REPORT OF

THE

STATE AUDITOR

Nursing Facility Quality of Care
Department of Public Health and Environment
Department of Health Care Policy and Financing

Performance Audit
February 2007

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February 5, 2007

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of nursing facility oversight in Colorado. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. The report presents our findings, conclusions, recommendations, and the responses of the Departments of Public Health and Environment and Health Care Policy and Financing.

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OFFICE OF THE STATE AUDITOR **REPORT SUMMARY**

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Authority, Purpose, and Scope

This performance audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. The audit work was conducted from January through December 2006 in accordance with generally accepted government auditing standards. As part of our audit, we reviewed the Department of Public Health and Environment's (CDPHE) and the Department of Health Care Policy and Financing's (HCPF) practices for overseeing nursing facilities to ensure quality care for residents and compliance with applicable state and federal requirements. We also reviewed data on reimbursement rates for nursing facilities participating in Medicaid. We gratefully acknowledge the cooperation and assistance extended by the management and staff at the Departments of Public Health and Environment and Health Care Policy and Financing.

Overview

A nursing facility, commonly referred to as a nursing home, is a residential long-term care health facility that offers a room, meals, and daily living assistance to people who are physically or mentally unable to live independently, and who require continuous or regular medical care. As of June 30, 2006, there were 217 nursing facilities in Colorado with a total of about 20,300 licensed beds. All but six nursing facilities in Colorado participated in the federal Medicare or Medicaid programs. Approximately 59 percent of all occupied nursing facility beds were occupied by Medicaid residents, 28 percent were occupied by private pay residents, and 13 percent were occupied by Medicare residents. In Fiscal Year 2006 the State paid a total of about $456.5 million in state general funds and federal matching funds on Medicaid reimbursements to nursing facilities.

Nursing home oversight in Colorado is a shared responsibility between the federal government and two state agencies. The federal government establishes health, safety, and quality-of-care standards that nursing facilities must meet as a condition of participation in Medicare and Medicaid. CDPHE is responsible for licensing nursing facilities in accordance with state laws and regulations. In addition, CDPHE is responsible under an agreement with the federal Centers for Medicare and Medicaid Services (CMS) for inspecting and monitoring nursing facilities participating in Medicare and Medicaid to determine whether they comply with applicable federal requirements. As the State's Medicaid Agency, HCPF provides policy and financial oversight of nursing facilities participating in Medicaid. This includes developing and administering a reimbursement rate schedule in accordance with the methodology prescribed by state statute.

Key Findings

Monitoring

CDPHE oversees quality of care at nursing homes through routine inspections, called certification surveys, as well as through complaint and occurrence investigations. We reviewed CDPHE's practices in these and other areas and found several problems, including:

- **Surveyors are not identifying all deficient practices at nursing facilities or citing deficiencies in accordance with federal requirements.** We hired a contractor with specialized expertise in nursing home quality of care and federal certification surveys to review a sample of 10 certification surveys conducted by CDPHE during Fiscal Year 2006. Overall, our contractor did not agree with the *scope* (i.e., number of residents affected) and/or *severity* (i.e., level of actual or potential harm to residents) for 32 of the 123 deficiencies (26 percent) cited by surveyors in the 10 sampled surveys. In some cases, documentation in the survey file indicated that more residents were affected by the deficient practice, or that the degree of harm involved for residents was greater than that assessed by the survey team. In other cases, documentation in the survey file was insufficient to demonstrate that the survey team fully investigated problems to determine an appropriate scope and severity for the deficiency citation, in accordance with federal requirements. For 7 of the 10 sampled surveys, our contractor also identified additional deficiencies that could have been cited. In addition to our contractor's file review, our analysis of the results of federal comparative surveys conducted by CMS showed that, on average, federal surveyors cited more than two times the average number of deficiencies cited per facility by CDPHE surveyors.

- **Certification surveys are not sufficiently unpredictable.** Federal regulations require that nursing facilities undergo a certification survey at least once every 15 months. Surveys must be unannounced and, consequently, should be as unpredictable as possible so that facilities do not have the opportunity to alter their normal operations in anticipation of the inspection. We reviewed two complete survey cycles from July 2003 through April 2006 and found that 76 out of the 405 certification surveys tested (19 percent) began in the same month as the previous year. Additionally, we found that 87 out of the 405 certification surveys tested (21 percent) were conducted within 15 days of the one-year anniversary date of the previous survey.

- **Nursing facility complaints and occurrences are not always investigated in a timely manner.** On average, CDPHE handles more than 400 nursing home complaint cases covering more than 1,300 separate allegations filed each year. CDPHE also receives and investigates an average of about 1,100 occurrence reports from nursing homes each year. Occurrences are certain types of incidents (e.g., injuries of unknown source, alleged resident mistreatment or neglect, and misappropriation of resident property) that nursing facilities

are required to self-report to CDPHE. First, we reviewed nursing home complaint data from Fiscal Years 2002 through 2006 and found that over 16 percent of all complaints were not investigated within federal and state time frames. We also found that CDPHE's complaint prioritization system could be improved to ensure that nursing home complaints are prioritized more consistently with current standards and practices. Second, we reviewed data for nursing home occurrences reported in Fiscal Years 2002 through 2006 and found that the average length of time taken to investigate 160 high-priority occurrences was almost twice the length of time allowed in CDPHE's policy for completing such investigations. We also found that CDPHE does not track all data relevant to measure the timeliness of occurrence reports and that state regulations establish a longer time frame for occurrence reporting by nursing homes than the time frame allowed by federal regulations and guidance from CMS.

- **Controls are insufficient to identify potential or perceived conflicts of interest.** We reviewed conflict-of-interest disclosures for a sample of surveyors and examined data on surveyors' survey assignments. We identified three situations that reasonably constitute a perceived conflict of interest between the surveyor and the facility the surveyor was assigned to inspect. First, we found that CDPHE's surveyor conflict-of-interest policy and disclosure forms are insufficient because they only require surveyors to disclose actual or potential conflicts of interest within the last two years. Perceived conflicts of interest may extend well beyond any predetermined time frames. Second, we found that surveyors do not provide clear or sufficient details on the facts of the situation when disclosing their potential conflicts of interest. Finally, we found that management does not fully document its review of conflict-of-interest disclosures.

Resident Care and Safety

Nursing home residents rely on nursing facility staff as their primary care givers to meet their ongoing health care needs and to provide assistance with even the most basic daily activities. In addition to meeting residents' health care needs, nursing facilities also have a responsibility to ensure resident safety. We found that poor or noncompliant practices by nursing facilities potentially compromise quality of care and resident safety.

- **Some resident assessments could not be validated, increasing the risk of poor quality of care and inaccurate Medicaid reimbursement rates.** Federal regulations require nursing facilities to use a standardized tool to assess every resident's physical, mental, and medical condition. The assessment provides a basis for how a resident's health care needs should be managed on a daily basis. State statute requires HCPF to adjust nursing facilities' Medicaid reimbursement rates for residents' acuity (i.e., clinical conditions and resource needs). This adjustment is made on the basis of data from resident assessments. When the resident assessment cannot be validated, the State lacks assurance that the resident is receiving the type and level of care and services required to address his or her needs and that Medicaid reimbursement rates are accurately adjusted for resident acuity. Our contractor

conducted site visits at 6 nursing facilities to review the medical records and resident assessment for a total sample of 60 residents. Overall, our contractor was unable to validate the resident assessment for 39 of the 60 (65 percent) sampled residents. This high error rate is a cause for concern.

- **Nursing facilities are not safeguarding and managing residents' personal funds in compliance with federal and state laws and regulations.** Nursing home residents may choose to deposit their personal funds with the facility, and the facility is required to act as a fiduciary to safeguard and manage the funds on the resident's behalf. We conducted site visits to 5 nursing facilities and reviewed account documentation for a total of 25 sampled residents with a total of about $17,100 in personal funds on deposit. We found problems with resident fund management practices for 16 of the 25 resident accounts (64 percent) we reviewed. We found a lack of sufficient documentation, such as a form or agreement signed by the resident, giving the facility authority to manage the funds. We also identified transactions lacking documentation showing that the resident had authorized the transaction. Finally, we found that nursing facilities do not routinely monitor resident fund account balances and notify Medicaid residents or their legal representatives, as required, when account balances reach certain thresholds. When account balances exceed these thresholds, the resident may be at risk of losing eligibility for Medicaid and/or federal Supplemental Security Income (SSI) benefits.

- **Nursing facilities are not sufficiently screening employees prior to employment.** State statute requires that nursing facilities must conduct a criminal history check no more than 90 days prior to employing any person. We conducted site visits to five nursing facilities and reviewed documentation of preemployment screening. For the 25 nursing facility employees in our sample, we identified 1 employee with no evidence of a criminal history check and 3 employees whose criminal history check was conducted after the employee's hire date. Additionally, we found that nursing facilities did not verify credentials prior to hiring 7 of the 14 employees in our sample with professional licenses (e.g., registered nurse). Finally, it was unclear that references for 5 of the 25 sampled employees had been checked in accordance with facility policies.

- **Nursing facility emergency and disaster plans are not comprehensive.** Federal and state regulations require nursing facilities to have plans and procedures for all potential emergencies and disasters. Emergency and disaster plans should also be tailored to such things as the facility's geographic location or resident population. During our site visits to five nursing facilities, we reviewed each facility's emergency and disaster plan and found that two of the five facilities lacked procedures for dealing with missing residents. Three facilities did not have emergency procedures for snowstorms, blizzards, or other severe winter weather. One facility lacked sufficient procedures for many common incidents such as flooding, utility outages, and resident evacuations. We also found that CDPHE could play a bigger role in working with nursing facilities to address common challenges, including planning for more widespread emergencies and disasters.

- **Health facility licensing activities do not comply with state statute and regulations.** Colorado's licensing laws and regulations intend for CDPHE to determine whether health facilities, including nursing homes, have the legal capacity, financial resources, and professional competence to operate a health care facility prior to issuing or renewing a state license. Licensure is a state requirement that is separate and distinct from federal certification for participation in the Medicare and Medicaid programs. We found that with the exception of assisted living residences, CDPHE does not perform comprehensive reviews as part of either the initial or renewal licensing process for *any* licensed health facility. According to CDPHE, current licensing fees are not sufficient to support the licensing activities specified in state statute and regulations. Without ongoing monitoring efforts to ensure that facilities continuously meet state licensing requirements, the fact that a nursing facility has a license issued by the State may provide false assurance to the public, residents, and CMS that state standards are being met. The State needs to evaluate a range of policy options for licensing health facilities and seek appropriate statutory and regulatory change. Options include increasing licensing fees or revising licensing requirements to be more in line with existing resources.

Medicaid Reimbursement Rates

HCPF sets reimbursement rates for nursing facilities that participate in Medicaid. In Fiscal Year 2006 the State reimbursed nursing facilities about $456.5 million in state and federal funds for serving Medicaid residents. During the 2006 Legislative Session the General Assembly enacted, and the Governor signed, Senate Bill 06-131 directing HCPF to conduct a feasibility study and report on recommendations for alternatives to Colorado's current reimbursement system, which reimburses nursing facilities based on *cost*. Among other things, the feasibility study was to include consideration of a new reimbursement system based on a reasonable *price* that would be paid by the State to meet the needs of nursing facility residents. The legislation requires that any recommendations for a price-based reimbursement system must consider cost adjustments for resident acuity and include a quality-of-care allowance. We found that in these two areas, HCPF needs to address some fundamental problems as part of its feasibility study. First, HCPF needs to address the problems we found with the validity of resident assessments and the implications our findings have for any new reimbursement system that uses resident acuity when establishing nursing facility Medicaid reimbursement rates. Second, HCPF needs to identify and addresses those factors that are critical to the successful implementation of a quality allowance or incentive payment when reimbursing nursing facilities under Medicaid. The General Assembly and HCPF have worked for a number of years and in various ways to include some type of quality incentive program for nursing facilities participating in Medicaid. However, historically, Colorado has not been successful in the implementation of these types of programs.

A summary of the recommendations and the responses of the Departments of Public Health and Environment and Health Care Policy and Financing can be found in the Recommendation Locator on Page 7. The complete audit findings, recommendations, and responses can be found in the body of the audit report.

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RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
1	29	Improve controls over the certification survey process by (a) ensuring that staff follow established quality review processes, (b) exploring ways to expand quality review processes, (c) ensuring timely communication between supervisors and survey teams, (d) implementing a standard organization format for survey files, (e) improving documentation standards for surveyors, and (f) providing surveyors with more training on general investigative skills and protocols.	Department of Public Health and Environment	a. Partially Agree b. Agree c. Agree d. Partially Agree e. Agree f. Partially Agree	a. Implemented b. October 2007 c. July 2007 d. October2007 e. October 2007 f. October 2007
2	34	(a) Ensure that predictability is routinely used as a key decision factor when scheduling certification surveys, and (b) monitor trends and assess performance related to survey predictability.	Department of Public Health and Environment	Agree	a. Implemented b. July 2007
3	41	Improve the prioritization and timeliness of nursing facility complaint investigations.	Department of Public Health and Environment	Agree	April 2007
4	46	(a) Strengthen time frames for occurrence investigations; (b) revise nursing facility occurrence reporting requirements to comply with federal regulations and guidance; (c) ensure accurate, systematic, and consistent tracking of data relevant to occurrence reporting and investigation; and (d) review data on the timeliness of occurrence reports and investigations on a routine basis.	Department of Public Health and Environment	Agree	a. Implemented b. July 2007 c. July 2007 d. July 2007
5	50	Ensure compliance with state and federal requirements governing informal dispute resolution (IDR) processes.	Department of Public Health and Environment	Agree	Implemented

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
6	53	Improve mechanisms for nursing facilities to provide meaningful, appropriate, and relevant feedback regarding the survey process, overall survey team performance, and individual surveyors.	Department of Public Health and Environment	Agree	July 2007
7	57	Improve controls over conflict-of-interest disclosure and monitoring processes.	Department of Public Health and Environment	Agree	October 2007
8	59	(a) Designate surveyors as security-sensitive positions and subject to criminal history check requirements prior to employment, (b) clarify staff responsibilities for conducting preemployment screening, and (c) develop and implement a checklist to document and track completion of preemployment screening tasks.	Department of Public Health and Environment	Agree	a. October 2007 b. July 2007 c. July 2007
9	70	(a) Continue to increase awareness among surveyors of the risk of problems with Minimum Data Set (MDS) assessments, (b) work with the Department of Health Care Policy and Financing (HCPF) to conduct more systematic review and analysis of available MDS reports and data, (c) work with HCPF to require that MDS coordinators at Medicaid-certified nursing facilities complete MDS training on a routine basis, (d) encourage nursing facilities to identify and use best practice approaches regarding MDS assessments, and (e) work with HCPF to evaluate options for the development and implementation of a state MDS validation team.	Department of Public Health and Environment	a. Agree b. Partially Agree c. Partially Agree d. Partially Agree e. Disagree	a. Ongoing b. July 2007 c. July 2007 d. July 2007 e. Not Applicable

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
10	72	Work with the Department of Public Health and Environment to (a) conduct more systematic review and analysis of available Minimum Data Set (MDS) reports and data, (b) require that MDS coordinators at Medicaid-certified nursing facilities complete MDS training on a routine basis, and (c) evaluate options for the development and implementation of a state MDS validation team.	Department of Health Care Policy and Financing	Agree	December 2007
11	80	(a) Train surveyors on the requirements and proper internal controls over resident fund accounts; (b) include specific questions about resident fund accounts in interviews with residents, family members, and facility staff; and (c) work to improve coordination of resident fund account monitoring efforts.	Department of Public Health and Environment	Agree	a. July 2007 b. July 2007 c. April 2007
12	81	(a) Develop and implement an audit program to conduct more routine audits of resident fund accounts managed by nursing facilities participating in Medicaid, (b) take steps to identify Medicaid residents with account balances exceeding applicable resource limits and recover and use excess funds to offset claims payments, and (c) work to improve coordination of resident fund account monitoring efforts.	Department of Health Care Policy and Financing	Agree	a. Implemented b. March 2007 c. March 2007
13	85	(a) Modify forms and checklists to include more detail on the factors that surveyors should use to review preemployment screening for nursing facility employees, and (b) work with the General Assembly to revise and clarify statutory requirements for criminal history checks of nursing facility employees.	Department of Public Health and Environment	Agree	a. April 2007 b. Upon General Assembly Request

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
14	91	(a) Train surveyors on emergency and disaster plans, (b) develop testing forms and checklists to help surveyors conduct a more focused review of emergency and disaster plans, (c) review for appropriateness any emergency and disaster plan deficiencies cited lower than a scope and severity of "F," (d) facilitate information sharing and the dissemination of model disaster and emergency practices and procedures among nursing facilities, and (e) encourage coordination among local agencies to ensure that the needs of nursing facilities are addressed in planning efforts for community-wide emergencies and disasters.	Department of Public Health and Environment	Partially Agree	a. January 2008 b. October 2007 c. October 2007 d. October 2007 e. October 2007
15	98	Work with the General Assembly and the Board of Health to evaluate policy options for licensing nursing homes and other types of health facilities, including (a) reevaluating the licensing fee set in statute, (b) exploring ways to revise licensing requirements, and (c) seeking statutory and regulatory change, as appropriate.	Department of Public Health and Environment	Agree	a. Ongoing b. July 2007 c. Ongoing
16	113	Address problems related to nursing facility resident assessments and the implementation of a quality allowance as part of the feasibility study required by Senate Bill 06-131.	Department of Health Care Policy and Financing	Agree	July 2008

Overview

Background

A nursing home is a residential long-term care health facility that offers a room, meals, and daily living assistance to people who are physically or mentally unable to live independently, and who require continuous or regular medical care. Nursing homes that participate in Medicaid are referred to as "nursing facilities" and provide residents with basic custodial care, such as assistance with activities of daily living and, in most cases, medical treatment for chronic illness or disability on a long-term basis. For example, many nursing facilities have special units for residents with Alzheimer's disease or other types of dementia. Nursing homes that participate in Medicare are referred to as "skilled nursing facilities" because they provide residents with more complex medical services, including extensive monitoring, pre- or post-operative care, and rehabilitation therapies. Medicare residents typically only receive skilled nursing care for a short time (i.e., up to 100 days following hospitalization) until the resident can be returned home. Throughout our audit report, we use the terms *nursing home* and *nursing facility* interchangeably to refer to homes that accept both Medicaid and Medicare residents. We specify when the discussion applies to nursing homes that only accept private pay residents (i.e., those facilities that do not accept any Medicaid or Medicare residents).

As the table below shows, as of June 30, 2006, there were 217 nursing facilities in Colorado with a total of about 20,300 licensed beds. Of the total licensed beds, about 16,900 were occupied, yielding an overall occupancy rate of nearly 84 percent. All but six nursing facilities in Colorado participated in Medicare, Medicaid, or both federal programs. Nearly 88 percent of all licensed beds were in facilities that serve both Medicare and Medicaid residents. All Medicare and Medicaid nursing homes accept private pay residents.

Department of Public Health and Environment Nursing Facility Count and Resident Census Data by Certification Type (As of June 30, 2006)				
Facility Certification Type	**Facility Count**	**Licensed Beds**	**Occupied Beds**	**Occupancy Rate**
Dual Medicare/Medicaid	175	17,803	14,934	84%
Medicaid Only	18	1,267	1,037	82%
Medicare Only	18	826	696	84%
Private Pay Only	6	356	269	76%
Totals	**217**	**20,252**	**16,936**	**84%**

Source: Office of the State Auditor's analysis of data provided by the Department of Public Health and Environment.
Note: All Medicare- and Medicaid-certified nursing homes accept private pay patients.

In Fiscal Year 2006 approximately 59 percent of all occupied nursing facility beds were occupied by Medicaid residents, 28 percent were occupied by private pay residents, and 13 percent were occupied by Medicare residents. As we mentioned earlier, Medicare residents are typically in nursing facilities for relatively short time periods. Finally, about 65 percent of Colorado's 217 nursing homes were owned by for-profit organizations, 26 percent were owned by nonprofit organizations, and the remaining 9 percent were owned by government entities (e.g., the State, counties, municipalities, or hospital districts).

Oversight Agencies

According to state law [Section 25-3-101(1), C.R.S.], all nursing homes that operate in Colorado must be licensed health care facilities. This includes those nursing homes that only accept private pay residents. Facilities that serve Medicare and Medicaid residents must also meet federal health, safety, and quality-of-care standards. Thus, oversight for most nursing homes is a shared responsibility between the state and federal governments.

Centers for Medicare and Medicaid Services (CMS)—Under the authority of Titles XVIII and XIX of the Social Security Act, the federal government establishes health, safety, and quality-of-care standards that nursing facilities must meet as a condition of participation in Medicare and Medicaid. CMS is within the U.S. Department of Health and Human Services and is the federal agency responsible for administering and overseeing the standards and compliance aspects of these programs. As mandated by the Social Security Act,

CMS enlists the help of state health agencies to determine whether nursing facilities participating in Medicare or Medicaid meet federal requirements.

Colorado Department of Public Health and Environment (CDPHE)—CDPHE is responsible for licensing nursing facilities in accordance with state laws and regulations. In addition, CDPHE is responsible under an agreement with CMS for "certifying" nursing facilities. Certification is a term used to refer collectively to activities and processes performed by CDPHE to determine whether Colorado nursing facilities participating in Medicare and Medicaid comply with federal requirements. CDPHE makes its certification recommendations to CMS based on the results of unannounced routine inspections called certification surveys. CDPHE also provides ongoing monitoring by investigating complaints and occurrences (i.e., self-reported incidents, such as allegations of resident abuse or injuries of unknown source). State survey teams issue deficiency citations to nursing facilities for noncompliance with federal regulations. Deficiencies typically result in enforcement remedies being taken against the facility and include such things as a directed plan of correction, assessment of civil money penalties, denial of payments, and termination from the Medicare or Medicaid programs.

Colorado Department of Health Care Policy and Financing (HCPF)—HCPF is the state agency responsible for overseeing the Colorado Medicaid Program. As such, HCPF provides policy and financial oversight of nursing facilities participating in Medicaid. HCPF develops and administers a reimbursement rate schedule in accordance with the methodology prescribed by state statute [Section 25.5-6-204, C.R.S.]. This methodology is intended to result in reimbursement rates that cover the actual or reasonable cost of providing care to Medicaid residents. In Fiscal Year 2006 the State paid a total of about $456.5 million—about half of which was state general funds and half of which was federal matching funds—on Medicaid reimbursement to nursing facilities. HCPF contracts with an independent accounting firm to audit facilities' Medicaid cost reports and to determine reimbursement rates and associated adjustments that are the basis for paying claims. HCPF also audits nursing facility billing practices and resident fund accounts, monitors changes in facility ownership, and administers other processes related to Medicaid benefits for residents.

In addition to the above-mentioned agencies, the Colorado Long-Term Care Ombudsman Program and the Division of Registrations are involved in nursing home oversight. First, the Long-Term Care Ombudsman Program is administered by a private nonprofit organization under contract with the Colorado Department of Human Services. Ombudsmen are not regulators or inspectors. Rather, ombudsmen advocate for resident rights, resident empowerment, and resident choice in nursing home care. Ombudsmen conduct monthly visits to nursing homes, investigate and

resolve complaints filed with the ombudsman office, and work closely with nursing home administrators, CDPHE, HCPF, and other health and aging organizations to identify and remedy facility deficiencies. State statute [Section 26-11.5-104(2), C.R.S.] prohibits the Long-Term Care Ombudsman Program from being administered by any agency or organization that is responsible for licensing or certifying long-term care services in the State. Second, the Division of Registrations within the Department of Regulatory Agencies issues professional licenses to nursing home administrators and to individuals, such as registered nurses, licensed practical nurses, and certified nurse aides, who provide resident care in nursing homes.

Fiscal Overview

Health Facilities and Emergency Medical Services Division

The Health Facilities and Emergency Medical Services Division (Division) is the organizational unit within CDPHE that is directly responsible for the licensing and certification of nursing homes. In Fiscal Year 2006 the Division was appropriated approximately 123 full-time equivalent positions (FTE) and had expenditures totaling about $15.3 million. Of these total resources, about $9.1 million (59 percent) and 109 FTE (89 percent) directly supported the health facility licensing and certification programs. The Division's licensing and certification activities extend beyond nursing homes and include 18 other types of health care facilities, such as hospitals, acute treatment units, community clinics, assisted living residences, and intermediate care facilities for the mentally retarded. The remaining 14 FTE and $6.2 million in Fiscal Year 2006 expenditures were for the Emergency Medical Services (EMS) Program, which performs activities such as training and certifying emergency medical technicians. The table below shows the Division's total expenditures and appropriated FTE for Fiscal Years 2002 through 2006.

Department of Public Health and Environment
Health Facilities and Emergency Medical Services Division
Expenditures, Full-Time Equivalent (FTE) Positions, License and Certification Survey Statistics
Fiscal Years 2002–2006

	Fiscal Year					Percent Change 2002–2006
	2002	**2003**	**2004**	**2005**	**2006**	
Licensure Programs[1]	$695,000	$918,000	$1,123,000	$1,222,000	$1,313,000	89%
General Licensure	$274,000	$232,000	$241,000	$265,000	$324,000	18%
Assisted Living Residences	$247,000	$517,000	$736,000	$795,000	$835,000	238%
Medication Administration	$174,000	$169,000	$146,000	$162,000	$154,000	-11%
Certification Program[1]	$7,328,000	$7,077,000	$7,437,000	$7,871,000	$7,792,000	6%
EMS Program[2]	--	--	--	$5,917,000	$6,202,000	--
Total Expenditures	**$8,023,000**	**$7,995,000**	**$8,560,000**	**$15,010,000**	**$15,307,000**	**91%**
Appropriated FTE	103	109	109	123	123	19%
Licenses Issued[3]	1,258	1,227	1,260	1,216	1,270	1%
Surveys Conducted[4]	1,935	1,975	2,161	2,098	2,050	6%

Source: Expenditure data are from the Colorado Financial Reporting System (COFRS), rounded to the nearest thousand dollars. Appropriated FTE data are from the Long Appropriations Bill for Fiscal Years 2002 through 2006. Licensing and survey data are reported by the Department of Public Health and Environment.
[1]Includes activities related to nursing homes, hospitals, community clinics, intermediate care facilities for the mentally retarded, assisted living residences, and other types of health care facilities.
[2]The Emergency Medical Services Section was added to the Health Facilities Division in Fiscal Year 2005.
[3]Includes initial, renewal, and change of ownership licenses for all facility types.
[4]Includes federal health certification surveys, Life Safety Code certification surveys, and complaint surveys for all facility types.

The Division's total expenditures and FTE grew sharply in Fiscal Year 2005 due to a department reorganization that added the Emergency Medical Services Section to the Division. Overall, expenditures for the Division's licensing programs grew by about 89 percent between Fiscal Year 2002 and Fiscal Year 2006. This increase was driven mostly by a 238 percent increase in licensing expenditures for assisted living residences. Expenditures for licensing other types of health facilities increased by about 18 percent. In contrast, expenditures for federal certification of health facilities have remained fairly stable, with a growth of about 6 percent over the same period. In terms of workload, the Division issued just over 1,200 licenses each year and conducted between 1,900 and 2,100 surveys each year. As the table illustrates, the license and survey statistics remained relatively stable between Fiscal Year 2002 and Fiscal Year 2006.

Financial support for the Medicare and Medicaid certification program comes primarily from federal funds. Under its agreement with the State, the federal government funds 100 percent of the cost of certifying nursing facilities to

participate in Medicare. The federal government also funds 75 percent of the cost of certifying nursing facilities to participate in Medicaid. The remaining 25 percent of Medicaid certification costs are paid with state general funds. We estimate that an average of about 71 percent of the Division's total certification program expenditures are specifically for the cost of certifying long-term care facilities.

The Division's licensing activities are supported by revenue from a $360 licensing fee paid annually by all types of health facilities, including nursing homes. However, this licensing fee does not apply to the approximately 129 government-owned health facilities, or to assisted living residences, which have a separate licensing fee structure. (As of August 2006, acute treatment units also pay a different licensing fee pursuant to House Bill 06-1277.) Revenue from the $360 licensing fee is credited to the Health Facilities General Licensure Cash Fund (Licensure Fund). In Fiscal Year 2006 the Licensure Fund had total revenues of about $249,000 and total expenditures of about $255,000. As of June 30, 2006, the Licensure Fund had a fund balance of just over $48,000. Historically, the Division has not carried a large fund balance, and the Division fully or very nearly fully expends all revenues to the Licensure Fund each fiscal year.

Nursing Facilities Section

The Nursing Facilities Section (Section) is the organizational unit within HCPF that directly oversees nursing homes participating in Medicaid. The table below shows the Section's total expenditures and FTE for Fiscal Years 2002 through 2006.

Department of Health Care Policy and Financing
Nursing Facilities Section
Expenditures and Full-Time Equivalent (FTE) Positions
Fiscal Years 2002–2006

	Fiscal Year					Percent Change 2002–2006
	2002	2003	2004	2005	2006	
Nursing Facility Audits[1]	$855,000	$863,000	$861,000	$1,095,000	$1,095,000	28%
Nursing Facility Appraisals[1]	--	$266,000	--	--	--	--
Personal Services[2] and Operating	$617,000	$481,000	$761,000	$382,000	$578,000	-6%
Total Expenditures	**$1,472,000**	**$1,610,000**	**$1,622,000**	**$1,477,000**	**$1,673,000**	**14%**
Allocated FTE[3]	--	--	8.5	8.5	9.0	--

Source: Expenditure data are from the Colorado Financial Reporting System (COFRS), rounded to the nearest thousand dollars. FTE data are reported by the Department of Health Care Policy and Financing (HCPF).
[1]Contract services for the purpose of determining nursing facilities' allowable costs eligible for reimbursement through Medicaid. Appraisals only occur once every four years to re-base the property cost component of the reimbursement rate.
[2]Expenditures for state employees in the Nursing Facilities Section.
[3]FTE are appropriated to HCPF and then allocated to the Nursing Facilities Section. HCPF was unable to provide data on FTE allocations to the Nursing Facilities Section prior to Fiscal Year 2004 because HCPF changed the method for tracking personal services.

The majority of the Section's expenditures are for contract audit services. For example, in Fiscal Year 2006 the Section expended a total of about $1.7 million, of which nearly $1.1 million (65 percent) was paid to HCPF's contract auditor. These contract services are for audits of nursing facility Medicaid cost reports, determining allowable costs for reimbursement under Medicaid, and establishing Medicaid reimbursement rates and adjustments in accordance with the methodology prescribed by state statute. The increasing cost of contract audit services is the primary reason for the approximately 14 percent increase in the Section's total expenditures over the last five fiscal years. The Section also contracts once every four years for an appraisal of nursing facilities' building, land, and fixed equipment for purposes of re-basing the property cost component of the Medicaid reimbursement rate. The remaining expenditures are for personal services and operating expenses for the approximately 9 FTE allocated to the Section who are responsible for other activities, such as reviewing nursing facility billing practices, as described earlier. The increase in personal services and operating expenditures in Fiscal Year 2004 was due primarily to a $200,000 lawsuit settlement for contract audit work performed in prior years. Funding to support the Section comes from state general funds and federal matching funds; the federal matching rate ranges from 50 percent to 75 percent, depending on the activity.

Nursing Home Penalty Cash Fund

The Nursing Home Penalty Cash Fund (Penalty Fund) is overseen by both CDPHE and HCPF and was created in state statute [Sections 25.5-6-205(3) and 25-1-107.5(4), C.R.S.] to protect the assets and well-being of residents in cases when a nursing home is found to be in violation of Medicaid regulations. Uses for the Penalty Fund are defined in statute and include such things as relocating residents to other facilities, maintaining the operation of a nursing facility pending correction of violations, closing a nursing facility, or reimbursing residents for misappropriated personal funds. Expenditures from the Penalty Fund require a legislative appropriation. Penalty Fund revenue comes from civil money penalties assessed against Medicaid-certified nursing facilities as a result of deficiency citations issued by CDPHE during certification surveys. Interest is also earned on the fund balance. In Fiscal Year 2006 the Penalty Fund had total revenues of about $450,000 and no expenditures. As of June 30, 2006, the Penalty Fund had a fund balance of over $1.2 million.

Audit Scope and Methodology

This performance audit reviewed the effectiveness of CDPHE's and HCPF's oversight of nursing facilities, as well as compliance with applicable state and federal requirements. We analyzed data, reviewed documentation, and interviewed staff related to certification surveys, complaint investigations, occurrence investigations (i.e., self-reported incidents, such as allegations of resident abuse or injuries of unknown source), licensing, and enforcement activities for nursing facilities. We contracted with TMF Health Quality Institute based in Austin, Texas, to review a sample of certification survey files and to validate resident assessments through site visits at six nursing facilities located across the State. We conducted site visits at five additional nursing facilities to review facility practices related to employee screening, facility management of resident fund accounts, and emergency and disaster preparedness. We interviewed nursing facility administrators and staff, and long-term care ombudsmen. Our audit included analysis of data on Medicaid reimbursement rates and a review of information from discussions taking place at HCPF pursuant to Senate Bill 06-131 to evaluate options for a new price-based reimbursement system for nursing facilities participating in Medicaid. Finally, we followed up on prior audit recommendations from our September 2000 *Nursing Facility Quality of Care Performance Audit.* Our audit scope did not include the Long-Term Care Ombudsman Program, the Division of Registrations, licensing and certification activities for other types of health facilities (e.g., intermediate care facilities for the mentally retarded), or the EMS Program.

Monitoring

Chapter 1

Background

The oversight of quality of care in nursing homes is a shared responsibility between the federal and state governments. In Colorado, the Department of Public Health and Environment (CDPHE) is responsible under an agreement with the federal Centers for Medicare and Medicaid Services (CMS) for "certifying" that nursing facilities participating in the Medicare and Medicaid programs comply with federal health, safety, and quality of care standards. CDPHE is also responsible for licensing all nursing facilities in accordance with state laws and regulations, including those nursing homes that only accept private pay residents. At the time of our audit, all but 6 of Colorado's 217 nursing facilities participated in Medicare or Medicaid. Thus, most of CDPHE's monitoring efforts focus on determining compliance with federal requirements. One of the primary ways that CDPHE oversees quality of care at nursing homes is through unannounced routine inspections called certification surveys. In addition to certification surveys, CDPHE investigates complaints filed against nursing facilities, as well as occurrences, which are incidents such as allegations of resident abuse or injuries of unknown source that nursing facilities are required by law to self-report to CDPHE.

During our audit we reviewed CDPHE's practices for conducting certification surveys in accordance with applicable requirements. We also reviewed processes for scheduling surveys, investigating complaints and occurrences, soliciting feedback from nursing facilities, identifying and mitigating conflicts of interest, and screening surveyors prior to employment. CDPHE has made changes to its operations in recent years and has met or partially met the federal performance standards prescribed by CMS in Federal Fiscal Years 2001 through 2005 for state long-term care monitoring functions. Nonetheless, we found problems in some of the same areas covered in our September 2000 *Nursing Facility Quality of Care Performance Audit*. This chapter includes our findings and recommendations related to improving the State's oversight of nursing facilities, including recommendations to strengthen controls over the certification survey process, schedule surveys more unpredictably, ensure the timely investigation of complaints and occurrences, and address potential or perceived conflicts of interest.

Certification Surveys

As mentioned earlier, nursing facilities that participate in Medicare and Medicaid are subject to routine inspections called surveys. Surveys ascertain whether the facility meets applicable federal requirements and evaluate the facility's performance and effectiveness in rendering a safe and acceptable quality of care to residents. As the State's designated Survey Agency, CDPHE conducts an initial certification survey when a facility first joins Medicare or Medicaid. Subsequent recertification surveys are conducted on a regular basis. We use the term *certification survey* to refer to both the initial and subsequent inspections.

CDPHE is required to conduct a certification survey of each Medicare and Medicaid nursing home at least once every 15 months. The statewide average interval between certification surveys for all facilities cannot exceed 12 months. Surveys are unannounced and conducted by interdisciplinary teams of health professionals; each survey team must include at least one registered nurse. Surveys generally take about one week to complete, including three to four days on-site at the nursing home. CDPHE completed an average of about 219 nursing facility certification surveys annually during Fiscal Years 2002 through 2006.

When surveyors identify noncompliance with federal standards, they cite the nursing home with a deficiency. State survey teams assess how many residents or staff are affected by or involved in the deficient practice (i.e., scope), and the amount of actual or potential harm caused to residents (i.e., severity). The scope and severity determinations result in the assignment of a letter code—A through L—with "A" signifying the least serious and isolated deficiencies and "L" signifying the most serious and widespread deficiencies. Under the federal certification system, CDPHE recommends enforcement remedies based on the scope and severity of the deficiencies, as well as on the facility's compliance history. CMS imposes the final enforcement remedies for all Medicare-only and dual Medicare/Medicaid-certified facilities. The Department of Health Care Policy and Financing (HCPF) imposes the final enforcement remedies for all Medicaid-only facilities. Available enforcement remedies include such things as a directed plan of correction, assessment of civil money penalties, denial of payments, and termination from the Medicare or Medicaid programs.

The table below shows a breakdown by scope and severity of the approximately 9,800 deficiencies cited by state survey teams on certification surveys conducted in Colorado nursing homes during Fiscal Years 2002 through 2006.

Department of Public Health and Environment
Nursing Facility Certification Survey Deficiency Citations
Fiscal Years 2002–2006

Severity	Scope		
	Isolated	*Pattern*	*Widespread*
Immediate Jeopardy Residents are at immediate risk for serious injury or death.	**J** 20 0.2%	**K** 14 0.1%	**L** 3 0.0%
Actual Harm Residents' ability to reach their highest physical and mental well-being is compromised.	**G** 782 8.0%	**H** 44 0.5%	**I** 0 0.0%
Potential for More Than Minimal Harm Minimal harm or discomfort to residents or the potential of actual harm to residents.	**D** 5,552 56.7%	**E** 2,109 21.5%	**F** 94 1.0%
Potential for Minimal Harm Potential of no more than minimal harm to residents.	**A** 401 4.1%	**B** 648 6.6%	**C** 121 1.2%
Total Deficiencies Cited = 9,788			

Source: Office of the State Auditor's analysis of health survey deficiency data provided by the Department of Public Health and Environment.
Notes: Numbers represent the number of deficiencies cited at each scope and severity level across all federally certified nursing facilities during Fiscal Years 2002 through 2006. Percentages represent the percentage of deficiencies cited at each scope and severity level out of the total number of deficiencies cited across all scope and severity levels.

More than three-quarters (about 78 percent) of the nursing home deficiencies cited over the last five fiscal years had a scope and severity of "D" or "E," indicating noncompliant facility practices with the potential for more than minimal harm to one or more than a very limited number of residents. Less than 1 percent of deficiencies cited constituted an immediate jeopardy situation in which residents were at immediate risk of serious injury or death. Facilities cited with deficiencies at a scope and severity of "A" through "C" are still considered to be in substantial compliance with federal regulations.

The total number of deficiencies cited by state survey teams has increased by about 41 percent over the last five years from about 1,700 deficiencies in Fiscal Year 2002 to about 2,400 deficiencies in Fiscal Year 2006. There were a total of about 229 licensed nursing facilities in Fiscal Year 2002 and about 217 licensed nursing facilities in Fiscal Year 2006. Although not all licensed nursing facilities undergo a certification survey (i.e., private pay nursing homes), surveyors appear to be citing more deficiencies per facility than in the past. In addition, data tracked by CDPHE show that Colorado's deficiency statistics generally exceed regional and national

statistics. For example, in Federal Fiscal Year 2005 CDPHE survey teams cited an average of about nine deficiencies per certification survey, whereas regional and national statistics show an average of about six deficiencies per certification survey. During this same period about 8 percent of Colorado's deficiencies were cited at a scope and severity of "G" or higher, whereas the regional and national percentages for "G" level or higher deficiencies were about 7 percent and 5 percent, respectively.

Federal law, regulations, and additional guidance issued by CMS outline specific protocols and procedures that surveyors must follow when conducting certification surveys and citing deficiencies at nursing facilities. Under its agreement with the federal government, CDPHE is responsible for ensuring that it complies with these requirements. Because the federal government dictates the overall structure and content of the nursing home inspection program for Medicare and Medicaid facilities, state survey agencies generally have few opportunities to deviate from these processes. As we describe in the following sections, our audit found that CDPHE's controls over the survey process do not provide sufficient assurance that surveyors are identifying all deficient practices on certification surveys and citing deficiencies at a level that accurately and sufficiently identifies the scope and severity of the deficiency, in accordance with federal requirements.

Survey File Review

As part of our audit, we contracted with TMF Health Quality Institute to provide specialized expertise in nursing home quality of care and certification surveys. Our contractor reviewed files documenting a judgmental sample of 10 nursing home certification surveys conducted by CDPHE during Fiscal Year 2006. We selected files to reflect surveys at facilities of different size and geographic location, and surveys with different deficiencies cited at a range of scope and severity levels. The purpose of the file review was to determine whether surveyors followed established federal protocols when conducting certification surveys and citing deficiencies.

Overall, our contractor reviewed the supporting documentation for a total of 123 deficiencies cited by CDPHE surveyors on the 10 sampled surveys. On the basis of its review, our contractor did not concur with the scope and severity determination for 32 of the 123 deficiencies (26 percent). As we discuss in further detail below, there were two general issues our contractor noted with these 32 deficiencies.

First, for 14 of the 32 deficiencies (44 percent) our contractor determined that the scope and severity should have been higher. More specifically, documentation contained in the survey file indicated that more residents or staff were involved in or affected by the deficient practice, or that the degree of actual or potential discomfort or harm involved for residents was greater than that assessed by the survey team. For example:

- In four cases, surveyors cited a deficiency because the facility did not store, prepare, and serve food under sanitary conditions. Among other things, the facilities did not store food at proper temperatures or use proper water temperatures and disinfecting agents when washing and sanitizing dishes and surface areas. Survey teams cited these deficiencies at a scope and severity of "E," indicating the potential for more than minimal harm to no more than a limited number of residents. Our contractor determined that, at a minimum, these deficiencies should have been cited at a higher scope and severity of "F" because poor food preparation, storage, and sanitation practices are likely to affect all or a large number of residents (i.e., widespread scope). In addition, surveyors did not document having made further inquiries to determine whether these poor practices resulted in food-related illnesses among residents, which would show evidence of actual harm and substantiate a higher severity determination.

- In three cases, surveyors cited a deficiency because of problems identified with the facility's infection control programs and procedures. One facility did not properly screen residents and workers for tuberculosis. The second facility did not ensure that staff washed their hands after direct resident contact. The third facility did not monitor and track active infections in residents and did not follow proper procedures for handling soiled linens and sanitizing laundry. Survey teams cited each of these deficiencies at a scope and severity of "E," indicating the potential for more than minimal harm to no more than a limited number of residents. Our contractor determined that, at a minimum, these deficiencies should have been cited at a higher scope and severity of "F" because of their potential to affect all or a large number of residents (i.e., widespread scope). Again, the survey teams also did not document having made further inquiries to determine whether these facility practices had actually contributed to infections among residents, which would show evidence of actual harm and substantiate a higher severity determination.

Second, our contractor found that survey files contained insufficient documentation to demonstrate that the survey teams fully investigated problems to determine whether more residents were involved, or whether the problems resulted in negative resident outcomes. As a result, for 18 of the 32 deficiencies (56 percent) that our contractor did not agree with , our contractor was unable to reasonably conclude that the survey team cited an appropriate scope and severity. In none of the cases did our contractor determine that the scope and severity should have been lower than what was cited. However, it is possible that further inquiry by the survey teams, such as additional record review or interviews with direct-care staff, residents, or family members, could have supported citing these deficiencies at higher scope and severity levels. For example:

- In one case, surveyors issued a deficiency citation because the facility did not honor a resident's Advance Directive. Specifically, the resident signed documentation upon being admitted to the facility indicating that she wanted cardiopulmonary resuscitation (CPR) to be administered in the event it became necessary. About eight months later, the resident's condition began to decline and she suffered cognitive impairments preventing direct communication with her family or facility staff. The resident's family subsequently completed a Do Not Resuscitate (DNR) order. Thus, contrary to the resident's specific directive, the facility made no attempt to resuscitate the resident when her vital signs stopped, and the resident died. The survey team found that the family and facility could provide no documentation that the resident had ever given legal authority to anyone to make medical decisions on her behalf. The survey team cited this deficiency at a scope and severity of "G," indicating actual harm occurred to one or very few residents. Our contractor was unable to concur with this scope and severity determination and noted that the survey team should have more thoroughly investigated this situation to assess whether a higher scope and severity was warranted. CDPHE staff reported that resident choice and DNR orders were a focus area for the resident samples on this survey. However, our contractor indicated that the survey team also should have examined past or current residents at the facility who had *not* signed a DNR order, since these were the residents most at risk if the nursing facility was not complying with residents' wishes. In addition, this particular problem was identified late in the survey process after the earlier resident samples had been reviewed. Thus, there is no assurance that surveyors' earlier reviews provided sufficient coverage of this type of problem.

- In another case, surveyors issued a deficiency citation because the facility did not ensure that call lights were accessible to residents. The survey team cited this deficiency at a scope and severity of "D," indicating the potential for more than minimal harm to one or a very limited number of residents. Our contractor was unable to concur with this scope and severity determination. When call lights are inaccessible, residents are at greater risk of falls or other injury because they may attempt activities, such as transferring from their bed to a wheelchair or using the bathroom, without assistance from facility staff. However, there was no evidence that the survey team took additional steps in their investigation to determine whether call lights being out of reach actually resulted in negative resident outcomes. Specifically, the survey team did not select resident falls as an area of focus for this particular survey. The survey team documented that resident concerns regarding the inaccessibility of call lights were known to facility staff for several months prior to the survey. However, surveyors did not investigate the facility's incident logs

for this same period to determine whether any falls or other injuries occurred that may have been related to inaccessible call lights.

- In a third case, surveyors issued a deficiency because the facility did not ensure the resident environment remained as free from accident hazards as possible. The survey team observed many potential accident hazards, including unlocked storage and supply rooms, exit doors being propped open, and exit door alarms not working. In one of the unlocked supply rooms, the surveyor identified a metal scraper containing a razor blade that had been left out in the open. The survey team cited this deficiency at a scope and severity of "E," indicating the potential for more than minimal harm to one or a very limited number of residents. Although the survey team properly noted that these situations created the potential for resident accidents and injuries, our contractor was unable to concur with the survey team's scope and severity determination because there was no evidence of further probes to identify whether any injury or other negative outcome resulted. For example, the surveyors found that exit doors to the facility were not properly secured, which could increase the risk for residents to leave the facility without the facility's knowledge. The survey team's observations should have led to a review of the facility's incident reports to determine whether any residents went missing in the preceding months.

Finally, our contractor identified additional deficiencies that were not cited by survey teams on 7 of the 10 sampled surveys. In particular, our contractor noted that surveyors' findings on five surveys documented that the facility did not adhere to residents' plans of care, which contributed to the deficient practices identified by the survey teams. CMS survey protocols instruct surveyors to determine whether problems identified with quality of care, quality of life, or resident rights can be attributed to incorrect implementation of the resident's plan of care, or lack of a care plan altogether. Although the survey teams cited quality of care deficiencies at these five facilities, surveyors did not also cite a care plan deficiency in accordance with CMS guidance. In addition to care plan deficiencies, our contractor determined that other deficiencies could have been cited on four surveys regarding facility staff competency, quality of care, pressure ulcers, failure to assess residents' physical conditions, and infection control issues.

Federal Comparative Surveys

A comparative survey is a type of monitoring survey that CMS conducts at Medicare- and Medicaid-certified nursing facilities. The main goals of the comparative survey are to assess state survey agency performance in interpreting and applying federal standards, recognize training needs of surveyors, identify problems that surveyors or providers encounter in implementing federal regulations, and identify deficient practices at facilities that need to be corrected. Comparative surveys are conducted by federal survey teams within 60 days after the selected state survey, thereby providing a basis for comparison with the state survey. We aggregated and analyzed the results of the 20 comparative surveys conducted by CMS during State Fiscal Years 2001 through 2005 and compared these results with those from state surveys conducted by CDPHE at the same facility just prior to the federal survey. Our analysis showed substantial differences in deficiency citations between state and federal surveys at the same nursing facility. These results corroborate those of our contractor's survey file review discussed in the last section. Overall, we found that state and federal survey teams cited the same deficiency with the same scope and severity only about 5 percent of the time. More specifically, we found:

- **State survey teams did not identify all deficiencies.** State and federal teams cited a total of 460 deficiencies on the 20 comparative surveys—267 were cited exclusively by federal surveyors, 75 were cited exclusively by state surveyors, and 59 were cited by both federal and state surveyors. Thus, state surveyors cited a total of 134 deficiencies, or an average of about 7 deficiencies per facility. However, federal surveyors cited a total of 326 deficiencies, or an average of about 16 deficiencies per facility. This is more than two times the average number of deficiencies cited per facility by state surveyors. Additionally, we found that for almost half (130 out of 267) of the deficiencies cited exclusively by federal surveyors, CMS expressed concern in its survey report that state survey teams had failed to cite deficiencies for conditions that were reasonably present in the facility at the time of the state survey.

- **State survey teams did not cite deficiencies at a sufficient level of scope and severity.** We found that of the 59 total deficiencies cited by both the state and federal survey teams, federal surveyors cited 26 deficiencies at a higher scope and severity than state surveyors. State surveyors cited 8 deficiencies at a higher scope and severity than federal surveyors. Federal and state survey teams cited the same scope and severity for the remaining 25 deficiencies.

Controls Over Surveys

Among other things, CMS considers a state's performance to be inadequate if the state demonstrates a pattern of failure to (1) identify deficiencies, and the failure cannot be explained by changed conditions in the facility or other case-specific factors; (2) cite deficiencies that are valid; or (3) conduct surveys in accordance with federal policies, protocols, and procedures. Our audit showed that Colorado's state survey teams are not going far enough in their inquiries and investigations to identify all deficient practices or to determine an accurate and sufficient scope and severity. To address the problems we identified, CDPHE needs to improve internal controls over certification surveys in several areas.

First, CDPHE needs to improve survey file documentation practices. Federal regulations [42 C.F.R. 488.18] as well as CMS guidelines require that survey findings be adequately documented and supported. However, our contractor's review of the deficiencies cited on the 10 sampled survey files was complicated by documentation problems. For example, some required forms were not completely filled out or easily identifiable in the survey files. The files did not follow a standard format and often contained unnecessary documentation. This made it difficult to link the written deficiency citation to the supporting documentation. Further, our contractor found that surveyors do not sufficiently document team decision-making processes, when negative outcomes are explored but not identified, or when potential issues have been resolved. Thus, as discussed earlier, in many cases our contractor was unable to reasonably concur with the scope and severity of the deficiency citation. There was no evidence that the survey team had fully investigated the issues and determined that no actual harm occurred, or that no other residents were at risk of harm. Certification surveys are an extensive process requiring surveyors to use their professional judgement when assessing facility practices against federal requirements. Consequently, good documentation practices are necessary to demonstrate the State's compliance with applicable federal survey requirements, to support surveyors' professional judgments and conclusions, and to defend deficiency citations during informal and formal appeals processes or court proceedings.

Second, CDPHE needs to ensure that staff follow and adhere to quality review processes and requirements. In February 2000 CDPHE established a quality review process and a corresponding form that survey supervisors must complete prior to releasing the survey results to the nursing facility or the public. The quality review form is intended to document and record changes to deficiencies, such as the addition or deletion of deficiencies and the reduction or increase in scope and severity. However, we found that survey supervisors do not follow required procedures for documenting their quality reviews. For example, the review form was missing or not completed for 2 of the 10 sampled surveys we reviewed. Review forms for seven of the eight remaining surveys were incomplete, had insufficient documentation of the

rationale for changes to deficiency citations, or lacked required reviewer sign-off and dates. Quality review processes are an important control to ensure that deficiency citations are defensible, promote consistency among surveyors when writing and categorizing deficiencies, and provide feedback to surveyors on their work. CDPHE should ensure that survey supervisors follow required quality review procedures, including use of the quality review form to track all changes made to deficiency citations. Rationale for changes as well as appropriate approval for changes should also be documented on the review form. In addition, CDPHE should explore ways to expand the use of existing quality review processes to ensure that survey files contain all required forms and sufficient documentation to support deficiencies cited, and that files are organized clearly and consistently by survey teams.

Third, CDPHE needs to strengthen supervisor involvement in the certification survey process. In particular, our contractor's interviews with surveyors indicated that supervisors and survey teams do not communicate with one another early enough in the survey process to help focus the review on potential problem areas, identify potential immediate jeopardy situations, and determine the full scope and severity of the deficient practice. Currently survey supervisors are only required to go in the field once per quarter. CDPHE should increase the frequency with which supervisors are required to be on-site with survey teams to provide guidance and observe surveyor performance during surveys. Identifying potential issues early in the survey is important, since survey teams are generally only on-site at a nursing facility for three to four days. If significant issues are not identified until late in the survey, the amount of time survey teams can spend fully investigating identified issues is limited and the team may not have sufficient evidence to cite a deficiency or to substantiate a higher scope and severity.

Finally, CDPHE should augment its surveyor training programs. Substantial federal and state resources are already dedicated to training surveyors. However, evidence from federal monitoring reports suggests that surveyors may need additional training on basic investigative skills. We aggregated the results from the 36 Federal Oversight Support Surveys (FOSS) conducted during Federal Fiscal Years 2001 through 2005. These surveys differ from the comparative surveys discussed earlier in that federal surveyors accompany and monitor state survey team performance during the state survey. Although the state survey teams generally scored high in each of the performance areas evaluated, the lowest scores were in the "general investigation" performance area. CDPHE should provide surveyors with more training on general investigative skills and protocols. According to CMS guidance on best practices, providing surveyors with more training in the legal aspects of the survey process can also enhance overall investigation and documentation skills and help surveyors perform effectively in the potentially adversarial regulatory environment.

Unidentified deficiencies or deficiencies that are not cited at an accurate or sufficient scope and severity potentially allow nursing facilities to continue deficient practices, placing residents at ongoing risk for harm and poor quality of care. Failing to cite deficiencies at an accurate or sufficient scope and severity further hampers efforts to seek more forceful enforcement remedies, such as civil money penalties, denial of payments for new admissions, or the facility's termination from Medicare or Medicaid. Moreover, CMS has the ability to impose sanctions against the State for failing to conduct certification surveys at nursing homes in accordance with federal requirements. Sanctions include such things as reducing federal matching funds for survey and certification activities.

Recommendation No. 1:

The Department of Public Health and Environment should improve controls over the certification survey process to ensure that surveyors identify all deficient practices and cite deficiencies at a level that accurately and sufficiently identifies the scope and severity of the deficiency, in accordance with federal requirements. Specifically, the Department should:

a. Ensure that survey staff follow established quality review procedures, including use of a standard review form to document and track all changes made to deficiency citations prior to their release to the nursing facility or the public. Rationale for all changes as well as appropriate approval for changes should be documented on the review form.

b. Explore ways to expand quality review processes to ensure the completion of required survey forms, the sufficiency of documentation in support of deficiency citations, and the overall survey file organization.

c. Work with survey supervisors to ensure timely communication with survey teams throughout the survey process and increase the frequency with which supervisors are required to be on-site with survey teams.

d. Implement a standard format for organizing certification survey files and relevant supporting documentation. Only documentation supporting the deficiency citations or demonstrating compliance with required survey protocols and procedures should be maintained in the survey file.

e. Improve documentation standards and work with surveyors and supervisors to ensure that required forms are properly labeled and completed and that results from inquiries, team meetings, and the resolution of potential issues are clearly and sufficiently documented.

f. Provide surveyors with more training on general investigative skills and protocols, as well as on the regulatory and legal aspects of the survey process.

Department of Public Health and Environment Response:

a. Partially agree. Implementation date: Implemented October 2006.

The CDPHE agrees that deficient practice should be cited at the most accurate scope and severity level; however, the CDPHE disagrees with the subjective evaluation criteria utilized by the Office of the State Auditor's hired contractor when reviewing past cited deficiencies. The CDPHE's citation of deficiencies against a facility is intended to notify the facility of a failure to meet standards and require a correction to get the facility back into substantial compliance with the federal standards. The citation of deficiencies against a certified facility typically results in the imposition of various remedies by CMS, up to and including termination of the facility's Medicare/Medicaid certification. The CDPHE cites the scope of the deficient practice as isolated, pattern, or widespread, and the severity as potential for minimal harm, potential for more than minimal harm, actual harm, and immediate jeopardy. It is important to note that the facility is required to rectify the deficient practice on a facility-wide basis, even when the deficiency cited was at an isolated or pattern level. Once the facility achieves substantial compliance with the standards as specified in their plan of correction and confirmed by the CDPHE surveyors on a revisit to the facility, any remedies imposed by CMS are retracted.

The CDPHE has modified the Protocol for Quality Review and the Quality Review Tool (QRT) Form for Long Term Care (LTC) Health Survey Deficiency Lists to include the recommendations made by the Office of the State Auditor. The standardized form is being utilized to document the review of all deficiency citations, including the tracking of changes made, the rationale for the changes, and how changes are communicated with the survey team. The protocol includes instructions for documenting additional citations, the movement of findings to different tag numbers, the reduction or increase in tag scope and severity, and the deletion of tags by the reviewer or team. The revised protocol and review form were put into effect in October 2006.

Auditor's Addendum:

Our contractor applied the criteria, protocols, and other guidance issued by the federal Centers for Medicare and Medicaid Services, which is the same criteria that CDPHE's surveyors must apply when conducting certification surveys and citing deficiencies. We note that CDPHE indicates it has taken the action contained in our recommendation.

b. Agree. Implementation date: October 2007.

The CDPHE will more closely examine its survey results and file organization to ensure that all Centers for Medicare and Medicaid Service (CMS) required forms are included and completed, and that appropriate documentation to support deficiency citations exists in the survey file.

c. Agree. Implementation date: July 2007.

The CDPHE will continue to have each of the four supervisors provide on-site supervision for one full survey each quarter. In addition, each supervisor will spend one day in the field per month providing on-site supervision during a survey. The survey teams will be expected to make phone contact with a supervisor on the second day of survey to review preliminary survey findings.

d. Partially agree. Implementation date: October 2007.

While the CDPHE agrees that enhanced file organization for linking written deficiency citations to supporting documentation is ideal, there are no specific CMS standards for file organization. This recommendation is beyond the Medicare/Medicaid certification requirements and must be prioritized in consideration of limited resources and workload needs. The CDPHE has a fixed federal budget for certification activities. Although enhanced file organization may be chargeable to that budget, doing so would require reducing the CDPHE's activities in some other certification tasks related to patient care and safety, such as performing on-site inspections or writing deficiencies. Implementation of this recommendation would require additional state funds. The CDPHE will take this recommendation into consideration when prioritizing future budget requests.

Auditor's Addendum:

Federal regulations require that state survey agencies' findings be adequately documented. Implementing a standard format for organizing survey files and other supporting documentation is a basic control to improve efficiency and ensure compliance with federal requirements.

e. Agree. Implementation date: October 2007.

While the CDPHE believes it has sufficient processes in place to maintain necessary documentation, we agree with the goal of improving documentation and will develop guidelines for documentation of the survey process in accordance with the CMS requirements. The guidelines will focus on improving documentation in the areas of investigations, interviews, and summaries of team meetings, consultations with supervisors, and whether potential issues identified have been resolved.

f. Partially agree. Implementation date: October 2007.

The CDPHE currently ensures that all surveyors receive required CMS training, which is substantial. While the Department agrees that additional surveyor training on investigative skills and the regulatory and legal aspects of the survey process would be valuable, especially for newer surveyors, it is outside of the scope of CMS training requirements. Implementation of this recommendation will require additional state funds. CDPHE will investigate its options for implementing this recommendation, including assessing whether additional state funds might be available for it.

Auditor's Addendum:

CMS's State Operations Manual specifies that each state survey agency is responsible for (1) providing continuing education to its surveyors and (2) ensuring that surveyors are trained to survey for all regulatory requirements and have the necessary skills to perform the survey. We believe the training needs identified by our audit fall within the scope of these existing federal requirements.

Survey Predictability

Federal law and regulations intend for surveys to be unpredictable and, therefore, place specific requirements on the timing and frequency with which CDPHE must conduct certification surveys at nursing facilities participating in Medicare or Medicaid. Specifically, federal regulations [42 C.F.R. 488.308] require that certification surveys be conducted at least once every 15 months; the statewide average interval between certification surveys of all nursing facilities cannot exceed 12 months. Federal regulations [42 C.F.R. 488.307] also require that all surveys be unannounced. Finally, CMS requires that at least 10 percent of surveys be scheduled in a staggered manner. This means that the survey must commence on a weekend day or holiday, or begin during the off-hours before 8:00 a.m. or after 6:00 p.m. on a weekday.

We reviewed the starting and ending dates for two complete survey cycles from July 2003 through April 2006. CDPHE complied with established requirements for survey timing and frequency. However, we found that a large percentage of certification surveys remain predictable. Using CMS guidance and criteria established by the U.S. Government Accountability Office (GAO), we considered a survey to be "predictable" if it took place in the same month as the previous certification survey, occurred within 15 days of the one-year anniversary date of the previous certification survey, or occurred within one month of the maximum 15-month interval between certification surveys. We found that 102 out of 405 surveys (25 percent) tested, or approximately one out of every four surveys, met at least one of these three predictability criteria. Additionally, there is evidence to suggest that surveys have become more predictable in recent years. Specifically, we found that:

- 76 out of 405 certification surveys (19 percent) began in the same month as the previous year.

- 87 out of 405 certification surveys (21 percent) were conducted within 15 days of the one-year anniversary date of the previous survey. On average, we determined that these 87 surveys fell within about 12 days of the one-year anniversary date of their prior survey. The percentage of surveys meeting this criterion has increased over the last several years. The GAO found that in 2002 about 9 percent of Colorado's surveys fell within 15 days of the anniversary date. The GAO found that in 2005 this percentage had increased to about 15 percent, which was just over the national average.

- 2 out of 405 certification surveys (less than 1 percent) occurred within one month of the maximum 15-month interval between standard surveys.

Certification surveys should be as unpredictable as possible to help ensure that surveyors get an accurate picture of how the facility operates on a daily basis when surveyors are not present. When nursing facilities are able to anticipate their certification survey they may potentially alter normal operations, such as increasing staffing levels or reviewing and correcting patient records, in an attempt to avoid receiving deficiency citations from surveyors. During our site visits, most nursing facilities reported that they generally anticipate when their next certification survey might take place. For example, one facility we visited was nearing the end of its 15-month survey window and reported to us they were expecting the state survey team to show up any day. This facility was part of a corporate chain and we noted during our site visit that the facility had a number of additional corporate staff on hand, presumably in anticipation of their survey. CDPHE started a survey at this facility four days after we had completed our site visit.

There are a number of factors CDPHE considers when scheduling certification surveys, including past noncompliance and staff availability. At the time of our audit, CDPHE did not routinely consider predictability as a key decision factor when scheduling certification surveys, nor did CDPHE use summary reports on survey interval data to monitor trends in survey predictability. Tracking data on survey predictability and routinely using predictability criteria as a key decision factor in the survey scheduling process would help CDPHE to decrease the percentage of certification surveys that are considered to be predictable. CDPHE could also make more use of surveys that start at staggered times (e.g., off-hours, weekend, or holiday) to help reduce survey predictability. For example, we found that only about 10 percent of staggered surveys met one of the three predictability criteria discussed earlier. Even in those cases where survey scheduling cannot avoid meeting one of the predictability criteria, utilizing a staggered start time would still make the survey less predictable to nursing facilities. Finally, less than 1 percent of CDPHE's surveys occur in the fifteenth month and just over 4 percent of surveys occur within nine months of the prior survey. Thus, making more use of the entire 15-month survey window could give CDPHE more flexibility when scheduling and further reduce nursing facilities' ability to anticipate their next certification survey.

Recommendation No. 2:

The Department of Public Health and Environment should work to improve the unpredictability of certification surveys by:

a. Ensuring that predictability is routinely used as a key decision factor when scheduling certification surveys. This should include exploring ways to utilize staggered surveys and the full 15-month survey window to diminish

the likelihood that nursing facilities can anticipate when they will be surveyed.

b. Including statistics in existing summary reports of survey interval data to monitor trends and assess performance related to survey predictability.

Department of Public Health and Environment Response:

a. Agree. Implementation date: Implemented October 2006.

According to the GAO-06-117 Nursing Home Quality and Safety Initiatives report, in 2005 Colorado's survey predictability was 15 percent versus the mean national average of 14.5 percent. CDPHE believes that survey predictability is only one factor in gaining an accurate picture of day-to-day care patterns and practices at facilities, but will strive to lower its survey predictability percentage. In October 2006, CDPHE modified its survey scheduling protocol to test against the three GAO predictability factors. Under the modified protocol, if scheduling the survey fails all three predictability factors that are typically due to uncontrollable circumstances (e.g., staffing issues, complaint investigation that trigger full surveys), a staggered survey is used to offset predictability. Any scheduled survey which meets one of these predictability factors must be approved by a program manager, with a written explanation of the scheduling issue, alternative used, and mitigating factors.

b. Agree. Implementation date: July 2007.

CDPHE has various reports and computerized data that will help us with survey scheduling and being less predictable in conducting nursing facility surveys. The CDPHE will consolidate and update these various reports and tools into one computerized interface that will make it easier for nursing home supervisors and managers to plan and monitor survey predictability and performance. The program manager will review reports on a quarterly basis to monitor trends and provide performance feedback to nursing home supervisors.

Complaints

An important part of CDPHE's oversight responsibilities includes receiving and investigating complaints against nursing facilities. Because certification surveys generally occur only once within a 15-month period, CDPHE relies on complainants to report problems or adverse conditions at nursing facilities, thereby providing on-going coverage and monitoring between certification surveys. Complaints come from many different sources, including residents, family members or guardians, current and former nursing home staff, and ombudsmen. Complaints may also be filed anonymously. On average, CDPHE handles more than 400 complaint cases covering more than 1,300 separate allegations filed each year. Complaints either initiate a separate survey at the facility or are included as part of a regularly scheduled certification survey. Survey teams investigate the complaint to determine whether the allegation is substantiated or unsubstantiated, and may cite the facility with a deficiency. CDPHE substantiated through investigation about 27 percent of all nursing home complaint allegations received over the last five fiscal years. About 43 percent of all complaints related to quality of care or treatment issues, such as call lights not being answered in a timely manner or medications not being administered according to physician instructions. Other common types of complaints related to resident rights and safety, allegations of resident abuse or neglect, dietary concerns, and facility staffing.

Prioritization

CMS guidance and CDPHE's complaint policies define criteria for placing nursing home complaints into one of five priority levels—Priority A through Priority E—based on an assessment of the level of actual or potential harm to residents' health and safety. All but the lowest-priority complaints require an on-site investigation at the facility. Lower-priority complaints may be included and investigated during the next certification survey.

The table below shows the total number of nursing home complaints by priority level for Fiscal Years 2002 through 2006. On average, nearly 60 percent of complaints received over the last five fiscal years were Priority B, indicating that the complainant alleged harm or other conditions of such consequence to the resident's well-being that a rapid response is necessary.

Department of Public Health and Environment
Nursing Facility Complaint Cases by Priority Level
Fiscal Years 2002–2006

Priority Level	Fiscal Year					5-Year Average
	2002	2003	2004	2005	2006	
Priority A Immediate Jeopardy	9 1.9%	26 6.1%	31 8.2%	40 9.6%	30 6.9%	27 6.4%
Priority B High, Non-Immediate Jeopardy	264 56.4%	254 59.9%	205 54.5%	264 63.5%	270 61.8%	251 59.3%
Priority C Medium, Non-Immediate Jeopardy	157 33.6%	107 25.2%	119 31.7%	97 23.3%	127 29.0%	121 28.6%
Priority D Low, Non-Immediate Jeopardy	28 6.0%	27 6.4%	12 3.2%	8 1.9%	6 1.4%	16 3.8%
Priority E Administrative Review	10 2.1%	10 2.4%	9 2.4%	7 1.7%	4 0.9%	8 1.9%
Total	**468** **100%**	**424** **100%**	**376** **100%**	**416** **100%**	**437** **100%**	**424** **100%**

Source: Office of the State Auditor's analysis of nursing facility complaint data provided by the Department of Public Health and Environment.
Note: Each individual complaint case may include more than one separate allegation to be investigated.

CDPHE maintains an automated system, known as the Complaint Priority Assessment System (COMPASS), that prioritizes nursing home complaints according to CMS and state guidelines by assigning points to information gathered during the complaint intake. For example, more serious allegations of abuse, or allegations where the level of actual or potential harm to residents is high, receive more points resulting in a higher overall priority level for the complaint. COMPASS also pulls historical data on the nursing facility and assigns more points to complaints filed against nursing facilities with a history of similar complaints, poor certification survey results, and enforcement actions. According to CDPHE's complaints manual, the initial complaint assessment and prioritization is made by COMPASS, followed by a secondary review of the priority evaluation by the complaints manager to confirm the correct priority. If the complaint manager decides to change the priority level from the COMPASS assignment, then an explanation for the change must be entered into the complaint tracking system.

We reviewed a sample of 10 nursing facility complaints CDPHE investigated in Fiscal Year 2006 to determine whether they were properly prioritized in accordance with federal and state criteria. We agreed with the final prioritization for all 10 complaints. However, we noted that for 4 of the 10 sampled complaints, COMPASS assigned an initial priority level that differed from the final priority level determined

by the complaint program manager. In all four cases, COMPASS assigned the complaint as "Priority B," indicating a high-priority non-immediate jeopardy situation. Upon secondary review by staff, two of the complaints were upgraded in priority and two of the complaints were downgraded in priority. This decision to "override" the system-generated priority suggests that COMPASS may not be prioritizing complaints in a manner that is consistent with current standards and practices. Only three of the four complaints had an explanation for the change in priority entered into the complaint tracking system.

Prioritization is an important part of efficiently managing limited resources and ensuring that the most serious complaints receive immediate attention. An effective decision support system is one that properly applies criteria and emulates human decision-making processes. Thus, there should be few instances of disagreement between the initial system-generated priority and the final priority determined through secondary review. Staff reported that the point schedules programmed in COMPASS have only been updated twice since the system was created; the most recent update was three years ago. CDPHE should review the point schedule in COMPASS on a more routine basis to ensure that the system continues to weigh relevant information and prioritize complaints appropriately and in accordance with current standards and practices.

Timeliness

Under federal regulations [42 C.F.R. 488.332 and 335], the State is responsible for establishing procedures and maintaining adequate staff to investigate complaints against nursing facilities in a timely manner. As noted earlier, CDPHE handles an average of more than 400 complaints covering more than 1,300 separate allegations each year, many of which are substantiated through investigation. Thus, investigating complaints in a timely manner is critical to ensuring that potentially serious health and safety risks to residents are addressed. As we discuss in this section, we found that the guidelines for investigating nursing home complaints are not clear or consistent. We also found that not all nursing home complaints are being investigated in a timely manner.

The table below illustrates the variation between federal and state standards for investigating nursing home complaints. The only priority level where state and federal time frames are specific and consistent is for Priority A complaints, which require an on-site investigation within two working days. Specific time frames for investigating complaints in the remaining four priority levels appear to be conflicting, insufficient, or are lacking. For example, an on-site investigation of Priority B complaints must begin within 10 working days or within an *average* of 10 working days, depending on which standards are used. There is no specific federal time frame for investigating Priority C complaints, only that an on-site investigation

is required. CDPHE's complaints policy states that an on-site investigation of Priority C complaints must begin within approximately 45 working days.

Department of Public Health and Environment
Comparison of Federal and State Standards for Investigating Nursing Facility Complaints

Priority Level	CDPHE Complaints Policy	CMS State Operations Manual[1]	CMS State Performance Standards[2]
Priority A Immediate Jeopardy	On-site investigation within two working days.	On-site investigation within two working days.	On-site investigation within two working days.
Priority B High, Non-Immediate Jeopardy	On-site investigation within an average of 10 working days.	On-site investigation within 10 working days.	On-site investigation within an average of 10 working days.[3]
Priority C Medium, Non-Immediate Jeopardy	On-site investigation within approximately 45 working days.	On-site investigation. No time line specified.	Not specified.
Priority D Low, Non-Immediate Jeopardy	On-site investigation with the next certification survey. No time line specified.	On-site investigation with the next certification survey. No time line specified.	Not specified.
Priority E Administrative Review	Off-site investigation. No time line specified.	No on-site investigation required. No time line specified.	Not specified.

Source: Office of the State Auditor's analysis of nursing home complaint investigation standards specified by the Department of Public Health and Environment (CDPHE) and the federal Centers for Medicare and Medicaid Services (CMS).
[1]Operational policies and procedures issued by CMS for carrying out the certification process as authorized in federal law and regulations.
[2]Threshold criteria specified by CMS to quantitatively measure and evaluate states' performance in the certification process.
[3]CMS has relaxed this standard in recent years. In Federal Fiscal Years 2001 and 2002 the performance standard required an on-site investigation of 100 percent of Priority B complaints within 10 working days. In Federal Fiscal Year 2003 the performance standard required an on-site investigation of 95 percent of Priority B complaints within 10 working days. In Federal Fiscal Year 2004 CMS established the current standard requiring an on-site investigation of 100 percent of Priority B complaints within an *average* of 10 working days.

In addition to the various written policies, CDPHE staff must enter complaint data into CMS's electronic complaint tracking system, known as ACTS, which automatically assigns each complaint case a due date for starting the investigation. ACTS sets due dates at 2, 10, 45, and 120 working days after receipt of the complaint for each of the five priority levels, respectively (Priority D and E complaints have the same time frame). CMS guidance further specifies that the State's time frames for investigating complaints should be used when they are more stringent than the federal time frames.

We obtained and analyzed nursing home complaint data from Fiscal Years 2002 through 2006. Because the criteria for investigating complaint cases were not always

clear or consistent, we used a reasonableness approach and applied 2-, 10-, 45-, and 120-working-day time frames to each corresponding priority level for evaluating the timeliness of CDPHE's nursing home complaint investigations. On the basis of these benchmarks, we found that the investigation of over 16 percent of all nursing home complaints did not begin in a timely manner. More specifically, we found:

- The investigation for 14 of 121 Priority A complaints (12 percent) did not begin within 2 working days in accordance with federal and state requirements. In the case of one substantiated Priority A complaint, CDPHE took 82 days to begin the investigation. This complaint raised a quality-of-care issue in which the facility failed to promptly assess a number of residents after a change in their physical or mental condition. One resident in particular was vomiting and had significant weight loss over a three-week period, yet the facility did not reassess the resident's condition or address these issues in the resident's care plan.

- The investigation for 201 of 1,136 Priority B complaints (18 percent) did not begin within 10 working days. On average, CDPHE began an investigation of all Priority B complaints within about nine working days. However, we found that CDPHE took 15 or more working days to start investigating 111 of the 201 Priority B complaints (55 percent) whose investigation started after 10 working days. In one case, CDPHE took 96 days to begin investigating a complaint filed by facility staff alleging physical abuse of a resident. Although the allegation was not substantiated, it is troubling that CDPHE did not initiate this investigation for more than three months, especially when considering the nature of the complaint.

- The investigation for 92 of 526 Priority C complaints (17 percent) did not begin within 45 working days in accordance with CDPHE's complaints policy. On average, CDPHE began an investigation of all Priority C complaints within about 28 working days. However, we found that CDPHE took more than 50 working days to start investigating 79 of the 92 Priority C complaints (86 percent) whose investigation started after 45 working days. One complaint case involved 13 separate allegations, including that the facility failed to provide a resident with adequate incontinence care or ensure that a resident's supplemental oxygen was operational. This complaint was not substantiated, but CDPHE took 167 working days to begin the investigation.

- The investigation for 5 of 104 Priority D and Priority E complaints (5 percent) did not begin within 120 working days. CDPHE took between 127 and 189 working days to begin investigating these 5 complaints.

CDPHE staff reported that flexible time frames for starting complaint investigations assists with allocating limited resources. However, flexible time frames also present a risk that complaint investigations will not begin in a timely manner. In particular, performance standards based on averages do not ensure accountability to individual complainants. As we have discussed, nearly 60 percent of nursing home complaints are classified as Priority B, and CDPHE took up to three months to begin investigating some of these complaints.

CDPHE needs to improve controls over the investigation of nursing home complaints by establishing clear and consistent time frames for initiating complaint investigations within each priority level. These time frames should ensure compliance with federal minimum standards while also ensuring accountability to individual complainants. Complaint investigations contribute to the overall effectiveness of CDPHE's oversight of nursing facilities. When complaint investigations are not started in a timely manner, CDPHE is unable to ensure that nursing home residents receive proper care and do not remain in substandard or potentially dangerous situations.

Recommendation No. 3:

The Department of Public Health and Environment should work to improve the prioritization and timeliness of nursing facility complaint investigations by:

a. Reviewing and updating the point schedules programmed in the Complaint Priority Assessment System (COMPASS) to ensure the proper prioritization of nursing home complaints in accordance with current standards, practices, and relevant decision criteria. Such review should be done at least annually.

b. Establishing clear and consistent time frames within which each complaint investigation at a given priority level should begin.

c. Review reports of complaints data on a routine basis to determine if nursing home complaint investigation time frames are being met, and take action as appropriate.

Department of Public Health and Environment Response:

a. Agree. Implementation date: April 2007.

The COMPASS program is a decision support system designed to aid the complaints manager and staff with setting early prioritization on complaints; however, the Department ensures that the correct prioritization of complaints occurs by using human judgment as the final determinant of a complaint's prioritization. The CDPHE will annually update the COMPASS program to prioritize complaints according to current standards, practices, and relevant decision criteria.

b. Agree. Implementation date: April 2007.

CDPHE will establish consistent time frames for beginning each of the complaint priority levels. CMS requires on-site investigation to start within 2 working days for Priority A complaints and to start within 10 working days for Priority B complaints. The CDPHE met CMS quality standards for 100 percent of Priority A and Priority B complaints in the draft federal fiscal year 2006 State Performance Standards Review Report. CMS does not specify when on-site investigations must start for Priority C, D, and E complaints. The CDPHE's practice has been to follow CMS policies when investigating certification complaints. Considering CMS workload requirements, complaint Priorities C, D, and E must be established to start investigations during the next on-site survey, which may be up to 15 months from when the complaint is alleged. Establishing and adhering to investigation start time frames sooner than 15 months for Priorities C, D, and E Medicare/Medicaid and comparable state priority complaints will require additional state funding and resources.

c. Agree. Implementation date: April 2007.

CDPHE will review the complaints data report (aging report) on a regular basis. Each reviewed report will be initialed by the complaints manager or designee and kept in a file. The complaints manager will use the data to ensure that complaint investigation time frames are being met in accordance with federal minimum standards and CDPHE-established time frames by priority level.

Occurrences

Federal regulations [42 C.F.R. 483.13(c)] require nursing facilities to investigate, report on, and take proper corrective action for all incidents involving alleged resident mistreatment, neglect, or abuse, injuries of unknown source, and misappropriation of resident property. In addition to federal regulations, state statute [Section 25-1-124(2), C.R.S.] requires all licensed health facilities, including nursing homes, to self-report certain types of incidents or "occurrences" to CDPHE. Reportable occurrences under state statute include such things as unexplained deaths; severe burns; missing persons; mistreatment or neglect; physical, verbal, or sexual abuse; diverted drugs; and misappropriation of resident property. According to CDPHE's occurrence investigation policy, nursing facilities must give notice to CDPHE within one business day of the occurrence and file a written report of their internal investigation with CDPHE within five business days. Occurrences differ from complaints in that the nursing facility is responsible for self-reporting the incident to the State and investigating the occurrence. CDPHE is responsible for logging the occurrence notification and reviewing the nursing facility's investigation to determine whether the facility took appropriate action. CDPHE can cite deficiencies if state or federal regulations were violated as a result of the occurrence.

Overall, CDPHE receives and investigates an average of about 1,100 occurrence reports from nursing homes each year. Allegations of physical abuse are the most frequently reported type of occurrence, representing 46 percent of all reports during Fiscal Years 2002 through 2006. Allegations of verbal abuse (12 percent), allegations of sexual abuse (10 percent), misappropriation of resident property (9 percent), and missing persons (8 percent) complete the top five most frequently reported types of occurrences. It is important to note that the reporting of an occurrence by a nursing facility does not necessarily mean that the allegation was founded or the facility failed to act appropriately.

As part of our audit, we analyzed data on nursing facility occurrences from Fiscal Years 2002 through 2006 and reviewed a sample of 10 closed occurrence cases from Fiscal Year 2006. We noted several concerns related to occurrence reporting and investigation, as described in the following sections.

Timeliness

We reviewed CDPHE's policies and practices for assessing the timeliness of facility notification and reporting of occurrences, as well as for assessing the timeliness of CDPHE's occurrence investigations. We determined that CDPHE's criteria for reporting and investigating occurrences are neither sufficient nor compliant with federal requirements.

State statute [Section 25-1-124(5), C.R.S.] charges CDPHE with investigating reported occurrences at all health care facilities, including nursing homes. CDPHE prioritizes occurrences into one of three categories: high, medium, or low. CDPHE designated about 67 percent of occurrence reports filed in the last five fiscal years as medium priority. CDPHE policy establishes standards for the timely completion of occurrence investigations based on the designated priority level. High-priority occurrences should be investigated within an average of 15 days, medium-priority occurrences should be investigated within an average 45 days, and low-priority occurrences should be investigated within an average of 60 days. The table below illustrates the average number of days it took CDPHE to investigate occurrences reported in the last five fiscal years.

Department of Public Health and Environment
Average Time to Complete Nursing Home Occurrence Investigations by Priority Level
Fiscal Years 2002–2006

Priority Level	Number of Occurrences	CDPHE Performance Benchmark	Average Length of Investigation
High	160 3%	Investigate within an average of 15 days.	29 days
Medium	3,550 67%	Investigate within an average of 45 days.	22 days
Low	1,567 30%	Investigate within an average of 60 days.	23 days
Total[1]	**5,277** **100%**		**23 days**

Source: Office of the State Auditor's analysis of occurrences data provided by the Department of Public Health and Environment (CDPHE).
[1]Total number of occurrences with valid data in CDPHE's occurrence tracking database. We excluded 46 cases from the analysis because of missing or invalid dates by which to measure the length of the investigation. We also excluded from the analysis a total of 272 cases across all priority levels where the investigation was "on hold" pending receipt of outside information (e.g., police report).

Although CDPHE met established benchmarks for low- and medium-priority occurrences, it did not meet the benchmark for high-priority occurrences. For the 160 occurrences designated as high priority in Fiscal Years 2002 through 2006, the average length of time for CDPHE to complete its investigation was 29 days. This is almost twice the length of time allowed in CDPHE's policy for completing such investigations. We found that 112 of the 160 high-priority occurrence cases (70 percent) took longer than 15 days to complete. Moreover, similar to our discussion in the previous section regarding complaints, using averages to set timeliness standards does not ensure accountability for the investigation of individual

occurrences. For example, although CDPHE met the established benchmark for investigating medium-priority complaints, 283 of the 3,550 medium-priority cases (8 percent) took CDPHE longer than 45 days to investigate. A total of 145 of the 283 cases (51 percent) took CDPHE longer than 60 days to complete, including one investigation of an abuse-related occurrence that lasted 120 days.

Our analysis focused on the timeliness of *completing* occurrence investigations in accordance with the criteria outlined in CDPHE's existing policy. CDPHE staff reported that, in the future, the occurrence policy will be revised to measure timeliness on the basis of when the occurrence investigation is *initiated*. As part of this policy revision, CDPHE needs to establish and adhere to more specific standards for occurrence investigations, including a set time frame within which each occurrence investigation at a given priority level should begin.

Finally, we found that the State's occurrence notification requirements do not comply with federal regulations for nursing facilities. As discussed earlier, federal regulations [42 C.F.R. 483.13(c)] require nursing facilities to give notice of certain alleged violations. Such notice must be made immediately to the nursing home administrator and to other state officials in accordance with state law. CMS guidance clarifies that this notice should be given within 24 hours. However, state licensing regulations [6 CCR 1011-1, Chapter II, Section 3.2] require health facilities to notify CDPHE of occurrences within one business day. CMS guidance specifically prohibits states from establishing longer time frames for reporting by nursing homes than what is mandated in federal regulations. CDPHE currently maintains a 24-hour telephone reporting line, which is capable of receiving occurrence notifications after hours and over the weekend. CDPHE should revise the state regulations for occurrence reporting by nursing facilities to comply with federal regulations requiring initial notification within 24 hours.

Data Issues

CDPHE maintains an electronic database that tracks information on occurrences, including such things as the type and date of the incident, persons involved, and reporting and investigation dates. During our audit we identified problems that compromise CDPHE's ability to accurately and effectively determine nursing facilities' compliance with state and federal occurrence reporting requirements and assess the timeliness of CDPHE's occurrence investigations.

First, we found that CDPHE does not track all data relevant to measure the timeliness of occurrence reports. We analyzed occurrence data and found that about 16 percent of the occurrences received during Fiscal Years 2002 through 2006 were reported after CDPHE's required time frame of one business day. However, we found that

about 60 percent of occurrence reports received after one business day were labeled as "on time" in CDPHE's occurrences database. Staff reported that this apparent discrepancy in the figures is due to the fact that it can be several days before a facility becomes aware of an incident and, therefore, is required to report it. This is a meaningful distinction to make when determining compliance with reporting time frames; however, CDPHE's occurrence database does not track the date the facility becomes aware of the incident separate from the actual date of the incident. Our review of data maintained for a sample of 10 occurrence cases confirmed that in 8 cases the occurrence date field was the actual date the incident occurred, and in 2 cases it was the date the nursing facility became aware of the incident.

Second, we found a problem with investigation hold dates entered into the system. CDPHE places occurrence investigations "on hold" pending the receipt of other outside information, including information related to police investigations or the results of concurrent complaint investigations. We found inconsistencies between the investigation hold dates and the investigation start and end dates. For example, 172 of the 272 (63 percent) occurrence investigations that CDPHE placed "on hold" had a hold end date in the system that fell after the date the investigation was completed. In 40 of the 272 cases (15 percent), we found that the hold start date fell after the date the investigation was completed. Placing an occurrence investigation on hold may be an appropriate action. However, these apparent inconsistencies between the investigation dates and the hold dates suggest that the investigation time frames may not be accurate for cases placed on hold. For this reason, we excluded occurrence cases with hold dates from our timeliness analysis discussed earlier.

Occurrence reports deal with serious incidents affecting the well-being of nursing home residents, including such things as injuries of unknown source, severe burns, missing persons, and alleged resident abuse. To ensure that occurrences receive sufficient oversight and attention, CDPHE needs good information for assessing facility compliance with reporting requirements and the timeliness of its investigations. CDPHE should modify its occurrence database and staff practices to ensure that all dates relevant to occurrence reporting and investigation time frames are captured accurately and tracked in a more systematic and consistent manner.

Recommendation No. 4:

The Department of Public Health and Environment should improve its occurrence reporting and investigation program by:

a. Strengthening standards for occurrence investigations to include specific time frames within which each occurrence investigation at a given priority level should begin.

b. Revising nursing facility occurrence reporting requirements set forth in state regulations to comply with federal regulations and guidance requiring notification within 24 hours.

c. Modifying the occurrences database and working with staff to ensure that all data relevant to occurrence reporting and investigation are captured accurately and tracked systematically and consistently.

d. Reviewing reports of occurrence data on a routine basis to determine if nursing home occurrence reporting and investigation time frames are being met, and taking action as appropriate.

Department of Public Health and Environment Response:

a. Agree. Implementation date: Implemented January 2007.

CDPHE modified its occurrence investigation policy in January 2007 to include specific time frames by priority level within which occurrence investigations should begin.

b. Agree. Implementation date: July 2007.

The CDPHE's regulations will be modified to mandate reporting of occurrences within 24 hours.

c. Agree. Implementation date: July 2007.

The occurrence database will be modified to track the date the incident occurred as well as the date the facility became aware of the incident. Additionally, the database will be reviewed to resolve any inconsistencies concerning investigation dates.

d. Agree. Implementation date: July 2007.

The CDPHE currently reviews the occurrence data on a routine basis to monitor nursing home compliance with reporting and takes action as appropriate. CDPHE will reassess its tracking and review processes and

make appropriate changes once the occurrence database modifications have been completed.

Informal Dispute Resolution

Federal regulations [42 C.F.R. 488.331(a)] require state survey agencies to provide an informal dispute resolution (IDR) process for nursing facilities participating in Medicare or Medicaid that wish to challenge a deficiency citation. CDPHE's IDR policy defines the specifics of this review process. Approximately 6 percent of all deficiencies cited on health surveys during Fiscal Year 2006 were disputed by nursing facilities through the IDR process. Most IDR requests are reviewed by an IDR Committee (Committee) comprising seven primary voting members and seven alternate members, including CDPHE staff, nursing facility representatives, long-term care ombudsmen, or other state agency personnel. The Health Facilities and Emergency Medical Services Division Director selects Committee members from a pool of applicants based on their qualifications and experience. The Committee meets monthly, and its recommendations are subject to final review and approval by the Division Director. Any disputed deficiencies that constitute immediate jeopardy (i.e., deficiencies cited at a scope and severity of "J," "K," or "L") bypass the Committee and go directly to the Division Director for review. Disputes of life safety code deficiencies also bypass the committee review process and are reviewed by CDPHE staff who did not participate on the original survey. Typically, facilities submit one IDR request, but the request may include disputes for multiple deficiencies. Approximately 29 percent of the nearly 470 deficiency citations reviewed through CDPHE's IDR process between August 2003 and August 2006 were either reduced in scope and severity or deleted altogether.

We examined documentation for 139 disputed deficiencies reviewed by the IDR Committee from September 2005 through August 2006 and observed two Committee meetings to determine whether established IDR policies were followed. We found concerns in two areas.

- **Unallowable Requests.** Under both CMS and CDPHE policy, nursing facilities cannot use the IDR process to challenge the scope and severity of a deficiency citation when the deficient practice itself is not challenged. The only exception to this is when the deficiency constitutes a determination of "Substandard Quality of Care" (i.e., deficiencies related to quality of life, quality of care, or resident behavior and facility practices that are cited at a scope and severity level of "F" or "H" through "L"). We found that 8 of the 139 (6 percent) deficiency requests accepted during the period we reviewed were unallowable because the facility petitioned for a reduction in the scope

and severity of the deficiency citation but did not actually dispute the deficient practice. In one case, the facility requested IDR for a deficiency cited at a scope and severity of "G" as a result of the facility's failure to administer a resident's pain medication in a timely manner. However, in the documentation submitted for IDR, the facility clearly requested that the scope and severity be reduced to a "D" but did not dispute the untimely delivery of the medication. For an additional 16 of the 139 (12 percent) deficiency requests we reviewed, it was unclear whether the request was allowable for IDR because the facility asked for either a deletion of the deficiency, a reduction in scope and severity, or both. CDPHE staff acknowledged that they accept these types of requests but reported that the Committee still reviews the basis for the deficiency before reviewing the scope and severity. Staff reported that this practice is to avoid sending the IDR request back to the facility for clarification, which can delay the process and require additional resources. However, according to CDPHE's policy, requests that do not meet the requirements for submission should be returned to the facility. In the cases noted above, CDPHE did not return the requests or notify the facilities that their requests did not meet state or federal requirements.

- **IDR Committee Members.** CDPHE's IDR policy prohibits the participation of alternate voting members in Committee proceedings unless the primary voting member is absent or is required to abstain from deliberations due to a conflict of interest. However, we observed primary voting members and alternate voting members regularly rotating on and off the Committee during a single meeting. For example, all primary voting members would participate in the discussion of the first facility's dispute. After the discussion related to that particular dispute ended, primary voting members would leave the table and the alternate voting members would join the table for discussion of the next facility's dispute. CDPHE staff reported that preparation for each monthly meeting is time-consuming and that the large volume of materials related to each request creates a heavy workload for the primary voting members. Therefore, Committee practices have evolved to regularly include alternate voting members in the review as a way of distributing the workload.

Accepting IDR requests that do not meet the requirements for review compromises the equitable treatment of nursing facilities and may provide an unfair advantage to those facilities who become aware of this practice. Moreover, this practice increases the risk that a deficiency may be inappropriately deleted or reduced in scope and severity. For example, the outcome of the IDR review for 5 of the 24 (21 percent) requests that we determined were unallowable or questionable ultimately resulted in a reduction in scope and severity or a deletion of the deficiency citation. Finally,

staff and Committee workloads are increased by reviewing unallowable requests or requests that do not clearly comply with CDPHE policy and federal requirements. CDPHE should strengthen its processes for accepting IDR requests to ensure that requests reviewed by the Committee comply with all applicable requirements. This could include the use of a standard form to help streamline the IDR intake process and better identify requests that do not meet such requirements. Requests that do not meet established requirements should be returned to the nursing facility for resubmission. Further, the alternate members' regular participation in the Committee proceedings is a reasonable approach to alleviate the Committee's heavy workload. However, it is not consistent with current policy. In this case, CDPHE should update its IDR policy to reflect current practice and address the fact that alternate voting members are no longer functioning as "alternates" but are acting as primary voting members on the Committee.

Recommendation No. 5:

The Department of Public Health and Environment should ensure compliance with state and federal requirements governing informal dispute resolution (IDR) processes by:

a. Strengthening the intake and staff review of nursing facilities' IDR requests for compliance with established submission requirements. Requests that do not meet established requirements should be returned to the nursing facility for resubmission.

b. Revising policies to reflect current practice regarding primary and alternate voting members' participation on the IDR Committee.

Department of Public Health and Environment Response:

a. Agree. Implementation date: Implemented September 2006.

In September 2006 the Informal Dispute Resolution policy was revised to address the issue of how requests would be handled if facilities only challenge the classification (scope and severity). If the committee chair determines that the facility has not met the established requirements for submission, the requests are returned to the facility for revision. On September 15, 2006 the policy was made available on the Division's Web site and all facilities were notified of the policy changes by fax. A follow-up notification was also given at the November 7, 2006 Long

Term Care Advisory Committee meeting and notice of the revisions were included in the Division's fall newsletter.

b. Agree. Implementation date: Implemented October 2006.

CDPHE has implemented policy changes to reflect the Division's practice regarding utilization of the primary and alternate voting members on the IDR Committee. The revised policy states, "the voting member and the alternate member may elect to share their positions, rotating their attendance monthly or attending monthly, but dividing the IDR requests between them." These policy changes also went into effect October 2006 after all voting and alternate voting members were advised of the change.

Feedback Mechanisms

Management has a responsibility to ensure an effective survey process, including upholding the expectation that surveyors are fair, objective, and professional in the conduct of their job duties. Soliciting feedback from nursing facilities provides information on the survey process and overall survey team performance that cannot be obtained through other means. Currently CDPHE invites feedback via a short questionnaire provided to nursing facilities at the end of each survey. The questionnaire asks facilities to rate various aspects of the survey, such as information sharing and communication, discussion of survey findings and deficiencies, conflict resolution, and overall survey team conduct. Facilities also have the opportunity to write in additional comments and are asked if they would like a follow-up phone call to further discuss any issues. During our audit we found that current practices prevent CDPHE from effectively using the post-survey questionnaire to obtain meaningful, appropriate, and relevant feedback from nursing facilities.

We conducted interviews with administrators and other senior staff (e.g., Director of Nursing) from 10 nursing facilities regarding their experiences with the certification survey process and interactions with CDPHE survey teams. The facilities we spoke with expressed perceptions of the survey process and concerns about surveyor conduct that do not appear to be effectively communicated to CDPHE. Administrators reported that the certification survey process is intimidating and difficult for facility staff. Administrators also reported that, in general, the survey process has become more abrasive and adversarial in recent years. Facilities consistently reported to us that surveyors have become more aggressive in their interactions with facility staff and that, in some cases, surveyors have been unprofessional and inappropriate in their conduct, behavior, and treatment of facility

staff and residents during the survey. Finally, administrators expressed concerns that conflicts with surveyors on one survey carry over and affect subsequent surveys. It is not unusual for regulated entities to complain about regulatory agencies; however, the frequency, tone, and specificity with which nursing facilities spoke on this issue during our interviews gave us cause for heightened concern.

We asked facility staff whether they had sufficient avenues for voicing their concerns and providing feedback on their experiences with survey teams. For example, we asked facility staff whether they complete the post-survey questionnaire. In cases where facilities had comments or complaints about a specific surveyor, we also asked whether the facility had contacted the surveyor's supervisor or management. Responses to our inquiries were inconsistent. Some facilities reported that they had completed the feedback questionnaire but were uncertain how the results were used, if at all. Other facilities we spoke with stated that they do not complete the questionnaire, or expressed reservations about being completely forthright in their responses for fear of retribution by surveyors. One facility administrator reported that during a recent survey she made a telephone call to the survey supervisor while the team was still on-site at the facility to voice concerns regarding a surveyor's inappropriate behavior. According to the administrator, shortly thereafter the surveyor confronted the administrator to ask her why she had complained.

We determined that CDPHE needs to make some specific changes to its post-survey questionnaire to ensure more effective communication of nursing facility concerns about the survey process and survey teams' overall performance. First, there is no centralized compilation, analysis, or reporting of responses received on the survey feedback questionnaire. Each of the items on the questionnaire has a measurable response set that could easily facilitate compilation of responses for aggregate reporting and summary analysis. For example, responses could be analyzed for all survey teams statewide or for survey teams within a specific region. Without such analysis, CDPHE lacks information to monitor and act on trends in facilities' responses.

Second, no independent party reviews or compiles data from the completed post-survey questionnaires. Instead, completed questionnaires are routed to supervisors and the individual surveyors participating on the survey. This increases the chances that surveyors will know which facility provided negative comments about the survey. Although the nursing facilities we spoke with expressed a fear of retribution by surveyors, we did not identify any instances of surveyor retribution during our audit. Nonetheless, CDPHE needs to revise its processes for collecting and compiling post-survey questionnaire data and information in a manner that (1) encourages nursing facilities to complete the questionnaire and provide meaningful feedback, and (2) reduces facilities' fear of retribution by surveyors. Specifically, CDPHE should designate a single individual, independent of the survey process, who

is responsible for receiving and retaining completed post-survey feedback questionnaires, data entering the responses and written comments, and preparing summary reports and analysis to management and survey teams on a quarterly basis. Completed questionnaires should not be returned to the survey teams or to individual surveyors. Nursing facilities and surveyors should be informed of procedures for handling post-survey questionnaires and for communicating the data to management and survey teams.

Finally, nursing facility administrators reported that their experiences with the survey process are heavily dependent upon the behavior—either good or bad—of the individual surveyors assigned to the survey team. As we mentioned earlier, some facilities we spoke with had negative comments about specific surveyors. CDPHE staff reported that survey teams provide nursing facilities with their supervisor's contact information at the start of the survey and instruct facilities to contact management with any questions or concerns. Additionally, CDPHE has a formal process for investigating written complaints concerning individual surveyors in accordance with State Personnel Board Rules [Rule 8-3]. Although there are informal and formal processes for nursing facilities to communicate with management about specific surveyors, our interviews with nursing facilities indicated that facilities either are unaware of, or frequently do not use, these separate processes. In addition to the post-survey questionnaire, CDPHE should instruct nursing facilities to use these separate processes for filing comments or complaints about individual surveyors.

Insufficient feedback mechanisms compromise CDPHE's ability to effectively identify and address nursing facilities' concerns. Consequently, nursing facilities feel that management is not receptive to their comments and are fearful of retribution. In the end, this strains the regulatory relationship between CDPHE and nursing facilities.

Recommendation No. 6:

The Department of Public Health and Environment should improve mechanisms for nursing facilities to provide meaningful, appropriate, and relevant feedback regarding the survey process, overall survey team performance, and individual surveyors. At a minimum, the Department should:

a. Designate a single individual, independent of the survey process, who is responsible for receiving and retaining completed post-survey feedback questionnaires, data entering the responses and written comments, and preparing summary reports and analysis to management and survey teams on

a quarterly basis. Completed questionnaires should not be returned to the survey teams or to individual surveyors.

b. Inform nursing facilities and surveyors about procedures for handling post-survey questionnaires and for communicating the data to management and survey teams. This should include instruction on informal and formal processes separate from the post-survey questionnaire available to nursing facilities for filing comments or complaints regarding individual surveyors.

Department of Public Health and Environment Response:

a. Agree. Implementation date: July 2007.

The CDPHE strives to obtain meaningful feedback from nursing homes concerning the surveyors and the survey process, and agrees that assignment of the recommended tasks to one individual should enhance the collection and review of this information.

b. Agree. Implementation date: July 2007.

CDPHE will publish clear rules and guidelines for responses to post-survey questionnaires and for reporting formal and informal complaints about surveyors to the CDPHE.

Conflicts of Interest

Federal regulations [42 C.F.R. 488.314] identify specific circumstances that constitute conflicts of interest and disqualify a surveyor from surveying at a particular nursing facility. CDPHE's conflict-of-interest policy for certification surveyors closely follows the federal regulations and guidance when specifying those situations that constitute actual conflicts of interest. These include cases in which:

- The surveyor currently works, or within the past two years has worked, as an employee or agent for the facility to be surveyed.
- The surveyor has any financial or ownership interest in a facility.
- The surveyor has an immediate family member who has a relationship with a facility.

CMS guidelines further specify that "states must consider all relevant circumstances that may exist beyond the benchmarks given to ensure that the integrity of the survey process is preserved." Moreover, CDPHE's policy states that "potential conflicts of interest give the appearance of compromising the integrity of the survey process and can be just as damaging as the existence of an actual conflict of interest." Thus, potential or perceived conflicts of interest reasonably may extend beyond any defined two-year window and should be mitigated.

CDPHE's conflict-of-interest policy requires surveyors to provide written disclosure of all actual and potential conflicts of interest on an annual basis or immediately upon discovering that such conflict exists or may exist. Employee disclosures must include the nature of the conflict, the reasons why the employee believes that a conflict of interest may exist, the date on which the conflict developed, and all other pertinent facts regarding the conflict.

We reviewed conflict-of-interest disclosures and related documentation for a sample of 11 surveyors. We also examined data on surveyors' survey assignments from October 2003 through June 2006. We identified three situations involving two surveyors that, at a minimum, give the perception that a conflict of interest existed.

- One surveyor disclosed a potential conflict of interest with a nursing facility because the surveyor's former employer and mentor worked as the facility's administrator. The surveyor participated on a survey at the facility within six months of disclosing the potential conflict of interest.

- The same surveyor described above participated on a survey at another facility in February 2006. The surveyor did not disclose any potential conflict of interest with this facility. However, we learned through our interviews with facility administrators that this surveyor's mother had been the Director of Nursing at the facility until being terminated in September 2002.

- In August 2004 a second surveyor disclosed a conflict with a facility because a family member resided at the facility. This surveyor did not disclose a conflict with this facility on her subsequent conflict-of-interest form completed in September 2005. The surveyor participated on a survey at the facility in November 2005, less than two years after the original disclosure.

CDPHE reported that no actual conflict of interest existed in any of these cases. In the first case, it had been more than two years since the surveyor worked with the administrator, and according to the surveyor, the two had not maintained a close relationship. In the second case, it had been more than two years since the surveyor's mother worked at the facility. In the third case, the resident was not a

member of the surveyor's immediate family, and the resident died several months prior to the survey. Nonetheless, we question the appropriateness of these survey assignments because the circumstances reasonably give rise to a perceived conflict of interest. As discussed earlier, perceived conflicts of interest can be just as damaging and extend beyond any predetermined time limits. For example, the fact that a facility administrator raised one of these cases to our attention during our interview demonstrates that facility staff still felt that, even after four years, a perceived conflict existed.

We identified several reasons why these instances of potential or perceived conflict of interest occurred. First, issues of potential or perceived conflict of interest do not receive sufficient attention and consideration by surveyors or management. CDPHE's surveyor conflict-of-interest policy and disclosure forms tend to only focus attention on a two-year window. However, as we have identified, there are circumstances and situations which extend beyond a two-year window that a reasonable person with knowledge of the relevant facts would consider to be a potential or perceived conflict of interest.

Second, contrary to CDPHE policy, surveyors do not provide clear or extensive details when disclosing their potential conflicts of interest. For example, disclosure statements for the two surveyors we identified with potential conflicts of interest only stated "former administrator and AIT mentor the NHA there (sic)" and "family member resides at this facility." This is not sufficient factual detail to enable management to assess the situation and make an informed decision regarding conflicts of interest. Additionally, management does not follow up with surveyors to obtain additional information regarding the disclosures. Complete facts about the three cases we identified were not obtained or documented until after we brought the situations to management's attention.

Finally, although management obtains disclosure forms and tracks disclosures on a spreadsheet, there is insufficient documentation by management to show how these disclosures are being reviewed or handled. For example, management does not document its review of the disclosure, whether it determined a real or perceived conflict of interest exists, or how it will mitigate the conflict. It is also unclear whether the supervisors responsible for scheduling surveys consult the conflict-of-interest disclosure information and consider perceived conflicts of interest when assigning surveyors to a specific facility.

Actual or perceived conflicts of interest impair the credibility of survey findings and the legitimacy of the certification survey process. As we have found through our interviews with nursing facilities, even the perception of a conflict of interest can fuel sentiments among some facilities that surveyors are not objective, consistent, or equitable in their treatment of nursing facilities during a survey. An important part

of addressing these sentiments is to effectively identify and mitigate actual and perceived conflicts of interest among surveyors.

Recommendation No. 7:

The Department of Public Health and Environment should improve controls over its conflict-of-interest disclosure and monitoring process by:

a. Modifying and clarifying conflict-of-interest policies and disclosure requirements, to ensure that potential or perceived conflict of interest are identified and evaluated. This should include evaluating situations that fall outside of established time frames and circumstances defining an actual conflict of interest.

b. Requiring surveyors to provide more extensive details and factual information when disclosing actual or potential conflicts of interest to management. Management should follow up with surveyors to obtain additional information as necessary to properly evaluate the conflict and determine an appropriate disposition.

c. Better documenting management's review of conflict-of-interest disclosure statements and their disposition. At a minimum, management should clearly document its review of the disclosure, whether a real or perceived conflict of interest exists, and how the conflict will be mitigated.

d. Ensuring that conflict-of-interest documentation is routinely reviewed when scheduling surveyors on survey teams.

Department of Public Health and Environment Response:

a. Agree. Implementation date: October 2007.

The CDPHE's policy will be modified to require disclosure of all potential conflicts and Division management will review this information and document its decisions with respect to potential conflicts of interest.

b. Agree. Implementation date: October 2007.

The CDPHE will modify its conflict-of-interest policy to ensure that managers have sufficient information to make informed decisions concerning potential conflicts of interest.

c. Agree. Implementation date: October 2007.

The CDPHE will maintain documentation of its decisions concerning potential conflicts of interest in accordance with Division records retention schedules.

d. Agree. Implementation date: October 2007.

The CDPHE will document its review of conflicts of interest when scheduling surveyors.

Surveyor Screening

Before an applicant is hired as a classified state employee, he or she must meet minimum specified qualification requirements. We reviewed personnel files for a sample of 11 surveyors to evaluate CDPHE's preemployment screening processes for surveyors and found problems in three areas.

First, we found that CDPHE does not conduct criminal history checks on surveyors. CDPHE has a departmental policy requiring criminal history checks prior to employing any person in a position of a safety- or security-sensitive nature. The policy defines security-sensitive positions to include positions which control records that may be of value to outsiders (e.g., medical or other confidential records) or that have direct contact with vulnerable persons. To date, surveyors have not been defined as security-sensitive positions despite their regular access to confidential and sensitive personal medical information and interaction with nursing home residents in the performance of their job duties. We contend that surveyors are employed in security-sensitive positions as defined in CDPHE's departmental policy and, therefore, should be subject to a criminal history check prior to employment.

We conducted criminal history checks for all long-term care surveyors employed by CDPHE at the time of our audit through the Judicial Branch's Integrated Colorado On-line Network (ICON) database. We found that in May 2004, subsequent to starting employment, one surveyor received a deferred sentence for a Class 1 Domestic Violence Misdemeanor, including probation. No other offenses were found for any other surveyors.

CDPHE's policy does not contain specific guidelines for the type of criminal histories that would disqualify an individual from employment in a security-sensitive position. Furthermore, there are no requirements to recheck criminal histories subsequent to hire. As mentioned earlier, we found one surveyor who committed a criminal offense after starting employment.

Second, CDPHE does not always check and document professional licenses, credentials, and references prior to employing individuals as surveyors. We found that each year CDPHE obtains and updates copies of surveyors' professional licenses and credentials (e.g., registered nurse, registered dietician, licensed physical therapist, social worker). All of the surveyors we reviewed had current and active licenses at the time of our audit. However, it was not evident that license, credentials, and reference checks were conducted and documented prior to hire for the 11 surveyors in our sample. These checks are important because they can reveal details about past employment, including whether disciplinary actions were imposed against a licensee, which may affect the employment decision. For example, we found that in 1993 the Board of Nursing issued a Letter of Admonition for alleged misconduct against one individual's license. It was unclear whether CDPHE was aware of this license action when the individual was hired as a surveyor in March 2004.

Finally, responsibility for different aspects of the hiring process for long-term care surveyors are distributed between the Human Resources Director, the Health Facilities and Emergency Medical Services Division Director, program managers, and other staff. However, there appears to be confusion among staff regarding who is responsible for conducting and documenting both license and reference checks of surveyor applicants prior to employment. At the time of our review, CDPHE did not have a tracking form to document the completion of required preemployment checks for surveyors.

Without proper preemployment screening, there is a risk that potential employees can pose a threat to the public, other state workers, and state property. A lack of due diligence by an employer in reviewing backgrounds, qualifications, and competency of job applicants can lead to costly legal fees if an employer should have known about an employee's potential threat to people or property through a preemployment screen. In addition, since CDPHE has decentralized responsibilities for pre-employment screening of surveyors, CDPHE needs controls in place to ensure that all preemployment screening tasks are completed and documented.

Recommendation No. 8:

The Department of Public Health and Environment should strengthen its preemployment screening processes for surveyors. Specifically, the Department should:

a. Designate surveyors as security-sensitive positions and subject to criminal history check requirements prior to employment. This should include taking

steps to periodically recheck criminal histories of employees after hire and developing guidelines regarding those offenses that would disqualify an applicant from employment as a surveyor.

b. Clarify with staff their responsibilities for conducting preemployment license checks, reference checks, and other screening.

c. Develop and implement a checklist to track and document completion of pre-employment screening tasks by responsible parties throughout the hiring process. This checklist should be maintained in the employee's personnel file.

Department of Public Health and Environment Response:

a. Agree. Implementation date: October 2007.

The CDPHE will investigate its options for designating surveyors as security-sensitive positions, conducting criminal history checks prior to employment, and periodically rechecking such histories.

b. Agree. Implementation date: July 2007.

CDPHE will implement this recommendation by July 2007.

c. Agree. Implementation date: July 2007.

The CDPHE will maintain documentation concerning the preemployment screening conducted for all surveyors in the hiring process.

Resident Care and Safety

Chapter 2

Background

As of June 30, 2006, nearly 17,000 individuals resided in one of Colorado's 217 nursing homes. Nursing home residents are a highly vulnerable population who are unable to live independently due to problems caused by physical deterioration, cognitive decline, or chronic illness. As a result, residents rely on nursing facility staff as their primary care givers to meet their ongoing health care needs and provide assistance with even the most basic daily activities. In addition to meeting residents' health care needs, nursing facilities also have a responsibility to ensure resident safety. Federal and state laws and regulations are in place to ensure that (1) nursing facilities properly assess residents' physical, mental, and psychosocial conditions as a basis for the delivery of care; (2) residents are protected from the risk of abuse, neglect, and mistreatment; (3) residents' assets are adequately safeguarded; (4) care is administered by qualified and competent staff; and (5) residents, as well as those who work in and visit nursing facilities, are protected in emergencies and disasters. As we describe in this chapter, our audit identified problems with the accuracy of resident assessments, nursing facility management of resident fund accounts, employee screening procedures, and emergency preparedness plans. We found that poor or noncompliant practices by nursing facilities in each of these areas potentially compromise quality of care and resident safety. Additionally, we found that more needs to be done to ensure that nursing facilities comply with state licensing laws and regulations.

Resident Assessments

To provide appropriate care to residents, nursing homes that participate in the federal Medicare and Medicaid programs must assess every resident's physical, mental, and medical condition when they first enter the facility and then periodically as long as the resident lives at the facility. Federal regulations require facilities to assess each resident, regardless of the source of payment for the care provided. Part of the resident assessment involves completing the Minimum Data Set (MDS), which is a standardized assessment tool used to rate residents in several areas, including cognition, communication, mood and behavior, health conditions, physical functioning, and activities of daily living. The MDS is intended to be completed by a multidisciplinary team of nursing facility staff using information from multiple

sources, such as review of the resident's medical record, observation, interviews with the resident and family members, and communication with direct-care staff, physicians, and others who have recently observed, evaluated, or treated the resident. All Medicare- and Medicaid-certified nursing facilities transmit their MDS data to the State MDS Database maintained by the Department of Public Health and Environment (CDPHE). The federal Centers for Medicare and Medicaid Services (CMS) also captures MDS information from the State MDS Database into its Central Repository on a monthly basis. The MDS assessment data are used as described below:

Resident Care Plans—The primary purpose of the MDS assessment tool is to identify residents' strengths, needs, medical diagnoses, treatments, and other characteristics according to standardized measures and definitions. On the basis of the MDS assessment, nursing facilities must develop an individualized care plan for each resident that includes measurable objectives and timelines to meet the resident's highest practicable physical, mental, and psychosocial well-being. Depending on how a resident scores on the MDS, additional review of the resident's condition may be necessary before the facility can develop an appropriate care plan. Facility staff, physicians, family members, and residents also provide input into the care plan. Once developed, the individualized care plan provides a blueprint for nursing facility staff to use to deliver care and meet the resident's needs on a daily basis.

Nursing Facility Payments—In Fiscal Year 2001 the State began using data from MDS assessments when establishing nursing facilities' Medicaid reimbursement rates. The federal government also uses MDS data as part of the Medicare reimbursement system. As described earlier, the MDS captures standard information that reflects the resident's acuity—that is, the resident's level of functional needs and the severity or intensity of his or her medical conditions and treatments. Because not all nursing home residents require the same level or type of care, the Department of Health Care Policy and Financing (HCPF) uses MDS data to classify each resident into one of 34 different groups called resource utilization groups (RUG). The RUG classification reflects the type of care and facility resources the resident requires to function at his or her highest practicable level. HCPF adjusts reimbursement rates upward or downward to account for the relative differences in Medicaid residents' care and resource needs when compared with the facility's overall resident population. (A schematic diagram of the RUG classification system is located in Appendix A.)

Quality Indicators and Measures—The federal government uses MDS data to monitor the quality of care in the nation's nursing facilities. Specifically, CMS developed a set of quality indicators and measures based on MDS data that

include such things as the prevalence of falls, use of high numbers of medications, residents with high weight loss, or residents who have become more depressed or anxious. Reports on these quality indicators and measures can be generated at the facility level or aggregated across all nursing facilities statewide. State survey teams rely on these reports to help identify potential problem areas that should be examined during certification surveys. CMS also makes quality indicator data and reports available on its Web site to help public consumers make informed decisions about nursing home care.

The MDS is an integral part of nursing facility operations and provides the foundation for resident care planning, quality-of-care monitoring, and payment activities. The importance of obtaining MDS data that provide an accurate and verifiable assessment of residents' conditions cannot be overemphasized. As we describe in the sections that follow, our audit identified problems with the overall accuracy and support for MDS assessments completed by nursing facilities. This raises serious concerns about the sufficiency of care being provided to residents, as well as the State's payment for this care.

Validating MDS Assessments

Federal regulations [42 C.F.R. 483.20] specify that nursing facilities must conduct ". . . a comprehensive, accurate, standardized, and reproducible assessment of each resident's functional capacity." According to CMS, the MDS assessment can be validated by a review of the medical record to verify that information contained in the record supports and is consistent with the MDS. In addition, maintaining clinical documentation that furnishes a picture of the resident's care needs and response to treatment is an accepted standard of practice, is part of good resident care, and is an expectation of trained and licensed health care professionals. Thus, the resident's condition at the time of the assessment should be well documented in his or her medical record.

As part of our audit, we contracted with TMF Health Quality Institute to provide specialized expertise in MDS review and validation. Our contractor conducted on-site reviews of the medical record and MDS assessment for a sample of 60 nursing facility residents (i.e., 10 residents at 6 different facilities). We selected a judgmental sample of facilities of different size and geographic location, and facilities showing frequent changes to their MDS data. Residents were selected randomly at each of the six facilities. While onsite at each facility, our contractor used information documented in the medical record to complete an independent MDS assessment for each sampled resident. Our contractor compared its results with the facility's MDS assessment that, at the time we drew our resident sample, was recorded in the State MDS Database and used in the most recent acuity adjustment for Medicaid reimbursement rates.

Overall, our contractor was unable to validate the MDS assessment for 39 of the 60 (65 percent) residents in our sample. More specifically, our contractor determined that these 39 residents should have had a different RUG classification (i.e., a different type of care and/or facility resources for the resident to function at his or her highest practicable level). Our contractor also found that medical record documentation supporting the facility assessments was often inconsistent, incomplete, or missing altogether. For example, information on resident behaviors, therapies, and other restorative services was documented in the medical record but not scored on the MDS assessment. Conversely, resident behaviors, activities of daily living, and cognitive patterns were scored on the MDS but not documented in the medical record. Our contractor also noted inconsistencies in facility staff documentation regarding the resident's level of functioning. We found that validity problems were most prevalent for those sections of the MDS intended to assess residents' activities of daily living, activity pursuit patterns, communication, and cognitive patterns.

In the summer of 2000, CDPHE conducted a one-time MDS validation review driven by concerns among certification surveyors that information on the MDS did not always seem to support the quality indicator reports they were using to identify potential concerns at nursing facilities. Although the intent of CDPHE's validation study was different, CDPHE found problems similar to those from our contractor's review. CDPHE's study did not include any specific recommendations or steps to help remedy the problems identified. Further, CDPHE's study was completed just prior to the implementation of acuity-adjusted reimbursement rates under Medicaid; however, it is unclear whether HCPF received the study report or considered the implications of CDPHE's findings for using acuity adjustments under Medicaid. In the following sections, we describe in more detail the 39 resident assessments that our contractor was unable to validate through its medical record review and the associated risks and potential effects on resident quality of care and Medicaid reimbursement rates.

Effect on Quality of Care

Federal regulations [42 C.F.R. 483.25] specify that "each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, *in accordance with the comprehensive assessment and plan of care."* (Emphasis added.) Thus, providing adequate care depends upon being able to accurately assess the resident. Although it is not the only factor used in resident care planning, the MDS provides a standardized foundation and starting point for the comprehensive resident assessment process. Ultimately, information from the MDS flows directly into the care plan that directs how a resident's health care needs should be managed on a daily basis. When the MDS assessment cannot be supported or corroborated by the

medical record there is increased risk that the facility has not developed an appropriate care plan and, consequently, that the resident is not receiving the type and level of care required for the resident to obtain his or her highest practicable well-being.

As described earlier, the RUG classification system uses MDS data to place each resident into 1 of 34 different groups that reflect the resident's assessed acuity and care requirements. Each of the 34 different RUG classifications is organized under 1 of 7 *major classification groups*: Extensive Services, Rehabilitation, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Functions. Changes in the MDS assessment can result in changes to the resident's RUG classification and the corresponding major classification group. These changes can indicate a potential change in the resident's care requirements.

First, our contractor's review found that documentation in the medical record for 22 of the 39 residents (56 percent) whose MDS assessments could not be validated supported a different RUG classification and a different major classification group for the resident. In particular, these residents should have been placed into a different major classification group requiring a wholly different level or type of care. Thirteen residents moved into a major classification group indicating a higher assessed acuity and greater care requirements. In these cases, there is a risk that the facility may be providing a level of care that is insufficient to meet the resident's care needs. The remaining nine residents moved into a major classification group indicating a lower assessed acuity and fewer care requirements. In these cases, there is a risk that the facility may be providing a greater level of care than the resident's assessed condition actually warrants.

Second, our contractor found that for 17 of the 39 residents (44 percent) whose MDS assessments could not be validated, the documentation in the medical record supported a different RUG classification, but the resident remained within the same major classification group. That is, the resident's RUG classification changed, but our contractor's independent MDS assessment did not classify the resident as requiring a wholly different level or type of care. Even in these cases, there is still a risk that the residents' care may not be properly aligned with their needs. Our contractor determined that the medical records for these residents supported a greater or lesser degree of resident functioning with activities of daily living, need for restorative nursing programs, or presence of depression and other "sad mood" indicators, than were captured by the facility's MDS assessment.

Effect on Rates

In Fiscal Year 2006 Colorado paid approximately $456.5 million in state and federal Medicaid funds to nursing facilities. According to CMS, resident health and functional status (i.e., acuity) have a major impact on the mix of resources necessary to provide an appropriate level of health care to nursing home residents. In turn, resource requirements drive nursing facilities' health care costs. State statute [Section 25.5-6-204(4)(g) and (h), C.R.S.] requires HCPF to use MDS assessments and the RUG classification system to make a "case-mix" adjustment to Medicaid reimbursement rates. This means that reimbursement rates are adjusted upward or downward to account for the relative differences in clinical condition and the resources needed to provide appropriate care for each nursing home's Medicaid resident population. Adjusting rates for case mix may encourage homes to accept residents who require more expensive care, and it helps avoid penalizing homes that have higher costs due to a more costly mix of residents. However, because the case-mix adjustment is based on MDS assessment data, inaccurate MDS assessments could ultimately affect the accuracy of the State's Medicaid payments to nursing facilities.

To make the case-mix adjustment, HCPF assigns a numeric weight—called a case-mix index value—to each of the RUG classification groups. (The case-mix index values associated with each RUG classification are shown in Appendix A.) This case-mix index value is used to translate the qualitative differences in resident acuity and care needs into numeric differences for rate-setting purposes. Higher case-mix index values generally contribute to upward adjustments in a facility's reimbursement rate, and lower case-mix index values generally contribute to downward adjustments in a facility's reimbursement rate. However, as shown in Appendix A, the numeric weights assigned to the RUG classification groups do not necessarily fall in rank order. That is, there are cases where HCPF has assigned a "higher" RUG classification a lower case-mix weight than a "lower" RUG classification.

As discussed earlier, our contractor's review resulted in changes to the RUG classification for the 39 residents whose MDS assessment could not be validated. This change in the RUG classification also means that the case-mix index value changes and, therefore, potentially has an impact on reimbursement rates. Specifically, our contractor found that its independent MDS assessment resulted in a lower case-mix index value for 26 residents (67 percent) and a higher case-mix index value for 13 residents (33 percent). As we described earlier, our contractor found cases where the facility assessed residents as having greater care needs than what was supported by the medical record, as well as conditions documented in the medical record that were not accurately or adequately captured in the facility's MDS assessment. Problems with over- or underassessing residents can have an impact on

the quality of care. However, since the MDS assessment is ultimately tied to reimbursement rates via the case-mix adjustment, problems with over- or under-assessing residents also increase the risk that the State could be setting nursing facility Medicaid reimbursement rates too high or too low.

Solutions

Federal regulations [42 C.F.R. 483.75(l)] require that residents' clinical records be complete, accurately documented, readily accessible, and systematically organized. Our contractor found that facilities did not sufficiently document or organize their medical records in support of information on the MDS assessments. For example, the facilities did not have systematic or coordinated processes for documenting the repeated observations over several days and several work shifts necessary to assess the level of assistance a resident needs with activities of daily living. Our review of survey deficiency data showed that in Fiscal Year 2006 state survey teams issued a deficiency citation for failure to maintain clinical records in accordance with accepted professional standards to four of the six facilities where our contractor conducted its MDS validation review. Overall, we found that 72 separate facilities, or about 34 percent of all certified facilities in Fiscal Year 2006, were cited with this deficiency. CDPHE should explore ways to improve record organization and consistency at the facility level by encouraging nursing facilities to identify and use best practices (e.g., standard flow charts or checklists) to help collect data, improve communication, and better substantiate their resident assessments. For example, CDPHE could provide assistance by focusing facilities' attention on more critical MDS data elements, such as those used to calculate the case-mix adjustment to Medicaid payments, or those identified as being more prone to errors, inconsistent scoring, or lack of supporting documentation. According to HCPF's contract auditor for nursing homes, some states (Indiana, Nevada, North Carolina, Pennsylvania, Virginia, and Washington) that use MDS data to adjust Medicaid payments have issued guidelines or requirements to facilities regarding supporting documentation for the MDS.

As mentioned earlier, the MDS assessment is intended to be completed by a multi-disciplinary team of nursing facility staff using information from multiple sources. Each individual contributing to the MDS assessment is responsible for certifying the accuracy of the information he or she provides. Most nursing facilities also have a dedicated MDS coordinator on staff—typically a registered nurse—who is responsible for overseeing the assessment process and ensuring the proper collection and transmission of MDS data to the State. CDPHE offers MDS training on a regular basis, but this training is not required for MDS coordinators or other individuals participating in the assessment process. HCPF should work with CDPHE to require that MDS coordinators at all Medicaid-certified nursing facilities complete either the State's MDS training or a comparable external MDS training on a routine

basis, as appropriate. CDPHE will need to track those facility coordinators attending the State's training and obtain proof of external training from the remaining facility coordinators. HCPF should obtain this training information from CDPHE and use a default case-mix adjustment for those Medicaid facilities whose MDS coordinator has not completed the State's training or a comparable MDS training. (HCPF already uses a default case-mix index value for residents with MDS assessments that are more than 120 days old.)

State Oversight

Currently the State's oversight of the MDS assessment process is not sufficient to provide assurance that MDS assessments submitted by nursing facilities are valid representations of residents' conditions. First, although MDS validation is not the intended goal of the certification survey process, surveyors regularly review resident records and MDS data to assess quality of care and resident outcomes. Surveyors are authorized to cite deficiencies for noncompliance with federal MDS requirements, including the requirement that the assessment accurately reflect the resident's condition. For example, our review of deficiency data for Fiscal Years 2002 through 2006 shows that surveyors cited MDS-related deficiencies 564 times; 101 of these deficiencies (18 percent) specifically related to the validity and accuracy of the MDS assessment. CDPHE should continue to work with surveyors through training and on-the-job monitoring to increase awareness of validity problems with MDS assessments and ensure that any such problems noted during certification surveys are investigated and resolved appropriately. This should include citing the facility with a deficiency if warranted.

Second, CDPHE and HCPF should make better use of standard reports available in the electronic MDS system and data maintained by HCPF's contract auditor on RUG classifications for Colorado nursing facility residents to identify those facilities at a higher risk of submitting invalid assessments. For example, both agencies could use aggregate data analysis and system reports to identify those facilities with large shifts in the distribution of residents across RUG classifications, a significant number of changes to their MDS assessments in a given period, or frequent data coding and transmission problems. Nursing facilities that exhibit these characteristics could be at a higher risk of making errors when assessing residents and in need of additional attention during certification surveys or the rate-setting process.

Third, the State could improve the reliability and validity of nursing home resident assessment data by establishing a stand-alone MDS review team. We found that separate validation teams appear to be a common approach among states with MDS-based reimbursement systems under Medicaid. For example, in February 2002 the U.S. Government Accountability Office (GAO) released a report highlighting MDS review programs in the 10 states (Indiana, Iowa, Maine, Mississippi, Ohio,

Pennsylvania, South Dakota, Vermont, Washington, and West Virginia) using MDS data as part of their Medicaid payment systems. Another eight states (Georgia, Idaho, Kentucky, Minnesota, New Jersey, New Hampshire, Utah, and Virginia) planned to establish separate MDS review programs. HCPF has not reviewed the validity or accuracy of MDS data since Colorado implemented the case-mix adjustment to nursing facility Medicaid rates in Fiscal Year 2001. As mentioned earlier, it is unclear whether HCPF received or considered the findings from CDPHE's MDS review study completed in 2000. At the time of the GAO study in 2002, Colorado was one of five states using MDS data for Medicaid payments that did not have a separate MDS review program.

There are some similarities in how other states have set up their MDS review teams. In most cases, the MDS accuracy reviews are separate from the certification survey process and are conducted by state Medicaid staff or contractors. The reviews entail on-site visits to nursing homes and involve a comparison of the documentation in the resident's medical record with the MDS assessment prepared by the facility. Cost can be an issue when implementing a separate MDS review program. However, the GAO reported that since MDS accuracy reviews are typically associated with the administration of states' Medicaid programs, state expenditures are eligible for 75 percent matching federal funds. Most states use results from their MDS reviews to recalculate Medicaid payments when MDS errors are found, and some states reported recouping overpayments in Medicaid reimbursement as a result of validation efforts. However, it is important to note that MDS reviews could also result in additional reimbursement being owed to facilities. CDPHE and HCPF should explore and evaluate options for implementing a separate state MDS review team to ensure the validity and reliability of assessments completed by nursing facilities participating in Medicaid.

Considering the importance of the MDS in planning for and guiding resident care and adjusting nursing facility payments, documenting the basis for the MDS assessment in a way that can be independently validated and verified is critical to achieving its intended purposes. Any inability to validate MDS assessments undermines assurance that residents' care plans are appropriate and, therefore, could result in poor resident outcomes, quality-of-care issues, and an inaccurate view of the overall needs of the resident population. Furthermore, lack of reliable assessments undermines the legislative goal that Medicaid reimbursements to nursing facilities be adjusted for the relative mix of resources required to care for Medicaid residents.

Recommendation No. 9:

The Department of Public Health and Environment should improve the oversight of nursing facility resident assessments and Minimum Data Set (MDS) data by:

a. Continuing to increase awareness among surveyors of the risk of problems with MDS assessments and ensure that surveyors investigate any problems noted with the MDS assessments, including problems with validity and reliability, during certification surveys. This should include citing the facility with a deficiency if warranted.

b. Working with the Department of Health Care Policy and Financing (HCPF) to conduct more systematic review and analysis of standard reports available in the electronic MDS system and data maintained by HCPF's contract auditor on resource utilization group classifications to identify those facilities that are at higher risk of submitting invalid assessments and, therefore, warrant further attention during certification surveys or require additional training. (See also Recommendation 10a.)

c. Working with the Department of Health Care Policy and Financing to require that MDS coordinators at all Medicaid-certified nursing facilities complete the State's MDS training or a comparable MDS training on a routine basis, as appropriate. Facility MDS coordinators attending the State's training should be tracked and proof of comparable external training should be obtained to identify those facilities whose MDS coordinator has not completed the required training. (See also Recommendation 10b.)

d. Encouraging nursing facilities to identify and use best practices, such as standardized flow charts and checklists, to help collect data, improve communication, and better substantiate MDS assessments. This could include focusing facilities' attention on more critical MDS data elements, such as those used to calculate the case-mix adjustment to Medicaid payments, or those identified as having the most problems.

e. Working with the Department of Health Care Policy and Financing to evaluate options for the development and implementation of a state validation team to perform routine on-site reviews of nursing facilities' MDS assessments for Medicaid residents. This should include working with the federal Centers for Medicare and Medicaid Services, the General Assembly, and other policy-making bodies, as appropriate. (See also Recommendation 10c.)

Department of Public Health and Environment Response:

a. Agree. Implementation date: Implemented and ongoing.

As discussed in the audit report, CDPHE surveyors have cited MDS-related deficiencies 564 times in the past 5 years against the 10 MDS-related federal citation tags. Two of the 10 tags (20 percent) are related to data accuracy, for which surveyors cited 101 tags (18 percent). CDPHE has provided surveyors with ongoing MDS training and updates to assist surveyors in finding and making appropriate citations and will continue to do so.

b. Partially agree. Implementation date: July 2007.

The CDPHE's existing electronic MDS standard reports will be used to help identify facilities and new MDS coordinators at higher risk of data accuracy problems who may need further survey attention and additional MDS training. The CDPHE will utilize any information provided by HCPF and its contract auditor with respect to RUGs data and reports as an additional tool to help CDPHE identify facilities prone to MDS data errors and, therefore, in need of additional training or survey activity. This recommendation is beyond the Medicare/Medicaid certification requirements and the current certification budget and must be prioritized in consideration of limited resources and workload needs. Implementation of this recommendation would require additional state funds. The CDPHE will investigate additional funding opportunities and options with HCPF for implementing this recommendation.

c. Partially agree. Implementation date: July 2007.

CDPHE will support HCPF's efforts to require Medicaid certified nursing facility MDS coordinators to attend the State's or comparable MDS training. HCPF will be responsible for defining and establishing this requirement through their rules or statute. Enhancing additional mandated training requirements are beyond the existing Medicare/Medicaid certification budget and must be prioritized in consideration of limited resources and workload needs. Implementation of this recommendation will require additional state funds. The CDPHE will investigate additional funding opportunities and options with HCPF for implementing this recommendation.

d. Partially agree. Implementation date: July 2007.

CDPHE will encourage nursing facilities to look for and use best practice forms, checklists, and documentation tools to improve MDS data collection and data item substantiation. CDPHE currently recommends and covers the need for such record keeping in its MDS training, but would need to expand on this topic in future training sessions. To implement this recommendation the CDPHE would need to expand its MDS training sessions to include information pertaining to critical MDS data elements that most affect RUGs scoring and case-mix adjustments. This recommendation is beyond the Medicare/Medicaid certification requirements and the current certification budget and must be prioritized in consideration of limited resources and workload needs. Implementation of this recommendation would require additional state funds. The CDPHE will investigate additional funding opportunities and options with HCPF for implementing this recommendation.

e. Disagree.

CDPHE agrees that validation of MDS assessment is best determined by on-site record review; however, CDPHE does not believe that the development and staffing of a specialized state validation team is the most efficient or cost-effective means by which MDS data can be validated. Further, this recommendation exceeds what is required under Medicare/Medicaid certification requirements for MDS record review during survey. This recommendation cannot be prioritized or implemented with existing Medicare/Medicaid resources.

Auditor's Addendum:

Many other states have implemented independent validation teams to increase the validity and reliability of nursing facility resident assessment data. Since resident assessments are key to ensuring quality of care and are used for setting reimbursement rates, this option deserves consideration and evaluation.

Recommendation No. 10:

The Department of Health Care Policy and Financing should improve the oversight of nursing facility resident assessments and Minimum Data Set (MDS) data by:

a. Working with the Department of Public Health and Environment to conduct more systematic review and analysis of standard reports available in the electronic MDS system and data maintained by its contract auditor on

resource utilization group classifications to identify those facilities that are at higher risk of submitting invalid assessments and, therefore, warrant further attention during rate-setting. (See also Recommendation 9b.)

b. Working with the Department of Public Health and Environment (CDPHE) to require that MDS coordinators at all Medicaid-certified nursing facilities complete the State's MDS training or a comparable MDS training on a routine basis, as appropriate. Training information should be obtained from CDPHE and a default case-mix adjustment should be used when setting reimbursement rates for Medicaid facilities whose MDS coordinator has not completed the required training. (See also Recommendation 9c.)

c. Working with the Department of Public Health and Environment to evaluate options for the development and implementation of a state validation team to perform routine on-site reviews of nursing facilities' MDS assessments for Medicaid residents. This should include working with the federal Centers for Medicare and Medicaid Services, the General Assembly, and other policy-making bodies, as appropriate. (See also Recommendation 9e.)

Department of Health Care Policy and Financing Response:

a. Agree. Implementation date: December 31, 2007.

The Department will work collaboratively with DPHE's surveyors to identify and investigate problems noted with MDS assessments.

b. Agree. Implementation date: December 31, 2007.

At a minimum, the Department will require all facility MDS coordinators to complete the State's MDS training one time. Annually, MDS coordinators will be required to complete the State's MDS training if facility survey deficiencies indicate that more training is needed. A default case-mix adjustment will be used when setting reimbursement rates for Medicaid facilities whose MDS coordinator has not completed the required training. An attestation statement will be added to the Medicaid cost report certification page that the facility's MDS coordinator(s) have taken the required training. The contract auditor will be required to substantiate the training.

c. Agree. Implementation date: December 31, 2007.

The Department will work collaboratively with DPHE and policy-making bodies to evaluate options for the development and implementation of a state validation team to perform routine on-site reviews of nursing facilities' MDS assessments of Medicaid residents. The Department currently does not have resources dedicated to this task.

Resident Fund Accounts

Nursing facilities participating in Medicare or Medicaid are required to protect and promote the rights of each resident, including the resident's right to manage his or her own financial affairs. Federal regulations [42 C.F.R. 483.10(c)(2)] state that "upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility." This means that if residents choose to deposit their personal funds with the facility, the facility must act as a fiduciary and manage the funds on the resident's behalf. Nursing facilities cannot refuse to handle resident funds if directed by a resident. Facilities also cannot require residents to deposit their personal funds with the facility. Knowingly misusing resident funds is a criminal act under state law [Section 25.5-6-206(8), C.R.S.].

All residents, regardless of payer type, may choose to deposit personal funds with the nursing facility. However, in most cases, Medicaid residents are only allowed to retain a total of $50 of their monthly income for personal needs. Any additional income is expected to be applied toward the resident's cost of care. Typically, residents use their personal funds to pay for such things as clothing, reading materials, cosmetic and grooming items, gifts, and outside social events or activities. Federal and state laws and regulations establish a number of requirements intended to ensure that residents with funds on deposit at a nursing facility have ready and reasonable access to the funds, and that the funds are properly protected. Some of these requirements include:

- Establishing and maintaining a system of accounting and records that ensures a full, complete, and separate accounting of residents' funds in accordance with generally accepted accounting principles. Resident funds may not be commingled in any way with the facility's funds.

- Purchasing a surety bond to ensure the financial security of all resident funds deposited with the facility.

- Limiting allowable charges to resident fund accounts. Items or services charged to resident accounts must be authorized by the resident. Except for any applicable deductible or coinsurance amounts, facilities may not charge resident fund accounts for any item or services for which payment is made under Medicare or Medicaid.

- Providing quarterly reports on account activity and, for Medicaid residents, notification when account balances approach resource limits used to determine eligibility for benefits.

- Conveying funds and a final accounting of those funds upon the resident's death to the person responsible for settling the resident's estate.

During our audit we conducted site visits at five nursing facilities across the State to review facility policies and procedures for managing resident fund accounts. We reviewed account documentation for the fiscal quarter ending March 31, 2006, for a total of 25 sampled residents (i.e., 5 residents at each facility) with personal funds on deposit at the facility. Account balances for these 25 sampled residents totaled about $17,100 at the time of our review. Overall, we found that facilities are not managing resident fund accounts in compliance with federal and state laws and regulations. Specifically, we identified the following problems:

- **Insufficient or missing authorization forms.** As described earlier, residents must authorize the nursing facility to manage their personal funds. For 12 of the 25 sampled residents with funds on deposit at the facilities we visited, we found a lack of sufficient documentation, such as a form or agreement signed by the resident, giving the facility authority to manage the personal funds. In six cases, the facility did not have any documentation that the resident had authorized the facility to manage his or her personal funds. In five cases, the facility provided us with a form signed by the resident, but the form did not actually contain language authorizing fund management. Finally, in one case, the authorization form was not signed and dated by the resident or his or her legal representative. Balances on the 12 resident accounts without proper authorization for facility management totaled about $9,900. Additionally, State Medicaid Rules [10 CCR 2505-10, Part 8.482.52(A)(3)] require facilities participating in Medicaid to have written documentation when a resident refuses participation in the facility's fund management service. We reviewed an additional sample of 10 residents (i.e., 2 residents at each facility) who did not have personal fund accounts. We found that the facilities did not have documentation showing that 5 of these 10 sampled residents had refused fund management services. All five of the nursing facilities we visited participated in Medicaid.

- **Lack of resident authorization of account activity.** Federal regulations [42 C.F.R. 483.10(c)(8)] and state statute [Section 25.5-6-206(4), C.R.S.] prohibit facilities from making any expenditures from resident fund accounts for any item or service without resident approval. We found that facilities' practices for documenting resident approval were insufficient and that the transactions were not always accompanied by receipts or other supporting documentation. Of the 25 sampled residents with personal fund accounts, we identified about $2,800 in transactions for 3 residents that lacked documentation showing that the resident had authorized the transaction. For example, one resident's account showed a direct deposit of about $1,370 in social security income and an automatic withdrawal of about $1,340 for the resident's cost of care. However, the resident had not authorized direct deposits to or automatic withdrawals from her account. The two remaining residents' accounts were charged a total of about $90 for hair care services, but there was no documentation to show that these charges were authorized by the residents or their legal representatives.

- **Lack of notification of account balances.** Federal regulations [42 C.F.R. 483.10(c)(5)] and state statute [Section 25.5-6-206(3)(b), C.R.S.] require nursing facilities to provide notification to Medicaid residents when their account balance reaches $1,800, which is $200 less than the federal Supplemental Security Income (SSI) resource limit currently set at $2,000 for one person. The facility is also required to notify the resident or his or her legal representative that if the account balance reaches $2,000, the resident could lose eligibility for Medicaid or SSI benefits. We found that nursing facilities do not regularly monitor resident fund account balances, and therefore, facilities are not notifying residents or their legal representatives as required. Specifically, we identified 3 of 25 sampled residents whose account balances were over $1,800 during the period we reviewed. Further, we found that the account balance for these three residents grew to exceed $2,000 in the months during or immediately following our review period. One resident's account balance exceeded $2,000 for nearly the entire three-month period we reviewed. In all three cases, we found no evidence that the facility made proper and timely notification of the account balance to the resident or legal representative. Facility staff reported that they primarily rely on informal means of notification, such as telephone calls; however, these calls were not documented in the resident files.

- **Accounting errors.** Federal regulations [42 C.F.R. 483.10(c)(4)] require nursing facilities to account for resident funds in accordance with generally accepted accounting principles. During our review we found that one facility made accounting errors while adjusting monthly income deposits and associated withdrawals for care costs for two of the five sampled residents

at the facility. For the first resident, the facility underbilled the resident's cost of care for three consecutive months by a total of about $2,000. This caused the resident's personal income to exceed the $50 monthly limit and the resident's account balance to exceed the individual resource limit for these months. The facility became aware of the error in the fourth month and made a subsequent adjustment to the resident's account to recover the remaining balance for the resident's cost of care. For the second resident, the facility calculated the resident's cost of care incorrectly for two consecutive months, which caused the resident's personal income to exceed the $50 monthly limit in both months.

- **Lack of quarterly account statements.** Federal regulations [42 C.F.R. 483.10(c)(4)] and state statute [Section 25.5-2-206(4), C.R.S.] require nursing facilities to provide residents or their legal representatives with quarterly account statements. We found there was no evidence of such notification in 15 of 25 sampled resident files. Although the facilities reported providing account statements to these residents, we were unable to verify facilities' compliance with this requirement due to a lack of documentation.

In general, improper management of resident fund accounts means that residents' rights are not being fully recognized and their financial assets are not being fully safeguarded. Lack of proper notification limits residents' ability to monitor their account activity and, in some cases, may ultimately place them at risk of losing eligibility for Medicaid benefits. Moreover, noncompliance and inadequate controls over the management of resident fund accounts increases the risk for fraud, abuse, and criminal activity. For example, in 2003 an employee at a nursing facility in Denver was found guilty of criminal charges for misusing resident fund accounts to perpetrate an embezzlement scheme.

Monitoring Resident Fund Accounts

As discussed earlier, there are numerous federal and state requirements governing nursing facilities' management of resident fund accounts. Currently CDPHE and HCPF share responsibility for overseeing nursing facilities' compliance with these requirements. We found that there needs to be more systematic and routine monitoring of resident fund accounts by both agencies.

First, although facilities can be cited with a deficiency citation for noncompliance with federal regulations, survey teams do not routinely review resident fund accounts. Survey teams cited a total of 46 resident fund account deficiencies during Fiscal Years 2002 through 2006, half of which were related to the conveyance of funds upon the death of the resident. Only 7 of these 46 (15 percent) deficiencies

were directly related to denying the resident the right to manage their own funds, or to problems with the facility's account management practices. CDPHE staff reported that they typically refer problems with resident fund accounts to HCPF. CMS provides guidance to surveyors for reviewing resident fund accounts; however, CDPHE staff reported that this detailed review is "triggered," which means that it only occurs if problems with resident funds are first identified through surveyors' interviews with residents or their families. We reviewed CMS's standard resident and family interview forms and found that they contain no questions specific to resident fund accounts. Moreover, many of the problems we identified during our audit may not be known to residents or their families and could only be identified through interviews with facility staff and a review of resident fund account documentation. CMS survey protocols only direct surveyors to review resident fund accounts when triggered; therefore, CDPHE needs to take steps to ensure that surveyors effectively and efficiently identify those circumstances where additional review of resident fund accounts is warranted. To this end, CDPHE should ensure that surveyors are trained on the requirements and proper internal controls over resident fund accounts, as well as on common problems and risks associated with resident fund accounts. Specific questions about resident funds should always be included in interviews with residents, family members, and facility staff to assess the facility's practices regarding such things as completion of management authorization agreements, account balance notification, and quarterly account statements. More in-depth review should then be done in accordance with CMS survey protocols depending on the results of these initial inquiries.

Second, most surveyors have a health care or social work background, which means they may lack sufficient expertise or experience in accounting or auditing to effectively evaluate and test facilities' management of resident fund accounts. CDPHE should provide training to all surveyors on resident fund management requirements and proper internal controls, as well as on common problems and risks associated with resident fund accounts. Additionally, CDPHE could explore ways to augment the expertise available to review resident fund accounts by periodically including individuals on survey teams with a background in accounting or auditing. CMS suggests that states consider using individuals in specialized disciplines who may not routinely participate as members of survey teams. These individuals would not necessarily be present on every survey, but instead could be made available to assist survey teams on an as-needed basis when specific problems or questions regarding resident fund accounts arise at a facility.

Third, state statute [Section 25.5-6-206(5), C.R.S.] authorizes HCPF to audit resident fund accounts managed by nursing facilities participating in the Medicaid program. However, State Medicaid Rules [10 CCR 2505-10, Part 8.482.54(C)] only require such audits when there is a change in facility ownership or when the facility discontinues its participation in the Medicaid program. This creates a large gap in

audit coverage, since nursing facilities can operate for many years before HCPF is required to conduct an audit. Since April 2004, HCPF has not conducted any audits of resident fund accounts at nursing facilities where there has not been a change in ownership. Resident fund account audits can be an effective way of ensuring that nursing facilities participating in Medicaid manage resident funds properly because HCPF is authorized to seek recovery of funds on behalf of residents. For example, from November 2004 through August 2006, HCPF completed 39 change-of-ownership audits and sought the return of more than $143,500 to resident fund accounts. HCPF should expand its audit program to include audits at all Medicaid nursing facilities on a more routine basis. In addition to issuing audit adjustments, HCPF's audit reports should contain recommendations to the nursing facility on how to improve internal controls over resident fund accounts in accordance with federal and state requirements.

Fourth, nursing facilities are required to give Medicaid residents notice when account balances approach the $2,000 individual resource limit for SSI; however, there is no requirement that nursing facilities notify either county eligibility specialists or the State when Medicaid residents' account balances actually reach or exceed this resource limit. As we described earlier, we found that nursing facilities did not give proper notice of account balances and that account balances for three residents in our sample grew to exceed $2,000 during our audit. Medicaid residents whose personal fund account balances exceed $2,000 are technically no longer eligible to receive Medicaid benefits because they have resources exceeding the individual resource limit. Not only could this negatively affect the resident, but this also means that the State could be paying Medicaid claims for ineligible individuals in violation of federal law. Medicaid is a payer of last resort. Therefore, when a resident's income or personal resources exceed established thresholds, the excess should be applied toward his or her cost of care. State Medicaid Rules [10 CCR 2505-10, Part 8.110.51(C)(3)] allow Medicaid residents to use resources in excess of the $2,000 limit to offset Medicaid payments in lieu of losing eligibility for Medicaid benefits. HCPF needs to take steps to identify Medicaid residents with account balances exceeding applicable resource limits. For example, HCPF could require nursing facilities to notify county eligibility specialists and the State when a Medicaid resident's personal needs account balance reaches the resource limit. Once residents with account balances exceeding applicable resource limits are identified, HCPF needs to recover the excess funds to offset Medicaid claims paid for the resident.

Finally, CDPHE and HCPF need to better coordinate oversight and monitoring of resident fund accounts. Each agency operates according to separate laws and regulations and their responsibilities for monitoring nursing facility accounts and addressing violations differ accordingly. HCPF audits resident fund accounts and is authorized to seek recovery of resident funds from Medicaid-certified nursing facilities based on the audit results. CDPHE conducts federal certification surveys

and is authorized to issue deficiency citations, require plans of correction, and recommend other enforcement actions, such as civil monetary penalties for noncompliant practices. Better coordination will increase the effectiveness of both agencies' efforts and help avoid duplication wherever possible. CDPHE should continue to make referrals to HCPF based on surveyors' review of nursing facility resident fund account management practices. In addition, survey teams should consult the results of HCPF's resident fund account audits during pre-survey planning activities. HCPF should consult the results of certification surveys when setting its audit schedule, as well as follow up on referrals from CDPHE. HCPF could also help provide training and guidance to survey teams on reviewing facilities' resident fund account management practices.

Recommendation No. 11:

The Department of Public Health and Environment should improve its oversight of nursing facilities to ensure compliance with federal and state requirements for managing resident fund accounts. Specifically, the Department should:

a. Ensure that surveyors are trained on the requirements and proper internal controls over resident fund accounts, as well as on common problems and risks associated with resident fund accounts.

b. Include specific questions about resident fund accounts in interviews with residents, family members, and facility staff. More in-depth review should then be done in accordance with CMS survey protocols depending on the results of these initial inquiries.

c. Work with the Department of Health Care Policy and Financing to improve communication and coordination and, to the extent possible, minimize the potential for duplication of resident fund account monitoring efforts.

Department of Public Health and Environment Response:

a. Agree. Implementation date: July 2007.

   CDPHE will provide surveyors with refresher and updated training and guidelines on Medicare/Medicaid certification requirements for resident fund account oversight by July 2007.

b. Agree. Implementation date: July 2007.

The CDPHE currently follows CMS Medicare/Medicaid certification guidelines and requirements for surveying resident fund accounts on triggered and sample resident bases. The CDPHE will use CMS guidelines and collaborate with HCPF to develop a surveyor checklist and protocol to better guide surveyor questions and review in this area, and help determine when to refer in-depth review of resident fund accounts to HCPF after citing the applicable deficiencies. The use of such tools and protocols and the potential inclusion of additional residents in the survey sample may increase surveyor time on resident fund account matters at the expense of other on-site survey tasks involving resident care and safety and must be prioritized in consideration of limited resources and workload needs. Implementation of this recommendation beyond current CMS requirements and guidelines will require additional state funds.

c. Agree. Implementation date: April 2007.

CDPHE will increase its communication and coordinate with HCPF on resident fund account efforts and monitoring and collaborate on surveyor checklists, protocols and criteria for referral of cases needing in-depth analysis to HCPF.

Recommendation No. 12:

The Department of Health Care Policy and Financing should improve its oversight of nursing facilities to ensure compliance with federal and state requirements for managing resident fund accounts. Specifically, the Department should:

a. Develop and implement an audit program consistent with its existing authority to conduct more routine audits of resident fund accounts managed by nursing facilities participating in Medicaid. This audit program should be risk-based and consider factors that identify the need to audit resident fund accounts prior to a change in facility ownership.

b. Take steps to identify Medicaid residents with account balances exceeding applicable resource limits. Amounts exceeding applicable resource limits should be recovered by the State and used to offset Medicaid claims paid for the resident.

c. Work with the Department of Public Health and Environment to improve communication and coordination and, to the extent possible, minimize the potential for duplication of resident fund account monitoring efforts.

Department of Health Care Policy and Financing Response:

a. Agree. Implementation date: Implemented November 2006.

A risk-based audit program was developed and put into place in November 2006.

b. Agree. Implementation date: March 31, 2007.

The Department has included in its risk-based audit program a step to audit 100 percent of the personal needs account balances. The Department's current staffing will allow all facilities to be audited every four years. The Department staff auditor will determine the excess amount required to be repaid to the State as an offset to Medicaid claims for the resident.

c. Agree. Implementation date: March 31, 2007.

The Department will work with the Department of Public Health and Environment to coordinate and communicate information between the two departments to minimize any duplication of monitoring efforts.

Nursing Facility Employee Screening

Nursing facilities have an obligation to ensure the employees they hire are qualified, competent, and otherwise fit to provide care to residents. Federal regulations [42 C.F.R. 483.13(c)] preclude nursing facilities from employing any individual found guilty of abusing, neglecting, or mistreating residents, or who has had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents, or misappropriation of their property. State statute [Section 25-1-124.5, C.R.S.] requires that prior to employing any person, nursing facilities must make an inquiry with the Colorado Bureau of Investigation (CBI) or a private background check company to ascertain whether such person has a criminal history, including arrests and convictions. Statute further authorizes the use of fingerprints for purposes of searching Federal Bureau of Investigation (FBI) records. The criminal history check cannot be conducted more than 90 days prior to employment.

Additionally, federal regulations [42 C.F.R. 483.75(g)] require nursing facility professional staff (e.g., nurses, nurse aides, registered dieticians, physical therapists) to be licensed, certified, or registered in accordance with applicable state laws. According to guidance from CMS, nursing facility screening of potential employees should include obtaining information from previous and current employers, and checking with the appropriate licensing boards and registries.

We conducted site visits at five nursing facilities across the State to determine compliance with federal and state laws and regulations governing criminal history checks and other preemployment screening practices. We reviewed facility documentation of preemployment screening for a total of 25 sampled nursing facility employees (i.e., 5 employees at each facility). We found that nursing facilities do not sufficiently screen employees prior to employment. Specifically, we found:

- **Criminal history checks are not conducted prior to hire.** We found no evidence of a criminal history check for 1 of 25 sampled facility employees. The facility completed a criminal history check for this employee subsequent to our site visit. We found that facilities conducted criminal history checks after hiring 3 of the 24 remaining employees. In these cases, the criminal history checks were completed 4 days, 10 days, and 3 weeks after the employee's hire date.

- **Professional license verification is not completed prior to hire.** We found that nursing facilities did not verify credentials prior to hiring 7 of the 14 employees in our sample who were licensed professionals, such as a registered nurse, certified nurse aide, or physical therapist. Although we were able to verify that all 14 employees held current and active licenses, facility documentation showed that license verification was not completed until 4 days, 25 days, and more than 2 months after the hire date for 3 employees. There was no documentation to show that the facilities verified professional licenses for four employees at any point in time.

- **Reference checks are not conducted in accordance with facility policies.** There are no federal or state requirements that nursing facilities check references for potential employees. However, all five facilities we visited had written policies in place requiring that a minimum of two references be checked prior to employment. It was unclear from documentation maintained by the facilities we visited that references for 5 of the 25 sampled employees had been checked in accordance with facility policies.

- **The scope of criminal history checks and disqualifying criminal offenses lack consistency.** State statute [Section 25-1-124.5, C.R.S.] authorizes the use of fingerprints to conduct national FBI criminal history searches. However, all five of the facilities we visited used private companies to conduct name-based searches of CBI records. Additionally, we found that there is broad variation in facility policies regarding crimes barring an individual from employment. For example, two facilities had hiring policies listing specific felony and misdemeanor criminal offenses, as well as a specific number of years since conviction, that disqualify an individual from employment. Two other facilities had less detailed hiring policies regarding specific misdemeanors or felonies but did specify broad groups of criminal activity (i.e., violent, abusive, or dishonest acts) and associated timelines for disqualifying offenses. The fifth facility's hiring policies did not list any specific offenses barring employment. Our file review showed that two of the five employees sampled at this facility were charged with misdemeanor and felony harassment charges and were convicted of misdemeanor harassment. There was minimal notation in the personnel files indicating how the facility considered or evaluated this information during the hiring decision.

To address the problems we identified, state survey teams need to conduct a more detailed review of nursing facility employee screening practices. Currently every certification survey includes review of a sample of facility employees hired within the previous four months. CDPHE has developed forms and checklists to assist surveyors in their examination of facilities' preemployment screening practices. Although these forms prompt surveyors to look at criminal history, license, and reference checks, the forms need to specify in more detail the factors that surveyors should review for each facility employee. For example, the form should require the surveyor to document the criminal history check date and compare it with the employee's hire date to assess facility compliance with state statutory provisions. The form should also specify how the results should be evaluated by survey teams, such as guidelines on the number and types of errors that would warrant a deficiency citation.

Additionally, CDPHE should work with the General Assembly to revise and clarify statutory requirements for criminal history checks of nursing facility employees. State statutes require nursing facilities to conduct criminal history checks on potential employees but do not mandate the type or comprehensiveness of the required criminal history check. Statutes also do not specify criminal offenses that disqualify individuals from employment in a nursing facility. As we mentioned earlier, nursing facility policies vary widely in this area. The State needs to evaluate the various methods for conducting criminal history checks and determine which methods are most appropriate to properly safeguard residents while controlling costs

to the facility or the applicant. For example, screening could follow a tiered approach with fingerprint-based checks required for nursing facility staff providing direct care to residents and name-based checks required for all other facility employees. Finally, statutes should clearly specify those offenses that disqualify an individual from employment at a nursing facility to ensure that nursing facilities evaluate and use criminal history information in a consistent and equitable manner.

Nursing home residents are a vulnerable population. Failure to properly or consistently screen potential employees prior to employment puts residents at increased risk of abuse, neglect, or harm. Furthermore, facilities could be held liable for failing to adequately protect residents or ensure that employees possess sufficient qualifications, skills, and competency to provide care to residents.

Recommendation No. 13:

The Department of Public Health and Environment should work to improve preemployment screening efforts at nursing facilities. Specifically, the Department should:

a. Modify forms and checklists used by surveyors during certification surveys to include more detail on the factors that surveyors should use to review the preemployment screening for each facility employee, as well as guidelines on how the results should be evaluated by survey teams. At a minimum, such factors should include verifying documentation that the facility completed applicable criminal history, license, and reference checks prior to each employee's hire date.

b. Work with the General Assembly to revise and clarify statutory requirements for criminal history checks of nursing facility employees, including specifying the type of search required and those criminal offenses that disqualify individuals from employment at a nursing facility.

Department of Public Health and Environment Response:

a. Agree. Implementation date: April 2007.

CDPHE will develop recommended forms and protocols for surveyors to use during certification surveys to aid in determination of facility preemployment screening by April 2007.

b. Agree. Implementation date: Upon General Assembly request.

The CDPHE will work with the General Assembly if it chooses to revise the statutory requirements for criminal background checks of nursing facility employees. Upon request from the General Assembly, the CDPHE will update and submit the analysis conducted as a result of a September 2001 performance audit on criminal history checks, which identified options for conducting background checks and proposed disqualifying crimes based on guidance established by existing statutes. During the 2003 Legislative Session, the Legislative Audit Committee sponsored Senate Bill 03-010 Concerning Criminal History Record Checks targeting persons who work with vulnerable persons. The bill was postponed indefinitely.

Emergency Preparedness

Federal regulations [42 C.F.R. 483.75(m)] require nursing facilities to have detailed written plans and procedures to meet *all* potential emergencies and disasters, such as fire, severe weather, and missing residents. Facilities must also train employees in emergency procedures and conduct unannounced drills. State licensing regulations [6 CCR 1011-1, Chapter V, Part 13] similarly require nursing facilities to develop written policies and procedures for the protection of persons within the building in case of emergencies, such as fire, flood, loss of utilities, explosion, and food or staff shortage. Policies must include procedures for evacuating residents, setting up an incident command structure (i.e., emergency reporting locations and staff responsibilities), and conducting drills. One of the many tragedies of Hurricane Katrina in the summer of 2005 was reports of nursing homes being ill-prepared to handle the evacuation and care for residents under widespread disaster circumstances. Although Colorado is not at risk for hurricanes, Hurricane Katrina demonstrated that resident safety extends well beyond adherence to the fire code and that attention needs to be paid to broader emergency preparedness and disaster planning efforts.

During our site visits to five nursing facilities, we obtained and reviewed each facility's emergency and disaster plan. We also interviewed facility administrators regarding their emergency and disaster planning efforts at a total of 10 facilities, including the 5 facilities we visited. We found that state survey teams need to monitor nursing facilities more closely and cite deficiencies for noncompliance with federal and state emergency and disaster planning requirements. We also found that the State should play a bigger role in working with nursing facilities to develop plans, especially for more widespread emergencies and disasters.

Types of Incidents

Nursing facilities are required to have plans and procedures for all potential emergencies and disasters. Some of these emergencies and disasters are specifically mentioned in federal or state regulations. However, facilities are largely responsible for determining the contents of their own emergency and disaster plans. We found wide variation in the types of disasters or incidents covered by the emergency and disaster plans we reviewed.

The table below shows the types of incidents covered by the emergency and disaster plans at the five facilities we visited. All five facilities' plans addressed common incidents, such as fire and tornado, and included a description of the incident command structure. Two facilities had comprehensive emergency and disaster plans that covered many different types of incidents; in contrast, one facility's plan did not cover some of the core emergencies and incidents. For example, federal regulations include missing residents as an example of the type of emergency for which facilities are required to plan. However, procedures for dealing with a missing resident were not addressed in the emergency and disaster plan for two of the five facilities we reviewed.

Department of Public Health and Environment Components of Sampled Nursing Facility Emergency and Disaster Plans					
	Facility				
Plan Component	**#1**	**#2**	**#3**	**#4**	**#5**
Armed Robbery	✓				✓
Bomb Threat	✓	✓	✓	✓	✓
Chemical Spill		✓	✓		✓
Civil Disturbance	✓				✓
Drill/Test Procedures	✓	✓		✓	✓
Earthquake	✓	✓			✓
Evacuation	✓	✓		✓	✓
Explosion	✓	✓		✓	✓
Fire	✓	✓	✓	✓	✓
Flooding	✓	✓		✓	✓
Food Shortage	✓			✓	✓
Hurricane		✓			
Incident Command Structure/Staff Responsibilities	✓	✓	✓	✓	✓
Mass Casualty					
Missing Residents	✓			✓	✓
Snowstorm/Blizzard	✓		✓		
Staff Shortage	✓				✓
Tornado/High Winds	✓	✓	✓	✓	✓
Water/Utility Outage	✓	✓		✓	✓
Source: Office of the State Auditor's review of sampled nursing facility emergency and disaster plans.					

CMS guidance further states that facilities should tailor disaster plans to their geographic location and the types of residents they serve. Our review showed that facilities do not appear to be successfully adapting their emergency and disaster plans. Specifically, we found:

- All five facilities had procedures included in their emergency and disaster plans related to tornados and high winds. However, three of the five facilities did not have emergency procedures for snowstorms, blizzards, or other severe winter weather. One of these three facilities had a procedure for hurricanes. This does not seem reasonable or appropriate, since Colorado

regularly experiences winter weather that, when severe, could adversely affect facility operations. For example, winter storms in March 2003 and, more recently, in December 2006 disrupted businesses and government services along the Front Range and Eastern Plains for several days.

- One facility had a procedure for prisoner escape, which was appropriate because of its location near a state correctional facility. However, this same facility's plan lacked procedures for many other common and, perhaps, more likely incidents, such as flooding, missing residents, and utility outages. This facility's plan also included bomb threat procedures, but we found that the procedures lacked sufficient detailed instructions for facility staff on the proper actions and steps to take in such an emergency.

Surveyors obtain and review emergency and disaster plans as part of the certification survey process; however, their review needs more focus and direction. During Fiscal Years 2002 through 2006, CDPHE only cited 21 total deficiencies for facilities' failure to have detailed written plans and procedures for potential emergencies and disasters. Moreover, surveyors cited all 21 deficiencies at a scope and severity of "E" or lower, indicating the potential for more than minimal harm to only a limited number of residents. We question the reasonableness of such determinations, since problems with facility emergency and disaster plans represent systemic failures with the potential to affect all persons in the facility, including residents, staff, and visitors. CDPHE should cite deficiencies with the potential to affect so many individuals at a scope and severity of at least "F," indicating a widespread scope. In addition, surveyors need to be trained on the attributes of a well-organized and comprehensive emergency and disaster plan, as well as on common problems with such plans. The use of detailed testing forms and checklists could help surveyors more effectively and efficiently identify and cite deficiencies with nursing facilities' emergency plans and procedures. Finally, survey supervisors should scrutinize any deficiencies related to facility emergency and disaster plans that survey teams cite at a scope and severity lower than "F."

Facility Challenges

A July 2006 report by the U.S. Government Accountability Office (GAO) highlights many of the challenges faced by nursing home administrators related to the 2005 hurricanes, including deciding whether to evacuate or stay in the facility and "shelter in place," obtaining transportation necessary for evacuations, and maintaining communication outside of the facility. Our interviews with 10 nursing home administrators in Colorado confirmed many of the same findings discussed in the GAO report, as discussed below.

- **Resident evacuations.** The biggest challenge identified by the nursing home administrators we spoke with was evacuating and relocating residents in the event of an emergency. This is because many residents have mobility and cognitive limitations and cannot be easily evacuated in the event of a fire or disaster. Support equipment, supplies, and medication often also need to be evacuated. One facility reported to us they had determined that in most disasters residents would be safer remaining in the building rather than attempting evacuation of the facility. However, this facility also had reciprocal agreements in place with two separate facilities—one close-by and another more distant—to serve as evacuation locations if needed.

- **Widespread disasters.** Some administrators reported that more widespread disasters affecting the community pose additional challenges because they can interrupt utilities and supplies, transportation routes, and communication networks that facilities may need to rely on for response. These factors can further complicate evacuation efforts. Administrators added that staff shortages become a secondary problem when disasters affect the broader community.

- **Rural settings.** Administrators at facilities located in more rural settings reported facing different challenges because not all of the same services (e.g., transportation companies, communication networks, food suppliers, or alternate facilities) are available in rural parts of Colorado as may be available in the Denver Metropolitan Area. Therefore, the challenge for facilities in rural settings is being able to maintain self-sufficiency for an extended period of time.

State licensing regulations for long-term care facilities require each facility to develop written plans for managing residents and treating mass casualties in an external or community disaster. Facilities are required to develop this plan in conjunction with local agencies and other health facilities in the area. However, as was shown in the table in the last section, none of the five facilities we reviewed contained these plans. Planning for more widespread emergencies and disasters is an important task and will require coordination with other agencies. The nursing facility administrators we spoke with consistently mentioned that the State could play a larger role in facilitating coordination among agencies for widespread disaster planning in addition to being more proactive in disseminating model practices, sharing information, and issuing directives and guidelines to nursing facilities regarding emergency and disaster preparedness. CDPHE is the state agency responsible for licensing and certifying nursing facilities, and is the Lead Agency under the State Emergency Operations Plan for the coordination of state health, medical, and mortuary resources. Consequently, CDPHE has the authority and

responsibility to help address the needs of nursing facilities in emergency and disaster planning efforts.

Recommendation No. 14:

The Department of Public Health and Environment should improve emergency and disaster planning efforts at nursing facilities by:

a. Training surveyors on the attributes of a well-organized and comprehensive emergency and disaster plan, as well as on common problems with emergency and disaster plans.

b. Developing testing forms and checklists to help surveyors conduct a more focused review of emergency and disaster plans and identify deficient practices.

c. Reviewing for appropriateness any emergency and disaster plan deficiencies that survey teams cite lower than a scope and severity of "F."

d. Facilitating information sharing and the dissemination of model disaster and emergency practices and procedures among nursing facilities. This should include assessing the need to issue additional directives to nursing facilities on emergency and disaster planning.

e. Encouraging coordination between local emergency managers, local health departments, nursing facilities, and other agencies to ensure that the needs of nursing facilities are addressed in planning efforts for community-wide emergencies and disasters. Specific attention should focus on addressing the needs of nursing home residents during evacuations, including identifying viable evacuation locations and the arrangements necessary to relocate residents to these locations.

Department of Public Health and Environment Response:

a. Partially agree. Implementation date: January 2008.

CMS recently shared a draft workgroup report on Emergency Preparedness Planning with State Survey Agencies (SSAs). SSAs may expect to receive Survey & Certification (S&C) written guidance and promising practices sometime during Federal Fiscal Years 2007-2008.

CDPHE will use the CMS workgroup product and work with the CDPHE's emergency management section to identify the risk assessments and emergency planning elements facilities need to make and include in their plans. From these sources and conditioned upon receipt of additional federal and/or state resources, surveyor guidelines and training for assessing facility emergency management plans can be created.

b., c., d. Partially agree. Implementation date: October 2007.

See CDPHE's response to 14a.

e. Partially agree. Implementation date: October 2007.

While CDPHE agrees that this is an important next step to facility emergency planning, implementation of this recommendation is beyond Medicare/Medicaid certification requirements and our current certification budget and must be prioritized along with other resource and workload needs. Additional state or federal grant funding will be necessary to implement this recommendation. CDPHE will investigate the availability of such funding by October 2007.

State Licensure

As we have discussed throughout the audit report, CDPHE monitors nursing facilities participating in Medicare or Medicaid for compliance with federal health, safety, and quality-of-care standards. Additionally, state statute [Section 25-1.5-103(1)(a), C.R.S.] authorizes CDPHE to annually license and to establish and enforce standards for the operation of 19 different types of health facilities, including nursing homes. CDPHE and the State Board of Health have promulgated regulations setting forth state licensing requirements for health facilities. Among other requirements, state regulations dictate how (1) nursing facilities are to be administered and staffed, (2) resident care is to be provided, and (3) resident rights are to be protected. State statutes and regulations provide CDPHE with the authority to take enforcement actions for noncompliance with state regulations, including denying, limiting, suspending, or revoking the facility's license. Because the State has a licensing requirement for nursing facilities, CMS requires nursing facilities to obtain a state license prior to being certified to provide care to Medicaid or Medicare residents. Although state regulations for operating nursing facilities may mirror some federal health, safety, and quality-of-care standards, state licensure and federal certification for participation in Medicaid and Medicare are not equivalent. Colorado

began licensing nursing facilities in 1971. Congress established the first set of standards applicable to nursing facilities under Medicare and Medicaid in 1967 with revisions in 1980 and 1987. The Nursing Home Reform Act, which was part of the Omnibus Budget Reconciliation Act of 1987, significantly changed the federal regulation of nursing home care and made each state responsible for establishing, monitoring, and enforcing state licensing and federal minimum standards for nursing homes.

We reviewed CDPHE's processes for licensing nursing facilities and found that currently CDPHE is not performing its licensing function as intended and specified by state statute and regulations. Ultimately, this compromises the State's ability to effectively use the licensing function to ensure that nursing homes provide quality care and adequately protect resident safety. As we describe in the following sections, the State needs to evaluate policy options for licensing nursing homes and other types of health facilities and consider the best direction for the State. Although this issue extends to all types of health facilities licensed by the State, our discussion is focused primarily on nursing homes.

Fitness Reviews

State statute and regulations [Section 25-3-102(1), C.R.S.; 6 CCR 1011-1, Chapter II, Part 2.5] require CDPHE to review the *fitness* of health facilities, including nursing facilities, either through on-site inspection or other appropriate investigation prior to issuing or renewing a state license. In determining the fitness of the nursing facility for state licensure, CDPHE must consider (1) whether the facility is authorized to do business in Colorado; (2) whether the facility has adequate financial resources to provide staff, services, and a physical environment that is sufficient to comply with state laws and regulations; and (3) whether the owners of the facility are competent to operate the facility in accordance with applicable standards, including state licensing standards and federal certification requirements. Additionally, CDPHE must determine whether the owners have been convicted of any health-related crimes. According to CDPHE staff, fitness reviews are needed to ensure compliance with state licensing laws and regulations and to provide a level of assurance over the delivery of care and protection of resident safety that the federal certification process does not provide. Specifically, the fitness review includes:

Financial Review—A detailed review of the facility's financial condition to ensure that the facility is sufficiently solvent to provide services in accordance with state laws and regulations. This includes reviewing the adequacy of the facility's insurance coverage, the facility's legal business status, and conducting background checks on the facility owners and operators.

Health Review—An on-site review to ensure that the facility's policies and procedures related to such things as resident care, staffing levels, kitchen sanitation, food storage and preparation, medication administration, and the level of supplies (e.g., medication, medical supplies, or personal care supplies) are in line with state regulations.

Life Safety Review—A review of building plans and an on-site review when construction is nearing completion to ensure compliance with the fire code. This includes an inspection of fire alarms, sprinkler systems, emergency evacuation plans, and emergency generators and supplies. State licensing standards and CDPHE's review are intended to provide for a consistent minimum level of assurance statewide for nursing facility fire safety, since local building codes vary from one jurisdiction to another or may not specifically address nursing facilities.

Quality Management Plans—A desk review and technical assistance provided to facilities related to their quality management plans that describe in detail the facility's procedures for evaluating the quality of resident care and safety. The plan includes, among other things, a description of (1) the types of cases, problems, or risks that the facility will review, and identification of staff responsible for reviewing and reporting to nursing facility management on such issues; (2) the methods for taking corrective action on problems identified and preventing the occurrence of future problems; and (3) the schedule for implementing the quality management plan. Additionally, state regulations [6 CCR 1011-1, Chapter II, Part 3.1.5] grant CDPHE the authority to audit the facility for compliance with its quality management plan.

CDPHE reported in its Fiscal Year 2008 Budget Request to the Joint Budget Committee that with the exception of assisted living residences, it does not perform comprehensive reviews, including any of the items listed above, as part of either the initial or renewal licensing process for *any* licensed health facility due to a lack of funding for the licensing function. (The licensing function for assisted living residences is funded through a separate licensing fee structure that provides more revenue for licensing activities.) During our audit CDPHE staff reported relying instead on attestations signed by facilities to provide a minimum level of assurance that state licensing requirements are being met. Effectively, this means that CDPHE is issuing state licenses to health facilities, including nursing facilities, on the basis of the facility's signed statement that it complies with applicable requirements. CDPHE does not perform any desk reviews of financial solvency, insurance coverage, and quality management plans. CDPHE also does not perform any on-site inspections of the facility to ensure compliance with applicable state health and life safety codes. We contacted licensing officials in eight other states and found that each of the six states responding to our inquiry (Kansas, Nebraska, Nevada, Oregon,

South Dakota, and Washington) conducts an initial on-site inspection of nursing facilities prior to licensure, and three states (South Dakota, Oregon, and Washington) conduct on-site inspections upon license renewal. In addition to the on-site inspections, these other states' licensure activities include procedures such as financial reviews and fire safety or environmental inspections.

Colorado's licensing laws and regulations intend for CDPHE to determine whether the health facility has the legal capacity, financial resources, and professional competence to operate a health care facility in compliance with state laws and regulations prior to issuing or renewing a state license. Without ongoing monitoring efforts to ensure that facilities continuously meet state licensing requirements, the fact that a nursing facility has a license issued by the State may provide false assurance to the public, residents, and CMS that state standards are being met. Further, attestations are a reactive rather than a proactive means for ensuring facility compliance with state licensing laws and regulations. For example, if a facility attests that it followed all required fire codes in the construction of its building, and the facility has not done so, an attestation will not identify and correct the problem prior to residents living in the facility. In contrast, an on-site inspection could identify and correct the problem before residents enter the facility. Relying on attestations potentially places residents at a greater risk.

Currently CDPHE is not performing its licensing activities as intended and specified by state statutes and regulations. To address this issue, we found that the State needs to evaluate policy options for the licensing function. As we describe below, options range from increasing licensing fees to support activities currently specified in statute and regulations, to substantially limiting the licensing requirements and review processes for state licensure.

Licensing Fees

CDPHE staff reported that with the exception of assisted living residences, CDPHE lacks sufficient resources to implement state licensing laws and regulations. This is because revenue from annual licensing fees is not sufficient to cover the cost of the licensing function. Thus, one solution for addressing CDPHE's ability to conduct fitness reviews as intended by state statute and regulations is to reevaluate the licensing fees paid by nursing homes and other types of health facilities.

Currently CDPHE's licensing program is primarily funded through a statutory $360 annual licensing fee paid by all health facilities, including nursing homes. In Fiscal Year 2006 CDPHE received about $70,900 in licensing fee revenue from Colorado's 197 non-state-owned nursing facilities. The licensing fee does not apply to the 20 government-owned nursing facilities; however, CDPHE is still required to review these facilities for compliance with state licensing requirements. On the basis of

average hourly salary and benefits data reported by CDPHE, we estimate that this revenue pays for about eight hours of direct staff time per nursing facility per year on licensing, monitoring, and enforcement activities. As mentioned earlier, CDPHE reported that this is not enough staff time to perform detailed reviews of facility documentation or to conduct on-site inspections for purposes of establishing and monitoring the facility's fitness for state licensure. CDPHE reported that resolving errors, omissions, and other problems with the license application and supporting facility documentation (e.g., inconsistent use of legal name, improperly signed documents) quickly use up existing resources. Further, there are some situations in which CDPHE issues a conditional license, which means that the scope of the facility's operations (i.e., services provided) are limited or restricted. CDPHE staff reported that conditional licenses require additional legal resources from the Attorney General's Office to prepare a legal agreement, known as a stipulation, between the State and the facility outlining the scope of the licensed activity.

Colorado's statutory licensing fee for health facilities, including nursing homes, was last changed in 2003 when it was increased from $150 to its current amount of $360 per year. We looked at nursing facility licensing fee schedules in eight other states (Arizona, Kansas, Nebraska, Nevada, Oregon, South Dakota, Utah, and Washington) and found that Colorado's licensing fee for nursing homes is substantially lower than fees in other states. In seven of the eight states we reviewed, the licensing fees for nursing homes are set separately from the licensing fees for other types of health facilities. In Colorado, only assisted living residences pay a different licensing fee. (As of August 2006, acute treatment units also pay a different licensing fee pursuant to House Bill 06-1277.) Some states set their fees in statute, while others set their fees in state regulations or through the annual appropriations process to afford more flexibility in adjusting fees. Moreover, in all eight states the amount of the nursing facility licensing fee is based to some extent on the number of beds in the facility. Three of the states have separate fees for initial licenses and license renewal. Five of the states use a combination of a base licensing fee plus a per bed amount. For example, Arizona has a $50 license application fee, plus a base fee that ranges from $100 to $500 depending on the number of beds in the facility, plus a $10 per bed fee. In Fiscal Year 2006 the average Colorado nursing home had about 93 licensed beds. If the average-sized Colorado nursing home paid the average of all licensing fees charged by the eight states we surveyed, the initial licensing fee would be over $4,800, or more than 13 times the amount of Colorado's current licensing fee.

As we found in other states, and even for assisted living residences and acute treatment units in Colorado, there are a number of options to consider when setting a health facility licensing fee structure to support the cost of licensing activities required in state statute and regulations. Options could include establishing fees based on the number of licensed beds at the facility to make fees more equitable among different-sized facilities; developing separate fees for each type of facility to

ensure that fees are adequate to fund the cost of licensing, monitoring, and enforcement activities for that facility type; differentiating between initial licensure fees and renewal licensure fees; and setting fees through regulations or the annual appropriations process.

Streamline Licensing Requirements

As an alternative to increasing licensing fees to support the cost of CDPHE's licensing activities, the State could consider substantially revising statutory and regulatory licensing requirements to a level that is more in line with existing resources. Currently all 50 states require nursing homes to be licensed. On one extreme, the State could choose to eliminate state licensing requirements for nursing homes or other types of health facilities. Another option the State could consider would be to maintain the licensing requirement but scale back monitoring efforts and rely on attestation. The State would issue licenses on the basis of signed statements that the facility complies with applicable licensing requirements. Under this type of system, the State would have little to no responsibility for monitoring nursing facilities on an ongoing basis for compliance with state licensing requirements. As we discussed earlier, CDPHE has taken this approach as a means of managing its limited resources. However, this approach appears contrary to current statutory and regulatory provisions. If licensure via attestation is the preferred policy alternative, then state statutes and regulations should be changed accordingly to avoid giving the public false expectations and assurances.

Since existing state regulations generally mirror federal regulations for nursing facility operations, and because Medicare- and Medicaid-certified nursing facilities are routinely inspected through federal certification surveys, an attestation approach may offer an adequate level of assurance for the *renewal* of a state nursing facility license. However, there are some concerns with using attestations for *initial* licensure because nursing facilities must be licensed by the State before they can be certified to participate in Medicare or Medicaid. There were approximately 9 new licenses and about 75 change-in-ownership licenses issued to nursing facilities in Fiscal Years 2002 through 2006. Moreover, licensure via attestation is of particular concern with respect to private pay-only nursing homes that do not undergo federal certification surveys because there is no routine review of operations by the State either upon initial licensure or upon license renewal. As of June 30, 2006, there were 6 private pay-only nursing homes in Colorado, with a total of more than 350 licensed beds.

As discussed earlier, relying on attestations as a basis for state licensure has some inherent problems. The State could instead choose to approach licensure on a risk basis. For example, different licensing requirements and inspection processes could be established for private pay-only facilities versus those facilities that also obtain

federal Medicare and Medicaid certification. The State could conduct a more thorough review for initial licensure or when the facility changes ownership, and rely on attestations or more limited reviews for license renewals. Licenses could also be made effective for more than one year at a time. Our audit only focused on nursing facilities; however, the State could establish different levels of review for licensing different types of health facilities (e.g., nursing homes versus assisted living residences). For example, federal regulations for nursing homes are quite extensive and, except in certain higher risk instances discussed above, may leave little need for CDPHE to conduct additional review for state licensure. However, federal certification for other types of health facilities may not be as extensive. Consequently, the State may choose to conduct more detailed state licensure reviews to ensure that requirements are being met. Implementing this type of a system will require CDPHE to conduct a side-by-side analysis of state and federal regulations to determine where overlap does or does not exist, as well as periodically update the analysis as federal requirements change.

Regardless of which direction the State moves in, the State needs to be clear and transparent about the level of review and monitoring performed when issuing a nursing facility license and, therefore, the level of assurance that state licensure provides to residents, the public, and CMS. Nursing facility oversight is a shared responsibility between the state and federal governments, which means that both state and federal regulations and resources must be used. CDPHE should work with the General Assembly and the Board of Health to evaluate policy options for licensing nursing homes and other types of health facilities. Either the licensing fees need to be set at a level that is sufficient to cover the cost of licensing activities as currently outlined in state statutes and regulations, or state licensing laws and regulations need to be revised to authorize more limited requirements and review processes for state licensure.

Recommendation No. 15:

The Department of Public Health and Environment should work with the General Assembly and the Board of Health to evaluate policy options for licensing nursing homes and other types of health facilities, and consider the best direction for the State's health facility licensing program. This should include:

a. Reevaluating the licensing fee set in statute.

b. Exploring ways to revise licensing requirements, including conducting a side-by-side analysis of state and federal regulations to identify areas of overlap.

c. Seeking statutory and regulatory change, as appropriate.

Department of Public Health and Environment Response:

a. Agree. Implementation date: Ongoing.

The CDPHE has been reevaluating the licensing fee in light of the program objectives as described in Recommendation 15b (see below). Currently, the statute establishes a uniform licensure fee ($360 annually) for all licensed facilities, except for assisted living residences and acute treatment units. Government entities do not pay any license fee. The Division is able to provide the issuance of a health facility license or certificate of compliance based on a cursory paper review of facility attestations to fitness and meeting regulatory licensing requirements; fire safety code attestation by local fire department jurisdictions; limited licensure technical assistance; and limited complaint investigations of the most egregious situations not covered by Medicare/Medicaid certification regulations for this $360 fee. However, the $360 annual license fee is insufficient to allow CDPHE to perform many of the mandated and often requested licensure activities including a comprehensive review of applicant's fitness to operate, specifically the applicant's past compliance performance, in addition to sufficient financial resources and insurance coverage; fire, safety and environmental construction plan review and technical support; on-site health, environmental and fire safety code inspections; and comprehensive state complaint investigations. The CDPHE has been closely examining this issue over the past several months and will work with the General Assembly and the Board of Health to seek options to improve the licensure program.

b. Agree. Implementation date: July 2007 start date, contingent upon additional resources.

The primary goals of facility oversight include ensuring:

- The organization's fitness to operate (e.g., do not have a history of egregious noncompliance in other states);
- That the physical plant is sound (e.g., safe from fire and is built in such a way as to prevent the spread of infections—has walls and floors that are easily washable and installs appropriate ventilation); and
- That health care is delivered by qualified staff and in a safe manner.

Using these measures, the CDPHE will determine the extent to which there is overlap with the requirements established by other regulatory entities. The analysis will be conducted in phases and is contingent upon the receipt of additional resources and implementation of Recommendation 15a.

c. Agree. Implementation date: Ongoing.

Based upon the reviews referenced in responses to 15a and 15b, the CDPHE will seek statutory and regulatory changes as needed to increase licensure funding and implement the program's objectives. Increased funding and resources are integral to implementing the recommendations of this audit and to meet the intended goals of the program. The CDPHE has been closely examining this issue over the past several months.

Medicaid Reimbursement Rates

Chapter 3

Background

In Fiscal Year 2006 the State spent approximately $456.5 million in state and federal Medicaid funds on payments to nursing facilities. Payments to nursing homes represent about 23 percent of the State's total Medicaid spending on premiums for medical services. Medicaid is the single largest source of financing for long-term care services in Colorado. As of June 30, 2006, a total of 193 of Colorado's 217 nursing facilities (89 percent) were certified to participate in Medicaid, and approximately 59 percent of all occupied nursing facility beds were occupied by Medicaid residents. The nursing home industry is one where the costs of operation are often paid by a government payer, such as Medicaid or Medicare, and not the actual consumer of the service. Thus, the consumer market does not drive the price of care, and rate-setting systems become necessary to (1) provide a basis for calculating the actual amount of the government payment, (2) control costs, and (3) ensure that a minimum level of service is provided. Reimbursement rates that are set too low may affect quality of care and reimbursement rates that are set too high result in wasteful use of taxpayer dollars.

The Department of Health Care Policy and Financing (HCPF) is the state agency responsible for the Colorado Medicaid Program and provides policy and financial oversight of nursing facilities that serve Medicaid residents. HCPF's primary responsibility related to nursing homes is to develop and administer a reimbursement rate schedule in accordance with the methodology prescribed by state statute [Section 25.5-6-204, C.R.S.]. HCPF then pays claims filed by nursing facilities for Medicaid residents in accordance with established reimbursement rates.

The methodology for setting Medicaid reimbursement rates for nursing facilities involves a number of steps and complex calculations. This methodology has been amended through the years resulting in a patchwork of adjustments to and limits on reimbursable costs. Recent legislation provides policymakers and administrators with an opportunity to revisit Colorado's system for reimbursing nursing homes that participate in Medicaid. This chapter is intended to provide information and data on Colorado's current system for setting nursing facility Medicaid reimbursement rates and to identify specific issues the State should consider as it moves forward with discussions regarding changes to the current reimbursement system. This chapter

does not apply to Medicaid reimbursement rates for intermediate care facilities for the mentally retarded.

Cost of Care

The cost of nursing facility care can be quite high. According to a September 2006 market survey of nursing home costs conducted by MetLife, the national average daily private pay rate for a private room in a nursing home is about $206 per day, or about $75,190 annually. Most private health insurance plans, as well as Medicare, only pay for short stays in nursing facilities under limited circumstances. Medicaid is available to pay for long-term stays but only for eligible individuals and only after other personal income and savings have been depleted. According to the Kaiser Commission on Medicaid and the Uninsured, long-term care consumes about 39 percent of all Medicaid spending nationwide, but only about 7 percent of the Medicaid population uses long-term care services. Some states, including Colorado, have been able to curb long-term care expenditures by using waivers under their Medicaid programs to offer long-term health care alternatives, such as home- and community-based services, for some beneficiaries. However, even with these other programs, payments for traditional nursing home care continue to represent a significant portion of total Medicaid spending.

As shown by the table below, payments to nursing facilities represented between 22 and 25 percent of the State's total Medicaid spending on premiums for medical services over the last five fiscal years. Medicaid payments to Colorado nursing facilities grew from about $377.2 million in Fiscal Year 2002 to about $456.5 million in Fiscal Year 2006, an increase of 21 percent. This increase is slightly higher than the increase in the medical care component of the consumer price index for all urban consumers, which increased by about 19 percent over the same period. The table also shows that although the average number of Medicaid residents has remained relatively stable over the last five fiscal years, the average dollar amount paid per Medicaid resident increased by about 22 percent, from approximately $37,400 to about $45,600 annually.

Department of Health Care Policy and Financing
State Medicaid Payments to Nursing Facilities
Fiscal Years 2002–2006

	Fiscal Year					Percent Change 2002–2006
	2002	2003	2004	2005	2006	
Nursing Facility Payments[1] (In Millions)	$377.2	$380.4	$416.0	$423.9	$456.5	21%
Total Medicaid Spending on Medical Services Premiums[2] (In Millions)	$1,536.8	$1,651.7	$1,841.7	$1,893.3	$1,982.4	29%
Nursing Facility Payments as a Percent of Total Medicaid Spending on Medical Services Premiums	25%	23%	23%	22%	23%	-6%
Average Number of Medicaid Residents in Nursing Facilities	10,089	9,961	9,875	9,938	10,012	-1%
Average Annual Nursing Facility Payment Per Medicaid Resident	$37,400	$38,200	$42,100	$42,700	$45,600	22%

Source: Expenditure data are as reported in the Department of Health Care Policy and Financing's Fiscal Year 2008 Budget Request. Average number of Medicaid residents are calculated from quarterly bed census data provided by the Department of Public Health and Environment.

[1] Includes total state and federal expenditures paid to nursing facilities on premiums for medical services provided to the following eligibility categories: adults 65 and over, disabled adults 60 to 64, disabled individuals to 59, categorically eligible low-income adults, qualified Medicare beneficiaries, and special low-income Medicare beneficiaries. Payments are to those facilities licensed and certified to provide general and skilled nursing facility care, and do not include facilities that are licensed and certified as intermediate care facilities for the mentally retarded (ICFs/MR).

[2] Includes total state and federal expenditures for premiums on medical services provided to all eligibility categories: adults 65 and over, disabled adults 60 to 64, disabled individuals up to 59, categorically eligible low-income adults, breast and cervical cancer program, eligible children, foster care, baby care program adults, non-citizens, qualified Medicare beneficiaries, and special low-income Medicare beneficiaries. Figures do not include expenditures for Medicaid Mental Health services, or Department of Human Services Medicaid-funded programs (e.g., services for people with developmental disabilities).

Reimbursement Rates

In 1980 Congress passed legislation, commonly referred to as the Boren Amendment, which provided that Medicaid reimbursement rates for nursing homes had to be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." The Balanced Budget Act of 1997 repealed the Boren Amendment and provided states with increased flexibility to develop approaches to pay nursing homes participating in Medicaid. However, states must continue to ensure that Medicaid reimbursement rates for nursing homes are consistent with efficiency, economy, and quality-of-care standards.

State statute [Section 25.5-6-204, C.R.S.] prescribes the factors and methodology used to establish nursing facility reimbursement rates that cover the actual or reasonable

cost of providing care to Medicaid residents. Colorado uses a prospective cost-based reimbursement system, which means that reimbursement rates are established for the current year on the basis of actual audited costs from a prior year. Nursing facilities prepare and submit Medicaid cost reports to HCPF on an annual basis. HCPF contracts with an independent accounting firm to audit these Medicaid cost reports and determine a reimbursement rate that is specific to each nursing facility. Rates are established on a "per diem" or per patient per day basis, which means that total allowable costs are divided by the nursing facility's total patient days. Medicaid claims submitted to the State are paid in accordance with this established per diem rate.

Nursing facility reimbursement rates are currently based on three cost components:

***Property*—**Every four years the base value of each nursing facility's building, land, and fixed equipment is established through an appraisal. The base value is limited to a per-bed maximum set by state statute. Allowable property costs are calculated according to a fair rental value system, which means that a rental rate is applied to the property's base value. On average, property costs account for about 7 percent of a facility's total reimbursement rate.

***Administrative and General*—**Allowable administrative and general costs include such things as laundry, housekeeping, dietary (not food), administrative personnel costs, legal fees, marketing, and travel. Facilities cannot be reimbursed for any administrative and general costs that increase by more than 6 percent from the previous year or that exceed 120 percent of the weighted average administrative and general costs for all facilities in the State. Nursing homes are paid an additional incentive allowance if they maintain their administrative and general costs below the established statewide maximum. This incentive allowance is intended to reward those facilities that work to control their administrative and general costs. On average, administrative and general costs account for about 29 percent of a facility's reimbursement rate.

***Health Care*—**Allowable health care costs are subdivided into two parts. Direct nursing costs include salaries, taxes, and benefits for nursing staff (e.g., registered nurses, licensed practical nurses, certified nursing assistants, and orderlies) that provide direct care to residents. Other health care costs include all remaining patient care costs, such as raw food, therapies, medical supplies, pharmacy, and laboratory services. Facilities cannot be reimbursed for total health care costs that increase by more than 8 percent from the previous year or that exceed 125 percent of the weighted average health care costs of all facilities in the State. Senate Bill 06-131 removed the 8 percent growth cap on the reimbursement of health care costs in Fiscal Year 2007 for those facilities whose Medicaid residents comprise more than 64 percent of the total resident population. On average, health care

costs account for about 64 percent of a facility's reimbursement rate (45 percent for direct nursing costs and 19 percent for other health care costs). Finally, as we described in Chapter 2, state statute [Section 25.5-6-204(4)(g) and (h), C.R.S.] requires HCPF to adjust direct nursing costs on the basis of the facility's "case mix." This means that nursing facilities' reimbursement rates are adjusted upward or downward to account for the relative differences in clinical condition and the resources needed to provide appropriate care for each nursing home's Medicaid residents. Using rates data for Fiscal Years 2002 through 2006, we estimate that the case-mix adjustment has reduced Medicaid reimbursement rates by an average of $1.99 per patient day compared with what the rate would have been without the case-mix adjustment. This reflects the fact that Medicaid patients generally do not require as much direct nursing care as Medicare patients who, for example, may be in the nursing home recovering from a hospital stay and receiving more rehabilitation services. When multiplied by the average number of Medicaid patient days per facility (18,800) and the number of Medicaid-certified facilities (193), this $1.99 downward adjustment in the daily per patient reimbursement rate equates to a total reduction in Medicaid payments of approximately $7.2 million per year.

During our audit we obtained and analyzed data on reimbursement rates for nursing facilities participating in Medicaid for Fiscal Years 2002 through 2006. We found that there is a wide variation in the reimbursement rates paid to nursing facilities, as well as in the percentage of the reimbursement rate represented by the different cost components described above. Overall, these variations give the appearance that the Medicaid reimbursement rates for nursing facilities are not reasonable or equitable across providers.

First, we found wide variation in the total Medicaid reimbursement rates paid to nursing facilities, as shown in the following table.

Department of Health Care Policy and Financing
Medicaid Per Diem Reimbursement Rates for Nursing Facilities
Fiscal Years 2002–2006

	Fiscal Year					Percent Change 2002–2006	5-Year Average
	2002	2003	2004	2005	2006		
Average Rate	$127	$133	$145	$150	$158	24%	$143
Highest Rate	$172	$187	$193	$198	$211	23%	$192
Lowest Rate	$80	$85	$93	$97	$101	26%	$91
Difference (High Rate - Low Rate)	$92	$102	$100	$101	$110	20%	$101

Source: Office of the State Auditor's analysis of nursing facility Medicaid rates data provided by the Department of Health Care Policy and Financing.
Note: Rates are rounded to the nearest whole dollar and are for facilities licensed and certified to provide general and skilled nursing facility care and do not include those facilities licensed and certified as intermediate care facilities for the mentally retarded (ICFs/MR).

The highest rates paid over the last five fiscal years averaged about $192 per patient day. In contrast, the lowest rates paid during the same period averaged about $91 per patient day. Thus, the highest rates paid have averaged more than two times the lowest rates paid. More specifically, in Fiscal Year 2006 alone there is about a $110 difference in the daily reimbursement rate between the highest- and lowest-paid facilities. The case-mix adjustment only accounts for about $32 of this difference in the per patient day rate. In other words, the Medicaid reimbursement for an individual residing in the lowest-paid facility for a full year would total about $37,000 ($101 x 365 days), whereas the Medicaid reimbursement for the same individual residing in the highest-paid facility for a full year would total about $77,000 ($211 x 365 days). This is a difference of about $40,000 in total Medicaid payments for one person that is mostly due to which facility the individual lives in and not necessarily due to the different medical needs of each facility's resident population.

Second, we found that the three different cost categories that make up the nursing facility Medicaid reimbursement rate (i.e., administrative and general costs, property costs, and health care costs) do not drive reimbursement rates in a uniform manner across facilities. On average, reimbursement for administrative and general costs represents about 29 percent of a facility's reimbursement rate. However, depending on the facility, we found that this percentage was as low as 17 percent for one nursing facility and as high as 44 percent for another. Administrative and general costs are a more substantial factor in the overall reimbursement rate for nursing facilities at the higher end of this range. On average, reimbursement for direct nursing costs represents about 45 percent of a facility's total Medicaid reimbursement rate. However, depending on the facility, we found that this percentage ranged from a low

of 29 percent for one nursing facility to a high of 59 percent for another facility. The costs associated with staff who provide direct care to residents are a less substantial factor in the overall reimbursement rate for nursing facilities at the lower end of this range.

Although cost can provide a reasonable basis for reimbursement, the wide variations in Medicaid reimbursement rates we identified raise questions about the reasonableness and equitability of the rates across nursing facilities. In fact, cost-based systems are often seen as problematic because they tend to result in wide variations in reimbursement rates without any meaningful explanation for why costs differ across providers. For example, it is difficult to rationalize why the State should pay one nursing facility more than $100 more per patient day than another facility when both facilities are providing the same or a similar level of services to Medicaid residents. Proponents of cost-based systems argue that they translate into better quality of care for residents because those facilities that spend more on caring for residents (i.e., higher staffing levels) get reimbursed for the cost of providing this care. However, without specific measures demonstrating that higher expenditures equate to higher-quality care, cost-based systems can result in paying for inefficient provider practices that do not positively affect resident care. For example, we found that facilities with higher reimbursement rates did not necessarily receive fewer deficiencies than facilities with lower rates. We compared deficiencies cited on the most recent certification survey for the 10 facilities with the highest allowable costs and the 10 facilities with the lowest allowable costs in Fiscal Year 2006. The highest-cost facilities were cited 149 deficiencies, 9 of which (6 percent) were at a scope and severity level of "G" or higher. However, the lowest-cost facilities were cited 73 deficiencies, 3 of which (4 percent) were at a scope and severity level of "G" or higher.

There have been adjustments and modifications to Colorado's cost-based system for setting Medicaid rates for nursing facilities. The most recent major change was the addition of the case-mix adjustment in Fiscal Year 2001. As discussed earlier, the federal government no longer requires that reimbursement rates be reasonable and adequate to meet the *costs* that must be incurred by efficiently and economically operated facilities. The only requirement is that states must continue to ensure that Medicaid reimbursement rates for nursing homes are consistent with efficiency, economy, and quality-of-care standards. As we discuss in the following section, there are some alternatives to a cost-based reimbursement system that HCPF is considering. However, in the absence of pursuing these alternatives, the wide variations in nursing facility Medicaid reimbursement rates is an issue that HCPF needs to examine and address as it continues to administer the current cost-based system.

Senate Bill 06-131

During the 2006 Legislative Session the General Assembly passed, and the Governor signed, Senate Bill 06-131. This legislation directed HCPF, in conjunction with representatives of nursing facilities and advocacy organizations representing Medicaid residents, to conduct a feasibility study and report to the General Assembly by November 1, 2006, on recommendations for a new reimbursement methodology for nursing facilities participating in Medicaid. HCPF released a report prepared by this workgroup on November 1, 2006; however, the report concluded that more time was needed to complete the feasibility study. Currently the workgroup plans to continue meeting with the goal of making recommendations for action in the 2008 Legislative Session.

The feasibility study was to consider different reimbursement systems, including a reimbursement system based on a reasonable *price* to be paid by the State to meet the needs of nursing facility residents. Under price-based systems, nursing facilities are reimbursed based on a rate or price that is established for a particular type of facility or, more commonly, a particular category of patient. Price-based systems still rely on cost data because the rates have to be actuarially sound. However, price-based systems typically result in less variation in the range of reimbursement rates. Differences in reimbursement rates tend to be driven by more meaningful factors, such as differences in resident acuity (i.e., residents' clinical conditions and resource needs). Consequently, price-based systems are seen as more appealing because the government pays the same price for a similar type of facility or category of resident, regardless of the facility's actual cost to provide the service. Opponents of price-based systems argue that quality of care can suffer because facilities with high costs are potentially forced to cut staffing to bring their costs more in line with the price being paid for the service. Opponents also argue that there is no incentive for facilities with low costs to invest the entire reimbursement amount into resident care (i.e., reimbursement exceeding costs could be kept as profit). For this reason, states using price-based systems tend to establish minimum spending floors and other performance measures to ensure that quality of care is not negatively affected.

Although Senate Bill 06-131 allows HCPF to consider a variety of reimbursement systems, the legislation specified that if HCPF recommends a price-based reimbursement system, the system shall (1) take into account actual patient days as opposed to imputed patient days, (2) consider cost adjustments for resident acuity based on a facility's case-mix index, (3) consider adjustments to employee and other labor expenses based on the facility's geographic location, (4) include a quality allowance based on patient care outcomes using developed criteria, and (5) include an adjustment for a facility that has Medicaid recipients who have moderately severe to seriously impaired cognitive skills and who require behavioral management care and services. As we describe in the following sections, we found that HCPF needs

to address problems and issues in at least two of these areas as part of its feasibility study.

First, Senate Bill 06-131 requires that any recommendations for a price-based reimbursement system consider cost adjustments for acuity based upon a facility's case mix. Adjusting rates for case mix is generally thought to encourage homes to accept residents who require more expensive care, and it helps avoid penalizing homes that have higher costs due to a more costly mix of residents. As we discussed in detail in Chapter 2, Colorado's current reimbursement system includes adjustments for resident acuity that are based on resident assessment data from the Minimum Data Set (MDS) collected for all nursing home residents. Our audit work identified problems with the validity and reliability of the MDS data that are the basis for the case-mix adjustment. Invalid and inaccurate resident assessments compromise the State's ability to properly adjust reimbursement rates to account for the relative mix of resources required to care for Medicaid residents. We found that the State's oversight of the resident assessment process needs to be strengthened to provide assurance that assessment data submitted by nursing facilities are valid representations of residents' conditions. A reimbursement system that uses resident acuity when setting reimbursement rates will not yield valid results unless the problems we identified with the MDS assessments are addressed. Therefore, changes are needed regardless of whether the State continues the cost-based system or adopts a new price-based reimbursement system. HCPF also needs to include the results of our MDS review and the implementation of Recommendation No. 10 into its feasibility study of a price-based reimbursement system. This is especially important given that resident acuity tends to be a more central factor when setting rates under price-based reimbursement systems.

Second, Senate Bill 06-131 requires that any recommendations for a price-based reimbursement system include a quality allowance based upon an appropriate measurement of a facility's patient care outcomes. Implementing a quality allowance as part of Colorado's nursing home Medicaid reimbursement system presents a significant challenge for policy makers and administrators. As we discuss below, the General Assembly and HCPF have worked for a number of years and in various ways to include some type of quality incentive program for nursing facilities participating in Medicaid. However, the State does not have a history of successful implementation of quality incentive programs for nursing homes.

- **Quality of Care Incentive Payment (QCIP) Program.** Repealed in 2002, the QCIP Program was intended to provide financial incentives to encourage nursing facilities to improve resident quality of care. Incentive payments were in addition to the standard Medicaid reimbursement rate and were based on results from federal certification surveys and other criteria. Our September 2000 *Nursing Facility Quality of Care Performance Audit* included a review

of $4.4 million in expenditures under the then-authorized QCIP Program. We found that the incentive payments lacked a reasonable basis. For example, the quality-of-care measures used were based solely on certification survey results and did not include other measures, such as staff turnover, staff expertise, resident satisfaction, financial stability, or frequency of complaints to assess quality of care. We also found that the criteria for awarding QCIP funds were too lenient, resulting in facilities with serious deficiencies receiving quality-of-care incentive payments. We made a number of recommendations to ensure accountability for QCIP incentive payments. Subsequent to our 2000 performance audit, HCPF worked to revise the QCIP program and make needed improvements. However, due to the State's fiscal constraints at the time, the QCIP program was repealed before HCPF could complete its work. The issues raised in our prior audit will continue to be relevant when considering a quality allowance as part of any new reimbursement system.

- **Resident-Centered Quality Improvement Program (ResQUIP).** Although it originally existed as part of the QCIP Program, the General Assembly established ResQUIP in 2001 and reauthorized it in 2002 when QCIP was repealed. State statute [Section 25.5-6-204(2)(d), C.R.S.] authorizes HCPF to issue incentive grants to nursing facilities for the purpose of encouraging improvement in the quality of life in nursing facilities through resident participation in activities promoting enhanced communication, better understanding of resident needs and self-determination, and building positive relationships and a sense of community. The General Assembly has made no appropriations for the purpose of issuing ResQUIP incentive grants since the program's reauthorization.

- **Customer Satisfaction Survey.** In 2001 the General Assembly directed the Department of Public Health and Environment (CDPHE) to develop and implement a nursing facility customer satisfaction survey to determine the level of satisfaction among residents and residents' families regarding the quality of care and quality of life in nursing facilities. The results from the customer satisfaction survey were originally intended to provide information to public consumers and to be used in determining incentive payments under QCIP. In 2002 full implementation of the customer satisfaction survey was postponed pending results of a pilot survey. Although funding to conduct the pilot survey was cut, CDPHE continued to assess the feasibility of implementing a customer satisfaction survey in Colorado nursing homes. In April 2003 CDPHE released a report and plan for full implementation of such a survey, including proposed processes and procedures for ensuring reliable and valid responses. This included receiving permission from the state of Ohio to use its survey instrument, which had already been validated. As mentioned earlier, full implementation of the customer satisfaction survey was

contingent upon completion of a pilot study that never took place due to a lack of funding.

- **Nursing Facility Patient Program Improvement Fund.** State statute [Section 25.5-6-204(2)(e), C.R.S.] establishes a nursing facility patient program improvement fund. Subject to appropriations by the General Assembly, HCPF is authorized to make payments from this fund to any qualified nursing facility submitting a proposal that would provide Medicaid services to a more difficult patient case mix or that would improve quality of care and quality of life within the facility. The General Assembly has made no appropriations to this fund, and HCPF has not adopted rules or regulations specifying the program requirements.

- **Non-Monetary Incentive Programs.** HCPF is authorized under state statute [Section 25.5-6-204(2)(c), C.R.S.] to research and develop a non-monetary incentive program for nursing facility providers. This program is intended to recognize those nursing facility providers who achieve the highest quality-of-care standards within their facilities. HCPF has not taken any steps to pursue non-monetary incentive programs.

Struggles with designing and implementing quality incentive programs for nursing homes do not appear to be unique to Colorado. For example, Illinois had a quality improvement program that awarded nursing homes additional reimbursement for demonstrating achievement of certain quality-related measures. However, a study of Illinois' program found that although more facilities qualified to receive bonus payments over time, the relationship between the quality measures and resident care had not been firmly established. Similar to the QCIP Program in Colorado, Illinois' quality incentive program no longer exists. In 2004 an advisory group to the Kansas Department on Aging recommended replacing that state's incentive factor in Medicaid nursing facility reimbursement. Iowa and Minnesota have worked since 2002 to design and implement new payment systems for nursing homes participating in Medicaid that incorporate a quality incentive component.

There are several academic studies which have identified key factors and issues that are important for successfully implementing quality incentive payments to nursing homes. With respect to developing a quality allowance as part of a price-based reimbursement system for nursing homes participating in Medicaid, HCPF needs to examine and address these factors and issues in its feasibility study. First, HCPF needs to define and use measures of quality that are valid, appropriate, provide a reasonable basis for Medicaid payments, and ensure accountability for taxpayer dollars. This is complicated by the fact that there is no general consensus on the definition of quality of care in nursing homes. Some aspects of nursing home care (e.g., physical environment, social opportunities, resident-staff interactions) have

implications for quality but can be difficult to measure and quantify. Factors such as staffing ratios, staff qualifications, and turnover rates may be easier to measure and the data may be more readily available. However, none of these factors is a direct measure of resident *outcomes*. Senate Bill 06-131 specifically lists resident outcomes as the basis for the quality allowance under a proposed price-based system. At the same time, focusing only on resident outcomes (e.g., results from resident satisfaction surveys or data from resident assessments) may not reveal those processes or factors contributing to the desired outcome. This makes it difficult when trying to apply best practice techniques across nursing facilities in hopes of achieving similar resident outcomes elsewhere.

In addition to measurement, a second challenge is how to price quality. HCPF needs to determine how much of a monetary incentive is sufficient to persuade nursing facilities to make improvements. Moreover, caution should be taken when constructing the incentive system, since linking payments to resident outcomes could potentially lead to undesired results. For example, the State should avoid linking payment only to one measure of quality. Since quality of care is multidimensional, facilities that score well on one indicator may do poorly on another. Additionally, when payment is only tied to one measure of quality and not to others, nursing facilities may have an incentive to divert resources toward that single dimension, and quality in other areas not linked to the payment could decline. Monetary incentives based on resident outcomes could also result in nursing facilities focusing their care efforts on residents with the greatest potential for positive outcomes, thereby disregarding residents with poor outcome potential. This is problematic, since the tendency for many nursing home residents is toward a decline in functioning and condition or, at a minimum, no improvement in functioning or condition. A final challenge to implementing a quality incentive allowance is addressing the perspective that when a nursing facility receives payment through Medicaid, the taxpayers are already paying for and expecting quality care.

Senate Bill 06-131 provides the State with an opportunity to consider options for a new way of reimbursing nursing facilities participating in Medicaid. However, to arrive at viable recommendations to the General Assembly, and in order for the State to move forward in its consideration of a price-based or other reimbursement system, HCPF needs to address the problems and issues discussed above as part of its feasibility study.

Recommendation No. 16:

The Department of Health Care Policy and Financing should address problems related to nursing facility resident assessments and the implementation of a quality allowance as part of the feasibility study required by Senate Bill 06-131. At a minimum, the Department should:

a. Incorporate the intent and provisions of Recommendation No. 10 into any recommendations for a new reimbursement system where resident acuity is used as a factor in establishing nursing facility Medicaid reimbursement rates.

b. Review academic literature, other states' practices, and past experiences in Colorado to develop a methodology that addresses those factors critical to the successful implementation of a quality allowance when reimbursing nursing facilities under Medicaid. This should include developing measures of resident outcomes that are valid, reasonable, quantifiable, and auditable.

Department of Health Care Policy and Financing Response:

Agree. Implementation date: July 1, 2008.

The Department will incorporate the recommendations in Recommendation No. 10 as part of the feasibility study.

As part of its ongoing commitment to develop a price-based reimbursement methodology, a workgroup consisting of nursing facility representatives, advocacy organizations, and the Department continues to contend with quality incentives. The quality indicators must be objective, measurable and under a provider's control. The workgroup is reviewing other states' practices and available literature to find a methodology that will work well for Colorado. While a national database on which to base the design and evaluation of quality incentives is steadily growing, the database remains incomplete and without substantial validation.

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Appendix

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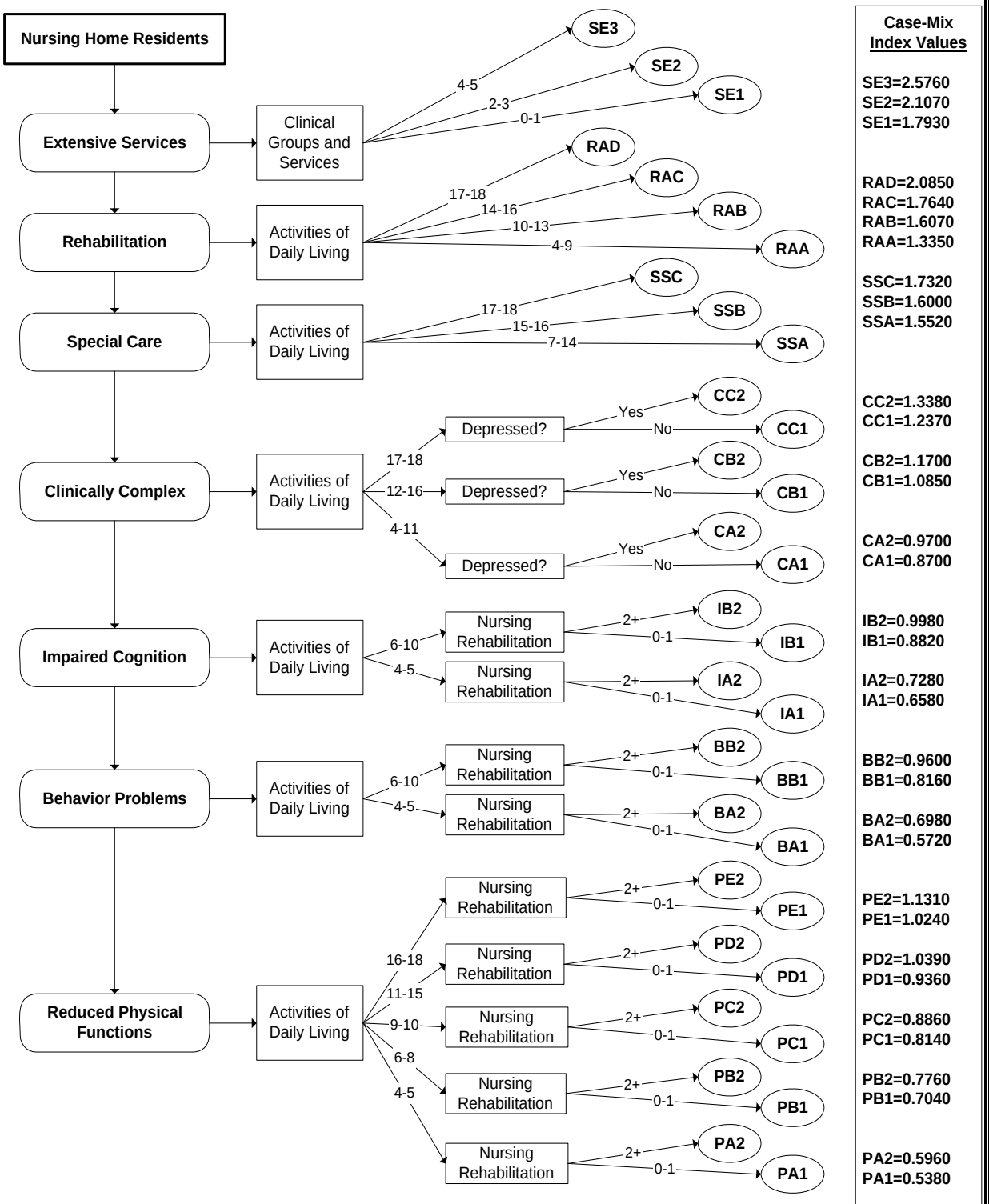
Appendix A.
Colorado Medicaid 34-Group RUG Classification System and Associated Case-Mix Index Values



Source: Department of Health Care Policy and Financing.

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