Department of Health Services

It Has Not Yet Fully Implemented Legislation Intended to Improve the Quality of Care in Skilled Nursing Facilities

REPORT NUMBER 2006-035, FEBRUARY 2007

Department of Health Services' response as of August 2007

The Skilled Nursing Facility Quality Assurance Fee and Medi-Cal Long-Term Care Reimbursement Act (Reimbursement Act), Chapter 875, Statutes of 2004, directed the Bureau of State Audits to review the Department of Health Services' (Health Services)[1] new facility-specific reimbursement rate system. Until the passage of the Reimbursement Act, facilities received reimbursements for Medi-Cal services based on a flat rate. The Reimbursement Act required Health Services to implement a modified reimbursement rate methodology that reimburses each facility based on its costs. In passing the Reimbursement Act, the Legislature intended the cost-based reimbursement rate to expand individual's access to long-term care, improve the quality of care, and promote decent wages for facility workers. The Reimbursement Act also imposed a Quality Assurance Fee (fee) on each facility to provide a revenue stream that would enhance federal financial participation in the Medi-Cal program, increase reimbursements to facilities, and support quality improvement efforts in facilities.

The Reimbursement Act required us to evaluate the progress Health Services has made in implementing the new system for facilities. It also directs us to determine if the new system appropriately reimburses facilities within specified cost categories and to identify the fiscal impact of the new system on the State's General Fund.

Finding #1: Health Services has not yet met all the auditing requirements included in the Reimbursement Act, having reviewed only about two-thirds of the State's facilities.

When a facility reports costs, Health Services has an obligation to perform an audit to ensure that those costs are reasonable. If an audit reveals a discrepancy, Health Services must make an audit adjustment, which becomes the amount Health Services uses to develop the facility's reimbursement rate. In fact, Health Services calculated approximately one-third of all facilities' reimbursement rates using unaudited cost data.

We recommended that Health Services conduct all the audits of facilities called for in the Reimbursement Act to reduce the risk of using flawed data to calculate reimbursement rates.

[1] Effective July 1, 2007, the Department of Health Services was renamed as the Department of Health Care Services as a result of Senate Bill 162.

Audit Highlights . . .

Our review of the Department of Health Services' (Health Services) progress in implementing the Skilled Nursing Quality Assurance Fee and Medi-Cal Long-Term Care Reimbursement Act (Reimbursement Act) revealed:

- *Although Health Services promptly obtained federal approval for the reimbursement rate and fee systems, it was delayed in installing the new rates for Medi-Cal payments.*
- *Health Services has not yet met all of the auditing requirements included in the Reimbursement Act, but has recently hired 20 additional auditors to meet the requirement.*
- *Health Services has not reconciled the fee payments made by facilities to its record of anticipated collections.*
- *Health Services believes the Reimbursement Act will result in General Fund savings. However, the savings projections do not consider $5.2 million in ongoing costs prompted by the act.*
- *Health Services did not follow sound contracting practices when it contracted with its consultant to develop a system to calculate rates.*
- *Health Services was not able to provide the methodology underlying the reimbursement rate system. As a result, we could not verify that the system appropriately calculates rates. To make such a verification in a separate public letter, we asked Health Services to provide a complete and accurate methodology of the system within 60 days of this report's publication.*

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» *Neither Health Services nor its consultants formally made changes to final reimbursement rates or to the reimbursement rate system.*

» *Health Services' contractor responsible for receiving and authorizing payment for Medi-Cal claims, authorized over $3.3 million in duplicate payments to some facilities for the same services.*

» *Health Services and its contractor have begun the process of recouping the duplicate payments.*

Health Services' Action: Partial corrective action taken.

Health Services reported that it plans to use the additional 19 auditor positions and two audit manager positions approved in the 2006–07 budget to conduct audits of all free-standing skilled nursing facilities (facility) as required in the Reimbursement Act. It plans to complete all of the required audits during the 2007–08 production year.

Health Services does not plan to identify which audits it conducted in 2004 stating that the Reimbursement Act was not enacted until 2005. In addition, it believes the number of audits completed in 2005 met the requirements of the Reimbursement Act. However, as stated in the report, before passage of the Reimbursement Act, Health Services conducted a field audit for each facility once every three years. To meet the requirement for the Reimbursement Act, Health Services must continue to complete a field audit once every three years and also complete a desk audit in the years in between. Since Health Services did not distinguish between field and desk audits in its records, it cannot be sure it has met the field audit requirement. We recommend that Health Services look back to the audits completed in fiscal years 2004–05 through 2006–07 to identify which facilities received a field audit within those three years and adjust its audit plan accordingly.

Finding #2: Health Services has not reconciled its fee receipts to its records of anticipated collections.

In addition to new facility rates, the Reimbursement Act established the quality assurance fee to provide a new revenue stream for Health Services. Before it started collecting fee payments, Health Services estimated each facility's annual reported resident days and recorded the estimate in a database. Since the fee amount each facility pays is based on resident days, each facility reports actual resident days for the period and the total fee due when it remits the fee payment. On receiving this information, Health Services records it in the database next to its estimates. However, Health Services had not reviewed these records and as a result it may not have collected all the 2004 fees due. By reviewing its records of fee payments received alongside its estimates, Health Services could have promptly identified delinquent facilities and facilities that have incorrectly reported resident days by investigating reported resident days that vary by more than 5 percent from its estimate.

We recommended that Health Services reconcile the fee payments made by facilities to the estimated payments due and follow up on significant variances. For those facilities that have not paid the full fee, we recommended that Health Services promptly initiate collection efforts.

Health Services' Action: Partial corrective action taken.

Health Services reported that it has begun notifying facilities of outstanding fee balances and is receiving regular responses from those facilities. In addition, it reports that it has completed reconciling its fee payment records and has a process in place for collecting aged fee receivables.

Finding #3: Although the Reimbursement Act allows contracting, we are concerned about Health Services' contracting practices and its continued reliance on contracted services to maintain and update the new reimbursement rate system.

Health Services did not always follow sound contracting practices. The consultant it hired to provide advice and research related to reimbursement rate methodologies was responsible for developing the reimbursement rate system, even though development work was not included in the scope of the contract. Health Services should have included detailed expectations in the contract for the final product. Additionally, it should have required the consultant to document the process used to build the system. Because it failed to include these details in the contract, Health Services does not have a blueprint of the system, leaving it vulnerable in the event of a system failure and at greater risk should the system fall short of Health Services' needs. In fact, when we attempted to replicate the reimbursement rate system that produced the 2005–06 rates, neither Health Services nor its consultant were able to provide a complete methodology used to develop the system. As a result, we have asked Health Services to develop and test formal, accurate and detailed documentation that includes all of the complexities of the rate development methodology within 60 days of this report's publication.

Additionally, Health Services anticipated taking over rate development but did not specify in its contract with its consultant a date for doing so.

We recommended that Health Services amend the contract to clearly describe the scope of work, include a statement that Health Services will obtain the logic and business rules of the reimbursement rate system, and a specific date that Health Services will take over the reimbursement rate calculation. In addition, we requested formal and detailed documentation that includes all of the complexities of the reimbursement rate development with its 60-day response.

Health Services' Action: Partial corrective action taken.

According to Health Services, it prepared a contract amendment that included a turnover plan. This turnover plan required the consultant to provide the logic and business rules of the reimbursement rate system and train Health Services' employees to operate the system. Health Services reported that the amended contract was approved in May 2007. Health Services further stated that its staff has received the training necessary to operate the reimbursement rate system and is working with the consultant to calculate and implement rates for the upcoming year.

Additionally, Health Services provided formal detailed documentation that included all of the complexities of the reimbursement rate development methodology used to produce the reimbursement rates Health Services published for fiscal year 2005–06 in its 60-day response.

Finding #4: Health Services does not have a mechanism in place to record changes made to published rates or the reimbursement rate system.

Health Services does not formally document and record changes to its published rates or changes to its reimbursement rate system. As a result of not keeping formal records, it could not provide an overall record of changes it made to its published rates or the basis for changing those rates. Health Services develops rates for facilities and forwards them to the Electronic Data Systems (EDS), Health Services' consultant. EDS is responsible for entering these rates into its system and applying them to Medi-Cal claims. However, EDS authorized payment for some Medi-Cal claims in fiscal year 2005–06 using rates that were different than those Health Services had published. When asked about changes to the published rates, Health Services stated that most of the changes were probably initiated by the facilities after the rates were finalized. However, since Health Services is responsible for developing rates, it is also responsible for formally tracking changes made to those rates.

In addition, neither Health Services nor the consultant that developed the reimbursement rate system have a formal change control process in place to record programming changes the consultant makes or may need to make to the system.

We recommended that Health Services formalize a rate change process that documents the reason for rate changes and any changes either it or its contractor responsible for administering the system makes to the reimbursement system's programming language.

Health Services' Action: Corrective action taken.

Health Services reported that it has implemented a system that provides an audit trail for any facility rate change. It further stated that it has developed and implemented procedure changes in the system's programming language.

Finding #5: Health Services is to report information that reflects changes in quality of care to the Legislature. Although the law does not require it, we believe including General Fund cost information in those reports would show how the new rates are affecting the General Fund.

Because the Reimbursement Act sunsets on July 1, 2008, the Legislature will be reviewing its overall impact on the quality of care in facilities and its fiscal impact on the State. The Reimbursement Act mandates that Health Services issue reports to the Legislature in January 2007 and January 2008. Both reports are to focus on elements outlined in the Reimbursement Act to give the Legislature an idea of what improvements the increased rates produced. The Reimbursement Act, in its outline of the information that Health Services should include in the reports, did not specify the inclusion of any information related to the effect higher reimbursement rates and the new fee revenue have on overall General Fund expenditures. In addition, although the Reimbursement Act requested that our audit provide information regarding the impact of the new reimbursement rates on the General Fund, we can provide only actual General Fund cost information for fiscal year 2005–06. By including General Fund cost information in both of the required reports from Health Services, the Legislature would have more information to assess the act's true costs and benefits.

We recommended that Health Services include information on any savings to the General Fund in the reports its licensing division is required to prepare.

Health Services' Action: None.

Health Services' Licensing and Certification Division (division) agrees that both cost and benefit information may be useful to the Legislature. However, because General Fund cost information is collected and maintained by either operational areas of the department, the division stated it would have to be prepared by another operational area. Health Services did not state whether it included or intends to include General Fund cost information in its reports to the Legislature.

Finding #6: Health Services ' contractor responsible for receiving and authorizing payment of facility Medi-Cal claims, authorized paying some facilities more than once.

Although this contractor was unaware that it was authorizing duplicate payments, we found more than 2,100 instances of such payments totaling over $3.3 million since October 2005. Because the scope of the audit included only long-term care Medi-Cal payments for the 2005–06 fiscal year, we were unable to reach a conclusion as to whether the duplicate payments extended beyond the population examined.

We recommended that Health Services further investigate the possibility that duplicate payments were authorized by the contract consultant to ensure that the magnitude of the problem is identified and controlled. In addition, we recommended that Health Services begin recouping those duplicate payments.

Health Services' Action: Partial corrective action taken.

After learning that its contractor, EDS, issued duplicate payments, Health Services reported that it took immediate corrective action by implementing a special processing guideline that discontinued the procedure to override suspended claims. It also conducted an investigation to determine the magnitude of the flawed procedure. In its six-month response, Health Services stated that it has also completed its investigation of Medical, Outpatient, and Vision claims and found a similar processing error that resulted in additional erroneous duplicate payments of certain claims. It further reported that it immediately issued a special processing guideline to temporarily correct the processing error while it develops the edit criteria that will permanently correct the error.

Health Services stated that it expects to recover the duplicate payments by issuing two Erroneous Payment Corrections (EPC). Health Services stated that the first EPC will recover approximately $5.3 million in duplicate Long Term Care payments and an additional $780,000 for duplicate or overlapping payments made to one or more different provider entities. The second EPC will recover funds for the Medical, Outpatient and Vision claims by October 2007. However, Health Services stated that it does not yet know the total dollar overpayment for that EPC.