STATE OF OHIO
OFFICE OF THE AUDITOR

JIM PETRO, AUDITOR OF STATE

Ohio Nursing Homes

Policy and Procedural Changes Can Reduce Costs and Increase Provider Accountability

An Operational Review by the:

Fraud, Waste, and Abuse Prevention Division

December 1997

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STATE OF OHIO
OFFICE OF THE AUDITOR

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Annually, the National State Auditors Association (NSAA) conducts a joint audit dealing with a systemic issue affecting different states. This year's audit focused on long-term care facilities. The principal objectives included determining whether and how the applicable state agencies (1) ensured long-term care providers continued to meet state licensing requirements and complied with applicable rules and regulations, (2) ensured the adequacy of processes and procedures for receiving and processing complaints, (3) imposed sanctions where a provider noncompliance was found, and (4) ensured services billed were actually provided. This report summarizes the results of work performed relating to operations in the State of Ohio.

Copies of this report are being sent to Ohio's President of the Senate, the Speaker of the House, the Senate Minority Leader, the House Minority Leader, members of the Senate Committee on Human Services and Aging, members of the House Subcommittee on Human Services, and other interested parties. In addition, a copy will be sent for inclusion in the NSAA joint audit report. Any questions concerning the content of the report should be directed to me at (614) 466-4483 or Richard Sheridan, Chief of our Fraud, Waste, and Abuse Prevention Division at (614) 728-7125.

JIM PETRO
Auditor of State

EXECUTIVE SUMMARY

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

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

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

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

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

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

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

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ABBREVIATIONS

CFR	Code of Federal Regulation
FY	Fiscal Year
ICFs-MR	Intermediate Care Facilities for the Mentally Retarded
ODH	Ohio Department of Health
ODHS	Ohio Department of Human Services
OAC	Ohio Administrative Codes
ORC	Ohio Revised Code

BACKGROUND

Long-term care services account for approximately one-third of Ohio's total Medicaid expenditures but represent only about five percent of the Medicaid recipients. During State Fiscal Year (FY) 1996[1], the Ohio Department of Human Services (ODHS) made Medicaid payments totaling $2.2 billion to its 1,098 nursing homes and 437 intermediate care facilities for the mentally retarded (ICFs-MR)[2]. These payments were made on behalf of approximately 120,000 Medicaid recipients.

The delivery of quality long-term care service in the State of Ohio is the principal responsibility of two key agencies--the Ohio Department of Health (ODH) and ODHS. The specific duties, responsibilities, and coordination efforts of both are documented in an interagency agreement updated July 1997.

OHIO DEPARTMENT OF HEALTH

The ODH has responsibility for monitoring the quality of health care in long term care facilities. This agency licenses all applicable nursing facilities, inspects them to ensure compliance with state and federal health care requirements, investigates complaints, and imposes monetary fines and/or sanctions when a noncompliance is found. These functions are primarily carried out by ODH's Division of Quality Assurance which has 160 surveyors responsible for inspecting nursing facilities.

ODH conducted 145 initial licensing inspections and 4,056 recertifications between FYs 1993 and 1996. Initially, licenses were granted to those facilities that generally complied with the following conditions:

- The applicant had not been convicted of a felony or crime involving "moral turpitude."
- The applicant was not violating any of the rules made by the public health council or any order issued by the Director of Health.
- The buildings in which the home was housed had been approved by the State Fire Marshal or other legally constituted fire department approved by the Marshal.
- The applicant was suitable financially and morally (individual applicants and principal participants if a corporation or an association) to operate a home.

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[1]Ohio's FY 1996 included the period July 1995 through June 1996.

[2]We generally refer to nursing homes and ICFs-MR as nursing facilities or providers in this report.

- The applicant was equipped to furnish humane, kind, and adequate treatment and care.

- The home did not maintain (1) a facility for performance of major surgical procedures or for providing therapeutic radiation; (2) an emergency ward; (3) a clinical laboratory unless under the supervision of a licensed physician in the state; or, (4) a facility for radiological exams unless performed by a person licensed to practice medicine, surgery, or dentistry in the state.

- The home generally did not accept or treat outpatients; home maternity cases; boarding children; and transient guests (other than participants in an adult day care program for 24 hours or less).

- The home complied with Sections 3721.28 and 3721.29 of the Ohio Revised Code (ORC) pertaining to training and proficiency of nursing aide staff.

In addition to conducting initial licensing and recertification surveys, ODH investigates complaints filed against nursing facilities. If an allegation involves an immediate or serious threat to the residents' health and safety, it must be investigated within two working days. Other less threatening complaints are investigated either within 30 days of receipt or during the next recertification survey which is currently required to be done within 15 months of the previous recertification.[3]

OHIO DEPARTMENT OF HUMAN SERVICES

With respect to nursing facility payments, ODHS

- Issues provider agreements specifying conditions for receiving Medicaid reimbursements;
- Establishes reimbursement rates;
- Pays provider claims;
- Collects fines and monetary sanctions;
- Resolves complaints about Medicaid eligibility; and
- Audits provider cost reports.

Major ODHS organizations involved in nursing home reimbursements include its Long-Term Care Administration--within the Office of Medicaid--which monitors provider ownership and other changes, sets the reimbursement rates, and audits provider cost reports; and, its Medical

[3]ODH recertifications are currently conducted approximately every nine months.

Systems Administration Bureau (within the Office of Management Information Services) which pays provider claims and makes claim adjustments.

On July 1, 1993, ODHS adopted its present nursing facility reimbursement system (applicable to FY 1995 and forward). Under this system, each nursing facility is required to file an annual cost report within 90 days after the end of the calendar year. Ohio Administrative Code (OAC) Section 5101:3-3-20 (G) requires ODHS to conduct a desk review of each cost report to
(1) ensure mathematical correctness of data furnished, (2) ensure consistency of rate setting calculations and formulas, and (3) identify any reported costs which materially exceed peer group averages or the provider's historical costs for further verification. If a provider disagrees with the results of the desk review, the provider may request a rate reconsideration in accordance with OAC Section 5101:3-3-24:

- if the provider believes there is a calculation error;
- the provider's allowable costs, because of extreme circumstances, exceed its prospective rate;
- an exception review of resident assessment information (case-mix data) shows a higher rate is warranted; or,
- the applicable rate will place the provider in an extreme hardship condition.

Following the desk review, ODHS uses the accepted costs and reported inpatient days[4] to compute the aggregate daily per diem rate. This rate consists of four cost center components which are computed as described below.

- Direct Care - preceding year's allowed direct care costs adjusted for inflation and divided quarterly by the lower of the facilities' average case-mix score[5] or the maximum case mix score determined for each facility's peer group (OAC Section 5101:3-3-44).

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[4]OAC inpatient days mean all days during which a resident, regardless of payment source, occupy a certified Medicaid bed.

[5]According to OAC Section 5101-3-3-01, a case mix score is a measure of the relative direct care resources needed to provide care and rehabilitation to a resident of a nursing facility or ICF-MR. Under a case mix system, facilities caring for recipients with heavier care needs generally receive higher reimbursement rates.

- Indirect Care - previous year's allowed indirect care costs adjusted for inflation divided by the greater of the facility's inpatient days for the period or the number of inpatient days the facility would have had if its occupancy rate had been eighty-five percent. This rate is then adjusted by an efficiency factor computed as the difference between the maximum rate authorized for each facility's applicable peer group and that peer group's average indirect care cost rate (OAC Sections 5101:3-3-01 and 5101:3-3-50).

- Other Protected Costs[6] - other protected cost per diem rate for the previous calendar year adjusted for inflation except for "franchise permit fees" (ORC Section 5111.235).

- Capital Costs - a proration of each facility's prior year per diem for cost of ownership and non extensive renovation elements adjusted for inflation plus an efficiency incentive and any amount for return on equity (OAC 5111.25).

After determining the applicable costs for each component, ODHS divides the total resulting costs by the applicable Medicaid days to determine the facilities' daily per diem rate. The number of Medicaid days used is the number reported by the facilities on their respective cost reports.

ODHS establishes new rates effective the beginning of each new fiscal year (July 1) for each long-term care facility. To the extent that the facilities' quarterly case mix scores result in a revision to the direct care component of the per diem rate, the revised rates become effective on the first day of each quarter.

ORC Section 5111.22 requires nursing facility payments to be made by the 15th of the month following the period of service. According to ODHS personnel, each nursing facility provider is automatically paid the daily authorized per diem rate for each recipient occupying a certified Medicaid bed unless the provider notifies ODHS of changes that affect the per diem entitlement such as the death of a recipient or days when a recipient is on leave from the facility.

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[6]Other protected costs are those which are closely related to direct care such as medical supplies, utilities, and property taxes, but which do not necessarily vary with case-mix or they are difficult to effectively control.

PURPOSE, SCOPE, AND METHODOLOGY

Ohio was one of 10 states that participated in this audit sponsored by the National State Auditors Association. The other states included the lead State of Louisiana and the States of Connecticut, Kentucky, New York, North Carolina, Oregon, Pennsylvania, Tennessee, and Texas. Our principal purpose was to identify any systemic weaknesses, inefficiencies or abuses in the delivery of long-term care services. This is important to Ohio since long-term care services account for approximately one-third of its Medicaid expenditures. Participation in this effort will also allow Ohio to contrast its long-term care operations to those of the other states included in this national effort.

Ohio's work was performed at two principal state agencies--Ohio Department of Health and the Ohio Department of Human Services. It generally focused on FYs 1994 through 1996 operations and included five of the six national objectives[7]. This work was conducted between April and November 1997 in accordance with Generally Accepted Governmental Auditing Standards.

To ensure that the long-term care providers met state licensing requirements, the Ohio Revised and the Ohio Administrative Codes were reviewed first to determine applicable criteria. Subsequently, ODH personnel were interviewed to clarify information on the licensing processes. ODH procedures for ensuring compliance with applicable licensing criteria were then compared by participating with ODH inspectors on two licensing surveys and by analyzing file documentation on 13 randomly selected facilities. The same general procedures were followed for the complaint investigations and sanction work. In addition, however, information was also gathered on specific complaints filed against 60 randomly selected facilities and discussions with ODH, ODHS, and Ohio Department of Aging personnel were held to obtain information on intended and actual uses of the Resident Protection Fund.

The work at ODHS was limited primarily to assessing how the agency ensured proper services were provided for which providers were reimbursed. This initially involved (1) a review of applicable state and federal regulations governing nursing facility reimbursements; (2) interviews with Bureau of Long Term Care and Medical System Administration personnel to obtain and/or clarify policy, procedures and operating issues relating to reimbursements; and (3) high level analyses of ODHS' Medicaid paid claims history files to identify trends, anomalies, and possible vulnerable areas requiring further review. The file analyses focused initially on the categories of services provided, types of claims filed, availability of Medicare coverage, and error codes generated as a result of the specific payments made. Subsequently, ODHS' Medicaid paid claims history files were matched with death files maintained by the Department of Health's Vital Statistics Unit to determine whether providers received payment for recipients that died during 1994, 1995 and 1996.

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[7]No work was done relating to patient assessments and care plans due to staffing limitations.

RESULTS

As a whole, ODH performed the required work to ensure long-term care facilities were properly licensed. Periodic inspections were also conducted to test provider compliance with applicable rules and regulations and to investigate various complaints filed. These inspections were generally adequate to detect the existence of conditions that jeopardized health and safety of residents. However, not all complaints were investigated in a timely manner. Thus, a backlog of unprocessed complaints exists at ODH. Further, although ODH and the U.S. Health Care Financing Administration imposed monetary sanctions where deficiencies were not corrected within the time specified by the facilities' approved corrective action plans, not all fines were collected. At ODHS, major control weaknesses were noted that involved reimbursing providers for deceased recipients and paying for services that should have been paid by others or not at all. These findings are discussed in detail in the sections that follow.

LICENSING AND INSPECTIONS

ODH uses a three-person inspection team to carry out the recertification surveys. Each team consists of a registered nurse and two other inspectors licensed by the state in a health care profession such as a dietitian, social worker, pharmacist, hospital administrator, sanitarian, and so forth. These inspectors (usually referred to as surveyors) must also meet federal minimum standards established for long-term care surveyors and successfully complete a training and testing program in survey and certification techniques.

The inspectors determine compliance with state and federal requirements usually through on-site inspections which focus on such factors as:

- the cleanliness and safety of the facility environment,
- the existence of actual or potential hazards,
- bed counts to ensure that the number in the facility does not exceed the maximum licensed capacity,
- infection control practices,
- grooming and personal care status of residents,
- adequacy of supplies and equipments, and,
- observation of residents' rights such as whether the residents are treated with courtesy and whether call lights are promptly answered.

The inspectors also (1) review a sample of employee records to verify professional licenses, (2) review pharmacy policies and procedures and, (3) observe the sanitation and adequacy of the kitchen for preparation of foods.

Ohio nursing facilities must be inspected at least once every 15 months after receipt of their initial license. ODH conducted 1,340 recertification surveys during FYs 1994 followed by 1,303 in 1995 and 1,413 during FY 1996. Only two nursing facilities had their licenses revoked during this period.

COMPLAINTS, INVESTIGATIONS AND VIOLATIONS

ODH's Division of Quality Assurance has responsibility for processing complaints filed against Ohio nursing facilities. This Division's Bureau of Provider and Consumer Services receives and initially prioritizes complaints and in turn forwards them to one of five district offices [8] under the Division's Bureau of Healthcare Standards and Quality for investigation.

Upon receipt of complaints, intake personnel screen them to assess their level of severity. For those complaints that potentially pose an immediate or serious threat to the health or safety of recipients--such as those involving (1) the use of physical or chemical restraints to discipline residents; (2) verbal, sexual, physical, and mental abuse; and (3) the mistreatment and neglect of residents--intake personnel notify the appropriate supervisor immediately via telephone so the complaints can be investigated within two working days. According to ODH personnel, these complaints are given priority and may even result in the deferral of other survey activities, the assignment of additional staff, or authorization of overtime to ensure the investigations are completed within the two-day time frame. Other complaints, such as those that could cause minimal harm to the recipients and those that could cause more than minimal harm but not immediate jeopardy to the health or safety of the recipients--are mailed to the applicable district office to be scheduled for investigation later.

At the district offices, the less serious complaints--that is, those where the perceived condition will not immediately result in severe injury, disability, or death if not corrected--are further evaluated by a survey supervisor to determine whether they can be resolved without conducting an on-site investigation[9]. Such would be the case if complaints could be resolved by inquiries to nursing facilities or appropriate policy agency personnel, or by the nursing facility submitting appropriate documentation to clarify a perceived deficiency. If this is not the case, an investigation is scheduled to take place within the next 30 days or deferred until the next recertification. Under Ohio law, recertifications must be conducted at least every 15 months after the initial license. ODH is currently conducting these surveys approximately every 9 months.

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[8]These offices are located in the Cities of Akron, Cambridge, Columbus, Dayton, and Toledo.

[9]The survey supervisors have various state, federal, and ODH criteria available to them, such as the Health Care Financing Administration's "Complaint Investigation Guidelines and Investigative Protocols" and Sections 3280 through 3298 of ODH's State Operations Manual, to guide them in screening and investigating complaints.

Prior to 1994, ODH investigated complaints as they were received regardless of severity level. In an effort to maximize resources, however, ODH discontinued this practice and now generally investigates the complaints that do not potentially pose an immediate or serious threat to the health or safety of recipients within the 30-day time frame or during the next recertification as mentioned above. ODH believes that the delayed investigation of complaints (referred to as batching) is authorized since the Health Care Financing Administration's annual Medicare budget preparation instructions state that in many cases, it will be "appropriate for the complaint to be investigated during the next scheduled visit to the facility." Furthermore, ODH officials stated that in practice, they do not allow more than four or five complaints to accumulate against a facility before conducting an on-site investigation. They also said that complaints may be investigated more frequently based on their specialized knowledge of the facilities such as prior deficiencies noted and their compliance history. Regardless, more than a quarter of the complaints filed are now batched instead of being investigated in a more timely manner. Table 1:1 shows the volume of unprocessed complaints on hand at the end of 1994-1996.

Table 1:1 Backlog of Unprocessed Complaints

Calendar Year	Number of Complaints Filed	Number of Complaints Not Investigated	Percentage of Complaints Not Investigated
1994	3,149	810	26
1995	2,561	746	29
1996	2,626	712	27
Total	**8,336**	**2,268**	**27**

Although only the less serious complaints are theoretically batched, there is still a risk that complaints may be inappropriately placed in lower risk categories. This could in turn result in a complaint being filed pursuant to ORC Section 3721.17 which requires ODH to investigate within 30 days or to refer the complaint to the Attorney General within 7 days those complaints submitted either by a facility grievance committee or by any other source alleging substantially less than adequate care or treatment or the existence of substantially unsafe conditions. The delay could also result in the loss of the audit trail necessary to confirm the severity level of the complaints and the delayed implementation of corrective action that may be needed. Further, providers are aware of ODH's batching practice and consequently, the element of surprise surrounding investigations has been lost.

During this audit, we randomly selected 60 facilities to identify the type of complaints filed. Of the 60, 51 (85 percent) received 464 complaints between July 1993 and June 1995. The complaints originated from a number of sources including Medicaid recipients and their families, current or former facility employees, the Department of Aging's Ombudsman,[10] and other governmental agencies such as ODHS, the Department of Mental Retardation and Developmental Disabilities, and the Board of Nursing. Table 1:2 documents the categorization of complaints found.

Table 1:2 Type of Complaints Filed on 60 Randomly Selected Nursing Facilities

Categories of Complaint	Complaints Filed	Percentage	Facilities With Complaints	Percentage of Total Facilities
Care or service	156	34	46	76.6
Resident rights	71	15	37	61.6
Other	68	15	34	56.6
Resident neglect	57	12	34	56.6
Environment related	55	12	27	45.0
Resident abuse	27	6	18	30.0
Dietary	23	5	13	21.6
Misuse of funds/property	5	1	4	6.6
Unqualified personnel	2	--	2	3.3
Total	464	100		

Of the 464 complaints filed, 81 (17 percent) were substantiated, meaning (1) one or more of the allegations were verified or federal deficiencies or state licensor violations were cited; or, (2) one or more of the allegations occurred but the facility identified the problem and took appropriate action to correct the deficiency prior to the ODH inspection.

PROVIDER SANCTIONS

According to ORC Section 5111.42, ODH is required to submit a detailed statement of deficiencies to facilities not later than ten days after completion of the licensing or recertification exit interview.

[10]The Ombudsman serves as a liaison between long-term care providers and consumers. In this regard, it addresses concern about the quality of services in these facilities.

At the same time, ODH is required to submit a separate written notice to the facilities advising them, among other things, that if the cited deficiencies are not substantially corrected within 90 days, payment for subsequently admitted recipients will be denied. ORC Section 5111.43 then requires the facilities to submit a plan to ODH for each finding cited identifying the corrective action to be taken. If the deficiencies are not corrected in accordance with these approved plans, ODH or the U.S. Health Care Financing Agency (if the facility has designated Medicare or Medicaid/Medicaid beds) will impose sanctions ranging from monetary fines to termination of the provider agreements that allow Medicaid payments.

Where monetary fines are assessed on facilities having certified Medicare or Medicaid/Medicare beds, the U.S. Health Care Financing Administration is the designated collection agency. This organization in turn will forward any applicable fines to ODHS for the pro-rata share involving Medicaid beds. Where the monetary fines are assessed against facilities having only certified Medicaid beds, ODHS is the collection agency. Regardless of which agency collects the funds, OAC Section 5101:3-3-63 requires Medicaid fines to be deposited into the Resident Protection Fund. This fund was established December 13, 1990 (1) to cover the cost of relocating residents to other facilities; (2) for maintenance of operation of a facility pending correction of deficiencies or closure; or (3) reimbursement to residents for the loss of monies managed by the facility under ORC Section 3721.15 and OAC Section 5101:3-3-60. The ODHS Facility Contracting Section is the designated coordinator of this fund and is responsible for the administration and collection of the assessed fines. This organization is also required to provide an annual report to the directors of ODHS, ODH, and the Ohio Department of Aging containing the following information:

- a listing of all fines deposited in the fund and the names and addresses of the nursing facilities that paid the fines, and

- a listing of all expenditures of the fund by type of expenditure.

For FYs 1994 through 1996, ODH and the U.S. Health Care Financing Agency imposed monetary sanctions totaling $464,850 ($90,623; $95,712; and $278,515, respectively) against Ohio nursing facilities for failing to correct cited deficiencies in accordance with their approved corrective action plans. The significant increase in 1996 resulted from imposing revised penalty thresholds under 42 CFR Section 488.408 which increased penalties up to $10,000 a day for noncompliance with federal provisions.

Although $464,850 in fines were assessed for FYs 1994 through 1996, collections for this period amounted to $239,813--51 percent of the amount assessed. However, ODHS did not prepare the required annual reports and supporting records were not in enough detail to explain the rationale for the differences in fines assessed and collected. Consequently, it could not be determined whether all facilities on whom fines were levied were collected and whether the amounts collected were in the correct amounts.

The Resident Protection Fund contained $527,680 as of late October 1997, according to the Ohio Department of Administrative Services' Central Accounting System. This money, according to ODHS personnel, may never be needed for the purpose for which it was initially established. First, only two nursing facilities have been terminated from the Medicaid program since creation of the Fund. In both instances, the facilities had alternative funding available to relocate the residents. Second, the officials said there is no need to use this money to reimburse residents for any personal allowance funds lost since reimbursement for this type of loss is covered by surety bonds.

A committee--consisting of representatives from ODH, ODHS, Department of Aging, and the Ohio Health Care Association--has submitted a draft proposal to the U.S. Health Care Financing Administration recommending that the money be used in several ways such as to:

- help defray increased costs associated with more frequent monitoring of poor performing nursing facilities;
- help defray the cost of complaint monitoring units;
- fund printing costs for literature outlining patient rights; and
- fund future relocation activity.

GENEROUS REIMBURSEMENT SYSTEM

A January 30, 1996-report[11] by a contractor, Lewin-VHI, Inc., reached several broad conclusions about ODHS' prospective reimbursement system. Overall, the report concluded that the system appeared to be working well in that

- the case mix system seemed to be improving the health care access of heavy care patients; and,
- a high percentage of facilities received rates that covered most or all of their cost.

However, the report also concluded that the new reimbursement system was generous. In this regard, it stated that for capital costs, the system reimbursed facilities in rates that far exceeded their capital costs and that as a whole, nursing homes were reimbursed an average of 98.9 percent of their

[11]This report was entitled "An Analysis of the Ohio Department of Human Services (ODHS) Medicaid Reimbursement System for Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)".

facility costs before disallowance and other adjustments compared to 100.6 percent for ICFs-MR. After adjustments, these percentages increased to a weighted average of 99.8 percent for nursing homes and 101.3 percent for ICFs-MR.

The generosity of the long-term care reimbursement system was not independently assessed as part of this audit. That was not one of the audit objectives. Nevertheless, the contractor's findings raise serious concerns about whether the State of Ohio's Medicaid reimbursement system is operating efficiently and economically especially when coupled with two systemic issues identified during this review--failure by ODHS to discontinue payments after recipients' deaths in a timely manner and the routine payment of Medicare related payments without verifying their propriety.

PAYMENT FOR SERVICES NOT PROVIDED

This audit identified overpayments totaling $54.5 million between January 1994 and June 1996 based on a match of ODHS' Medicaid claims payment records with death records maintained by the Department of Health's Vital Statistics Unit[12]. These overpayments involved 600 nursing facilities. Table 1:3 below identifies time frames for which the payments were made after the recipients died.

[12] ODH's Vital Statistics Unit is the centralized unit responsible for maintaining the official death records for the State of Ohio.

Table 1:3 Payments on Behalf of Deceased Recipients During Calendar Years 1994, 1995, and 1996 (Through June)				
Months After Death	1994	1995	1996 [13]	Cumulative Total
1 or less	$ 9,938,139	$ 11,412,761	$4,003,692	$25,354,592
2	4,525,756	5,105,104	1,681,648	11,312,508
3	2,516,844	2,966,926	687,247	6,171,017
4	1,503,536	1,829,069	290,321	3,622,926
5	1,195,689	1,185,720	105,016	2,486,425
6	834,799	835,213		1,670,012
7	686,999	434,919		1,121,918
8	560,544	232,437		792,981
9	324,451	161,095		485,546
10 or more	1,153,187	382,335		1,535,522
Total	$23,239,944	$24,545,579	$6,767,924	$54,553,447

Of the $54.5 million, 46 percent ($25.4 million) occurred one month or less after the recipients died and $42.8 million (78 percent) occurred within the first 3 months of death. Thus, a large percentage of providers notified ODHS of the recipients' deaths in a timely manner. However, $5.6 million in overpayments, 10 percent, occurred 6 months or more after the recipients died. Consequently, many providers either did not notify the County Departments of Human Services or ODHS of the recipients' death in a timely manner; or, the changes were not updated in ODHS' claims payment system in a timely manner. Regardless, ODHS' controls were not adequate to prevent payment on behalf of deceased Medicaid recipients. In addition, ODHS did not collect the overpayments in a timely manner. Of the $54.5 million made on behalf of deceased Medicaid recipients, $12.4 million (23 percent) had not been recouped as of June 30, 1996 (see Table 1:4) including 11 percent that had been outstanding since 1994. This means that providers--including 11 that had overpayments ranging from several thousand to more than a million for recipients that died in 1994--had interest free-use of funds for extended periods of time.

[13]The 1996 death file used represented an interim file as ODH, as of October 1997, had not finalized the compilation of Ohioans that died during 1996.

Table 1:4 Analysis of Overpayments Outstanding As of 6/30/96 For Deceased Recipients by Year of Payment				
Year of Overpayment	Total Payment	Overpayment Recovered	Overpayment Outstanding	Percentage Outstanding
1994	$23,239,944	$20,733,545	$ 2,506,399	11
1995	24,545,579	19,459,601	5,085,978	21
1996	6,767,924	1,908,387	4,859,537	72
Total	$54,553,447	$42,101,533	$12,451,914	23

Failure to recover overpayments in a timely manner relating to deceased Medicaid recipients is not only inappropriate but also expensive given the potential earnings on these funds or other projects that could have been funded. Table 1:5 shows the potential earnings lost assuming the overpayment was invested from January 1 of each applicable year until June 30, 1996 at a 6 and 10 percent rate of return on the $12.4 million outstanding since 1994.

Table 1:5 Estimated Lost Opportunity Cost Resulting From Overpayments Resulting From Deceased Recipients			
Year of Overpayment	Overpayment Outstanding 6/30/96	Earnings Potentially Lost at 6 Percent	Earnings Potentially Lost at 10 Percent
1994	$2,506,399	$ 404,533	$ 708,548
1995	5,085,979	477,720	819,414
1996	4,859,536	147,621	248,095
Total	$12,451,914	$1,029,874	$1,776,057

In addition to routinely overpaying nursing facility providers on behalf of deceased Medicaid recipients, ODHS also had more than $50 million in payments outstanding as of June 30, 1996 that were identified by its claim payment system as a possible duplication of, or a conflict with, other claim types. Subsequent analysis of these payments, which were made between January 1994 and June 1996, showed that most of the charges were identified in the system as Medicare inpatient or outpatient charges. Yet, ODHS paid them without first confirming that the payment was proper. This may have been done to comply with ORC Section 5111.22 which requires nursing facility payments to be made by the 15th of the month following the period of service. However, since most facilities receive their per diem payments by the 15th of the month and these payments are to

reimburse the facilities for care and services provided to nursing facility recipients, there may be no need to pay any other claims to nursing facilities by that same time frame.

ODHS' nursing facility reimbursement processes and practices allow many opportunities for waste and abuse even without any deliberate action by providers. First, although ODHS performs desk audits of provider cost reports and may conduct more in-depth field audits where its audit selection criteria indicate significant risk factors,[14] the agency does not periodically verify the existence of the recipients for which providers seek per diem payment nor does it verify the number of days for which providers are entitled to receive reimbursement for these recipients. Yet, the per diem rates are determined by dividing the applicable operating costs by the number of Medicaid days, thus, days have a major impact on nursing facility reimbursed costs.

Second, ODHS automatically pays providers the authorized per diem rate for each recipient of record occupying certified Medicaid beds unless the providers report changes such as new admissions, transfers, and deaths. However, although ODHS requires providers to notify it of recipient changes, it neither imposes a time frame by which providers must notify it of such changes nor does it have a mechanism for assessing providers' performance in this area. As a result, ODHS cannot ensure that overpayments are promptly identified nor can it penalize providers for not reporting these overpayments.

In addition, ODHS' practice of paying claims identified by its payment system as potentially erroneous results in avoidable overpayments. This, in turn, results in the expenditure of a large amount of resources to correct the errors created. ODHS has a staff of 10 dedicated to making payment related adjustments based on changes identified by nursing facility providers. ODHS also works with a contractor to identify and recover overpayments from third-party insurers including Medicare. The latest contract covers FYs 1998 and 1999 and provides for an 8.75 percent fee of all Medicaid funds recovered. Thus, for every million dollars recovered, the contractor will receive a payment of $87,500.

However, collectibility of many overpayments is jeopardized. First, collectibility may not occur at all if the providers do not voluntarily notify ODHS of the existence of overpayments. With the exception of system edits which may or may not be analyzed in a timely manner, ODHS does not use other tools or techniques to help identify overpayments and abnormal activity relating to claims filed. Second, collection of overpayments may be hampered by the untimely notification by providers (such as those involving deceased Medicaid recipients) and/or ODHS' untimely processing of related adjustments. As a result, some overpayments may not be recovered prior to final rate setting exercises. In addition, at least one Ohio nursing home association has challenged

[14]Examples of these risk factors include significant provider cost increases between years or instances where provider costs significantly exceeded peer group averages. These indicators would generally suggest that an on-site field audit is required.

ODHS' right to recover $29.2 million in overpayments relating to claims with overlapping service dates[15] identified during an August 1996 report by the U.S. Health and Human Services' Inspector General. According to ODHS officials, the Association is alleging that repayment of these charges is not proper since the majority of these overpayments occurred during 1994 and 1995 and ODHS has set "final" per diem rates for these years. ODHS is working with its legal counsel to resolve the collectibility issue. Regardless of whether it recovers the overpayments from the nursing facilities or not, ODHS has a contingent liability for the federal share of the overpayments. The federal government typically pays approximately 60 percent of the state's Medicaid costs.

CONCLUSIONS

This audit addressed several key issues relating to the delivery of long-term care services within the State of Ohio. These issues included determining whether (1) nursing facilities met applicable licensing requirements and whether inspections were conducted to ensure that providers complied with applicable rules and regulations, (2) the cognizant agency(s) imposed sanctions and collected fines for noncompliance, and (3) whether the services billed were actually provided.

Within the State of Ohio, ODH has responsibility for monitoring the quality of care for long-term care facilities. This audit showed that ODH' surveys and inspections were generally adequate to ensue that all nursing facility providers met applicable licensing requirements and these providers complied with applicable rules and regulations. Using a team of health care personnel, ODH conducted 4,056 recertification surveys on Ohio nursing facilities between FYs 1994 and 1996. Only two facilities during this period were terminated from the Medicaid program.

ODH also investigated complaints filed against nursing facilities. Between 1993 and 1996, more than 8,336 complaints were filed against Ohio nursing facilities. Of these, ODH investigated 6,068 (72.7 percent) before the end of the respective fiscal years. These complaints originated from a number of sources including Medicaid recipients and their families, current or former employees, the Department of Aging's Ombudsman, and other state agencies such as ODHS, the Ohio Department of Mental Retardation and Developmental Disabilities, and the Board of Nursing. The complaints work also showed that 464 complaints were filed against 60 randomly selected facilities between July 1993 and June 1995. Seventeen percent of these, upon investigation, was later substantiated. Where deficiencies were not corrected in accordance with the facilities' approved corrective action plans, ODH (and the U.S. Health Care Financing Administration) also impose monetary fines and/or other sanctions to bring about corrective action.

[15]Some of these claims involved duplicate payments by Medicaid and Medicare. Others involved overpayments resulting from patient leave days for which the providers were reimbursed at a rate of 100 percent instead of the allowable 50 percent rate.

ODHS has responsibility for reimbursing long-term care providers as well as overall management responsibility for Ohio's Medicaid program. It was found that this agency, which reimburses long-term care providers a daily per diem rate for recipients of record occupying a certified Medicaid bed, has serious control weakness. For example, while ODHS performed desk audits of provider cost reports to test the accuracy of reported cost items, it did not verify the number of recipients actually being represented by the reported costs. Consequently, this audit showed $54.5 million was overpaid to providers during a 2.5 year period for deceased Medicaid recipients. Further, while ODHS required providers to notify it of changes impacting per diem amounts, it neither imposed a time frame for reporting such changes nor did it have a mechanism for ensuring that required changes were reported. Also, while ODHS' claims payment system in some cases identified possible erroneous payment conditions, the agency did not investigate the charges prior to payment. As a result, it paid more than $50 million in charges identified by its payment system that possibly should have been paid by Medicare or not at all since the claims represented duplicates of others that had been paid.

RECOMMENDATIONS

Given the high number of complaints being subjected to deferred investigations (an average of 27 percent for years 1994 through 1996), it is recommended that ODH strengthen controls to better ensure that the delayed investigation of complaints (batching) does not adversely affect the health, safety, and well-being of Ohio's nursing facility recipients. In this regard, it is recommended that ODH periodically perform a limited desk audit on a random sample of the unprocessed complaints prior to batching to rule out conditions requiring more immediate corrective action. The desk audit results on the sample selection should be projected to the universe of unprocessed complaints and a record maintained to document ODH's assessment. Where the results indicate a higher degree of risk to recipient's health, safety, or well-being than initially assessed, it is recommended that ODH commence an investigation of such complaints shortly thereafter to assess the merits of the complaints.

Given the systemic nature of findings at ODHS, it is recommended that this agency immediately take action to recover the overpayments identified by this audit plus applicable interest from the date of the overpayment. This can be done in a number of ways including the withholding of future payments over a period of time to satisfy the liabilities involved. A listing of overpayments identified for each nursing facility was provided to ODHS under separate cover.
Concerning the collectibility of any future overpayments, it is recommended that ODHS revise the Ohio Administrative Code specifying that identified overpayments will be collected regardless of whether final per diem rates have been set. It is also recommended that ODHS account for and report funds in the Resident Protection Fund as presently required by the Ohio Revised Code.

To prevent future overpayments of the type identified in this report, it is recommended that ODHS immediately take the following action.

- Initiate a revision to the Ohio Administrative Code that will allow it to impose a time-frame by which long-term care providers will have to notify ODHS of changes involving the status of Medicaid recipients.

- Initiate a revision to the Ohio Administrative Code that will allow ODHS to assess a non-waivable penalty for failing to report changes in recipient status within the prescribed time frame.

- Suspend payment on all future claims identified by its claims payment system as potential duplicates and possibly conflicting with other claim types until it has determined that the payment is proper (meaning that payment has not already occurred or should be made by Medicare or other reimbursable sources).

- Resolve edit messages on all other claims types involving payments to nursing facilities prior to payment.

To improve its controls for detecting the existence of overpayments and improper charges, it is recommended that ODHS match its paid claims records with official death records maintained by ODH at least quarterly to minimize overpayments on behalf of deceased Medicaid recipients and to recover overpayments identified in a timely manner. It is further recommended that ODHS expand its audit efforts by periodically verifying the existence of Medicaid recipients for which payment is being made.

SUMMARY OF AGENCY COMMENTS

ODH and ODHS generally agreed with the contents of this report. Their comments were incorporated into the body of this report, as appropriate, and are included in their entirety in Appendixes I and II.

OHIO DEPARTMENT OF HEALTH

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GEORGE V. VOINOVICH
Governor

PETER SOMANI, M.D., Ph.D.
Director of Health

DEC 1 0 1997

Richard Sheridan, Chief
Fraud, Waste and Abuse Prevention Division
State of Ohio
Office of the Auditor
88 East Broad Street
Columbus, Ohio 43216-1140

Dear Mr. Sheridan:

We have reviewed the draft audit report covering Ohio's nursing facilities which focused on long term care issues involving the licensing and inspecting of nursing facilities, the processing of complaints and the imposing of sanctions. We appreciate the opportunity to provide comments prior to the issuance of the final report. We have the following comments pertaining to your review of the Department's practices and the recommendations contained in the draft report.

1. *Implement controls to ensure that the delayed investigation of complaints (batching) does not adversely affect the health, safety, and well-being of Ohio's nursing facility residents.*

All complaints forwarded to a district office (surveying office) for action are first received and undergo triage by the Complaint Intake Unit. Allegations of the immediate jeopardy to a resident or residents of a nursing facility are classified as two-day complaints and dispatched without delay to the appropriate district office. These complaints are given priority scheduling that often involves deferring other survey activities or diverting surveyors from scheduled activities to conduct the two-day complaint. It is the practice to immediately authorize overtime as may be required to assure timely investigation of any complaint alleging a serious threat to resident mental or physical health or safety.

Complaints alleging noncompliance with Federal Regulations (Medicare and/or Medicaid certification requirements) are investigated in accordance with protocols and guidelines set down by the Health Care Financing Administration (HCFA). In this regard, HCFA, as a part of the annual Medicare budget preparation instructions, provides guidelines for scheduling of complaint investigations. This guidance has been essentially unchanged since 1992 and instructs ODH to do an "...immediate on-site visit if the complaint alleges a serious threat to patient mental or physical health or safety." HCFA guidelines continue that, in many cases, it will be "appropriate for the

complaint to be investigated during the next scheduled visit to the facility." Excessive complaint investigation time brought about by the state's own statutes, regulations, procedures rather than Federal guidelines, may precipitate a response from HCFA that includes setting an upper limit on Medicare complaint funding.

While batching is employed to the extent possible to maximize resources and operate within the limitations of state and federal budgets, the districts, in practice, do not allow complaints to accumulate in number exceeding 4-5 separate intakes before scheduling for onsite investigation. This assures a more manageable workload at the onsite visit and assures that contributing facility practices or conditions bringing about the multiple complaints are not allowed to go unchecked for an excessive period of time.

2. *Perform a limited desk audit on each complaint prior to batching to rule out conditions requiring more immediate corrective action.*

While each complaint received at a district office has already undergone triage by the Complaint Intake Unit, a second screening is done by a survey supervisor at the receiving district office prior to the decision to batch. Regardless of the lower priority that may have been assigned by the Intake Unit, the complaint may be scheduled earlier by the survey supervisor. This may be based upon special knowledge of the facility, the compliance history of the facility, or some other measure such as relation of the allegation to a facility's quality indicators ranking or other related findings in past surveys. A standardized set of criteria is avoided in favor of a case-by-case approach based upon the aforementioned factors.

This review is accomplished under the umbrella administrative duties of a survey supervisor. Establishment of a separate and specific tasking for a desk audit of each complaint received would be exclusive of that required of the State Survey Agency by HCFA under Medicare survey and certification procedures. Priority levels or categories of complaints are set by the state not HCFA. By virtue of this exclusion, the costs of such a desk audit--supervisor salary, fringe, and indirect costs would have to be borne by the state.

3. *Maintain records of procedures performed during these desk audits to document rationale for deferring investigation of complaint.*

The survey supervisor is aided in the case-by-case screening of each complaint received in the district office for investigation by varied source material. These include the *State Operations Manual*, sections 3280 through 3298; the *Complaint Investigation Guidelines* and *Investigative Protocols* published by HCFA's Health Standards and Quality Bureau; Chapter 3721 of the Ohio Revised Code; and internal operational procedures, CMP 92-01 and CMP 94-02. The *Investigative Protocols* in particular aid the survey supervisor in the planning and evaluation of complaints received. By applying investigative guidelines that are to be followed during the on-site investigation, a supervisor can more effectively screen each complaint based upon the characteristics of the circumstances or situations presented in the intake information.

The fact that the above guidance is readily available and used during the screening process, assures that complaints deferred for investigation at the next facility visit are appropriately categorized and scheduled, as the audit verified.

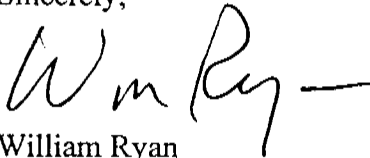
3. *Monitor complaints against facilities to identify trends or other indicators identifying questionable practices or procedures that could threaten the health, safety, and well-being of nursing facility recipients.*

The survey bureau uses a computer-based survey tracking system (STS) that affords ODH a comprehensive system for tracking the compliance history of health care provider/suppliers. Every complaint against a facility is logged into the STS data base identified by the facility identifiers and the control number assigned to the complaint at time of intake. Base data for each complaint includes the allegations by category, whether the complaint was substantiated or not, and a ancillary file containing the identifying tag number for .each citation and the correction status for that deficiency citation. Current data in STS goes back five years with a planned history of three years data as the norm. The system is capable of producing various reports that can either summarize each complaint investigation in terms of deficiencies cited or provide a cumulative record of the number of complaints received pertaining to the facility for any given period.

This system, when teamed with the intake data base containing identification of allegations, provides a reliable and capable monitoring system that aids supervisors in the batching screening and decision-making process.

Again, we appreciate the opportunity to have the Department's comments reflected in the final report. If you have any questions please contact Rebecca S. Maust, Chief, Division of Quality Assurance at (614) 466-7857.

Sincerely,



William Ryan
Director of Health

c: Rebecca S. Maust, DQA
Lou Ellen Fairless, Assistant Director of Health

George V. Voinovich
Governor

APPENDIX II

Arnold R. Tompkins
Director

Ohio Department of Human Services

30 East Broad Street, Columbus, Ohio 43266-0423

December 11, 1997

Mr. Richard Sheridan, Chief
Fraud, Waste and Abuse Prevention Division
Office of the Auditor
88 E. Broad Street
P.O. Box 1140
Columbus, Ohio 43216-11140

Dear Mr. Sheridan:

My staff has reviewed your recently submitted audit titled " Ohio Nursing Homes, Policy and Procedural Changes Can Reduce Costs and Increase Provider Accountability." They reviewed only those issues which pertained to the claims payment system for residents of long term care facilities. We did not comment on those issues which pertained to the Ohio Department of Health.

The issues raised in the audit report are issues which we have been taking action to address and resolve for some time now as a result of an audit by the Office of the Inspector General of the Health Care Financing Administration, as well as a result of our own initiatives in this area. Those steps have included the hiring of an external source, with expertise in third party payment recovery, to help identify and subsequently recover Medicaid funds incorrectly utilized to pay bills which should have been paid by another source, such as Medicare; the implementation of a new claims payment process for long term care facilities; and the automation of leave day reporting. The claims payment modification increases the accountability of the individual long term care facility to make timely and accurate changes to it's Medicaid census. It also reduces the number of hands through which these documents must flow prior to being implemented, as well as streamlining the overall claims reporting process for long term care facilities. The leave day automation will significantly improve the timeliness and accuracy of reporting in this area. As leave day reports are received by ODHS, they are entered into our current reimbursement system and the necessary adjustments to days and payment are made at that time. This will significantly limit the opportunities for this to become an issue again. In addition, we are developing, in-house, a new computer system based on state-of-the-art technology to replace our present long term care computer system. This particular modification will enhance our capability to support a conversion to a direct billing process for this group of providers.

While the Ohio Department of Human Services (ODHS) essentially serves as the hub of the wheel in this particular process, there are a multitude of spokes which feed into this hub. For example, ODHS serves approximately 1300 long term care providers who in turn serve about

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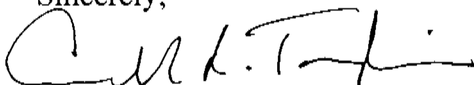
70,000 Medicaid recipients. All of these providers generate thousands of claims on behalf of the recipients who reside in their facilities. Many of these claims are then funneled through 88 different county departments of human services and countless numbers of different hands, as well as a number of fiscal intermediaries serving the Medicare program. The complexity of this system does require ongoing efforts to improve performance.

Some of the changes I have mentioned previously, specifically the new claims payment process, are designed to simplify, expedite and improve the way in which long term care claims are submitted, handled and paid by those who play a role in the process. However, it is important to note that even with these improvements, the system will not be infallible. For instance, even if we receive same-day notification of a recipients' death, there is a very strong likelihood that a provider will be paid for that recipient after they are deceased, depending on what day of the month that notification is received. If a recipient dies after a vendor check has been cut, overpayment will occur. We are working to operate a claims payment system that will work to recover that money from the next vendor check. In this same vein, while there are current regulations which require a Medicaid recipient's responsible party, if they have one, which not all do, to notify the county human services agency when a recipient dies, there is no such requirement for nursing homes. I have asked staff to look into this and submit recommendations for including such a requirement in our rules.

We intend to continue to look for ways to improve the claims payment process for long term care facilities. The previously mentioned improvement to the claims payment process was never intended to be the final solution. Ultimately we would like to implement a direct billing process for long term care facilities if that proves to be a feasible option for these facilities.

Finally, I will be meeting with my staff this week to discuss a process to begin recovery of whatever monies are ultimately determined to be owed to the Medicaid program. I expect that we will agree on an approach for dealing with this matter at that time. As you referenced in your report, I fully expect this to be a contentious issue, but one which must be dealt with. I appreciate the time and effort expended by your staff and do appreciate the suggestions they have made to improve some of our processes. We will look at the individual issues raised therein and address each accordingly. Thank you again for your report.

Sincerely,



Arnold R. Tompkins
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Ohio Nursing Homes: Policy and Procedural Changes Can Reduce Costs and Increase Provider Accountability

CLERK'S CERTIFICATION

This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

By: Jill M. Burch
Clerk of the Bureau

Date: DEC 19 1997