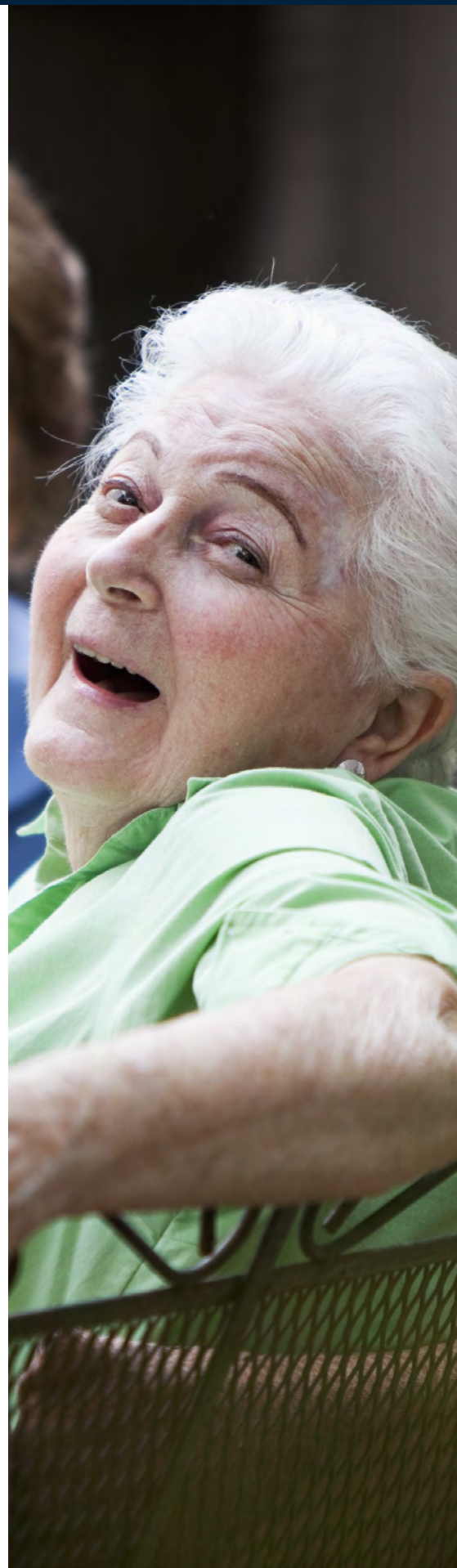


Residential Care

Office of Performance Evaluations
Idaho Legislature





Office of Performance Evaluations

Created in 1994, the legislative Office of Performance Evaluations (OPE) operates under the authority of Idaho Code §§ 67-457–464. Its mission is to promote confidence and accountability in state government through independent assessment of state programs and policies. The OPE work is guided by professional standards of evaluation and auditing.

Joint Legislative Oversight Committee 2017–2018

The eight-member, equally bipartisan Joint Legislative Oversight Committee (JLOC) selects evaluation topics; OPE staff conduct the evaluations. Reports are released in a public meeting of the committee. The findings, conclusions, and recommendations in OPE reports are not intended to reflect the views of the Oversight Committee or its individual members.

Senators



Cliff Bayer



Mark Harris



Michelle Stennett



Cherie Buckner-Webb

Representatives



Mat Erpelding



Maxine Bell



Caroline Nilsson Troy



Elaine Smith

Senator Cliff Bayer (R) and Representative Mat Erpelding (D) cochair the committee.

From the director

January 24, 2018

Members
Joint Legislative Oversight Committee
Idaho Legislature

Adults and children who live in residential care facilities are some of society's most vulnerable people. The state and providers share a responsibility to keep these people safe and give them quality care. Surveys done by the Department of Health and Welfare's Division of Licensing and Certification are part of this shared responsibility.

Tension is inherent in any relationship between the regulator and the regulated. When this tension is managed poorly, fear and mistrust develop and undermine the shared responsibility. In this evaluation, we found a dysfunctional work environment in the nursing home survey team, which was contributing to fear and mistrust between the surveyors and providers.

In their formal responses to our evaluation, the Governor and the department director acknowledged the problems we found and committed to resolve them.

We thank the Department of Health and Welfare, the provider community, and neighboring states for their invaluable help in conducting this study.



Sincerely,

A handwritten signature in blue ink that reads "Rakesh Mohan".

Rakesh Mohan, Director
Office of Performance Evaluations



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**Formal
responses from
the Governor and
the Department
of Health and
Welfare are in
the back of the
report.**



Ryan Langrill and Tony Grange of the Office of Performance Evaluations and Bob Thomas of Robert C. Thomas and Associates conducted this study.

Margaret Campbell of the Office of Performance Evaluations copy edited and desktop published the report.

Jen Schneider, PhD Associate Professor at Boise State University provided technical assistance.

Chris Barrott of Idaho's Division of Medicaid helped develop case studies of hard-to-place individuals.

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Executive summary



Why we were asked to do this study

The Division of Licensing and Certification in the Department of Health and Welfare conducts surveys of 17 types of healthcare facilities to ensure compliance with state and federal requirements. The division had not been meeting mandated intervals of conducting surveys of nursing homes and assisted living facilities. With the delay in nursing home surveys, new nursing homes were unable to be certified to accept Medicare or Medicaid payments.

In addition to the delays, providers reported to the Legislature that surveys were stricter and felt more punitive than in other states. The request to the Joint Legislative Oversight Committee for an evaluation asked us to identify how to make the process more collaborative.

Hospitals had also told the Legislature about difficulties finding residential care placements for children and adults, particularly those with complex behavioral issues. Legislators who requested the evaluation suggested that punitive surveys and the risk of fines led nursing homes and assisted living facilities to decline the placement of residents with complex behavioral issues.



The nursing home survey team has a dysfunctional work environment and survey culture.



Based on early fieldwork and discussions with study requesters, we limited our evaluation of surveys to 3 of the 17 types of facilities surveyed by the division: assisted living facilities, children's residential care facilities, and nursing homes. We also studied barriers to adult residential care, such as state licensure requirements, Medicaid reimbursement rates, and services available to the hard-to-place population.

What we found and next steps

Surveyors and nursing home providers described to us an overly antagonistic survey environment. Though we make recommendations to the division about all three survey teams, the most pressing recommendation focused on ensuring corrective action with the nursing home survey team.

We also identified systemic issues, apart from the survey process, that pose challenges to serving the most hard-to-place individuals in residential settings. How other states have addressed these challenges can provide some guidance for Idaho.

We worked with health departments in five comparison states—Montana, Oregon, Utah, Washington, and Wyoming—to compare residential care options and the management of surveys.

Surveys of nursing homes

A dysfunctional work environment has played a significant role in the dysfunctional survey culture. Nursing home surveyors described the workplace at the division as hostile and demeaning. Surveyors feel berated and belittled; they also believe the work environment explains the ongoing retention problems of the survey team. We did not directly observe the poor treatment of nursing home surveyors; however, multiple sources of evidence supported these concerns. We shared our findings with the director of Health and Welfare, and he immediately initiated an investigation.

Our interviews and results from a questionnaire revealed that providers fear and distrust the nursing home survey team. Surveyors reported that individuals on the team intentionally instill this fear. Barriers in the nursing home survey team and a gap in trust between the division and providers have undermined work by surveyors and division management to improve survey culture.

We did not find evidence that nursing home surveys led to excessive fines or citations. Nursing home citations varied greatly among federal regions, and Idaho's citation rates are similar to the rates of other states in its region. We do not know whether the dysfunctional environment had an effect on citation rates; however, we reviewed limited nursing home survey documentation and concluded that the available evidence supported citations at the given severity.

The Joint Legislative Oversight Committee should consider directing us to commence a follow-up report in three months that focuses on the work environment of the nursing home survey team. The follow-up would ensure that corrective action was implemented and no retaliation or intimidation had taken place.

The division has effectively used contract surveyors to eliminate its survey backlog. The division's management of contract surveyors has been cost-effective and appears to have brought the state back into compliance with federal timelines. Nevertheless, a fully staffed nursing home survey team would provide long-term advantages, such as institutional knowledge, that contract surveyors cannot offer. The team has long had a high vacancy rate, now over 50 percent.

The division should take steps to improve retention of nursing home surveyors beyond addressing issues with the work environment. One option may be a career ladder for surveyors that we found elsewhere in the department and in comparison states.

Surveys of assisted living facilities

The assisted living survey team needs a permanent solution to address workforce capacity and support for team management. In contrast to the nursing home survey team, which can hire fully-trained contractors, the assisted living survey team has compensated for too few resources by hiring temporary surveyors. The temporary surveyor model uses excessive training resources and has undermined team cohesion. The use of temporary surveyors and the need for additional support for team management have likely exacerbated provider concerns about survey consistency.

The division should also consider implementing a dispute resolution process for assisted living providers to challenge

The nursing home survey team has long had a high vacancy rate, now over **50%.**



Providers have no formal recourse to challenge the assisted living survey team's interpretation of rules for noncore citations.



noncore citations. Although noncore citations are less serious than core citations, the division can ban new admissions or impose a provisional license based on noncore citations. Providers have no formal recourse to challenge the assisted living survey team's interpretation of rules for noncore citations.

Surveys of children's residential care facilities

Most providers highly regard surveyors of children's residential care facilities. We found that division management was aware of and had taken steps to address provider concerns about surveyor rule interpretation and consistency. These concerns had developed before the team was managed by the division. Nevertheless, the team should implement a method for providers to give anonymous feedback, similar to methods available to other state-licensed facilities. The division should also give notice, in writing, of formal and informal methods to dispute citations or investigation findings.

A lack of certification of residential treatment facilities for children prevents Idaho facilities from accepting payment for children covered by Idaho Medicaid. Idaho's Medicaid plan does not have a residential treatment benefit for children, and the division does not certify this facility type to accept Medicaid payments. However, Medicaid must pay for residential treatment when medically necessary. The lack of certified facilities in Idaho means that all eligible facilities are out of state. The division should evaluate options to certify providers in Idaho so that Medicaid has the option to pay for children who are placed in Idaho facilities.

Barriers to placement for adults

Idaho has fewer residential care options and a lower Medicaid reimbursement rate for assisted living than comparison states. In addition, Medicaid reimbursement in Idaho does not increase as much with increased resident needs as in comparison states. Idaho has a high ratio of assisted living to nursing home beds compared with the national average but has minimal capacity in adult family homes. Adult family homes are a primary option in Oregon and Washington for hard-to-place individuals.

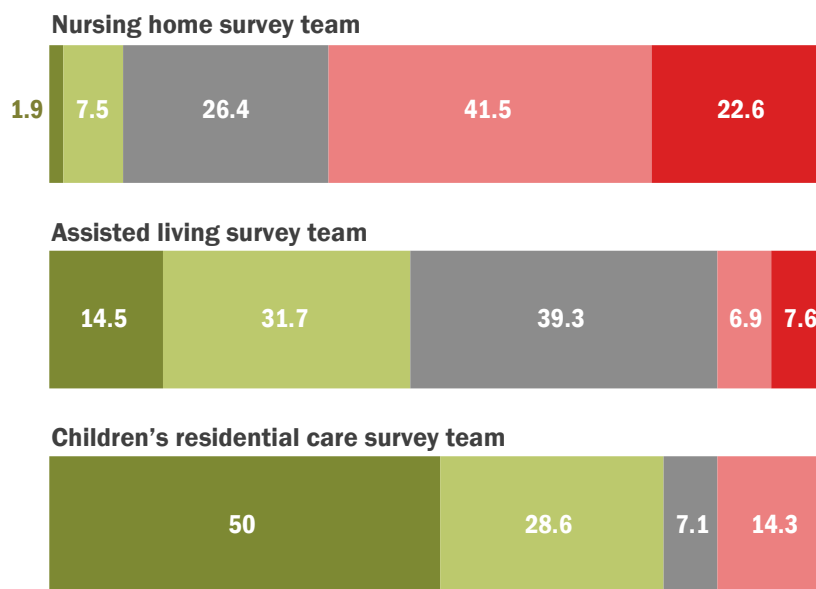
Resources and relationships

Of comparison states, Idaho is the only state that does not collect licensing fees for assisted living facilities or nursing homes. Licensing fees offer a source of revenue that changes with workload. The Legislature may wish to consider authorizing the division to collect licensing fees for assisted living facilities and nursing homes.

The division is unlikely to succeed in improving the survey culture without support and collaboration from the provider community. We found that many stakeholders had constructive criticism about the survey process. However, some stakeholders told us that some criticism that providers directed at the division was unconstructive, unprofessional, or targeting specific personnel. The survey process introduces a natural tension between the regulator and the regulated, but both parties must manage this tension for the division to be successful in implementing our recommendations and improving the survey culture.

Nursing home administrators do not have confidence in the survey team.

Percentage of administrators who indicated they had a **very high**, **high**, **moderate**, **low**, or **very low** level of confidence in the survey team.



Source: OPE questionnaire of facility administrators, September through December 2017.



Both the regulator and the regulated must manage a natural tension for the division to be successful.

1

Introduction

Legislative interest

In March 2017 the Joint Legislative Oversight Committee asked us to evaluate the survey process through which residential care facilities are regulated. The committee also asked us to study barriers to finding residential care options for individuals with complex medical and behavioral issues.

The Division of Licensing and Certification in the Department of Health and Welfare had fallen out of compliance with mandated intervals of conducting surveys of nursing homes and assisted living facilities. The delay in nursing home surveys led to delays in certification for new nursing homes to accept Medicare or Medicaid payments. In addition to the delays, providers reported to the Legislature that surveys were stricter and felt more punitive compared with other states.

Legislators were also concerned with reports they heard that the unavailability of residential care was causing difficulty in



discharging patients from hospitals. Many of these patients had dementia and related behavioral issues. The requesters of this evaluation linked unwillingness of facilities to admit these patients to a fear of being subjected to fine-related citations or other enforcement actions. Their request letter to the Joint Legislative Oversight Committee details these concerns (see appendix A).

Evaluation approach

The division surveys 17 types of facilities, both residential and nonresidential. Based on the interest of study requesters and on our initial fieldwork, we narrowed our evaluation to surveys of nursing homes, assisted living facilities, and children's residential care facilities. See appendix B for the scope of this evaluation.

To evaluate the management of surveys, we attended surveys of each facility type, sent a questionnaire to the administrator of each facility, and conducted interviews of the survey teams. Each facility is required to have a single administrator who is responsible for a facility's day-to-day operation. In the case of nursing homes and assisted living facilities, the administrator must be licensed by the Idaho Bureau of Occupational Licensing.

We conducted significant outreach to the provider community, interviewing owners, administrators, regional managers, facility staff, and consultants. For nursing home surveys, we compared citation rates and enforcement actions across states. For nursing home and assisted living surveys, we worked with five neighboring states to compare appeal options, survey staff, and pay rates. More detail on our methods for evaluating the management of surveys is available in appendix C.

For our study of hard-to-place residents, we worked with five neighboring states to compare available residential care options with a focus on three hard-to-place individuals. More detail about our approach to the study of residential care for hard-to-place residents is in appendix D.

We reached out to the provider community: owners, administrators, regional managers, and staff of facilities as well as consultants.

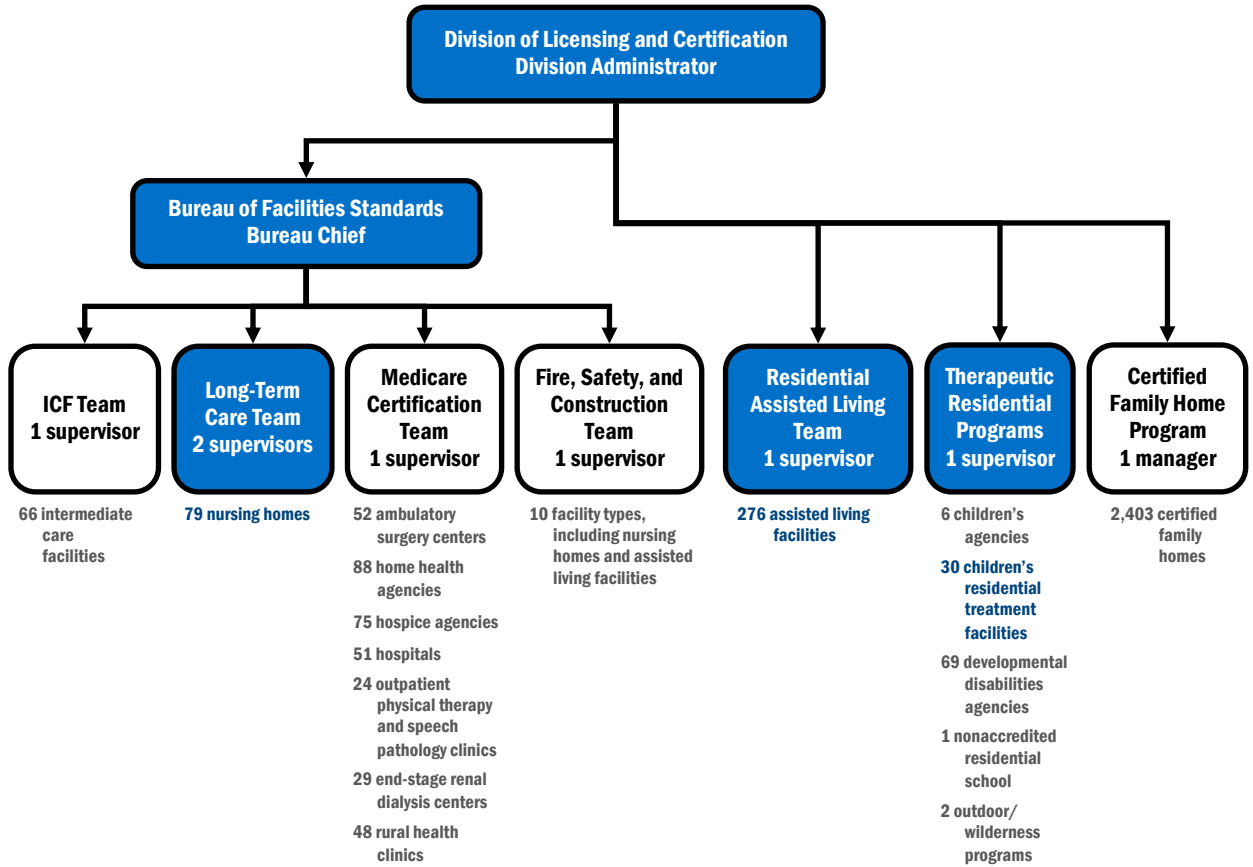
A survey is an inspection of a facility to determine compliance with state or federal regulations and to ensure the health and safety of the facility's residents. Surveys of residential care facilities are managed by the Division of Licensing and Certification in the Department of Health and Welfare.



Under the Division of Licensing and Certification, the Bureau of Facilities Standards oversees all teams that conduct federal certification surveys. Teams that conduct surveys of state-only licensed facilities are outside of the bureau. Exhibit 1 shows the division's organizational chart.

Exhibit 1

We evaluated the management of surveys by three teams in the Division of Licensing and Certification.



Source: Division of Licensing and Certification. One supervisor who works for the ICF team and Medicare certification team is counted only once.

2

Hard-to-place adults

As of 2016, Idaho was home to more than 256,000 individuals age 65 and over and almost 101,000 age 75 and over. Many of these individuals, as well as those with physical or developmental disabilities or with mental illness, are served or may be served in an adult residential care facility.

Hospitals, residential care providers, and advocates reported to us and to the Legislature that placement in residential facilities is more difficult for individuals with complex medical conditions or behavioral problems. They may remain in hospitals or move out of state to receive appropriate care.

States have been moving away from nursing homes as the primary option for long-term care. They have instead moved to caring for individuals in their own homes or in community-based settings such as assisted living facilities. Home- and community-based care is less institutional and significantly lower in cost. According to a 2016 study by the Centers for Disease Control and Prevention, western states have the fewest nursing home beds and the most assisted living beds of any region.

The federal government has recognized the cost-effectiveness of alternatives to nursing homes for aged and disabled individuals. It has authorized states to develop plans to offer home- and community-based alternatives to nursing homes through Medicaid, which is a jointly funded state and federal program administered by the states.

Each state has a unique system of adult residential care. This chapter explains differences other than the survey process that may affect Idaho's ability to serve hard-to-place individuals.

Nursing homes offer 24-hour skilled nursing care and assistance with activities of daily living. Nursing homes care for long-term residents and short-term rehabilitation patients. As of 2014, nursing homes were the most common form of residential care in the United States, with about 64 percent more nursing home beds nationwide than assisted living beds.

Assisted living facilities and residential care facilities are community-based alternatives to nursing homes. These facilities assist with activities of daily living. Assisted living facilities are regulated by the state and have restrictions on the level of care a facility can provide that vary by state. Idaho does not distinguish between assisted living and residential care facilities, while other states do. For example, Oregon has residential care facilities, assisted living facilities, and memory care facilities with distinct regulatory frameworks. In Oregon, residential care facilities tend to be more institutional, have higher staffing ratios, and have shared rooms. Assisted living facilities tend to allow more independent living in individual apartments. Memory care facilities are secured to prevent individuals from leaving the facility without regard for their personal safety.

Adult family homes, also known as certified family homes or adult foster homes, are group homes, typically with fewer than six residents. Adult family homes assist with activities of daily living.

Other care options include in-home care provided at an individual's residence or in an independent living or retirement community. Independent living and retirement communities are not licensed and, in Idaho, cannot directly assist with activities of daily living.

We use the term *adult residential care facility* to refer to any type of facility that assists individuals with activities of daily living.



In 2014 nursing homes were the most common form of residential care in the United States, with about 64 percent more nursing home beds nationwide than assisted living beds.

Idaho has more assisted living beds relative to its population of individuals age 75 and over than any of the comparison states.

Idaho's adult residential care is highly focused on assisted living facilities.

To understand Idaho's adult residential care and to identify any barriers to serving hard-to-place residents, we selected five of Idaho's neighbors to use as comparisons: Oregon, Montana, Utah, Washington, and Wyoming. We worked with each state's health department to evaluate differences in licensure and available services.

Idaho has more assisted living beds relative to its population of individuals age 75 and over than any of the comparison states. Apart from Wyoming, each comparison state and Idaho have a greater ratio of assisted living beds to nursing home beds than the national average.

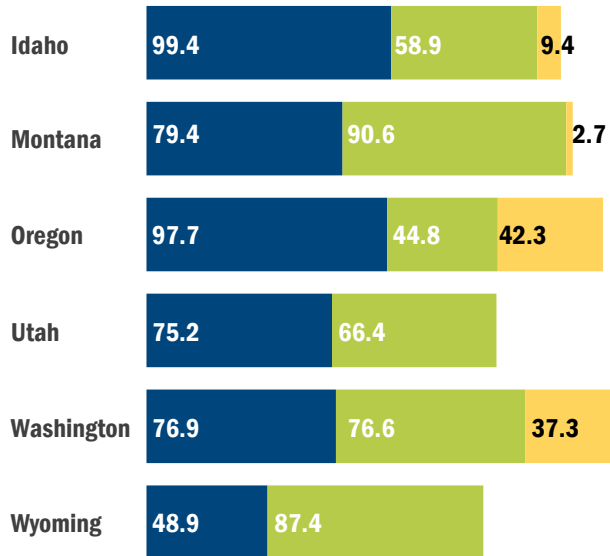
We found that nursing homes had different roles in each state. In Oregon, nursing homes are meant to be for short-term rehabilitation only, with as much long-term care happening in the community as possible. In contrast, Wyoming reported that residents who could be served in a community-based setting in the other four states would likely be placed in a nursing home in Wyoming.

Idaho has about 168 adult residential care beds per 1,000 individuals age 75 and over. This ratio is comparable to Montana, fewer than Oregon and Washington, and more than Utah and Wyoming.

As exhibit 2 shows, Idaho, Oregon, Utah, and Washington have fewer nursing home beds relative to assisted living beds.

Exhibit 2

Idaho has more assisted living beds per 1,000 individuals age 75+ than comparison states, but fewer nursing home or adult family home beds than most.



Source: OPE calculations based on OPE survey of state health agencies; and CMS Quality, Certification, and Oversight Reports, <https://pdq.cms.hhs.gov> in December 2017 and US Census Bureau, 2016 American Community Survey 1-year estimates. Idaho's assisted living facility beds are from 2017 annual reports.

Idaho is not the only state where individuals with complex medical or behavioral issues are difficult to serve.

Other states reported a broader range of options that could serve our hard-to-place individuals.

Two Boise hospitals provided us with information on patients whose discharge was delayed by difficulty finding an appropriate residential facility. We selected three hard-to-place individuals and asked the Idaho Division of Medicaid to develop a narrative and mock assessment of those individuals. Four neighboring states evaluated these individuals and reported to us their appropriate residential care options, their Medicaid reimbursement rate, and any other considerations.

Our case studies are based on real individuals, though names and other personally identifiable information have been changed. By using this case study method, the difficulty finding placement for these individuals was verifiable rather than anecdotal. Looking at each state's residential care from the perspective of hard-to-place individuals allowed us to compare states despite differences in licensure types and Medicaid plans.

Idaho is not the only state where individuals with complex medical or behavioral issues are difficult to serve. In 2017 Montana and Washington each developed a new licensure option to serve this population. When we described Idaho's problems to individuals at health departments in other states, they said that Idaho's problems sounded familiar.

Profiles of the three case-study individuals (Michael, Linda, and Mary) are in exhibit 3. After almost three weeks at a hospital, these individuals were each accepted at assisted living facilities; two had come to the hospital from an assisted living facility that was unwilling to take them back.

Wyoming was an outlier among comparison states. In Idaho, Montana, Oregon, and Washington, all three individuals would likely be served in community settings. In Wyoming, Michael could be appropriately served in an assisted living facility, but Linda and Mary would require care in a nursing home at a much greater expense.

Oregon and Washington distinguish between assisted living and residential care, and these two facility types have different reimbursement rates. Any Medicaid client eligible for care in an assisted living facility or residential care facility could choose between the two.

Exhibit 3**Three hard-to-place individuals at Boise hospitals formed the basis of our case study.**

Michael is a male in his late fifties with a history of combative and destructive behavior and a mental health diagnosis. He is also being treated for a chronic disease and several chronic conditions that require skilled assistance.



Linda is a female in her early eighties with multiple chronic conditions, including extensive cognitive impairment, mental health challenges, and profound impairment to her judgment, which requires extensive assistance. She sleeps during the day and is awake at night.



Mary is a female in her early eighties with considerable cognitive loss. She needs constant supervision and assistance and is physically violent. Because of her impaired cognition, she displays sexually inappropriate and aggressive behavior, and has a history of leaving a facility without regard for her personal safety.

Oregon and Washington distinguish between assisted living and residential care.

Washington recently developed a residential option for individuals with complex behaviors who are difficult to place.

Oregon and Montana have an option for facilities to be additionally licensed for memory care.

In Oregon, nursing homes, assisted living facilities, and residential care facilities can receive an endorsement for memory care. To receive an endorsement, the facility must demonstrate the capacity to provide memory care and meet additional requirements, such as staff training and behavior management.

In Montana, assisted living facilities have three options for additional licensure. A facility may apply to provide skilled nursing care to five or fewer individuals, to provide services to residents with cognitive impairment who are at risk of leaving the facility without regard for personal safety, or to serve residents involuntarily committed by the courts or whose behavior makes them a threat to themselves or others.

Though Linda and Mary have serious cognitive impairment, only Mary was assessed as a danger to herself by leaving the facility without regard for her personal safety. Oregon and Montana reported that Mary would be best served in a facility endorsed for memory care, but that Linda could be served in a less restrictive community setting.

Washington does not specifically license memory care facilities, but Washington Medicaid contracts with facilities for dementia care or care of individuals with complex behaviors who are difficult to place. The state recently developed a residential option to serve individuals being discharged from a state hospital or who are particularly hard to place in the community. The facility, known as an enhanced services facility, may serve a maximum of 16 residents and has stricter staffing requirements than other community options.

Adult family homes, which can serve hard-to-place residents, are fewer in Idaho than in Oregon and Washington.

Adult family homes, known in Idaho as certified family homes, were selected as an appropriate placement for each case-study individual by Idaho, Oregon, and Washington and are an appropriate option for hard-to-place individuals. Oregon believed that an adult family home, particularly one home to all male smokers, was the best fit for Michael. Oregon also noted that “an [assisted living facility] that doesn’t specialize in dementia behaviors may be attractive to the children shopping for an aging parent, but the [adult family home] with door alarms and dementia experience may be a better fit.”

In Idaho, our hard-to-place individuals would be appropriately served in a certified family home. The certified family home supervisor reported that Linda would easily be served in many homes, while Michael would likely require a provider with mental health training and Mary a home with exclusively female residents and caretakers.

Montana has adult family homes, but it does not allow homes to assist with medication and would be inappropriate for our hard-to-place individuals. Wyoming has a licensure option for adult family homes but no licensed homes.

Idaho’s certified family homes are primarily family serving family; only 32 percent of residents are not related to the owner. Excluding family serving family, certified family homes represent only 6 percent of the state’s residential care capacity. In Oregon, 23 percent of residential care beds are in adult family homes and in Washington, 20 percent. Adult family homes in Oregon may serve up to five residents and in Washington up to six residents, more than Idaho’s limit of four residents. The number of Idaho’s certified family homes has been growing, from 2,270 in 2015 to 2,429 in 2017. As of July 2017, however, only 141 homes had three or four beds.

Adult family homes are a primary residential option in Oregon and Washington, but in Idaho they are an underdeveloped option. Adult family homes may not be able to take advantage of the economies of scale like larger facilities can. However, adult

In Idaho certified family homes are an underdeveloped option for hard-to-place individuals.

Adult family homes may allow for a greater variety of living arrangements.

If Idaho served hard-to-place individuals in a nursing home rather than in a community setting, Idaho Medicaid would pay at least three times as much.

family homes may allow for a greater variety of living arrangements to fit an individual's specific needs, such as Mary's best fit in an all-female environment or Michael's living with other male smokers. This variety may not be feasible at larger facilities.

Idaho Medicaid's reimbursement rates tend to be lower and more uniform than in other states.

In addition to other states having a broader range of facility types available to serve hard-to-place individuals, Oregon and Washington had more diverse Medicaid payment options. Montana and Wyoming, on the other hand, cap their Medicaid reimbursement rates. Montana and Wyoming assessed each of the case-study individuals at the maximum reimbursement rate. Exhibit 4 shows each state's placement options and Medicaid reimbursement rate for the hard-to-place individuals.

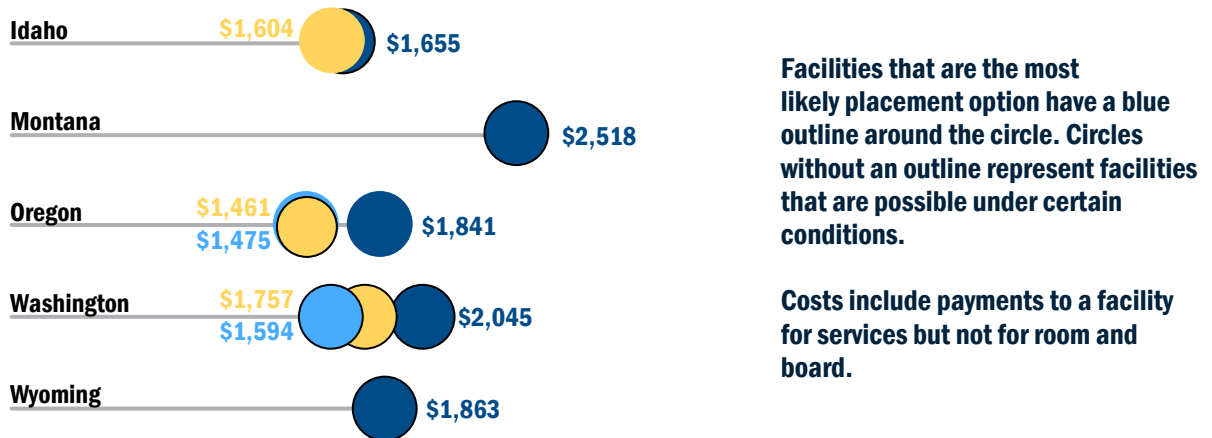
Medicaid is prohibited from paying for an individual's room and board in community settings, so a facility would receive a payment for room and board in addition to payment for services. The rates in exhibit 4 include payments to the facility for assisting in activities of daily living and for the facility's medical care.

If Idaho served these hard-to-place individuals in a nursing home rather than in a community setting, Idaho Medicaid would pay at least three times as much. In fiscal year 2017, Medicaid reimbursed nursing homes between \$5,530 and \$9,850 per month.

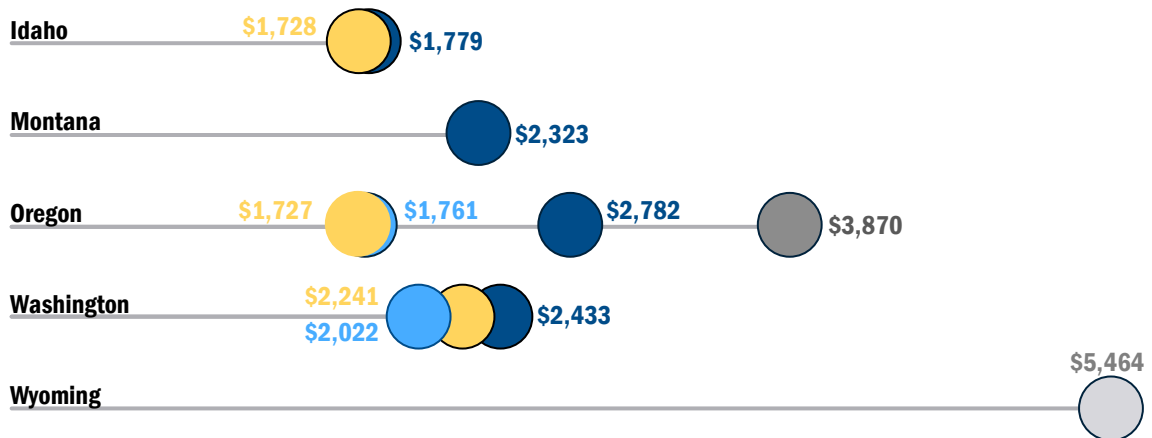
Exhibit 4

Idaho's monthly reimbursement rate tends to be lower and varies less with need than comparison states.

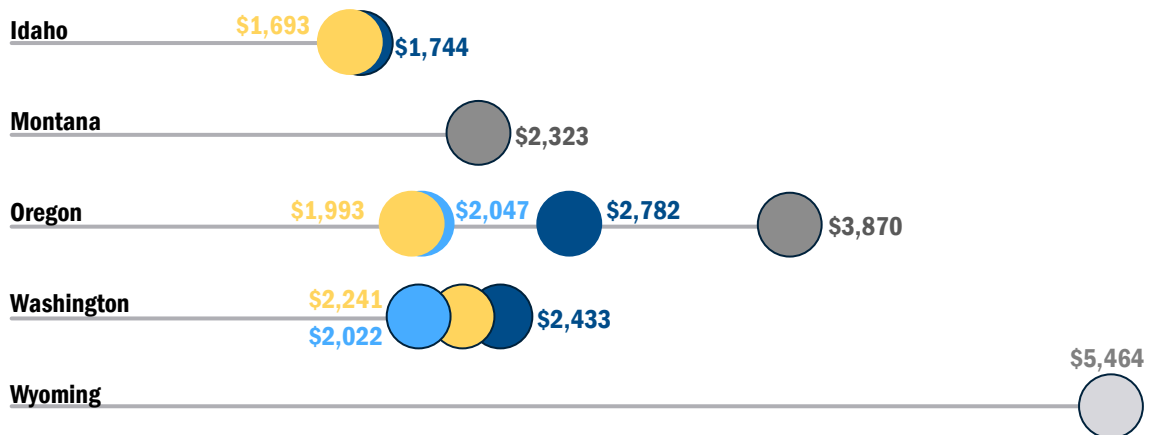
Michael could be served at an **adult family home**, assisted living facility, or **residential care facility**.



Linda could be served at a memory care facility in Oregon. In Wyoming, a nursing home is her only residential care option.



Mary would best be served at a memory care facility where available.



For every dollar Idaho spends on services through Medicaid, the federal government reimburses Idaho **71.5 cents.**

In assisted living facilities, Idaho Medicaid clients self pay **21% of their Medicaid bills.**

Idaho pays the lowest share of Medicaid costs of our comparison states.

States and the federal government share Medicaid expenses. The federal government's share is a minimum of 50 percent and a maximum of 83 percent and is based on a comparison of individual income within a state to the national average. Idaho's reimbursement rate in fiscal year 2017 was 71.5 percent; for every dollar Idaho spends on services through Medicaid, the federal government will reimburse Idaho 71.5 cents. Some additional considerations, including financial participation and differences in Medicaid plans, affect the true fiscal impact to the state.

Medicaid clients also share in the cost of their care. In Idaho, when an assisted living facility bills for services for a Medicaid client, the client must pay the facility an amount based on their income. The cost to the state and federal government is reduced by that amount. According to Idaho Medicaid, from November 2016 to October 2017, Idaho Medicaid clients were required to pay 21 percent of what assisted living facilities billed Medicaid. In contrast, Wyoming Medicaid pays for the full amount of an individual's care in an assisted living facility. However, an individual must put any income above a certain amount in a trust that names Wyoming Medicaid as a beneficiary. Wyoming will pay the full amount for services and be reimbursed later. These differences make comparing what each state pays difficult.

Montana, Oregon, and Washington opted to provide Medicaid community-based services through a Community First Choice State Plan Option. The federal government reimburses expenses made through this option at a 6 percentage-point higher rate than other expenses. Nursing homes are not community-based facilities and are not reimbursed at this higher rate. If Idaho were to exercise the option, the federal government would cover 77.5 percent of Idaho's expenses. The federal government's share of spending for Idaho and our comparison states is in exhibit 5.

Exhibit 5

Idaho has a higher federal reimbursement rate for Medicaid but does not benefit from the higher rate of a Community First Choice Option.

	2017 Federal medical assistance percentage (%)	Addition from Community First Choice Option (%)	Federal reimbursement rate for community- based care (%)
Idaho	71.5	–	71.5
Montana	65.6	6	71.6
Oregon	64.5	6	70.5
Utah	69.9	–	69.9
Washington	50.0	6	56.0
Wyoming	50.0	–	50.0

Source: CMS and Kaiser Family Foundation.

90% of assisted living facilities in Idaho accept Medicaid, but not all facilities are open to new Medicaid placements.

Idaho's assisted living facilities are smaller, more likely to accept Medicaid, and offer more access in rural areas than most comparison states.

Idaho's facilities are smaller in size, on average, than all the comparison states except Montana. Idaho's assisted living facilities, on average, have a lower occupancy rate than the national average (77 percent as compared with 87 percent). Characteristics of assisted living facilities in comparison states are in exhibit 6.

In Idaho, 90 percent of assisted living facilities accept Medicaid; however, not all of those facilities are open to new placements. Of assisted living facility administrators who indicated on our questionnaire that their facility accepted Medicaid, 19 percent reported only accepting Medicaid for residents who were private pay for a certain length of time. Another 44 percent said their facility limits the number of beds available to Medicaid residents.

Exhibit 6

Idaho's assisted living facilities tend to be smaller and more likely to serve Medicaid residents and rural counties than comparable states.

	Average beds per facility	Facilities that accept Medicaid (%)	Beds in rural counties (%)	Population in rural counties (%)
Idaho	36.4	90	15	22
Montana	28.2	69	25	36
Oregon	50.8	79	3	3
Utah	41.5	85	2	4
Washington	60.8	57	4	5
Wyoming	51.8	63	14	21

Source: OPE calculations based on surveys of state health agencies and 2010 census estimates of population in counties more than 50 percent rural.

Smaller assisted living facilities that disproportionately serve Medicaid and mentally ill residents have been closing in Idaho.

The profile of Idaho’s assisted living facilities has been changing. As shown in exhibit 7, from September 2015 to September 2017, the number of residents that assisted living facilities were licensed to serve increased over 7 percent, from about 9,350 to 10,040. However, the number of facilities decreased from 284 to 276.

Exhibit 7
Idaho is gaining assisted living beds while losing facilities.

	Facilities	Beds	Beds per facility
2015	284	9,352	32.9
2016	278	9,705	34.9
2017	276	10,039	36.4

Source: Assisted living facility annual reports from the division. Reports are based on the final week of September each year.

Twenty-seven facilities closed from July 2015 to November 2017. For the 21 facilities that we have data for, these facilities were, on average, smaller and served a larger portion of mentally ill residents and Medicaid clients. As exhibit 8 shows, the facilities that closed were not struggling to find residents. Facilities that closed had occupancy rates similar to the industry average.

Exhibit 8
Facilities that closed in 2015–2017 had a greater share of Medicaid and mentally ill residents.

	Average beds	Residents with mental illness (%)	Residents on Medicaid (%)	Occupancy rate (%)
Closed facilities	15.6	43	81	77
All facilities (2017)	36.4	13	38	77

Facilities that closed were not struggling to find residents.

The department and providers linked the closure of small facilities to a change in rule that put small facilities at a financial disadvantage.

The department and providers linked the closure of small facilities to a change in rule. Before 2015, facilities with 15 or fewer beds were only required to have staff awake and caring for residents if they needed assistance at night. In 2015 rules were changed to require every facility to have staff awake 24 hours; Oregon and Wyoming have a similar requirement, while Montana, Utah, and Washington have the requirement under certain circumstances.

Profiles of closed facilities suggest that larger facilities have become more cost-effective. Large facilities benefit from economies of scale; if a 16-bed facility and an 8-bed facility only need one staff member awake at night, the 16-bed facility can spread the cost over more residents.

Large facilities can more easily specialize and achieve economies of scale in a large population base. In rural areas with a smaller population base, facilities may not be able to achieve the same economies of scale and are more sensitive to Medicaid reimbursement. Because facilities are less able to specialize, individuals in rural facilities may more likely be served at inappropriate levels of care. Mixing residents, for example, those with and without cognitive impairment, can cause problems for both populations. The supervisor of the assisted living survey team noted that the past three deaths of cognitively impaired individuals leaving a secure facility were caused by individuals without dementia living in the secure facility and letting someone with dementia out.

Assisted living facilities had fewer residents on Medicaid in 2017 than they did in 2016.

As shown in exhibit 9, Idaho assisted living facilities served almost 3,000 residents on Medicaid and almost 4,500 private pay residents in September 2016. In September 2017, they reported serving 281 more private pay residents but 32 fewer residents on Medicaid. Idaho Medicaid reported an increase in the number of aged and disabled Medicaid clients over that same time period.

Exhibit 9
Assisted living facilities in Idaho are serving fewer Medicaid clients.

	Private pay residents	Medicaid residents	Medicaid residents (%)
2015	4,286	2,843	39.9
2016	4,494	2,950	39.6
2017	4,775	2,918	37.9

Source: Assisted living facility annual reports from the division. Reports include resident information based on the final week of September.

Idaho Medicaid found in 2016 that Medicaid clients were having problems accessing assisted living facilities and in response, initiated a cost study of Medicaid facilities. Based on their cost study, Medicaid requested about a 20 percent rate increase for fiscal year 2019.

In our interviews and questionnaire, providers who accepted Medicaid expressed frustration with surveys. They said they felt that the state did not provide enough reimbursement to offer a level of care expected by surveyors. The survey team emphasized that they cannot take into account a resident’s payer.

New federal regulations are intended to enhance the quality of services received by Medicaid clients.

New federal regulations contribute to the decision of some assisted living providers to stop accepting Medicaid.

The Centers for Medicare and Medicaid published new regulations for home- and community-based settings in 2014. Idaho Medicaid plans to be in full compliance with these regulations in 2019. The intent of the regulations is to enhance the quality of services received by Medicaid clients and to ensure clients have full access to the benefits of community living.

The new regulations are enforced and monitored by Idaho Medicaid and apply only to Medicaid residents. Our interviews and questionnaire found that some providers have ceased or plan to cease accepting Medicaid rather than adhere to additional regulations for residents who they may already lose money on.

The Legislature endorsed the Idaho Alzheimer's Planning Group's statewide plan in 2013



The plan identified five major findings:

A need for improved access to information

A need for improved education of care providers

A need for increased family support

A need for an improved regulatory environment and for additional financial incentives

A need for improved data collection

Many individuals who are hard to place in Idaho have Alzheimer's or some other form of dementia. The state plan of the Idaho Alzheimer's Planning Group addresses barriers beyond those we discuss in this chapter. The state plan was the result of a yearlong, statewide community needs assessment to determine how to best serve individuals with Alzheimer's and related dementia.

Surveys of nursing homes



The Bureau of Facilities Standards surveys nursing homes for federal certification and state licensure requirements. For federal certification, the division acts as a contractor of the federal Centers for Medicare and Medicaid (CMS) and must comply with federal contractual requirements.

Idaho's contract to conduct federal surveys prioritizes surveys from tier I to tier IV. If overdue surveys are in a higher priority tier, they must be completed before lower priority surveys.

Each nursing home is required to have an administrator licensed by the Idaho Bureau of Occupational Licensing. The administrator manages the day-to-day operations of the home.

The division conducts three main types of nursing home surveys



Recertification surveys must be completed on average of every 12.9 months, with no facility going longer than 15.9 months between surveys. Recertification surveys are prioritized as tier I, the highest priority.

Complaint Investigations must be completed within a specified timeline based on the seriousness of the allegation. Complaints are made to the division from residents, facility staff, long-term care ombudsmen, and the public. Complaint investigations are prioritized from tier I to tier IV, depending on the seriousness of the allegation.

Initial certification surveys must be completed before a nursing home can accept Medicare or Medicaid. Initial surveys are prioritized as tier III or tier IV and are always a lower priority than recertification surveys.

High turnover caused the division to fall out of compliance with federally mandated timelines.

Beginning in January 2016, the division hired contract surveyors to help bring the nursing home survey team into compliance.

The division has caught up on its overdue nursing home surveys.

In 2013 the division reported that it expected all but three surveyors to leave by 2015, most of them retiring. It has struggled with high vacancy ever since. In addition, surveyor exit interviews from 2012 and 2013 indicate that high turnover had already been an issue for years before 2013.

High turnover caused the division to fall out of compliance with federally mandated timelines. In December 2015 the division had 23 overdue recertification surveys and 58 overdue complaint investigations. This backlog led the division to inform nursing homes that the nursing home survey team would be delayed 18 months before they could complete an initial survey, as CMS prioritizes initial surveys lower than recertification surveys. In January 2016 the division hired contract surveyors through Healthcare Management Solutions to help bring the team into compliance with federal requirements for the timing of nursing home surveys.

Based on the division's reports to the Legislature and documentation the division provided to us, by April 2017 the nursing home survey team no longer had any overdue surveys and had few overdue complaint investigations.

From January 2016 to November 2017, the division paid more than \$59,800 per month for contract nursing home surveyors. The cost of contract surveyors has been offset by vacancies in survey staff and has not cost the state more money than a fully staffed team. Though the division has successfully managed contract surveyors to overcome its backlog, this solution does not address surveyor turnover or allow the team to develop institutional knowledge.

A dysfunctional work environment has played a significant role in a dysfunctional survey culture.

The division is authorized to employ 13 nursing home surveyors. As of December 2017, six of these positions were filled and seven were vacant. In December 2015 the division reported the same number of unfilled positions. Turnover has been high; when we concluded our interviews with the nursing home survey team, only two surveyors had been with the division for more than two years.

Interviews with the nursing home survey team indicated that they feel the division is a hostile and demeaning workplace. The environment has developed under current division management. Surveyors told us they had communicated with management and human resources about the dysfunctional work environment, but those who did so believed that management had taken minimal or no corrective action. We did not directly observe the poor treatment of surveyors. Exit interviews and interviews with the assisted living survey team indicated a dysfunctional working environment for the nursing home survey team and also indicated that the dysfunction did not extend to other teams.

Surveyors feel berated and belittled. They believe the dysfunctional environment is a major cause of the survey team's recent turnover and believe other surveyors had been forced out or fired for reasons other than performance. Additional workplace issues reported to us include poor training, inconsistent messages from superiors, a frustrating and time-consuming writing process, and a culture that discourages staff from raising concerns. Surveyors also reported they are prohibited from consulting with one another on survey-related issues.

Surveyors told us that they had been making efforts to improve what they perceived as a punitive survey environment. However, they have faced barriers in the team, and they told us that some staff intentionally intimidate or instill fear in providers. Surveyors said they feel demoralized when they receive praise for giving facilities harm or immediate jeopardy citations. Some surveyors believe good job evaluations rely on issuing many citations or citations of a high level.

Surveyors reported that they had communicated with management and human resources about the dysfunctional work environment.

Staff feel berated and belittled.

Surveyors told us that they had been making efforts to improve the survey environment.

Nursing home citations are categorized by scope and severity



Scope: How many residents are or potentially are affected by a deficiency?

Severity: What level of harm or potential harm occurred?

Severity	Scope		
	Isolated	Pattern	Widespread
Potential for minimal harm	A	B	C
Potential for more than minimal harm	D	E	F
Actual harm	G	H	I
Immediate jeopardy	J	K	L

Immediate jeopardy is a violation that has or is likely to cause serious injury, harm, impairment or death to a resident.



The director immediately initiated an investigation into the work environment.

Recommendation

Considering the serious and time-sensitive nature of the personnel issues, we reported our findings to the director of the Department of Health and Welfare in advance of finalizing this report. Because of the sensitive nature of the personnel issues, we gave the director a more detailed accounting than described here. We kept individual responses confidential. The director committed to address the work environment and immediately initiated a reliable, comprehensive workplace assessment to better understand the issues to be addressed.

The Joint Legislative Oversight Committee should consider directing us to conduct a follow-up evaluation of the work environment in three months. The follow-up would assess whether corrective actions of management have been implemented and ensure there were no signs of intimidation or retaliation.

High turnover, poor communication, and inadequate training have undermined survey consistency.

Survey accuracy and consistency ensure that residents are adequately protected in every nursing home, consumers have accurate information about nursing home performance, and facilities are treated fairly. Some nursing home providers said they feel demoralized because they felt surveyors would stay until accruing a certain number of citations, regardless of the level of compliance. On the other hand, staff gave examples, though rare, of situations that they felt put residents in immediate jeopardy but were instructed by superiors not to cite at that level. Surveyors felt that not citing at the appropriate level endangered the affected residents.

Federal regulations and interpretive guidelines are meant to be applied consistently across states. However, CMS told us that there is variation among regions, states, and individual surveyors. Studies from the Government Accountability Office (GAO) in 2009 and 2015 add to the evidence of variation among regions and states.

GAO found in 2009 that inexperienced staff led to inconsistency among states. GAO also found that 30 percent of surveyors nationwide had less than two years' experience and that states averaged a 14 percent vacancy rate. In comparison, as of December 2017, 67 percent of Idaho's surveyors had less than two years' experience and a 54 percent vacancy rate.

We found that the assisted living survey team, as well as survey teams in our comparison states, ensure consistency in part through good internal communication—surveyors confer with one another and with management. High turnover in the nursing home survey team means that staff do not have the time to develop institutional knowledge. In addition, the team's workplace culture discourages communication among surveyors, so experienced staff have less opportunity to pass on institutional knowledge. Although high turnover undermines survey consistency, poor internal communication of the nursing home survey team is not conducive to ensuring survey consistency, regardless of turnover. We asked facility administrators whether

Some providers felt like surveyors would stay until they had accrued a certain number of citations.

The culture of the nursing home survey team discourages communication among surveyors.

In December 2017 CMS required states to implement a new survey process, which surveyors believe is more objective.

they believed surveyors had the same interpretations of rule—88 percent responded either not true at all or mostly untrue.

Surveyors told us that they did not receive enough training and the training they did receive was inadequate, which undermined survey consistency. The training problems appear to be a recent development and coincide with the division's efforts to catch up on overdue surveys. Division management said that with supervisors performing survey work, the training program was redesigned to include less one-on-one time with supervisors. Exit interviews, which ask about training, did not indicate the same problems before 2015 that we heard in our surveyor interviews and found in later exit interviews.

In December 2017 CMS required states to adopt a new survey process. The process is intended, in part, to improve survey consistency. Surveyors said they feel the new process is more objective, while the previous process used by Idaho was more subjective.



Pay, a lack of career advancement, and understaffing had been issues that led to turnover before a dysfunctional workplace developed.

Before the development of the dysfunctional work environment, surveyor exit interviews indicated that surveyors were dissatisfied with pay and a lack of career advancement opportunities. Surveyors also reported that understaffing led to overwork and burnout.

The survey team reported that money appropriated by the Legislature for higher pay beginning July 2017 has improved recruitment. Surveyors said they believe, however, that pay remains uncompetitive for nurses who comprise a majority of nursing home surveyors. As shown in exhibit 10, comparison states reported a wide range of surveyor pay, and after July 2017 raises, Idaho’s surveyor pay is fairly consistent with comparison states.

Exhibit 10
Idaho’s surveyor pay is similar to comparison states, though with a lower ceiling.

	Pay range (\$)	Median pay (\$)
Idaho	59,000–66,500	61,880
Oregon	39,300–85,400	61,140
Utah	43,500–69,000	*
Washington	46,600–121,900	*
Wyoming	54,000–66,200	62,480

*Did not report median pay.

Comparison states have a career ladder for surveyors with at least two levels of surveyor. For example, Wyoming has surveyors and lead surveyors; Oregon has compliance specialists I to III. Exit interviews indicate that Idaho’s surveyors felt that they were on a rungless ladder and had presented to management in 2008 or 2009 a career ladder concept that could improve problems with turnover. No action on that proposal was taken at that time.

Higher pay beginning in July 2017 has improved recruitment.

Idaho’s surveyors felt like they were on a rungless career ladder.

Idaho has more facilities per surveyor position than comparison states.



The division's strategic plan for 2017–2018 included the development of a career ladder for surveyors to improve retention and staff satisfaction, but no action has taken place since 2016.

Without ever having a full staff, neither the department nor we could evaluate whether the team has enough full-time positions for its workload. We found that Oregon and Washington had almost twice as many surveyors per facility as Idaho. As shown in exhibit 11, Idaho has more facilities for each surveyor position than do comparison states. Although Idaho and Utah have comparable staff per resident, Utah's population is much more concentrated in urban areas. In Utah, 4 percent of the population lives in counties more than 50 percent rural compared with 22 percent of the population in Idaho. Utah's more concentrated population means that surveyors do not travel as much.

Exhibit 11

Idaho has more facilities for each surveyor position than comparison states have.

	Surveyor positions per 1,000 residents	Facilities per surveyor position
Idaho	3.4	6.1
Oregon	5.8	3.3
Utah	3.3	5.6
Washington	5.1	2.7
Wyoming	*	*

* 15 surveyors complete surveys for all healthcare facilities, including nursing homes and assisted living facilities.

Source: OPE survey of state health agencies. Facility and resident data calculated using CMS Quality, Certification, and Oversight Reports, <https://pdq.cms.hhs.gov>.

Recommendation

The division should take steps to improve retention beyond addressing the dysfunctional work environment. One option might be to develop a career ladder. Elsewhere in the department, nurses are employed at the same pay grade as surveyors, with senior positions at the pay grade between that of surveyors and supervisors. The division could use this model to create an intermediate position that offers additional responsibility and career advancement opportunities.

The division has implemented positive changes, but a lack of trust continues to undermine the effectiveness of those changes.

Almost two-thirds of nursing home administrators responding to our questionnaire reported a low or very low level of confidence in the survey agency. Providers reported that the survey culture is punitive, confrontational, and inconsistent.

In response to provider concerns about the nursing home survey culture, division management has asked the office of the director to call providers six weeks after a recertification survey. These calls, which began in 2016, are intended to gather feedback on the survey and allow providers to share concerns about surveyor behavior. The responses are known only by the director's office and the division administrator, not the bureau chief or the nursing home survey team.

The director's office has been very successful at getting responses from providers. The division administrator reported that, of providers contacted by the director's office, only one had not replied. According to the division administrator, the responses are seen only by her and the person in the director's office who makes the call, which protects the identity of respondents from anyone involved in nursing home surveys.

However, of respondents to our questionnaire, almost three-fourths who had received a call reported that they do not feel they could be candid on the call. Almost every administrator who reported that they could not be candid said that they could not because they feared retaliation. We also found a widespread fear of retaliation during our provider interviews, though we did not observe any concrete evidence.

The bureau chief has been holding monthly calls with providers, and the providers reported finding these calls helpful. In our questionnaire of nursing home administrators, we asked them what was most helpful from the division. The two most common activities mentioned were the division's availability to answer questions over the phone and the recently implemented monthly conference calls.

The director's office calls providers six weeks after each recertification survey.

3/4 of administrators who received a call from the director's office reported that they did not feel they could be candid.

A few providers told us about particular surveys they believed were retaliatory.

Providers did not dispute citations because they believed doing so would be ineffective and invite retaliation.

A few providers told us about particular surveys they believed were retaliatory in nature. We received documentation on seven recertification surveys. Although we are unable to know the intent of survey activities, we examined survey documentation to identify whether claims of retaliation aligned with inflated citations. We focused on the most severe citations that had the potential to result in fines or other enforcement actions. We found sufficient evidence in the available record to support the citations and concluded that the cited scope and severity aligned with CMS guidance for scope and severity.

Lack of trust in the dispute resolution process

States are required by CMS to develop an informal dispute resolution process for any citations. Idaho's dispute resolution process includes a five-member panel with two department employees, two representatives from the provider community, and the long-term care ombudsman, who works for the Idaho Commission on Aging. Idaho is the only one of our comparison states that includes provider representatives or the ombudsman in resolving disputes. In comparison, states' dispute resolutions were typically handled by a single state employee.

Some staff suggested that the low number of disputed citations speaks to how well citations are supported. Although citations may be well supported, we found that providers did not dispute citations because they believe doing so would be ineffective and invite retaliation. In our questionnaire, 79 percent of administrators said they feel it is somewhat true or very true that if they push back against a citation, surveyors will be stricter on the next survey. Over 60 percent of administrators, excluding those who said they did not know, said that it is mostly untrue or not at all true that they could go through the dispute resolution process without fear of retaliation.

In December 2016, the division added another level of review to the informal dispute resolution process to address situations in which the panel's recommendation to CMS is not consistent with the recommendation of the chief of the Bureau of Facility Standards. The bureau chief reviews the panel decision for compliance with CMS requirements. If that review results in a disagreement with the panel decision, the director and deputy directors of the department review evidence from the survey team and the facility and make the final decision, which they forward to CMS.

CMS considers the state's recommendation but has final approval over any decisions to modify survey findings. Providers expressed concern that if the division did not like the panel's findings, the division would ask CMS to reject the findings. They also expressed concern that panel members from the provider community might be reluctant to disagree with the division out of fear of retaliation. These concerns suggest that providers would not trust that the process was fair regardless of how the division chose to resolve disputes.

Recommendation

Calls from the director's office and monthly calls are positive developments. In addition, the dispute resolution process includes the provider community and the ombudsman, who is widely trusted. The division should take additional steps to assure nursing home providers that feedback collected by the director's office cannot be traced back to individual providers by the nursing home survey team.



CMS believed that Idaho's process was perceived as less helpful because of a lack of resources.

Providers reported they do not receive the information that CMS directs surveyors to convey.

CMS limits the technical assistance surveyors can give providers on any federal certification survey. However, CMS guidance instructs surveyors to provide enough information to assist providers in expediting their correction of deficiencies. In our questionnaire of facility administrators, 57.7 percent responded that it is mostly untrue or not at all true that they receive enough information at the exit conference to begin corrective action.

CMS's regional branch managers said that a survey should be educational. However, they emphasized that it was the provider's responsibility to comply with rule, not the survey agency's responsibility to bring providers into compliance. The limitation on technical assistance is meant to avoid providers' attempt to comply with an individual surveyor's expectations rather than with federal rule.

Nursing home administrators in Wyoming responded to a questionnaire with the same questions we asked of Idaho nursing home administrators. Of those who responded, only 9.1 percent said they almost never or only occasionally receive useful information during a survey. In Idaho over 75 percent of those who responded to our questionnaire said they almost never or only occasionally receive useful information during a survey.

The regional branch managers told us that a lack of resources led to the perception that the division was less helpful than its counterparts in other states. Washington, which CMS used as a positive comparison, has separate resources dedicated to technical assistance. In addition, Washington has twice as many surveyors per facility as Idaho has.

Citation rates are not a useful comparison among states for nursing home quality.

When we asked CMS about comparing surveys done in different states by federal surveyors, CMS said that we could not do a valid comparison because they claimed survey outcomes vary among individual surveyors. Other differences, such as state licensing requirements and average time between surveys, further complicate interstate comparisons.

In addition, when states like Idaho rely more on community-based care than the national average, they will tend to have nursing home residents who need more care than the national average; residents who need less care can be more easily served in the community. The difference in levels of care would also complicate interstate comparisons.

A 2009 GAO study found that states varied in practices not to cite certain deficiencies or not to cite deficiencies at a higher scope and severity. This practice is inconsistent with federal policy. Idaho was one of only nine states where less than 10 percent of surveyors reported a practice not to cite certain deficiencies. Idaho was also one of seven states without any missed serious deficiencies on comparison surveys done by CMS. In addition, GAO noted variations based on surveyor experience that CMS regions varied in their oversight activities, and states varied in their regulatory philosophy.

We found that CMS reports its citation data using an antiquated database that overreports citations in certain situations. We counted individual citations and found that our counts differed from statistics reported by CMS. The error arises when a complaint investigation is combined with a recertification survey. CMS's data system attributes any citation from the combined survey to both the recertification survey and complaint investigation, inflating citation totals.

The error inflated citation totals for Idaho twice as much as it inflated totals nationwide. The higher inflation occurred because a larger portion of Idaho's citations, compared with the national average, came from recertification surveys that included complaints. In our correspondence with CMS's central office, CMS reported that it had known of the issue but had been unaware that it persisted.

The difference in levels of care complicates interstate comparison.

Of 10 CMS regions, Idaho's region had the second most citations per survey every year from 2014 to 2017.

Idaho is not an outlier in levying fines.

Idaho's citation rates are typical of states in its CMS region, and Idaho is not an outlier in levying fines.

Idaho's nursing homes received 47 percent more citations per recertification survey than the national average in federal fiscal year 2016 and 36 percent more in 2017. However, as shown in exhibit 12, Idaho's citation rates are comparable to other states in CMS region X in 2016 and 2017. CMS region X comprises Alaska, Idaho, Oregon, and Washington. Of the ten CMS regions, region X has had the second most citations per survey every federal fiscal year from 2014 to 2017. Idaho was second in the region in citations in 2014 and 2015, and third in 2016 and 2017.

Exhibit 12

Idaho's citations per recertification survey are higher than the national average but have been typical for CMS region X over the past two federal fiscal years.

	2014	2015	2016	2017
Idaho	10.9	10.8	8.7	8.0
Alaska	11.7	11.4	10.3	9.2
Oregon	4.6	6.2	6.6	7.2
Washington	7.0	6.8	8.8	10.1
Region X	7.3	7.4	8.2	8.9
National average	5.7	5.7	5.9	5.9

Source: CMS Quality, Certification, and Oversight Reports, <https://pdq.cms.hhs.gov>. Citations from complaint investigations were excluded because of data quality issues.

Idaho is not an outlier in levying fines. Idaho's rank among states (and D.C.) in the dollar amount of fines per facility in federal fiscal years 2014–2017 was forty-fourth, forty-fifth, first, and twenty-fourth. More than half of the total in 2016, when Idaho had the highest fines per facility, was levied against a single facility.

Individuals we interviewed who had worked as administrators in comparison states reported that Idaho's survey atmosphere, however, was much more negative and antagonistic than in other states where they had worked. Our questionnaire responses supported this perception. When we asked if the survey process felt like it was us versus them, 63.5 percent of administrators selected very true and another 25 percent selected somewhat true, rates that were higher than we found in comparison states.



88.5%
of administrators
said that the
survey process
feels like “us
versus them.”

Idaho tends to have more citations for isolated instances of actual harm than other states.

Region X has a much higher than average rate of isolated instances of actual harm, called G citations. The region had the highest average number of G citations per standard survey among every region for federal fiscal years 2015, 2016, and 2017. As shown in exhibit 13, Idaho had the highest rate of G citations every federal fiscal year from 2014 to 2016 in region X. In each of these years, Idaho's G citation rate was higher than every other state in the nation.

In 2016 the division implemented an additional review of high-level citations. This additional review seems to coincide with a decline of G level citations in 2017.

Exhibit 13

Idaho has more G-level citations per recertification survey than other region X states.

G-level citations indicate an isolated instance of harm.

	2014	2015	2016	2017
Idaho	0.6	0.5	0.8	0.4
Alaska	0.3	0.2	0.2	0.2
Oregon	0.1	0.2	0.3	0.1
Washington	0.1	0.1	0.3	0.5
Region X	0.2	0.2	0.4	0.3
National average	0.1	0.1	0.1	0.1

Source: CMS Quality, Certification, and Oversight Reports, <https://pdq.cms.hhs.gov>, December 29, 2017. Citations from complaint investigations excluded because of data quality issues.

Surveys of assisted living facilities

4

As of September 2017, Idaho had 276 licensed assisted living facilities with over 10,000 beds and almost 8,000 residents. Nine permanent, full-time surveyors based in Boise conduct annual licensing surveys and complaint investigations. Assisted living facilities are regulated solely by the state, unlike nursing homes.

Assisted living surveys may contain core and noncore citations. Core citations are serious deficiencies such as abuse, neglect, and inadequate care. If a survey includes a core deficiency, surveyors must return to the facility within 45 days to ensure the deficiency is corrected. For core citations, the division has several enforcement actions available, including bans on admission, requiring an independent contractor, or imposition of temporary management. If a facility has two licensing surveys in a row without any core citations, it only needs to be surveyed every three years.

Noncore citations result from less serious deficiencies and do not require surveyors to return to the facility. A facility that has three successive surveys with the same noncore citation can be charged civil monetary penalties. Although the division can also impose civil monetary penalties under other circumstances, most penalties are imposed for citations on three or more consecutive surveys.

The assisted living survey team also gives providers technical assistance during a survey. The purpose of technical assistance is to address concerns that do not rise to the level of a citation or to improve the quality of care. The issues addressed during technical assistance are recorded and, if uncorrected, may result in a citation in a subsequent survey.

46%

of administrators reported a high or very high level of confidence in the assisted living survey team.

Most providers have confidence in the assisted living survey team.

We conducted a questionnaire of 250 administrators in 276 assisted living facilities and received 158 responses, for a response rate of 63.2 percent. The number of administrators is smaller than the number of facilities because administrators can serve multiple facilities.

We found that assisted living administrators had a much larger degree of confidence in the assisted living survey team than nursing home administrators had of the nursing home survey team. Of administrators who responded, 46 percent reported a high or very high level of confidence in the assisted living survey team. Another 39 percent had a moderate level of confidence.

Administrators also reported that their level of confidence had increased over the past two years; 41 percent said they were more confident in the team than they were two years ago, while 24 percent said they were less confident.

A minority of administrators, 15 percent, had a low or very low level of confidence in the team. These administrators were likely to feel that surveys were punitive. They did not feel like the team acknowledged their successes. We asked administrators what the team could do to improve its relationship with the provider community; of 96 responses, 24 indicated that they would like to see surveyors be less punitive or less intimidating.

The assisted living survey team has offered numerous resources outside of surveys that providers find helpful.

The assisted living survey team offers resources outside of surveys to help providers understand rules and implement quality care. In our questionnaire and interviews, administrators and managers of assisted living facilities were positive about tools the team has made available. The resources they felt were most useful were the following:

The availability of a surveyor by phone 8–5, M–F

Administrator boot camps, which the team has offered across the state

Behavior management training, which the team gave five times across the state in 2017

A frequently asked questions document

The team also distributes quarterly newsletters to administrators, has a mock survey tool and documents to prepare for survey, and makes quality assurance checklists and other documents available on its website.

The team may find that information would be more accessible if resources were organized by topic. The website has guidance on particular topics, but guidance for each topic is distributed among rules, frequently asked questions, checklists, newsletter articles, and trainings. When we asked administrators what trainings they would like to see, some mentioned trainings the team already has online. This disconnect suggests that some information the team makes available is not reaching these administrators.

Information would be more readily accessible if resources were organized by topic.

A majority of providers believed they had received citations for things surveyors had approved in the past.

The supervisor reviews every citation before the provider receives it.

Providers feel surveys are inconsistent.

The most common frustration expressed to us was a lack of consistency across surveys and among surveyors. Of respondents to our questionnaire, 67.3 percent of administrators responded mostly untrue or not at all true to the statement, “All surveyors have the same interpretation of rules.” In addition, 72.9 percent of administrators thought it very true or somewhat true that their facility receives citations for things approved by surveyors in the past, even though rules have not changed.

Inconsistency can be caused by disagreements among surveyors, surveyor inexperience, or unclear rules. Administrators shared examples of what they perceived as inconsistency. Organizations with multiple facilities had received conflicting feedback about admission agreements or behavior management forms that were the same between facilities.

In our initial interviews, providers spoke positively of Oregon’s survey process. A similar proportion of Oregon administrators as Idaho administrators said it is mostly untrue or not at all true that all surveyors had the same interpretation of rules. However, a smaller proportion of Oregon administrators reported receiving citations for things approved by surveyors in the past.

Two primary methods the team uses to ensure survey consistency are to (1) change the makeup of who works together and who visits which facility and (2) meet every two weeks as a team to discuss rule interpretation. In addition, many of the supervisor’s activities are intended to ensure survey consistency. The supervisor reviews every citation before it is received by a provider. Whenever surveyors are considering whether to issue a core deficiency, they report to the supervisor to ensure the rules are being consistently interpreted. The supervisor also makes unannounced quality assurance assessments of surveys.

The division's use of temporary surveyors to expand workforce capacity is unsustainable.

In December 2015 the assisted living survey team had 162 overdue surveys and 78 overdue complaint investigations. The division retained temporary surveyors to help eliminate the backlog and has made progress. As of December 10, 2017, the team had 67 overdue surveys and 16 overdue complaints.

The number of assisted living beds has increased 7.3 percent since 2015. The division has not added any permanent assisted living surveyors. Instead, the division has been using temporary surveyors to handle the increased workload. In addition, two surveyors now focus on complaint investigations. Although the team had eliminated its complaint backlog as of December 2016, it has started to fall behind again.

The assisted living survey team has hired temporary surveyors, who had previously been trained by and worked for the division, to conduct surveys and special projects such as trainings. The team also hired untrained temporary surveyors to conduct surveys; these temporary surveyors received full training. The training program typically takes six months of one-on-one guidance from an experienced surveyor. In addition, new surveyors receive guidance from experienced surveyors for a few years.

Unless surveyors are hired permanently, they may only work 1,385 hours during any 12-month period, or 8 months full time. The short tenure of temporary surveyors means training is done continuously and with no long-term benefit.

The use of temporary surveyors has helped the team reduce the number of overdue surveys in spite of industry growth. However, it has also undermined team cohesion and overextended members of the team responsible for training. New hires take time to understand the job, and temporary surveyors do not have much time left on the job after they are fully trained.

The number of assisted living beds has increased **7.3%** since 2015.

The short tenure of temporary surveyors means training is done continuously.

The temporary surveyor model has negative effects on morale.

Permanent and temporary surveyors told us that the temporary surveyor model has negative effects on morale. Permanent surveyors said that the high turnover of temporary surveyors has led to less productive team dynamics and has undermined survey consistency. Trainers were frustrated that their efforts were unlikely to have long-term benefits.

Options for increasing surveys per surveyor

Idaho's assisted living surveyors are based out of one central office. Two or more surveyors conduct each survey. Oregon and Utah also survey from a central office with no fewer than two surveyors per survey. Washington's surveyors are stationed throughout the state and allowed to survey alone. Idaho's assisted living survey team could increase the number of surveys it completes with existing staff by having surveyors survey alone or by stationing staff in other regions of the state to reduce travel time. However, allowing surveyors to survey alone or stationing staff in other regions of the state would likely exacerbate concerns about inconsistency.

Although surveyors are overwhelmingly positive about management, the assisted living survey team has workload challenges at the management level.

In our interviews with surveyors and our review of exit interviews, we found high praise for the supervisor of the assisted living survey team and for division management.

The team supervisor has responsibilities beyond managing surveyors. The team told us that the supervisor reviews every citation, is consulted during surveys for core citations or citations involving behavior management, and conducts unannounced quality assurance visits to evaluate surveys. The supervisor also has responsibilities for provider outreach.

The supervisor of the assisted living survey team reports directly to the division administrator. This structure is different from the model used by the Bureau of Facilities Standards, which has a bureau chief as another layer of management between team supervisors and the division administrator. Lacking this extra layer of management means that the assisted living supervisor has duties that supervisors on teams in the bureau do not have.

With the growth of the industry and the use of temporary surveyors, several surveyors told us that they have been receiving less managerial feedback, both individually and as a team. Surveyors said they feel the recent lack of quality assurance visits has led to survey inconsistency.

Recommendation

The division has requested three more surveyors in its 2019 budget. In addition to addressing workload issues in a sustainable way, we recommend the division provide more support for the management of the assisted living survey team.

A career ladder, as discussed in the previous chapter, could allow for the delegation of management activities. Experienced surveyors already have additional job responsibilities, and a career ladder could formalize that position. Surveyors expressed concern, however, about a co-supervisory model. They believed that it would cause inconsistencies among surveyors and reduce the quality of communication in the team.

The growth of the industry and the use of temporary surveyors has resulted in less managerial feedback.



Providers wanted rules for behavior management to be more specific.

Administrators indicated that the survey process discourages them from accepting residents with complex behavioral issues.

We asked providers which rules they felt were most burdensome relative to their benefit. The rules for managing resident behavior were mentioned twice as much as the next most common response. We also asked providers which rules should be more specific. Behavior management was the most common response—four times more than the next most common response.

Some providers told us that the division's expectations for resident behavior management were unrealistic, especially in light of Medicaid reimbursement rates. They also believed that the expectations of the survey team led to residents with difficult behaviors only being served by facilities whose staff would not report inappropriate behavior.

The assisted living survey team conducted five behavior management trainings throughout the state in 2017. Surveyors reported that providers who had taken the training were less likely to receive citations for behavior management and were better able to care for residents with difficult behaviors.

In our questionnaire, 53.7 percent of administrators reported that the survey process almost always or usually discourages them from accepting residents with complex behavioral issues. This rate compares to 35.5 percent of administrators in Oregon. In our interviews, providers reported that the survey process particularly discourages them from accepting Medicaid clients with behaviors.

In our interviews and questionnaire, providers mentioned a fear of receiving fines for core citations. Although some enforcement actions, such as a ban on admission, can be costly to providers, the division typically does not levy fines for core citations.

Of the 31 fines in fiscal years 2016 and 2017, one was for operating without a license and 30 were for having the same noncore citation three or more surveys in a row. The fines ranged from \$3,200 to \$10,800 and totaled almost \$230,000 over the two fiscal years. The maximum amount that Idaho can fine assisted living providers is comparable to maximum fines in Oregon, Utah, and Washington. Montana and Wyoming do not impose fines.

Only three fines were related to behavior management. Although the survey process may make providers feel discouraged from accepting individuals based on a fear of fines, fines have been few and relatively small.

Fines for behavior management citations have been few and relatively small.



A narrow majority of providers believe they do not have a fair method to dispute citations or do not know whether they do.

Providers do not have a formal method to ensure the team's interpretations are in line with rule.

The appeals process does not allow for an opportunity to improve the survey process.

Providers have the opportunity to challenge citations informally by talking to the lead surveyor or the team supervisor. Providers may also challenge a core citation through a rarely-used informal dispute resolution process. The informal dispute is heard by a five-person panel, composed of one advocate, one department employee, and three industry representatives.

If a survey leads to an enforcement action, such as an admission ban, fine, or license revocation, the provider can go through an administrative appeal to challenge the action. The first step in an administrative appeal is a review of the action by the division administrator.

A narrow majority of administrators—51.3 percent—responded that they do not know whether they have a fair method to dispute citations or they believe they do not have a method.

Most citations are noncore citations, and providers have no formal recourse to appeal noncore citations. The division is reluctant to expand informal dispute resolutions to include noncore citations because it believes that using a five-person panel to consider noncore citations will not be cost-effective.

In comparison states, we found that informal disputes were generally decided by a single person who had not been involved in the survey. In Utah, for example, providers dispute the citation to the program manager. If the citation is upheld, the provider can appeal to the agency director. We did not find that other states had different rights to dispute resolution based on the type of citation.

Although the team has methods to ensure that surveyors interpret rules consistently, providers do not have a formal method to ensure the team's interpretations are in line with rule. A formal record of overturned citations would allow the team to identify opportunities for surveyor training and improve survey consistency.

Recommendation

The division should consider implementing a dispute resolution process that does not require the use of a five-person panel but still allows noncore citations to be reviewed by individuals outside the team. The process would also allow the division to formally track and trend overturned citations. If the assisted living survey team interprets behavior management rules too strictly, a dispute resolution process would also give providers a formal opportunity to challenge the team's interpretations of rule.

The division should also ensure that survey teams give providers a list of informal methods to resolve disputes, either at the beginning of the survey or at the exit conference. This list already exists in the division's guidelines for an informal dispute.



Some providers felt that they should be allowed to retain any resident they could care for.

Providers reported that Idaho's rules contain outdated building requirements and excessive admission requirements.

In our questionnaire and provider interviews, we found areas in rules that providers feel are inappropriate or overly burdensome. We found that Idaho's rules are less detailed than Oregon's or Washington's, but more detailed than Montana's, Utah's, or Wyoming's.

Other than concerns about behavior management, providers' most common concerns are about admission and discharge requirements.

Idaho requires providers be able to give adequate care to any resident they admit or allow to stay. In addition, rules prohibit facilities from admitting or retaining any resident who requires ongoing skilled nursing care or has other enumerated conditions, such as residents who require food through a syringe or who have an advanced pressure ulcer.

Some providers feel that some of the specific requirements are inappropriate and that facilities should be able to retain any resident they can adequately care for. In particular, providers feel that residents on hospice or who are approaching end of life should be allowed to remain in the facility as long as it can give adequate care.

Providers also commented on outdated fire and life safety standards for buildings. Idaho code refers to standards published in 2000 or 2001 by the National Fire Protection Association. These standards reportedly do not align with some current practices. With the exception of Wyoming, comparison states use more recent standards.

Children's residential care



Two surveyors in the Division of Licensing and Certification conduct annual surveys and complaint investigations of 30 children's residential care facilities. Facilities licensed as children's residential care facilities range from 6 to 96 beds and include small residential therapy programs, therapeutic boarding schools, and hospital-based psychiatric residential treatment programs.

Until 2016 the surveyors were managed by Family and Children's Services in the Department of Health and Welfare. Since the move to Licensing and Certification, the division has made efforts to ensure surveyors see their role as holding providers accountable to requirements in rule rather than as quality improvement personnel.

The therapeutic residential program manager manages the children's residential care survey team and surveyors of developmental disabilities agencies and residential habilitation agencies, which are state-only licensed facilities. The children's residential care team also surveys children's adoption agencies, foster care agencies, outdoor therapeutic programs, and nonaccredited residential schools.

Although some providers expressed frustration with survey inconsistency, most providers had an overwhelming positive assessment of the survey agency and reported that their confidence in the survey agency has increased over the past two years, when the team moved to the division.

Providers told us the annual application and survey process was staff intensive.



Children’s residential care facilities are one of the few state-licensed programs with no option for extended periods between surveys.

The approval of each license of a children’s residential care facility includes an on-site survey, usually conducted by a single surveyor. A facility will usually have the same surveyor from year to year. These surveys, unlike assisted living or nursing home surveys, are scheduled with the facility ahead of time.

Providers were very positive about working with surveyors. However, providers reported that the annual application and survey process was staff intensive. Most other state-licensed programs allow for extended licensure which would mitigate this concern. For example, assisted living facilities may be surveyed every one or every three years. Developmental disability agencies can be licensed for up to three years based on the agency’s compliance history.

The team’s program manager indicated that the team intends to increase the number of surveys it conducts by using both of its surveyors on each survey to ensure consistency and to reduce the duration of the on-site survey. To save resources for the provider and the survey team, the program manager also indicated that the division has considered allowing providers to use an abbreviated application depending on the provider’s compliance history.

Using an abbreviated application or an extended licensure may allow the team to conduct more surveys with both surveyors without additional staff.

Recommendation

The division should develop criteria for implementing an extended license or abbreviated application process for children’s residential care facilities based on their compliance history.

The team should track the duration of surveys for facilities in which the team plans to use two surveyors, so that it can evaluate the effect of two surveyors on program and provider staff time.

Most providers have a positive relationship with the team.

We conducted a questionnaire of every administrator of a children's residential care facility. We had 62.5 percent of administrators respond. Of those respondents, 79 percent reported that their level of confidence in the division was high or very high; 14 percent reported a low level of confidence. No one reported a very low level of confidence.

Providers who were critical of the survey agency in our interviews or on our questionnaire said they have an antagonistic relationship with their surveyor. Others said they feel surveyors are inconsistent and hold different facilities to different standards. We found that the program manager was already aware of these concerns and had taken steps to address them.



79%
of administrators
reported that
their level of
confidence in the
survey team was
high or very high.

The division lacks a formal process for providers to give anonymous feedback to the children's residential care survey team.



The division only offers formal appeals for enforcement actions.

The survey team and program manager told us that most disputes over rule interpretation are handled through discussion with the team or program manager. We found the division has no formal notice of methods to dispute survey findings or investigation results, though the division has notice and a formal process for appealing enforcement actions.

Developmental disability and residential habilitation agencies have an informal dispute resolution process similar to the assisted living informal dispute resolution process. The panel who decides informal dispute resolutions is composed of two provider representatives, two department representatives, and one advocate.

The program manager said that, while developmental disability and residential habilitation agencies are given the opportunity to provide feedback to the program manager directly and without their identity being revealed to the surveyor, children's residential care agencies do not have that opportunity.

Recommendation

The division should provide to administrators, in writing, notice of recourses to dispute investigation findings and citations, even when discussion with the program manager is the primary method. The division should also extend its informal dispute resolution process for developmental disability and residential habilitation agencies to children's residential care.

The division should also offer children's residential care administrators the same opportunity for anonymous feedback as developmental disability and residential habilitation agencies.

Idaho does not certify psychiatric residential treatment facilities, resulting in children being treated out of state.

A psychiatric residential treatment facility is a facility other than a hospital that serves individuals under the age of 21 in an inpatient setting. For certification purposes, a facility must meet federal requirements to be verified by the state survey agency during a survey at least every five years. A facility must be certified to receive Medicaid payments.

Idaho's Bureau of Facilities Standards does not certify psychiatric residential treatment facilities because Idaho Medicaid does not cover these facilities in its state plan. However, Medicaid is required to pay for any medically necessary care for children, whether in the state plan or not. If a child requires psychiatric care at a residential treatment facility, Medicaid has no in-state options. Medicaid reported that it placed 22 children in out-of-state residential treatment facilities in fiscal year 2017.

In the questionnaire we sent to children's residential care administrators, we found that eight facilities would be interested in certification as a psychiatric residential treatment facility if certification were available in Idaho. One facility was used as a psychiatric residential treatment facility by other states. Although a child's unique treatment needs may still be best served out of state, in-state treatment options should not be foregone due to a lack of certification.

Recommendation

The division should formally evaluate options for certifying Idaho facilities, including an agreement with another state to conduct certification surveys, if possible under CMS rule.

During our evaluation, the division reported that it had contacted CMS about whether another state could survey Idaho's facilities for federal certification. CMS has so far been nonresponsive to Idaho or to other states that have requested this information. If survey by another state is not possible, the division should evaluate whether surveying psychiatric residential treatment facilities is possible with current resources.

Medicaid reported that it placed 22 children in out-of-state residential treatment facilities in fiscal year 2017.



6

Resources and relationships

Our focus for this evaluation was on the Division of Licensing and Certification's survey process for nursing homes, assisted living facilities, and children's residential care facilities. The division surveys 17 facility types regulated by 21 sets of federal or state rules.

The division's challenges in meeting federal timelines are not isolated to nursing homes. For example, when we began our evaluation in March 2017, CMS data indicated that some critical access hospitals, which are certified by the Medicare Certification survey team, had not been surveyed in more than 10 years. The federally mandated intervals for surveys of critical access hospitals are a three-year statewide average with no facility going longer than five years between surveys.

Although surveys of critical access hospitals are not prioritized as high as those of nursing homes, the percentage of overdue surveys for these facilities was highest in the nation. During our evaluation, the division made successful efforts to overcome its backlog of overdue surveys for critical access hospitals. However, stakeholders told us that the division's efforts to remain in compliance may not be sustainable given current resources.

Idaho does not charge licensing fees for assisted living or nursing home facilities, even though every comparison state does.

We found that Montana, Oregon, Utah, Washington, and Wyoming, our comparison states, charged licensing fees to cover some of the cost of licensing activities. These states have a wide range of fees, from \$1 per bed per year in Montana to \$106 per assisted living bed and \$359 per nursing home bed in Washington. Idaho’s only licensing fee for these facilities is a \$500 initial building inspection fee for assisted living facilities. The cost of license renewals for nursing homes and assisted living facilities in the comparison states is in exhibit 14.

Licensing fees offer a source of revenue that changes with workload. The fees could mitigate a misallocation of resources that occurs when industries surveyed by the division grow at different rates.

Exhibit 14
Idaho is the only state without license renewal fees.

	Assisted living	Nursing home
Idaho	None	None
Montana	\$1 per bed, minimum \$20	\$1 per bed, minimum \$20
Oregon	1–15 beds: \$360 fee 16–49 beds: \$520 fee 50–99 beds: \$1,040 fee 100–150 beds: \$1,340 fee 151 or more beds: \$1,500 fee Additional fee for memory care endorsement	1–15 beds: \$180 fee 16–49 beds: \$260 fee 50–99 beds: \$520 fee 100–150 beds: \$670 fee 151 or more beds: \$750 fee Additional fee for memory care endorsement
Utah	\$1,040 fee	\$520 fee plus \$31.20 per bed
Washington	\$106 per bed	\$359 per bed
Wyoming	0–50 beds: \$100 fee 51–100 beds: \$200 fee 101–150 beds: \$300 fee 151–200 beds: \$400 fee 201 or more beds: \$500 fee	0–50 beds: \$100 fee 51–100 beds: \$200 fee 101–150 beds: \$300 fee 151–200 beds: \$400 fee 201 or more beds: \$500 fee

Licensing fees are a source of revenue that changes with workload.



Stakeholders told us that some criticism of the division has been unconstructive or unprofessional.

To rebuild trust, both parties must demonstrate a genuine change in actions and attitudes.

Recommendation

To address a lack of resources, the Legislature may wish to consider authorizing the division to collect licensing fees. Other states provide models that Idaho could consider. A fee that scales with the size of a facility would likely prevent smaller facilities from feeling an undue burden.

Division efforts to improve the survey culture will need support and collaboration of the provider community.

As discussed earlier, a gap in trust exists between the provider community and the division responsible for surveying residential facilities in Idaho. We found that many stakeholders had constructive criticism for the division and its management of surveys. However, some stakeholders expressed their concerns to us that some of the criticism had been unconstructive, unprofessional, or targeting of specific personnel in the division.

Understandably, enforcement of regulations creates a natural tension between the regulator and the regulated. Therefore, one can expect to see an adversarial element to the relationship in any regulatory environment. However, for the regulatory process to be effective in serving the intended population, both the regulator and the regulated must manage this tension. To rebuild the trust in any situation takes time and necessitates a willingness of the parties involved to demonstrate a genuine change in actions and attitudes.

Any of the division's efforts to implement our recommendations for improving its survey processes are most likely to be successful with the support and collaboration of the provider community. The division and the provider community share a common goal: to ensure that residents, including some of society's most vulnerable individuals, are protected and receive quality care.

Request for evaluation



Sen. Brent Hill



Sen. Dan Johnson



Sen. Mark Harris



Sen. Michelle Stennett



Rep. Mike Moyle



Rep. Kelley Packer



Rep. Janet Trujillo



Rep. Caroline Troy



Rep. Paul Amador



Rep. Megan Blanksma



House of Representatives STATE OF IDAHO CAPITOL BUILDING

P.O. BOX 83720
BOISE, IDAHO 83720 – 0038

March, 2017

OPE Request

Problem: The Survey Process

The number of available residential care homes/beds for Idahoans' with behavior, physical, and age-related issues is decreasing throughout Idaho while the demand for such living arrangements is increasing as the populations needing such care is increasing. The licensing and certification process, managed by the Department of Health and Welfare's Licensing and Certification division seems to be at the center of the issue. Operators of facilities caring for these individuals, stating a fear of fine-related citations and revocation of licenses as a result of the survey process used in monitoring these facilities are increasingly refusing to admit these types of residents, or being prevented from admitting such patients. Data appears to indicate that survey outcomes in Idaho are much more punitive than in other states and in many cases, does not reflect the actual care provided. Idaho residents are being transferred to hospitals and homes in Utah, Colorado and other states due to the lack of beds and homes within the state. The increased risk to providers for accepting these populations (children through elderly) into facilities appears to be creating a significant barrier to access to care. There is an urgent need for an independent, unbiased evaluation of the licensing and certification process of the Idaho Department of Health and Welfare to clearly identify and better understand the structural and cultural issues that are causing the system of care for these vulnerable populations to be increasingly dysfunctional for the Idahoans it is intended to serve.

Problem: Timeliness of Certification

In addition to the vulnerable children and elderly who are affected, there is a profound effect on the business community. Idaho's Licensing and Certification division uses significantly more surveyors per survey than other states and are continually delinquent in meeting the federal and state mandatory deadlines. This potential ineffective use of resources hinders them from completing a timely survey of a new facility. For instance, new skilled nursing facilities planning to open have been told it would be 18 months before the state could come to complete a survey, resulting in losses of \$1 million/month to the facility. The current system also leads to a costly and often unnecessary appeals process.-Currently at least 50% of nursing home appeals are being overturned.

Magnitude of the Problems:

Those most often affected by this problem are vulnerable children and people suffering from dementia who have behavior problems. The costs of this problem are is extensive. In 2014, a study conducted by Boise State University's Center for the Study of Aging showed that Ada County spent over \$1-million on first responder calls related to people with dementia. St. Luke's hospital in Boise reports having an increasing inability to discharge patients with dementia and accompanying

behavioral issues. In 2016, this one hospital alone, had to admit 20 patients with dementia to their medical/surgical unit, and one patient had to remain on a medical/surgical unit for 239 days due to the inability to find a long-term care facility in Idaho that would accept the patient. Many of these patients are Medicaid recipients, resulting in clinically inappropriate and extremely costly “housing” of these patients at the state’s expense.

Study Objectives:

- Identify the extent to which the current licensing and certification structure, culture and system is affecting the availability of beds for those with behaviors, including: discharges, license suspension, facility closures and the timeliness of new facility licenses being issued.
- Identify a process for allowing residents with behavioral issues to remain in their place of residence.
- Identify a process for collaboration and partnership between providers and the division of Licensing and Certification that protects residents with behavioral issues, and improves their access to care.
- Review best practices by CMS, other states, and within the Department of Health and Welfare and identify how Idaho can learn from and adopt these practices.
- Identify a procedure for review of citations that are overturned.
- Identify training opportunities for surveyors and providers in survey practices.

Desired Outcomes and OPE Report Use:

- A Licensing and Certification system that ensures quality care and safety for residents and partnerships with providers to achieve the best outcomes.
- OPE findings, conclusions, and recommendations will be used to ensure the Department’s licensing and certification program is working efficiently, effectively, and in compliance with state and federal laws and regulations.


Representative Paul Amador


Representative Megan Blanksma


Representative Mike Moyle


Representative Caroline Troy


Representative Janet Trujillo


Representative Kelley Packer


Senator Mark Harris


Senator Brent Hill


Senator Dan Johnson



Evaluation scope

This evaluation will focus on two key questions:

1. Does the survey process promote safety and quality care in a cost-effective way?

To answer this question, we will look at the following:

- Staffing, including surveyor training and pay

- Processes to ensure survey consistency

- Number and type of citations

- Appeals processes

- Communication of regulatory requirements to providers

- Collaboration with stakeholders

- Internal quality improvement efforts

We will look at the diversity of facilities surveyed by the division and the requirements for surveys done under CMS contract. We will focus on the survey process for assisted living facilities, skilled nursing facilities, and residential care facilities for children.

2. What are the barriers to caring for individuals in Idaho who are hard-to-place, placed out-of-state, or served by inappropriate levels of care?

To answer this question, we will compare the resources available to these individuals with the resources available in other states and identify the cause of any differences. We will focus on the following aspects of long-term care:

Costs of serving individuals at inappropriate levels of care

Regulatory requirements

Payment structure, particularly for Medicaid clients

Available services

Other barriers identified over the course of the evaluation



Methods: Survey process

We were asked to evaluate the survey process managed by the Division of Licensing and Certification in the Department of Health and Welfare. The letter of request noted that the division was not meeting federal and state mandates for intervals between surveys of nursing homes and assisted living facilities.

Requesters asked us to focus on specific populations: hard-to-place individuals, particularly those with complex behavioral issues, and children who are sent out of state.

Of the 17 facility types surveyed by the division, care in a residential setting is offered by assisted living facilities, certified family homes, children's residential care facilities, intermediate care facilities for individuals with intellectual disabilities, and nursing homes. Initial interviews with stakeholders and requesters of the evaluation led us to exclude surveys of certified family homes and intermediate care facilities from our study. Our focus, then, was on surveys of assisted living facilities, children's residential care facilities, and nursing homes.

Our early interviews and review of the literature led us to select five comparison states: Montana, Oregon, Utah, Washington, and Wyoming.

Approaches for all survey types

The survey of each facility type is unique. To come up with a method of evaluation that applied to all survey teams, we did the following:

- Interviewed individuals at the department involved with the survey process and the placement of individuals at facilities.

- Conducted provider outreach and interviews. We selected interview subjects from a list of suggested providers given to us by the division and the Idaho Health Care Association. We used a snowball sampling technique to attain a representative sample for our interviews and asked each interview subject for other suggestions until we found overlapping suggestions.

Accompanied each survey team on a survey. We worked with each survey team to identify facilities where our presence would be least disruptive to the survey. We did not observe a random survey, but facilities and survey teams selected one for us.

Developed a questionnaire that we sent to each administrator of an assisted living facility, children's residential care facility, and nursing home in Idaho. The division gave us the email contacts. We intended to send a similar questionnaire to administrators in each comparison state, but some state health departments did not respond, so our questionnaires were limited to Oregon and Wyoming.

Conducted interviews of the survey teams, starting with surveyors who we had accompanied on a survey. Two evaluators conducted each of the interviews together, writing a report of each interview separately, to ensure that any topics from the interviews were independently observed. We also reviewed exit interviews of division employees collected from 2012 to 2017. These exit interviews came from 14 nursing home staff, 7 assisted living staff, and 9 other staff.

Nursing home survey team

Because the division conducts nursing home surveys under contract with the Centers for Medicare or Medicaid (CMS), we were allowed only limited access to documentation and to nursing home surveys. In the interest of time, we did not pursue full access to survey documentation.

At our request, the department gave us documentation for 7 recertification surveys and follow-up visits and 2 initial surveys. The documentation allowed us to observe the type and amount of evidence gathered by the nursing home survey team and assess allegations of retaliation.

We accompanied the nursing home survey team on three parts of a survey: the entrance conference, the kitchen tour, and part of the exit conference. CMS's instructions were interpreted as to deny us access to the part of the exit conference where surveyors discussed their complaint investigation. The survey team included the two most senior surveyors and two contract surveyors.

We interviewed eight members of the nursing home survey team: all six surveyors and the two team supervisors. Our first interviews were with the surveyors we had accompanied on our survey. As we noted in chapter 3, we reported our concerns of these interviews to the director before the release of this report so that the department could address the concerns in a timely manner. CMS had delayed our observation of a nursing home survey, which delayed our interviews with the team and our discovery of personnel problems by several months.

The requesters of the evaluation had expressed concerns about Idaho's citation rates and fines. CMS makes information about citation rates available in two places: (1) a spreadsheet from CMS's nursing home quality rating website that lists every citation and (2) a website that allows queries from CMS's database for total citation counts and average citation counts. As discussed in chapter 3, we found that the two sources did not match. In correspondence with CMS central office, CMS confirmed that the second source incorrectly counted the number of citations. As a result of this error, we limited our citation counts to recertification surveys only.

In addition to comparing citation rates by scope and severity among states, as discussed in chapter 3, we compared citation counts with other states based on the tag number—the reason that the facility was out of compliance. For most of the tags that Idaho cited more often than the national average, Idaho's CMS region X also cited the tags more often than the national average.

Assisted living survey team

We used the assisted living survey team's database, which contains survey notes and results, as well as correspondence between the team and the providers. We gathered information on facilities and resident counts, citations, monetary penalties, and license revocations.

We accompanied the survey team on two surveys: one complaint survey and one relicensing survey. We conducted interviews of the survey team, starting with surveyors on the surveys we had accompanied. We interviewed 13 of the 14 members of the survey team; one surveyor was unavailable during our interview times.

Children's residential care survey team

Based on the concerns of providers and the requesters of the evaluation, we requested documentation on the notification of survey results and investigation findings. We found that many provider concerns were based on incidents that occurred before the survey team for children's residential care was managed by the division.

We accompanied each surveyor on a survey. The two facilities that we visited represented two very different types of facilities licensed as children's residential care facilities: one survey was of a small home and the other was of a facility connected to a hospital.





Methods: Hard-to-place residents

Each state cares for those who need assistance with activities of daily living with a different array of institutional, community-based, and in-home care. To understand barriers in finding residential care placements for individuals with complex medical or behavioral issues in Idaho, we looked at how other states serve hard-to-place residents.

Facility comparison

We selected five neighboring states to compare with Idaho: Montana, Oregon, Utah, Washington, and Wyoming. In our initial fieldwork, providers and advocates for residents we interviewed shared positive assessments of residential care in Oregon, Utah, and Washington. Oregon and Washington also had the benefit of being in the same CMS region as Idaho, which would reduce possible variation caused by differences in federal survey. In addition, we selected Montana and Wyoming because those states share challenges with Idaho that come with a rural population.

Nursing homes are federally regulated and expected to provide similar care among states; other residential care facilities are state licensed. Facilities that offer similar services may be known by different names in different states. In addition, facilities may have the same name but offer different levels of care from state to state.

The request for this evaluation expressed concerns for hard-to-place individuals with dementia. To answer these concerns, we focused our evaluation on requirements for memory care.

Data on comparison states

We developed a standardized spreadsheet for other states to input information on their assisted living facilities or similar facilities. For each state, we received a list of facilities, their addresses, licensed capacity, and whether they provided memory care or served Medicaid clients.

We combined the facility data with county-level population data from the 2016 American Community Survey by the US Census Bureau to calculate how much of each state's assisted living capacity serves rural counties.

Hard-to-place case study

In their letter, requesters of the evaluation discussed problems Idaho was having serving residents with behavioral issues caused by dementia, mental illness, or complex medical issues. We wanted to compare Idaho's services for hard-to-place individuals with other states. However, each state has its own state Medicaid plans for residential care, and plans are not directly comparable. The differences in Medicaid plans, in addition to the differences in licensure, complicate comparisons among states. To control for differences, we decided to compare how the same individual would be treated in each state.

Requesters of the evaluation referred to a list of residents that St. Luke's, a Boise hospital, was delayed in discharging because residential care placements were not available. We conducted interviews with advocacy groups and hospitals to understand the process of discharging individuals from hospitals to residential care facilities and to understand the barriers they identified.

Based on requester interest and these initial interviews, we developed criteria for three case studies: (1) someone hard to place due to dementia and complex behavioral issues, (2) someone with dementia and complex medical issues, and (3) someone with behaviors related to mental illness. Hospitals gave us high-level profiles of several individuals. We used assessments by Idaho Medicaid of these individuals to select which ones matched our criteria.

This selection method limited us to selecting individuals served and assessed by Idaho Medicaid and excluded individuals with another payer or served exclusively in nursing homes where Idaho Medicaid uses a different assessment tool.

After our selection, we asked Idaho Medicaid’s Bureau of Long-Term Care to develop a narrative and mock assessment for one of our selected individuals. We gave the narrative and assessment to five neighboring states and asked them whether we had provided enough information to conduct a mock assessment.

Oregon and Washington requested additional information. We modified the narrative with the assistance of the bureau. Montana and Wyoming indicated that we had given them enough information to conduct their assessment. Utah provided us feedback on this initial assessment, but did not give us any final assessments.

In Idaho, each of our selected individuals was discharged to an assisted living facility. We gave the narratives and assessments to the supervisor of the Idaho Certified Family Home Program to determine whether the individuals could have been served in a certified family home.

Montana, Oregon, and Wyoming selected the most likely placement option for each individual and the reimbursement level. Washington indicated that each individual would have three placement options from which to choose. Washington gave us a table that showed reimbursement levels for each of the placement options in different geographic settings. It has different reimbursement rates for providers in King County (Seattle), metropolitan counties, and rural counties. We calculated a weighted average of the three reimbursement rates based on 2010 county-level population data from the US Census.

Montana, Oregon, Washington, and Wyoming reimburse community-based facilities based on levels of care, ranging from 3 levels in Wyoming to 17 levels in Washington. In contrast, Idaho calculates the number of hours an individual qualifies for and pays a facility based on those hours. The smallest step between pay levels in Wyoming is \$271 per month, but Idaho’s steps could change by as little as \$3.55 if an individual qualified for slightly different services.

Michael, the individual we selected with behaviors related to mental illness, would be an appropriate placement in a community-based facility in Idaho and each comparison state. His placement options are in the table.

Monthly reimbursement (\$) from Medicaid for Michael

	Idaho	Mont.	Ore.	Wash.	Wyo.
Adult family home	1,604	-	1,461	1,757	-
Assisted living facility	1,655	2,518	1,841	2,045	1,863
Residential care facility	-	-	1,475	1,594	-

Idaho noted that Michael's certified family home provider would likely need mental health training. Montana indicated that Medicaid would include additional reimbursement for an individual to accompany Michael into the community for medical appointments. Oregon believed an adult family home would be the best fit for Michael but assisted living or residential care facilities would also be acceptable. Montana and Wyoming assessed Michael at their highest reimbursement rate for assisted living facilities.

Linda, the individual with dementia and complex medical conditions, was an appropriate placement in the community in each state except Wyoming. Her placement options are in the table below. In every state except Montana, Linda's reimbursement rate was higher than Michael's.

Oregon noted that although memory care may be an appropriate option, Linda would likely be served at a less restrictive level of care.

Monthly reimbursement (\$) from Medicaid for Linda

	Idaho	Mont.	Ore.	Wash.	Wyo.
Adult family home	1,728	-	1,727	2,241	-
Assisted living facility	1,779	2,323	2,782	2,433	-
Memory care facility	-	-	3,870	-	-
Nursing home	-	-	-	-	5,464
Residential care facility	-	-	1,761	2,022	-

Mary, the individual with dementia and complex behavioral issues, had the same placement options as Linda. Her placement options are in the table below. Idaho assessed Mary at a lower level of care like Linda, while Oregon assessed Mary at a higher level of care. Montana, Washington, and Wyoming assessed Linda and Mary at equivalent levels of care.

Idaho noted that Mary would be difficult to place in a certified family home, but a home with female residents and caretakers could be appropriate. Oregon assessed Mary as best served in a memory care facility, though other community-based facilities would remain options. Washington noted that Mary's assessment score almost put her in a higher level of care; if she had been assessed at the higher level, she would qualify for about \$60 more per month in assisted living and over \$500 per month more in a residential care facility or adult family home.

Monthly reimbursement (\$) from Medicaid for Mary

	Idaho	Mont.	Ore.	Wash.	Wyo.
Adult family home	1,693	-	1,993	2,241	-
Assisted living facility	1,744	-	2,782	2,433	-
Memory care facility	-	2,323	3,870	-	-
Nursing home	-	-	-	-	5,464
Residential care facility	-	-	2,047	2,022	-

Responses to the evaluation



I am aware of the challenges facing the Division of Licensing and Certification. The issues presented have been discussed and improvement plans have been developed.

—Butch Otter, Governor



We will resolve these issues [raised in the report]. The quality and integrity of our work requires experienced and well trained surveyors as well as strong working relationships with nursing home owners and operators.

**—Russ Barron, Director
Department of Health and Welfare**





C.L. "BUTCH" OTTER
GOVERNOR

January 17, 2018

Rakesh Mohan, Director
Office of Performance Evaluations
954 W. Jefferson St.
Boise, ID 83702

Dear Rakesh,

Thank you for the opportunity to respond to the draft report, *Residential Care*. The report provides a comprehensive review of the management issues within the Idaho Department of Health and Welfare's Division of Licensing and Certification.

I am aware of the challenges facing the Division of Licensing and Certification. The issues presented have been discussed and improvement plans have been developed in collaboration with department staff to foster changes in resource and process management, as well as cultural changes to the work environment.

I welcome the Office of Performance Evaluations' recommendations. They support changes that already are being implemented. I will continue to support further advancement in the identified areas of concern.

Thank you again for your thorough research and positive suggestions regarding the residential care certification and licensing programs.

As Always – Idaho, "Esto Perpetua"

A handwritten signature in black ink, reading "C.L. Butch Otter". The signature is written in a cursive, flowing style.

C.L. "Butch" Otter
Governor of Idaho

CLO/tp



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "Butch" Otter - Governor
Russell S. Barron - Director

OFFICE OF THE DIRECTOR
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January 22, 2018

Sent Via Email: rmohan@ope.idaho.gov

Rakesh Mohan, Director
Office of Performance Evaluations
954 W. Jefferson St., Ste 202
Boise, Idaho 83720-0055

Dear Mr. Mohan;

I want to thank you and your staff for your work on the evaluation of Residential Care in Idaho and the Department's Division of Licensing and Certification. We appreciate the approach used in this evaluation, which identified systemic issues that pose challenges in serving individuals who are difficult to place in residential settings. The information about how some other states have addressed similar challenges will definitely help us as we move forward.

We find it unacceptable that despite our efforts over the past two years, surveyors and nursing home providers feel the work environment and culture continue to be harsh. We are currently conducting a workplace assessment to determine strategies to address the work environment and culture.

We will resolve these issues. The quality and integrity of our work requires experienced and well-trained surveyors as well as strong working relationships with nursing home owners and operators. I am committed to marked improvements in the near future.

The Department has experienced firsthand the impacts of the closure of several small assisted living facilities resulting from financial difficulties because of the requirement that facilities employ staff who are required to be awake and caring for residents during all shifts. These small facilities primarily serve residents with mental illness. To address this issue, the Department's Divisions of Licensing and Certification and Medicaid worked with the Division of Behavioral Health to develop a new facility type called Homes for Adult Residential Treatment (HART). HARTs provide a residential setting with enhanced supervision and treatment for individuals with severe and persistent mental illness who are difficult to place in assisted living facilities.

Rakesh Mohan
January 22, 2018
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The Department is currently conducting a pilot program for this new facility type with three small assisted living facilities who have expressed interest in becoming HARTs. The pilot program will help inform the Department how best to move forward with this new residential treatment model. In addition, the Division of Medicaid is conducting a cost survey of all residential assisted living providers.

Thank you again for the time and effort you invested in improving residential care in Idaho.

Sincerely,



RUSSELL S. BARRON
Director

