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An Audit Report on the Long-Term Care Regulatory Program at the Department of Human Services

June 1997

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Key Points of Report

An Audit Report on the Long-Term Care Regulatory Program at the Department of Human Services

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Overall Conclusion

The Department of Human Services (Department) has generally complied with federal and state regulations in the conduct of surveys and complaint investigations. However, compliance with the inspection protocol does not ensure effective regulation, and more importantly, quality care in nursing facilities. Many factors have hindered the Department's ability to be effective in its regulatory role over nursing facilities, which has allowed substandard providers to exist.

Key Facts and Findings

- As the Department reengineers the long-term care regulatory process, it should continually focus on improvements in the inspection process by clarifying criteria, terminology, and procedures. Additionally, the Department should establish measurable performance standards for nursing facilities and require all facilities to report performance measures on a regular basis.
- Management should make continuous efforts to improve the enforcement function by evaluating the overall effectiveness of remedies on the quality of care in nursing facilities. The Department should fully utilize its authority to use a facility's and owner's history of noncompliance as a basis for imposing remedies. The Department should evaluate its current use of state licensing remedies and administrative penalties as enforcement tools.
- Management and staff of the Department and the Office of the Attorney General should continue to improve communication through frequent correspondence and meetings to address past problems and to develop solutions. The Department should clarify the definition of violations that constitute a threat to resident health and safety, with input from the Office of the Attorney General.
- Management should continue to evaluate methods for minimizing the risk of disclosure of unannounced inspections. Management should fully manage potential conflicts of interest identified by employees.

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Executive Summary

The Department of Human Services (Department) has generally complied with federal and state regulations in the conduct of surveys and complaint investigations. However, compliance with the inspection protocol does not ensure effective regulation, and more importantly, quality care in nursing facilities. Many factors have hindered the Department's ability to be effective in its regulatory role over nursing facilities, which has allowed substandard providers to exist.

The State Auditor's Office reported on a review of nursing home regulation in December 1993 (*A Review of Nursing Home Regulation in Texas*, SAO Report No. 94-015). While the Department has made a good-faith effort to address prior findings and recommendations, opportunities still exist to improve the regulatory function. In consideration of the prior audit and this current audit, the Department should continue to focus on the processes by which policies and procedures are developed, reviewed, and distributed; the quality control process; and training. On April 15, 1997, the Department's Acting Commissioner issued a directive to reengineer the long-term care regulatory process, demonstrating a commitment to improve.

The Department Has Generally Complied With Federal and State Protocol in the Conduct of Inspections

Long-term care facility surveyors generally complied with federal and state regulations in the survey and certification of nursing facilities and in the conduct of complaint investigations during fiscal year 1996. A review of survey and investigative files showed that surveyors followed the defined protocol and used the correct forms. Observation of two surveys and two complaint investigations resulted in the same conclusion.

Inspection Criteria and Performance Standards Should Be Specified

While the Department generally follows federal and state protocol in the conduct of inspections, breakdowns have occurred which can be traced to a lack of specific criteria, unclear policies and procedures, and a focus on compliance versus performance.

Concerns about the development of deficiencies were noted during this review. The development of deficiencies is the means by which the Department determines a facility's compliance with laws and regulations, and if necessary, the need for further enforcement action. Documented criteria and procedures exist, but they are not always clear. For example, the Department has no specific ratios by which to evaluate the adequacy of staffing at nursing facilities, except for licensed nurses. In one case, a facility had a history of problems associated with adequacy of staffing. Sometimes, surveyors would cite the facility, and other times they would not. Ultimately, legal proceedings concluded that inadequate staffing contributed to a resident's injuries and subsequent death.

The Department has not defined measurable performance standards for nursing facilities, nor does it require facilities to report performance measures on a regular basis. The Department contracts with nursing facilities for services as defined for the Medicaid program, but the contracts do not contain specific outcome measures requiring nursing facilities to perform at a certain level of success. This is a statutory requirement that arose from the State Auditor's review of contract monitoring of purchased services in 1994 (*A Review of Contract Monitoring of Purchased Services*, SAO Report No. 95-007).

Executive Summary

The Department Should Improve the Use of Available Remedies in the Enforcement Function

The Department has not effectively used available remedies to regulate nursing facilities. A wide range of remedies are available under federal and state law; yet, the Department has primarily focused on the imposition of federal remedies related to the Medicaid program. State licensing remedies have been used very little. Additionally, the Department has not used a history of noncompliance at a facility as a basis for imposing remedies.

Since January 1, 1994, Department records show that license denial or revocation for nursing facilities and intermediate care facilities for the mentally retarded has been recommended at least 309 times as a result of a survey, but a license has only been denied once (in 1994), and none have ever been revoked. The Department has generally allowed facilities to correct deficiencies and return to compliance to avoid license denial or revocation, regardless of the facility's history of noncompliance. Additionally, the Department has not fully used its authority in the imposition of administrative penalties, which is one of three types of monetary penalties that can be assessed.

Communication and Coordination Between the Department and the Office of the Attorney General Should Be Improved

The referral of cases from the Department to the Office of the Attorney General for trustee appointments has generally been handled effectively. However, the assessment of civil penalties against nursing facilities has not been effectively used as an enforcement tool due to breakdowns in communication between

the Department and the Office of the Attorney General. Out of 119 case referrals between September 1, 1993, and December 31, 1996, 18 cases have resulted in a monetary settlement or judgment totaling \$418,500, according to the Office of the Attorney General.

Some of the breakdowns were caused by the lack of a clear definition of violations that constitute a threat to resident health and safety. Others were due to a lack of timely response from the Department to requests from the Office of the Attorney General for additional information. Management and staff of the Department and the Office of the Attorney General have recently held frequent meetings to address past problems and to develop solutions.

Management Should Continue to Evaluate Methods for Minimizing the Risk of Disclosure of Unannounced Inspections

Evidence of disclosure of unannounced inspections was not found during this audit. However, management should continue to evaluate its approach to the scheduling of standard surveys. Even without disclosure of unannounced inspections, inspection schedules can be predicted with some degree of accuracy, given the limited time frame in which they are conducted.

Procedures should be improved to manage potential conflicts of interest identified by employees. As of April 1997, 136 regional employees had affirmatively identified a potential conflict of interest with a long-term care facility, such as a relative who is an employee or resident of a facility. During fiscal years 1995 and 1996, 38 of those employees participated in 147 visits to a facility identified on disclosure forms.

Executive Summary

Procedures Should Be Improved for Referrals to Other Regulatory Agencies

Procedures should be improved for referrals to the Board of Nurse Examiners, the Health and Human Services Commission for Medicaid fraud, and the Board of Nursing Facility Administrators. With the many referrals that the Department makes, procedures should be in place to review adherence to established policies and procedures. For example, in three cases at three different facilities, circumstances warranted the referral of nurses to the Board of Nurse Examiners, but no referrals were made.

Information Systems Should Be Improved

The approach to automation within the Long-Term Care Regulatory Program (Program) has not been well-coordinated. For example, the sections of Licensure, Certification, and Provider Enrollment have been unified within the Long-Term Care Regulatory Division since September 1, 1993, and have not yet coordinated their work. Each section has a separate information system and there is duplication in the data collected. Also, a wide variety of personal computer architectures, network topologies, and software exist in the regions, which is caused by decentralized management of automation resources and a lack of standardized procedures for purchasing.

The Program's primary automated system is not designed to provide necessary and useful reports for management and staff. Management at the Department's State Office does not have a formal tracking and reporting system to assist in the monitoring and evaluation of the Long-Term Care Regulatory Program. A thorough analysis and assessment of the current system was completed in

January 1997, and discussions are underway to address the recommendations.

Summary of Management's Response

Based on the recommendations contained in this report the Department will evaluate each of the areas identified. The Department has already initiated a reengineering project for Long Term Care-Regulatory. The purpose of this project is to evaluate the long term care survey process and support operations in order to improve the effectiveness of long term care regulation in Texas. The Department will include each of the Auditor's recommendations as part of the evaluation of this program through the reengineering effort. The Department has also initiated a comprehensive review of the data automation needs of this program. The purpose of this project is to provide automation support sufficient to provide accurate and readily available information for the purposes of program operations and management oversight.

Summary of Objective and Scope

The objective of this audit was to evaluate the Department's effectiveness and its compliance with statutory duties and responsibilities in the regulation of long-term care facilities. The scope of this audit included the duties and responsibilities of the Department of Human Services' Long-Term Care Regulatory Division. The primary focus of review and testing was nursing facilities and skilled nursing facilities. However, the control systems over inspections, licensing, and the enforcement function apply to licensed personal care homes and intermediate care facilities for the mentally retarded. Some review and testing was conducted of these facilities.

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Overall Conclusion

The Department of Human Services (Department) has generally complied with federal and state regulations in the conduct of surveys and complaint investigations of nursing facilities. However, compliance with the inspection protocol does not ensure effective regulation, and more importantly, quality care in nursing facilities. Many factors have hindered the Department's ability to be effective in its regulatory role over nursing facilities, which has allowed substandard providers to exist. This conclusion is similar to critical reviews of the past. For example:

Even though most nursing homes provide good care in a compassionate environment, there is a significant number of homes in Texas that seriously neglect the needs of their patients The compliance game must end now.¹

Though many nursing homes provide adequate care for residents, and action has been taken to shut down poor providers or to correct deficiencies, significant problems still exist Instead of doing whatever it takes to pass state inspection, also known as playing the "compliance game," providers must focus on doing whatever it takes to help residents live safely and comfortably.²

The State Auditor's Office reported on a review of nursing home regulation in December 1993 (*A Review of Nursing Home Regulation in Texas*, SAO Report No. 94-015). While the Department has made a good-faith effort to address prior findings and recommendations, opportunities still exist to improve the regulatory function. In consideration of the prior audit and this current audit, the Department should continue to focus on the processes by which policies and procedures are developed, reviewed, and distributed; the quality control process; and training. On April 15, 1997, the Department's Acting Commissioner issued a directive to reengineer the long-term care regulatory process, demonstrating a commitment to improve.

Section 1:

The Department Has Generally Complied With Federal and State Protocol in the Conduct of Inspections

Long-term care facility surveyors generally complied with federal and state regulations in the survey and certification of nursing facilities and in the conduct of complaint investigations during fiscal year 1996. A review of 11 survey and certification files randomly selected (one from each region) and a review of 33 investigations randomly selected (two complaints and one incident from each region) indicated that surveyors followed the defined protocol and

¹ Bragg, David, *Make Texas a Good Place To Grow Old*, A Report to the Honorable Ann W. Richards, Governor of Texas, December 11, 1991.

² Nursing Home Work Group, *Improving Care in Nursing Homes*, A Report to the Legislative Health and Human Services Board, December 1992.

used the correct forms. Additionally, observation of two surveys and two complaint investigations resulted in the same conclusion.

A few exceptions were noted during the review of complaint investigations:

- Evidence of pre-investigative activities, as specified in the *Investigative Handbook*, was missing in 4 of the 33 cases reviewed. Additionally, a site visit revealed failure to review relevant facility reports prior to the investigation.
- In 1 of the 33 cases reviewed, a higher priority should have been assigned to a complaint. This situation was also noted during a special review of two other selected files. Criteria for priority assignments are defined, but they are neither definitive nor all-encompassing. Thus, the assignment of priorities requires the professional judgment of an intake specialist and is subject to different interpretation. Given the volume of complaints (approximately 13,000 in fiscal year 1996), priority assignment is a critical task in effectively and efficiently regulating nursing facilities.

Recommendation:

Management should ensure that pre-investigative activities are conducted for all complaint investigations; this could be achieved through the quality control process. Pre-investigative activities are particularly relevant to understanding the history of a facility, which could be important in the recommendation of remedies. (The use of history of noncompliance as a basis for imposing remedies is discussed further in Section 3-B.)

Management should continually review and strengthen its process for assigning priorities to complaints and incidents. Criteria should be reviewed and refined based on actual experiences. Priority assignments for individual cases should be subject to a continuous quality assurance review.

Management's Response:

The Department's investigation handbook will be reviewed to ensure that appropriate procedures are in place regarding pre-investigative activities including the evaluation and use of facility's history of non-compliance in the investigative process. The current reengineering effort in Long Term Care-Regulatory (LTC-R) will review the process for assigning priorities to complaints and incidents to strengthen it.

Section 2:

Inspection Criteria and Performance Standards Should Be Specified

While the Department generally follows federal and state protocol in the conduct of inspections, breakdowns have occurred that can be traced to a lack of specific criteria, unclear policies and procedures, and a focus on compliance versus performance. As reported in 1993 by the State Auditor's Office, the Department works within a maze of complex laws and

regulations. Since 1993, the Legislature and the Department have taken steps to streamline laws and regulations. However, further efforts are needed by the Department to clarify and implement statutory requirements.

Section 2-A:

Criteria and Terminology Used in the Development of Deficiencies Are Not Clear

Concerns about the development of deficiencies were noted during this audit. For example:

- Out of approximately 400 cases that went to an informal dispute resolution in the regional offices from February 1996 to February 1997,³ approximately 29 percent of the deficiencies disputed were changed or deleted after the review.
- Instances were noted during a review of survey files where the rationale for not writing deficiencies was not clear. For example, in one case the Department did not cite a facility for noncompliance in reporting an incident related to a resident's death.

The development of deficiencies is the means by which the Department determines a facility's compliance with laws and regulations, and if necessary, the need for further enforcement action. Documented criteria and procedures exist, but they are not always clear. For example, the Department has no specific ratios by which to evaluate the adequacy of staffing at nursing facilities, except for licensed nurses. In one case, a facility had a history of problems associated with adequacy of staffing. Sometimes, surveyors would cite the facility, and other times they would not. Ultimately, legal proceedings concluded that inadequate staffing contributed to a resident's injuries and subsequent death.

Much of the concern about the development of deficiencies is related to an apparent lack of consideration by surveyors of systemic problems—"cause and effect" evidence that would demonstrate faulty facility practices. For example, two complaint investigation files reviewed showed that even though complaints were not substantiated, deficiencies should have been cited in related areas. Another example was noted during observation by the State Auditor's Office of a complaint investigation at a licensed personal care home. The complaint was substantiated but the facility was not cited because it took appropriate action to address the incident. However, there was no consideration of system controls needed to prevent recurrence of this type of problem.

Additional examples of this nature were noted at another facility. In response to a complaint investigation, the investigator did not look to see if other residents were being assaulted and what system, if any, was in place to protect all residents. In response to a separate incident investigation at the same facility, the facility corrected a specific problem with the use of cards on food trays but did not address the failure on the part of licensed staff to supervise and assign resident care in a manner consistent with their needs.

³ The number of cases was obtained from monthly reports submitted from each region to the State Office. It may not include all informal dispute resolutions since reports were not available from all regions for every month.

The development of deficiencies is further complicated by broad terminology used to describe the effect of deficiencies. Terms such as “a threat to resident health and safety,” “immediate jeopardy,” “actual harm,” and “the potential for more than minimal harm” are presented in federal and state statutes without specific definitions. Thus, they are subject to various interpretations and can create barriers in the regulatory process. An example of this, related to the definition of “a threat to resident health and safety,” is discussed in Section 4.

Section 2-B:

The Department Has Not Defined Performance Measures by Which Nursing Facilities Can Be Evaluated

The Department has not defined measurable performance standards for nursing facilities, nor does it require facilities to report performance measures on a regular basis. The Department contracts with nursing facilities for services as defined for the Medicaid program, but the contracts do not contain specific outcome measures requiring nursing facilities to perform at a certain level of success. In October 1994, the State Auditor’s Office recommended the inclusion of outcome measures during a review of contracting at the Department (*A Review of Contract Monitoring of Purchased Services*, SAO Report No. 95-007). A statutory provision was inserted in the General Appropriations Act requiring contracts for the purchase of client services to include clearly defined goals, outputs, and measurable outcomes which directly relate to program objectives.⁴ The Department has not complied with this provision.

The Department’s *Nursing Facility Requirements for Licensure and Medicaid Certification* provides the basis from which performance measures can be defined. Section 19.701 refers to goals related to residents’ quality of life, and Section 19.901 refers to goals related to quality of care. One goal within Section 19.901 states that “the facility must ensure that a resident’s abilities in activities of daily living do not diminish unless the circumstances of the individual’s clinical condition demonstrate that diminution is unavoidable.” A performance measure related to this goal could be defined as the percentage of residents who do not demonstrate over a period of time a diminution of abilities in activities of daily living. Since circumstances of an individual’s clinical condition may occur that make diminution unavoidable, a reasonable target would be greater than 0 percent.

The Department’s focus on compliance with federal and state regulations to the extent of excluding performance standards leaves a gap in the regulatory function. This compliance orientation also carries over to nursing facilities in their delivery of services. For example, during observation by the State Auditor’s Office of a complaint investigation, a deficiency was presented based on a finding that five out of eight residents had soiled diapers that had not been changed for an extended period of time. However, the nursing facility administrator objected to the deficiency by saying that the standard survey protocol was not followed. Regardless of the survey procedure, it was apparent that residents had received inadequate care.

⁴ General Appropriations Act, 74th Legislature, Article II, Special Provisions, Section 15

Recommendation:

As the Department reengineers the long-term care regulatory process, it should continually focus on improvements in the inspection process through training, communication and coordination, and management review and oversight. These processes will help to increase the quality of surveyor judgment.

The Department should continuously monitor and evaluate the development of deficiencies, focusing on the specificity and soundness of criteria, terminology, and inspection procedures. Additionally, the Department should ensure the quality of evidence to support deficiencies. Management should:

- Universally share the general results of informal dispute resolution cases and formal hearings as a learning tool.
- Consider the development of specific ratios by which to evaluate the adequacy of staffing, in addition to licensed nurses, at nursing facilities.
- Continue to emphasize and clarify the consideration of systemic problems, or “cause and effect” evidence that would demonstrate faulty facility practices by using examples through training and performance feedback.
- Continue to clarify terms such as “threat to resident health and safety,” “immediate jeopardy,” “actual harm,” and the “potential for harm,” by rule, by policy, or by operational examples.

Results and feedback from actual inspections should be continuously shared among all management and staff members to promote consistent and effective regulation. Management should consider the use of external experts for consultation and advice when necessary and appropriate.

The Department should establish measurable performance standards for nursing facilities and require all facilities to report performance measures on a regular basis. This may simply require the compilation and analysis of existing information reported to the Department. For example, information relating to residents’ assessments could be compiled to evaluate the overall performance of a facility. During the developmental phase, the Department should seek input from nursing facilities and advocates for residents. Measures should be incorporated into the contract for Medicaid services. The Department should then incorporate a review of the reported performance measures into its inspection process. The survey process already has some tools in place to verify reported data related to quality of life and quality of care in nursing facilities.

Management’s Response:

Each of the recommendations in this section will be evaluated as a part of the LTC-R reengineering process. Specific training needs will be evaluated with the assistance of the Office of General Counsel and others as appropriate. The results of this evaluation will be

used to develop specific surveyor training with a schedule and format for delivery of such training. The Office of General Counsel will review nursing facility contracts for the inclusions of facility performance measures.

Section 3:

The Department Should Improve the Use of Available Remedies in the Enforcement Function

The Department has not effectively used available remedies to regulate nursing facilities. A wide range of remedies are available under federal and state law. Yet, the Department has primarily focused on the imposition of federal remedies related to the Medicaid program. State remedies have been used very little. Additionally, the Department has not used a history of noncompliance at a facility as a basis for imposing remedies.

Section 3-A:

The Department Has Imposed Federal Remedies, But Has Not Evaluated Their Effectiveness

Federal remedies have been imposed, but their overall effectiveness on the quality of care in nursing facilities has not been fully evaluated. The most serious remedies are for those situations that are judged to pose an immediate jeopardy to resident health or safety.⁵ Remedies include temporary management or trusteeship and termination of the Medicaid contract. According to Department records, from July 1, 1995, (which was the effective date of new federal regulations) to December 31, 1996, the inspection process identified 37 immediate jeopardy situations which resulted in five trusteeships and four terminated contracts. The latter four facilities were later recontracted. Immediate jeopardy was found twice at one facility over a six-month period, but no trustee or contract termination occurred.

Management and staff have a sense that trustees are effective when assigned to a nursing facility, but there is no formal evaluation. The intent of a trusteeship is to operate a facility, oversee correction of deficiencies, and assure the health and safety of the facility's residents while the corrections are being made. A trustee may also oversee the orderly closure of a facility. According to Department records, trustees were appointed 36 times from September 1, 1993, to December 31, 1996; seven were on a voluntary basis. Four facilities required the return of a trustee for a second time. Seven of the facilities were closed and the residents transferred.

Between September 1, 1993, and December 31, 1996, Department records show that the inspection process produced 843 recommendations for contract terminations and 174 recommendations for denial of Medicaid certification or recertification. Yet, there have only been 26 actual terminations or decertifications of nursing facilities from the Medicaid

⁵ Immediate jeopardy is defined as a situation in which the nursing facility provider's noncompliance with one or more requirements of Medicaid/Medicare participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

program. There were no terminations of intermediate care facilities for the mentally retarded. During fiscal years 1995 and 1996, 14 out of 15 terminated nursing facilities were recontracted and 2 of the 15 facilities have returned to the Critical List of Terminations as of March 7, 1997.

Section 3-B:

Remedies Have Not Been Imposed Based on a History of Noncompliance

The Department has not fully used a history of noncompliance at a facility as a basis for imposing remedies. A review of four selected files revealed a history of noncompliance that has not been considered in the imposition of remedies. For example, a review of the history of the facility with the highest number of complaint and incident investigations since 1991 shows repeated citations for similar deficiencies during 1995 and 1996. Surveyors recommended a 180-day termination six times, civil monetary penalties four times, and a 90-day termination once. The facility did not meet licensing inspection requirements four times. Yet, neither license revocation or termination from the Medicaid program occurred. Two remedies were imposed during this time period: a monetary penalty in 1995 and denial of payment for new admissions for approximately three months in 1996.

Since 1991, the Department has had the ability to use history of noncompliance for denying an initial license or renewal of a license. A new rule proposed in 1997 will allow the Department to use history of noncompliance for revocation of a license. However, the proposed new rule does not describe specific criteria, standards, procedures, and definitions in its use, which leaves the Department open to the same challenge presented in 1991 by the Texas Health Care Association. Furthermore, while the Department has a record of terminating certification, it has no record of denying or revoking a license. (See Section 3-D.)

Management referred to a 1991 lawsuit by the Texas Health Care Association against the Department of Health⁶ as a reason for not using history of noncompliance to impose remedies. Yet, the lawsuit related to the use of history of noncompliance for termination of Medicaid certification only. Although there was nothing to preclude the Department of Health from using history, it was challenged on the lack of specific criteria, standards, procedures, and definitions in its use. In other words, the Department of Health did not have specific rules to govern the use of history of noncompliance for termination of certification. The Department of Health settled with the Texas Health Care Association by agreeing not to use history until new rules were developed. It appears that the Department of Health did not act to develop new rules before the program was transferred to the Department of Human Services on September 1, 1993. The only action taken by the Department of Health was to repeal the rule referring to the use of history of noncompliance for termination of certification effective September 1, 1993.

⁶ Prior to September 1, 1993, the Long-Term Care Regulatory function was located at the Texas Department of Health. House Bill 1510, 73rd Legislature, moved the function to the Department of Human Services effective September 1, 1993.

While the Code of Federal Regulations did not include specific reference to the use of history of noncompliance for termination of certification at the time of the lawsuit, the Federal Government adopted new rules effective July 1995 that allowed its use. Specifically, remedies are to be imposed immediately on a “poor performing facility,” which is one with a history of being in and out of compliance. Department records show that it designated a poor performing facility 64 times from July 1995 to December 1996. However, 13 of those designations did not result in a remedy. In one case, a facility was designated a poor performing facility three different times with no imposition of remedies.

Additionally, provisions for use of a “three-strike rule” were approved by the Federal Health Care Financing Administration effective July 1, 1995, which the Department has used with five facilities. This provision allows the termination of a contract on the basis of the imposition of enforcement actions three times within an accountability period.

Section 3-C:

The Department Does Not Adequately Track Nursing Facility Owners

The Department does not adequately track and use ownership information in its regulatory activities. The Department focuses its regulatory activities on nursing facilities, not nursing facility owners. Management and staff spoke of the difficulties in tracking owners because of the complexities of corporate structures. For example, the Department is aware of an owner of several facilities with a poor history of service. However, the owner uses different corporate structures for each facility, which makes it difficult to identify and track the common parties involved.

The Department requests some ownership information for the past two years on the license application, including the identification of each limited and general partner if the applicant is a partnership and each director and officer if the applicant is a corporation. The Department also requests identification of each person having an ownership interest of five percent or more in the business entity. However, the Department does not verify the information. Nor does it request financial information, such as an annual financial report, that may be useful in regulatory activities.

The Texas Administrative Code gives the Department authority to consider the owner’s history (in addition to the facility’s history) when issuing and renewing a license. Yet, as noted in Section 3-D, a license has only been denied once since September 1, 1993.

Section 3-D:

State Licensing Remedies Have Not Been Fully Utilized

Since January 1, 1994, Department records show that license denial or revocation for nursing facilities and intermediate care facilities for the mentally retarded has been recommended at least 309 times as a result of a survey, but a license has only been denied once, in 1994, and none have ever been revoked. The Department has generally allowed facilities to correct deficiencies and return to compliance to avoid license denial or revocation, regardless of the facility’s history of noncompliance. This appears to have led to the withdrawal of 59 out of

77 cases which had been referred to a formal hearing before a Departmental Administrative Law Judge in 1996. In some cases, this has allowed chronic non-complying facilities to remain in business.

The Department's focus on federal remedies, without full consideration of state remedies, limits its options with substandard providers. At one facility, termination from the Medicaid program was recommended. However, contract termination was not enforced because the Federal Health Care Financing Administration apparently denied the facility due process. However, licensure authority was not used by the Department. A review of survey files and the history of this facility showed significant deficiencies that should have been considered under the Department's licensure authority.

Section 3-E:

Administrative Penalties Have Been Used on a Limited Basis

The Department has not fully used its authority in the imposition of administrative penalties, which is one of three types of monetary penalties that can be assessed. (See Appendix 4.) According to the Department, 725 administrative penalties were assessed against nursing facilities for \$384,250 between September 1, 1993, and December 31, 1996. However, between July 1, 1995, and December 31, 1996, 167 administrative penalties were assessed against nursing facilities for \$84,000. Management and staff referred to an unwritten policy since 1995 that administrative penalties were to be used on a very limited basis for administrative matters rather than health-related matters. The numbers in Table 1 show this to be true.

Similar results were noted for administrative penalties assessed against intermediate care facilities for the mentally retarded. Between July 1, 1995, and December 31, 1996, 116 administrative penalties were assessed for \$59,500, and 109 of those penalties were for failure to submit a license renewal application at least 45 days before the current license expiration date.

The Department has attempted to use civil penalties instead of administrative penalties for health-related matters. Yet, the Texas Administrative Code's definitions of criteria and health-related conditions for the assessment of administrative penalties show little variance from the intent for civil penalties. Furthermore, civil penalties must be referred to the Office of the Attorney General. As discussed in Section 4, the assessment of civil penalties against nursing facilities has not been used effectively due to breakdowns in communication between the Department and the Office of the Attorney General.

The Department has not defined administrative penalty assessments to fully use statutory authority. Rules have been enacted that provide specific conditions and assessments for violations, ranging from \$500 to \$3,000 for each violation. However, statutory authority allows the Department to impose an administrative penalty of up to \$10,000 a day for each violation.

Table 1

Number of Administrative Penalties Assessed From July 1, 1995, to December 31, 1996		
Type of Administrative Penalty	Number of Nursing Facilities	Number of Intermediate Care Facilities for the Mentally Retarded
Failure to submit a license renewal application at least 45 days before the current license expiration date	124	109
Failure by prospective purchaser during a change of ownership to submit a license application at least 30 days before the anticipated sale date	29	1
Failure to maintain the physical plant	10	
Failure to provide a safe and/or sanitary environment through the practice of storage, preparation, or distribution of foods	2	
Failure to observe, recognize, record, or report to the physician sudden and/or severe changes in resident clinical signs or symptoms and/or conditions	1	
Failure to obtain emergency medical care	1	
Failure to ensure or provide a continuous, consistent, and aggressive program of training, treatment, and activities which are directed towards acquisition of behaviors and/or the prevention or deceleration of regression or loss of optimal functional status		3
Failure of the Qualified Mental Retardation Professional to provide ongoing coordination and integration, and continuous monitoring of an individual's active treatment program to ensure adequate delivery of services		2
Failure to provide sufficient direct care staff to manage and supervise clients in accordance with their individual plans of care		1

Source: Department of Human Services;

Recommendation:

Management should make continuous efforts to improve the enforcement function by evaluating:

- The overall effectiveness of remedies on the quality of care in nursing facilities
- The imposition of remedies relative to inspection recommendations
- The long-term effect of imposed remedies on facilities

The Department should fully utilize its authority to use a facility's and owner's history of noncompliance as a basis for imposing remedies. The Department should implement procedures to verify and use ownership information submitted on license applications. For example, information could be compared to records at the Secretary of State's office. The Department should also consider requesting financial information, such as audited financial reports, to be used in planning and risk assessment.

The Department should evaluate its current use of state licensing remedies and administrative penalties as enforcement tools. Rules for administrative penalties should be reviewed and changed to fully use statutory authority.

Management's Response:

The Department will reevaluate the availability of all enforcement tools contained in state law and federal regulation. The Department will evaluate the use of these tools to ensure quality of services and enforcement of regulations in long term care facilities. All necessary rules changes and additions will be made to fully utilize the Department's statutory authority.

Section 4:

Communication and Coordination Between the Department and the Office of the Attorney General Should Be Improved

The referral of cases from the Department to the Office of the Attorney General for trustee appointments has generally been handled effectively. However, the assessment of civil penalties against nursing facilities has not been used effectively as an enforcement tool due to breakdowns in communication between the Department and the Office of the Attorney General. Out of 119 case referrals between September 1, 1993, and December 31, 1996, 18 cases have resulted in a monetary settlement or judgment totaling \$418,500, according to the Office of the Attorney General.

Some of the breakdowns were caused by the lack of a clear definition of violations that constitute a "threat to resident health and safety." The Department refers a facility to the Office of the Attorney General for the assessment of civil penalties for a violation that threatens the health and safety of a resident. However, the Department has not clearly and specifically defined a "threat to resident health and safety" for the purpose of referring cases to the Office of the Attorney General. Policy statements have been issued by the Department simply describing these cases as "most grievous" and "most egregious." Surveyors have been instructed to document the cause and effect relationship between the violation and the identified threat, but there has been no other specific description or guidance.

Delays in processing resulted from breakdowns in communication. According to the Department's records, 66 percent of the pending cases were referred in 1993 or 1994. While referrals for trustees have had fewer problems, breakdowns in communication occurred with at least 39 (46 percent) of the 84 non-trustee cases. Most of those breakdowns were a lack of timely response from the Department to requests from the Office of the Attorney General for additional information.

Communication breakdowns are most apparent in the numerous discrepancies between each agency's records on the status of case referrals between September 1, 1993, and December 31, 1996.⁷ Out of 119 case referrals, discrepancies were noted on 33 (28 percent) of the cases. For example, the Department's records showed 47 cases closed while the Office of the Attorney General showed 67 cases closed. In two cases, the Office of the Attorney General recorded settlements of \$10,000 and \$12,000 collected, but the Department had no record of the settlements. The State Auditor's Office was unable to determine the actual status of all

⁷ Case referrals include nursing facilities, skilled nursing facilities, and intermediate care facilities for the mentally retarded.

cases, but noted that the Department should record seven additional cases closed and the Office of the Attorney General should record two less cases closed.

In at least one case, it appears that weak communication between the Department's Legal Division and the Long-Term Care Regulatory Division may have heightened breakdowns in communication with the Office of the Attorney General. For example, the Department's Legal Division was aware of and appeared to concur with the Office of the Attorney General on a proposed settlement agreement of \$2,000. Then, four months later, the Legal Division sent a letter to the Office of the Attorney General stating disagreement with the settlement after recent discussions with Long-Term Care Regulatory Division management.

Management and staff of the Department and the Office of the Attorney General have recently held frequent meetings to address past problems and to develop solutions. The Department is developing suggested guidelines for referrals to the Office of the Attorney General in order to strengthen the referral process.

Recommendation:

Management and staff of the Department and the Office of the Attorney General should continue to improve communication through frequent correspondence and meetings to address past problems and to develop solutions. Routine tasks should include the tracking of timeliness of case processing and the reconciliation of records between the two agencies. Additionally, the Department should:

- Clarify the definition of violations that constitute a threat to resident health and safety, with input from the Office of the Attorney General.
- Provide timely response to requests from the Office of the Attorney General for additional information.
- Improve communication and coordination between its Legal Division and Long-Term Care Regulatory Division.
- Work to expeditiously implement written guidelines for referrals to the Office of the Attorney General in order to strengthen the referral process.

Management's Response:

The Department's Legal and LTC-R Divisions in coordination with the Office of the Attorney General will continue the activities which have already been initiated to address the audit recommendations.

(Office of the Attorney General's response is included at Appendix 5.)

Section 5:

Management Should Continue to Evaluate Methods for Minimizing the Risk of Disclosure of Unannounced Inspections

Evidence of disclosure of unannounced inspections was not found during this audit. Six internal investigations have been conducted by the Department since September 1, 1993, to determine criminal misconduct on the part of Department employees. The investigations did not establish a criminal violation. However, management may not have considered appropriate preventive action to address possible systemic breakdowns based on investigation results. For example, in one case, evidence suggested that a breakdown occurred at a region office, but records did not identify specific individuals. Management did not evaluate the information to determine what, if any, action should be taken to address the possible breakdowns.

Section 5-A:

Inspection Schedules Can Be Predicted With Some Degree of Accuracy

Even without disclosure of unannounced inspections, inspection schedules can be predicted with some degree of accuracy, given the limited time frame in which they are conducted. Federal regulations require that each nursing facility shall be subject to a standard survey not later than 15 months after the date of the previous standard survey and that the statewide average interval between standard surveys shall not exceed 12 months. Persons in the nursing home industry spoke of the ease with which persons can anticipate surveys. A review of a sample of 33 facilities (111 surveys) showed 40 percent of the surveys were conducted in the same month or within two and a half weeks of the date of the survey in the previous year. Furthermore, 90 percent of those standard surveys began on Monday or Tuesday. In two of the criminal investigations, it was noted that the facility administration anticipated its survey in relation to another facility in the same region.

During observation by the State Auditor's Office of surveys and complaint investigations, opportunities were noted to improve the confidentiality of scheduled surveys. For example, during an observed site visit, an employee from the regional office called the facility prior to the survey team's arrival to talk with a member of the survey team, which effectively alerted the facility of the pending survey (even if it was very short notice). Also, it was noted in one regional office that schedules are placed on the desks of absent employees.

Section 5-B:

Potential Conflicts of Interest Identified by Employees Are Not Actively Managed

Management does not fully manage potential conflicts of interest identified by employees. As of April 1997, 136 regional employees (out of approximately 590 employees in the regional offices) had affirmatively identified a potential conflict of interest with a long-term care facility, such as a relative who is an employee or resident of a facility. During fiscal years 1995 and 1996, 38 employees participated in 147 visits at a facility identified on disclosure forms. Ten employees did not specifically identify the facility on their disclosure form.

Management stated that employees are not assigned to facilities where a potential conflict of interest exists, but a policy is not in writing nor is there evidence of such decisions by management for each employee. The Department has a policy to require all Long-Term Care Regulatory Division employees to complete a disclosure form annually to identify potential conflicts of interest with a long-term care facility and to designate the facility. However, the policy does not require an employee to submit a form when a change occurs, for example, when a relative becomes employed by a nursing facility. Since employees have access to inspection schedules, the form requires each employee to acknowledge the prohibition from disclosure of unannounced inspections and the penalty for such disclosure. The form is signed by the employee's immediate supervisor.

Department policy also requires employees to obtain prior approval to ensure that a conflict of interest does not exist if the employee's spouse is considering contracting with, becoming a board member of, or owning an enterprise regulated by the Department. However, the policy does not address similar situations with relatives other than the spouse.

Recommendation:

Management should broaden the scope of internal investigations to identify opportunities to improve overall controls.

Management should consider variation in its scheduling of inspections. For example, management should avoid:

- Scheduling a survey in the same month or within two and a half weeks of the date of the survey in the previous year
- Beginning surveys on Monday or Tuesday
- Consistently scheduling surveys of facilities in the same region in relation to one another.

Procedures should be improved to protect the confidentiality of schedules. For example, management should avoid:

- Contacting the survey team at the facility prior to the survey team's arrival
- Placing schedules in open areas

Procedures should be improved to manage potential conflict of interest by employees:

- An affirmative response to the disclosure form should require the identification of any long-term care facility affected.
- In addition to the annual requirement, the policy should be revised to require employees to submit a disclosure form when a change occurs.

- Management should document scheduling and assignment decisions related to potential conflicts of interest. The use of an existing form “Supervisor/Employee Conference Notes,” would meet this need. Management should ensure legal review when appropriate.
- The Department should consider broadening, to include other relatives, the existing policy requiring employees to obtain prior approval to ensure a conflict of interest does not exist if the employee’s spouse is considering contracting with, becoming a board member of, or owning an enterprise regulated by the Department.

Management’s Response:

The Department has already initiated many steps to improve the security of information regarding investigations and surveys at long term care facilities. Procedures are in place to identify potential conflicts of interest by employees in the conduct of their duties. The Department will evaluate these procedures and determine a necessity for any changes in or additional agency rules related to conflicts of interest. The LTC-R reengineering process will also address these issues.

Section 6:

Procedures Should Be Improved for Referrals to Other Regulatory Agencies

Procedures should be improved for referrals to the Board of Nurse Examiners, the Health and Human Services Commission for Medicaid fraud, and the Board of Nursing Facility Administrators. With the many referrals that the Department makes, procedures should be in place to review adherence to established policies and procedures. In three cases at three different facilities, circumstances warranted the referral of nurses to the Board of Nurse Examiners but no referrals were made.

The Department has defined procedures for referrals to other regulatory agencies with one exception. The Department has not documented procedures for the identification and referral of Medicaid fraud cases to the Health and Human Services Commission (Commission). The Commission is responsible for handling Medicaid fraud, and it provides the only means for placing individuals’ names on a list excluding them from receiving federal funds.

In September 1996, the Department was unable to provide evidence that nursing facility administrators had been referred to the Board of Nursing Facility Administrators for 8 out of 23 nursing facilities where a trustee had been placed in 1994 and 1995. In response to a newspaper article, management reported that these cases occurred prior to December 1, 1994, and then formally referred the cases to the Board of Nursing Facility Administrators in September 1996. No other instances of nonreporting were identified in the audit. However, it was noted that the survey protocol does not require surveyors to determine that an administrator is licensed.

Recommendation:

The Department should continually evaluate its procedures for referral to other regulatory agencies, and ensure that timely and appropriate referrals are made to relevant regulatory agencies.

The Department should define and document procedures for the identification and referral of cases of suspected Medicaid fraud to the Health and Human Services Commission.

The Department should establish a routine procedure for surveyors to confirm that nursing facility administrators are licensed.

Management's Response:

The Department will continually evaluate its procedures and rules for referral of individual professionals to their respective licensing authorities for disciplinary actions. The Department will also contact the Health and Human Services Commission to determine the nature and scope of referrals they wish to receive concerning suspected Medicaid fraud detected in the LTC-R survey and certification process. Any rules which may be necessary to implement these recommendations as well as all policies necessary to clarify these relationships will be developed as part of the reengineering process.

Section 7:

Information Systems Should Be Improved

The approach to automation within the Long-Term Care Regulatory Program (Program) has not been well-coordinated. For example, the sections of Licensure, Certification, and Provider Enrollment have been unified within the Long-Term Care Regulatory Division since September 1, 1993, and have not yet coordinated their work. Each section has a separate information system and there is duplication in the data collected. For example, each section collects some of the same ownership data from facilities. Also, a wide variety of personal computer architectures, network topologies, and software exist in the regions; this variety is caused by decentralized management of automation resources and a lack of standardized procedures for purchasing.

Participation and support in automation has come from at least four different segments within the Department, and each segment has a different manager. Roles and responsibilities have been unclear. Communication breakdowns have occurred. The Department has taken recent action to partially address organizational issues by having the Long-Term Care Regulatory Network Managers report directly to the Regional Operations Automation Directors, but more is needed.

As noted in a prior audit by the State Auditor's Office in 1993, many of these problems were inherited when the Program transferred from the Department of Health. While some actions have been taken in response to that audit, there are several key recommendations that have not yet been implemented.

Section 7-A:

The Integrated System Is Not Meeting the Program's Needs

The automated Integrated System is not designed to provide necessary and useful reports for management and staff. For example, a report of a history of actual remedies imposed on an individual facility cannot be easily obtained from the Integrated System. (This is significant as it relates to the use of history for the imposition of remedies. See Section 3-B.) As noted in Section 7-B, the compilation of performance measures cannot be simply retrieved from the Integrated System.

A thorough analysis and assessment of the Integrated System was completed in January 1997 by the Management Information Systems Division, which took almost two years. It is estimated that a minimum of three years is needed to implement the recommendations. Estimated cost for the Integrated System begins at \$1 million. Yet, maintenance of the existing Integrated System has used most of the Management Information System's budget dedicated to the Long-Term Care Regulatory Program.

Weak internal controls have been identified with the Integrated System, which have resulted in inaccurate data. Control weaknesses include:

- Inadequate user and application documentation
- Inadequate training for users
- No backup for Regional Network Managers
- Lack of programming standards
- Informal change request procedures

Additionally, inefficiencies have been identified with the Integrated System:

- Data is not entered at the source of data origination (the regions), and duplicate data entry exists.
- Network performance is problematic with excessive response time and downtime.
- Network management does not include formal monitoring of downtime, service levels, response time, or capacity.
- Information retrieval is difficult.
- Staff are not fully using available technology, for example, laptops.

Section 7-B:

Management Information Is Not Available to Fully Evaluate the Program

Management at State Office does not have a formal tracking and reporting system to assist in the monitoring and evaluation of the Long-Term Care Regulatory Program. An abundance of data and various methods of communication exist within the Program. Furthermore, various reports exist among the departments and sections. (A review of tracking and reporting

systems in the regional offices was not done.) Yet, it is difficult to obtain summary information on the Program's effectiveness. Currently, the Department cannot easily fulfill a proposed legislative requirement to provide "summary reports relating to the quality of care, recent investigations, litigation, and other aspects of the operation of the institution."

Existing performance measures, which are reported to the Legislative Budget Board and the Federal Government, are predominantly output measures. There has been little effort to evaluate the general effectiveness of enforcement actions other than through informal means. For example, as discussed in Section 3, management and staff have a sense that trustees are effective when assigned to a nursing facility, but there is no formal evaluation. Also, there is no analysis of implemented remedies relative to proposed remedies.

The process for collecting and compiling performance measures is inefficient and contains control weaknesses. It involves excessive data entry, which raises the risk of human error. Weaknesses include:

- Re-entry of Integrated System data to personal computer spreadsheets
- Duplicate data entry to Integrated System and personal computer spreadsheets
- Duplicate reporting by regions
- Use of at least four different software products

Recommendation:

Management of automation and information systems within the Long-Term Care Regulatory Program should be improved. Efforts should be taken to improve coordination and communication within the Program and with other divisions of the Department. As changes occur in reporting relationships, roles and responsibilities should be clearly defined.

As the Department evaluates its options with the Integrated System, internal control weaknesses and inefficiencies should be addressed.

Management should establish a formal tracking and reporting system to assist in the evaluation of the Program. Critical success factors should be identified, efficient processes should be established to collect the right data, and summary reports should be produced. Controls should be in place to ensure the accuracy of performance measure data.

Management's Response:

The LTC-R Department has been working with the Department's Management Information System Division to evaluate an overall rewrite and improvement of automated systems in LTC-R. The Department will continue to pursue the necessary funding to support this rewrite and improvement.

Objective, Scope, and Methodology

Objective

The objective of this audit was to evaluate the Department's effectiveness and its compliance with statutory duties and responsibilities in the regulation of long-term care facilities.

Scope

The scope of this audit included the duties and responsibilities of the Department of Human Services' Long-Term Care Regulatory Division. The primary focus of review and testing was nursing facilities and skilled nursing facilities. However, the control systems over inspections, licensing, and the enforcement function apply to licensed personal care homes and intermediate care facilities for the mentally retarded. Some review and testing was conducted of these facilities.

Methodology

Conventional audit procedures were applied to collect information, including interviews with management and staff of the Department and other external parties. Operational data was analyzed and relevant reports and documentation were reviewed. Audit testing and analysis included control review, analysis of inspection results and performance statistics, review of survey and certification files, review of complaint investigation files, review of contract files, and observation of inspections. Our work will not necessarily reveal all internal control weaknesses.

Information collected included the following:

- Documentary evidence such as:
 - Texas Health and Safety Code
 - Code of Federal Regulations
 - Various management reports
 - Department documents, memoranda, and publications, including the Department Strategic Plan and the 1998-99 Legislative Appropriations Request
 - Policy and procedures manuals
 - Prior State Auditor's Office reports
 - Departmental operational studies
- Interviews with management and staff of the Department, including regional personnel
- Interviews with management and staff of the Office of the Attorney General
- Interviews with interested citizens and special interest groups
- Interviews with staff of the Health Care Financing Administration
- Interviews with staff of the Health and Human Services Commission
- Documentary evidence from the Department of Health related to nursing facility administrators

Procedures and tests conducted:

- Observation of two surveys and two complaint investigations
- Review of documentation relating to Department operations
- Review of survey and certification files, complaint investigation files, and contract files
- Review of legal files from the Department and the Office of the Attorney General
- Review of the Long-Term Care Regulatory Integrated System data
- Review of internal investigative files
- Review of employee disclosure forms and personnel records

Analysis techniques used:

- Control review
- Comparison of records among Department divisions
- Comparison of records between the Department and the Office of the Attorney General
- Trend and ratio analysis of inspection results and performance statistics
- Process flowcharting of Department operations
- Comparison of records between the Department and the Department of Health related to nursing facility administrators

Criteria used:

- State Auditor's Office Methodology Manual
- Texas Health and Safety Code
- Code of Federal Regulations
- Other standard audit criteria established during fieldwork

Fieldwork was conducted from December 1996 to April 1997. The audit was conducted in accordance with applicable professional standards, including:

- Generally Accepted Government Auditing Standards
- Generally Accepted Auditing Standards

There were no instances of noncompliance with these standards.

The audit work was performed by the following members of the State Auditor's Office:

- Jon Nelson, CISA (Project Manager)
- Sandy Bootz
- Judy Hatton, CISA
- Michelle Joseph
- Nick Villalpando, CPA
- Tom Wise
- Leslie Ashton, CPA (Quality Control Reviewer)
- Tom Valentine (Audit Manager)
- Craig Kinton, CPA (Director)

Background Information

Appendix 2.1:

Financial Information

Expenditures and number of employees for the Long-Term Care Regulatory program:

	Expended 1995	Estimated 1996	Budgeted 1997
Department of Human Services Strategy 01-02-01 Survey and Certification	\$33,322,070	\$29,960,285	\$29,867,730
Full-Time Equivalent Positions	780.1	776.8	761.7

Total payments made to nursing facilities, which include federal and state funds:

	Expended 1995	Estimated 1996	Budgeted 1997
DHS Strategy 01-01-04 Nursing Facility Payments	\$1,251,763,168	\$1,348,024,022	\$1,437,583,216

Source: Department of Human Services Legislative Appropriations Request for Fiscal Years 1998-99

Appendix 2.2:

Profile of Long-Term Care Regulatory Program

The Long-Term Care Regulatory Division is responsible for licensure, certification, and complaint investigation in nursing facilities, skilled nursing facilities, personal care homes, intermediate care facilities for the mentally retarded, and other long-term care facilities. It also enforces penalties and sanctions against facilities that do not meet state and federal requirements for quality care. The program was transferred from the Department of Health to the Department of Human Services on September 1, 1993.

As of December 31, 1996, the Division reported the following number of long-term care facilities:

Type of Provider	Number of Providers
Nursing Facilities	1,160
Intermediate Care Facilities for Mentally Retarded	889
Personal Care Homes	806
Other Long-Term Care Facilities	406
TOTAL	3,261

References List

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- _____. Office of the State Auditor. *A Review of Contract Monitoring of Purchased Services*. SAO Report No. 95-007. October 1994.
- _____. Office of the State Auditor. *Contract Administration at Selected Health and Human Services Agencies - Phase Three*. SAO Report No. 96-047. February 1996.
- _____. Office of the State Auditor. *An Audit Report on Contract Administration at Selected State Agencies - Phase Four*. SAO Report No. 97-002. September 1996.
- Texas Health Care Association. *Nursing Home Reimbursement and Regulatory Considerations*. May 1994.

Monetary Penalties

Type of Penalty	Range	Statutory Basis	Imposed	Assessed	Collected
Administrative Penalties	\$500 - \$3,000	Texas Health & Safety Code, Chapter 242.066; 40 Texas Administrative Code Section 19.2112	Information not available	\$462,250.00 (from September 1, 1993, to April 18, 1997)	\$337,436.50
Civil Penalties	\$100 - \$10,000/day	Texas Health & Safety Code, Chapter 242.065; 40 Texas Administrative Code Section 19.2110	Information not available	\$418,500.00 (from September 1, 1993, to December 31, 1996)	\$245,500.00
Civil Monetary Penalties	\$50-\$3,000/day; \$3,050-\$10,000/day	42 Code of Federal Regulations; 40 Texas Administrative Code Section 19.2121	\$8,658,450.00 (from July 1, 1995, to October 1, 1996)	\$202,697.50	\$140,460.00

Source: Department of Human Services provided data on administrative penalties and civil monetary penalties; Office of the Attorney General provided data on civil penalties

Administrative Penalties

Administrative penalties are monetary fines for violations of state licensing law or rules. Administrative penalties are applied according to the rules described in the Texas Administrative Code, Section 19.2112.

Civil Penalties

When violations of the licensing standards create a threat to the health and safety of a facility's residents, the Department may refer the matter to the Office of the Attorney General. The Department may request that the Attorney General file a suit for civil penalties.

Civil Monetary Penalties

Civil monetary penalties may be imposed by the State or the Health Care Financing Administration (Administration) for the number of days that a facility is not in substantial compliance with one or more Medicaid/Medicare participation requirements. The State imposes civil monetary penalties for Medicaid-only facilities and the Administration imposes civil monetary penalties for Medicare and dually certified facilities. Civil monetary penalties are used for violations which do create a threat to the health and safety of a facility's residents as well as for those that do not. Civil monetary penalties cannot be collected until the facility has been given the opportunity for a hearing to contest the noncompliance which led to the imposition of the civil monetary penalty. Facilities may waive their right to a hearing; if they do so, the amount of the civil monetary penalty is reduced by 35 percent.

Appendix 5:

Response From the Office of the Attorney General



Office of the Attorney General State of Texas

DAN MORALES
Attorney General

June 3, 1997

Office of the State Auditor
P.O. Box 12067
Austin, Texas 78711-2067

Re: Audit of Long-Term Care Regulatory Report Draft

Dear State Auditors,

I would like to thank you for the opportunity to comment on portions of the above-referenced report that mention the Office of the Attorney General (OAG).

As pointed out on page 14 of the draft, management and staff of the Department of Human Services and the OAG have been holding frequent meetings to address past communications issues and develop solutions. In addition to these meetings, the OAG staff has also been having regular meetings to discuss case review and status with Long-Term Care Regulatory staff. These meetings have been very helpful in improving communications and improving case review.

I believe that both agencies are committed to seeing that the issues you pointed out in your report can be addressed and improved. All parties concerned share the common goal of protecting nursing home residents.

Thank you for your time and effort on this project. If we can be of further assistance, please do not hesitate to contact David Talbot at (512) 936-1105.

Sincerely,

Jorge Vega
First Assistant Attorney General

512/936-1300

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