The dollar value of federal civil money penalties assessed against nursing homes increased nearly tenfold over four years.

From FY 1997-98 through FY 2000-01, nursing homes were assessed $1.2 million in civil money penalties. As shown in Table 17, the number of assessments more than quadrupled over this period, and total assessments increased nearly tenfold. Department staff attribute this increase to changes in federal requirements in September 1998 and December 1999 that limited nursing homes' ability to correct certain deficiencies before penalties were imposed if they had been cited for serious deficiencies in the past. The assessment amounts shown in Table 17 reflect any reductions that were negotiated through appeal or settlement.

Table 17

Nursing Home Federal Civil Money Penalty Assessments[1]
FY 1997-98 through FY 2000-01

	1997-98	1998-99	1999-2000	2000-01
Number assessed	7	15	28	33
Average assessment	$8,520	$16,504	$11,321	$16,890
Total assessment	$59,640	$247,557	$316,999	$557,369
Maximum assessment	$17,000	$88,985	$103,000	$245,000
Minimum assessment	$877	$1,430	$390	$1,000

[1] Assessed by statement of deficiency.

Assisted Living Facility Forfeitures

As with nursing homes, forfeitures are the state penalty most frequently imposed on assisted living facilities. Of the 854 penalties imposed on assisted living facilities from FY 1997-98 through FY 2000-01, 578, or 67.7 percent, were forfeitures. These forfeitures totaled $341,266 and were imposed exclusively on community-based residential facilities because the Department did not implement inspections for residential care apartment complexes until 2002, and statutes do not allow the imposition of forfeitures on adult family homes. As shown in Table 18, the average forfeiture assessed per statement of deficiency in FY 2000-01 was $507, while the maximum forfeiture assessed was $12,200.

Table 18

Assisted Living Facility Forfeiture Assessments[1]
FY 1997-98 through FY 2000-01

	1997-98	1998-99	1999-2000	2000-01
Number assessed	86	127	175	190
Average assessment	$488	$599	$725	$507
Total assessment	$41,957	$76,019	$126,898	$96,392
Maximum assessment	$4,000	$6,200	$30,180	$12,200
Minimum assessment	$50	$49	$100	$50

[1] Includes community-based residential facilities only. Assessed by statement of deficiency.

Forfeiture notices are sent to assisted living facilities at the same time statements of deficiency are issued. Statutes require the forfeitures to be paid within ten days of receipt of the assessment and do not provide a discount for timely payment. The assisted living facility providers with whom we spoke did not express concern about the timeliness of forfeiture assessment.

The Department has not developed written criteria for use in determining forfeiture amounts for assisted living facilities.

Assisted living facility forfeitures are not based on written criteria such as statutes, administrative code, or the Department's formal written policies. Rather, regional and central office staff confer to determine forfeiture amounts based on a facility's compliance record and the Department's treatment of other facilities for similar violations. Such a practice, which relies exclusively on the individual judgements of staff, could lead to inconsistencies. Therefore, *we recommend the Department of Health and Family Services establish a written procedure to guide the assessment of forfeitures for assisted living facilities.*

Other Penalty Options

In addition to state forfeitures and federal civil money penalties, the Department may assess a number of other penalties on nursing homes and assisted living facilities that do not comply with state or federal regulations. These other options, which are listed in Table 19, range from restrictions on admissions or federal reimbursements to licensure constraints and management controls. In addition, the Department of Justice may issue state criminal charges against a facility, individual nursing home administrators, or facility staff members.

Table 19

Other Penalties for Nursing Homes and Assisted Living Facilities
By Type of Violation

Other Penalties	Nursing Home Violations		Assisted Living Facility Violations
	Federal	State	State
Restrictions on Admissions or Reimbursement			
Suspension of new admissions	●[1]	●	●
Suspension or denial of federal payment	●		
Licensure Constraints			
Conditional license		●	●
License suspension		●	●[2]
License revocation		●	●
Management Controls			
State monitoring	●	●	●[3]
Temporary management	●		
Receivership		●	●[3]
State Criminal Charges		●	●

[1] Federal suspension of new admissions applies to Medicare and Medicaid residents only.
[2] This penalty is not applicable to adult family homes.
[3] This penalty is applicable to community-based residential facilities only.

Restrictions on Admissions or Reimbursement

Nursing home admissions may be restricted for violations of state or federal regulations; only the State can restrict new admissions to assisted living facilities because federal regulations do not apply to these facilities. According to staff in the Department, restricting new admissions can be an effective enforcement option. However, the Department has not imposed admissions restrictions on nursing homes because s. 50.04(4)(d), Wis. Stats., limits its ability to do so in a timely manner. The statute allows the Department to suspend admissions of new residents to nursing homes with serious violations of state statutes or administrative code when subsequent serious violations are cited. However, nursing homes must have a history of serious violations in order for the penalty to be considered, and they have 90 days to correct the violation before the Department can suspend new admissions.

Admissions have been restricted in assisted living facilities but not in nursing homes.

In contrast, statutes allow the Department to suspend new admissions to assisted living facilities at the same time a statement of deficiency is issued, which provides an immediate penalty. Of the 854 penalties imposed on assisted living facilities from FY 1997-98 through FY 2000-01, 60, or 7.0 percent, involved suspensions of new admissions. Most of these suspensions were for community-based residential facilities.

Because restricting admissions may be effective in compelling compliance with regulations and because current statutory authority limits the instances in which it may be used, *we recommend the Legislature amend s. 50.04(4)(d), Wis. Stats., to allow the Department of Health and Family Services to restrict nursing home admissions in a more timely manner.*

Reimbursement for Medicaid or Medicare residents may be restricted to compel compliance.

Federal regulations permit a number of additional restrictions on nursing home admissions or reimbursement. Specifically:

- The State may restrict admissions by suspending Medicaid and Medicare reimbursement for new residents. The requirements regarding the types of violations that must have occurred before this penalty is imposed are less stringent than the requirements for a state penalty. In FY 2000-01, federal suspension of reimbursement for new admissions was imposed on nine nursing homes.

- The federal government may suspend reimbursement for all Medicaid and Medicare residents in a nursing home. In FY 2000-01, this penalty was not imposed on any Wisconsin nursing homes.

- The federal government may restrict reimbursement by terminating its agreement with the nursing home to participate in Medicaid and Medicare, which ends federal funding to the facility. This penalty is usually imposed if there is immediate jeopardy to resident health or safety, or if the facility does not achieve substantial compliance within six months of the inspection that found noncompliance. In FY 2000-01, no providers were terminated from the federal programs.

Licensure Constraints

Suspending, revoking, or placing conditions on the licenses of nursing homes or assisted living facilities is another means by which the Department can enforce compliance with state—but not federal—regulations. License revocation, which closes a facility, is one of the most severe penalties that can be imposed; in addition to affecting revenue, it affects employees and is disruptive to residents, who must find alternative placements. Revocation is, therefore, considered a penalty of last resort and is typically imposed either after other penalties fail to compel compliance or when there is an immediate and direct threat to the health, safety, and welfare of residents.

License revocation has been used against 29 assisted living facilities.

Conditional licenses require nursing homes to meet certain conditions, such as hiring a consultant with expertise in areas in which the home has been issued citations. From FY 1997-98 through FY 2000-01, the Department issued three conditional nursing home licenses but did not revoke or suspend any nursing home licenses. However, 29 assisted living facilities faced license revocation during that period.

Management Controls

Management controls that restrict a nursing home or assisted living facility provider's ability to operate independently include:

- state monitoring, which can be imposed on nursing homes and community-based residential facilities, but not other types of assisted living facilities;
- temporary management, which can be imposed only on nursing homes; and
- receivership, which can be imposed on nursing homes and community-based residential facilities, but not other types of assisted living facilities.

These controls have not been used frequently for nursing homes because operators have the opportunity to correct violations before they are imposed, the controls may be imposed only after serious problems have developed or persisted, and the cost involved in imposing them can be high and may be incurred by the Department. They have never been applied to assisted living facilities.

When a long-term care provider is monitored, an employee or contractor of the State is assigned to oversee the correction of cited deficiencies. Monitoring is intended to be a safeguard against further harm to residents when harm or a situation with potential for harm has occurred.

Monitoring may be imposed when nursing homes violate either state or federal regulations; the criteria for determining that the penalty is appropriate are similar for both types of violations. Statutory conditions under which a monitor may be used to correct state violations include:

- lack of a valid license, or suspension or revocation of the existing license by the Department;
- pending closure of the nursing home without adequate arrangements for relocation of residents; or
- the existence of an emergency, as determined by the Department, that threatens the health, safety, or welfare of the residents.

Nursing home monitoring was imposed three times in FY 2000-01.

The Department notes that the federal government does not fund the costs of monitors, even in response to violations of federal regulations, and will not permit the State to charge a facility for a monitor. The cost of a monitor, which the Department reports can be as high as $80 per hour, would therefore be incurred by the State, and the Department reports that it does not have funds available for this purpose. Statutes allow the Department to charge a facility for the cost of a monitor that is imposed in response to a violation of state regulations, but in many cases nursing homes do not have the funds to pay for monitors and, therefore, appeal the penalty. The Department indicates that monitoring was imposed three times in FY 2000-01.

Temporary management, in which the State selects or recommends a person to manage a nursing home, oversee correction of deficiencies, and ensure the health and safety of residents while the corrections are being made, may be imposed when the nursing home has violated federal regulations that rise to the level of immediate jeopardy or when there are widespread deficiencies constituting actual harm to residents. The temporary manager has the authority to hire, terminate, or reassign staff; obligate funds; alter procedures; and otherwise manage a nursing home to correct operational deficiencies. Federal regulations require nursing homes to pay the salaries of temporary managers. In FY 2000-01, temporary management was not imposed on any nursing home in Wisconsin.

One skilled nursing facility has been placed in receivership.

When a nursing home or assisted living facility is placed in receivership, the Department becomes the license holder and is responsible for daily operations until residents can be relocated and the nursing home or assisted living facility can be closed. The Department may place nursing homes or community-based residential facilities, but not other types of assisted living facilities, in receivership for violating state regulations. As noted, this penalty has never been applied to community-based residential facilities, and it is rarely used for nursing homes because

of the expense involved for the State. From FY 1997-98 through FY 2000-01, the Department placed one skilled nursing facility in receivership. In addition, three facilities for the developmentally disabled, which are another type of nursing home, were placed in receivership during this time period. The Department indicated that it contracts for receivership services because it does not have the staff to operate a nursing home or assisted living facility full-time.

The Department believes that increased use of other state penalties might help to prevent the conditions that lead to receivership, and the Department is developing a proposal to amend ch. 50, Wis. Stats., to allow for the imposition of other penalties before conditions at nursing homes become serious enough for receivership. The proposal includes:

- allowing monitoring for nursing homes that the Department has identified as being financially unstable, which will be defined by the Department in cooperation with provider groups;

- allowing monitoring for nursing homes that frequently cycle in and out of compliance with regulations;

- allowing conditional licenses to be imposed before a nursing home has a serious violation that persists; and

- allowing for probationary licenses that extend beyond the 12 months currently allowed.

State Criminal Charges

The Department of Justice's Medicaid Fraud Control Unit or local law enforcement may file criminal charges against either facility operators or individual caregivers based on information gathered through the regulation of nursing homes and assisted living facilities. Department of Justice data indicate one assisted living facility, one facility for the developmentally disabled, and 24 individual caregivers were charged with criminal resident abuse and/or neglect from July 1999 through June 2002.

The Department of Justice investigates resident abuse or neglect, misappropriation of resident funds, and Medicaid fraud.

The Medicaid Fraud Control Unit is responsible for compliance with federal regulations that direct states to investigate Medicaid fraud and allegations of resident abuse or neglect, as well as misappropriation of resident funds for Medicaid recipients. Currently, one attorney directs the unit's two staff attorneys, six investigators, and two administrative support staff. The unit is funded by a federal matching grant that supports 75 percent of its costs; the remaining 25 percent is funded by GPR.

The Medicaid Fraud Control Unit gathers information on potential criminal resident abuse or neglect cases primarily from the Department of Health and Family Services, as well as private citizens, local law enforcement, and providers. While the Department of Health and Family Services investigates noncompliance with state and federal regulations, as well as instances of caregiver misconduct that may result in civil findings against individuals, the Department of Justice determines whether criminal conduct has occurred.

We also note that staff from the Department of Health and Family Services participate in monthly meetings to share information regarding potential resident abuse or neglect with representatives of the Medicaid Fraud Control Unit, the Western and Eastern U.S. Attorney's offices, the Department of Regulation and Licensing, the Board on Aging and Long-Term Care, and others. Department of Health and Family Services' staff present information related to nursing homes that have received citations for which actual harm to residents occurred, and assisted living facilities facing serious accusations of resident abuse or neglect.

From January 2000 through July 2002, the Department of Health and Family Services made 194 referrals to the Department of Justice that included:

- 181 referrals involving skilled and intermediate care nursing homes and facilities for the developmentally disabled; and

- 13 referrals involving assisted living facilities.

At the Department of Justice, if a preliminary review warrants further examination, the case is referred to a team of one investigator and one attorney in the Medicaid Fraud Control Unit. These staff investigate and evaluate cases to determine whether criminal charges can be supported and should be filed. These determinations require legal judgement on the quality and credibility of available evidence and witnesses, as well as whether the legal standard of beyond a reasonable doubt can be met. Between July 1, 1999 and June 30, 2002, the Department of Justice was

notified of approximately 845 instances of potential resident abuse or neglect, and 265 instances of potential misappropriation of resident funds.

From July 1999 through June 2002, criminal complaints were issued against two long-term care facilities.

As of June 2002, complaints were issued by the Department of Justice against one assisted living facility and one facility for the developmentally disabled:

- In January 2002, criminal charges were filed against Homes for Independent Living, located in Jefferson County, regarding the Linden Corners community-based residential facility. In August 2002, the company paid $20,000 in penalties as part of a settlement agreement with the Department of Justice.

- In February 2002, criminal charges were filed against Benchmark Healthcare of Wisconsin, Inc., located in Milwaukee County, regarding The Jackson Center, a facility for the developmentally disabled. In June 2002, Benchmark entered a no-contest plea and was convicted of five felony counts and one misdemeanor count of resident abuse, four felony counts of neglect of a resident, and one felony count of second-degree sexual assault. As a result, the corporation was ordered to pay $101,000 in fines.

As of June 2002, criminal charges had been filed against 24 caregivers for resident abuse or neglect, and against 4 caregivers for misappropriation of resident funds. Since no reporting is required from local law enforcement agencies to the Department of Health and Family Services, the Department does not track the outcomes of all criminal cases. The analyses that would be required to evaluate the efficiency and effectiveness of enforcement activities involving criminal charges were outside the scope of this evaluation.

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Informal dispute resolution is available only to nursing homes.

Although the inspection process is designed so that concerns can be addressed in daily meetings and an end-of-inspection conference, providers sometimes disagree with inspectors' findings and the citations issued. A nursing home that disagrees with a citation may participate in the informal dispute resolution process that has been required by federal regulations since 1995, file a formal appeal, or both. From FY 1997-98 through FY 2000-01, nursing homes requested informal dispute resolution for an estimated 12.4 percent of all federal citations and 18.0 percent of all state citations. However, they have expressed concerns related to the outcomes and the timeliness of the informal dispute resolution process. The formal appeals process, which is available to both nursing homes and assisted living facilities, is not used frequently by either type of long-term care provider.

Informal Dispute Resolution

The informal dispute resolution process is intended to resolve differences between nursing homes and the Department in a timely manner and to prevent costly and time-consuming formal appeals. We analyzed the outcomes and timeliness of the informal dispute resolution process from FY 1997-98 through FY 2000-01.

Outcomes of Informal Dispute Resolution

Contested nursing home citations were not changed in 50.5 percent of informal dispute resolution decisions.

From FY 1997-98 through FY 2000-01, informal dispute resolution was requested for 1,972 citations, and we were able to analyze the outcomes of 1,657. Providers withdrew requests for informal dispute resolution for 160 of the 1,657 citations. As shown in Table 20, 50.5 percent of decisions for the remaining 1,497 disputed nursing home citations resulted in no change, and 15.7 percent of the decisions resulted in deletion of citations from the statement of deficiency. The number of decisions in which citations were deleted increased from 12.1 percent of decisions for FY 1997-98 to 23.0 percent of decisions for FY 2000-01.

Many informal dispute resolution decisions resulted in citations that were partially rewritten. For example, wording was changed in 17.7 percent, examples were deleted in 11.1 percent, the severity level was changed in 3.2 percent, and regulatory references were changed in 1.3 percent. Outcomes of informal dispute resolution for federal and state citations are shown separately in Appendix 6.

Table 20

Informal Dispute Resolution Decisions
FY 1997-98 through FY 2000-01

Decision	1997-98	1998-99	1999-2000	2000-01	Total	Percentage
No change to citation	238	195	167	156	756	50.5%
Specific wording changed	68	71	56	70	265	17.7
Citation deleted	54	53	44	84	235	15.7
Examples deleted	56	50	25	35	166	11.1
Severity level changed	22	9	6	11	48	3.2
Regulation or code changed	8	2	3	7	20	1.3
Other	2	1	1	3	7	0.5
Total	448	381	302	366	1,497	100.0%

Timeliness of Informal Dispute Resolution Decisions

Federal regulations require that nursing homes request informal dispute resolution within ten days of receiving a statement of deficiency. Nursing homes are required to submit specific information that refutes or clarifies information contained in the statement of deficiency, explain why this information was not available during the inspection, and identify the resolution sought.

Federal regulations allow states discretion in determining who will conduct reviews and how reviews will be conducted, as well as in establishing a time line for the process. The Department used its discretion to establish a policy that:

- allows providers to request informal dispute resolution for both federal and state citations, although not for state forfeitures;
- allows providers to request an in-person meeting or a telephone conference call within 3 days or a desk review within 10 days of receiving a statement of deficiency;

- requires providers to submit additional documentation within 7 to 10 days of receiving a statement of deficiency, depending on the type of review requested; and

- requires the Department to issue a decision within 21 days of issuing a statement of deficiency.

Only 32.5 percent of the Department's decisions met its timeliness standard.

As shown in Table 21, the Department met its 21-day standard for timeliness for only 32.5 percent of decisions from FY 1997-98 to FY 2000-01. During that period, providers requested either an in-person meeting or a telephone conference call for 88.1 percent of citations contested through the informal dispute resolution process. Desk reviews, which are significantly less time-consuming, were requested for 10.8 percent of citations. Department staff attribute the delay in issuing informal dispute resolution decisions to the workload being too great for one staff person to manage; from April 2000 through June 2002, one staff person was assigned to this task.

Table 21

Informal Dispute Resolution Decision Notification Timeliness
FY 1997-98 through FY 2000-01

Days to Notification[1]	1997-98	1998-99	1999-2000	2000-01	Total	Percentage
0-21 days	191	152	113	31	487	32.5%
22-54 days	210	221	166	235	832	55.6
55-70 days[2]	47	8	23	58	136	9.1
More than 70 days	0	0	0	42	42	2.8
Total	448	381	302	366	1,497	100.0%

[1] From the day the nursing home receives the statement of deficiency.
[2] Department policy suggests inspectors conduct verification visits during this time, which is 45-60 days after the inspectors leave the facility. Federal regulations require inspectors to conduct verification visits by the end of this time.

Methods used by other midwestern states may assist with timeliness.

Other midwestern states report mixed success in meeting their timeliness standards for issuing informal dispute resolution decisions, which range from approximately 20 to 40 days after a facility receives the statement of deficiency. However, the limits that some states place on their review process may assist them in issuing timely decisions. For example, Michigan allows in-person conferences only in rare instances,

Ohio does not offer them at all, and Illinois restricts them to serious federal citations only and holds them at department offices. Indiana, Iowa, and Minnesota all allow providers to choose a desk review or in-person conference but limit in-person conference time to one hour.

From January 1995 through March 2000, the Department's five regional managers decided informal dispute resolution cases for providers in their respective regions. Beginning in July 2002, the Department returned responsibility for informal dispute resolution decision-making to these regional managers. This action may improve timeliness. The Department could consider a number of other options to improve the timely issuance of decisions, including:

- revising the informal dispute resolution policy to limit citations for which informal dispute resolution may be requested, such as federal citations only;

- revising the informal dispute resolution policy to limit in-person conferences to serious citations only and/or to restrict their length; or

- conducting all informal dispute resolution conferences at offices of the Department.

To apprise the Legislature of its efforts to improve the timeliness of decisions it issues in the nursing home informal dispute resolution process, *we recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by July 1, 2003, on:*

- *the effect on timeliness of returning responsibility for informal dispute resolution decision-making to regional managers;*

- *the number of cases resolved through informal dispute resolution; and*

- *the number of cases resolved through informal dispute resolution that were subsequently appealed.*

Although the regional managers do not review citations issued by inspectors they supervise, providers remain concerned about both the potential for inconsistent decision-making among regions and the independence of the five managers. In addition, nursing home providers have previously expressed concern that the staff who resolve informal disputes do not have formal medical credentials. Federal regulations do not require a medical background for informal dispute resolution

decision-makers; they only encourage states to include at least one person not directly involved in the inspection in the informal dispute resolution decision-making process. We also found that other midwestern states do not always have staff with medical backgrounds conducting informal dispute resolution. For example, although a panel of physicians and nurses conducts informal dispute resolution in Michigan, attorneys serve as the decision-makers in Iowa. In Illinois, Indiana, Minnesota, and Ohio, current or former inspectors and supervisors of inspectors conduct informal dispute resolution. These staff are usually registered nurses, social workers, or dieticians.

A more independent process for informal dispute resolution is being tested by the federal government.

According to the federal Centers for Medicare and Medicaid Services, the current informal dispute resolution process, as required by federal regulations, is not universally regarded as an objective process that adequately addresses disagreements about noncompliance with federal regulations. As a result, the Centers for Medicare and Medicaid Services are currently conducting a federally funded pilot project in Iowa and Texas to test the effectiveness of an independent informal dispute resolution process. In this pilot, organizations or individuals not associated with or employed by the state inspection agency or the nursing home industry are responsible for coordinating informal dispute resolution. Results of the project are expected in summer 2003.

Appeals Process

A formal appeals process is available to both assisted living facilities and nursing homes.

Federal regulations allow nursing homes to appeal to the federal Department of Health and Human Services (DHHS) when federal citations result in penalties. Under state regulations, nursing homes and assisted living facilities may appeal both statements of deficiency for state citations and forfeiture amounts they have been assessed for these citations to the Department of Administration's Division of Hearings and Appeals (DHA).

In FY 2000-01:

- 788 statements of deficiency were issued to nursing homes for federal violations, and 10 nursing home providers filed appeals with DHHS;
- 316 statements of deficiency were issued to nursing homes for state violations, and 96 appeals were filed with DHA;
- 116 state forfeitures were assessed against nursing homes, and 14 appeals were filed with DHA; and

- 808 statements of deficiency were issued to assisted living facilities, and 34 of these statements of deficiency and associated forfeitures were challenged in appeals filed with DHA.

It should be noted that appeals filed during FY 2000-01 may reflect citations, statements of deficiency, or forfeiture assessments issued during FY 1999-2000.

Federal citations are appealed to the federal government.

After receipt of a statement of deficiency containing a federal citation, nursing home providers are granted 60 days under federal law to request a hearing before an administrative law judge at DHHS. The decision of this judge may be appealed to the DHHS Appeals Board, which is a panel of three administrative law judges. A nursing home provider has 60 days to file an appeal of the Appeals Board's decision with a federal district court. Appeals Board decisions regarding civil money penalties must be reviewed by the federal court of appeals, rather than a federal district court. Federal law does not allow the federal government to appeal decisions of the DHHS Appeals Board.

For violations of state regulations, Wisconsin law allows nursing home and assisted living providers ten days to file an appeal with DHA after receiving a statement of deficiency or a forfeiture assessment. Wisconsin law gives providers the right to a hearing within 30 days of the date the appeal was filed, but staff in the Department indicate that many providers waive their right to a timely hearing. On appeal to DHA, the State must prove that the factual basis of a citation is valid and that assessed forfeitures were reasonable. Either the State or the provider may appeal decisions issued by DHA to circuit court. Rather than conducting an examination of the validity of the statement of deficiency or forfeiture assessment, the circuit court focuses on whether the DHA judge exceeded his or her legal authority.

From FY 1998-99 through FY 2000-01, 79.1 percent of appeals filed with DHA were closed before hearings were held.

As shown in Table 22, 79.1 percent of appeals filed from FY 1998-99 through FY 2000-01 were closed before hearings were held. Many providers indicate that they file appeals in order to preserve their right to do so while the matter is also examined through the informal dispute resolution process. If providers accept the outcome of informal dispute resolution, they withdraw their requests for appeal to DHA.

Table 22

Appeals Filed with the Division of Hearings and Appeals
FY 1998-99 through FY 2000-01

Timing of Closure	Appeals	Percentage
Appeals closed prior to hearing	405	79.1%
Appeals closed via hearing	21	4.1
Appeals unresolved	86	16.8
Total	512	100.0%

Extending the time to request an appeal to 60 days would parallel the federal appeals process. Since the majority of existing appeals are closed before they are heard but entail administrative costs for providers, the Department, and DHA, *we recommend the Legislature modify ch. 50, Wis. Stats., to create a 60-day time frame for providers to file appeals after receiving statements of deficiency for state violations.*

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Appendix 1

Federal Categories of Scope and Severity for Nursing Home Citations

Federal nursing home citations can be categorized according to the four levels of severity and three scope or frequency measures shown in the first table. Federal nursing home citations are shown by severity level in the second table.

Federal Categories of Scope and Severity

Level of Severity	Scope or Frequency		
	Isolated	Pattern	Widespread
No actual harm but potential for minimal harm	A	B	C
No actual harm but potential for more than minimal harm	D	E	F
Actual harm but not immediate jeopardy	G	H	I
Immediate jeopardy to resident health or safety	J	K	L

Nursing homes are considered in "substantial compliance" with federal regulations for citations issued at levels A, B, and C when no actual harm occurs but there is potential for minimal harm. Citations at levels D through L indicate that a nursing home is "out of substantial compliance."

Nursing homes are determined to have "substandard quality of care" when they receive citations at levels F, H, I, J, K, and L involving resident behavior and facility practices, quality of life, or quality of care.

Federal Nursing Home Citations by Level of Severity
FY 1997-98 through FY 2000-01

Level of Severity	1997-98	1998-99	1999-2000	2000-01	Total
No actual harm but potential for minimal harm	383	408	312	354	1,457
No actual harm but potential for more than minimal harm	2,066	2,266	1,862	2,245	8,439
Actual harm but not immediate jeopardy	190	183	182	142	697
Immediate jeopardy to resident health or safety	2	12	24	23	61
Severity level not available	6	6	5	2	19
Total	2,647	2,875	2,385	2,766	10,673

Appendix 2

State Categories of Severity for Nursing Home Citations

State nursing home citations can be categorized according to the four levels of severity and three statutory classifications shown in the first table. State nursing home citations are shown by severity level in the second table. The third table shows the average number of state nursing home citations issued during routine inspections.

State Categories of Severity

Level of Severity	Statutory Classification	Explanation
Correction orders for no direct threat to resident health, safety, or welfare	Class C	Relates to the operation and maintenance of a home without threat to residents' health, safety, or welfare; issued when the provider has not violated the same statute or administrative rule in the previous two years
No direct threat to resident health, safety, or welfare	Class C	Relates to the operation and maintenance of a home without threat to residents' health, safety, or welfare
Directly threatens resident health, safety, or welfare	Class B	Directly threatens residents' health, safety, or welfare; similar to federal violations with potential for harm or actual harm
Substantial probability for death or serious harm	Class A	Involves death or serious harm, or their substantial probability; similar to federal immediate jeopardy violations

State Nursing Home Citations by Level of Severity
FY 1997-98 through FY 2000-01

Level of Severity	1997-98	1998-99	1999-2000	2000-01	Total
Correction orders for no direct threat to resident health, safety, or welfare	201	228	198	191	818
No direct threat to resident health, safety, or welfare	8	26	20	21	75
Directly threatens resident health, safety, or welfare	180	240	235	230	885
Substantial probability for death or serious harm	11	13	24	21	69
Severity level not available	4	3	2	7	16
Total	404	510	479	470	1,863

Average Number of State Nursing Home Citations Issued During Routine Inspections
FY 1997-98 through FY 2000-01

Region	1997-98	1998-99	1999-2000	2000-01
Northeastern	0.3	0.3	0.2	0.3
Northern	0.3	0.3	0.3	0.6
Southeastern	0.3	0.4	0.5	0.4
Southern	0.1	0.4	0.3	0.2
Western	0.5	0.6	0.5	0.6
Statewide average	0.3	0.4	0.4	0.4

Appendix 3

Nursing Home and Assisted Living Facility Citations by Region

State Nursing Home Citations
FY 1997-98 through FY 2000-01

Region	FY 1997-98	FY 1998-99	FY 1999-2000	FY 2000-01	Total
Northeastern	75	75	51	58	259
Northern	33	31	34	61	159
Southeastern	122	157	192	155	626
Southern	27	67	54	33	181
Western	147	180	148	163	638
Total	404	510	479	470	1,863

Percentage of State Nursing Home Citations by Level of Severity
FY 1997-98 through FY 2000-01

Level of Severity	Northeastern	Northern	Southeastern	Southern	Western	Total
Correction orders for no direct threat to resident health, safety, or welfare	16.3%	5.1%	25.8%	8.4%	44.4%	100.0%
No direct threat to resident health, safety, or welfare	12.0	4.0	22.7	1.3	60.0	100.0
Directly threatens resident health, safety, or welfare	12.0	11.5	42.5	11.2	22.8	100.0
Substantial probability for death or serious harm	7.3	15.9	29.0	13.0	34.8	100.0
Severity level not available	37.5	6.3	12.5	18.7	25.0	100.0

Federal Nursing Home Citations
FY 1997-98 through FY 2000-01

Region	FY 1997-98	FY 1998-99	FY 1999-2000	FY 2000-01	Total
Northeastern	470	298	263	301	1,332
Northern	258	278	249	337	1,122
Southeastern	966	1,005	932	938	3,841
Southern	359	562	467	650	2,038
Western	594	732	474	540	2,340
Total	2,647	2,875	2,385	2,766	10,673

Percentage of Federal Nursing Home Citations by Level of Severity
FY 1997-98 through FY 2000-01

Level of Severity	Northeastern	Northern	Southeastern	Southern	Western	Total
No harm but potential for minimal harm	19.7%	17.2%	20.7%	11.5%	30.9%	100.0%
No harm but potential for more than minimal harm	11.2	9.1	38.2	20.9	20.6	100.0
Actual harm but not immediate jeopardy	13.5	12.8	40.7	13.8	19.2	100.0
Immediate jeopardy to resident health or safety	6.6	22.9	26.2	16.4	27.9	100.0
Severity level not available	0.0	5.3	89.4	0.0	5.3	100.0

Assisted Living Facility Citations
FY 1997-98 through FY 2000-01

Region	FY 1997-98	FY 1998-99	FY 1999-2000	FY 2000-01	Total
Northeastern	252	629	1,060	582	2,523
Northern	32	342	264	1,291	1,929
Southeastern	553	1,394	1,115	1,517	4,579
Southern	843	742	1,421	666	3,672
Western	185	1,285	791	426	2,687
Total	1,865	4,392	4,651	4,482	15,390

Appendix 4

Estimated Medicaid Reimbursement

Some suggest that the percentage of allowable Medicaid costs reimbursed is an indicator of the ability of a nursing home to provide quality care, and nursing home providers and their professional associations have expressed concern over the adequacy of reimbursement they receive through the Medicaid program. However, we updated a Legislative Fiscal Bureau analysis and found, in most cases, no statistically significant relationship between the percentage of allowable costs reimbursed and a number of factors identified as being related to a nursing home's ability to provide quality care.

Estimated Percentage of Allowable Costs Reimbursed

The Department reimburses nursing homes for care provided to Medicaid recipients through payments based on a daily rate, adjusted for resident care levels. The daily rate is contingent upon the amount of funding appropriated by the Legislature for nursing home reimbursement and the estimated costs of nursing homes statewide, based on their prior year costs. In setting the daily rate, state law allows the Department to consider nursing homes' over-the-counter drug expenses but requires that it consider six cost centers, including:

- direct care, which includes the staffing costs of nurses and certified nursing assistants;
- support services;
- administrative and general;
- fuel and other utilities;
- property taxes, municipal services, or assessments; and
- capital.

Because of limited federal and state funding to reimburse facilities, the Department establishes maximum rates of reimbursement for each cost center. In general, as long as a home's costs do not exceed the maximum rates, it will be reimbursed for its expenditures. However, if a home's expenditures exceed the maximum rates, even if its costs are determined to be allowable according to federally established criteria, it will have its expenditures reimbursed only up to the maximum rate.

To quantify the extent to which homes have allowable costs that are not reimbursed, the Wisconsin Health Care Association and the Wisconsin Association of Homes and Services for the Aging employed BDO Seidman, a private consulting firm, to analyze the percentage of allowable costs reimbursed to nursing homes through the State's reimbursement formula. That analysis, released in September 2000, included the skilled nursing facilities, intermediate care facilities, and facilities for the developmentally disabled whose prior-year cost reports were available at the time. It estimated that 17 percent of the 328 nursing homes included in its analysis were reimbursed for all of their allowable Medicaid costs in FY 1999-2000.

In June 2001, the Legislative Fiscal Bureau prepared a similar analysis for the 2001-03 biennial budget deliberations; that analysis also reflected estimated reimbursement in FY 1999-2000 but incorporated additional payments to nursing homes that were not included in the BDO Seidman report, including supplemental payments to county and municipally owned nursing homes and the wage pass-through, which were payments authorized by the Legislature to improve the ability of homes to compensate direct care staff. Additionally, the Legislative Fiscal Bureau included 402 nursing homes in its analysis, 74 more than the 328 included in the BDO Seidman study. The Legislative Fiscal Bureau estimated that 24 percent of the nursing homes included in its analysis were fully reimbursed for their allowable costs, while about 77 percent of homes had an estimated 90 percent or more of their allowable costs reimbursed.

We updated the Legislative Fiscal Bureau analysis to estimate reimbursement in FY 2000-01. However, in order to be consistent with other analyses in this report, we included only skilled or intermediate care nursing homes that were certified to receive funding through the federal Medicaid or Medicare programs. In addition, we excluded facilities with special circumstances, such as a large decrease in licensed beds, which would have made estimates less reliable. As shown in the table that follows, we estimate that 9.9 percent of homes in our analysis had their allowable Medicaid costs fully reimbursed in FY 2000-01, while 61.8 percent had an estimated 90.0 percent or more of their allowable costs reimbursed. Statewide, an estimated 88.6 percent of allowable costs were reimbursed.

Estimated Percentage of Allowable Medicaid Costs Reimbursed
FY 2000-01

Estimated Percentage of Costs Reimbursed	Number of Facilities	Percentage of Facilities
0% to 49%	1	0.3%
50% to 59%	3	0.8
60% to 69%	10	2.7
70% to 79%	45	12.3
80% to 89%	81	22.1
90% to 99%	190	51.9
100% or more	36	9.9
Total	366	100.0%

As was shown in the table, 36 facilities in our analysis received reimbursement of 100 percent or more of their allowable costs. The Department makes a number of additional payments to nursing homes that may increase the estimated percentage of allowable costs reimbursed above 100 percent, including:

- intergovernmental transfers to county-owned nursing homes;
- wage pass-through payments to improve the ability of homes to compensate direct care staff; and
- other programs that provide additional funding for homes with specific characteristics, such as those that have undertaken energy savings projects, those with a high percentage of private rooms, and those with a high percentage of Medicaid or Medicare residents.

It should be noted, however, that even homes receiving reimbursement totaling more than 100 percent of their allowable costs likely have less than 100 percent of their total costs reimbursed, as not all costs incurred by a nursing home are reimbursable under federal Medicaid regulations.

Although the percentage of allowable Medicaid costs reimbursed provides a picture of the degree to which homes have made expenditures recognized as appropriate by the federal government for which they are not reimbursed, it provides an incomplete explanation of a facility's ability to provide quality care. For example, facilities receive other sources of revenue, such as fees from residents who pay for care with their own funds. Additionally, a facility may be reimbursed a lower percentage of its allowable costs because it is spending more on resident care than the maximum reimbursement rate. As such, the quality of care may be better at a facility with a lower percentage of Medicaid costs reimbursed than at a facility with a higher percentage of costs reimbursed, which may be reflective of that facility's inability to provide additional resources beyond those reimbursed through Medicaid.

Relationship to Other Facility Characteristics

To determine whether a relationship existed between the estimated percentage of allowable costs reimbursed through the Medicaid formula in FY 2000-01 and various factors thought to be indicative of quality, we performed statistical analyses. Specifically, we reviewed:

- the number of state and federal citations;
- the number of complaints investigated by the Department;
- the amounts of state forfeitures and federal civil money penalties that were assessed and paid;
- measures of capacity and volume, including the number of licensed beds and total patient days; and
- facility staff turnover, including registered nurses, licensed practical nurses, and certified nursing assistants.

In most cases, we could not establish any statistical relationship between the estimated percentage of costs reimbursed and these facility characteristics. For example, there was no consistent pattern of citations, forfeitures, or turnover among facilities with either a high or low percentage of allowable costs reimbursed. However, we were able to identify a weak statistical relationship between the estimated percentage of allowable costs reimbursed and both the number of licensed beds in a home and the total number of patient days, which is a measure of the volume of residents served each day over the course of the year. Specifically, we identified a weak inverse relationship in both cases, indicating that homes with a higher estimated percentage of allowable costs reimbursed tended to also have a relatively smaller number of licensed beds and total patient days, and vice versa. It should be noted, however, that these analyses do not support a causal relationship.

In addition to performing statistical analyses on the total number of citations, we compared the severity of federal citations to the estimated percentage of allowable costs reimbursed by grouping homes according to the severity of citations received. Of the 366 homes in our analysis:

- 80 homes received at least one actual harm or immediate jeopardy citation and were reimbursed an estimated 90.4 percent of their allowable costs;
- 231 homes did not receive any of the more serious citations but received at least one citation constituting no actual harm and were reimbursed an estimated 88.3 percent of their allowable costs;
- 45 homes received no federal citations and were reimbursed an estimated 86.8 percent of their allowable costs; and
- 10 homes were not inspected in FY 2000-01.

These data indicate that homes with more serious citations were generally reimbursed a higher percentage of their allowable Medicaid costs. This may indicate that the percentage of allowable costs reimbursed is not the most important factor in determining whether a facility is able to provide the level of care that remains in compliance with federal regulations. Conversely, it may indicate that homes with a lower percentage of their allowable costs reimbursed, which may have relatively more revenue from sources other than the Medicaid program, are more able to provide the level of care that remains in compliance with federal regulations.

Appendix 5

Forfeiture Ranges for State Nursing Home Violations

The Department of Health and Family Services developed a document to guide staff in determining the amount of a nursing home forfeiture. The text and tables presented in this appendix were extracted verbatim from that document.

Forfeiture Ranges—Class A Violations

The following ranges may be used in setting forfeiture amounts. The ranges are meant to encompass most violation categories, however, all violations are reviewed for a forfeiture on a case-by-case basis and depending on the overall picture, it may be appropriate to set a forfeiture at an amount outside a listed range. The statutory maximums for forfeitures may not be exceeded for any day of violation.

Mitigating and aggravating circumstances will be weighed to further determine a forfeiture amount. This may include why the deficient practice occurred, what facility system(s) broke down, what measures the facility initiated to ensure the deficient practice would not reoccur; how many residents were affected; what the facility did to prevent the violation; what the facility did to correct; and, what was done in response to the violation. The fact that the facility provided appropriate training, initially and ongoing, or has a quality assurance committee who reviews facility systems and systems' failures, may be considered mitigating evidence in establishing a forfeiture amount. Previous violations and any financial benefit gained by the facility as a result of the deficient practice will be weighed in determining the forfeiture amount.

Forfeiture Ranges—Class A Violations

	Substantial Probability that Death or Serious Harm Will Occur
(3) Death or actual, serious harm. Harm that has occurred compromises resident's ability to attain highest level of functioning and well-being.	$5,000—$10,000
(2) Actual harm. Harm that has occurred does or does not compromise resident's ability to attain highest level of functioning and well-being.	$3,000—$7,000
(1) No harm, but substantial probability that death or serious harm could have occurred.	$0—$5,000

Forfeiture Ranges—Class B Violations

The following ranges may be used in setting forfeiture amounts. The ranges are meant to encompass most violation categories, however, all violations are reviewed for a forfeiture on a case-by-case basis and depending on the overall picture, it may be appropriate to set a forfeiture at an amount outside a listed range. The statutory maximums for forfeitures may not be exceeded for any day of violation.

Mitigating and aggravating circumstances will be weighed to further determine a forfeiture amount. This may include:

- Why the deficient practice occurred
- What facility system(s) broke down
- What measures the facility initiated to ensure the deficient practice would not reoccur
- How many residents were affected
- What the facility did to prevent the violation
- What the facility did to correct
- What was done in response to the violation
- Did the facility provide appropriate training, initially and ongoing
- Does the facility have a quality assurance committee who reviews facility systems and systems' failures
- What are the facility's previous violations
- Did the facility gain any financial benefit as a result of the deficient practice.

Forfeiture Ranges—Class B Violations

Harm Levels	Harm Probability		
	(a) Low probability for harm to have occurred, or for harm to occur, or for more harm to occur	(b) Medium probability for harm to have occurred, or for harm to occur, or for more harm to occur	(c) High probability for harm to have occurred, or for harm to occur, or for more harm to occur
(4) Actual, serious harm. Harm that has occurred compromises resident's ability to attain highest level of functioning and well-being.	$2,500 to $4,050	$3,000 to $4,450	$4,050 to $5,000
(3) Actual harm. Harm that has occurred does or does not compromise resident's ability to attain highest level of functioning and well-being.	$1,800 to $2,700	$2,250 to $3,150	$2,700 to $3,600
(2) No harm, but potential for harm. Harm that may occur could compromise resident's ability to attain highest level of functioning and well-being.	$500 to $1,350	$900 to $1,800	$1,350 to $2,750
(1) No harm, but potential for harm. Harm that may occur will not compromise resident's ability to attain highest level of functioning and well-being.	–	$0 to $500	$250 to $900

Appendix 6

Nursing Home Informal Dispute Resolution Decisions

Informal Dispute Resolution Decisions for Federal Citations
FY 1997-98 through FY 2000-01

Decision	1997-98	1998-99	1999-2000	2000-01	Total	Percentage
No change to citation	189	161	118	113	581	48.6%
Specific wording changed	56	54	45	55	210	17.6
Citation deleted	42	46	39	63	190	15.9
Examples deleted	50	48	23	30	151	12.6
Severity level changed	21	9	6	10	46	3.9
Regulation or code changed	7	2	1	3	13	1.1
Other	1	1	1	1	4	0.3
Total	366	321	233	275	1,195	100.0%

Informal Dispute Resolution Decisions for State Citations
FY 1997-98 through FY 2000-01

Decision	1997-98	1998-99	1999-2000	2000-01	Total	Percentage
No change to citation	49	34	49	43	175	57.9%
Specific wording changed	12	17	11	15	55	18.2
Citation deleted	12	7	5	21	45	14.9
Examples deleted	6	2	2	5	15	5.0
Severity level changed	1	0	0	1	2	0.7
Regulation or code changed	1	0	2	4	7	2.3
Other	1	0	0	2	3	1.0
Total	82	60	69	91	302	100.0%

State of Wisconsin
Department of Health and Family Services

Scott McCallum, Governor
Phyllis J. Dubé, Secretary

December 6, 2002

Janice Mueller, State Auditor
Legislative Audit Bureau
22 West Mifflin Street, Suite 500
Madison, WI 53703

Dear Ms. Mueller:

Thank you for the opportunity to comment on the Legislative Audit Bureau's (LAB) report regarding the regulation of Wisconsin nursing homes and assisted living facilities. The Department of Health and Family Services (DHFS), Bureau of Quality Assurance (BQA), is the state agency responsible for the regulation of nursing homes and assisted living facilities. The Department is committed to ensuring the health, safety and welfare of Wisconsin seniors and individuals with disabilities residing in long term care facilities. It oversees the delivery of quality health care services through the enforcement of state and federal standards in nursing homes, and state standards in assisted living facilities.

The Department agrees with the LAB recommendations contained in the report. We will include them, along with several other initiatives, as part of the Department's action plan for continuous quality improvement in its regulation of Wisconsin nursing homes and assisted living facilities.

The audit recognizes significant resource challenges facing the Department in meeting the workload demands related to imposing state enforcement remedies against deficient nursing homes. The Department agrees state forfeitures should be issued on a more timely basis. At this point, we are hampered by the lack of sufficient staff to carry out this function. Our DHFS biennial budget request contains a non-GPR initiative to expand staff capacity to more timely issue forfeitures. We also agree with the recommendation to explore strategies to use other enforcement remedies more frequently. We agree with the recommended legislative change allowing the Department to retain a portion of the state forfeitures issued against deficient nursing homes as a means of covering the administrative costs incurred by DHFS in determining them.

The Legislative Audit Bureau reviewed records up to 2001. The Department is pleased to note a number of substantial improvements, not reflected in the audit, have been accomplished since 2001:

- In 2000, the Centers for Medicare and Medicaid Services (CMS) reviewed every state survey agency for the quality of surveyor documentation in writing Statements of Deficiencies (SODs). CMS concluded that Wisconsin surveyors needed to improve their performance in this area. The Department responded by requiring training of all BQA surveyors, supervisors, and managers. DHFS legal staff, as well as experts from CMS, conducted training for BQA staff. BQA continues to emphasize principles of documentation training for its staff.

In a report released earlier this year, the same CMS review concluded that 91.5 percent of federal SODs issued by BQA long term care surveyors in 2002 met principles of documentation requirements. This represented a substantial improvement from the 2000 review. Furthermore, CMS conducted 18 on-site reviews of BQA staff during actual nursing home surveys. In the area of deficiency documentation, on a scale of one to five, with five being "extremely effective," BQA received an overall evaluation of 4.6. In this category for the 18 reviews, BQA received a score of 5 on 13 surveys, and 4 on the remaining 5 surveys. This verifies substantial performance improvement from 2000 to 2001.

- In July 2002, the Department created the Assisted Living Section through an internal reorganization of BQA. Staff responsible for the oversight of assisted living facilities was separated from the Resident Care Review Section (which retains nursing home oversight). In completing this reorganization, staff in the new Assisted Living Section is better able to perform its regulatory responsibilities, assure the regulatory compliance of assisted living facilities, and provide the technical assistance necessary to ensure safe, high quality services are delivered to Wisconsin citizens residing in assisted living facilities.

- Given the rapid and continuing growth of the assisted living industry, the Department has approved the reallocation of nine positions within BQA to expand the number of staff who conduct assisted living surveys. The Department will also increase the clinical expertise of assisted living surveyors by including nurses among the assisted living survey staff. This expansion will be GPR cost-neutral, and is predicated on DHFS's ability to capture additional federal Medicaid funds. The Department will provide to the Legislature a progress report as to the success or failure of obtaining these additional federal funds for the staff expansion by March 1, 2003.

While the audit report presents accurate and balanced information, we do not agree with the interpretation of statistics pertaining to regional office patterns in citing deficiencies. The presentation of statistical data, found on pages 23 through 30 of the report, is primarily "cumulative." The report does not provide comparative data on the information relating to the number of facilities by region; average facility size by region; average number of citations by size and by region; number of facility closures; and, inclusion of comparative CMS regional and national nursing home data. This data would offer a more valid analysis of BQA citing patterns. For instance, the table on page 27 indicates that 12% of nursing home citations were issued in the Northern Region, while the Southeastern Region issued 34% of citations. The table omits the fact that 9% of state nursing homes are in the Northern region, while 26% of nursing homes are in the Southeastern Region. Without this comparative information, the reader is left to conclude there is citing inconsistency across regions.

We appreciate the time and effort expended by the LAB staff in performing this audit. Thank you for your consideration of our comments.

Sincerely,

Phyllis J. Dubé
Secretary