TEXAS HEALTH AND HUMAN SERVICES COMMISSION

OFFICE OF INSPECTOR GENERAL

AUDIT REPORT

FINANCIAL IMPACT OF CLUSTERING THERAPY SERVICES DURING MDS ASSESSMENT LOOK-BACK PERIODS FOR TEXAS MEDICAID RESIDENTS OF LONG-TERM CARE NURSING FACILITIES

June 6, 2019
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INTRODUCTION

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Audit Division has completed an audit of the statewide financial impact of therapy practices at long-term care nursing facilities in state fiscal year 2017, which covers the period from September 1, 2016, through August 31, 2017.

This audit was conducted after previous HHSG OIG audits of two nursing facilities identified a practice of clustering therapy sessions (clustering) during the Minimum Data Set (MDS)[1] assessment look-back period. The practice of clustering therapy sessions at the two nursing facilities increased the Resource Utilization Group (RUG) level assigned to associated residents and resulted in managed care organizations (MCO) paying higher daily RUG reimbursements to the nursing facilities. The following reports detail the results of the two earlier audits:

- Assessment and Evaluation Practices at Sunny Springs Nursing and Rehabilitation (issued October 25, 2017)

- Assessment and Evaluation Practices at Mission Nursing and Rehabilitation (issued May 11, 2018)

For Medicaid residents in nursing facilities who are members of an MCO, HHSC makes a capitation payment to the MCO for each resident. The MCO, in turn, reimburses the nursing facility a daily rate for the resident based on the RUG level of the resident. In state fiscal year 2017, nursing facilities billed MCOs $488 million for therapy RUG level reimbursements. HHSC made capitation payments of $765 million for state fiscal year 2017 to MCOs for these nursing facility residents. Medicaid and CHIP Services (MCS) promulgates policy and rules related to the participation of nursing facilities in Medicaid, and, in the case of managed care, administers those policies and rules through provisions of the Texas Uniform Managed Care Contract. Additional background information is detailed in Appendix A.

Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31.

[1] "Minimum Data Set" (MDS) is a standardized collection of demographic and clinical information that describes a person's overall condition. All licensed nursing facilities in Texas are required to submit MDS assessments for all residents admitted into their facility.

Objective and Scope

The objective of the audit was to estimate the financial impact to Texas Medicaid MCOs and the State of Texas of nursing facilities' practice of clustering the scheduling of resident therapy sessions during MDS assessment look-back periods.

The scope of the audit included MDS assessments with therapy RUG levels conducted during the period of September 1, 2016, through August 31, 2017, and associated MCO payments to nursing facilities.

Methodology

To assess the extent and statewide impact of the clustering practice, the OIG Audit Division tested a statistically valid random sample of 150 MDS assessments that established a therapy RUG level for Medicaid members residing in a nursing facility. The MDS assessments were performed for 150 residents at 133 facilities throughout Texas. Appendix C presents a map of counties where the nursing facilities associated with the selected 150 MDS assessments are located.

Using MCO encounter data, the OIG Audit Division determined the daily care rate nursing facilities billed for residents whose MDS assessments were based on clustering. It then determined the daily care rate nursing facilities would have billed if clustering had not occurred. The difference between these amounts for the sampled items was applied to the population from which the sample was selected, resulting in an estimated financial impact of clustering for 2017.

The OIG Audit Division presented preliminary audit results, issues, and recommendations to MCS in a draft report dated May 3, 2019. MCS provided a management response to the recommendation indicating it would adopt a phased approach to eliminating the clustering practice to include (a) adding a new rule to address intentional clustering of therapy and (b) developing and implementing CMS's new Patient Driven Payment Model for reimbursing nursing facilities to replace the RUG based methodology. MCS's management response are included in the report following the recommendation.

Criteria

The OIG Audit Division used the following criteria to evaluate the information provided:

- 42 C.F.R. § 483.20 (2012 through 2016)
- Tex. Gov. Code § 531.1011 (2015)
- 1 Tex. Admin. Code § 371.1 (2016 and 2017)

- 40 Tex. Admin. Code §§ 19.101 (2016 through 2017), 19.801 (2015) 19.1202 (1995), 19.1301 (1995 and 2017), 19.1306 (2008 and 2017), 19.1910 (1995), 19.1911 (2016), 19.1912 (2002), and 19.2413 (2008)

- Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v. 1.13 (2015) and v. 1.14 (2016)

Auditing Standards

Generally Accepted Government Auditing Standards

The OIG Audit Division conducted this audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States, except for specific applicable requirements that were not followed which were identified as not relevant to the limited audit scope and objectives of this project. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the issues and conclusions based on our audit objectives. The OIG Audit Division believes the evidence obtained provides a reasonable basis for our issues and conclusions based on our audit objectives.

AUDIT RESULTS

Nursing facilities billed Texas Medicaid MCOs an estimated $39.2 million more for resident daily care in 2017, because of a nursing facility practice known as clustering of therapy services during the MDS assessment look-back period, than nursing facilities would have billed MCOs if the practice was prohibited by Texas Medicaid policy. This practice, if prohibited by Texas Medicaid policy, could save the State of Texas approximately $39.2 million each year after the policy is implemented.

Nursing facilities are allowed, according to CMS MDS instructions, to set the assessment reference date (ARD) which establishes the ending date of a seven-day look-back period[2] that is used to complete various components of the MDS assessment. The completed MDS is used to set RUG levels. Nursing facilities have the ability to schedule therapy that clusters therapy sessions during the look-back period to achieve a higher RUG level.

For residents associated with 59 of 150 (39 percent) audited MDS assessments, nursing facilities scheduled therapy sessions within a seven-day look-back period in a way that supported a therapy RUG level. As an example of the difference between therapy and non-therapy rates, a therapy RUG level in one service delivery area pays a daily rate of $52.50 more per day than a non-therapy RUG level. This difference represents an increase of $1,575.00 per month for one Medicaid resident.

Clustering occurs when a nursing facility schedules a resident's therapy sessions in a pattern that results in a higher therapy RUG level, even though the resident's therapy order is for a number of days or minutes per week that fall below the threshold for a therapy RUG level. This practice increases the number of therapy sessions within the look-back period without increasing the number of therapy sessions prescribed to a resident per week, or the number of therapy sessions provided to the resident.

Figure 1 shows how therapy sessions for a resident with a physician's order for three therapy sessions a week can be scheduled to support a therapy RUG level based on five therapy sessions within a seven-day look-back period. Scheduled therapy sessions are represented by an "X," with shaded cells representing the seven-day look-back period.

[2] Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Chapter 2, v. 1.13 (Oct. 1, 2015) and v. 1.14 (Oct. 1, 2016); 40 Tex. Admin. Code § 19.801(2)(A) (Aug. 31, 2015).

Figure 1. Example of Clustering

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
X			X	X		
X	X	X				
X		X		X		

Source: OIG Audit Division

In each of the two full calendar weeks that are part of the seven-day look-back period in this example, the prescribed number of three therapy sessions per week were scheduled for the resident, but the therapy sessions were scheduled in a way (two sessions at the end of the first week and three sessions at the beginning of the second week) that allowed the seven-day look-back period (Thursday of the first week through Wednesday of the second week) to contain five therapy sessions. This resulted in a therapy RUG level, based on five therapy sessions within the seven-day look-back period, that paid more than a non-therapy RUG level, based on the prescribed frequency of three therapy sessions per week, would have paid.

In the weeks following the seven-day look-back period, just as they did for the two weeks included in the seven-day look-back period, nursing facilities scheduled therapy sessions consistent with the physician's order (for example, three sessions per week). But instead of billing MCOs based on a RUG level that reflected the prescribed three therapy sessions per week, the nursing facilities billed MCOs based on a RUG level that reflected five therapy sessions per week. For some residents, nursing facilities discontinued therapy soon after the MDS assessment was performed because the physician's order for therapy expired.

Because therapy RUG level payments can continue until the next MDS assessment is completed, which should be at least 92 days after the previous MDS assessment was completed, regardless of whether therapy continues to be provided at the frequency (number of days) and duration (number of minutes) reflected within the seven-day look-back period, or whether therapy is provided at all, the potential for waste exists under current Medicaid policy. Waste is defined as "practices that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items, or services."[3]

Clustering of therapy services within the look-back period resulted in MCO payments to nursing facilities that were higher than payments would have been if the MDS assessments had reflected the frequency and duration of therapy prescribed in physicians' orders. To evaluate the potential financial impact of clustering, the OIG Audit Division estimated the difference between amounts nursing facilities billed MCOs for RUG levels based on clustering, to amounts that would have been billed if clustering had been prohibited by Medicaid policy.

[3] 1 Tex. Admin. Code §§ 371.1(97) (May 1, 2016) and 371.1(96) (Feb. 12, 2017).

Prohibiting the Practice of Clustering Therapy Sessions Within the MDS Assessment Look-Back Period Would Reduce Medicaid Costs

The OIG Audit Division estimated that the cost in 2017 attributable to the practice of clustering therapy sessions within a seven-day MDS assessment look-back period was approximately $39.2 million. The methodology used to estimate the impact of clustering is detailed in Appendix B. Details of how the OIG Audit Division applied this methodology to estimate the financial impact of clustering follow.

For the statistically valid random sample of 150 MDS assessments tested, nursing facilities billed MCOs $1.8 million for daily care in 2017, and were paid $1.5 million.[4] Within the sample of 150 MDS assessments, 59 MDS assessments (39.334 percent) were performed using the practice of clustering therapy services within the seven-day look-back period, each resulting in a therapy RUG level. The daily care billing amount associated with these 59 MDS assessments totaled $674,054.

For each MDS assessment where nursing facility records indicated clustering had occurred, the OIG Audit Division identified the number of days in which the nursing facility billed for the associated resident's daily care, based on MCO encounter data. It obtained the daily rate for the RUG[5] that had been established by the completed MDS assessment, then multiplied (a) the number of days the nursing facility billed for daily care by (b) the difference between the therapy RUG established by clustering and the non-therapy RUG that would have been established without clustering. The sum of this calculation for each of the 59 MDS assessments represents the estimated impact of clustering.

The OIG Audit Division calculated the RUG level and daily rate that would have been applied to each of the 59 MDS assessments if the facilities had each reported the number of therapy sessions per week, during the seven-day look-back period, equal to the number of therapy sessions per week the physicians prescribed, instead of reporting the amount of therapy based on clustering The Nursing Facility Utilization Review (NFUR) application[6] was used to derive the appropriate RUG level and daily rate for each of the 59 MDS assessments. It multiplied the applicable calculated daily RUG levels by the number of days during which each

[4] The difference in amounts billed and paid is due to multiple factors, such as resident's applied income amounts, changes to nursing facility base rates, and changes to resident RUG levels during a billing cycle.

[5] HHSC Rate Analysis Department, "Texas Nursing Facility (NF) Medicaid Rate Sets Effective 9/1/14," accessed at https://rad.hhs.texas.gov/sites/rad/files/documents/long-term-svcs/2015/2015-nf-rates.pdf.

[6] The OIG Audit Division recalculated RUG levels using the NFUR system, which utilizes the same algorithm as the CMS MDS assessment software to establish RUG levels.

resident was assigned the original therapy RUG level identified on the MCO encounter data. Results indicated that the total of the daily RUG levels associated with the 59 MDS assessments was $475,171.

By taking the difference between the billed amount, with clustering, and the estimated billed amount, without clustering, and dividing the difference by the 59 MDS assessments where clustering of therapy sessions during the seven-day look-back period was used, the average potential savings, assuming clustering were prohibited, per MDS assessment where clustering was used, is calculated to be $3,371, as shown in Table 1.

Table 1: Average Potential Savings for 59 Sampled MDS Assessments Where Clustering of Therapy Sessions Occurred Within the Look-Back Period

Category	Amounts
Billed Amount With Clustering	$ 674,054
Estimated Billed Amount Without Clustering	(475,171)
Estimated Excess Amounts Billed Due to Clustering	198,883
Potential Savings per MDS Assessment Where Clustering Was Used	$ 3,371

Source: OIG Audit Division

The OIG Audit Division applied the percent of MDS assessments in the sample that used clustering, 39.334 percent, to the entire population of MCS assessments associated with therapy level RUGs, and estimated that 11,626 MDS assessments involved clustering of therapy sessions during the seven-day look-back period. After applying the average potential savings per MDS assessment where clustering was used, the result was an estimate of $39.2 million attributed to clustering in 2017, as shown in Table 2. This amount represents the midpoint of a statistical estimate. Based on the statistical estimate, there is a 95 percent probability that the actual financial impact is between the range of $29.5 million and $45.4 million.

Table 2: Estimated Amount Attributed to Clustering of Therapy Sessions Within the MDS Assessment Look-Back Period

OIG Calculation	Population
Number of MDS Assessments in Population	29,557
Percent of MDS Assessments in the Sample Where Clustering Was Used	39.334%
Estimated Number of MDS Assessments with Clustering	11,626
Potential Savings per MDS Assessment Where Clustering Was Used	$ 3,371
Estimated Amount Attributed to Clustering in 2017	$ 39,189,280

Source: OIG Audit Division

Texas Medicaid policy does not prohibit nursing facilities from setting resident assessment dates that are not aligned with the nursing facility's therapy week. The

practice of clustering of therapy services and nursing facilities' subsequent billings for therapy RUG levels resulted in higher cost to the Medicaid program than had the clustering not occurred and, consequently, in the inefficient and wasteful use of Medicaid resources.

The amounts nursing facilities billed MCOs for daily care in 2017 would have been about $39.2 million less if the practice of clustering therapy sessions within the MDS assessment seven-day look-back period had been prohibited. In addition, because HHS uses historical MCO payment data to develop MCO capitation rates in subsequent years, Medicaid costs for nursing facility residents, through the continuation of MCO capitation rates that reflect the practice of clustering, will continue to be higher than they would if the practice were prohibited.

Since future capitation rates are a function of MCO payments to nursing facilities in previous years, HHSC Rate Analysis indicated that if policy were changed to prohibit clustering, MCO capitation rates in future years would be approximately $39.2 million lower per year. The actual amount, however, could vary with caseload changes and trends related to specific nursing facilities involved, members impacted, and the revised nursing facility rates in each service delivery area.

Additional Observations

Review of medical records and other support documentation for the selected MDS assessments indicated that nursing facilities sometimes performed MDS assessments just before the resident's therapy order expired. Specifically:

- Nursing facilities discontinued therapy within 2 weeks of an MDS assessment on 68 occasions, or in 45 percent of the 150 MDS assessments tested. In 44 of the 68 occasions, therapy was discontinued within 3 days of the MDS assessment that established a therapy RUG level.

- Nine MDS assessments were supported by therapy orders for a duration of two weeks or less, during which time an MDS was performed to establish a therapy RUG level.

In situations where an MDS assessment occurred just before the therapy order expired, nursing facilities received daily care payments from MCOs based on the therapy RUG level established during the MDS assessment for as long as 92 days without delivering any therapy to the resident.

Just as with clustering, the ability of the nursing facility to receive payment for a therapy RUG level for up to 92 days after the assessment is not prohibited by Texas Medicaid policy, even if the resident receives less therapy or no therapy after the assessment is completed.

Recommendation 1

MCS should specify in policy or procedure that therapy RUG levels should not be based on:

- More therapy than the number of therapy days and the duration in minutes of each session as documented in a physician's written order.

- An amount of therapy that would not qualify for a therapy RUG level if therapy decreases or ceases for a sustained period of time during a therapy RUG payment period.

Management Response

In October 2018, the Health and Human Services Commission (HHSC) was made aware of the Centers for Medicare and Medicaid Services' (CMS') decision to replace the Resource Utilization Group (RUG) based payment methodology for nursing facilities (NFs) with the new Patient Driven Payment Model (PDPM) effective October 1, 2020. This new payment structure does not incentivize the number of rehabilitation days or minutes.

To align with CMS, HHSC seeks to move away from a therapy payment group, which primarily uses the volume of therapy services provided to the resident as the basis for payment classification. CMS and HHSC OIG have noted that this creates an incentive for NFs to furnish therapy to residents regardless of the resident's unique characteristics, goals, or needs, and in a way that benefits reimbursement, which results in the clustering of therapy visits to ensure a rehabilitation RUG. CMS' new PDPM eliminates this incentive, and should improve the overall accuracy and appropriateness of NF payments by classifying residents into payment groups based on specific, data-driven resident characteristics.

HHSC envisions the new NF reimbursement structure will be simpler, and will incentivize quality of care, reduce unnecessary hospitalizations and emergency room utilization, use person-centered assessments, and account for the characteristics and health status of the NF residents. This new methodology will also alleviate intentional clustering of services.

HHSC will make changes to the NF reimbursement methodology in phases. By October 1, 2020, HHSC will implement a solution that does not depend on CMS calculation of a Medicaid RUG and allows NFs to continue to bill; however, the short-term solution will not appropriately address the intentional clustering of services. By September 30, 2022, HHSC will move to the CMS PDPM, a hybrid payment structure, or a different, simplified payment structure which will eliminate the NFs therapy clustering practices.

Prior to implementing these solutions, HHSC will pursue a rules project to address the intentional clustering practices of NF therapy services under the current reimbursement methodology. While HHSC has been pursuing rules changes to respond to OIG findings, there have been challenges relating to ownership of NF rules and the transition of health and human services rules to HHSC.

Current efforts to address the therapy clustering practices are noted in the Action Plan outlined below.

Action Plan and Target Implementation Dates

- *July 2019 - HHSC will issue a NF provider communication advising against the use of clustering therapy visits for the sole purpose of obtaining a rehabilitation RUG. This NF provider communication will be shared with the STAR+PLUS Managed Care Organizations and NFs.*

- *June 2020 - HHSC will add a new rule to address intentional therapy clustering.*

- *October 2020 - HHSC will continue to develop a new NF reimbursement methodology to align with CMS and will implement the first phase of changes to the NF reimbursement methodology.*

- *September 2022 - HHSC will implement the new NF reimbursement methodology.*

Responsible Manager

Deputy Associate Commissioner, Office of Policy and Program

CONCLUSION

Nursing facilities billed Texas Medicaid MCOs an estimated $39.2 million more for resident daily care in 2017, because of a nursing facility practice known as clustering of therapy services during the MDS assessment look-back period, than the nursing facilities would have billed if the practice was prohibited by Texas Medicaid policy. In addition, if the practice is prohibited, future savings to the State of Texas could be approximately $39.2 million each year after the change is implemented.

The practice of clustering of therapy services and nursing facilities' subsequent billings for therapy RUG levels resulted in higher cost to the Medicaid program than had the clustering not occurred and, consequently, in the inefficient and wasteful use of Medicaid resources.

Therapy services were scheduled more often during MDS assessment look-back periods than for other weeks outside of the look-back periods for 59 of a statistically random sample of 150 MDS assessments that produced therapy RUG levels. Specifically, the OIG Audit Division concluded that in 2017:

- Clustering of therapy services during the residents' assessment periods occurred in 39 percent of the MDS assessments performed by nursing facilities that resulted in therapy RUG levels.

- The practice of clustering resulted in nursing facilities billing MCOs an estimated $39.2 million more for Medicaid residents daily care than would have been billed had clustering not occurred.

- Nursing facilities sometimes discontinued therapy services shortly after completing the MDS assessments that established a therapy RUG level, because the physicians' orders expired. Nursing facilities are allowed, by policy, to receive payment for a therapy RUG level for up to 92 days after the assessment, even if the resident receives less therapy or no therapy after the assessment is completed.

The OIG Audit Division offered a recommendation to MCS, which, if implemented, would result in policy changes and associated procedures designed to limit the number of therapy sessions used to conduct an MDS assessment to the frequency and duration per week prescribed for the resident. This policy change would prohibit the practice of clustering therapy sessions within the seven-day MDS assessment look-back period and eliminate higher therapy RUG level payments associated with clustering. This would result in cost savings to the Texas Medicaid program by lowering the MCO costs upon which future MCO nursing facility capitation rates are based.

The OIG Audit Division thanks management and staff at MCS and at nursing facilities for their cooperation and assistance during this audit.

Appendix A: Background

Nursing facilities provide institutional care to Medicaid recipients and are required to have licensed nurses on duty at all times. For Medicaid residents in nursing facilities who are members of an MCO, the state makes a capitation payment to the MCO for each resident. The MCO, in turn, reimburses the nursing facility a daily rate for the resident based on the RUG level of the resident.

Medicaid and CHIP Services (MCS) promulgates policy and rules related to the participation of nursing facilities in Medicaid, and, in the case of managed care, administers those policies and rules through provisions of the Texas Uniform Managed Care Contract. MCS is also responsible for the contract oversight of Medicaid MCOs.

MDS assessments provide a comprehensive summary of the resident's mental and physical states, and contain items that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status. MDS assessments are required for residents at the time of admission to the facility, then quarterly, annually, when the resident experiences a significant change, and upon discharge from the nursing facility. Medicare and Medicaid certified nursing facilities are required to collect the resident assessment data used in the MDS assessment using guidelines specified by the state and approved by the Centers for Medicare and Medicaid Services (CMS).[7]

Facilities must follow the instructions provided by the Resident Assessment Instrument (RAI) when entering information into the MDS assessment.[8] The RAI also provides instruction to facilities regarding possible selections for the assessment reference date (ARD), but the selection of the ARD is at the discretion of the nursing facility. The ARD establishes the look-back period which, for the purposes of this audit, is defined as the ARD and the six days prior to the ARD. The look-back period is used to report the amount of therapy provided during that period. Texas Medicaid policy does not prohibit nursing facilities from setting resident assessment dates that are not aligned with the nursing facility's therapy week. A therapy week is a seven-day period beginning the first day rehabilitation therapy is given to a resident.[9]

The RAI requires facilities to report the number of therapy days and the number of therapy minutes provided during the look-back period. To qualify for a therapy RUG level, a resident must have at least 5 calendar days and 150 minutes of

[7] 42 C.F.R. § 483.20(b)(1) and (c) (July 16, 2012, through Nov. 28, 2016).

[8] 40 Tex. Admin. Code § 19.801(2)(A) (Aug. 31, 2015).

[9] 40 Tex. Admin. Code § 19.101(148) (July 21, 2016) and 19.101(151) (Mar. 27, 2017).

therapy during the look-back period. The Activities of Daily Living (ADL)[10] scoring on the MDS assessment reflects a nursing facility's evaluation of the level of resident need for assistance with physical mobility and dexterity. ADL scores, the frequency (number of days) and duration (number of minutes) of therapy, and other information is used to classify residents into RUG levels.

Facilities must use information from the look-back period when reporting on the MDS assessment, and facilities are required to ensure that assessments accurately reflect the resident's status.[11]

In summary, the RUG level, which can be determined in large part by the ADL scoring and therapy reported, dictates the amount of money per day the MCO will reimburse the nursing facility for a resident's stay and is a factor in calculating capitation amounts that HHSC pays to MCOs. RUG levels, once established, are valid until the next MDS assessment establishes a new RUG level. A new MDS assessment should be completed, according to the RAI, at least every 92 days.[12]

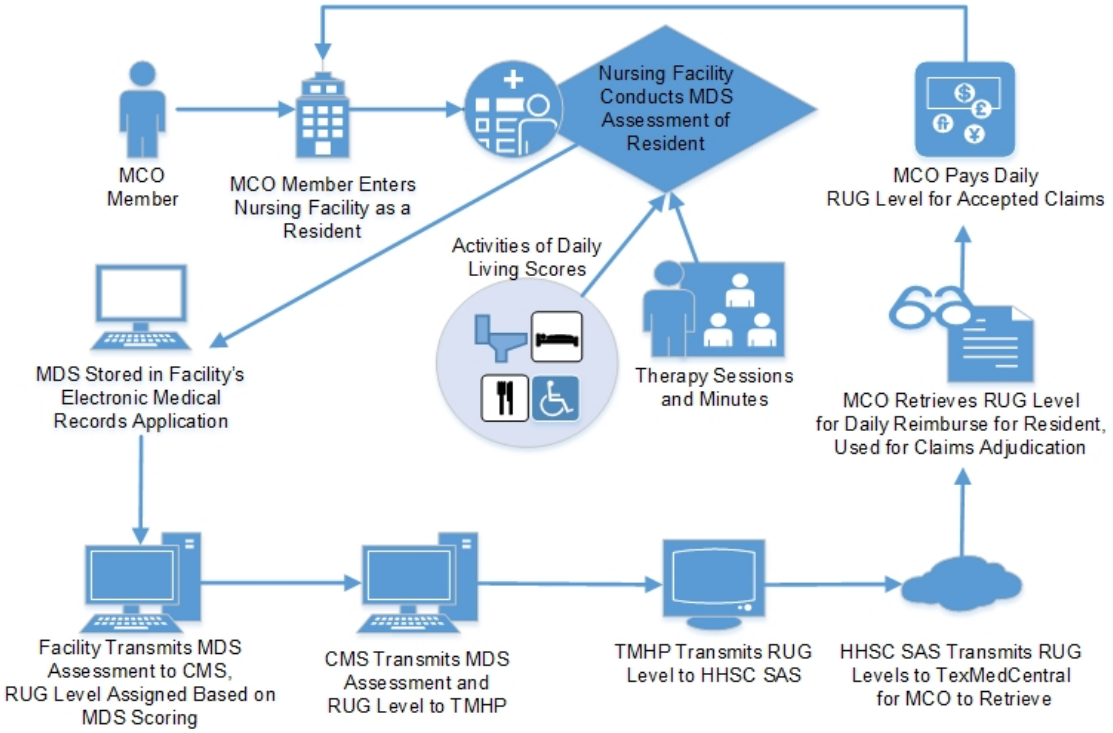
Nursing facilities or billing agents transmit MDS assessment information electronically to the national MDS database at CMS. After receiving a complete MDS assessment, software at CMS assigns the RUG level. CMS sends the MDS assessment and the assigned RUG level to the Texas Medicaid and Healthcare Partnership (TMHP). TMHP updates the assigned RUG level in the HHSC Service Authorization System (HHSC SAS), which acts as the system of record for nursing facilities residents' RUG levels. HHSC SAS automatically transmits, on a daily basis, RUG levels for residents to a TMHP repository called TexMedCentral. The MCOs use the assigned RUG levels when paying nursing facilities. Each MCO retrieves RUG level information from TexMedCentral for each resident for the applicable service period. Figure 2 depicts the flow of MDS assessment information for Medicaid managed care members who are residents in Texas nursing facilities.

[10] "Activities of Daily Living" (ADLs) are basic self-care tasks such as feeding, bathing, dressing, toileting, grooming, and mobility.

[11] Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Chapter 2, v. 1.13 (Oct. 1, 2015) and v. 1.14 (Oct. 1, 2016).

[12] Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Chapter 2, v. 1.13 (Oct. 1, 2015) and v. 1.14 (Oct. 1, 2016).

Figure 2: Flow of MDS Assessment Data and Assignment of RUG Levels



Source: OIG Audit Division

Appendix B: Methodology

Methodology for Sampling and Testing

For the sampling universe, the OIG Data Analysis and Technology (DAT) Division provided the OIG Audit Division with copies, obtained from the Medicaid Fraud and Abuse Detection System, of all 2017 nursing facility MDS assessments filed with the state that contained five days or more of physical or occupational therapy documented during the seven-day look-back period. Residents for whom an MCO did not receive capitation payments were excluded from the sampling universe, as were speech therapy services. The results of two previous audits showed that speech therapy was not associated with clustering at a level that warranted inclusion in this audit.

In total, there were 29,557 MDS assessments in the sampling universe. An encounter data file consisting of 455,832 records, obtained from Vision 21 and provided by OIG DAT, indicated that nursing facilities billed MCOs $598 million for daily care, and were paid $488 million.

The OIG DAT Division selected a statistically valid random sample from the 29,557 MDS assessments utilizing the RAT-STATS application. It selected the sample based on a 95 percent confidence level and a 10 percent precision with a 10 percent anticipated error rate. The sample size was 154 MDS assessments involving members at 136 separate nursing facilities.

The OIG Audit Division requested medical and business records for the 154 residents from the 136 nursing facilities. Of the 154 MDS assessments selected, the OIG Audit Division received support documentation for 150 MDS assessments from 133 nursing facilities. Records supporting four MDS assessments were not provided by the three associated nursing facilities (one nursing facility was associated with two MDS assessments). Three of the four missing MDS assessments are associated with two nursing facilities that are no longer operating. The fourth MDS assessment was, according to the nursing facility, lost or destroyed in a hurricane.

For the 150 MDS assessments tested involving 133 nursing facilities, total RUG payments for assessments with look-back periods during 2017 were $1.5 million.

The OIG Audit Division reviewed the support documentation it received from the nursing facilities to determine whether clustering of therapy occurred.

Clustering was determined to have occurred when both of the following were present for a selected MDS assessment:

- The corresponding physician's therapy order was for a frequency and duration that would not qualify for a therapy-level RUG, such as three sessions per week.

- Nursing facility documentation indicated therapy delivered outside of the MDS assessment look-back period was at a frequency and duration below the therapy threshold of 5 sessions and 150 minutes.

The statistically valid random sample of MDS assessments is representative of the population of MDS assessments for 2017 where five days or more of physical or occupational therapy were documented during the seven-day look-back period; therefore, the type and frequency of the observations within the sample, such as documentation issues, can be considered systemic and present in the population of MDS assessments not selected for testing.

Methodology for Calculating the Financial Impact of Clustering

For the 59 sampled MDS assessments where clustering was used, the OIG Audit Division calculated the financial impact of clustering by comparing (a) the amount nursing facilities billed MCOs for daily care based on the therapy RUG level established by MDS assessments that used clustering to (b) the non-therapy RUG level amount nursing facilities would have billed had those billings been based on MDS assessments that did not use clustering. The amounts nursing facilities would have billed based on MDS assessments that did not use clustering were determined based on the assumption that RUGs would have been established by therapy documented on MDS assessments that was consistent with the weekly frequency and duration contained on the physician's therapy order.

The OIG Audit Division then determined the amount of therapy and the appropriate RUG level based on prescribed therapy orders. The OIG Audit Division recalculated RUG levels using the NFUR system, which utilizes the same algorithm as the CMS MDS assessment software to establish RUG levels. The recalculated daily RUG level was multiplied by the number of days during which the associated resident was assigned the original therapy RUG level, as identified in MCO encounter data. The OIG Audit Division considered the impact of applied income and insurance proceeds, and determined changes to RUG levels do not materially affect applied income and insurance proceeds amounts.

It then calculated the difference between (a) total amounts billed by nursing facilities for residents daily care whose RUGs were determined by the 59 MDS assessments that used clustering, and (b) total amounts the nursing facilities would have billed in daily care for residents whose RUGs would have been determined by

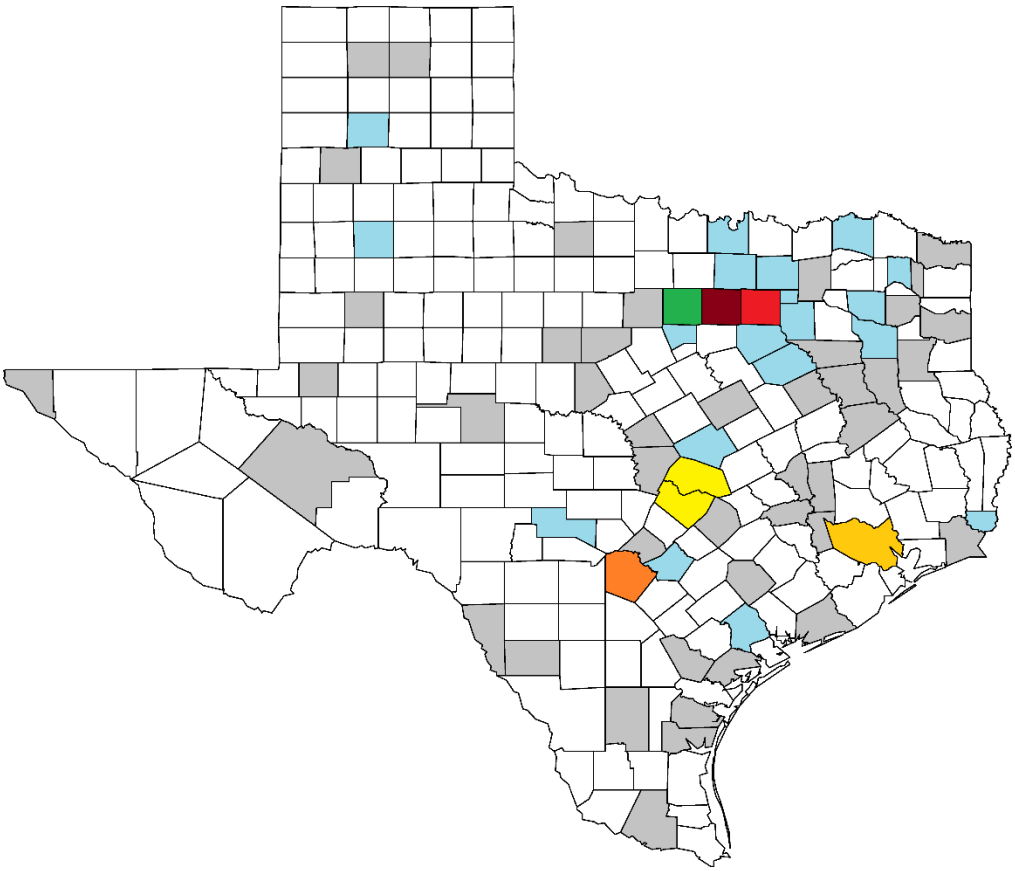
59 MDS assessments that did not use clustering. It divided this difference by 59 to determine the average financial impact per MDS assessment in the sample where clustering was used.

To make the final financial impact calculation, the OIG Audit Division multiplied the total number in the universe of MDS assessments with a therapy RUG level by the percent of the sampled MDS assessments that used clustering, multiplied by the average financial impact of each MDS assessment in the sample that was based on clustering.

The estimated financial impact of the clustering practice in 2017 is reliable and accurate to the extent that the daily care amounts billed for the 150 MDS assessments selected for testing are representative of the population of MDS assessments. The sample error rate and the average dollar error amount of the clustering practice only applies to 2017 and should not be applied or used to make estimates across any other population or time periods.

Appendix C: Location of Sampled Nursing Facilities

The map below shows the concentration of nursing facilities sampled, by county.



Source: Texas Association of Counties

Counties	# Sampled	Key
Anderson, Bastrop, Baylor, Bee, Bowie, Brazos, Brown, Burnet, Callahan, Castro, Cherokee, Comal, Dawson, Dimmit, Duval, Eastland, Ector, El Paso, Freestone, Grimes, Harrison, Henderson, Hidalgo, Houston, Hunt, Hutchinson, Jefferson, Kleberg, Lampasas, Lavaca, Matagorda, Maverick, McLennan, Moore, Morris, Nueces, Palo Pinto, Pecos, Refugio, Rusk, Upshur, Waller, Washington	1	
Bell, Collin, Cooke, Denton, Ellis, Guadalupe, Hood, Kaufman, Kerr, Lamar, Lubbock, Navarro, Orange, Randall, Rockwall, Smith, Titus, Tom Green, Victoria, Wood	2	
Parker	3	
Travis, Williamson	4	
Harris	7	
Bexar	9	
Dallas	10	
Tarrant	16	

Appendix D: Report Team and Distribution

Report Team

The OIG staff members who contributed to this audit report include:

- Steve Sizemore, CIA, CISA, CGAP, Audit Director
- Melissa Larson, CIA, CISA, CFE, IT Audit Project Manager
- Darrell Edgar, CFE, Audit Project Manager
- Krisselda Bactad, Staff Auditor
- Louis Holley, Staff Auditor
- Kathryn Messina, Senior Audit Operations Analyst
- Mo Brantley, Senior Audit Operations Analyst

Report Distribution

Health and Human Services

- Dr. Courtney N. Phillips, Executive Commissioner
- Cecile Erwin Young, Chief Deputy Executive Commissioner
- Victoria Ford, Chief Policy Officer
- Karen Ray, Chief Counsel
- Karin Hill, Director of Internal Audit
- Enrique Marquez, Chief Program and Services Officer, Medical and Social Services Division
- David Kostroun, Deputy Executive Commissioner, Regulatory Services
- Stephanie Muth, State Medicaid Director, Medicaid and CHIP Services
- Dee Budgewater, Deputy Associate Commissioner, Office of Policy and Program
- Grace Windbigler, Director, Managed Care Compliance and Operations, Medicaid and CHIP Services

Appendix E: OIG Mission and Contact Information

The mission of OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG's mission and statutory responsibility includes:

- Sylvia Hernandez Kauffman, Inspector General
- Susan Biles, Chief of Staff
- Dirk Johnson, Chief Counsel
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Olga Rodriguez, Chief of Strategy and Audit
- Quinton Arnold, Chief of Inspections and Investigations
- Brian Klozik, Chief of Medicaid Program Integrity
- Tony Owens, Deputy IG for Third Party Recoveries
- David Griffith, Deputy IG for Audit
- Alan Scantlen, Deputy IG for Data and Technology
- Lizet Hinojosa, Deputy IG for Benefits Program Integrity
- Judy Hoffman-Knobloch, Assistant Deputy IG for Medical Services

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- OIG website: https://oig.hhsc.texas.gov

To Report Fraud, Waste, and Abuse in Texas HHS Programs

- Online: https://oig.hhsc.texas.gov/report-fraud
- Phone: 1-800-436-6184

To Contact OIG

- Email: OIGCommunications@hhsc.state.tx.us
- Mail: Texas Health and Human Services Commission
  Office of Inspector General
  P.O. Box 85200
  Austin, Texas 78708-5200
- Phone: 512-491-2000