix) calculations.

Summary of Management's Response: DHH agrees with this recommendation and notes that the recommendation has also been made by the Health Care Reform Panel (see Appendix B for management's full response).

Recommendation 14: DHH should further amend the rule to eliminate the minimum floor of 9.25% and instead use the actual Treasury Bond rate plus a risk factor of 2.5% as the rental factor.

Summary of Management's Response: DHH agrees with this recommendation and states that the T-bond rate plus a risk factor of 2.5% should result in a sufficient return on capital investment (see Appendix B for management's full response).

Recommendation 15: DHH should also amend the rule to increase the minimum occupancy rate used in the calculations from 70% to 90%.

Summary of Management's Response: DHH agrees with this recommendation and states that the 70% occupancy rate results in providers being paid for empty beds at a time when demand for nursing facility services are declining and that the recommendation has also been made by the Health Care Reform Panel (see Appendix B for management's full response).

HOW DOES DHH ENSURE THE ACCURACY OF INSTITUTIONAL COSTS?

Private nursing facilities and ICFs/MR are required by the Medicaid Standards for Payment to submit cost reports to DHH each year. The cost reports are supposed to include all allowable costs as defined by the Medicare Provider Reimbursement Manual and the Standards for Payment. DHH has a contract with Postlethwaite and Netterville (P&N), a private CPA firm, to conduct audits of the cost reports. The contract requires P&N to conduct full scope audits of 80 private nursing facilities and 120 private ICFs/MR each year. P&N also conducts limited scope audits of 40 private nursing facilities and 60 private ICFs/MR each year. Finally, P&N conducts desk reviews of all private nursing facilities and ICFs/MR each year.

If P&N identifies costs that should not be included in facilities' cost reports, it disallows the costs and makes adjustments to those facilities' cost reports and the database that is used to determine subsequent reimbursement rates. For state fiscal years 2001, 2002, and 2003, P&N disallowed over $49 million from private nursing facility cost reports. For state fiscal years 2001 and 2002, P&N disallowed over $7.8 million from private ICF/MR cost reports. Exhibit 26 shows P&N's audit results for the last three years.

Exhibit 26
Results of Postlethwaite and Netterville Audits
State Fiscal Years 2001 Through 2003

State Fiscal Year	Disallowed Costs Private Nursing Facilities (1/3rd of All Facilities)	Percent of Total Reported Costs	Disallowed Costs Private ICFs/MR (1/3rd of All Facilities)	Percent of Total Reported Costs
2001	$19,769,520	2.7%	$4,106,953	2.4%
2002	$17,093,034	2.8%	$3,756,157	2.2%
2003	$12,494,132	1.4%	Not yet available	n/a
Total Disallowed Costs (State Fiscal Years 2001-2003)	**$49,356,686**		**$7,863,110**	

Source: Prepared by legislative auditor's staff using P&N audit data provided by DHH.

When P&N auditors cannot audit a facility because of insufficient records, they issue a disclaimer. The costs associated with facilities that receive disclaimers are excluded from the database used to rebase reimbursement rates. In state fiscal years 2001 and 2002, 11 nursing facilities and 6 ICFs/MR received disclaimers. Thus, their costs were not included in the database and were not used to rebase rates.

DHH Has Not Sanctioned Facilities That Report Disallowed Costs or Receive Disclaimers

In state fiscal years 2001 and 2002, DHH did not sanction any facilities that had costs disallowed from their cost reports or that were issued disclaimers by the auditors, despite provisions in state law that allow or require such sanctions. The Standards for Payment for ICFs/MR allow DHH to sanction providers with large disallowed costs. The provisions say that cost report errors greater than 10% of aggregate costs may result in a maximum penalty of 10% of the current per diem rate for each month the cost report errors are not correct. Under this provision, 67 ICFs/MR could have been sanctioned in state fiscal years 2001 and 2002, but were not. The Standards for Payment for Nursing Facilities do not include sanctions for disallowed costs. However, in state fiscal years 2001 and 2002, 38 nursing facilities had over 10% of their reported costs disallowed. Including sanctions in the Standards for Payment for Nursing Facilities similar to the sanctions for ICFs/MR would help deter reporting of unallowable nursing facility costs and help ensure that the costs entered into the database used to recalculate reimbursement rates are complete and accurate.

The Standards for Payment for Nursing Facilities and ICFs/MR also contain provisions that allow and/or require DHH to sanction providers that receive disclaimers. According to the ICF/MR Standards for Payment, if the auditors determine that a facility's records are unauditable, vendor payments may be withheld until the facility submits an acceptable plan of correction to reconstruct the records, and additional costs for completing the audit shall be paid by the provider. The Standards for Payment for Nursing Facilities contain even stronger language. They say that DHH shall withhold payment to nursing facilities when their records are unauditable (i.e., when they are issued a disclaimer). However, DHH did not use either of these provisions to sanction the 17 ICFs/MR and nursing facilities that were issued disclaimers in state fiscal years 2001 and 2002.

Currently, the only "penalty" for receiving a disclaimer is excluding a facility's cost report from the database that is used to calculate future reimbursement rates. As previously stated, the Standards for Payment for ICFs/MR allow DHH to charge providers the cost of an audit if disclaimers are issued. Therefore, the Standards for Payment for Nursing Facilities should also allow DHH to charge for the cost of an audit when the facilities receive disclaimers. Had DHH charged the 17 ICFs/MR and nursing facilities with disclaimers for the cost of conducting full scope audits, it would have collected $149,900 in state fiscal years 2000 and 2001.

In addition, DHH does not have a database that tracks audit findings. However, according to DHH, P&N began entering more detailed information on facilities with disallowed costs into a database in July 2004. A database that includes a history of audit findings and disallowed costs would help the department see trends across years and target problem providers, which could be used as criteria for selecting facilities to be audited.

Recommendation 16: DHH should amend the Standards for Payment for ICFs/MR and Nursing Facilities to include mandatory sanctions for facilities that report unallowable costs in excess of 10% of total reported costs or receive disclaimers. The sanctions should be applied consistently to both types of facilities. DHH should also ensure that all documents referring to

the Standards for Payment (e.g., provider agreements) contain the sanction language. DHH should ensure compliance with the new sanction provisions.

Summary of Management's Response: DHH partially agrees with this recommendation and states it will also consider sanctions for other cost report deficiencies (see Appendix B for management's full response).

Recommendation 17: DHH should develop a database that includes a history of all audit findings and disallowed costs and use the database to help identify providers with repeat audit findings and other cost report errors.

Summary of Management's Response: DHH partially agrees with this recommendation and states that it will develop an integrated database should additional resources be made available (see Appendix B for management's full response).

Private Nursing Facility Medicaid Reimbursement Rates Are Based on Potentially Inaccurate and Incomplete Cost Data

As noted previously, P&N conducts full scope audits of approximately one-third of private nursing facilities' cost reports each year. When P&N auditors identify unallowable costs, they adjust the facilities' cost reports and send the adjustments to M&S, the contractor DHH uses to rebase private nursing facility reimbursement rates. M&S adjusts the balances in the database it uses to rebase the rates for the disallowed costs. Thus, the disallowed costs are not included in its reimbursement rate calculations. Excluding the costs disallowed by audits helps ensure that the reimbursement rates calculated are based on reasonable cost data.

However, as previously noted, P&N does not conduct full scope audits on all facilities. Some facilities only receive limited scope audits or desk reviews. If those facilities include disallowed costs in their cost reports, they may not be discovered by the auditors. Thus, disallowed costs could be included in the database that M&S uses to calculate future reimbursement rates.

In addition, the database used to rebase rates does not include costs of facilities that have received disclaimers or that submit partial-year cost reports due to changes in ownership. The database also excludes providers that do not submit cost reports and cost reports that were submitted using incorrect forms. In state fiscal year 2003, a total of 70 providers were excluded from the database that was used to calculate the rates that went into effect on July 1, 2004.

We conducted a cost benefit analysis of the benefits of auditing all private facilities every year. Based on the average disallowed cost identified by P&N for state fiscal year 2003, we estimated that P&N would have identified approximately $20 million in additional disallowed costs if it had audited all private nursing facilities that year. P&N estimated that total additional

audit costs would have been $1,690,000, resulting in net disallowed costs of approximately $18 million. However, auditing all private ICFs/MR each year does not yield similar cost benefits.

Recommendation 18: DHH should require its audit contractor to audit all private nursing facilities either each year or in all rebase years. DHH should also review ICF/MR data periodically to determine at what point (if any) it would become cost beneficial to audit all ICFs/MR every year.

Summary of Management's Response: DHH partially agrees with this recommendation and is in the process of obtaining cost estimates of auditing of all facilities every year or auditing all facilities in rebase years (see Appendix B for management's full response).

Case Mix Data on Resident Acuity, Used to Calculate Private Nursing Facility Reimbursement Rates, Are Often Inaccurate

DHH also contracts with M&S to conduct Minimum Data Set (MDS) verification at private nursing facilities. The purpose of the verification is to determine if a sample of Resource Utilization Group (RUG) classifications are supported by documentation in resident files. RUG classifications are derived from MDS assessments and are used to calculate each facility's case mix. The case mix is then used to determine the facility's reimbursement rate. If facilities do not have appropriate documentation to support RUG categories, DHH can modify the RUG classifications and recalculate the reimbursement rates.

DHH and M&S conducted verification at all private nursing facilities in state fiscal year 2003. State fiscal year 2003, as required by rule, was an educational year where facilities were given the opportunity to learn about appropriate documentation. Because of differing interpretations of the rule by DHH versus the industry, DHH again gave the nursing facilities an educational year in state fiscal year 2004. In state fiscal year 2004, M&S conducted verification at 142 (or 50%) of the nursing facilities and found $906,639 in errors. According to DHH, in state fiscal year 2005, if the percentage of unsupported assessments is greater than 40%, the RUG classifications will be recalculated, the Medicaid reimbursement rates will be recalculated, and facilities will have to pay back the difference. However, because state fiscal year 2004 was an educational year, nursing facilities were not required to pay back the $906,639.

Recommendation 19: DHH should determine if it would be cost-beneficial to verify MDS data at all nursing facilities each year. If it is, DHH should verify MDS data at all nursing facilities each year.

Summary of Management's Response: DHH partially agrees with this recommendation but notes that the verification of MDS data at all nursing facilities would not be economically justified (see Appendix B for management's full response).

Recommendation 20: DHH should determine if the Elderly Trust Fund could be used to pay for the MDS verification conducted by M&S since the Elderly Trust Fund was established for case mix purposes. If allowable, DHH should use these funds to pay for its contract.

Summary of Management's Response: DHH agrees with this recommendation but may need approval from the legislature and CMS to implement it (see Appendix B for management's full response).

DHH Has Not Always Followed Its Criteria for Selecting Private Nursing Facilities and Private ICFs/MR to Be Audited

DHH uses certain selection criteria to generate a sample of private nursing facilities and private ICFs/MR to be audited each year. However, DHH did not always follow the criteria for facilities audited in state fiscal years 2002 and 2003. As a result, some facilities were not audited when they should have been. In addition, the selection criteria could be improved by adding risk-based factors.

One selection criterion requires that private nursing facilities and ICFs/MR that received disclaimers the previous year be included in the following year's audit sample. Another criterion requires that private ICFs/MR that have over 10% of reported costs disallowed in the previous year be audited the following year. Exhibit 27 on the following page summarizes whether DHH followed these criteria in recent years.

Exhibit 27
Summary of Whether DHH Met Audit Criteria
State Fiscal Years 2001 and 2002

State Fiscal Year	Type of Facility	Audit Criteria	Number of Facilities Meeting Criteria	Number (%) of Those Facilities Audited the Following Year	Number (%) of Those Facilities Not Audited the Following Year
2001	Private Nursing Facility	Received Disclaimer Prior Year	9	6 (66.7%)	3 (33.3%)
	Private ICF/MR	Over 10% of Costs Disallowed Prior Year	34	17 (50.0%)	17 (50.0%)
	Private ICF/MR	Received Disclaimer Prior Year	1	0 (0%)	1 (100.0%)
2002	Private Nursing Facility	Received Disclaimer Prior Year	2	2 (100.0%)	0 (0%)
	Private ICF/MR	Over 10% of Costs Disallowed Prior Year	33	25 (74.8%)	8 (24.2%)
	Private ICF/MR	Received Disclaimer Prior Year	5	5 (100.0%)	0 (0%)
Total			**84**	**55 (65.5%)**	**29 (34.5%)**

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

According to DHH, the 29 facilities were not audited because the audit sample had probably already reached its quota. That is, once the sample reaches the number specified in the audit contract, no more facilities are selected, even if they meet the selection criteria. In addition, DHH does not use the 10% criteria for nursing facilities. However, in state fiscal years 2001 and 2002, 38 nursing facilities had over 10% of their reported costs disallowed.

Recommendation 21: If DHH does not require its auditor to audit all facilities every year or in every rebase year, it should use the 10% disallowance criteria for nursing facilities as well as ICFs/MR. In addition, DHH should designate this criterion as a higher risk than some of the other criteria.

Summary of Management's Response: DHH partially agrees with this recommendation and will consider the value of applying this criterion (see Appendix B for management's full response).

WHAT ARE THE MAJOR COSTS OF MEDICAID LONG-TERM CARE HOME AND COMMUNITY-BASED (WAIVER) SERVICES?

From state fiscal year 2000 through state fiscal year 2004, DHH expenditures for home and community-based services increased 139% from approximately $103 million to approximately $248 million. The NOW waiver (formerly the MR/DD waiver) received 89% of total waiver expenditures during this five-year time period. As discussed previously, individuals on the NOW registry on June 9, 2004, must wait over nine years for services. Exhibit 28 summarizes waiver expenditures since state fiscal year 2000.

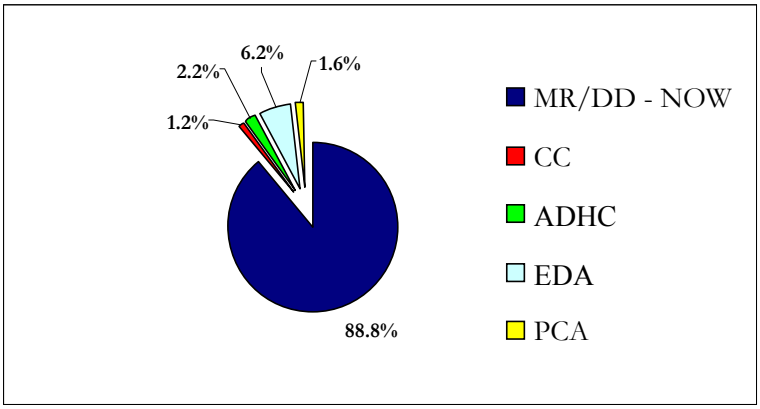
Exhibit 28
Waiver Expenditures
State Fiscal Years 2000 Through 2004

State Fiscal Year	MR/DD - NOW	CC	ADHC	EDA	PCA	Total All Waivers
2000	$95,374,253	N/A	$2,225,061	$4,079,568	$1,797,332	**$103,476,214**
2001	$124,978,164	$1,250	$2,550,576	$4,925,860	$1,787,171	**$134,243,022**
2002	$141,391,937	$461,448	$3,395,755	$4,762,602	$1,872,604	**$151,884,715**
2003	$161,598,759	$2,965,761	$3,854,869	$9,970,327	$2,475,734	**$180,865,457**
2004	$203,500,918	$6,566,161	$5,694,664	$26,728,495	$5,253,609	**$247,743,851**
Total	**$726,844,031**	**$9,994,620**	**$17,720,925**	**$50,466,852**	**$13,186,450**	**$818,212,878**

N/A = The Children's Choice waiver did not begin until state fiscal year 2001.
Source: Prepared by legislative auditor's staff using information provided by DHH.

Exhibit 29 shows the percent of total waiver expenditures by waiver since state fiscal year 2000. As can be seen, the MR/DD - NOW waiver is by far the largest.

Exhibit 29
Percentage of Total Expenditures by Waiver
State Fiscal Years 2000 Through 2004



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

DHH offers different services through its waivers. For example, the NOW waiver offers center-based respite, supported employment, supervised independent living, and individual and family support services (formerly called personal care attendant services). Other waivers offer only one service. For instance, the ADHC waiver offers only adult day health care services, and the PCA waiver offered only personal care attendant services.

Personal care attendant services (also called individual and family support and personal care services) comprise the service category with the highest expenditures. In state fiscal year 2004, 71.1% of all MR/DD-NOW expenditures, 74.3% of all CC expenditures, and 86.7% of all EDA expenditures were for personal care attendant services. Exhibit 30 on the following page summarizes waiver expenditures by service category for state fiscal year 2004.

Exhibit 30
Waiver Expenditures by Service Category
State Fiscal Year 2004

MR/DD-NOW Waiver		
Services	**Expenditures**	**Percent**
Personal Care Attendant/Individual and Family Support (Day and Night)	$144,774,156	71.14%
Companion Care (Supervised Independent Living)	28,417,081	13.96%
Center-Based Respite	13,960,155	6.86%
Day Habilitation	3,771,744	1.85%
Supported Employment	1,891,934	0.93%
Individual Employment Training	2,809,033	1.38%
Environmental Modifications	498,797	0.25%
Medical Equipment/Supplies	89,613	0.04%
Substitute Family Care	99,754	0.05%
Personal Emergency Response System	33,466	0.02%
Other[5]	7,155,185	3.52%
Total	**$203,500,918**	**100.00%**
Children's Choice Waiver		
Services	**Expenditures**	**Percent**
Family Support	$4,880,561	74.33%
Case Management	968,750	14.75%
Environmental Modifications	342,228	5.21%
Diapers	277,458	4.23%
Center-Based Respite	50,227	0.76%
Family Training	24,937	0.38%
Crisis Support	21,394	0.33%
Other	608	0.01%
Total	**$6,566,163**	**100.00%**
Elderly and Disabled Adults Waiver		
Services	**Expenditures**	**Percent**
Personal Care Services	$23,170,059	86.69%
Environmental Modifications	668,687	2.50%
Personal Emergency Response System	198,692	0.74%
Case Management	2,609,156	9.76%
Other	81,902	0.31%
Total	**$26,728,496**	**100.00%**
Adult Day Health Care Waiver		
Service	**Expenditures**	**Percent**
Adult Day Health Care Services	**$5,694,664**	**100.00%**
Personal Care Attendant Waiver		
Service	**Expenditures**	**Percent**
Personal Care Attendant Services	**$5,253,609**	**100.00%**
Source: Prepared by legislative auditor's staff using information provided by DHH.		

[5] DHH expenditures are from ISIS and from MMIS. Since ISIS does not capture detailed service level data, DHH included an 'other' category to reconcile the totals.

NOW Waiver Needs Cost Control Mechanism

As previously mentioned, the average cost for direct NOW waiver payments in state fiscal year 2004 per waiver recipient was $49,016. This cost is only $251 less expensive than the state fiscal year 2004 average cost per private ICF/MR resident, which was $49,267.[6] The NOW waiver is the only waiver in Louisiana that does not have an overall cap, although some services within the NOW waiver are capped. The CC waiver has a cap of $15,000 per year. The EDA waiver is limited to $60.00 per day (or $21,900 per year) in order to maintain cost effectiveness. The ADHC waiver is capped at 80% of the weighted average of the nursing facility rate. The only "cap" in the NOW waiver is that it must be cost effective as compared to the institutional cost, on average, according to a formula required by CMS. Section 1915(c) of the Social Security Act says that the average per capita expenditures for waivers must not exceed 100% of the average per capita expenditures for institutional care.

We analyzed the budgets of 4,115 NOW recipients who had annual comprehensive plans of care (CPOCs) in effect for the entirety of state fiscal year 2004. The budgets ranged from $600 to $177,098. We used budgeted amounts because they are the amounts that DHH has deemed necessary to meet recipients' needs. Exhibit 31 shows the distribution of the budgets we analyzed.

Exhibit 31
Distribution of Annual CPOC Budget Amounts for NOW Waiver Recipients
State Fiscal Year 2004

Amount	Number	Percent
$0 - $14,999	157	3.82%
$15,000 - $24,999	250	6.08%
$25,000 - $49,999	1,387	33.71%
$50,000 - $74,999	1,141	27.73%
$75,000 - $99,999	435	10.56%
$100,000 - $124,999	713	17.33%
Over $125,000	32	.77%
Total	**4,115**	**100.00%**

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

As the exhibit shows, the majority of NOW recipients (2,321 or 56.41%) had budgets of $50,000 or more, which is higher than the average direct waiver cost of private ICF/MR care of $49,267. Specifically, 2,358 of the 4,115 NOW recipients had budgets exceeding $49,267. If the NOW waiver had been capped at the cost of a private ICF/MR, DHH could have incurred $74,228,237 less costs for this waiver. We estimated that this amount could have been used to serve approximately 1,507 additional individuals who were waiting for NOW services.

[6] We used the average cost for private ICF/MR care instead of the average cost for private + state ICF/MR care because current DHH policy is to admit individuals to state ICFs/MR (i.e., the state developmental centers) as a last resort. In addition, DHH is currently downsizing the state facilities.

Other states have developed a variety of cost containment strategies to keep waiver costs down. Examples are as follows:

- **North Carolina** has a cap equivalent to the per person cost in an ICF/MR.

- **Texas** uses the ICAP assessment tool to assess client needs and assigns cost caps based on the different levels of need. The scores on the ICAP correspond to five different levels of need, each which has a different cost cap. The recipients' scores on the assessment tool determine their cost caps. DHH is currently using the same assessment tool in private ICFs/MR.

- **Florida** adopted a Waiver Cost Review Policy that requires staff to give more consideration to cost when deciding whether to enroll a client in a waiver. Under the policy, an individual whose community-based cost plan exceeds the average cost of ICF/MR placement will be offered placement in the less costly ICF/MR. Exceptions require special review by an interagency team.

- **Washington** has replaced its all-inclusive Community Alternative Placement Waiver with four targeted waivers, each with specific limits on benefits, services, and enrollees. The change has allowed individuals with different needs and risks to receive services through waivers that are appropriate for them. The four targeted waivers are summarized as follows:

    1. **Basic Waiver**: This waiver is for individuals who live with their families or in their own homes and have strong natural support systems. Certain services are capped from $1,425 to $6,500 per year, depending on the services. Personal care limits are determined by standardized assessment.

    2. **Basic Plus Waiver**: This waiver is for individuals who live with their families or in other settings with assistance (e.g., in ICFs/MR) and are at high risk of out-of-home placement or loss of current living situation. Certain services are capped from $6,070 to $9,500 per year or have limits that are determined by standardized assessment.

    3. **Core Waiver**: This waiver is for individuals who require residential habilitation or who live at home but are at immediate risk of out-of-home placement. Costs are capped at the average cost of an ICF/MR for any combination of services necessary to meet assessed needs.

    4. **Community Protection Waiver**: This waiver is for individuals who are living in or are moving to the community and require 24-hour care. Costs are capped at the average cost of an ICF/MR for any combination of services necessary to meet assessed needs.

Recommendation 22: DHH should explore ways to contain the cost of the NOW waiver and then implement appropriate cost controls. As a part of its efforts, DHH should evaluate the merits and impact of other states' cost containment strategies.

Summary of Management's Response: DHH agrees with this recommendation and notes that it is part of the department's long-term care immediate action plan (see Appendix B for management's full response).

HOW DOES DHH ENSURE THE ACCURACY OF WAIVER COSTS?

Section 1915(c) of the Social Security Act requires that states provide various assurances related to providing home and community-based services. One of these assurances is that states ensure the financial accountability for the funds they expend. To fulfill these requirements, BCSS has contracted with Statistical Resources, Inc. (SRI) to develop and maintain electronic systems that help prevent case managers and direct service providers from billing for more services or hours than they were approved to provide. Since claims for services are self-reported, BCSS also monitors providers and reviews billing records to determine if documentation shows that services were actually provided.

Prior Authorization Helps Ensure That Providers Do Not Bill for More Services Than They Were Approved to Provide

Case managers develop comprehensive plans of care in conjunction with waiver recipients, their families, and other supports that list the services and supports that are needed for the individuals to fulfill their goals and outcomes. The CPOCs also list service hours and a schedule for providing those services. The hours listed on the CPOCs are the maximum number of service hours that can be provided each year unless the CPOCs are revised because of changing circumstances. Once a CPOC is approved by a BCSS regional office, SRI enters relevant data, including service hours and provider information, into the Client Linkage System.

For direct services providers, SRI electronically sends a quarterly prior authorization form to each provider that lists the maximum number of hours by service that can be provided for that quarter. Once providers enter their service hours into the Louisiana Service Tracking System (LAST), SRI releases the service hours to UNISYS, DHH's contractor that processes Medicaid claims. The provider can then file a claim for those service hours. UNISYS matches the number of service hours delivered to the number of hours billed. This process helps ensure that providers do not bill for more services than approved on the CPOCs. According to SRI, as of September 30, 2004, the prior authorization system had blocked payments of $1,477,464, the CPOC-approved limits in the EDA, NOW, and CC waivers.

In addition, for case management claims, SRI electronically sends a quarterly prior authorization form that lists the maximum service requirements for that quarter. Case managers enter their units of service into the Case Management Information System, and SRI releases the units of service to UNISYS. UNISYS then matches those units to the ones that the case managers bill. If a case manager fails to provide any of the monthly, quarterly, or annual services (e.g., home visit or update to the CPOC), the case manager is not paid for any service during that time frame. According to SRI, this system blocked $845,092 in payments to case management agencies for services that were not delivered from January 1, 2002, through September 30, 2004.

In addition, according to SRI, the LAST system has prevented $37,141,808 of potential overpayments by ensuring that providers were only paid for services reported as being delivered as opposed to the maximum amount of services allowed on the CPOCs. According to SRI, in the past providers often billed for services listed on the CPOCs instead of what they actually provided.

Provider Monitoring Helps Detect Billing Errors, But the Process Could Be Improved

To help ensure that providers actually provide the services for which they bill, BCSS conducts provider monitoring. Provider monitoring consists of reviewing the records of a random and targeted sample of 5% of waiver recipients and their waiver providers and case managers. BCSS reviews time sheets, progress notes, and the CPOCs to ensure that those documents support billing statements. However, BCSS only reviews a random sample total of 5% of waiver recipients' providers. Because BCSS' sample size is small, random, and designed to select waiver recipients instead of providers, it is possible that some providers may never have been monitored.

Providers that receive monitoring deficiencies may be required to complete a plan of correction or agree to a voluntary recoupment of payments. Others with large patterns of deficiencies may be referred to DHH's Surveillance and Utilization Review System (SURS) for further investigation. According to BCSS, 13 providers had recoupments totaling $13,837 for the last half of state fiscal year 2004. However, BCSS currently does not enter recoupment information by provider in a database. Having a database of providers who have billing errors would help BCSS target its monitoring on providers with previous billing problems. For more information on provider monitoring, see page 93.

To help ensure that ADHC facilities report accurate costs, DHH has a contract with P&N to audit or desk review each facility's cost report each year. For state fiscal years 2001 through 2003, P&N made audit adjustments totaling $1,482,915 for these facilities. P&N issued only one disclaimer during this time period for a state fiscal year 2002 cost report. According to DHH, no penalties or sanctions were assessed against ADHCs in state fiscal years 2001, 2002, or 2003.

Recommendation 23: DHH should develop a database that includes all payments recouped from providers for whom billing errors were detected through monitoring visits. DHH should use the database to target problem providers in subsequent monitoring visits.

Summary of Management's Response: DHH agrees with this recommendation and will develop an integrated database for tracking provider billing practices as resources are made available (see Appendix B for management's full response).

Recommendation 24: DHH should amend the Standards for Participation for ADHCs to include mandatory sanctions for facilities that report unallowable costs in excess of 10% of total reported costs or receive disclaimers. DHH should initiate procedures to ensure compliance with the new sanction provisions.

Summary of Management's Response: DHH agrees with this recommendation and will incorporate it into its integrated database (see Appendix B for management's full response).

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WHAT REGULATORY PROCESSES DOES DHH USE TO ENSURE THE QUALITY OF LONG-TERM CARE SERVICES IN NURSING FACILITIES AND ICFS/MR, AND HOW CAN THOSE PROCESSES BE IMPROVED?

The Health Standards Section (Health Standards) within DHH is responsible for overseeing the quality of care in nursing facilities, ICFs/MR, and approximately 18 other health-related programs (e.g., hospitals, hospice, dialysis centers, home health agencies, etc.) across Louisiana. Health Standards uses the following processes to monitor the quality of care that nursing facility and ICF/MR providers deliver:

- **State Licensing**
- **Federal Certification**
- **Complaints**
- **Informal Dispute Resolution**
- **Abuse and Neglect Reporting**
- **Enforcement and Sanctions**

Source: Photo courtesy of St. Clare Manor.

A description of each of these processes, our findings related to them, and recommendations to improve the processes are summarized in the following sections.

State Licensing of Nursing Facilities and ICFs/MR

Health Standards is responsible for ensuring that nursing facilities and ICFs/MR operating in Louisiana meet all state licensing requirements. Health Standards reviews compliance with the requirements by conducting licensing surveys of all facilities. Health Standards annually licenses over 300 nursing facilities and almost 500 ICFs/MR. The minimum licensing standards for nursing facilities include requirements related to resident rights, physician and nursing services, infection control, and other provisions. The minimum licensing standards for ICFs/MR include requirements related to human resources, quality of life, and physical environment. The licensing process for both nursing facilities and ICFs/MR also includes annual inspections by the State Fire Marshall and the Office of Public Health. The focus of those inspections is fire safety and sanitation, respectively.

Minimum Staffing Requirement for Nursing Facilities Too Low

According to the state licensing regulations, nursing facilities must provide a sufficient number of nursing service personnel consisting of registered nurses (RNs), licensed practical nurses (LPNs), and nurse aides to provide nursing care to all residents 24 hours a day. The regulations further require a minimum of 1.5 hours of nursing care per resident each day, which means that the facilities are only required to provide each resident with 1.5 hours of assistance for activities such as bathing, eating, toileting, and administering medication. While CMS does not require a specific number of hours per resident day (HPRD), it does recommend three minimum staffing levels to avoid harm to residents. According to CMS, staffing levels below 2.75 HPRD could result in serious harm to nursing facility residents. Exhibit 32 shows CMS' three recommended levels of care and a description of each.

Exhibit 32
CMS Recommended Minimum Staffing Levels
to Avoid Harm
Nursing Facilities

Minimum Staffing Level	HPRD	Description
Optimum Level	3.9	Includes 2.9 hours of nurse aide time and 1 hour of RN/LPN time
Preferred Minimum Level	3.0	Includes 2 hours of nurse aide time and 1 hour of RN/LPN time
Minimum Level to Avoid Harm	2.75	Includes 2 hours of nurse aide time and 45 minutes of RN/LPN time
Source: Prepared by legislative auditor's staff using information obtained from the Kaiser Commission on Medicaid and the Uninsured.		

The minimum staffing requirement for nursing facilities in Louisiana is significantly lower than the minimum staffing levels CMS recommends to avoid harm. In addition, while the CMS-recommended minimum staffing levels include only direct care personnel (i.e., RNs, LPNs, and nurse aides), Louisiana's state licensing requirements do not prohibit nursing facilities from including individuals other than direct care personnel in their staffing calculations. Therefore, while the minimum staffing requirement for nursing facilities in Louisiana is low, the actual staffing levels may be even lower.

Recommendation 25: DHH should increase the minimum staffing requirement for nursing facilities from 1.5 HPRD to at least 3.0 HPRD based on CMS' recommended preferred minimum level to avoid harm. In addition, DHH should mandate that the minimum staffing requirement only include direct care personnel and specify how the staffing hours should be broken down between nurses and nurse aides.

Summary of Management's Response: DHH agrees with this recommendation and states that the 3.0 staffing level is preferable (see Appendix B for management's full response).

Federal Certification of Nursing Facilities and ICFs/MR

In addition to being licensed, nursing facilities and ICFs/MR that accept Medicaid residents must be certified according to federal guidelines. CMS contracts with DHH to annually conduct standard surveys of nursing facilities and ICFs/MR for the purpose of certification. Health Standards conducts federal certification surveys at the same time as state licensing surveys to conserve resources such as time, staff, and money. The federal certification requirements for nursing facilities and ICFs/MR focus on many aspects of quality such as resident care practices, staff/resident interaction, and environment. Nursing facilities must meet over 175 regulatory standards and ICFs/MR must meet over 350 regulatory standards at all times. During the standard survey process, Health Standards surveyors identify deficiencies, or deviations from the regulations.

Nursing Facilities

During calendar year 2003, Health Standards conducted 267 standard surveys of 266 nursing facilities. The surveys resulted in 2,088 federal deficiencies, or an average of 7.8 deficiencies per survey. The 43 nursing facilities in the sample we reviewed[7] received 820 (39.3%) of those deficiencies. Over half (52.8%) of the deficiencies cited for the sample nursing facilities fell in the areas of quality of care, resident assessment, and health care related services. Appendix F shows the numbers, the types, and some examples of the federal deficiencies cited by Health Standards during the surveys of the nursing facilities in our sample.

ICFs/MR

Health Standards also conducted 507 standard surveys of 479 ICFs/MR during calendar year 2003. The surveys resulted in 1,424 federal deficiencies, or an average of 2.8 deficiencies per survey. The 57 ICFs/MR in the sample we reviewed[8] received 586 (41.2%) of those deficiencies. Over half (57.2%) of the deficiencies cited for the sample ICFs/MR fell in the areas of active treatment services, health care services, and facility staffing. Appendix G shows the numbers, the types, and some examples of the federal deficiencies cited by Health Standards during the surveys of the ICFs/MR in our sample.

[7] The nursing facility sample consisted of all facilities that received more than 12 deficiencies during their calendar year 2003 standard surveys.
[8] The ICF/MR sample consisted of all facilities that received more than six deficiencies during their calendar year 2003 standard surveys.

Health Standards "Very Effective" in Surveying Nursing Facilities

CMS conducts Federal Oversight and Support Surveys (FOSS) to monitor the quality of care and services that nursing facilities provide to their residents and to monitor the performance of state survey agencies with respect to the standard survey process. CMS does not conduct FOSS surveys of ICFs/MR. During FOSS surveys, CMS evaluates the Health Standards survey teams on the following six measures:

1. Concern Identification
2. Sample Selection
3. General Investigation
4. Kitchen/Food Service Investigation
5. Medication Investigation
6. Deficiency Determination

The survey team receives a score of 1 (lowest) through 5 (highest) for each performance measure. Exhibit 33 below shows the definition of each score.

Exhibit 33
FOSS Measure Ratings
Federal Fiscal Year 2003

Score	Definition
1	Unsatisfactory
2	Less Than Satisfactory
3	Satisfactory
4	Very Effective
5	Extremely Effective

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

During federal fiscal year 2003, CMS conducted FOSS surveys of 13 nursing facilities. Health Standards received a statewide overall average of 4.2. The score indicates that Health Standards is doing a very effective job of surveying nursing facilities with respect to the six FOSS measures. With regard to deficiency determination, Health Standards scored 3.5, or between satisfactory and very effective. Exhibit 34 on the following page shows Health Standards' overall rating for each individual measure.

Exhibit 34
Health Standards' Rating for Each FOSS Measure
Federal Fiscal Year 2003

Measure	Rating
1. Concern Identification	4.7
2. Sample Selection	4.8
3. General Investigation	3.6
4. Kitchen/Food Service Investigation	4.6
5. Medication Investigation	4.0
6. Deficiency Determination	3.5
Overall Average	**4.2**

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

Recommendation 26: DHH should continue the processes and procedures that resulted in the high FOSS ratings from CMS and make amendments as called for in the future.

Summary of Management's Response: DHH agrees with this recommendation and will continue the processes and procedures (see Appendix B for management's full response).

Predictability of Standard Nursing Facility Surveys Has Declined

Federal regulations require that standard surveys of nursing facilities be unannounced. The regulations further require that DHH conduct a standard survey of each nursing facility no later than 15 months after the date of the previous standard survey and that the statewide interval between standard surveys be 12 months or less. A 1998 performance audit conducted by our office found that the timing of DHH's 1997 surveys was predictable. Specifically, the audit found that 20.0% of nursing facilities in the audit sample were surveyed within two days of the dates of their 1996 inspections, while 37.0% were surveyed within two weeks of the dates of their 1996 inspections.

We compared the calendar year 2002 and 2003 standard survey dates for the 43 nursing facilities in our sample and found that two (4.7%) of the 2003 surveys were conducted within two days of the dates of the 2002 surveys and four (9.3%) were conducted within two weeks of the dates of the 2002 surveys. Over 31 (72.0%) of the 2003 surveys took place in a different month than the month in which the 2002 surveys were conducted. These figures indicate that the predictability of the survey visits has declined. The improvement Health Standards has made in increasing the variability of survey dates means that nursing facility providers are less able to predict when their surveys will occur. As a result, they are less able to prepare for the surveys. Exhibit 35 on the following page shows a breakdown of the standard survey time frames for the sample nursing facilities reviewed in 1997 and 2003.

Exhibit 35
Comparison of Standard Survey Dates for Sample Nursing Facilities
Calendar Years 1997 vs. 2003

Time Frame of Surveys	1997 Standard Surveys		2003 Standard Surveys	
	Number of Facilities	Percent of Facilities	Number of Facilities	Percent of Facilities
Conducted within 2 days of date of previous year's survey	6	20.0%	2	4.7%
Conducted within 3-14 days of date of previous year's survey	5	16.7%	2	4.7%
Conducted within 15-30 days of date of previous year's survey	12	40.0%	8	18.5%
Conducted within 31-60 days of date of previous year's survey	3	10.0%	21	48.8%
Conducted within over 60 days after date of previous year's survey	4	13.3%	10	23.3%
Total Sampled	**30**	**100.0%**	**43**	**100.0%**

Source: Prepared by legislative auditor's staff using information from *Management and Oversight of Long Term Care in Louisiana* dated April 1998 and the CMS PDQ database.

Recommendation 27: DHH should continue to vary the dates of the annual standard surveys for nursing facilities.

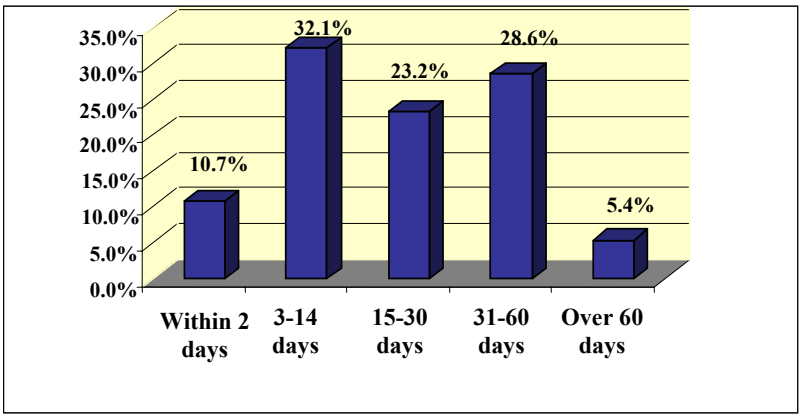
Summary of Management's Response: DHH agrees with this recommendation and will continue to strive to vary annual survey dates (see Appendix B for management's full response).

Timing of ICF/MR Standard Surveys Is Predictable

Federal regulations require that standard surveys of ICFs/MR be unannounced and that they be conducted every 12 months. We compared the calendar year 2002 and 2003 standard survey dates for 56[9] ICFs/MR providers in our sample and found that 6 (10.7%) of the surveys were conducted within two days of the dates of the 2002 surveys and 24 (42.8%) were conducted within two weeks of the dates of the 2002 surveys. In contrast to the nursing facility surveys, only 19 (34.0%) of the 2003 surveys took place in a different month than the month in which the 2002 surveys were conducted. The regularity of survey dates from year to year means that ICF/MR providers can predict with some certainty when their next surveys will occur, despite the surveys being unannounced. As a result, providers have time to prepare for the surveys. Exhibit 36 on the following page shows a breakdown of the survey time frames for the 56 sample ICFs/MR.

[9] We did not include one facility from the original sample of 57 because it was a new facility and received only one standard survey during calendar years 2002 and 2003.

Exhibit 36
Standard Survey Time Frames for Sample ICFs/MR
January 1, 2002, Through December 31, 2003



Source: Prepared by legislative auditor's staff using information from the CMS PDQ database.

Recommendation 28: DHH should increase the variability of the standard survey dates for ICFs/MR so that providers are less able to predict when their next surveys will occur.

Summary of Management's Response: DHH agrees with this recommendation and will vary the time frame within the constraints of the survey process (see Appendix B for management's full response).

Complaints

Health Standards is the point of entry for all complaints filed against nursing facilities and ICFs/MR. Complaints can be filed in person, in writing, or by telephone. State law requires that DHH review all nursing facility and ICF/MR complaints and determine whether reasonable grounds for investigation exist. If a complaint requires an investigation, a program manager assigns it an investigation priority and forwards it to the regional office that oversees the facility against which the complaint was lodged. Each investigation priority designates a particular time frame in which the complaint must be investigated. Regardless of the investigation priority assigned, state law (R.S. 40:2009.14) requires DHH to conduct all complaint investigations within 30 days of receiving a complaint report.

Nursing Facilities

During calendar year 2003, Health Standards conducted 501 complaint surveys of 207 nursing facilities, resulting in 488 federal deficiencies. Of the 207 nursing facilities, 21 (10.1%) received more than four complaint surveys during the year, with two facilities receiving 10 complaint surveys each. Of the 43 nursing facilities in our sample, Health Standards surveyors conducted complaint surveys of 24 (55.8%). These 24 facilities received 141 or 28.9% of all complaint deficiencies cited during the year. Over half of the deficiencies cited during

the complaint surveys for the sample nursing facilities fell in the areas of resident assessment (24.8%), quality of care (22.7%), and resident rights/facility practices (17.7%). Exhibit 37 shows a breakdown of the types of federal deficiencies cited during these complaint surveys.

Exhibit 37
Federal Deficiencies Cited During
Complaint Surveys of Sample Nursing Facilities
Calendar Year 2003

Category of Deficiency	Number of Citations	Percent of Total Citations
Resident Assessment	35	24.8%
Quality of Care	32	22.7%
Resident Rights/Facility Practices	25	17.7%
Administration	17	12.1%
Health Care Related Services	17	12.1%
Quality of Life	11	7.8%
Infection Control	3	2.1%
Physical Environment	1	0.7%
Total	**141**	**100.0%**

Source: Prepared by legislative auditor's staff using information provided by the CMS PDQ database.

ICFs/MR

During calendar year 2003, Health Standards conducted 53 complaint surveys of 42 ICFs/MR, resulting in 97 federal deficiencies. Of the 57 ICFs/MR in our sample**,** the surveyors conducted complaint surveys of four (7.0%). These facilities received 19 or 19.6% of all complaint deficiencies cited during the year. The majority of those deficiencies fell in the areas of client protections (36.7%), facility staffing (21.1%), and health care services (15.7%). Exhibit 38 on the following page shows a breakdown of the types of federal deficiencies cited during these complaint surveys.

Exhibit 38
Federal Deficiencies Cited During
Complaint Surveys of Sample ICFs/MR
Calendar Year 2003

Category of Deficiency	Number of Citations	Percent of Total Citations
Client Protections	7	36.7%
Facility Staffing	4	21.1%
Health Care Services	3	15.7%
Staff Treatment of Clients	2	10.6%
Active Treatment Services	1	5.3%
Client Behavior and Facility Practices	1	5.3%
Physical Environment	1	5.3%
Dietetic Services	0	0.0%
Governing Body and Management	0	0.0%
Total	**19**	**100.0%**

Source: Prepared by legislative auditor's staff using information provided by the CMS PDQ database.

DHH Has Not Assigned Investigation Priorities to Nursing Facility Complaints Timely

Our analysis of the complaint logs for August, September, and October 2004 indicates that, on average, it took Health Standards 7.1 working days to contact complainants and obtain the information needed to assign investigation priorities to complaints filed against nursing facilities. As of October 31, 2004, Health Standards had a backlog of 12 nursing facility complaint calls, extending back to October 22, 2004. In contrast, we found no backlog in assigning investigation priorities to ICF/MR complaints. In most cases, priorities for ICF/MR complaints are assigned the same day a complaint is received.

According to Health Standards staff, the delay in contacting complainants and assigning investigation priorities to nursing facility complaints occurred because of the large volume of complaints and the additional work duties of the nursing facility complaint manager. Such delays may place residents of nursing facilities at risk of harm, depending on the nature and severity of the circumstances surrounding the complaint. In addition, depending on the time it takes surveyors to initiate and complete their investigations, DHH may not be in compliance with R.S. 2009.14, which requires all complaints to be investigated within 30 days of receiving a complaint report.

Recommendation 29: DHH should re-evaluate the complaint intake process to ensure that nursing facility complaint calls are returned, and complaint investigations are assigned, in a timely manner.

Summary of Management's Response: DHH agrees with this recommendation and has made some personnel adjustments that have improved the timeliness of contacting persons who leave messages (see Appendix B for management's full response).

Informal Dispute Resolution

Once a standard survey or complaint survey is completed, nursing facility and ICF/MR providers can request an Informal Dispute Resolution (IDR) forum to refute deficiencies that Health Standards surveyors cited. Providers can also use the IDR process to refute sanctions Health Standards imposed as a result of the deficiencies. During the IDR process, providers present their concerns to employees of the Health Standards Section who have not been involved in the facility surveys or the imposition of sanctions. Survey deficiencies can be affirmed, modified (e.g., changes to scope and severity, wording, etc.), or deleted. Likewise, sanctions can be affirmed, modified (e.g., lowered), or rescinded.

Few Deficiencies and Sanctions Disputed; Fewer Overturned

Nursing Facilities

Health Standards conducted 50 IDRs for nursing facility providers as a result of deficiencies cited during calendar year 2003 standard and complaint surveys. During the IDRs, providers disputed 115 or 4.46% of the 2,576 total deficiencies cited in 2003**.** Of the 115 deficiencies disputed, 53 (46.1%) were affirmed, 19 (16.5%) were modified, and 43 (37.4%) were deleted. Overall, DHH modified or deleted only 62 (2.4%) of all deficiencies cited for nursing facilities during calendar year 2003. The majority (74.2%) were modified or deleted because of insufficient evidence (50.0%) and additional information that was provided after the surveys (24.2%). Exhibit 39 shows the reasons why deficiencies were modified or deleted.

Exhibit 39
Reasons Why Nursing Facility Deficiencies Were Modified or Deleted
Calendar Year 2003

Reason	Number of Times Cited	Percent of Times Cited
Insufficient Evidence/Facts Do Not Support Deficiency	31	50.0%
Additional Information Provided After Survey	15	24.2%
Inaccurate Facts	7	11.3%
Other	4	6.5%
Wording/Grammar Change	3	4.8%
Facility Found Non-Culpable for Incident	2	3.2%
Total	**62**	**100.0%**

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

ICFs/MR

In addition, Health Standards conducted 12 IDRs for ICF/MR providers as a result of deficiencies cited during calendar year 2003 standard and complaint surveys. During these IDRs, providers disputed 22 or 1.5% of the 1,521 total deficiencies cited in 2003. Of the 22 deficiencies disputed, 10 (45.5%) were affirmed, 4 (18.2%) were modified, and 8 (36.4%) were deleted. Overall, DHH modified or deleted only 12 (0.8%) of all deficiencies cited for ICFs/MR during calendar year 2003. The majority (83.3%) of these deficiencies were modified or deleted because of insufficient evidence (33.3%) and additional information provided after the surveys (50.0%). Exhibit 40 shows the reasons why deficiencies were modified or deleted.

Exhibit 40
Reasons Why ICF/MR Deficiencies Were Modified or Deleted
Calendar Year 2003

Reason	Number of Times Cited	Percent of Times Cited
Additional Information Provided After Survey	6	50.0%
Insufficient Evidence/Facts Do Not Support Deficiency	4	33.3%
Inaccurate Facts	1	8.3%
Facility Found Non-Culpable for Incident	1	8.3%
Total	**12**	**100.0%**

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

Nursing facility and ICF/MR providers used the IDR process to refute a total of 22 sanctions that were imposed as a result of deficiencies cited during calendar year 2003 surveys. Of the 18 nursing facility sanctions that were refuted, DHH affirmed 14 (77.9%), modified one (5.6%), and rescinded three (16.7%). Reasons for rescinding the sanctions included facility hardship and insufficient evidence to support the deficiency. DHH affirmed all of the four ICF/MR sanctions that were refuted.

Abuse and Neglect Reporting

Federal regulations require DHH to review all allegations of resident neglect and abuse and misappropriation of resident property in long-term care facilities. State law [R.S. 40:2009.20(B)(1)] requires nursing facility and ICF/MR providers to report all incidents or allegations of abuse and/or neglect to Health Standards or local law enforcement within 24 hours. Providers must also conduct internal investigations and send copies of the investigation reports to Health Standards within five working days.

Abuse - Infliction of physical or mental injury, or causing the deterioration of a consumer by means including, but not limited to, sexual abuse, or exploitation of funds or other things of value to an extent that an individual's health or emotional well-being is endangered.

Neglect - Failure to provide the proper or necessary medical care, nutrition, or other care necessary for an individual's well-being.

Examples of the types of incidents providers must report to Health Standards are physical abuse, sexual abuse, verbal abuse, neglect, and injury of unknown origin. Health

Standards estimates that it receives hundreds of abuse and neglect reports each month from nursing facilities and ICFs/MR. The majority of the incidents, according to Health Standards personnel, are resident-against-resident encounters.

Upon receipt by Health Standards, a program manager reviews each abuse and neglect report to ensure that the facility handled the incident appropriately. If the incident involved a criminal act (e.g., physical or sexual incidents involving staff members), the program manager is supposed to notify local law enforcement and the Attorney General's office, even if the facility has already done so. The program manager or clerical person then enters the information into a database.

To assist the program manager in identifying potential trends, patterns, and root causes regarding abuse and neglect, Health Standards instituted infraction limits into the database to alert the program manager when a reported incident constitutes a certain number of instances within a particular time frame. For example, the system will alert the program manager if a facility reports five burns or two deaths in a six-month period. Using professional judgment, the program manager then determines what further action, if any, needs to be taken. Further actions may include initiating a formal complaint investigation or referring the information to the appropriate regional office for use during the next survey of the facility.

Because of the self-reporting nature of the abuse and neglect reporting process, an inherent risk is that providers may not report all incidents. If, during a survey, a surveyor uncovers an incident that should have been reported, the facility may receive a deficiency for failing to report it. During calendar year 2003, Health Standards surveyors cited 50 nursing facility providers and 25 ICF/MR providers with deficiencies associated with failing to report incidents of abuse and neglect.

Health Standards Lacks Policies and Procedures to Ensure That Nursing Facility and ICF/MR Residents Are Notified of Sex Offenders Living in the Facilities

State regulations require sex offenders to undergo a notification and registration process that includes notifying all persons residing within a three square block area, or one square mile area in a rural area of their name, address, and crime. According to the Louisiana State Police Sex Offender and Child Predator Registry, as of November 18, 2004, a total of 11 registered sex offenders resided in 11 different nursing facilities, and two registered sex offenders resided in an ICF/MR. Examples of crimes for which these offenders were convicted included indecent behavior with juveniles, sexual assault, aggravated rape, and aggravated oral sexual battery.

While the 13 sex offenders we identified may have fulfilled the registration and notification requirements, Health Standards does not have policies or procedures in place to ensure that residents (or their families/guardians) who are admitted to the facilities after the offenders fulfill the registration requirements are notified of the offenders' presence. The close living arrangements inherent in nursing facilities and ICFs/MR combined with the health (e.g., stroke, generalized weakness, etc.) and cognitive issues (e.g., Alzheimer's, mental

retardation, etc.) faced by many of the residents leave them vulnerable to sexual predators and at risk for abuse. Implementing policies and procedures in this area would help ensure that residents and their families are aware of potential risks to the individuals' health and safety.

Recommendation 30: DHH should develop and implement policies and procedures that require nursing facility and ICF/MR providers to notify new residents and their families/guardians of sex offenders living in their facilities upon admission. The notification should continue for as long as the information is considered a public record. During the annual licensing process, Health Standards surveyors should verify providers' compliance with the policy.

Summary of Management's Response: DHH partially agrees with this recommendation and states that it will analyze the recommendation's legality (see Appendix B for management's full response).

Enforcement and Sanctions

Nursing Facility Enforcement Process

Once the licensing and survey process is complete, the surveyors assess the scope and severity of the federal deficiencies cited in the surveys using an enforcement grid. The grid categorizes the deficiencies from A (least serious) to L (most serious), depending on the number of residents (scope) and the level of harm (severity) involved. Exhibit 41 shows the various scope and severity categories under which a deficiency may fall.

Exhibit 41
Nursing Home Enforcement Grid

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate Jeopardy to Resident's Health or Safety	J	K	L
Actual Harm That Is Not an Immediate Jeopardy	G	H	I
No Actual Harm With Potential for More Than Minimal Harm	D	E	F
No Actual Harm With Potential for Minimum Harm	A	B	C

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

Depending on the scope and severity of the deficiencies cited, the surveyors determine whether or not the nursing facilities are in substantial compliance with federal certification requirements. A nursing facility that is in substantial compliance but has deficiencies with a scope and severity level of B or above is required to submit a plan of correction informing DHH of how it will correct the deficiencies. If a facility is not in substantial compliance with federal

certification requirements, a program manager determines whether or not the facility will be given an opportunity to correct the deficiencies before federal enforcement actions or state civil money penalties are imposed. This decision is based on the scope and severity of the facility's deficiencies. A facility that is given an opportunity to correct deficiencies must submit an acceptable plan of correction to Health Standards. The facility has 90 days to achieve substantial compliance before denial of payment for new admissions is imposed and six months before its Medicaid and/or Medicare provider agreement is terminated. Health Standards will conduct a revisit to ensure that the facility achieved substantial compliance.

In addition to submitting a plan of correction, a facility given no opportunity to correct deficiencies has 15 days to achieve substantial compliance before denial of payment for new admissions is imposed and six months before the facility's Medicaid and/or Medicare provider agreement is terminated. When an immediate jeopardy situation exists and remains in place at the end of the survey, the time frame for terminating the provider agreement is decreased to 23 days. Health Standards will conduct a follow-up visit to ensure that the facility achieved substantial compliance within the specified time frames. In addition to denial of payment and possible termination of its provider agreement, a facility given no opportunity to correct deficiencies automatically receives a civil money penalty for being out of compliance with federal regulations. Appendix H illustrates DHH's enforcement process for nursing facilities.

Immediate Jeopardy - A situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

ICF/MR Enforcement Process

ICFs/MR that receive deficiencies during the licensing and survey process must submit plans of correction to DHH. Once Health Standards approves the plans of correction, surveyors revisit the facilities to ensure that the providers have corrected all of the deficiencies. The only federal enforcement action for ICFs/MR is termination of the Medicaid provider agreement. If a facility is out of compliance with one of the eight federal conditions of participation, the program manager will place the facility on a 23-day or 90-day termination track, depending on the seriousness of the situation. For example, a facility where an immediate jeopardy situation is occurring or has occurred and has not yet been corrected is put on a 23-day termination track. A facility where the circumstances surrounding the condition(s) of participation do not involve an immediate jeopardy situation is put on a 90-day termination track. The Health Standards surveyors will revisit the facility to determine if the condition(s) of participation can be lifted (i.e., to determine if the facility has corrected the problem). Appendix I illustrates DHH's enforcement process for ICFs/MR.

Sanctioning of Nursing Facilities and ICFs/MR

In addition to the federal enforcement actions of denial of payment and termination of Medicare/Medicaid provider agreements, the Standards for Payment for both nursing facilities and ICFs/MR allow DHH to sanction any facility found to be in violation of a state licensing or federal certification requirement. Sanctions range from requiring a facility to submit a plan of correction or pay a civil money penalty to withholding vendor payments or revoking a facility's

licensure. DHH has broad discretion over the types and severity of sanctions to impose. According to the Standards for Payment for Nursing Facilities, DHH shall impose the sanction that will bring the nursing home into compliance in the most efficient and effective manner with the care and well-being of the residents being the paramount consideration.

State Civil Money Penalties May Not Be High Enough to Deter Noncompliance

According to the Standards for Payment for Nursing Facilities and ICFs/MR, DHH can assess civil money penalties for five classes of violations ranging from Class A, which is the most serious, to Class E, which is the least serious. Whereas mandatory civil money penalties are required for Class A violations, DHH has discretion when imposing Class B through Class E violations. DHH also has discretion when affixing the amounts of penalties to be imposed. Examples of the factors DHH may consider when determining whether to assess a penalty and what the penalty amount should be include the gravity of the violation, the extent to which applicable statutes or regulations were violated, and the good faith exercised by the licensee (e.g., prior compliance with requirements, efforts to correct, etc.).

In cases of repeat deficiencies, DHH can penalize nursing facility and ICF/MR providers on a per day basis. However, according to R.S. 40:2009.11(B)(3), the total amount of penalties assessed against nursing facilities for Class A or Class B violations cannot exceed $10,000 in any one month, and the total amount for Class C, D, or E violations cannot exceed $5,000 in any one month. Also, according to R.S. 40.2199(B)(3), the total amount of penalties assessed against ICFs/MR for Class A or Class B violations cannot exceed $10,000 in any one month, and the total amount for Class C, D, or E violations cannot exceed $5,000 in any one month. According to Health Standards sanction logs, Health Standards assessed approximately $333,900 and $24,600 in civil money penalties against nursing facilities and ICFs/MR, respectively, during calendar year 2003. Exhibit 42 on the following page lists the classes of violations, the associated penalties, and a description of the deficiencies associated with each class.

Repeat Deficiency - A deficiency that is reasonably expected to continue until corrected or a same/similar violation occurring within 18 months.

In addition to state civil money penalties, DHH can also impose federal monetary sanctions on nursing facilities. The federal penalties are generally higher than the state penalties, and the federal caps are higher than the state caps. DHH has chosen to only impose state civil money penalties. Because there are monetary caps on all violation levels, however, the state civil money penalties may not be high enough to deter noncompliance. For example, because of the monetary cap on the state civil money penalties for Class A and B violations, the most a facility can be penalized in one month for a violation that resulted in death or serious harm of one or more residents is $10,000.

In addition, the monetary caps render the "per day" penalties allowed for repeat violations ineffective because in some instances, the caps are reached in a matter of days. For example, the maximum amount a facility can be penalized in one month for a Class A violation (i.e., death or serious harm) is $10,000. As a result, a facility cited for a repeat deficiency that

falls under a Class A violation can only be penalized for two days before reaching the monetary cap. Similarly, because the maximum amount a facility can be penalized in one month for a Class C violation (i.e., potential harm that threatens the health, safety, rights, or welfare of a resident) is $5,000, a facility cited for a repeat deficiency that falls under a Class C violation can only be penalized for five days before reaching the monetary cap. Because the penalties DHH imposes are not as high as they could be, the department may be missing an opportunity to discourage facilities from future noncompliance. Removing or increasing the caps would result in higher penalties for providers who do not correct deficiencies in a timely manner as well as those who annually fall in and out of compliance with state licensing and federal certification requirements.

Exhibit 42
Classes of Violations for Nursing Facilities and ICFs/MR

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

*Defined as occurring within 18 months of first offense.
Source: Prepared by legislative auditor's staff using information provided by DHH and Louisiana Revised Statutes.

Matter for Legislative Consideration 3: The legislature should consider amending R.S. 40.2009.11(B)(3) and R.S. 40.2199(B)(3) to remove or increase the caps on all classes of violations for nursing facilities and ICFs/MR.

Recommendation 31: If the legislature does not remove or increase the monetary caps on violations, DHH should reconsider its decision to not impose federal monetary sanctions on nursing facilities found to be out of compliance with federal certification requirements.

Summary of Management's Response: DHH agrees with this recommendation and states that if the cap is not increased or removed, the department could refer cases to CMS (see Appendix B for management's full response).

DHH Consistently Imposed Penalties on Nursing Facilities for Repeat Deficiencies, But Not on ICFs/MR

Unless an immediate jeopardy situation exists or actual harm has occurred, nursing facilities and ICFs/MR are given an opportunity to correct deficiencies before Health Standards assesses civil money penalties. The surveyors conduct revisits (i.e., follow-ups) after the facilities have taken corrective action to ensure that the deficiencies have been corrected and that the facilities have attained compliance with state licensing and federal certification requirements. According to Health Standards, the average cost of a nursing facility revisit is approximately $1,942 and the average cost of an ICF/MR revisit is approximately $486. If providers have not corrected deficiencies by the time of the revisits, the surveyors rewrite the deficiencies and a program manager determines whether or not the circumstances surrounding the deficiencies were the same as or similar to the circumstances when the deficiencies were first cited. If they are, the deficiencies are considered repeat deficiencies.

Nursing Facilities

Health Standards cited the 43 nursing facilities in our sample for a total of 820 deficiencies during their calendar year 2003 standard surveys. Of the 820 original deficiencies, 118 (14.4%) resulted in civil money penalties, with 95 (80.5%) penalized as Class C violations for being repeat deficiencies. The remaining 23 deficiencies were penalized as Class B violations. Overall, 33 (76.7%) of the facilities in our sample received civil money penalties for at least one deficiency.

Because all 43 facilities were found to be out of substantial compliance with federal certification requirements, Health Standards conducted revisits of the facilities. Six (14.0%) facilities required two revisits before all deficiencies were cleared. The average total cost for all 49 revisits, based on Health Standards' estimate of the cost per revisit, was $95,158. During the revisits, the surveyors rewrote 11 (1.3%) of the 820 original deficiencies. Eight (72.7%) of the rewritten deficiencies resulted in civil money penalties for being repeat deficiencies.

ICFs/MR

Health Standards cited the 57 ICFs/MR in our sample for a total of 586 deficiencies during their calendar year 2003 standard surveys. Of the 586 original deficiencies, however, only seven (1.2%) resulted in civil money penalties, with four (57.1%) penalized as Class C violations for being repeat deficiencies. One of the remaining deficiencies was penalized as a Class A violation, and the remaining two were penalized as Class C, but not repeat, violations. Overall, only 3 (5.3%) of the ICFs/MR in our sample received civil money penalties for at least one deficiency.

Because all 57 facilities were found to be out of compliance with federal certification requirements, Health Standards conducted revisits of the facilities. Twenty-three (40.4%) facilities required two revisits before all deficiencies were cleared, and three (5.3%) required three revisits. The average total cost for all revisits, based on Health Standards' estimate of the cost per revisit, was approximately $41,796. During the initial revisits, the surveyors rewrote 86 (14.7%) of the 586 original deficiencies. Seven (8.1%) of the 86 rewritten deficiencies resulted in civil money penalties for being repeat deficiencies. During the second revisits, the surveyors rewrote 8 (1.4%) of the original 586 deficiencies. Two (25.0%) resulted in state civil money penalties for being repeat deficiencies. By the third revisits, all of the original deficiencies were cleared.

The number of repeat deficiencies, rewritten deficiencies, and state civil money penalties assessed for the nursing facilities and ICFs/MR in our sample as a result of their calendar year 2003 standard surveys and revisits are summarized in Exhibit 43 on the following page.

Exhibit 43
Summary of Revisits, Rewritten Deficiencies, and Sanctions for Repeat Deficiencies
Sample Nursing Facilities and ICFs/MR
Calendar Year 2003

	Number (%) of Nursing Facilities (Sample Size = 43)	Number (%) of ICFs/MR (Sample size = 57)
Number of Facilities Receiving Civil Money Penalty for at Least One Deficiency	33 (76.7%)	3 (5.3%)
Number of Facilities Requiring One Revisit	37 (86.1%)	31 (54.4%)
Number of Facilities Requiring Two Revisits	6 (14.0%)	23 (40.4%)
Number of Facilities Requiring Three Revisits	0	3 (5.3%)
Original Standard Survey		
Total Deficiencies Cited	820	586
Total Deficiencies Sanctioned	118 (14.4%)	7 (1.2%)
Total Deficiencies Sanctioned as Repeats	95 (80.5%)	4 (57.1%)
1st Revisit		
Number of Original Deficiencies Rewritten	11 (1.3%)	86 (14.7%)
Number of Rewritten Deficiencies Sanctioned as Repeats	8 (72.7%)	7 (8.1%)
Number of Rewritten Deficiencies Not Sanctioned	3 (27.3%)	79 (91.9%)
2nd Revisit		
Number of Original Deficiencies Rewritten	N/A	8 (1.4%)
Number of Rewritten Deficiencies Sanctioned as Repeats	N/A	2 (25.0%)
Number of Rewritten Deficiencies Not Sanctioned	N/A	6 (75.0%)
3rd Revisit		
Number of Original Deficiencies Rewritten	N/A	0
Number of Rewritten Deficiencies Sanctioned as Repeats	N/A	N/A

N/A = Not applicable.
Source: Prepared by legislative auditor's staff from analysis done using nursing facility and ICF/MR certification files provided by Health Standards.

While Health Standards is permitted to give facilities an opportunity to correct deficiencies before assessing penalties, DHH regulations require that facilities be sanctioned for repeat deficiencies. Based on the information presented in this finding, Health Standards has not been consistent in the sanctioning of repeat deficiencies for ICFs/MR. While nursing facilities appear to be sanctioned routinely for repeat deficiencies, ICFs/MR are rarely sanctioned for any deficiencies, let alone those that are repeat deficiencies. Assessing civil money penalties in a consistent manner would help encourage all providers to correct deficiencies by the first revisit. It would also decrease the time and money Health Standards expends to conduct revisits.

Recommendation 32: Health Standards should evaluate and amend the process it uses to assess civil money penalties on ICF/MR providers for all deficiencies, including repeat deficiencies. In doing so, Health Standards should ensure that penalties are assessed consistently among ICF/MR providers as well as across all provider groups (e.g., nursing facilities, etc.).

Summary of Management's Response: DHH agrees with this recommendation (see Appendix B for management's full response).

Source: Parade photo courtesy of St. Clare Manor.

Revenue From Penalties Could Be Used to Improve Quality of Care in Facilities

The money DHH collects from civil money penalties assessed against nursing facilities and ICFs/MR is deposited into the Nursing Home Residents' Trust Fund and the Health Care Facility Fund, respectively. Both of these funds are maintained by the state treasurer. The balance of the Nursing Home Residents' Trust Fund as of June 30, 2004, was $1,285,000. The balance of the Health Care Facility Fund was $241,200. The Health Care Facility Fund contains civil money penalties collected from many types of health care facilities, including ICFs/MR, substance abuse/addiction facilities, ambulatory surgery centers, home health agencies, hospice, and hospitals.

Nursing Home Residents' Trust Fund

According to R.S. 40:2009.11(F), the monies in the Nursing Home Residents' Trust Fund may only be used as specified in the federal Omnibus Budget Reconciliation Act of 1987**.** The law states that the money DHH collects from civil money penalties shall be used to protect the health or property of residents of nursing facilities that DHH finds deficient, including the cost of relocating residents to other facilities, maintenance and operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds lost. According to DHH, as of December 31, 2004, no claims had ever been made against the fund. However, Health Standards recently received approval from the Division of Administration to use money in the fund to host a conference on culture change for nursing facility providers in March 2005. The focus of the culture change initiative is to improve the quality of care and quality of life of residents in long-term care facilities through resident-centered care.

Recommendation 33: DHH should continue to explore ways to use Nursing Home Residents' Trust Fund monies to improve the quality of care and quality of life of nursing facility residents. Examples include provider education and grants for facilities to assist with the implementation of quality improvement projects such as the culture change initiative.

Summary of Management's Response: DHH agrees with this recommendation and is hosting a Culture Change conference in March (see Appendix B for management's full response).

Health Care Facility Fund

According to Act 1185 of the 2001 Regular Session, which amended R.S. 40:2199(F) as of July 1, 2001, the Health Care Facility Fund was abolished and the balance of the fund was to be transferred to the state general fund. Civil money penalties collected after the fund was abolished were supposed to be deposited directly into the state general fund. According to DHH,

however, the deposits into the general fund have not occurred. Instead, funds received from civil money penalties are currently in an escrow account at the State Treasury.

Matter for Legislative Consideration 4: The legislature should consider allowing DHH to use civil money penalties collected from sanctioning ICFs/MR to improve the quality of care and quality of life of individuals receiving services from those facilities.

Recommendation 34: If the legislature allows DHH to use civil money penalties from sanctions of ICFs/MR as described in Matter for Legislative Consideration 4, DHH should explore ways to use the funds to improve the quality of care and quality of life of residents in ICFs/MR.

Summary of Management's Response: DHH partially agrees with this recommendation and states that the funds should also be available to address quality issues in other facilities as well as ICFs/MR (see Appendix B for management's full response).

WHAT REGULATORY PROCESSES DOES DHH USE TO ENSURE THE QUALITY OF LONG-TERM CARE SERVICES PROVIDED THROUGH WAIVERS, AND HOW CAN THOSE PROCESSES BE IMPROVED?

BCSS oversees four[10] waivers that totaled over $242 million in state fiscal year 2004. This figure is expected to increase to over $285 million in state fiscal year 2005. However, BCSS' oversight over the regulatory processes designed to ensure quality in the waiver program has not been sufficient. While BCSS has developed some regulatory processes designed to help ensure quality, the BCSS state office does not gather and analyze vital information that would help management evaluate whether waiver programs, services, and processes are effective. In addition, some processes are not efficient and have not been consistently and formally communicated to the regions.

According to the U.S. Government Accountability Office's *Government Auditing Standards*, agency management and oversight should include the following:

- Implementation of systems to achieve compliance with applicable laws and regulations
- Establishment of a system to ensure that reliable data is obtained, maintained, and disclosed
- Efficient and economic application of its resources to achieve program requirements and objectives

Because of the lack of easily accessible, centralized data, we could not assess whether waiver providers were in compliance with certain policies and standards, whether providers corrected instances of noncompliance, or whether waiver recipients received quality services. Many of the issues discussed in this section were identified to BCSS upper management in an internal memo dated October 11, 2001, from the Quality Assurance Program Manager. Among other things, the memo discusses inconsistency in the way regions cite deficient practices and the need for standardization of survey processes, criteria for plan of care approvals and follow-up surveys, and organization of monitoring documentation and reporting.

A brief description of the regulatory processes BCSS uses is summarized in the following sections followed by findings and recommendations regarding BCSS management's oversight and implementation of the processes.

[10] We did not include the PCA waiver because DHH began phasing it out in state fiscal year 2004.

Provider Licensing

The purpose of licensing is to ensure that providers comply with state licensing standards. BCSS licenses case management agencies and ADHC facilities. BCSS also annually renews the licenses for those entities. DSS licenses and annually renews the licenses of other waiver providers, as well, such as personal care attendant providers, respite care providers, supervised independent living providers, and adult day care providers.

Provider Enrollment

BCSS enrolls all providers,[11] including case management agencies and ADHCs, for Medicaid reimbursement every year. As of September 2003, all new providers must follow the Standards for Participation to be reimbursed by Medicaid. All providers must be enrolled and comply with the Standards for Participation by August 2005. Standards for Participation include requirements related to staffing, quality assurance plans, training, and fiscal accountability. Providers must be licensed and enrolled before they can provide services to waiver recipients. BCSS must re-enroll all providers each year.

Provider Monitoring

BCSS monitors a random sample of 5% of waiver recipients and all high risk[12] waiver recipients each year. The purpose of monitoring is to ensure compliance with BCSS policies and applicable regulations. As a part of the monitoring activities, BCSS regional staff members interview waiver recipients in their homes to evaluate whether the recipients are satisfied with the waiver services they receive. The regional staff members also conduct record reviews at the providers' and case management agencies' places of business. The record reviews help determine whether the providers are providing the required supports and services outlined in recipients' comprehensive plans of care.

When conducting monitoring activities, BCSS can cite deficiencies and/or significant findings to assure compliance. If BCSS regional offices cite deficiencies, the providers must submit appropriate plans of correction. Significant findings do not require plans of correction. BCSS may or may not conduct follow-up visits to determine if all deficiencies and significant findings have been corrected.

Investigation of Complaints and Critical Incidents

Complaints

BCSS has a 1-800 Help Line number for individuals to file complaints. The BCSS state office staff logs calls relating to complaints into the complaint tracking system. After sending a letter acknowledging each complaint to the complainant or referring agency, BCSS Help Line

[11] BCSS began enrolling direct service providers in September 2003.
[12] High risk waiver recipients are those determined to be at risk for physical or emotional abuse, neglect or exploitation, and those who are emotionally or physically fragile or have been determined to have an unsatisfactory home or social environment and/or an inadequate support system.

staff notifies BCSS state and regional offices of the complaint. The BCSS state office determines whether the complaint should be referred to the appropriate protection agency, such as the Bureau of Protective Services, Office of Community Services, or Elderly Protective Services (if the complaint involves abuse, neglect, exploitation, extortion, or self-neglect) as well as the appropriate regional office.

The BCSS regional office manager assigns the complaint an investigation priority level (i.e., immediate jeopardy, 24 hours, 48 hours, 5 days, or 30 days) and assigns the complaint to regional office staff. The regional office staff conducts a complaint investigation and requires a plan of correction if deficiencies are found. The regional office notifies the complainant of the investigation results, and the BCSS state office then closes the case and updates the complaint tracking system.

Critical Incidents

Critical Incidents - Incidents that allege that an individual is abused, neglected, exploited, extorted, or suffers from serious harm or physical injury. Other situations considered critical incidents include serious illness, unauthorized use of restraints, emergency room visits, missing, or whereabouts unknown, and death.

Case management agencies and direct service providers are required to report all critical incidents within two hours of first knowledge of the incidents to BCSS, the regional office, and other appropriate agencies. BCSS is supposed to enter the critical incident reports into a critical incident electronic log and refer them to the appropriate protection agency if it has not already been referred. The regional manager assigns each critical incident report an investigation priority level (i.e., immediate jeopardy, 24 hours, 48 hours, 5 days, or 30 days) and assigns it to regional office staff. The regional office staff must submit a preliminary report to the BCSS state office within 72 hours of receiving the initial report. The regional office staff must also conduct a critical incident investigation, if necessary, and complete a critical incident narrative within 30 days unless the BCSS state office grants an extension. The regional office will require a plan of correction if deficiencies are found. Once a critical incident has been resolved, the BCSS state office closes the case and updates the critical incidents log.

Certification of Waiver Recipients

BCSS regional staff must conduct an initial certification of each new waiver recipient. The certification involves review and approval of the comprehensive plan of care (CPOC) prepared by the case manager, the provider, and the recipient and/or authorized representative as well as observation of the living environment through home visits. The home visit provides the opportunity for BCSS staff to interview the waiver applicant and/or family members to make informal assessments of the applicant's functional abilities and to assess the safety of the environment.

Case Management

Case management services assist recipients in gaining access to the full range of needed services, including medical, social, educational, and other support services. Case management services are mandatory in the CC and EDA waivers. Case managers are responsible for conducting assessments of each recipient's interests, capabilities, preferences, and support needs and generating a comprehensive plan of care. Plans of care include recipients' desired personal

outcomes and specific strategies to achieve those outcomes. The plans also include budgets and schedules of services. Case managers are required to review all plans quarterly and revise them annually to ensure that they remain consistent with the needs and desires of the recipients. Case managers are also required to make quarterly home visits to all recipients to assess their progress toward meeting personal outcomes and to review progress notes to ensure that the direct service providers are providing required services.

Lack of Easily Accessible, Centralized Electronic Data Makes It Difficult to Evaluate Quality

Most data that could be used to evaluate the quality of waiver programs are not easily accessible or kept centrally in an electronic database. In addition, data are not always systematically reported to the state office. Instead, they are kept in physical files at the regional offices. If the state office needed to know, for example, whether a certain provider has a history of deficiencies or if all high-risk waiver recipients received the necessary home visits, it would have to contact the regional offices, and the regional offices would have to review the physical files to locate the needed information. Not having centralized and easily accessible data makes it difficult to effectively manage and monitor the waiver programs as a whole. Specific examples of problems we noted that are associated with the lack of data are summarized in the following findings.

The BCSS state office does not track or compile data on provider deficiencies. BCSS does not electronically track the results of licensing, monitoring, or enrollment processes. The purpose of licensing, enrollment, and monitoring visits is to ensure that providers comply with licensing standards, Medicaid Standards for Participation, requirements related to the health and welfare of recipients, and other policies and procedures. We were unable to determine whether providers were in compliance because we could not easily obtain information on whether BCSS cited any deficiencies during their visits. While some of the results from the visits are sent to the state office, most of the information is kept in physical files at the regional offices.

To determine whether providers were in compliance with mandated requirements, we had to review physical monitoring files that were available at the BCSS state office and manually record each deficiency or significant finding. Another problem we encountered was that the files were often incomplete. For example, one region did not submit letters summarizing instances of noncompliance to the state office. In addition, because the state office does not require the regional offices to submit plans of correction or results of follow-up visits, we could not determine whether providers corrected deficiencies. Our analysis shows that there were approximately 665 instances of provider noncompliance in the sample of providers that BCSS regional offices monitored from January 1, 2004, through June 30, 2004. Exhibit 44 on the following pages shows these instances by type of deficiency/significant finding.

Exhibit 44
Instances of Monitoring Noncompliance for
Waiver Providers Monitored
January 2004 Through June 2004

Subject*	Approximate** Number of Instances of Noncompliance	Examples of Noncompliance
Provider Documentation	152	No evidence in personnel file of annual evaluation, reference checks, copy of driver's license, etc.
Client Documentation	74	No copy of Freedom of Choice form; documentation of services rendered conflicts or is inaccurate. • For example, in a 6/2/04 survey, surveyors noted that no documentation showing that services were rendered from 5 a.m. to 8 a.m. from 7/27/03 to 5/11/04 was present.
Training	70	No evidence of training or insufficient evidence of training. • For example, in a 6/2/04 survey, surveyors noted that two staff members had documentation showing 40 hours of training in one day.
Progress Notes	63	Progress notes do not exist or do not support the CPOC.
Plans/CPOCs	53	CPOC is not in the home or it has expired.
Complaints/Critical Incidents	49	Outdated procedures or no tracking system for complaints or critical incidents.
Confidentiality	37	No confidentiality policy exists or no confidentiality form was found.
Time Sheets	35	Time sheets do not match progress notes or other records.
Client Services	33	Documentation shows that client is not receiving services or that additional services are needed but have not been obtained. • For example, in a 5/19/04 survey, surveyors noted that a waiver recipient had not received services since 2/28/04 when the direct service provider resigned.
Criminal Background Checks	27	No evidence of criminal background check; agency has not received criminal background check from the appropriate authorities.

Subject*	Approximate** Number of Instances of Noncompliance	Examples of Noncompliance
Billing	26	Provider billed for services that were not rendered or were not supported by time sheets. • For example, in a 4/28/04 survey, surveyors noted that the agency over-billed $3,584 and $1,008 for services.
Physician Delegation Forms	13	No evidence of physician delegation forms, although direct service provider administers medications.
Case Manager Monitoring of Provider	12	No documentation that case manager conducted quarterly monitoring of service provider.
DSS Survey	8	No evidence that DSS survey deficiencies were resolved.
Staffing	6	Staff working inappropriate hours, such as working over 16 hours per day. • For example, in a 6/2/04 survey, surveyors noted that the direct care staff was working 24-hour shifts on an ongoing basis.
Provider/client address	3	Service provider has the same address as the recipient and the recipient's brother.
Caseload	2	Caseload exceeds 35 clients.
Client financial issues or abuse and neglect policy	3	Service provider borrowed money from the client.

* We had to generate our own subjects since instances of noncompliance are not linked to policies or regulations and were written in a narrative format.

** These figures are approximate because we had no mechanism to ensure that all required letters were in the BCSS state office files and because Region 8 did not have letters in its files. In addition, if several providers at the same agency had an identical instance of noncompliance, we counted it as one instance. The actual numbers of instances are probably higher than those stated in this exhibit.

Source: Prepared by legislative auditor's staff using information obtained from review of deficiency and/or significant finding letters in BCSS state office.

While many of these instances of noncompliance are relatively minor and relate to documentation issues (i.e., paperwork compliance), others warrant concern. For example, we identified several instances of inaccurate or inconsistent documentation of time sheets, billing, and progress notes. These problems may indicate that providers did not always provide the services they said they provided.

Because of the vulnerability of many residents receiving home and community-based services, it is imperative for BCSS to be able to detect and track provider compliance. Because BCSS does not have a systematic means of tracking provider compliance, it cannot view deficiencies on a statewide basis or determine if providers have the same deficiencies from year to year. In addition, it cannot determine whether providers corrected deficiencies.

Recommendation 35: Because of the lack of data needed to effectively manage the waiver programs, DHH should immediately develop an integrated database. The database should have sufficient controls to ensure the data are complete and accurate and should include the following information:

- Deficiencies resulting from licensing, monitoring, and enrollment activities
- Results of investigations of complaints and critical incidents, including all relevant time frames (i.e., priority level, date investigated, date report due, etc.)
- Enforcement actions taken and sanctions assessed
- Information from home visits, pre-certification visits, and case management quarterly home visits
- Other data as deemed necessary by DHH

Summary of Management's Response: DHH agrees with this recommendation and will address the concerns as resources are made available (see Appendix B for management's full response).

Legislative Auditor's Additional Comments: Although DHH notes that resource constraints will limit its ability to develop an integrated database, DHH should use available computer resources (such as spreadsheets and/or databases with adequate controls) to immediately begin gathering and tracking data.

The BCSS state office has not provided sufficient guidance to regions on how to consistently cite instances of noncompliance. BCSS has little formal guidance for regions to use when citing the severity of noncompliance with waiver requirements (i.e., significant findings versus deficiencies). According to BCSS, the determination of whether to issue a significant finding or a deficiency is subjective. However, the difference between the two types of citations is important because significant findings do not require any action, whereas deficiencies require acceptable plans of correction. Therefore, it is essential that surveyors categorize instances of noncompliance appropriately to ensure that problems are corrected.

Our analysis found that the regions cited instances of noncompliance inconsistently. For instance, we found 25 instances where criminal background checks were cited by BCSS regional offices. However, one region cited the cases as deficiencies, while three cited them as significant findings. In addition, we found 26 instances of noncompliance related to billing. In these cases, similar billing errors (e.g., billing information did not match time sheets) were cited as significant findings by some regions and as deficiencies in other regions.

Recommendation 36: DHH should develop a mechanism to ensure that surveyors cite instances of noncompliance accurately and consistently across the state. The mechanism should include an enforcement grid that assesses scope and severity similar to the one that Health Standards uses for nursing facilities and ICFs/MR (see Exhibit 41 on page 83).

Summary of Management's Response: DHH agrees with this recommendation and notes that an integrated database will help assure that accuracy and consistency will occur (see Appendix B for management's full response).

Legislative Auditor's Additional Comments: An integrated database will help. However, DHH should also develop consistent policies and procedures and ensure that they are communicated adequately to the regions.

Because of the lack of centralized electronic data on provider deficiencies, we were unable to assess the effectiveness of BCSS' enforcement process. Some regions noted that little enforcement exists outside of requiring providers with deficiencies to submit plans of correction. However, because plans of correction are reviewed and approved at the regional level, we were unable to evaluate them. We were also unable to determine whether providers with repeat deficiencies received escalated enforcement actions. BCSS also cannot evaluate the effectiveness of its enforcement activities because it lacks the necessary data to do so.

Recommendation 37: DHH should include fields for enforcement data in the new database system discussed in Recommendation 35. As a part of its oversight of the regional offices, the BCSS state office should regularly review the enforcement data and use the data to assess the effectiveness of regional enforcement activities.

Summary of Management's Response: DHH agrees with this recommendation and states that an integrated database will be developed as resources are available (see Appendix B for management's full response).

BCSS does not have provisions to impose civil money penalties on all non-compliant waiver providers. While BCSS has some sanctions available in its rules, the provisions could be strengthened by including civil money penalties. The waiver service provider Standards for Participation say that failure to meet minimum standards shall result in a range of required corrective actions including, but not limited to, the following:

- Removal from the Freedom of Choice listing
- A citation for deficient practices
- A request for a corrective action plan
- Administrative sanctions

The Standards for Payment also say that continued failure to meet minimum standards (i.e., repeat deficiencies) shall result in loss of referral of new waiver recipients and/or continued enrollment as a waiver service provider. However, because of the lack of centralized enforcement data, we were unable to determine how often these corrective actions were applied.

Recommendation 38: DHH should add provisions to its rules that require civil money penalties by class of violation similar to the ones Health Standards uses for nursing facilities and ICFs/MR. DHH should develop a grid to ensure that sanctions are applied consistently across waiver providers.

Summary of Management's Response: DHH agrees with this recommendation but notes that it will require, among other things, legislative action (see Appendix B for management's full response).

BCSS does not electronically compile health, safety, or satisfaction information collected during home visits of waiver recipients. As noted earlier, either BCSS or case management agencies conduct home visits of all waiver providers each year. The purpose of the visits is to assess the safety, sanitation, and health of the recipients' home environment and to determine if appropriate service planning was conducted. BCSS also uses the visits to assess the quality of services in various domains, including environment and safety, recipient's health, supports and services, and customer satisfaction. BCSS regional staff and/or case managers complete paper forms during the visits. Copies of the forms are forwarded to the quality assurance committee at the BCSS state office. The committee compiles the data either biannually or quarterly to compute its quality performance indicators. However, because the committee must rely on paper forms, the review and compilation of the data is not as efficient as it could be. If the BCSS state office developed a way for regions to submit data electronically, information on quality could be easily compiled, reviewed, and used for decision-making purposes.

Recommendation 39: Once the database discussed in Recommendation 35 is developed, DHH should require the regional offices to submit home visit information to the BCSS state office electronically.

Summary of Management's Response: DHH agrees with this recommendation and states that various monitoring data will be included in the integrated database (see Appendix B for management's full response).

BCSS's quality assurance efforts are limited. BCSS has a Quality Assurance/Quality Enhancement Program that is responsible for assessing the effectiveness and efficiency of waiver services. The program has developed quality indicators that are based on domains specified in CMS' quality framework. However, the program uses paper forms to compile the indicators. Therefore, the ability to obtain and compile reliable quality indicators on waiver services has been limited. However, if DHH implements the other recommendations cited in this report, those problems should be alleviated.

Recommendation 40: After DHH has implemented the other recommendations cited in this report, the department should begin evaluating the quality of waivers on an ongoing basis using reliable quality indicators.

Summary of Management's Response: DHH agrees with this recommendation and states that an electronic database is needed to make this process more efficient (see Appendix B for management's full response).

Regulatory Processes for Ensuring Quality Need Improvement

BCSS and DSS both regulate waiver providers. BCSS annually licenses case management agencies and adult day health care facilities. In state fiscal year 2004, BCSS had a regional staff of 77 to conduct licensing visits of 37 ADHCs and 67 case management agencies. R.S. 46:2683 authorizes DSS to license other waiver providers each year, including personal care attendant providers, respite care providers, adult day care providers, and supervised independent living providers. According to DSS, in state fiscal year 2004, DSS had a staff of 23 that conducted 796 licensing visits and 3,040 renewal visits. In addition, according to DSS, it had a backlog of between one and 11 months in issuing and renewing licenses. As a result, some providers may have to wait for long periods of time prior to providing services. In addition, because licensing is done by two different agencies, inefficiencies and inconsistencies in the licensing function can result.

Matter for Legislative Consideration 5: The legislature should consider repealing R.S. 46:2683 to legally transfer the licensing authority for all waiver providers from DSS to DHH. In doing so, the legislature should ensure that DHH has sufficient resources to effectively carry out the licensing function for all providers within required time frames.

Licensing, enrollment, and monitoring processes lack coordination and standardization. Since BCSS monitors and enrolls the same waiver providers that DSS licenses, it may be more efficient for BCSS to conduct licensing, enrollment, and monitoring during the same visit. In addition, during the visits, the staff members generally review the same types of information, such as criminal background checks, personnel information (reference checks, annual evaluations), and specific policies (related to the reporting of abuse and neglect and critical incidents). Thus, duplication of effort occurs under the current system.

Developing a standardized form that combines all licensing, enrollment, and monitoring requirements and includes references to specific policies or rules would help surveyors cite deficiencies consistently and eliminate their reliance on narrative to explain the deficiencies. The surveyors could then group the deficiencies they cite into common categories that are aligned with specific regulatory provisions. Some providers we interviewed complained that BCSS employees survey providers inconsistently. For example, one provider who has offices in various locations around the state said that deficiencies in one region may not be considered deficiencies in another region. Using a standardized form with well-defined policy and rule references would help increase consistency among regions.

Recommendation 41: If DHH becomes the sole licensing agency for waiver providers, DHH should conduct licensing, enrollment, and monitoring visits at the same time, if possible, using a standardized instrument that contains all relevant standards.

Summary of Management's Response: DHH agrees with this recommendation and will consider merging surveys into one visit when possible (see Appendix B for management's full response).

Some DSS licensing regulations are outdated. According to DSS, most of the DSS regulations governing the licensing of waiver providers have not been updated since 1989. As a result, some of the provisions no longer apply to the types of services currently provided. For example, the supervised independent living (SIL) regulations were originally designed for individuals who need a minimum amount of supervision to live independently in the community. However, SIL under the NOW includes recipients who need 24-hour care. Approximately 19.3% of NOW recipients receiving SIL and other services require 24-hour care.[13] However, the current SIL regulations require providers to contact recipients only a minimum of three times per week. The regulations should be updated to better reflect the current types of services offered.

Recommendation 42: Whoever is deemed the sole licensing agent should update the rules and regulations DSS uses to govern waiver providers.

Summary of Management's Response: DHH agrees with this recommendation and notes that all licensing rules should be reviewed on an ongoing basis (see Appendix B for management's full response).

Rules and regulations for provider training requirements lack specificity. Currently, the rules, regulations, and licensing requirements governing waiver providers all require some amount of training. Annual training is important to help ensure that providers continue to develop the skills needed to provide quality services. However, not all of the rules, regulations, and licensing requirements specify the subject areas in which providers should be trained. In addition, the licensing standards (and Standards for Participation) do not provide important specifics such as who should conduct the training, how the training should be conducted (e.g., via video or face-to-face), or what evidence is appropriate to support that providers actually attended the training. Therefore, BCSS cannot be sure that providers actually obtained appropriate training. In our analysis of provider monitoring deficiencies, we found that providers had at least 70 deficiencies (10.5%) related to training.

One way to strengthen its oversight over the waiver programs is for BCSS to develop a training curriculum that includes an approved list of qualified trainers. DSS has developed a similar curriculum and a list of trainers for child care providers to use to meet their licensing standards. Requiring waiver providers to choose specific classes from qualified trainers would help ensure that providers actually receive appropriate training. It would also help ensure that training classes include subjects that are valuable and relevant to providers.

Recommendation 43: DHH should develop a training curriculum that includes subjects that are relevant and valuable to providers and a list of approved trainers. To help determine what subjects are needed, DHH should periodically assess deficiency data in the aggregate from licensing, enrollment, and monitoring visits, determine what problems exist on a

[13] This estimate was provided by Statistical Resources, Inc.

statewide level, and then develop a curriculum of approved training courses to address those problems.

Summary of Management's Response: DHH agrees with this recommendation and is in the process of implementing it through the Real Choice Systems Change Grant (see Appendix B for management's full response).

BCSS would benefit from electronic survey capabilities. Unlike Health Standards, BCSS regional office staff records findings resulting from licensing, monitoring, and enrollment visits on paper forms. The use of computerized technology would help BCSS become more efficient and enable the staff to track whether processes are working effectively. DSS has a computerized inspection program on laptop computers that is used by its surveyors. When the surveyors conduct licensing visits, they are able to quickly check off whether the providers have met the licensing standards by touching the computer screen. Once a survey is complete, the surveyor can print out a copy of the inspection report and leave it with the provider. The surveyor can also archive the inspection results into the DSS licensing database, which contains survey results for all providers. The use of the laptops improves efficiency because it decreases the time that surveyors spend writing on paper forms and automatically transfers licensing data to a central database.

Recommendation 44: DHH should acquire laptop computers that include a software program that tracks information on licensing, monitoring, and enrolling providers. The information should be entered into a database so that the results of BCSS' activities can be transferred to an integrated database system.

Summary of Management's Response: DHH agrees with this recommendation but says it needs additional state dollars to purchase laptops (see Appendix B for management's full response).

Critical incidents were not always resolved within the required time frame. BCSS policy requires that regions complete each critical incident investigation and issue a final report within 30 calendar days from the receipt of the initial report. However, of the 2,372 critical incident reports received in the second half of state fiscal year 2004, 1,600 (67.5%) were resolved as of November 23, 2004. Of the 1,600, 34.9% (559) were not resolved within 30 calendar days. Exhibit 45 on the following page summarizes this information by type of critical incident.

Exhibit 45
Critical Incidents Resolved in Over 30 Calendar Days
January 1, 2004, to June 30, 2004

Type of Critical Incident	Number Resolved	Number Resolved in Over 30 Days	Percent Resolved in Over 30 Days
Abuse	46	20	43.5%
Death	150	35	23.3%
Exploitation	14	6	42.9%
Extortion	3	1	33.3%
Illness	886	310	35.0%
Injury	148	47	31.8%
Missing	7	3	42.9%
Neglect	37	23	62.2%
Other	259	92	35.5%
Sensitive	50	22	44.0%
Total	**1,600**	**559**	**34.9%**

Source: Prepared by legislative auditor's staff using data obtained from BCSS critical incident log.

Of the 2,372 critical incident reports, we also identified 772 that were pending (i.e., not resolved) as of November 23, 2004. The average number of calendar days the reports had been pending ranged from 183 to 245. Exhibit 46 summarizes this information by type of critical incident.

Exhibit 46
Critical Incident Reports
January 1, 2004, to June 30, 2004
Pending as of November 23, 2004

Type of Critical Incident	Number Pending	Average Number of Days Not Resolved
Abuse	33	224
Death	21	227
Exploitation	8	211
Extortion	5	245
Illness	356	226
Injury	95	222
Missing	6	183
Neglect	28	231
Other	193	228
Sensitive	27	221
Total	**772**	**226**

Note: Critical incident data are as of November 23, 2004.
Source: Prepared by legislative auditor's office using data obtained from BCSS critical incident log.

Although the data we analyzed shows that the critical incidents in both exhibits were either not resolved timely or were pending, it is possible that some or all of the cases had been closed but the data had not been updated to reflect this fact. If this is the case, BCSS should develop a method to keep the data current.

Recommendation 45: DHH should develop an electronic system whereby regions can report the resolution of critical incident investigations to DHH in a timely manner.

Summary of Management's Response: DHH agrees with this recommendation and is currently implementing the Online Tracking Information System (OTIS) (see Appendix B for management's full response).

Complaint data are incomplete and unreliable. We attempted to analyze BCSS' investigation of complaints filed against waiver providers, but the data were incomplete and contained numerous inaccuracies. For example, 169 complaints were logged in the complaint log from July 1, 2003, through December 31, 2003. We noted the following problems with the information in the log:

- For 42 complaints, the log did not include the types of complaint.
- For 20 complaints, the log included no investigation report due dates.
- For 80 complaints, the log showed no evidence that investigation reports had been received.
- For 75 complaints, the log included no descriptions of the complaint resolution.

We also reviewed the complaint log from January 1, 2004, through June 30, 2004. While the fields in the log were more complete for this time period, important information was still missing. For example, 44 (34.1%) of 129 complaints on the log showed no evidence that they had been resolved.

In addition to the incompleteness of the data, the controls over the accuracy and reliability of the data are weak. We traced some complaints back to the physical files and found discrepancies. In addition, the complaint log is an Access database that relies entirely on manual entry without edit checks.

Recommendation 46: DHH should include a complaint tracking module in the integrated database system mentioned in Recommendation 35.

Summary of Management's Response: DHH agrees with this recommendation and is currently implementing the Online Tracking Information System (OTIS) (see Appendix B for management's full response).

The BCSS state office does not monitor the timeliness or appropriateness of the regions' investigations of complaints and critical incidents. As noted earlier, the BCSS state office refers complaints and critical incident reports to the appropriate regional offices. The regional managers are responsible for assigning investigation priorities, which dictate how soon the complaints and critical incidents must be investigated. Required investigation time frames range from 24 hours (if a recipient has suffered serious harm or injury) to 30 days (if a recipient is not at risk of physical or emotional harm). The information is not reported to the state office or input into the complaint or critical incident logs. As a result, the state office does not know whether the regions consistently assign complaints and critical incidents to the appropriate priority level or investigate them timely.

Recommendation 47: DHH should include a module in the integrated database system discussed in Recommendation 35 that allows the regions to report investigation priorities assigned to complaints and critical incidents and the time frames in which the investigations were completed. DHH should review this information periodically to ensure that the regions are in compliance with related requirements.

Summary of Management's Response: DHH agrees with this recommendation and is currently implementing the Online Tracking Information System (OTIS) (see Appendix B for management's full response).

The BCSS state office is not notified of the resolution of all abuse and neglect cases. BCSS refers critical incidents and complaints involving suspected abuse and neglect to at least three different offices for investigation and resolution. These offices and the populations they serve are as follows:

- Office of Community Services (within DSS): Children aged 0-17
- Bureau of Protective Services (within DHH): Adults aged 18-59
- Elderly Protective Services (within Governor's Office of Elderly Affairs): Adults over 60

The Bureau of Protective Services is the only office that reports the results of its investigations to the BCSS state office. In state fiscal year 2004, the Bureau of Protective Services investigated and substantiated 23 cases involving abuse, neglect, exploitation, or extortion. The other agencies did not formally notify the BCSS state office of the resolution of the cases referred to them. As a result, the state office does not know the resolution of those cases. BCSS has developed a formal Memorandum of Understanding (MOU) with the Bureau of Protective Services to investigate abuse and neglect cases, but an MOU has not been developed with the other agencies.

Recommendation 48: DHH should develop a formal MOU or other agreement with the Office of Community Services and Elderly Protective Services that requires that those agencies formally report the resolution of their investigations of complaints and critical incidents to DHH. DHH should include this information in the integrated database discussed in Recommendation 35 and review it periodically to identify trends and patterns.

Summary of Management's Response: DHH agrees with this recommendation and has developed a draft MOU with Elderly Protective Services (see Appendix B for management's full response).

Case management agencies did not always provide required services. The BCSS state office relies on case management to be its "eyes and ears" in the community. Case management agencies are required by the Standards for Participation and by their contracts to fulfill certain functions regarding all waiver recipients. However, according to data obtained from SRI, they did not always provide all required services from January 1, 2002, through December 31, 2004. The primary requirements not met are summarized in Exhibit 47.

Exhibit 47
Primary Case Management Service Requirements Not Met
January 1, 2002, Through December 31, 2004

Requirement	Number and Percent of Times Not Met
Quarterly Home Visits to Recipient	2,763 (2.1%)
Quarterly Monitoring of Service Provider	4,263 (3.3%)

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

Recommendation 49: DHH should determine why certain case management agencies did not provide required services and develop policies and procedures to correct those problems.

Summary of Management's Response: DHH agrees with this recommendation and intends to impose much stricter requirements on case management contractors in the future (see Appendix B for management's full response).

Quality information derived from case management home visits is not routinely reported to the BCSS state office. The purpose of the case management quarterly home visits is to ensure that recipients are receiving appropriate services and that personal outcomes outlined in their CPOCs are being achieved. However, the BCSS state office has not developed a standardized system that would enable case managers to electronically compile and report this information. In addition, while regional staff members review the information as part of their monitoring activities, the state office does not require the regions to report the information to the state office. Therefore, the state office cannot use the information to evaluate the effectiveness of services provided through waivers.

Recommendation 50: DHH should develop a system to gather and analyze information obtained from case management monitoring functions and use it to evaluate the quality of waiver services.

Summary of Management's Response: DHH agrees with this recommendation and will develop an integrated system as resources are available (see Appendix B for management's full response).

WHAT ADDITIONAL INITIATIVES CAN DHH USE TO HELP ENSURE THE QUALITY OF LONG-TERM CARE SERVICES?

We identified the following practices that DHH could use to help ensure quality in the state's Medicaid long-term care program:

- **Encouraging culture change in nursing facilities**
- **Disseminating quality and compliance information to the public**
- **Developing an abuse registry for ICFs/MR and waiver providers**
- **Measuring consumer satisfaction**
- **Ensuring attainment of personal outcomes for waiver recipients**
- **Partnering with nonprofit organizations to provide the Program of All-Inclusive Care for the Elderly (PACE)**

These practices are discussed in the following sections.

Culture Change in Nursing Facilities

Source: Photo of tailgate party courtesy of St. Clare Manor.

In an effort to improve the quality of care in nursing facilities, DHH and the Governor's Office of Elderly Affairs are sponsoring a culture change conference in March 2005 for all nursing facility providers. The conference will address various topics related to culture change implementation. According to DHH, culture change represents the shift from the traditional medical model to a model that focuses on resident centered care and has an overall goal of improving the quality of care and quality of life of residents. Following the conference, DHH plans to convene an advisory panel of stakeholders to discuss culture change implementation and to offer grants to facilities to assist with implementing culture change projects.

Recommendation 51: DHH should continue its efforts to encourage nursing facilities to participate in culture change activities.

Summary of Management's Response: DHH agrees with this recommendation and will continue to explore ways to improve the quality of life for residents in nursing facilities (see Appendix B for management's full response).

Dissemination of Quality and Compliance Information to the Public

Nursing Facilities

Federal and state laws include requirements related to dissemination of information to the public on nursing facility deficiencies and other quality information. For example, federal law provides nursing facility residents with the right to examine the most recent federal and state survey findings and any plans of correction. Federal law also requires facilities to post survey findings in a readily accessible place to residents. In addition, Louisiana has Act 295 of 2004, known as the "The Stella Act," which requires nursing facilities to provide a copy of the most recent survey findings to any applicant upon request.

In addition to survey information, the federal government publishes information on quality through the Nursing Home Compare section on the Medicare Web site. Although the information may be valuable to members of the general public, it may be difficult for the public to interpret the language and meaning of the data. For this reason, it would be beneficial for DHH to include compliance information on nursing facility providers on its Web site.

Recommendation 52: DHH should include compliance information on nursing facilities on its Web site. DHH should post the actual survey document used to survey the facilities and the results of the most recent surveys.

Summary of Management's Response: DHH agrees with this recommendation and states that it expects to go live with a database soon and that it is pursuing the purchase of an electronic system for scanning and posting information to its Web site (see Appendix B for management's full response).

ICFs/MR

As previously discussed, DHH has federal and state survey procedures for ICFs/MR that are similar to those for nursing facilities. However, no federal or state laws and/or policies require that compliance information be made available to the public or posted in the facilities. As a result, the public has limited information on which to base decisions about the facilities.

Recommendation 53: DHH should develop and promulgate rules and/or develop policies that require the most recent survey findings for ICFs/MR to be posted on its Web site.

Summary of Management's Response: DHH agrees with this recommendation and states that the compliance Web site that Health Standards has been working on will include ICFs/MR (see Appendix B for management's full response).

Waivers

BCSS provides a copy of the Freedom of Choice list, which lists all approved waiver providers, to all individuals who receive waivers. The individuals are required to choose providers from the list. If the list were linked with compliance and other quality information, the individuals could make more informed choices. However, BCSS does not maintain compliance data on providers, thus no such linkage can exist.

Recommendation 54: Once DHH compiles data on provider compliance, it should link the information with the Freedom of Choice list.

Summary of Management's Response: DHH agrees with this recommendation but states that additional resources are needed (see Appendix B for management's full response).

Abuse Registry for ICFs/MR and Waiver Providers

Health Standards has a nurse aide registry that contains substantiated complaints and findings regarding nurse aides who work in nursing facilities. Nursing facilities are required to check the registry during the hiring process. However, DHH does not have an abuse registry for ICFs/MR or waiver providers. Ohio has established an on-line abuse registry that includes waiver providers that have substantiated charges of abuse against them. Employers are prohibited from hiring any person on the abuse registry and must document that they reviewed the registry prior to hiring staff. Having a registry for all long-term care providers would help prevent facilities from hiring individuals who have a history of committing abuse.

Matter for Legislative Consideration 6: The legislature should consider requiring DHH to develop an on-line abuse registry of ICF/MR and waiver providers.

Measurement of Consumer Satisfaction

Measuring consumer satisfaction is an important part of quality assurance because it enables long-term care agencies to evaluate the strengths and weaknesses of the services they provide or oversee. Currently, DHH gathers only limited consumer satisfaction data. For example, as part of the monitoring process, BCSS measures satisfaction through a series of questions asked during home visits. However, the home visits only constitute approximately 5% of waiver recipients. A better source for satisfaction information may be case management agencies. Case managers are required to conduct annual satisfaction surveys of all clients and submit the results to the BCSS state office. However, although the surveys may be a better source of client satisfaction information, the fact that they are not standardized makes it difficult

to consistently evaluate satisfaction information statewide. Requiring case management agencies to report the survey results in a standardized electronic format would enable BCSS to easily compile and evaluate the data. Collecting and analyzing consumer satisfaction information on nursing facilities and ICFs/MR would also be beneficial.

Recommendation 55: DHH should develop a system to periodically measure consumer satisfaction in all long-term care settings. The information should be compiled electronically and used for management decisions and system evaluation.

Summary of Management's Response: DHH agrees with this recommendation and states that the various long-term care settings have consumer satisfaction elements. However, coordination and resources are needed for implementation of the recommendation (see Appendix B for management's full response).

Attainment of Personal Outcomes for Waiver Recipients

Personal outcome information is included on the CPOC of each waiver recipient. Personal outcomes are individually defined goals that recipients would like to accomplish. Case management agencies are required to make quarterly home visits to waiver recipients to measure recipients' progress toward achieving the goals. The information gathered on the visits is important because it measures the success of waiver services in meeting client needs. However, the information is not kept electronically or reported to the BCSS state office.

Recommendation 56: DHH should develop an electronic system that measures whether waiver recipients have met their personal outcomes.

Summary of Management's Response: DHH agrees with this recommendation and notes that the information will be included in the integrated database (see Appendix B for management's full response).

Partnering With Nonprofit Organizations to Provide the Program of All-Inclusive Care for the Elderly (PACE)

The emphasis of the PACE program is on enabling older individuals to remain in their communities and enhance quality of life. To accomplish these objectives, PACE programs coordinate and provide the preventative, primary, acute, and long-term care services participants need. PACE programs are required to provide all Medicare and Medicaid services, including physician, hospital care, and nursing home services. Basic services like adult day health care services, physical and occupational therapies, and primary medical care are generally provided onsite at the PACE center. Other services the PACE program provides include transportation, recreational therapy, nutritional counseling, and any other services deemed necessary to improve and maintain the participant's overall health status. PACE providers are not-for-profit organizations that bear financial risk for all medical and support services required for enrollees.

PACE is different from any other Medicaid service in that each PACE provider must submit a provider application to CMS. Once the application is approved, a three-way program agreement is executed among the state administering agency (e.g., DHH), CMS, and the PACE provider. Currently, 32 PACE programs operate in 21 states. DHH is developing regulations and procedures for the operation of PACE programs in Louisiana. PACE Greater New Orleans, sponsored by Catholic Charities of New Orleans, is expected to be operational in early 2005.

Recommendation 57: DHH should expand its efforts to partner with nonprofit agencies to provide PACE programs throughout the state.

Summary of Management's Response: DHH partially agrees with this recommendation and states that further expansion and implementation of PACE will be made on the 'lessons learned' in the pilot project (see Appendix B for management's full response).

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APPENDIX A: SCOPE AND METHODOLOGY

We conducted this performance audit under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. All performance audits are conducted in accordance with generally accepted governmental auditing standards as promulgated by the Comptroller General of the United States.

Scope

Louisiana Revised Statute (R.S.) 24:513(D)(4) directs the Office of Legislative Auditor to conduct performance audits, program evaluations, and other studies to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operations of state programs and activities. At its July 30, 2003, meeting, the Legislative Audit Advisory Council approved an audit of the Department of Health and Hospitals as part of our plan for fiscal year 2005. The audit focused on Medicaid-funded long-term care for the elderly and individuals with disabilities. Personal care services are also considered long-term care services. However, we did not include them in the scope of the audit because DHH has not fully implemented this program. We obtained and analyzed data from calendar and/or state fiscal years 2003 and 2004 when possible. In some cases, we obtained data since state fiscal year 2000 to establish trends and patterns.

Methodology

To identify major issues related to long-term care, we interviewed over 230 individuals, including service recipients, provider organizations, advocacy and citizen groups, DHH and other state agency staff, and various other stakeholders. We also reviewed various articles and reports, including reports from CMS on promising practices, audit reports from other states, and reports from national organizations. We also attended two meetings of the Governor's Health Care Reform Panel and one meeting of a regional consortium.

ACCESS TO LONG-TERM CARE SERVICES

For the areas in which DHH could improve access to long-term care, we completed the following tasks.

Area 1: Reducing Fragmentation

To determine how DHH is addressing fragmentation and developing a single point of entry, we interviewed DHH staff, staff from the Governor's Office of Elderly Affairs, service providers, service recipients, and various other stakeholders. In addition, we reviewed relevant revised statutes and policy manuals, and listened to testimony on this subject from national experts. We obtained and reviewed DHH's report to the Governor's Health Care Reform Panel, which was published in September 2004; CMS information; promising and/or best practices;

information on the Aging and Disabilities Resource Center grant; and information from DHH's contract with ACS and reviewed other relevant literature on the subject.

Area 2: Improving Admissions Review and Assessment

Admissions Review

To obtain information on admission requirements for nursing facilities, we interviewed DHH Health Standards staff and reviewed applicable statutes, rules, regulations, and policies and procedures. We also obtained the definition of nursing facility level of care from Arkansas Texas, Oklahoma, and New Mexico and compared it to Louisiana's definition. Because Louisiana lacks a specific definition for nursing facility level of care, we obtained self-reported Minimum Data Set (MDS) data from the CMS Web site as of June 30, 2004, and analyzed the data to determine how Louisiana nursing home residents compared to the national average in the performance of various activities of daily living (ADLs).

> **Note:** We did not validate MDS data. In an October 2002 report, GAO noted some concerns about the accuracy and reliability of MDS data. However, since that time, CMS has developed initiatives to address data inaccuracy. Also, the data are used extensively for research purposes and in some states (including Louisiana) to establish acuity for case mix reimbursement systems.

Assessment

To obtain information on the assessment process for nursing facilities, ICFs/MR, and waivers, we interviewed DHH staff and other stakeholders. We also reviewed relevant federal and state laws, rules and regulations, policies and procedures, and other documents containing information on the processes. To determine if individuals were served in the most cost-effective settings, we did the following:

- **For private ICFs/MR,** we obtained ICAP (Inventory for Client Agency and Planning Data) as of October 18, 2004, and analyzed ICAP assessment scores and resident ages to determine how many individuals needed limited and intermittent supports. We then applied the average annual direct cost of a private ICF/MR and of the NOW and CC waivers for state fiscal year 2004 to determine what the cost difference would be if these individuals were served in the NOW and CC waivers instead of in private ICFs/MR.

- **For state and private nursing facilities,** we obtained final reports from DHH of analyses conducted by Dr. Brant Fries of the University of Michigan in Ann Arbor. We then applied the average annual direct cost of residents in private and state nursing facilities and in the EDA waiver for state fiscal year 2004 to the percentage of individuals identified by Dr. Fries in the "A Category Reduced Physical Functions" group and determined what the cost difference would be if this percentage of individuals were served in the EDA waiver instead of in state and private nursing facilities. We also obtained DHH's estimate of an

approximate Medicaid reimbursement rate for assisted living (i.e., $33.00 to $36.00 per person per day) and used the average of these two numbers ($34.50) to calculate the cost difference in certain individuals in nursing facilities moved to Medicaid assisted living settings.

- **For state ICFs/MR (developmental centers),** we were unable to obtain assessment data. Therefore, we determined the cost difference if all individuals in the developmental centers as of June 30, 2004, moved to private ICFs/MR. We also estimated the cost difference if 25% of the residents moved to the NOW waiver. For both calculations, we used the average annual direct cost for state fiscal year 2004 of a state developmental center, a private ICF/MR, and the NOW waiver.

Area 3: Addressing Inequitable Funding

For **waivers,** we obtained information from DHH on the number of funded slots and the number of individuals waiting for waiver services for the last five state fiscal years. We compared the number of funded slots to the number of individuals waiting for services and calculated how long individuals on the waiver registries (waiting lists) as of June 9, 2004, had been waiting for services. We also obtained data on the number of individuals on the registries who reside in nursing facilities and ICFs/MR from Statistical Resources, Inc., to show how many individuals in institutions want waivers. Finally, we researched best and/or promising practices and obtained information from other states to compare to Louisiana.

For **institutions**, we obtained occupancy rates for private nursing facilities and ICFs/MR for the last five state fiscal years from DHH's LTC-2 and MR-2 reports. Because state nursing facilities and ICFs/MR (developmental centers) include only staffed beds in their occupancy rates, we obtained census data from DHH for the last five state fiscal years. We obtained expenditures from DHH and rates from rate letters or from staff in DHH's Rate and Audit Division and analyzed the data across years.

Area 4: Improving Allocation of Waiver Slots

We interviewed BCSS staff and obtained stakeholder input regarding the BCSS Request for Services Registries and reviewed policies and procedures related to waiver slot allocation. We also validated a random sample of waiver registry entries as of July 12, 2004, to determine if they were accurate and found that the registry was sufficiently accurate for the purposes of our audit. Finally, we determined how other states allocate waiver slots and compared their methods to DHH's.

Area 5: Modifying or Eliminating Facility Need Review

We reviewed applicable federal laws, state laws, state rules published in the *Louisiana Register*, and other information regarding the Facility Need Review Program. We also interviewed various DHH staff, a nursing facility administrator, and other stakeholders about the Facility Need Review Program. We reviewed the February 2004 *National Directory of Health Planning, Policy, and Regulatory Agencies* and the Federal Trade Commission's and U.S.

Department of Justice's July 2004 report "Improving Health Care: A Dose of Competition." We also reviewed the alternate use provision of the Facility Need Review Rule and obtained and analyzed the LTC-1 report from DHH to determine the number of nursing facility beds currently in alternate use. We corresponded with DHH to determine the types of alternate use that facilities with beds in alternate use have.

MAJOR COSTS OF LONG-TERM CARE SERVICES

Major Costs and Reimbursement Methodologies of Nursing Facilities and ICFs/MR

In conjunction with DHH, we identified major cost categories reported in facilities' cost reports that appeared to have the greatest potential impact on the quality of long-term care services.

- To identify the major costs of **state nursing facilities**, we obtained and reviewed state fiscal year 2003 cost reports for the Villa Feliciana Medical Complex and the New Orleans Home and Rehabilitation Center from DHH. We calculated total and average major costs for these selected cost categories, as well as average major costs per resident day for all major cost categories. We obtained feedback on our methodology and report exhibits from the contractor who prepares the cost reports for these facilities (PCG) and DHH staff.

- To identify the major costs of **private nursing facilities**, we obtained and reviewed cost data used in the July 2004 rate rebase from Myers and Stauffer, LC. We calculated total and average major costs, as well as average major costs per resident day for all major cost categories. We obtained feedback on our methodology and report exhibits from Myers and Stauffer, LC and DHH staff.

- To identify the major costs of **state ICFs/MR (developmental centers)**, we obtained and reviewed state fiscal year 2002 cost reports for the nine developmental centers from DHH. We calculated total and average major costs, as well as average costs per resident day for all major cost categories. We obtained feedback on our methodology and report exhibits from DHH staff.

- To identify the major costs of **private ICFs/MR**, we obtained and reviewed the state fiscal year 2002 cost report database from DHH. We calculated total and average major costs, as well as average major costs per resident day for all major cost categories. We obtained feedback on our methodology and report exhibits from the audit contractor (Postlethwaite and Netterville) and DHH staff.

In addition, we documented the reimbursement methodologies for each type of facility using rules published in the *Louisiana Register*. Because the private nursing facility methodology appeared to contain certain overly generous provisions, we conducted the following additional work:

- Requested that Myers and Stauffer compile information from other states with case mix reimbursement systems
- Compared the information to Louisiana
- Requested that Myers and Stauffer calculate the potential cost savings if DHH adopted certain provisions similar to other states
- Reviewed Myers and Stauffers' work for reasonableness and accuracy

Accuracy of Costs of Nursing Facilities and ICFs/MR

To determine how DHH ensures that nursing facility and ICF/MR costs are accurate, we reviewed the Standards for Payment for Nursing Facilities and ICFs/MR and other relevant policies and procedures. We also accompanied DHH's audit contractor, Postlethwaite and Netterville, on a full scope audit of a nursing facility and interviewed staff from DHH's Rate and Audit Division as well as from Postlethwaite and Netterville. For state fiscal years 2001 and 2002, we analyzed DHH's database of facility cost report information to determine how many disclaimers the Postlethwaite and Netterville auditors issued and how much of the costs reported by facilities the auditors disallowed. Finally, we compared DHH's audit sample for the same time periods to its selection criteria to determine if DHH had Postlethwaite and Netterville audit all required facilities. We also determined whether facilities with disallowed costs and disclaimers were issued sanctions outlined in the Standards for Payment.

Major Costs of Home and Community Based Waivers

To identify the major costs of home and community based waivers, we obtained expenditure information for state fiscal years 2000 through 2005 from DHH. Because of the high cost of the NOW waiver, we conducted additional analysis on the NOW waiver as follows:

- Obtained budget information from SRI on NOW waiver recipients that had annual Comprehensive Plans of Care in state fiscal year 2004
- Analyzed the data to determine how many additional individuals could have been served if the NOW waiver had been capped at the average annual direct cost of private ICF/MR care in fiscal year 2004
- Reviewed information from other states to determine how they contain waiver costs

Accuracy of Costs of Home and Community Based Waivers

To determine how DHH ensures the accuracy of waiver costs, we interviewed DHH's contractor (SRI) and reviewed and analyzed relevant reports. We also obtained and reviewed information on disallowances and disclaimers for adult day health care centers from DHH's Rate and Audit Division.

QUALITY OF LONG-TERM CARE SERVICES

NURSING FACILITIES AND ICFS/MR

Identification of regulatory processes DHH uses to ensure the quality of institutional long-term care services. To gain an understanding of the regulatory processes DHH uses to ensure the quality of long-term care services, we reviewed applicable federal and state laws, DHH policies and procedures, the CMS Web site, and the DHH Web site. We toured six private nursing facilities, one state nursing facility, three state ICFs/MR (developmental centers), one large private ICF/MR, and one small private ICF/MR. We made observations and interviewed staff and residents at each facility. We also accompanied Health Standards personnel on licensing and certification surveys of three of the private nursing facilities and one of the private ICFs/MR. In addition, we interviewed DHH personnel, representatives of the LNHA and CARSA, the LTC Ombudsman, and parents of children living in a large ICF/MR.

Sample Selection. To evaluate DHH's implementation of regulatory processes, we chose a judgmental sample of 43 nursing facilities and 57 ICFs/MR based on the number of deficiencies facilities received during their calendar year 2003 standard surveys. Because nursing facilities received an average of 7.82 deficiencies per standard survey, we chose facilities with more than 12 deficiencies for our sample. Because ICFs/MR received an average of 2.81 deficiencies per standard survey, we chose facilities with more than six deficiencies for our sample. For each item in our samples, we obtained deficiency information from CMS' PDQ database. We tested the reliability of the database by checking the calendar year 2003 survey data in DHH's files against the information in the database. We found that the information in the files was accurately presented in the database.

State licensing process of nursing facilities and ICFs/MR. We did not conduct detailed audit work on the state licensing process, as it does not focus on quality of long-term care issues. Instead, we reviewed applicable state laws and regulations pertaining to the licensing of nursing facilities and ICFs/MR and compared the state minimum staffing requirement for nursing facilities to CMS' recommended staffing levels.

Federal Certification of Nursing Facilities and ICFs/MR. Using information in the PDQ database, we determined the number of standard surveys DHH conducted for nursing facilities and ICFs/MR during calendar year 2003 and the number of federal deficiencies DHH cited. We also determined the number and types of deficiencies cited for the facilities in our samples. We reviewed CMS' monitoring reports (i.e., FOSS surveys) to determine DHH's effectiveness in surveying nursing facilities. We could not do the same for ICFs/MR, however, as CMS does not conduct FOSS surveys of those facilities. Finally, we analyzed calendar years 2002 and 2003 standard survey dates of the nursing facilities and ICFs/MR in our sample to determine if the timing of the surveys was predictable. We then compared the timing results of the nursing facility surveys with the findings of a 1998 performance audit report of DHH to determine if DHH had improved with regard to making the survey visits less predictable.

Complaint Process. Using information in the PDQ database, we determined the number of complaint surveys DHH conducted for nursing facilities and ICFs/MR during calendar year

2003 and the number of complaint deficiencies DHH cited overall. For the facilities in our samples, we determined the number of complaint deficiencies and categorized the related deficiencies according to type. Finally, we analyzed the nursing facility complaints logs for August 2004 through October 2004 to determine how long it took Health Standards to assign investigation priorities to complaints after receiving complaint reports. We did not conduct detailed audit work on the amount of time it took surveyors to conduct complaint investigations once complaint investigations were assigned because a 1998 performance audit found that most complaints were investigated within established timeframes.

IDR Process. We reviewed the calendar year 2003 and 2004 IDR logs for nursing facilities and ICFs/MR to determine the number of deficiencies and sanctions nursing facility and ICF/MR providers disputed as a result of calendar year 2003 standard and complaint surveys. We then conducted a file review to categorize the information according to the reasons why federal deficiencies were deleted or modified and why sanctions were rescinded.

Abuse and Neglect Reporting Process. To determine if any registered sex offenders reside in Louisiana nursing facilities or ICFs/MR, we entered the addresses of all nursing facilities and ICFs/MR into the Louisiana State Police Sex Offender and Child Predator Registry and determined the number of hits that resulted.

Enforcement and Sanctions. We obtained the calendar year 2003 sanction logs for nursing facilities and ICFs/MR and determined the total amount of civil money penalties DHH assessed against the facilities. We compared the state civil money penalties to the federal civil money penalties with regards to amounts and caps. We then conducted a file review of the nursing facilities and ICFs/MR in our samples to determine if DHH consistently imposed state civil money penalties for repeat deficiencies during 2003 calendar year standard surveys. Finally, we obtained the balances of the Nursing Home Residents' Trust Fund and the Health Care Facility fund as of June 30, 2004, from the Comprehensive Annual Financial Report and ISIS, respectively, and determined how these funds could be used.

HOME AND COMMUNITY-BASED WAIVERS

Identification of regulatory processes DHH and DSS uses to ensure the quality of waiver long-term care services. To gain an understanding of the regulatory processes DHH uses to ensure the quality of long-term care services, we interviewed relevant BCSS state office and regional staff and reviewed pertinent federal and state laws, rules, and regulations, as well as BCSS policies and procedures. We accompanied three BCSS regional offices on five licensing, enrollment, and monitoring visits and interviewed various waiver providers and recipients. In addition, we interviewed DSS licensing staff and accompanied DSS surveyors on two licensing visits.

Analysis of BCSS monitoring and enforcement data. We requested data on deficiencies of waiver processes from the BCSS state office. However, we were only able to obtain a limited amount of data because most the data we needed was kept at the regional offices. For instance, we were able to obtain letters of significant findings and deficiencies/citations associated with monitoring activities from January 1, 2004, to June 30, 2004, for all regions

except Region 8. Since the information was paper-based, we had to manually enter information from these letters into a Microsoft Excel spreadsheet to perform our analysis. After our data entry was complete, we developed a system to categorize the data since BCSS does not capture monitoring data electronically. After categorizing the monitoring data, we obtained clarification from BCSS on the differences between deficiencies/citations and significant findings and reviewed our analysis for consistency across regions. We were unable to review BCSS' enforcement data because enforcement data (such as provider plans of correction) are housed at the regional offices. However, we did review applicable rules, regulations, and policies associated with enforcement actions to determine the extent of enforcement activity available for DHH to use.

Quality assurance/quality enhancement (QA/QE) program. We reviewed the process used to obtain QA/QE data, specifically noting that the data (e.g., health, safety, and satisfaction information obtained during home visits) is not electronically compiled.

Regulation of waiver providers. To evaluate how waiver providers are regulated, we reviewed staffing data, laws, and regulations (particularly regarding training requirements). We reviewed the methodology and forms used by DHH and DSS to regulate waiver providers. We also interviewed DHH officials, DSS officials, and waiver providers to obtain additional information.

Complaints and critical incidents. To determine how complaints and critical incidents regarding waiver services are managed, we obtained relevant data from BCSS and attempted to validate a sample of data. Although we were able to validate the critical incidents data, we were unable to validate our sample of complaints data. Based on results of our data validation, we then analyzed the critical incident data. We also reviewed BCSS' policies on complaints and critical incidents (including referral of complaints and critical incidents to other offices) and interviewed BCSS staff.

Case management agencies. To evaluate BCSS' oversight of services provided by case management agencies, we interviewed BCSS staff, reviewed the Request for Proposals (RFP) issued by DHH for case management services, reviewed BCSS' Case Management Manual and Standards of Participation for Case Management Services, and interviewed personnel at two case management agencies. We also obtained data from SRI on the extent to which case management agencies fulfilled specific requirements. Finally, we determined whether waiver quality information gathered by case management agencies were reported to, and reviewed by, the BCSS state office.

Additional initiatives. To determine if there were any additional initiatives that DHH could use to improve the quality of long-term care services in Louisiana, we reviewed best and/or promising practice information and other information gathered throughout the audit on culture change in nursing facilities, dissemination of quality and compliance information to the public, development of abuse registries for ICF/MR and waiver providers, measurement of consumer satisfaction, attainment of personal outcomes for waiver recipients, and partnering with nonprofit organizations (e.g., the PACE program).

Management's Response

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

March 2, 2005

Mr. Steve J. Theriot, CPA
Legislative Auditor
Office of Legislative Auditor
P. O. Box 94397
Baton Rouge, LA 70804-9397

Dear Mr. Theriot:

This letter is to provide the Department of Health and Hospitals' (DHH) response to your audit regarding long term care services provided by DHH. From discussions with your staff, we decided that the best format to respond to the audit's recommendations was in the form of a chart. Please find the attached chart that sets forth the audit's recommendations and DHH's position, whether we agree, partially agree, disagree and any comments we may have regarding the recommendations.

Please advise if you have any questions about this response. Thank you for your consideration.

Very Truly Yours,

Charles F. Castille
Undersecretary

cc: Frederick P. Cerise, M.D., M.P.H.
Raymond Jetson
Ben Bearden

RECOMMENDATION CHECKLIST

RECOMMENDATION	AGREE	PARTIALLY AGREE	DISAGREE	RESPONSE
ACCESS				
Recommendation 1: DHH should continue working toward single points of entry for the elderly and individuals with physical disabilities. The single point of entry system should truly be a 'one stop shop' that allows individuals to contact local offices to obtain information and/or referrals, undergo assessments and eligibility determination, and apply for appropriate services. DHH should require that all individuals needing long-term care use the local single points of entry before accessing services.	X			Effective 7/1/04, DHH implemented a single point of entry (SPOE) that has as an end-goal of becoming a 'one stop' regionally-based entry point for individuals with physical disabilities and the elderly requesting Long Term Care (LTC).
Recommendation 2: DHH should ensure that individuals can access long-term care services timely through its single point of entry system. One possibility may be to implement a Fast Track system similar to Colorado's.	X			Plans are under development for the LTC SPOE to include "Fast Track" access, modeled after the Colorado plan.
Recommendation 3: DHH should develop a specific, measurable assessment-based definition of nursing facility level of care.	X			Although there are currently definitions of what the specific levels are, these definitions definitely should be improved by basing it on a measurable assessment tool, which DHH is in the process of doing.
Recommendation 4: DHH should develop a standardized assessment process that is conducted for each applicant before entry into the long-term care system. Ideally, the assessment should be conducted at the designated single point of entry and should include cost and individual choice as factors in determining where individuals will be placed and what services they will receive.	X			DHH is currently developing an assessment process which would implement this recommendation.
Recommendation 5: DHH should develop a similar assessment process and entry point for the MR/DD population.	X			DHH is in the process of implementing inventory of Client and Agency Planning (ICAP) for assessing the acuity level of people in ICF/MR facilities, which

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				will assist in identifying the needs of persons with mental retardation and/or developmental disabilities. Additionally, this recommendation is part of our MR/DD law rewrite and long term care immediate action plan.
Recommendation 6: DHH should work with legislative staff to develop a funding plan for a full array of long-term care services. The plan should include closing one or both state nursing facilities and should also consider options for closing or downsizing more state developmental centers.		X		The Governor's Health Care Summit may assist in developing a funding plan for long term care services. DHH is proposing closure of one state nursing facility, and Developmental Centers are currently attempting to meet downsizing goals. These goals are difficult to attain without options for people who have challenging behaviors or are court committed.
Recommendation 7: DHH should determine whether individuals listed on all registries, not just the NOW registry, can go on 'inactive' status when waiver slots are offered and the individuals do not currently want waiver services.		X		DHH is moving toward implementation of a needs based access system through the SPOE for individuals who are disabled and the elderly. This will address the current need for "inactive' status. Currently, those on register for the EDA and ADHC waivers are re-evaluated for need via an annual validation process.
Recommendation 8: DHH should use multiple means of contacting requestors for waiver services when offering waiver slots and validating registry information. For instance, DHH should follow-up after its offer letters with personal phone calls. DHH should also use OCDD regional office staff to assist when DHH does not receive responses from individuals since regional staff are often in contact with many of those individuals.	X			DHH currently uses multiple means of contact and with implementation of the proposed regionally-based SPOE in recommendation number 1 above, this process will be enhanced.
Recommendation 9: If the legislature does not repeal or modify the Facility Need Review law, DHH should modify the rule to enable the department to legally revoke the approval of certain percentage of empty beds that were	X			Revoking previously approved beds will require legislative authorization. Recommendation however is reasonable given the current low level of occupancy.

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previously approved under the Facility Need Review Program and allocate them on an as-needed basis using a combination of the following criteria: • Quality performance indicators published by CMS • Survey deficiencies • Existence of waiting lists • Consumer choice • Others as deemed appropriate by the department.				
Recommendation 10: DHH should revise the Facility Need Review Rule to specify acceptable types of alternate use.	X			We are in the process of amending our rules to clarify that alternate use must be for a medical purpose.
Recommendation 11: DHH should monitor the types of alternate use into which nursing facilities beds are place to ensure compliance with the amended rule.	X			Once our rules are revised to make clear that alternate use must be for medical purposes, we will monitor for compliance.
COST				
Recommendation 12: DHH should periodically review all cost report data in the aggregate and assess whether certain costs are unreasonable and then use the information to help guide management and policy decisions.		X		The current audit process, designed to assure that providers adhere to Medicare cost reporting principles, sufficiently addresses the determination of unreasonable costs on a facility by facility basis. The only way to assure complete reasonableness on an aggregate basis is through annual audits of all cost reports or to put in place sanctions which are strong enough to deter abuse. We will explore the feasibility both financially and staff resources.
Recommendation 13: DHH should amend the rule governing private nursing facility Medicaid reimbursement rate calculations to include only Medicaid residents in the acuity (case mix) calculations.	X			This is a Health Care Reform recommendation which if approved by the governor will be implemented under our Long Term Care (LTC) plan.
Recommendation 14: DHH should further amend the rule to eliminate the minimum floor of 9.25% and instead use the actual treasury	X			T-bond rate plus a risk factor of 2.5% should result in a sufficient return on capital investment.

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bond rate plus a risk factor of 2.5% as the rental factor.				
Recommendation 15: DHH should also amend the rule to increase the minimum occupancy rate used in the calculations from 70% to 90%.	X			We recognize that case mix payment methodology currently using 70% occupancy rate results in providers being reimbursed for empty beds, at a time when demand for nursing home services are declining. This is also a Health Care Reform Panel recommendation for our LTC plan.
Recommendation 16: DHH should amend the Standards for Payment for ICFs/MR and Nursing Facilities to include mandatory sanctions for facilities that report unallowable costs in excess of 10% of total reported costs or receive disclaimers. The sanctions should be applied consistently to both types of facilities. DHH should also ensure that all documents referring to the Standards for Payment (e.g., provider agreements) contain the same sanction language. DHH should ensure compliance with the new sanction provisions.		X		DHH will also consider sanctions for such things as repeated inclusion of unallowable costs less than 10% of total reported costs and failure to provide plan of corrections related to audit findings.
Recommendation 17: DHH should develop a database that includes a history of all audit findings and disallowed costs and use the database to help identify providers with repeat audit findings and other cost report errors.		X		DHH currently has a database for storing and retrieving disallowed costs. With additional resources, we will develop an integrated database for tracking all audit findings and provider billing practices with sanctions to non-compliant providers.
Recommendation 18: DHH should require its audit contractor to audit all private nursing facilities either each year or in all rebase years. DHH should also review ICF/MR data periodically to determine at what point (if any) it would become cost-beneficial to audit all ICF(s)/MR every year.		X		DHH is obtaining cost estimates of requiring 100% annual audits or 100% audit in rebase years.
Recommendation 19: DHH should determine if it would be cost-beneficial to verify MDS data at all nursing facilities each year. If it is, DHH should verify MDS data at all nursing facilities		X		Through the first four weeks of the verification process only 4 of 30 facilities (13%) have exceeded the unsupported threshold. This trend and the fact that the penalties are assessed on a maximum of 40%

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every year.				of residents for a single quarter of the year indicates that verification of MDS data at all nursing homes would not be economically justified.
Recommendation 20: DHH should determine if the Elderly Trust Fund could be used to pay for the MDS verification conducted by M&S since the Elderly Trust Fund was established for case mix purposes. If allowable, DHH should use these funds to pay for its contract.	X			We may need approval from the legislature and the Centers for Medicare and Medicaid Services (CMS) to implement this recommendation**.**
Recommendation 21: If DHH does not require its auditor to audit all facilities every year or in every rebase year, it should use the 10% disallowance criteria for nursing facilities as well as ICFs/MR. In addition, DHH should designate this criterion as a higher risk than some of the other criteria.		X		DHH will consider the value of applying the 10% disallowance criterion in this instance. This criterion may or may not produce desired outcomes as there is not a direct correlation between disallowance and performance.
Recommendation 22: DHH should explore ways to contain the cost of the NOW waiver and then implement appropriate cost controls. As part of its efforts, DHH should evaluate the merits and impact of other states' cost containment strategies.	X			This recommendation is part of our Long Term Care Immediate Action Plan.
Recommendation 23: DHH should develop a database that includes all payments recouped from providers for whom billing errors were detected through monitoring visits. DHH should use the database to target problem providers in subsequent monitoring visits.	X			DHH will develop an integrated database for tracking provider billing practices as resources are available.
Recommendation 24: DHH should amend the Standards for Participation for ADHCs to include mandatory sanctions for facilities that report unallowable costs in excess of 10% of total reported costs or receive disclaimers. DHH should initiate procedures to ensure compliance with the new sanction provisions.	X			DHH will consider the best, most timely method for implementing this recommendation and include in the integrated database noted in Recommendation number 23 above.
QUALITY				

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Recommendation 25: DHH should increase the minimum staffing requirement for nursing facilities from 1.5 HPRD to at least 3.0 HPRD based on CMS' recommended preferred minimum level to avoid harm. In addition, DHH should mandate that the minimum staffing requirement only include direct care personnel and specify how the staffing hours should be broken down between nurses and nurse aides.	X			We have been working on revisions to standards for payment and had decided to increase minimum to 2.5 when we promulgated rule changes. However, the 3.0 does seem to be more preferable.
Recommendation 26: DHH should continue the processes and procedures that resulted in the high FOSS ratings from CMS and make amendments as called for in the future.	X			We will continue these processes and procedures.
Recommendation 27: DHH should continue to vary the dates of the annual standard surveys for nursing facilities.	X			We will continue to strive to vary annual survey dates within the constraints of staff available and federal requirements.
Recommendation 28: DHH should increase the variability of the standard survey dates for ICF(s)/MR so that providers are less able to predict when their next surveys will occur.	X			Although the process does lock us into a timeframe of not conducting surveys any earlier than 120 days and no later than 90, we can monitor this to move us to the 14 – 30 day window and beyond.
Recommendation 29: DHH should re-evaluate the complaint intake process to ensure that nursing facility complaint calls are returned, and complaint investigations are assigned, in a timely manner.	X			The problem that HSS had identified and was confirmed with this audit is related to timeliness of contacting persons who leave messages on the complaint hot line in a 1-2 working day timeframe. Once the complaint intake process is complete the triage and routing to field offices is usually completed within 1 working day. We had made some personnel adjustments and timeframes have improved. We will continue to monitor.
Recommendation 30: DHH should develop and implement policies and procedures that require nursing facility and ICF/MR providers to notify new residents and their families/guardians of sex offenders living in their facilities upon admission. The notification should continue for as long as the information is		X		The statute and regulations relating to sex offender notification requirements are directives for law enforcement agencies and are strictly applied. The statute, regulations, Louisiana Attorney General Opinions and court cases interpreting the sex offender notice requirements will need to be analyzed to determine DHH obligations and

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considered a public record. During the annual licensing process, Health Standards surveyors should verify providers' compliance with the policy.				discretion, if any, in promulgating administrative rules to implement this recommendation.
Recommendation 31: If the legislature does not remove or increase the monetary caps on violations, DHH should reconsider its decision to not impose federal monetary sanctions on nursing facilities found to be out of compliance with federal certification requirements.	X			If the legislature does not increase or remove caps, we can look at cases that we feel the civil monetary penalty (CMP) should be more than our limit and refer these to CMS for action.
Recommendation 32: Health Standards should evaluate and amend the process it uses to assess civil money penalties on ICF/MR providers for all deficiencies, including repeat deficiencies. In doing so, Health Standards should ensure that penalties are assessed consistently among ICF/MR providers as well as across all provider groups (e.g., nursing facilities, etc.).	X			
Recommendation 33: DHH should continue to explore ways to use Nursing Home Residents' Trust Fund monies to improve the quality of care and quality of life of nursing facility residents. Examples include provider education and grants for facilities to assist with the implementation of quality improvement projects such as the culture change initiative.	X			We are co hosting a "Culture Change" Conference at three sites in the state March 14, 15, & 16. Funded by CMP(s).
Recommendation 34: If the legislature allows DHH to use civil money penalties from sanctions of ICFs/MR as described in Matter for Legislative Consideration 4, DHH should explore ways to use the funds to improve the quality of care and quality of life of residents in ICFs/MR.		X		The funds should also be available to address quality of life for residents in other type facilities as well as ICF(s)/MR.
Recommendation 35: Because of the lack of data needed to effectively manage the waiver programs, DHH should immediately develop an	X			Data related to this recommendation is not automated due to limited resources and will be addressed as resources are available.

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integrated database. The database should have sufficient controls to ensure the data are complete and accurate and should include the following information: • Deficiencies resulting from licensing, monitoring, and enrollment activities • Results of investigations of complaints and critical incidents, including all relevant timeframes (i.e., priority level, date investigated, date report due, etc.) • Enforcement actions taken and sanctions assessed • Information from home visits, pre-certification visits, and case management quarterly home visits • Other data as deemed necessary by DHH.				
Recommendation 36: DHH should develop a mechanism to ensure that surveyors cite instances of noncompliance accurately and consistently across the state. The mechanism should include an enforcement grid that assesses scope and severity similar to the one that Health Standards uses for nursing facilities and ICFs/MR. (See Exhibit 41 on page 78).	X			An integrated Management Information System (MIS) will help to assure that this will occur. The tool for manual use is under development at this time. An integrated MIS will be developed as resources are available.
Recommendation 37: DHH should include fields for enforcement data in the new database system discussed in Recommendation 35. As a part of its oversight of the regional offices, the BCSS state office should regularly review the enforcement data and use the data to assess the effectiveness of regional enforcement activities.	X			An integrated MIS will be developed as resources are available.
Recommendation 38: DHH should add provisions to its rules that allow for civil money penalties by class of violation similar to the ones Health Standards uses for nursing facilities and	X			This will require legislative action along with changes in Medicaid provider agreements and a quality work plan. Sanctions will be included as a part of the regionally-based SPOE contract.

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ICFs/MR. DHH should develop a grid to ensure that sanctions are applied consistently across waiver providers.				
Recommendation 39: Once the database discussed in Recommendation 35 is developed, DHH should require the regional offices to submit home visit information to the BCSS state office electronically.	X			Home visit data as well as other monitoring data obtained from DHH staff and contractors such as Case Managers will be included in an integrated data system as resources are available.
Recommendation 40: After DHH has implemented the other recommendations cited in this report, the department should begin evaluating the quality of waivers on an ongoing basis using reliable quality indicators.	X			This is currently done using manual processes and would be more efficiently completed with an electronic data base.
Recommendation 41: If DHH becomes the sole licensing agency for waiver providers, DHH should conduct licensing, enrollment, and monitoring visits at the same time, if possible, using a standardized instrument that contains all relevant standards.	X			If Health Standards becomes the sole regulatory agency, we will look at merging surveys into one visit as applicable. This process is what is currently done for the other providers that we license and certify, and it does maximize state resources and streamline process for providers. However in some instances it is not possible or beneficial to combine all visits.
Recommendation 42: Whoever is deemed the sole licensing agent should update the rules and regulations DSS uses to govern waiver providers.	X			As with all licensing rules, they should be reviewed on an ongoing basis and revised as needed.
Recommendation 43: DHH should develop a training curriculum that includes subjects that are relevant and valuable to providers and a list of approved trainers. To help determine what subjects are needed, DHH should periodically assess deficiency data in the aggregate from licensing, monitoring, and enrollment visits, determine what problems exist on a statewide level, and then develop a curriculum of approved training courses to address those problems.	X			BCSS is in the process implementing this recommendation with initial work underway through the Real Choice Systems Change Grant. This grant project's activities should be continued, expanded upon and implemented based on activities already underway. Health Standards has been trying to implement this recommendation especially for the providers who have repeat deficiencies. However, it is resource intensive and if it is going to be done consistently and timely, more staff resources are necessary or

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				development of an automated system
Recommendation 44: DHH should acquire laptop computers that include a software program that tracks information on licensing, monitoring, and enrolling providers. The information should be entered into a database so that the results of BCSS' activities can be transferred into an integrated database system.	X			This recommendation for BCSS has been a departmental goal for several years. Health Standards has purchased laptops with the use of federal monies and have maximized what is allowed under federal guidelines. For this to be possible for all surveyors, we would need to look at state dollars to purchase an additional 35 – 40 laptops ($90,000.00 state funds).
Recommendation 45: DHH should develop an electronic system whereby regions can report the resolution of critical incident investigations to DHH in a timely manner.	X			BCSS is within weeks of implementing an electronic critical incident /compliant system in collaboration with the Bureau of Health Standards and the Bureau of Protective Services using the DHH developed Online Tracking Information System-(OTIS). Health Standards and Adult Protective Services (APS) have been working on an online tracking system for 24 hr reports over the last year. This online system went live approximately 6 months ago. Currently providers are using the system on a voluntary basis. The Department can explore making the system mandatory in the future.
Recommendation 46: DHH should include a complaint tracking module in the integrated database system mentioned in Recommendation 35.	X			Same response as for recommendation number 45 above.
Recommendation 47: DHH should include a module in the integrated database system discussed in Recommendation 35 that allows the regions to report investigation priorities assigned to complaints and critical incidents and the time frames in which the investigations were completed. DHH should review this information periodically to ensure that the regions are in compliance with related requirements.	X			Same response as for recommendation number 45 above.

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Recommendation 48: DHH should develop a formal MOU or other agreement with the Office of Community Services and Elderly Protective Services that requires that those agencies formally report the resolution of their investigations of complaints and critical incidents to DHH. DHH should include this information in the integrated database mentioned in Recommendation 35 and review it periodically to identify trends and patterns.	X			DHH has worked with the Office of Elderly Affairs/Elderly Protective Services on this recommendation and a draft MOU has been developed. It is expected that this MOU will be finalized shortly. In addition, one meeting with the Office of Community Services has occurred to discuss this need and a follow-up meeting to continue this discussion will be scheduled.
Recommendation 49: DHH should determine why certain case management agencies did not provide required services and develop policies and procedures to correct those problems.	X			Case Management agencies are regulated by licensing, policy and procedures related to the various targeted populations they serve as well as agency contracts through an RFP process. Agencies are sanctioned when identified as being out of compliance with the contracts. DHH intends to impose much stricter requirements on case management contractors in the future to insure compliance.
Recommendation 50: DHH should develop a system to gather and analyze information obtained from case management monitoring functions and use it to evaluate the quality of waiver services.	X			An integrated MIS will be developed as resources are available that will greatly assist in realizing this recommendation.
Recommendation 51: DHH should continue its efforts to encourage nursing facilities to participate in culture change activities.	X			Currently, there are 600 registrants, representing approximately 135 nursing facilities, for the conferences scheduled for this month. If 10% take something back from these conferences to their nursing home that improves the quality of life for residents, we have the potential of touching over 1000 residents' lives. We are also pursuing appointment of an advisory panel made up of various stakeholders to award small grants to providers with innovative ideas and also exploring various other ways that CMP(s) can be used to improve quality of life for residents in

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				nursing homes.
Recommendation 52: DHH should include compliance information on nursing facilities on its Web site. DHH should post the actual survey document used to survey the facilities and the results of the most recent surveys.	X			Health Standards has been working on a database for over a year. DHH expects to go live with the database soon. Health Standards is pursuing the purchase of an electronic system for scanning and posting to website – if funds are available then the actual document could be linked to the website.
Recommendation 53: DHH should develop and promulgate rules and/or develop policies that require the most recent survey findings for ICFs/MR to be posted on its Web site.	X			The requirement for facilities to post their survey findings is a federal requirement for NF and not for ICF(s)/MR; however the compliance website Health Standards has been working on would include ICF(s)/MR in the near future.
Recommendation 54: Once DHH compiles data on provider compliance, it should link the information with the Freedom of Choice list.	X			This will be accomplished as resources become available.
Recommendation 55: DHH should develop a system to periodically measure consumer satisfaction in all long-term care settings. The information should be compiled electronically and used for management decisions and system evaluation.	X			The various LTC settings have consumer satisfaction elements in their monitoring activities. Coordination and applicable resources are needed to implement this recommendation.
Recommendation 56: DHH should develop an electronic system that measures whether waiver recipients have met their personal outcomes.	X			Will be included in MIS referred to in Rec. #37.
Recommendation 57: DHH should expand its efforts to partner with non-profit agencies to provide PACE programs throughout the state.		X		The current PACE project is a pilot. Plans for further expansion and implementation of PACE statewide will be made based on the "lessons learned" and successful implementation of the pilot project.

Rate Component	Costs Included in Rate Component	Methodology Used to Determine Rate Component
Direct Care and Care-Related	• RN, LPN, nurse aide salaries and benefits • Fees paid to staffing companies to hire these staff • Costs indirectly related to providing clinical care services to residents	1. Per diem direct care and care-related costs are calculated for each nursing facility. 2. The per diem direct care and care-related costs are inflated to the middle of the rate year and the direct care component is then normalized to account for case mix differences. 3. The inflated and normalized costs are ranked for all facilities, and the resident-day-weighted median cost for all of the facilities is determined. For example, as of October 2004, the resident-day-weighted median cost for all facilities was $44.64. 4. A statewide price is calculated at 110% of the resident-day-weighted median cost. For example, 1.10 x $44.64 = $49.10 statewide price. 5. A statewide floor is set at 94% of the resident-day-weighted median cost. Through a series of calculations, a floor for each facility is also calculated. For example, if a facility's per diem is **$50.19**, the facility only has to spend $42.90 of the $50.19 on direct care and care-related services. • Effective with cost report periods beginning on or after January 1, 2003, each nursing facility is required to spend at least the floor amount on direct care and care-related expenses each year. • Nursing facilities that do not meet this minimum amount must remit the amount they under-spent to DHH 6. The facility specific direct care and care-related component percentages are calculated based on the percentage they make up of the facility's total inflated and normalized direct care and care-related costs. 7. The direct care component of the statewide price and the statewide floor is adjusted quarterly to account for changes in the facility-wide average case mix index. The facility-wide average case mix index is the average of all resident case mix indices on the first day of each calendar quarter.

Rate Component	Costs Included in Rate Component	Methodology Used to Determine Rate Component
Administrative and Operating	• Costs associated with general administration and operation of the facility	1. Per diem administrative and operating costs are calculated for each nursing facility after inflating costs to the middle of the rate year. 2. Inflated per diem costs are ranked for all facilities. 3. The resident-day-weighted median cost for all facilities is determined and a statewide price is calculated at 107.5% of the resident-day-weighted median cost. For example, as of October 1, 2004, the resident-day-weighted median cost for the state was $30.24. The statewide price is calculated as 1.075 x $30.24 = $32.51. All nursing facilities will receive **$32.51** per resident per day for administrative costs.
Capital	• Depreciation • Capital-related interest • Rent payments and/or lease and amortization expenses	1. Each facility's allowable square footage is multiplied by $97.47 plus $9.75 for land (a total of $114.88 trended value) and an additional $4,000 per licensed bed ($4,285 trended value) for equipment to get the gross facility value. For example, a facility has 50,231 square feet and 180 licensed beds, or 279 square feet per bed. Because the square footage per bed is lower than the floor of 300, it would be raised to 300. The facility's total allowable square footage would be 300 x 180 = 54,000. • Allowable square footage is equal to a minimum of 300 and a maximum of 450 feet per licensed bed (occupied and vacant). 2. The gross facility value is trended forward annually using the construction index, which is adjusted using the average total city cost index for New Orleans regardless of the facility's location in the state. As shown above, the gross facility value factors are currently at $114.88 (land and building) and $4,285 (equipment). 3. The trended value (excluding the $9.75 inflated for land per allowable square feet) is depreciated at 1.25% per year, according to each individual facility's weighted age. The maximum allowable age for a facility is 30 years.

Rate Component	Costs Included in Rate Component	Methodology Used to Determine Rate Component
		4. To get the fair rental value, the depreciated value is multiplied by a rental factor. • The rental factor is defined as the average 20-year Treasury Bond Rate for the calendar year preceding the rate year plus 2.5%, with the stipulation that the rate must be at least 9.25% and cannot exceed 10.75%. For example, if the depreciated facility value is $5,692,716, the fair rental value would be determined by multiplying this figure by .0925, for a $526,576 fair rental value. 5. The fair rental value per diem is calculated by dividing the annual fair rental value by the annualized actual resident days. • However, if resident days do not equal 70% of the annualized licensed capacity, the annual fair rental value is divided by 70% of the annualized licensed capacity. For example, if the facility had a 54.1% occupancy rate (35,543 bed days), then the minimum occupancy rate would be raised to 70% (45,990 bed days). The fair rental value ($526,576) is divided by the bed days (45,990) to obtain the fair rental value per diem of **$11.45** per resident per day for capital expenses.
Pass-Through	• Property taxes • Property insurance • Provider fees	1. Per diem property tax and property insurance costs are calculated and trended forward using an index factor. 2. The rate paid to each facility is the sum of the per diem costs trended forward plus the provider fee paid by the nursing facility to the Medical Assistance Trust Fund. For example, if a facility's trended forward amount for per diem property tax and property insurance is $0.85, this amount would be added to the current provider fee of $6.27 to obtain a **$7.12** rate per resident per day paid to the facility for pass-through expenses.
TOTAL RATE PAID TO FACILITY PER RESIDENT PER DAY: $50.19 + $32.51 + $11.45 + $7.12 = $101.27		

Source: Created by legislative auditor's staff using information provided by DHH. Information was reviewed by Myers and Stauffer, LC.

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APPENDIX D: NURSING FACILITY COST CATEGORY DESCRIPTIONS

Cost Category	Description
Administrative and General	Purchasing; general accounting; billing; administrative staff; amortization of start-up costs; administrator/assistant administrator salaries (after applying Louisiana Medicaid limitations); professional dues; general liability insurance; operating interest expense; pharmacy consultant; miscellaneous
Capital	Depreciation, leases, and rentals for the use of facilities and/or equipment; interest incurred in acquiring land or depreciable assets used for patient care; or depreciable assets used for patient care
Employee Benefits	Employee benefits for all areas of the facility (e.g., personnel department; employee health service; hospitalization insurance; workers' compensation; employee group insurance; social security taxes; unemployment taxes; annuity premiums; past service benefits and pensions)
Provider Fees	Provider assessments (bed tax) from the State of Louisiana
Maintenance, Repair, and Operation of Plant	General maintenance and repair costs of the facility; utilities
Dietary	Entire facility meal costs (except for raw food cost); dietitian consultant
Raw Food	Raw food costs related to patient care
Nursing Administration	Normally includes only the cost of nursing administration; excludes nurse aide training cost for Louisiana Medicaid
Housekeeping	Salary and supply costs of housekeeping staff
Laundry	Resident and general laundry expense
Property Taxes and Insurance	Property taxes and insurance on depreciable assets used for patient care
Social Service	Social service salaries and supplies
Central Services and Supply	Includes overhead cost of medical supplies including supply clerk; may also include actual medical supply cost
Pharmacy	Includes overhead cost of chargeable and non-chargeable drugs; may also include actual drug costs
Activities	Recreational therapy and resident activity expenses
Physical Therapy	Direct salary and supply costs for physical therapy. General Service cost centers are allocated to this category.
Occupational Therapy	Direct salary and supply costs for occupational therapy. General Service cost centers are allocated to this category.
Drugs Charged to Patients	Chargeable drug costs (not routine items). Includes drugs required for patient care and that can be billed separately under Medicare. Normally includes all prescription drugs but does not include routine over-the-counter drugs. General Service cost centers are allocated to this area.
Speech Pathology	Direct salary and supply costs for speech therapy. General Service cost centers are allocated to this category.

Cost Category	Description
Medical Supplies Charged to Patients	Chargeable medical supply cost (not routine items). Any medical supply that is required for patient care (in the plan of treatment) and that can be billed separately under Medicare. This category would include most significant medical supplies but would not include routine items like swabs, cotton balls, adhesives, gloves, incontinent supplies, thermometers, and tongue depressors. Some billable medical supplies include sterile dressings, sterile applicators, IV supplies, catheters, drainage bags, syringes, needles, enemas, and irrigation trays. General Service cost centers are allocated to this category.
Laboratory	Direct lab costs. General Service cost centers are allocated to this category.
Radiology	Direct radiology salary and supply costs. General Service cost centers are allocated to this category.
Respiratory Therapy	Direct salary and supply costs for respiratory therapy. General Service cost centers are allocated to this category.
Skilled Nursing Facility/ Nursing Facility	Direct salaries of registered nurses, licensed practical nurses, nurse aides, and contract nurses. Nursing supply costs and non-chargeable drugs. General Service cost centers are allocated to this category.

Source: Prepared by legislative auditor's staff using information provided by Myers and Stauffer, LC.

Cost Category	Description
Administrative and General	• Administrative Salaries and Wages, Payroll Taxes, Employee Benefits • Advertising and Promotion, Printing, Office Supplies, Postage • Bad Debts • Data Processing, Dues, Interest, Licenses, Professional Services • Insurance (Officers' Life, Workers' Compensation, Liability, Motor Vehicle, Malpractice, and Other) • Taxes (including provider fees) • Subscriptions, Telephone • In-Service Training Supplies and Expenses, Travel and Seminar Expenses • Central Office Overhead, Directors' Fees, Management Fees • Other
Plant Operation and Maintenance	• Salaries, Wages, Payroll Taxes, Employee Benefits • Contracts for Outside Services • Building and Grounds Maintenance/Repairs • Furniture and Equipment Maintenance/Repairs • Supplies, Utilities • Miscellaneous
Dietary Expense	• Salaries, Payroll Taxes, Employee Benefits • Food • Supplies (dishes, flatware, napkins, utensils, etc.) • Contracts for Outside Services • Miscellaneous
Laundry and Linen Expense	• Salaries, Wages, Payroll Taxes, Employee Benefits • Supplies, Linen and Bedding • Contracts for Outside Services • Miscellaneous
Housekeeping Expense	• Salaries, Wages, Payroll Taxes, Employee Benefits • Supplies • Contracts for Outside Services • Miscellaneous
Medical and Nursing Expense	• Physician, Nurse, Aide, and Orderly Salaries, Payroll Taxes, Employee Benefits • Routine and Extraordinary Medical Services • Medical Supplies • Other

Cost Category	Description
Therapeutic and Training Expense	• Psychologist, Social Worker, Therapist, Houseparent, Aide, and Other Child Care Staff Salaries, Payroll Taxes, Employee Benefits • Therapeutic and Training Supplies • Shared Costs (Allocated) • Habilitation (Day Program) • Other
Recreational Expense	• Director and Other Staff Salaries, Payroll Taxes, Employee Benefits • Supplies • Miscellaneous
Consultants	• Registered Nurse, Social Worker (MSW), Pharmacist, Psychiatrist, Psychologist, Physician, Physical Therapist, Speech Therapist, Audiologist, Recreational, Records Librarian, Other
Costs Related to Capital Assets	• Depreciation • Interest (Mortgage on Buildings or Equipment) • Lease Expenses • Property Taxes • Other

Source: Prepared by legislative auditor's staff using fiscal year 2002 ICF/MR cost reports.

Types of Federal Deficiencies Cited in Surveys of Sample Nursing Facilities
Calendar Year 2003

Types of Deficiencies	Examples *	Number of Citations	Percent of Total Citations
Quality of Care	Necessary care and services to attain the highest practicable well-being; proper treatment to prevent/heal pressure sores; environment free of hazards; sufficient fluid intake to maintain proper hydration; drug regime free of unnecessary drugs; free of medication error rates of 5% or more.	153	18.66%
Resident Assessment	Comprehensive assessments; accuracy of assessments; services provided meet professional standards of quality; services provided by qualified persons in accordance with plan of care, etc.	150	18.29%
Health Care Related Services (e.g., physician, nursing, rehabilitation, dental, and dietary services)	Sufficient nursing staff on a 24-hour basis; menus meet nutritional needs of residents; store, prepare, and distribute food under sanitary condition; storage of drugs and biologicals, etc.	130	15.85%
Resident Rights/Facility Practices	Notification of changes in resident condition, treatment, and accidents; personal privacy and confidentiality of personal/clinical records; right to be free from physical restraints not required for treatment; no employment of individuals found guilty of abuse, etc.	109	13.29%
Administration	Proficiency of nurse aides; provide or obtain lab services to meet the resident's need; clinical records meet professional standards, etc.	100	12.20%
Quality of Life	Maintains or enhances residents' dignity and respect; accommodation of needs and preferences; provide for on-going program of activities; safe, clean comfortable and homelike environment; housekeeping and maintenance services, etc.	98	11.95%

Types of Deficiencies	Examples *	Number of Citations	Percent of Total Citations
Physical Environment	Assure full visual privacy; facility provides for safe, functional, sanitary, and comfortable environment; adequate ventilation; maintains effective pest control program, etc.	46	5.61%
Infection Control	Facility establishes infection control program; staff washes hands after each direct resident contact, etc.	34	4.15%
Total		**820**	**100.00%**

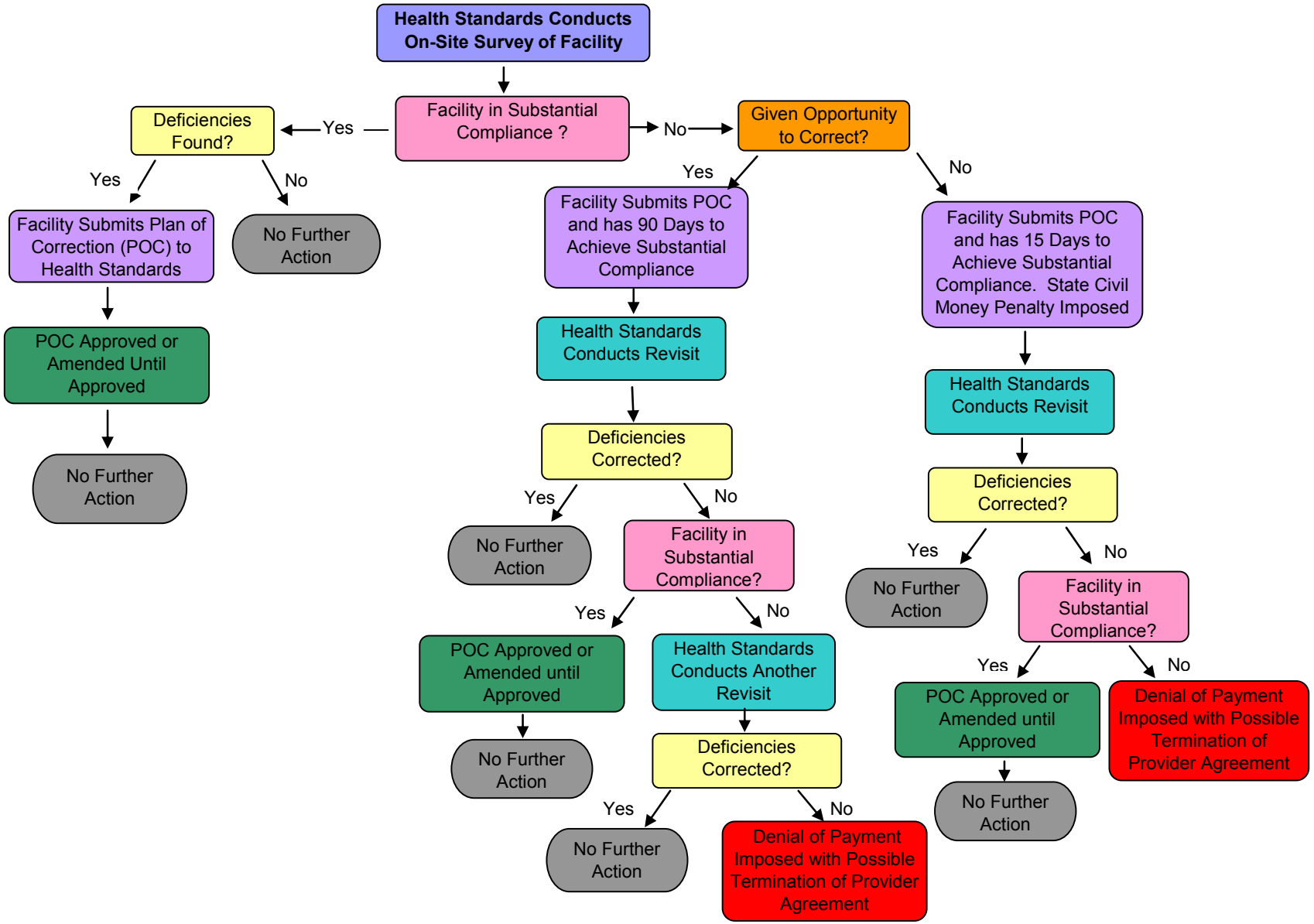
* These examples cite the areas in which nursing facility providers were deficient.
Source: Prepared by legislative auditor's staff using information obtained from CMS.

Types of Federal Deficiencies Cited in Surveys of Sample ICFs/MR
Calendar Year 2003

Types of Deficiencies	Examples *	Number of Citations	Percent of Total Citations
Active Treatment Services	• Assessment identifies develop-mental needs • Active treatment program implemented when program plan formulated • Committee reviews, approves, and monitors program plans • Committee ensures individual program plans conducted with consent of clients	140	23.89%
Health Care Services	• Facility provides preventative and general medical care • Nursing services provided in accordance with client needs • Drugs administered without error	126	21.50%
Facility Staffing	• Active treatment program coordinated by qualified mental retardation professional • Employee training provided • Employee training directed toward client health needs • Staff able to manage inappropriate client behavior	69	11.77%
Client Protections	• Clients informed of condition, status, right to refuse treatment • Clients exercise rights as clients and citizens • Clients manage own financial affairs • Clients retain and use personal possessions and clothing	67	11.43%
Governing Body and Management	• Governing body exercises direction • Outside services meet needs of clients	54	9.22%

Types of Deficiencies	Examples *	Number of Citations	Percent of Total Citations
Physical Environment	• Water temperature does not exceed 110 degrees Fahrenheit • Facility furnishes and maintains specialized equipment and device • Facility has procedures to prevent, control, and investigate cases of infection	52	8.87%
Staff Treatment of Clients	• Mistreatment, neglect, abuse of client prohibited • Allegations of abuse reported immediately • Alleged violations investigated thoroughly	32	5.46%
Dietetic Services	• Clients receive nourishing, well-balanced diet • Food served at appropriate temperatures • Menus provide a variety of food at each meal	23	3.93%
Client Behavior and Facility Practices	• Client conduct allowed and not allowed is specified • Interventions applied with sufficient safeguards • Behavior management not used for disciplinary purposes	23	3.93%
Total		**586**	**100.00%**

* These examples cite the areas in which the nursing facility providers were deficient.
Source: Prepared by legislative auditor's staff using information obtained from CMS.



Source: Developed by legislative auditor's staff.

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