United States General Accounting Office

GAO

Report to Congressional Requesters

September 2000

NURSING HOMES

Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives

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GAO/HEHS-00-197

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Abbreviations

CPR	cardiopulmonary resuscitation
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OSCAR	On-Line Survey, Certification, and Reporting System
SAQIP	State Agency Quality Improvement Program

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United States General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-284751

September 28, 2000

The Honorable Charles E. Grassley
Chairman
The Honorable John B. Breaux
Ranking Minority Member
Special Committee on Aging
United States Senate

The Honorable Christopher S. Bond
United States Senate

Since 1997, the Senate Special Committee on Aging has focused considerable attention on the need to improve the quality of care for the nation's 1.6 million nursing home residents, a highly vulnerable population of elderly and disabled individuals. In a series of reports and testimonies prepared at the Committee's request, we found significant weaknesses in federal and state survey and oversight activities designed to detect and correct quality problems.[1] For example, we reported that about 15 percent of the nation's 17,000 nursing homes—an unacceptably high number—repeatedly had serious care problems that caused actual harm to residents or placed them at risk of death or serious injury (immediate jeopardy). Our key findings on the nursing home survey process included the following:

- The results of state surveys understated the extent of serious care problems, reflecting procedural weaknesses in the surveys and their predictability.
- Serious complaints by residents, family members, or staff alleging harm to residents remained uninvestigated for weeks or months.
- When serious deficiencies were identified, federal and state enforcement policies did not ensure that the deficiencies were addressed and remained corrected.
- Federal mechanisms for overseeing state monitoring of nursing home quality were limited in their scope and effectiveness.

Concurrent with the Committee's July 1998 hearing, the President announced a series of initiatives intended to address many of the

[1]See related GAO products listed at the end of this report.

weaknesses we identified. Since that time, the Administration has expanded the number of initiatives to about 30 and the Congress has appropriated additional funds to support the increased workload associated with implementing the initiatives. To determine the effect of the initiatives, you asked us to assess (1) progress in improving the detection of quality problems and changes in measured nursing home quality, (2) the status of efforts to strengthen states' complaint investigation processes and federal enforcement policies, and (3) additional steps taken at the federal level to improve oversight of states' quality assurance activities.

In conducting our review, we analyzed data from the federal On-Line Survey, Certification, and Reporting (OSCAR) System, which compiles the results of state nursing home surveys. We visited California, Missouri, Tennessee, and Washington, interviewing officials in state survey agencies and their district offices.[2] California and Missouri represented states that were about average in terms of the number of actual harm and immediate jeopardy deficiencies cited in state surveys prior to the initiatives. Tennessee represented the low end of the range and Washington the high end. We also contacted officials in Maryland and Michigan, states that were included in our prior work. In addition, we interviewed Health Care Financing Administration (HCFA) officials at both headquarters and regional offices. HCFA, an agency within the Department of Health and Human Services (HHS), is responsible for ensuring that each state establishes and maintains the capability to periodically survey nursing homes that receive federal payments in order to ensure that the homes provide quality care to residents. Finally, we reviewed relevant documents from both state agencies and HCFA. We conducted our review from January to August 2000 in accordance with generally accepted government auditing standards.

Results in Brief

Overall, the introduction of the recent federal quality initiatives has generated a range of nursing home oversight activities that need continued federal and state attention to reach their full potential. The states are in a period of transition with regard to the implementation of the quality

[2]State surveyors are typically assigned to local district offices (sometimes referred to as regional offices) that are responsible for conducting nursing home surveys and complaint investigations. In Missouri, separate state offices are responsible for overseeing hospital-based and all other nursing homes. We focused our work on the Missouri office that oversees the approximately 85 percent of all nursing homes that are not hospital-based.

initiatives, in part because HCFA is phasing them in and in part because states did not begin their efforts from a common starting point. Efforts at the federal level toward improving the oversight of states' quality assurance activities have commenced but are unfinished or need refinement.

Federal initiatives were introduced to strengthen the rigor with which states conduct required annual nursing home surveys. The states we visited have begun to use the new methods introduced by the initiatives to spot serious deficiencies when conducting surveys, but HCFA is still developing important additional steps that may not be introduced until 2002 or 2003. Likewise, efforts to reduce the predictable timing of the surveys—that is, to minimize the opportunity for homes so inclined to cover up problems—have been modest to date. To measure the effect of the survey process improvements, we analyzed the change in the number of nursing homes cited for serious deficiencies in the periods before and after the introduction of the quality initiatives. Our results showed a marginal increase nationwide in the proportion of homes with documented actual harm and immediate jeopardy deficiencies, although there was considerable variation across states, with some states experiencing a decrease in homes with these deficiencies. These results suggest that states may have become more rigorous in their identification and classification of serious deficiencies. The results could also indicate that the volume of such deficiencies has actually increased slightly nationwide, a situation consistent with states' heightened concerns about potential facility staff shortages during this same time period.

The states we contacted also have made strides in improving their investigations of and follow-up to complaints, but not enough time has elapsed to consider these efforts complete. For example, the states in our review were not yet investigating all complaints that allege actual harm to a resident within 10 days, as HCFA now requires, but were working toward that goal by hiring additional surveyors to staff the investigations, establishing procedures that make it easier to file complaints, or developing new tracking systems to improve their oversight of complaint investigations by local district offices. For some states, the provision of federal funding to support the nursing home initiatives came too late in the state budget cycle for agencies to capitalize on the additional funds for fiscal year 1999. HCFA also has strengthened the enforcement tools available to sanction nursing homes that are cited for actual harm and immediate jeopardy violations, but too little time has elapsed to assess the application of these tools. Early indications from some states are that their referrals of homes to HCFA for sanctions are on the rise. Finally, additional

funds were provided in fiscal years 1999 and 2000 to hire new HHS staff in order to reduce the large number of pending appeals by nursing homes and to collect assessed fines faster. The expectation is that the more expeditious resolution of appeals will heighten the deterrent effect of civil fines. It is too early to assess the effect of the additional funding on the number of pending appeals because the new staff were only hired within the past year and other changes in enforcement policy are expected to increase the volume of nursing home appeals.

To improve nursing home oversight at the federal level, HCFA has made recent organizational changes to address past consistency and coordination problems between its central office and 10 regional offices. It also intends to intensify its use of management information data systems and reports to verify and assess states' oversight activities and view more closely the performance of the homes themselves. Our review showed that an examination of previously available information could have identified shortcomings in a state's survey activities even before they came to light as the result of a criminal investigation.

Background

Oversight of nursing homes is a shared federal and state responsibility. On the basis of statutory requirements, HCFA defines standards that nursing homes must meet to participate in the Medicare and Medicaid programs and contracts with states to assess whether homes meet these standards through annual surveys and complaint investigations. The "annual" standard survey, which must be conducted on average every 12 months and no less than once every 15 months at each home, entails a team of state surveyors spending several days in the home to determine whether care and services meet the assessed needs of the residents and whether the home is in compliance with long-term-care facility requirements. HCFA establishes specific protocols, or investigative procedures, for state surveyors to use in conducting these comprehensive surveys. In contrast, complaint investigations, also conducted by state surveyors but following the individual state's procedures, within certain federal guidelines and time frames, typically target a single area in response to a complaint filed against a home by a resident, the resident's family or friends, or nursing home employees. Quality-of-care problems identified during either standard surveys or complaint investigations are classified in one of 12 categories according to their scope (the number of residents potentially or actually affected) and their severity. An A-level deficiency is the least serious and is isolated in scope, while an L-level deficiency is the most

serious and is considered to be widespread in the nursing home (see table 1). At some homes, state surveyors identify no deficiencies.

Table 1: Scope and Severity of Deficiencies

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

[a]Actual or potential for death/serious injury.

[b]Nursing home is considered to be in "substantial compliance."

Ensuring that documented deficiencies are corrected is likewise a shared responsibility. HCFA is responsible for enforcement actions involving homes with Medicare certification—about 86 percent of all homes.[3] The scope and severity of a deficiency determines the applicable enforcement action and whether it is optional or mandatory. Enforcement actions can involve, among other things, requiring corrective action plans; monetary fines; denying the home Medicare and Medicaid payments; and, ultimately, terminating the home from participation in these programs. Sanctions are imposed by HCFA on the basis of state referrals. HCFA normally accepts a state's recommendations for sanctions or other corrective actions but can modify them. Before a sanction is imposed, federal policy generally gives nursing homes a grace period of 30 to 60 days to correct a deficiency. States may also use their state licensure authority to impose state sanctions, and some prefer to do so because they may impose them immediately, without giving the home a grace period to correct the deficiency.[4] States are responsible for enforcing standards in homes with Medicaid-only certification—about 14 percent of the total. They may use the federal

[3]Included in this percentage are homes certified for both Medicaid and Medicare.

[4]If a state has a unique enforcement sanction, it may obtain HCFA approval to use it in lieu of a federal remedy. The state must satisfy HCFA that its sanction is as effective as a federal remedy in deterring noncompliance and correcting deficiencies. In addition, state sanctions must meet several general requirements, including timing and notice requirements in federal regulations and, according to HCFA, consistency with statutory intent.

sanctions or rely upon their own state licensure authority and nursing home sanctions.

HCFA also is responsible for overseeing each state survey agency's performance in ensuring quality of care in its nursing homes. Its primary oversight tools are the federal comparative and observational surveys conducted annually in at least 5 percent of the nation's certified Medicare and Medicaid nursing homes. A comparative survey involves a federal survey team conducting a complete, independent survey of a home within 2 months of the completion of a state's survey in order to compare and contrast the findings.[5] In an observational survey, one or two federal surveyors accompany a state survey team to a nursing home to watch the team conduct survey tasks, give immediate feedback, and later rate the team's performance. The vast majority of federal surveys are observational. Additionally, in 1996 HCFA initiated the State Agency Quality Improvement Program (SAQIP), which requires states to self-report their compliance with seven performance standards and to implement quality improvement plans to address any deficiencies identified in their survey processes.

In its federal monitoring role, HCFA directs the states' implementation of the Administration's nursing home initiatives, which are intended to improve nursing home oversight and quality of care. Many of the initiatives address previous problems identified by us, HCFA, and others. This report focuses on selected initiatives from the following three areas:

- Improving nursing home reviews. These initiatives are intended to strengthen states' periodic surveys and complaint investigations, enabling surveyors to better detect quality-of-care deficiencies.
- Ensuring compliance. These initiatives are intended to ensure that homes with serious deficiencies or homes that repeatedly cause harm to residents promptly correct deficiencies and sustain compliance with federal requirements thereafter.
- Improving federal monitoring. These initiatives are intended to ensure that HCFA and its regional offices use appropriate oversight mechanisms and data systems to assess the effectiveness of states' survey activities.

[5]The Omnibus Budget Reconciliation Act of 1987 requires HCFA to conduct comparative surveys within 2 months of states' surveys. In August 1999, HCFA urged its regional offices to commence comparative surveys within 14 to 28 days after a state's survey.

Appendix I provides a chronology of and summarizes the key quality initiatives discussed in this report. Though many initiatives were announced in July 1998, some important changes were not implemented until the second half of 1999 and others are still in the planning phase.

Progress Made in Improving Annual Surveys, but Measuring the Effect Is Problematic

HCFA and the six states we contacted have taken important steps toward improving the rigor of nursing home surveys. HCFA has begun a major redesign of its nursing home survey methodology, but only phase one of the overall plan has been implemented by state survey agencies. When phase two is completed, HCFA should have significantly improved the tools for effectively identifying the scope and severity of care problems. However, the second phase is not expected to be implemented until 2002 or 2003. Despite the progress to date in improving surveyors' ability to detect deficiencies, the timing of nursing home surveys in some states continues to be predictable, allowing facilities to mask certain deficiencies if they choose to do so. Recognizing the need for self-improvement in the type and extent of oversight, the states we visited are beginning to identify and address other weaknesses in the survey process not covered by the Administration's initiatives. Consistent with the expectation that improvements in the survey process would lead to the identification of more problems, the proportion of homes with serious deficiencies increased in many states after the introduction of survey methodology improvements. Although the identification of more deficiencies could be the result of better detection, growing reports of problems with nursing home staffing raise concerns that the actual proportion of homes with deficiencies may have increased. This possibility underscores the importance of adequate federal and state oversight of nursing homes.

Survey Methodology Strengthened and Further Improvements Are in the Planning Phase

Annual standard surveys provide states the opportunity to systematically and comprehensively assess nursing home quality. In our prior work, we found that surveyors often missed significant care problems—such as pressure sores, malnutrition, and dehydration—because the methods they used lacked sufficient rigor.[6] In addition, problems went undetected because nursing homes were able to predict the timing of their next survey

[6] *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight* (GAO/HEHS-98-202, July 27, 1998).

and, if so inclined, conceal problems such as routinely having too few staff to care for residents.

Sampling Methodology

In response to survey methodology weaknesses, HCFA planned a two-phase revision of the survey process. Phase one introduced a new tool to help surveyors do a better job of selecting a resident sample, instructed states to increase the sample size in areas of particular concern, and required the use of investigative protocols intended to make the survey process more systematic. Still in the planning stages, phase two improvements will tackle problems that remain, such as ensuring rigor in the augmentation of the initial sample selected off-site and improving the thoroughness of the on-site investigations.

Surveyors' assessment of the quality of care provided to a sample of residents serves as the basis for evaluating nursing homes. Effective July 1999, HFCA instructed state survey agencies to begin using "quality indicators" to review information on the care provided to a home's residents before actually visiting the home. Quality indicators are essentially numeric warning signs of the prevalence of care problems, such as greater-than-expected instances of weight loss, dehydration, or pressure sores. They are derived from nursing homes' assessments of residents and rank a facility in 24 areas compared with other nursing homes in the state.[7] By using the quality indicators to select a preliminary sample of residents before the on-site review, surveyors are better prepared to identify potential care problems.[8] Surveyors augment this preliminary sample with additional resident cases once they arrive at the nursing home. In conjunction with the introduction of quality indicators, HCFA also instructed surveyors to (1) increase the sample size in areas such as maintaining proper body weight (nutrition), fluid intake (dehydration), and pressure sores and (2) begin using a series of investigative protocols in these and other areas. The protocols are procedural instructions intended to provide greater standardization and make the on-site surveys thorough.

[7]Quality indicators were the result of a HCFA-funded project at the University of Wisconsin. The developers based their work on nursing home resident assessment information known as the minimum data set—data that all homes are required to report to HCFA. See Center for Health Systems Research and Analysis, *Facility Guide for the Nursing Home Quality Indicators* (University of Wisconsin-Madison: Sept. 1999).

[8]Prior to the introduction of quality indicators, selection of the sample was less systematic, relying on a listing of residents and their conditions maintained at the nursing home and on observation of residents made during a walk-through of the facility.

Our prior work noted that the sample typically included an insufficient number of different types of resident cases to adequately identify serious quality problems.

The need to provide training in the use of quality indicators to the approximately 3,500 state nursing home surveyors delayed implementation. HCFA held four training sessions for about 800 supervisory-level staff—state survey directors, state trainers, and lead surveyors—during April through June 1999. In turn, these individuals trained surveyors in their local offices.

Though the use of quality indicators and protocols introduced more rigor into the survey process, they are not a panacea for all survey methodology problems. Because the basis for quality indicators is self-reported data by nursing homes, there needs to be confidence that the data are accurate. In addition, some portion of the residents selected using the quality indicators may no longer be in the nursing home—a problem frequently identified by the surveyors we interviewed. These problems highlight the importance of on-site augmentation of the sample. Finally, the current protocols are a starting point, but additional steps need to be taken to ensure that surveyors thoroughly and systematically assess the care areas targeted using the quality indicators.

To address these remaining problems with sampling and the investigative protocols, HCFA is planning a second revision of its survey methodology to be implemented in 2002 or 2003. The focus of phase two is (1) improving the on-site augmentation of the preliminary sample selected off-site using the quality indicators and (2) strengthening the protocols used by surveyors to ensure more rigor in their on-site investigations. We continue to believe that implementation of this phase is necessary for HCFA to fully respond to our recommendation to significantly improve the ability of surveys to effectively identify the existence and extent of deficiencies.

Survey Predictability

To address the predictability problem, HCFA required states to start at least 10 percent of standard surveys outside the normal workday—either on weekends, in the early morning, or in the evening—beginning January 1, 1999. HCFA also instructed the states to avoid, if possible, scheduling a home's survey for the same month as the one in which the home's previous standard survey was conducted.

Tracking states' progress in implementing surveys that begin outside the normal workday has been problematic for HCFA. The agency did not modify its data system to allow states to identify such surveys in OSCAR until August 1999—8 months after the requirement to conduct such surveys was implemented. In February 2000, HCFA instructed states to begin identifying off-hours surveys in OSCAR for those conducted on or after October 1, 1999. HCFA data for the period October 1, 1999, through June 30, 2000, indicate that nationally about 10 percent of surveys were started outside normal working hours. However, in August 2000, HCFA sent letters to states performing well below the 10-percent target, reminding them of the requirement, asking them to confirm the accuracy of OSCAR data, and asking how they intend to increase their percentage of off-hour surveys.[9]

Though varying the starting time of surveys may be beneficial, this initiative is too limited in reducing survey predictability. Our analysis of the most current survey data shows that between 29 percent and 56 percent of the surveys conducted in six states were predictable (see table 2). Many surveys could be viewed as being predictable because they were conducted within a month of the 15-month limit between annual surveys. As the 15-month limit approaches, homes are aware that the survey will soon occur. Both California and Maryland officials attributed delays in conducting annual surveys to the increased emphasis on investigating complaints more promptly, which required delaying many annual surveys. In fact, a third of the surveys in Maryland as well as 10 percent of California and 7 percent of Michigan surveys were late—that is, conducted after the 16th month.

Surveys that occur at nearly the same time each year may also be considered predictable. As table 2 shows, over half the surveys in Tennessee were conducted within 15 days of the anniversary of the previous standard survey. Tennessee officials told us that their predictability problem resulted in large part from a state law requiring homes to be surveyed at least every 12 months instead of the maximum 15 months permitted by federal law.[10] We continue to believe that our July 1998 recommendation to make annual surveys less predictable by segmenting them into more than one review throughout the year has merit.

[9]States still have the opportunity to meet the 10-percent requirement by performing more than 10 percent of surveys off-hours during the remainder of the fiscal year.

[10]In May 2000, Tennessee modified this law to permit homes to be surveyed at a maximum interval of 15 months.

Such an approach would give surveyors more opportunities to observe problematic homes and initiate broader reviews when warranted.

Table 2: Predictable Surveys for Nursing Homes in Six States

State	Number of homes	Surveyed within 15 days of 1-year anniversary of last survey (percent)[a]	Surveyed between 14 and 15 months after last survey (percent)	Surveyed between 15 and 16 months after last survey (percent)	Predictable surveys (percent)
California	1,301	8.0	31.4	15.0	54.4
Maryland	243	4.9	14.8	9.0	28.7
Michigan	434	14.0	14.3	9.9	38.2
Missouri	476	11.1	13.9	8.8	33.8
Tennessee	351	56.1	0	0	56.1
Washington	278	15.1	17.6	1.0	33.7

Note: Data were extracted from OSCAR in August 2000. Homes not showing a prior survey date were not included in this analysis.

[a]For the "15-day" analysis, we included homes whose current survey was conducted between 15 days preceding and 15 days following the 1-year anniversary of the prior survey.

[b]For Missouri, hospital-based nursing homes were excluded (see footnote 2).

State Initiatives

States are also undertaking their own initiatives to improve the survey process. In some cases, these changes are under way but not complete. Some states plan to hire new surveyors (see table 3) and have made efforts to improve the monitoring of their local survey offices. California plans to hire 200 new surveyors in 2000 in order to increase the frequency and unpredictability of surveys and to expand its oversight of poorly performing homes. In Maryland, the number of surveyors is projected to reach 59 by January 2001—a 100-percent increase since July 1999. Prior to the initiatives, local district offices in California had generally operated with considerable autonomy and with little centralized control. When we visited in April 2000, California was in the process of increasing the number of district offices and realigning existing districts to obtain a more appropriate balance between workload and staffing. To facilitate oversight, each office will report to one of four field coordinators (north, central, south, and Los Angeles) who report directly to the assistant deputy director of the state survey agency. California is also expanding its quality assurance reviews of survey findings after identifying significant problems in survey documentation, including the scope and severity of deficiencies classified lower than the evidence in the survey documentation warranted and errors

in survey procedure. Missouri officials told us that by the end of 2000, they plan to establish a new quality assurance unit that will be responsible for reviewing a largely random sample of completed surveys and complaint investigations from each of its seven district offices. Tennessee increased oversight and control of district office operations by hiring a full-time quality inspector to conduct targeted reviews in each of the state's three district offices. These reviews have resulted in the identification of serious weaknesses in the survey process and the scheduling of remedial training sessions for surveyors.

Table 3: Examples of Planned State Funding Increases to Hire Additional Surveyors and Enhance Oversight of Nursing Homes

State	Objective of state funding increase
California	California's 2000-2001 budget contained an "Aging With Dignity Initiative." It provided over $15 million to hire more than 200 new surveyors to (1) increase the frequency and unpredictability of nursing home surveys, (2) expand reviews of poorly performing nursing homes, and (3) guarantee a rapid response to nonemergency complaints. This initiative also included substantial funding for nursing home quality-of-care enhancements such as providing $10 million for cash awards to exemplary nursing homes. California officials estimate that about one-third of these increases respond to Medicare requirements.
Maryland	Maryland plans to provide $1.1 million for increased state oversight in a supplemental budget for fiscal 2001. Of that, about $600,000 would hire 20 additional inspectors, allowing the state to visit nursing homes twice a year instead of once.
Missouri	Missouri's state legislature provided $318,000 in appropriation authority to help fund 27 positions to meet new or enhanced state and federal mandates related to survey, licensure, and complaint activities at long-term-care facilities.

Considerable Inter-State Variation Still Exists in Citation of Serious Deficiencies, but Range Is Beginning to Narrow

Consistent with the expectation that improvements in the survey process would lead to the identification of more problems, the proportion of homes identified with serious deficiencies increased in a majority of states after the introduction of survey methodology improvements. The variation in actual harm and immediate jeopardy deficiencies is still great—ranging from 10.5 percent of homes in Maine to 58 percent in Washington—but appears to be narrowing.

Table 4 shows the change in actual harm and immediate jeopardy deficiencies in states where a minimum of 100 nursing homes was surveyed since January 1999.[11] In some states, these shifts were significant:

- Seventeen states had a 5 percentage point or greater *increase* in the proportion of homes identified with actual harm and immediate jeopardy deficiencies. Most were states with the lowest proportion of homes with such serious deficiencies before the initiatives.
- Eight states experienced a 5 percentage point or greater *decrease* in the identification of serious deficiencies. These states generally cited a high proportion of homes with serious deficiencies before the initiatives (well above the national average), and some were still near or above the national average after the initiatives.
- The remaining 13 states were relatively stable—experiencing approximately a 3-percentage-point change or less.

Our analysis suggests that the extent of the variation across states in actual harm and immediate jeopardy citations has begun to narrow. This outcome is consistent with the initiatives' intent to reduce the considerable inter-state variation through a strengthened and more consistent survey process.

[11]We excluded Alaska, Delaware, the District of Columbia, Hawaii, Idaho, Mississippi, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Rhode Island, and Wyoming from this analysis because fewer than 100 homes were surveyed and even a small increase or decrease in the number of homes with serious deficiencies in such states produces a relatively large percentage point change.

Table 4: Homes With Actual Harm and Immediate Jeopardy Deficiencies Before and After Implementation of the Quality Initiatives

State (includes only those in which 100 or more homes were surveyed since 1/99)	Number of homes surveyed (1/99 to 7/00)	Percentage of homes with actual harm and immediate jeopardy deficiencies		Percentage point difference
		Before initiatives (1/97 to 7/98)	After initiatives (1/99 to 7/00)	
Increase of 5 percentage points or greater				
Arizona	125[a]	17.2	36.8	19.6
Arkansas	253[a]	14.7	30.8	16.1
New York	606	13.3	27.6	14.3
Tennessee	353	11.1	24.1	13.0
North Carolina	409	31.0	42.1	11.1
New Jersey	336[a]	13.0	23.8	10.8
Oregon	157	43.9	53.5	9.6
Massachusetts	541	24.0	32.9	8.9
West Virginia	144	12.3	20.1	7.8
Indiana	581	40.5	48.2	7.7
Louisiana	365[a]	12.7	20.3	7.6
Georgia	364	17.8	25.0	7.2
Mississippi	196[a]	24.8	31.6	6.8
Oklahoma	394[a]	8.4	15.0	6.6
Colorado	229	11.1	16.6	5.5
Maryland	188[a]	19.0	24.5	5.5
Missouri[b]	565	21.0	25.7	4.7
Change of less than 5 percentage points				
Maine	124	7.4	10.5	3.1
Minnesota	437	29.6	32.5	2.9
Texas	1,313	22.2	24.9	2.7
Michigan	442	43.7	45.9	2.2
Nation	**16,854**	**27.7**	**29.5**	**1.8**
Pennsylvania	774	29.3	30.7	1.4
Illinois	891	29.8	31.1	1.3
South Carolina	176	28.6	29.5	0.9
Connecticut	260	52.9	53.5	0.6
Montana	105	38.7	39.0	0.3
California	1,301[a]	28.2	28.2	0.0
Wisconsin	424	17.1	14.6	-2.5
Ohio	995	31.2	28.6	-2.6

(Continued From Previous Page)

State (includes only those in which 100 or more homes were surveyed since 1/99)	Number of homes surveyed (1/99 to 7/00)	Percentage of homes with actual harm and immediate jeopardy deficiencies		Percentage point difference
		Before initiatives (1/97 to 7/98)	After initiatives (1/99 to 7/00)	
Kentucky	306	28.6	25.2	-3.4
Decrease of 5 percentage points or greater				
Virginia	282	24.7	19.5	-5.2
Washington	281	63.2	57.7	-5.5
Nebraska	241	32.3	26.6	-5.7
Alabama	225	51.1	41.3	-9.8
Kansas	404[a]	47.0	36.9	-10.1
South Dakota	112[a]	40.3	29.5	-10.8
Florida	746	36.3	21.7	-14.6
Iowa	428[a]	39.2	22.7	-16.5

[a]Compared with the period before the initiatives, there was more than a 10-percent difference in the number of homes analyzed for these states. In part, these differences are explained by the fact that some states have still not recorded the results of a home's most recent survey in OSCAR.

[b]Although our work in Missouri focused on the agency responsible for oversight of non-hospital-based nursing homes, hospital-based facilities in the state were included in developing this table.

Concerns Exist That Quality Has Been Affected by Problems in Maintaining Adequate Facility Staffing

Although increased deficiencies could be the result of better detection, reports from states of problems with nursing home staffing raise concerns that actual deficiencies may have increased. In July 2000, HCFA released a report that found a direct relationship between low nursing home staffing levels and poor quality of care.[12] Recruiting and retaining staff for nursing homes has been a long-term concern. According to state officials and nursing home surveyors we interviewed in the spring of 2000, however, recruiting and retaining nursing home aides has become more difficult, a situation that they also believe has affected the quality of care provided to nursing home residents. We were told that nursing homes often have difficulty filling vacancies, resulting in an inadequate number of qualified and trained staff. Reasons cited for the growing staffing problems include a highly competitive job market resulting from the robust economy; increased demand for staff from alternatives to nursing homes, such as assisted living facilities; and lower wages and benefits for nursing aides compared with other health- and non-health-sector opportunities.[13]

A significant number of states have taken steps that attempt to improve the recruitment and retention of direct care staff. We identified 16 states that have increased and 4 others that plan to increase Medicaid payments to supplement nursing home staff wages and/or benefits by a specific amount, commonly referred to as a "wage pass-through."[14] For example, Michigan's current wage pass-through provides for a maximum increase of 75 cents per hour for staff. Maine has implemented a one-time supplement to its payments, which gives nursing homes the flexibility to either establish new positions or to increase the wages of direct care staff. Some states are requiring that facilities maintain minimum staffing levels in order to receive the additional funding through their wage pass-through programs. In

[12]See *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes* (Baltimore, Md.: HCFA, Summer 2000), Vols. I-III.

[13]A 1996 Institute of Medicine study documented similar reasons for turnover and retention problems among nurse's aides: Institute of Medicine, *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?* (Washington, D.C.: National Academy Press, 1996).

[14]Wage pass-throughs provide a specific amount or percentage increase in reimbursement, earmarked typically for direct care staff's—such as nurses and nurse's aides—salaries and/or benefits. States that have enacted wage pass-throughs include Arkansas, California, Connecticut, Florida, Kansas, Maine, Michigan, Minnesota, Montana, Oklahoma, South Carolina, Texas, Utah, Vermont, Virginia, and Wisconsin. Four other states—Louisiana, Maryland, Massachusetts, and Missouri—recently passed legislation and have not yet implemented their wage pass-through programs.

Arkansas, facilities are required to maintain state established minimum staffing levels based on the number of facility residents if they choose to receive the $4.93 increase in Medicaid reimbursement per patient day. (See app. III for a brief description of each state's program.)

Complaint and Enforcement Processes Are Improving, but States Report Fiscal Year 1999 Federal Initiatives Funding Was Largely Unspent

In addition to taking steps to improve the detection of serious deficiencies during annual surveys, the Administration's nursing home initiatives instructed states to investigate complaints that allege actual harm more promptly. Recognizing that this change and others required by the initiatives, such as the introduction of quality indicators and investigative protocols, would increase the workload of state survey agencies, the Congress appropriated additional funds for their implementation. States reported that their fiscal year 1999 initiatives funds were not fully used, in part due to their late distribution. This situation, in turn, slowed down the hiring of additional staff needed to be fully responsive to the initiatives, including investigating complaints more promptly. Finally, it is too early to determine whether the changes in federal enforcement policy intended to make it harder for nursing homes to avoid sanctions will achieve their goal of encouraging facilities to sustain compliance with federal requirements.

States Have Increased Priority Attached to Complaints but Generally Have Been Unable to Meet New Investigative Time Frames

Complaint investigations provide an opportunity for state surveyors to intervene promptly if quality-of-care problems arise between surveys. However, in our prior work we found numerous problems in states' complaint investigation processes. For instance, some states were making it unnecessarily complicated for individuals to file complaints; some were inappropriately classifying complaints of actual harm as low priority for investigation; and some frequently did not investigate complaints within required time frames, potentially prolonging harm to residents.[15] HCFA had historically played a minimal role in providing states with guidance and oversight of complaint investigations.[16]

[15] *Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents* (GAO/HEHS-99-80, Mar. 22, 1999).

[16] *Nursing Homes: Stronger Complaint and Enforcement Practices Needed to Better Ensure Adequate Care* (GAO/T-HEHS-99-89, Mar. 22, 1999).

In March 1999, HCFA took a major step to strengthen state complaint procedures by instructing the states to investigate complaints alleging actual harm to a resident within 10 working days of receiving the complaint. Previously, states could set their own investigative time frames, except that they were required to investigate within 2 working days all complaints alleging immediate jeopardy conditions. Two of the six states we contacted previously had requirements for investigating complaints alleging actual harm that exceeded 10 days, but have since formally modified their complaint criteria in response to HCFA's instruction.[17] Despite modifying their complaint investigation time frames to include a 10-day requirement, states generally have not been able to investigate all such complaints on time. For instance, Tennessee was able to investigate about one-fourth of its actual harm complaints within 10 days, while Washington was able to investigate more than three-fourths on time. (See table 5.) State officials we interviewed generally attributed their inability to investigate all actual harm complaints in 10 days to an increase in the number of complaints received, limited staff, and competing priorities, particularly the need to complete standard surveys on time.

Table 5: State Investigative Time Frames for Complaints Prior to the Initiatives and Extent to Which States Meet the 10-Day Requirement for Actual Harm

State	Had a 10-day requirement prior to HCFA's March 1999 instruction?	Number of 10-day complaints received in 1999	Percentage of 10-day complaints investigated timely in 1999
California	Yes	6,484	56[b]
Maryland	Yes	547[a]	33[c]
Michigan	No—30 days	17[a]	100[d]
Missouri	[e]	2,577[a]	74[f]
Tennessee	No—60 days	563[a]	About 25[f]
Washington	Yes	2,614	76

[a]Data for Maryland, Michigan, and Tennessee represent the last 6 months of 1999 and thus do not portray all complaints received in 1999. Data for Missouri are for the 12-month period ending June 30, 2000.

[17]Because of the requirement for annual surveys and other priorities, HCFA recognized that not all states would be able to meet the 10-day standard and, in October 1999, issued guidance including techniques to help states identify complaints having a higher level of actual harm.

[b]California's low percentage is due in part to state regulations that permit only two categories of complaints: (1) complaints alleging immediate jeopardy requiring investigation within 2 days and (2) all other complaints that must be investigated within 10 days. To ensure that actual harm complaints are investigated within 10 days, California officials told us that they first attempt to identify such complaints and then triage those to ensure that the most serious are promptly investigated.

[c]This represents a substantial improvement from early 1998, when it investigated only 1 of 18 complaints—about 6 percent—within 10 days.

[d]Although Michigan investigated all actual harm complaints timely, it categorized only 17 of 902 complaints received in the last half of 1999 as actual harm. It categorized 67 complaints as immediate jeopardy, requiring investigation in 24 hours, and 818 as nonpriority, requiring a visit to the home within 15 days.

[e]Prior to Missouri's adoption of the 10-day requirement, complaint investigations were initiated within 24 hours if there was "imminent danger" to a resident or a "direct or immediate relationship to the health, safety or welfare of any resident, but which did not create any imminent danger." Missouri officials told us that some actual harm complaints fell into this latter category but that not all could be initiated within 24 hours. Those not investigated within 24 hours would have slipped into the next category, which at the time was 90 days. In addition to creating a 10-day category, Missouri no longer allows complaint investigations of less serious complaints to be delayed as long as 180 days. The maximum time for investigating complaints is now 60 days.

[f]Officials told us that this is an estimate because the state's ongoing transition to a new complaint tracking system makes it difficult to determine the exact percentage.

Source: State survey agency officials.

The increased attention HCFA and the states have placed on conducting complaint investigations in the past 18 months has had some positive results. For example, among the states we visited, as well as Maryland and Michigan, we noted the following improvements:

- Increased survey resources. Several states have increased, or plan to increase, the number of surveyors, some of whom will be assigned to complaint investigations. The increased staff will enable states to devote more attention to complaint investigations. Some states also have dedicated staff to conducting complaint investigations. For instance, Michigan has created a complaint investigation team of 11 surveyors representing about 10 percent of the state's total surveyors. Washington also plans to increase its number of complaint investigators from 8 to 13.
- Improvements in classifying complaints and setting investigation priorities. All the states in our study require that the seriousness of complaints be determined by an experienced surveyor, and Tennessee and Washington further require that the surveyor be a licensed nurse. In Missouri, individuals without survey experience had been responsible for classifying complaints, but now an experienced district office surveyor, normally a nurse, does so. While positive, these changes do not obviate the need for centralized oversight by state survey agency management. Thus, the low number of actual harm complaints in Michigan compared with other states raises a question about whether

complaints are being appropriately classified. We noted a similar issue in one of Tennessee's three district offices.

- Organizational changes. To improve control and oversight of complaint investigations, both Maryland and Michigan have consolidated their nursing home complaint and survey activities into one office under a single manager. In addition, Michigan added a manager responsible for direct oversight of the complaint investigation team. Missouri created a state complaint coordinator to ensure that complaints are handled in a timely manner.
- Upgraded information systems. Several states now are automating their information systems to help track complaints more effectively. Such data systems are necessary to ensure compliance with HCFA guidance on complaint investigation prioritization and timeliness. For example, Missouri plans to implement a new automated system in 2001 that is expected to significantly improve management's ability to track the status and results of complaint investigations. Tennessee is implementing a new system that will replace the manual tracking of complaints. Also, in early 1999, Washington modified its complaint tracking system to permit its district offices to better track complaints during the investigation process.

HCFA intends to issue more detailed guidance to the states in 2001 as part of its complaint investigation improvement project. Among other things, the project will (1) identify complaint investigation processes that all states could implement, (2) establish elements of a national reporting system, (3) identify methods for HCFA to monitor state complaint investigation processes, and (4) identify model programs or practices that make complaint investigations more effective and prevent abuse and neglect. Our comparison of six states' complaint processes also identified variations in practices and results that HCFA could address in any additional guidance it issues. For instance, although there is no federal requirement that states operate a toll-free complaints line, Tennessee was the only state among those we visited that has chosen not to provide this service. Tennessee received only about half as many complaints per nursing home in 1999 as Missouri and Washington, both of which have a consumer-friendly toll-free service that is an integral part of the complaint intake process. Maryland partially attributes a recent 250-percent increase in the number of complaints received to its new toll-free number. In addition, some significant differences appear to exist in how states classify complaints. For instance, during the last 6 months of 1999, Maryland categorized 62 percent of the complaints it received as potential actual harm, while

Michigan put only 2 percent of its complaints in this category during the same period.

States Report That Additional Federal Funds Provided for Nursing Home Initiatives Were Largely Unspent During Fiscal Year 1999

The Administration and the Congress recognized that additional resources were needed to address expanded workloads associated with implementing the nursing home quality initiatives.[18] However, the distribution of initiatives funding late in the fiscal year contributed to implementation delays. The Medicare survey and certification budget was increased significantly in fiscal years 1999 and 2000 (see table 6). About $8 million of a $21 million fiscal year 1999 increase and $23.5 million of a $34.7 million fiscal year 2000 funding infusion were for workload growth attributable to the nursing home initiatives. However, the initial federal allocation of fiscal year 1999 money to the states occurred in March 1999 and the final federal allocation in June 1999.[19] Although several reporting discrepancies are evident, a majority of states reported not using (that is, expending or obligating) their full fiscal year 1999 initiatives allocation. However, interviews with state officials sometimes contradicted information provided in these reports, raising questions about the actual disposition of these funds. According to state officials we interviewed, other factors that contributed to some or all of the initiatives funds not being used in fiscal year 1999 included (1) the need for state legislative authorizations to raise staffing ceilings and to use the new federal funds and (2) problems in meeting HCFA's requirement to account for initiative funds separately from other survey and certification funding.[20] States have not yet submitted final expenditure reports for their fiscal year 2000 initiative allocations.

[18]HCFA determined that additional state resources would be consumed by initiatives that required states to better target and monitor poorly performing homes and to investigate any complaint alleging actual harm within 10 days of complaint receipt. HCFA also anticipated that the use of quality indicators would increase surveyor preparation time prior to visiting a nursing home and that this could lead to a net increase in total survey time.

[19]Appropriated funds are neither automatically nor immediately available for use. First, the funds must be apportioned by the Office of Management and Budget to HHS and allotted (a delegation of authority to incur obligations) by HHS to HCFA. HCFA then determines, on the basis of state workload and expenditure data, what amount should be allocated to each state and advises its regional offices of these suggested amounts. In fiscal year 1999, regional offices could reallocate among the states up to 15 percent of the suggested amounts. The regional office then notifies states of award determinations and the ability to incur obligations for these amounts.

[20]This requirement applies to nursing home initiatives funding for fiscal years 1999 and 2000.

Table 6: Federal Medicare and Medicaid Funding for State Survey and Certification Activities

Dollars in millions

Fiscal year	Medicare funding	Medicare funding associated with initiatives	Medicaid funding[a]	Total federal funding
1994	$145.8		$130.4	$276.2
1995	145.8		133.0	278.8
1996	147.6		136.2	283.8
1997	158.0		127.4	285.4
1998	154.0		136.2	290.2
1999	175.0	$8.0[b]	135.1	310.1
2000	209.7[c]	23.5	149.0	358.7
2001[d]	234.1	29.7	Not available	Not available

Note: The state survey and certification budget is used to ensure that institutions providing health care services to Medicare and Medicaid beneficiaries meet federal health, safety, and quality standards. Institutions covered include hospitals, home health agencies, and end-stage renal disease facilities, as well as nursing homes. The federal government funds 100 percent of costs associated with certifying that nursing homes meet Medicare requirements and 75 percent of the costs associated with Medicaid standards. States usually pay additional costs associated with ensuring that nursing homes meet state-established licensing standards.

[a]Medicaid funding is reported retrospectively on state expenditure reports. The 2000 level is projected on the basis of the expenditure reports that have been received to date (the first 2-3 quarters of fiscal year 2000).

[b]In fiscal year 1999, the Congress appropriated $4 million for initiative-related costs (P.L. 105-277, Oct. 21, 1998). Subsequently, HCFA reprogrammed another $4 million to help the states cover four key initiatives.

[c]For fiscal year 2000, Medicare funding to states included about $5 million that was reprogrammed from the Medicare contractor termination budget. The $5 million reprogramming was primarily intended to support additional complaint investigations required by one of the initiatives.

[d]President's budget request.

Source: Center for Medicaid and State Operations, HCFA.

According to fiscal year 1999 initiatives expenditure reports, only six states used their full fiscal year 1999 initiatives allocation, and less than $4 million of the $8 million available for the initiatives was spent.[21] Discrepancies between the initiatives expenditure reports and the separate reports that capture all survey and certification expenditures (including the initiatives) raise the possibility that some states may have spent their initiatives funding but failed to account separately for initiatives expenditures as required by HCFA.[22] Overall, however, the two reports indicated that 28 states did not use their full fiscal year 1999 initiatives or survey and certification funding allocations, suggesting that a substantial portion of the $8 million was not used for the nursing home initiatives during fiscal year 1999.

We attempted to clarify these issues by contacting nine states, including seven that HCFA officials indicated had not filed a nursing home initiatives expenditure report. Officials in three states told us that, essentially, these funds were used even though their initiatives expenditure reports showed otherwise. Officials in the other six states said that they did not expend their full fiscal year 1999 initiatives allocation. (See table 7.) In some cases, however, what state officials told us appears inconsistent with their other survey and certification expenditure reports. Neither HCFA nor state officials were able to explain these discrepancies. For example, two Missouri budget officials told us that none of the state's $262,000 fiscal year 1999 initiatives funding was used, while an official at the state survey agency was certain that an undetermined amount had been expended on initiatives related training. This latter interpretation is supported by the state's survey and certification expenditure report that suggests that $161,000 of these funds may have been spent during fiscal year 1999.

[21]According to HCFA officials, nursing home initiatives funds appropriated in fiscal year 1999 may only be used for this purpose. These officials advised us that after HCFA makes the funds available to the states, the states must expend or obligate the funds during the same federal fiscal year. They explained that HCFA may reallocate funds not spent by one state during a particular fiscal year to a state that expended more than it was initially provided for that fiscal year.

[22]One possible explanation of these discrepancies is the fact that HCFA did not require states to specifically account for nursing home initiatives expenditures until December 1999.

Table 7: Summary of Information Provided by Nine States on Their Fiscal Year 1999 Nursing Home Initiatives Allocation

State	Allocation amount	Amount reported as not expended	Summary of remarks by state officials
California	$1,002,400	$277,508	State officials told us that the full nursing home initiatives allocation was used and indicated a supplemental expenditure report would be submitted to HCFA.
Delaware	24,540	24,540	None of the state's allocation was used because of reorganization issues, existing surveyor vacancies, and late availability of funds.
Illinois	432,316	325,544[a]	The full allocation was not used because of the late availability of funds and the provision of more funds than were needed for new mandates.
Kansas	125,245	67,700[a]	The full allocation was not used because start-up of several initiatives was delayed past originally expected dates.
Missouri	261,958	Some[b]	Only part of the allocation was used because of the late availability of funds and the difficulty meeting accounting requirements.
Nebraska	70,179	1,604	HCFA did not have the state's initiatives expenditure report and believed the state had not used any of these funds. The state was able to provide a copy of its report showing that all but a small amount of its allocation had been used.
Pennsylvania	286,030	154,200[a]	The full allocation was not used because of delays in the start-up of initiatives (July 1999). Labor relations issues related to surveys initiated outside normal work hours were also a problem.
Tennessee	100,974	94,530[a]	Although the late availability of initiatives funding was a problem, most of the money was used. The state would have preferred using the money to hire additional surveyors but, because of late availability, used most of the funds for a surveyor pay increase.
Utah	49,351	24,675	The full allocation was not used because of late availability of funds.

[a]Though state officials said some of their initiatives allocation was not used, the state's survey and certification expenditure report showed that the entire budget was used during fiscal year 1999, including the allocation targeted for the initiatives.

[b]Missouri's survey and certification expenditure report showed only $101,000 unspent, suggesting that it may have spent $161,000 of its initiatives allocation in fiscal year 1999.

In Missouri, state officials said that the initiatives placed new requirements on the state agency but did not provide resources quickly enough to support these initiatives in fiscal year 1999. The state survey agency's budget authority is set legislatively and cannot be used for new requirements, such as the initiatives, without legislative approval (unless the agency's appropriations bill allows for spending unanticipated federal funds up to a preestablished spending level).[23] Missouri officials also stated that there was insufficient time to implement system adjustments to separately account for the fiscal year 1999 initiatives dollars, as HCFA required. The timing of the fiscal year 1999 increase was considered problematic by several other states, though they were able to use some of these funds. States were not aware of the initiatives when their legislatures met in early to mid-1998 as the initiatives were not announced until July 1998. In addition, officials told us that the availability of funds late in the fiscal year limited their efforts to respond to the new initiatives.

A primary objective of the initiatives funding was to enable states to hire additional nursing home surveyors, particularly to perform complaint investigations. Generally, state officials told us that hiring in the current competitive economy is difficult, that state hiring processes are lengthy and may require legislative authorizations, and that new surveyors are not fully trained for up to a year after they are hired. For example, a Missouri official told us that the time needed to hire surveyors made it hard for the state to use initiatives funds during fiscal year 1999 for this purpose. A Tennessee official said that because of the need for legislative approval to increase staffing the state was unable to use initiatives funds during fiscal 1999 for this purpose. Even with such approval, we were told, it takes 6 months to hire—assuming suitable candidates are available. Instead, Tennessee used the bulk of its initiatives funding for pay increases for long-term-care facility surveyors.

Initiatives Intended to Put More Teeth Into Enforcement Options

Overall, it is too early to tell whether the improvements in federal enforcement policies will have their intended effect of encouraging nursing homes to sustain compliance with federal requirements. The weaknesses in federal enforcement policies we identified in previous reports were essentially attributable to the ability of nursing homes to evade sanctions. For example, our prior work found that the threat of federal sanctions did

[23]Thirty states provide gubernatorial budget authority to spend unanticipated federal funds without approval of the legislature.

not prevent homes from cycling in and out of compliance. In virtually every case of noncompliance, homes were granted a grace period to correct deficiencies before sanctions were recommended or imposed, even when homes had been cited repeatedly for actual harm violations. HCFA guidance also allowed states to accept, in some cases, a home's assertion that it had returned to compliance rather than confirming the correction of serious deficiencies through an on-site visit ("revisit"). Under these circumstances, most deficient homes, even those with repeated deficiencies that harmed residents, did not have sanctions that actually took effect.

HCFA and HHS have attempted to put more teeth into enforcement options by (1) requiring immediate imposition of sanctions without a grace period for homes that repeatedly cause harm to residents, (2) issuing new guidance on revisits, (3) increasing funding for the board that handles nursing home appeals to reduce the backlog of cases, (4) introducing a new type of civil monetary penalty, (5) taking measures intended to reduce delays in imposing a denial of payment for new admissions, (6) closing loopholes associated with its most severe sanction—termination from Medicare and Medicaid, and (7) increasing oversight of certain facilities with histories of providing poor care. In addition, HCFA's Long Term Care Enforcement Tracking System—the first comprehensive national database on federal enforcement actions against nursing homes—became operational in all regions in January 2000 and includes data beginning with fiscal year 2000.[24]

Denial of a Grace Period

The denial of a grace period for serious repeated deficiencies was implemented in two stages. In September 1998, HCFA modified its policy to require that states refer for immediate imposition of a sanction any nursing home with a pattern of harming a significant number of residents on successive surveys (levels H and above in HCFA's scope and severity grid). Effective December 15, 1999, HCFA expanded this policy to include deficiencies that harmed only one or a small number of residents (level G

[24]OSCAR does not contain complete or reliable data on enforcement actions. As a result, each region maintained its own enforcement action data, which varied in sophistication from comprehensive computer databases to illegible hand-kept logs with inconsistent formats.

deficiencies) on successive standard surveys.[25] In an earlier report, we estimated that this change could increase the percentage of homes referred immediately for sanctions from approximately 1 percent to as many as 15 percent of homes nationally.[26] The regional offices we visited in 2000 reported an increase in enforcement referrals over a similar period during the previous year. For example, HCFA's Kansas City office reported that between January and June 2000, almost one-half of the 127 referrals were due to HCFA's elimination of a grace period for certain homes. Washington, where about 50 percent of nursing homes have been cited for isolated actual harm, began implementing this policy in March 2000. For the period March 1 through August 17, 2000, the state recommended 63 enforcement actions that it would not have a year earlier—23 percent of surveyed homes, compared with our national estimate of 15 percent. Because Washington has historically cited actual harm deficiencies at a greater percentage of nursing homes than any other state, referrals under HCFA's new policy were expected to be high. According to state officials, this large number of referrals created a significant additional workload for the state survey agency.

Revisits

In August 1998, HCFA began requiring states to perform revisits to ensure that homes with serious deficiencies had in fact returned to compliance. In some cases, states were previously allowed to accept a nursing home's "credible allegation"—a declaration that it was back in compliance—without on-site verification. HCFA's new guidance requires state survey agencies to conduct one or more revisits at a nursing home for any deficiency originally classified as having caused actual harm or placed residents in immediate jeopardy (G-level or higher), until the agency has verified that the home is in full compliance for each deficiency cited. The policy applies even if the severity of the original deficiency was reduced during a prior revisit.

[25]Previously, states referred for sanction any homes with deficiencies at the immediate jeopardy level (J-L) without granting a grace period. However, because of the very serious nature of immediate jeopardy deficiencies, the state, nursing home, and regional office often work in concert to resolve the situation as soon as possible. States are now required to deny a grace period to homes that are assessed one or more deficiencies at the actual harm level or above (G-L in HCFA's scope and severity grid) in each of two successive surveys within a survey cycle. A survey cycle is two successive standard surveys and any intervening survey, such as a complaint investigation.

[26]*Nursing Homes: HCFA Initiatives to Improve Care Are Under Way but Will Require Continued Commitment* (GAO/T-HEHS-99-155, June 30, 1999), p. 12.

Departmental Appeals Board

HCFA has taken actions intended to reduce delays in collecting fines—called civil monetary penalties—from nursing homes. A fine is the only federal sanction that can be imposed retroactively against a nursing home, making it impossible for a home to avoid having the sanction become effective. However, if a nursing home appeals its fine, payment is automatically suspended until the appeal is resolved. Before the initiatives, insufficient staffing at the HHS Departmental Appeals Board and HHS Office of General Counsel resulted in delayed resolution of pending cases and corresponding delays in collection of fines, enabling nursing homes to indefinitely postpone payment of fines by filing an appeal. To provide for the more timely processing of nursing home appeals, the Congress, at HHS' request, increased funding for the Appeals Board by a total of $2.8 million in fiscal years 1999 and 2000.[27] Many of the 15 new positions created with this increased funding were only filled within the past year. In addition, the HHS Office of General Counsel received $4.4 million in fiscal year 2000 to hire 33 additional regional office attorneys to handle appeal cases. After increasing rapidly between September 1996 and September 1998, the number of pending nursing home appeals decreased in 1999 and then rose again in 2000 (see table 8). It is unlikely, however, that many enforcement actions resulting from the new policy of denying a grace period to homes that repeatedly harm residents have yet reached the point of appeal; when they do, this may result in a significant increase in the volume of nursing home appeals.[28]

[27]The Departmental Appeals Board provides the administrative law judge review and the final administrative appellate level review for nursing home appeals of any federal enforcement sanction. The HHS Office of General Counsel includes the regional office attorneys who represent HHS and HCFA in such appeals.

[28]In commenting on our draft report, California officials indicated that an additional effect of appeals is that HHS' attorneys are requiring state surveyor and consultant staff to provide testimony to support HCFA's action. The state said that preparation time and hearings can last 8 to 10 days and that during this time the involved surveyors are not available to accomplish survey and certification work.

Table 8: Comparison of Pending Appeals and Increased Staffing at the Departmental Appeals Board

		Appeals Board staffing			
Date	Pending nursing home appeals	Administrative law judges	Attorneys	Paralegals and clerical staff	Total
Sept. 30, 1996	234				
Sept. 30, 1997	472				
Sept. 30, 1998	605				
Sept. 30, 1999	555	4	9	4	17
Sept. 25, 2000	698	8	13	11	32

Note: Staffing data for fiscal years 1996-98 are not available. Staffing levels are for the component of the Board that hears nursing home cases. The 1999 staffing levels do not include individuals who were temporarily assigned to the Board.

Per-Instance Fines

In May 1999, HCFA issued regulations giving states an additional enforcement option—a per-instance fine—that is imposed immediately. In the past, fines could only be levied for each day of noncompliance. The per-instance authority allows states to recommend a fine for a specific instance of non-compliance. Such fines may be more easily applied, particularly in circumstances in which states find it difficult to determine the number of days the home was noncompliant.[29] HCFA reported that the number of per-instance fines is increasing, from 33 between May and September 30, 1999, to 354 for the period October 1, 1999, through August 31, 2000.[30] In comparison, per-day fines for the first 10 months of fiscal year 2000 totaled 1,359 (see table 9). Per-instance fines are capped at $10,000 and therefore may not be as effective a deterrent to noncompliance as per-day fines, which can rise to higher dollar amounts.[31] For example, the average per-instance fine was about $2,000, while the average per-day fine totaled almost $8,000.

[29]For example, HCFA's San Francisco regional office suggested that it was appropriate to use per-instance fines for isolated instances of noncompliance at a nursing home with a generally good compliance record.

[30]A HCFA official noted that although states had the authority to use the per-instance fine in May 1999, they may have been reluctant to do so before the issuance of HCFA's implementing guidance in March 2000.

[31]In contrast to the per-instance maximum of $10,000 per survey, the per-day monetary fine has a $10,000 per-day limit, which accrues until the home achieves substantial compliance. HCFA regulations preclude use of a per-instance and a per-day monetary fine on the same survey.

Table 9: Comparison of Per-Instance and Per-Day Fines for Fiscal Year 2000, as of August 8, 2000

Type of civil monetary penalty	Number imposed	Amount due[a]	Amount collected
Per-instance	354	$749,436	$312,548
Per-day	1,359	$10,722,899	$4,023,795

[a]Amount due excludes cases where (1) the nursing home's 60-day period to appeal the fine had not yet expired or (2) the fine had been appealed.

Source: HCFA.

Denial of Payment for New Admissions

HCFA has also made efforts to ensure that the sanction of denial of payments for new admissions is imposed in a timely manner, as required by law. Modified regulations now permit states to provide the notice to the nursing home within 2 days of submitting a recommendation to HCFA (if not disapproved). HCFA also encourages states to meet referral deadlines so that the denial of payment can be imposed within 3 months as required by statute. One of the four regional offices we visited was piloting an optional expedited notice provision. HCFA is considering whether to make such an expedited notice mandatory in all cases. We found, however, that some states still had problems meeting the deadline for imposing the sanction.

Termination

HCFA took two actions to increase the deterrent effect of its most severe sanction—termination from the Medicare and Medicaid programs. First, it altered its policy to require pretermination performance to be considered in determining any future enforcement actions against terminated homes subsequently readmitted to Medicare. Second, it gave additional guidance to HCFA regional offices about the length of the so-called "reasonable assurance period" during which terminated homes must demonstrate that they have corrected the deficient practices that led to their terminations.[32]

Special-Focus Facilities

In January 1999, HCFA instructed each state to begin enhanced monitoring of 2 nursing homes that historically had records of providing poor care

[32]Before readmitting a terminated facility to Medicare, HCFA requires nursing homes to address the situation that led to termination and provide reasonable assurance that it will not recur. To give this assurance, a home is required to have two surveys not more than 180 days apart, each of which shows the problem to be corrected. The reasonable assurance period is the time between these two surveys.

(some states selected an additional one or two homes). Surveys were to be conducted at 6-month intervals rather than annually. Known as focused enforcement, the initiative was modeled after a similar California program. In September 2000, HCFA reported that semiannual surveys had only been conducted at a little more than half of the original 110 facilities. HCFA indicated that both state survey agencies and HCFA regional offices have been reminded, in writing, of the semiannual survey requirements for special-focus facilities and that its regional offices are now working closely with states to achieve better compliance. Of the 60 homes that received semiannual surveys

- 12 have been terminated or have voluntarily withdrawn from the Medicare and Medicaid programs,
- 31 have had civil monetary fines imposed and 18 have received a denial of payment for new admissions sanction, and
- 28 are now in substantial compliance.

In addition, the most recent surveys show that the percentage of homes with deficiencies that harmed residents (G or higher) decreased from 66 percent to 50 percent.

Although this initiative is worthwhile, we believe that its narrow scope excludes many homes that provide poor care. In contrast, California's state focused enforcement program, which began in June 1998, was significantly larger, initially covering 36 of the state's facilities with the worst compliance histories.[33] Based on the program's success to date, California plans to expand the number of closely monitored homes to 100 by June 2001. Rather than selecting two homes per district office, the expansion will identify facilities throughout the state with the worst compliance history. Of the original 36 facilities, 14 continue to be closely monitored. The remainder have left the program because they returned to compliance (11), changed ownership (10), or closed (1).

Nursing Home Chains With Performance Problems

HCFA has not yet implemented an initiative that would deny a grace period to homes belonging to nursing home chains with performance problems, but it recently circulated draft guidance to states for implementing this initiative. Problems with defining a chain and determining which homes

[33]Initially, California targeted 34 facilities—2 for each of the state's 17 district offices. Two additional homes were added to the list to replace homes that left the focused enforcement program.

belong to each chain contributed to the delay and remain a problem. As a result, HCFA's draft guidance is applicable only to chains with over 100 homes nationally. The policy will be phased in for all remaining chains when data on chains' ownership of homes become available on a broader basis.

Improvements Continue in Federal Oversight of State Survey Activities

In our prior work, we found that HCFA's oversight of state efforts had serious limitations that prevented it from developing accurate and reliable assessments of state survey agency performance. HCFA regional offices' policies, practices, and oversight were inconsistent, a reflection of coordination problems between HCFA's central office and its regional staffs. Moreover, in important areas such as the adequacy of complaint investigations or surveyors' findings, HCFA relied on self-evaluation under the SAQIP program that essentially allowed states to write their own report cards. Though OSCAR data were available to monitor state performance, they were infrequently used, and neither states nor HCFA regional offices were held accountable for failing to meet or enforce established performance standards. Finally, HCFA rarely conducted federal comparative surveys that allowed a comprehensive look behind the state survey process but instead relied primarily on limited, direct observation of state surveyors—called an observational survey.

HCFA's initial efforts to improve federal oversight were limited.[34] However, the agency recently embarked on a major overhaul of its oversight strategy. In the late spring of 2000, it introduced several organizational changes intended to improve consistency, coordination, and accountability. In addition, effective October 2000, direct federal oversight using a new series of periodic reports based largely on OSCAR data will replace states' self-evaluation of their survey activities. According to HCFA, many implementation details are still being worked out. In addition, HCFA is exploring the feasibility of conducting more comparative surveys and contemplating changes in the way it allocates funds for state survey and certification activities. Because these changes are either recent or have not

[34]Effective October 1998, the number of comparative surveys was increased to about 10 percent of the approximately 900 federal surveys conducted annually—either one, two, or three per state, depending on the number of nursing homes. Though the majority of federal surveys continued to be observational, HCFA issued new protocols to ensure they were conducted more consistently and set up a centralized tracking system to analyze the results.

yet been introduced, it is too soon to tell how effective they will prove in resolving past problems.

HCFA Has Created Coordinating Mechanisms to Ensure More Consistent Federal Oversight

HCFA has established several coordinating mechanisms to improve the consistency of federal oversight of state survey activities and to provide greater accountability. In earlier work, we raised concerns about the lack of a direct link between HCFA's central and regional office components regarding nursing home oversight. HCFA's Medicaid and State Operations Director was responsible for establishing national oversight policy, and the 10 regional offices were charged with day-to-day monitoring of state survey agency activities.[35] Both the director and the regional office administrators answered separately to the HCFA Administrator without any formal reporting links. These organizational reporting lines complicated coordination and communication, weakened oversight, and blurred accountability when problems arose. For example, we reported significant differences in the nature and extent of the oversight provided by regions. Recent or planned changes to improve consistency, coordination, and accountability include the following:

- National Oversight Policy. In May 2000, HCFA established a Nursing Home Survey and Certification Oversight Board. The Oversight Board, which meets monthly, will make recommendations on oversight policy to the HCFA administrator. Recent meetings involved the survey and certification budget. Chaired by the Director of the Center for Medicaid and State Operations, the Oversight Board includes two regional office administrators as well as other central office representatives.[36] Its composition is intended to improve communication and coordination among senior HCFA managers responsible for nursing home oversight.

[35]HCFA relies on 129 federal surveyors in 10 regional offices to carry out its responsibility for evaluating the adequacy and effectiveness of each state's nursing home survey process.

[36]Board members include representatives from HCFA's Center for Medicaid and State Operations, Center for Beneficiary Services, Center for Health Plans and Providers, Office of Financial Management, Office of Clinical Standards and Quality, and two HCFA regional administrators. The HCFA Administrator and Deputy Administrator are ex officio members, and the Offices of General Counsel and Legislation have permanent, nonvoting members.

- Managing Day-to-Day Oversight. HCFA designated two co-leaders—the director of the Survey and Certification Group (who reports to the Medicaid and State Operations Director) and the Philadelphia Regional Office Administrator—to manage and coordinate day-to-day survey and certification activities. The former is responsible for providing a national perspective on oversight activities, while the latter works directly with associate regional administrators—individuals with day-to-day responsibility for nursing home oversight—to help ensure greater consistency across regions.[37]
- Regional Office Focal Points. By October 2000, each HCFA region will assume the lead for ensuring consistency in 1 of 10 policy areas, such as data collection and analysis, training, and survey and certification budgets.[38] HCFA is still working out details as to the specific duties in each area and establishing coordination procedures. In the past, there was inconsistency across regions, but the new focal points are expected to overcome this problem. For example, concerning data collection and analysis, some regions had the capability to use OSCAR data in their monitoring efforts and others did not. The data tracking coordinator will be responsible for ensuring that regions have the necessary trained personnel and that regional administrators and the central office are apprised of the results of tracking efforts.
- Policy Clearinghouse. Effective in June 2000, HCFA established a seven-member policy clearinghouse, with representatives from the HCFA central office, the four HCFA regional office consortia, and the states, to ensure that regional office directives to states are consistent with national policy.[39] For example, the clearinghouse ordered the withdrawal of guidance issued by the Dallas and Chicago regional offices to state surveyors on how to determine the oral and dental health of nursing home residents because of concern about the resource implications. HCFA is now considering whether it should develop national guidance on this issue. Achieving an appropriate balance between the need to apply consistent national policy and fostering an

[37]In each regional office, the associate regional administrator responsible for nursing homes reports to a regional administrator. The Philadelphia Regional Office Administrator will not evaluate an associate administrator's performance but will provide feedback to the appropriate regional administrator.

[38]The other lead areas are state survey performance, cross-regional surveys, quality, federal monitoring surveys, certification of new providers, surveyor staffing, and non-long-term-care surveys.

[39]States are represented by the Association of Health Facility Survey Agencies.

environment that encourages regional offices to develop improved practices will be an ongoing effort.

Increasing Federal Oversight and Requiring Greater Use of Management Information Systems Should Improve State and Regional Office Accountability

HCFA will require regional offices to begin producing periodic reports on state survey activities and, effective October 2000, these reports will be used to assess state performance in key areas. HCFA officials recognized that neither the central office nor the regional offices had made the most effective use of existing data to monitor state activities and to take appropriate action when serious state survey agency problems were identified. For example, while the Atlanta regional office used OSCAR data to actively monitor state performance and required state survey agencies to correct problems, the other regions we visited did not. Recent state experiences illustrate the opportunity to use OSCAR and other available data to monitor state activities, including variations among local district offices. HCFA is also examining ways to increase its use of comparative federal surveys.

Standardized Reports to Assess State and Regional Office Performance

To provide both the central and regional offices with the basic data needed to improve federal oversight, HCFA has directed its 10 regional offices to periodically prepare 18 "tracking" reports on areas that measure both state and regional office performance. Examples of reports that will track state activities include pending nursing home terminations (weekly), oversight at problem facilities selected for more frequent surveys (monthly), meeting OSCAR data entry timeliness (quarterly), tallies of state surveys that find homes deficiency-free (semiannually), and analyses of the most frequently cited deficiencies by states (annually). Examples of reports that will track regional office performance include those on the results of comparative surveys (semiannually) and on the processing of enforcement cases (monthly). These reports, in standard format, will enable comparisons within and across states and regions and should help to surface problems and identify the need for intervention—either by HCFA's central office or regional offices.

Tables 10 and 11 provide examples of how available data could have been used to identify potential performance problems in state survey agencies and district offices.

Table 10: HCFA Analysis of OSCAR Data and Comparative Surveys Could Have Raised Questions About the Performance of Oklahoma's State Survey Agency

Background	In May 2000, the state official responsible for nursing home survey activities was indicted for bribery. Allegedly, in exchange for payments, the director gave some nursing homes preferential treatment, such as notifying homes in advance about the date of their annual surveys so the homes had time to prepare for them.
Issue	Although existing data from OSCAR or federal comparative survey results would not have uncovered bribery, HCFA officials acknowledged that this information could have alerted them to shortcomings in Oklahoma's survey activities.
Deficiency citations	Compared with the national average, Oklahoma had a higher percentage of deficiency-free homes (22 percent versus 16 percent) and a lower percentage of homes with actual harm or immediate jeopardy deficiencies (15 percent versus 30 percent).
OSCAR data entry	About 20 percent of the state's annual nursing home surveys reported in OSCAR were from 1998 and some were up to 2 years old, an apparent violation of the federal requirement to inspect each nursing home at least once every 15 months.[a]
Revisits	Since early 1999, the state had not entered any data on nursing home revisits into OSCAR, raising a question as to whether the state had conducted the required on-site review to determine that cited deficiencies had been corrected.
Comparative surveys	Four 1999 federal comparative surveys in Oklahoma cited a total of 45 deficiencies, compared with the state's total of 3. Eight of the 45 federal citations involved quality of care, some at the actual harm level. In contrast, none of the state surveys found any quality-of-care deficiencies. In fact, state surveyors found two of the homes to be deficiency-free.

Note: The HHS Office of Inspector General, the Federal Bureau of Investigation, the Internal Revenue Service, and the Oklahoma Attorney General's Medicaid Fraud and Control Unit participated in an investigation leading to the May 2000 legal charges brought against the Oklahoma State Department of Health's Deputy Commissioner, who was responsible for state nursing home survey activities. It has been alleged this individual received payments from nursing homes in exchange for preferential state survey treatment.

[a]At our request, HCFA's Dallas regional office determined that surveys had been conducted for some of these homes in 1999 but that the results had not been entered into OSCAR—a violation of HCFA's guidance that states promptly enter survey results into OSCAR.

Table 11: HCFA Analysis of Available Data Could Have Raised Questions About the Performance of Missouri's State Survey Agency

Issue	Of the four states we visited, Missouri had the highest percentage of deficiency-free homes—both before and after the introduction of the nursing home initiatives. For example, 3 percent of California nursing homes were found deficiency-free on their most recent survey, compared with about 16 percent in Missouri. To gain a better understanding of the adequacy of state surveys in Missouri, we reviewed the results of 368 complaints registered against 34 of 84 homes found to be deficiency-free during the period January 1999 through January 2000.[a] Our hypothesis was that deficiency-free homes should have few complaints. Missouri's 84 deficiency-free homes received 605 complaints, an average of 7 complaints per home (compared with an average of 2 per deficiency-free home in California). The number of complaints against Missouri's deficiency-free homes ranged from 1 to 39, and 19 homes had 10 or more complaints.
Complaints against deficiency-free homes	Twenty-two of the 34 deficiency-free homes had substantiated complaints. For example, one home with a total of 39 complaints had 17 actual harm deficiencies substantiated, including 3 substantiated at the immediate jeopardy level, during complaint investigations.
Adequacy of complaint investigations	The rate of substantiation of complaints was generally much lower in one of the state's seven district offices—one of the two districts that had a significantly higher percentage of deficiency-free homes (34 percent, compared with a statewide average of slightly less than 16 percent). In reviewing complaints investigated by this district over the past 3 years, we noted several anomalies and problematic investigations: • Regarding one complaint, the district office wrote the complainant a letter indicating that the investigation had substantiated the allegations and action was being taken. In fact, however, the district found the allegation to be invalid and took no action against the nursing home. • In another case, the district investigated a complaint about a resident who died without being provided CPR (cardiopulmonary resuscitation), even though her husband had signed a form asking that CPR and all other necessary measures be taken in the event of a medical crisis. The investigation concluded that there was no evidence to suggest that the home's staff did not act appropriately during the crisis, but it failed to address the issue of whether the nursing home had a system in place to alert staff to a resident's desire for resuscitation. Instead, the investigation focused on whether performing CPR would have made a difference in the resident's outcome. The file also indicated that, during the course of the investigation, the home advised the surveyors that it would have its lawyer present a seminar to the home's staff about complying with residents' wishes for resuscitative measures. However, there is no indication in the file that the surveyors verified that the home actually took such action.
Federal comparative surveys	In February 2000, a federal comparative survey was conducted at a nursing home that was found to have had no care-related deficiencies in its prior two annual surveys. The state surveys had been conducted by surveyors assigned to the same district office discussed above. • The comparative survey found 11 deficiencies, including actual harm to residents because of failure to ensure that residents maintain their ability to perform normal daily functions and failure to provide adequate nutrition. • Federal surveyors told us that these care problems should have been detected by the state's survey 1 month earlier, which found this home to be in substantial compliance with federal quality standards. • Missouri's state auditor had questioned the circumstances surrounding the deletion of all 11 deficiencies from this same home's 1998 survey, including deficiencies similar to those found in the federal comparative survey.

[a]We examined the results of all complaints against deficiency-free homes that received 10 or more complaints and a random sample of all complaints against 25 percent of deficiency-free homes that received fewer than 10 complaints.

HCFA's 18 new standardized status reports should help to track the states' compliance with an initial set of seven state performance standards, including survey timing, deficiency documentation, complaints

investigation, conduct of surveys in accordance with guidance, and OSCAR data entry (see app. IV, table 17). In areas such as deficiency documentation and complaints, the regional offices will go beyond examining computerized data and review actual records. For example, the appropriate documentation of survey findings will involve regional office reviews of samples of survey reports from each state. As noted earlier, a state that conducted similar reviews of a sample of its own surveys found both an understatement of deficiencies and investigative weaknesses. Regional offices will also conduct an on-site review of each state's complaints system and procedures. The seven standards are drawn largely from those used under the SAQIP program, which will be discontinued as of October 2000. HCFA is developing protocols to ensure that the regions consistently enforce the seven standards.

HCFA is in the process of redesigning its on-line management information system, OSCAR. OSCAR's new nursing home module is projected to be available in the summer of 2001. While OSCAR currently provides extensive information about state surveys, including when surveys are conducted, the deficiencies cited, and the length of time between a home's annual survey, generating analytical reports from OSCAR is difficult, and most regions lack the expertise to do so. The new nursing home module in OSCAR will be more user-friendly because it will require less computer-programming experience to conduct data analysis.

Reevaluation of Comparative and Observational Surveys

In October 1998, HCFA acknowledged the need to do more comparative surveys than the 21 conducted in the previous 2 years. As a result, it required regional offices to perform between one and three comparative surveys per state annually, depending on the number of nursing homes. Comparative surveys now account for about 10 percent of federal surveys. The remaining 90 percent are observational.

HCFA currently is exploring the adequacy of the number of comparative surveys and is considering either (1) increasing the number of federal surveyors available to conduct them or (2) narrowing their scope to allow more surveys to be done. Increasing the proportion of federal surveys that are comparative would respond to our 1999 recommendation.[40] We believe that the results offer a more accurate picture of the adequacy of state

[40] *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight* (GAO/HEHS-98-202, July 27, 1998) and *Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality* (GAO/HEHS-00-6, Nov. 4, 1999).

survey activities than do observational surveys, which primarily are used to help identify training needs. Seventy percent of the 157 comparative surveys conducted between October 1998 and May 2000 found more serious care problems than did the corresponding state survey. On average, state surveyors identified 3 deficiencies per home, while federal surveyors found almost 10. Currently, however, too few comparative surveys are completed in each state to assess whether the state appropriately identifies serious deficiencies. Although most do not meet the timing requirement to be classified as comparative surveys, the results of 16 federal surveys recently conducted in Oklahoma underscore the value of increasing the number of comparative surveys per state (see table 12).[41] More comparative surveys in Oklahoma could have provided HCFA with broader evidence about the adequacy of state survey activities.

Table 12: Results of Federal Surveys of 16 Nursing Homes in Oklahoma

Issue	Between April and June 2000, HCFA conducted federal surveys at the 16 nursing homes suspected of bribing the state survey agency director. This number is significant because most states have only one or two federal surveys each year.
Number of deficiencies	In 8 of the 16 surveys, federal surveyors found a minimum of 20 more deficiencies than were cited on the most recent state survey for the same homes. In one of the more glaring examples, the federal survey cited 37 deficiencies and the most recent state survey cited only 1.
Scope and severity	In 15 of 16 surveys, federal surveyors also cited deficiencies at higher scope and severity levels than did state surveyors.
Quality-of-care problems	Overall, federal surveyors found significantly more quality-of-care problems than did state surveyors—averaging 5.3 versus 1.5 quality-of-care deficiencies (see app. IV, fig. 1).

HCFA is also examining how its regional offices conduct observational surveys and how the current scoring system may be improved to assess a state's performance on such surveys. First, HCFA is completing 10 cross-regional surveys to identify differences in how regions conduct observational surveys. Each HCFA cross-regional team consists of surveyors from two regional offices who join the federal surveyors in a third region to watch how they conduct an observational survey. Differences are already emerging among regions, such as how a particular

[41]Comparative surveys are generally conducted within 2 months of the state's survey to ensure that conditions in the home are similar for both the federal and state survey team. Four of these 16 federal surveys would qualify as comparatives because 2 months or less had elapsed since the most recent state survey. As with typical comparative surveys, the federal surveyors conducted a complete review of the care provided by each nursing home.

nursing home is selected for a federal survey and the extent to which federal surveyors identify nursing home deficiencies. During the fall of 2000, a report together with recommendations will be sent to the HCFA Oversight Board concerning changes to ensure consistency in the federal monitoring survey process. Second, the current methodology for scoring the results of observational surveys only indicates whether a state team performed a required survey task—not the quality of the survey or of the judgment exercised by the state surveyors. HCFA has contracted for the design of a scoring mechanism that would allow federal surveyors to better and more consistently assess the quality of a state survey. Due in part to concerns about the scoring system, HCFA has not issued a planned report on the results of observational surveys conducted in fiscal year 1999.

Changes to Allocation of Survey Funding Could Enhance State Survey Oversight

HCFA is exploring options for better distributing future survey and certification funding. The current survey and certification budget process bases funding requests and state funding allocations on past state practices and costs, rewarding states that spent substantial amounts in the past by establishing those expenditures as a budget baseline. Conversely, states that spent less for survey and certification activities may have baseline costs that are too low. Differences in state survey and certification budgets may be a significant factor in the variations in time devoted to performing surveys. A 1998 study by the Center for Health Systems Research and Analysis identified significant imbalances in survey time and resource utilization among the survey teams—imbalances that still exist. Our recent analysis of OSCAR data showed that Tennessee surveyors spent an average of 94 hours to perform a nursing home survey, whereas Washington surveyors spent an average of about 162 hours. Differences such as these may significantly affect the quality of oversight, because the Center's study showed a correlation between the average survey time and the number of deficiencies identified.

HCFA officials reported that efforts are ongoing to identify better options for distributing future survey and certification funding. The agency's Fiscal Year 2001 Annual Performance Plan establishes a performance goal of moving from the current budget process to a price-based process. HCFA proposes developing national standard survey measures and costs that would be used to price the workload for each state survey agency.

Conclusions

Sustained efforts by HCFA and the states are essential to realizing the potential of the nursing home quality initiatives. For example, better

detection and classification of serious deficiencies through the standard survey process will require further refinement of survey methods and a reduction in survey predictability to limit the opportunities for homes to prepare for these reviews. In the states we reviewed, efforts to expedite complaint investigations and systematize the reporting of investigation results are at various stages of implementation and remain incomplete. As for the application of strengthened federal enforcement policies, more time must elapse before progress in this area can be assessed. Similarly, with respect to improved federal oversight, the effectiveness of recent internal HCFA reorganizations and management information reporting enhancements can only be judged in the months to come. In short, the current momentum should neither be taken for granted nor relaxed. The extent of the progress in improving quality of care is uncertain, but fully and effectively implementing the initiatives is an essential component in securing the necessary improvements.

Agency Comments and Our Evaluation

We provided a copy of our draft report to HCFA and the states included in the scope of our work. We received written comments from HCFA; the California Department of Health Services; the Division of Aging, Missouri Department of Social Services; the Michigan Department of Consumer and Industry Services; and Residential Care Services, State of Washington Aging and Adult Services Administration, Department of Social and Health Services. Maryland and Tennessee had no comments other than that they believed the report was fair.

HCFA generally agreed with our findings and conclusions. Recognizing that progress had been made in improving the quality of care in nursing homes, HCFA stated that it agreed with us that it is still too early to draw definitive conclusions about the impact of various nursing home initiatives from the preliminary data available. HCFA likewise agreed that sustained federal and state actions are necessary to realize the full potential of the initiatives. HCFA said that it was committed to taking additional steps on a number of issues raised in our report such as (1) survey predictability, (2) the continued variability across states in citing serious deficiencies, (3) discrepancies in state reports regarding the expenditure of nursing home initiatives funding, (4) the timeliness requirements for completing complaint investigations, (5) regional office consistency in implementing enforcement initiatives, (6) consistency in the monitoring of state performance, and (7) refining data systems to provide more timely, useful, and customer-friendly information. HCFA also indicated that it is committed to specific actions that would help strengthen and build upon

the nursing home initiatives, including exploring ways to make optimal use of available remedies as well as exploring the need for additional authorities, working with states to meet the 10-percent goal for off-hour surveys, and developing more streamlined methods for investigating serious complaints. (HCFA's comments are in app. V.)

California, Missouri, Michigan, and Washington also generally agreed with our findings and conclusions. Washington reflected that the full implementation of the nursing home initiatives is ongoing. California, Michigan, and Missouri elaborated on the improvements made in their oversight of nursing homes but also noted that implementation is not yet complete. For example, California is in the process of implementing recently enacted state legislation that will significantly increase survey staff, and Missouri has not yet completed implementing its overhaul of complaint investigations.

Missouri identified several areas where it believed continued dialogue between HCFA and states would be fruitful, such as modifying the survey process to focus on noncompliant homes, the use of the OSCAR system as the primary data source on survey results, improvements needed in resource planning, potential expansion of the special focus facilities initiative, and consistency in surveyor training. It also believed that refinements were required in federal comparative surveys because they are conducted with criteria different from that set forth by HCFA for use by state agencies and are not required to be legally defensible. While our report acknowledges steps recently taken by HCFA to ensure consistency in federal oversight, Missouri's assertion that federal comparative surveys are not required to be legally defensible is erroneous. Federal comparative surveys must meet the same documentation standards as state surveys, and the federal survey may be subject to administrative appeals if HCFA takes enforcement action on the basis of the survey's findings. Missouri also said that the periods of time surveyed are not the same. Consistent with our November 1999 recommendation, HCFA has directed its regional offices to initiate comparative surveys within 14 to 28 days after the completion of the state's survey rather than within two months as specified in statute. This step should further ensure that conditions in a home are as similar as possible for both the state and federal survey. We had also recommended that federal surveyors should include as many of the same residents as possible in their comparative survey sample as the state included in its sample.[42] The similarities between the initial results of Missouri's November 1998 survey of a nursing home and the findings of a February 2000 federal comparative survey of that same home also suggest that

identified deficiencies can continue to exist over an extended period of time. (Comments from the four states are included in apps. VI through IX.)

Technical comments provided by HCFA and the states were also incorporated as appropriate.

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to the Honorable Nancy-Ann Min DeParle, Administrator of HCFA, and others upon request.

Please contact me or Kathryn G. Allen, Associate Director, at (202) 512-7114 if you or your staffs have any questions. GAO staff acknowledgments are listed in appendix X.

William J. Scanlon
Director, Health Financing
and Public Health Issues

[42]GAO/HEHS-00-6, Nov. 4, 1999, pg. 28.

Implementation Chronology for Key Nursing Home Quality Initiatives

The implementation dates in this chronology generally reflect HCFA's issuance of final guidance to states. Actual implementation of many of the Administration's nursing home initiatives is dependent upon state action. During our work, we encountered examples where state implementation did not coincide with the HCFA "implementation" dates shown below in table 13. Other activities to promote the consistency and effectiveness of HCFA oversight of state survey activities are not being formally tracked as initiatives.

Table 13: Implementation Chronology for Key Nursing Home Initiatives

Initiative and date	Implementation status
Survey procedures	
January 1999	Staggered surveys: State survey agencies required to initiate 10 percent of annual surveys outside normal work hours.
July 1999	Survey methodology, phase one: HCFA instructed states to incorporate quality indicators into the survey process. Quality indicators are derived from nursing homes' assessments of residents and rank a facility in 24 areas with other nursing homes in the state. By using the quality indicators to select a preliminary sample of residents before the on-site review begins, surveyors are better prepared to identify potential care problems. Concurrently, HCFA published new investigative protocols for use by surveyors on key issues such as abuse prevention, pressure sores, hydration, and unexplained weight loss.
Projected completion date 2002 or 2003	Survey methodology, phase two: As a follow-up to the quality indicator and protocol initiative mentioned above, HCFA plans to (1) improve the on-site augmentation of the preliminary sample selected off-site using the quality indicators and (2) strengthen the protocols used by surveyors to ensure more rigor in their on-site investigations.
Complaints	
March 1999	Actual harm complaints: Within 10 workdays, state survey agencies are to begin investigating complaints that allege actual harm by conducting an on-site visit (when necessary).
Enforcement	
August 1998	Revisits: Revised revisit policy by requiring states to actually visit nursing homes to ensure that serious deficiencies have in fact been corrected and that facilities have returned to compliance.
September 1998	Grace period for H- and I-level deficiencies: HCFA eliminated the grace period for homes with repeated serious violations (H- and I-level deficiencies). Now states are required to refer such homes to HCFA for immediate sanctions.
January 1999	Special-focus facilities: State survey agencies instructed to begin enhanced monitoring of two nursing homes per state—facilities with histories of providing poor care.
May 1999	Per-instance civil monetary penalties: States allowed to impose per-instance civil monetary penalties when period of noncompliance is unclear or in other appropriate circumstances. States may not impose both a per-instance and per-day fine for the same survey.

(Continued From Previous Page)

Initiative and date	Implementation status
May 1999	Appeals backlog: For fiscal years 1999 and 2000, the HHS Departmental Appeals Board received a $2.8 million funding increase to hire more personnel to help reduce the backlog of nursing home appeals. The fiscal year 1999 increase was in the form of a supplemental appropriation. The HHS Office of General Counsel also received a funding increase of $4.4 million in fiscal year 2000 to hire 33 regional office attorneys to represent the government in cases appealed to the Board.
December 1999	Reasonable assurance: States instructed to ensure adequate “reasonable assurance” period for terminated homes seeking readmission to Medicare. Typically, two surveys are required within this period to verify that the reason for termination no longer exists and that the provider has maintained substantial compliance with all applicable participation requirements.
December 1999	Considering pretermination history: States instructed to consider a nursing home’s pretermination history when taking enforcement actions after a home has been readmitted.
December 1999	Grace period for G-level deficiencies: HCFA eliminated the grace period for homes with repeated violations at the G level, and states are required to recommend such homes to HCFA for immediate sanctions.
Projected completion date of late 2000	Poorly performing nursing home chains: HCFA has developed and released for comment draft manual instructions that provide criteria for defining a nursing home chain with performance problems. The instructions would require states to deny an opportunity to correct (grace period) before sanctions are imposed on facilities that are part of a chain with performance problems. The instructions would only be applicable to chains having over 100 homes nationally. The policy would be phased in for all remaining chains when data on chains become available on a broader basis.
Oversight	
October 1998	Federal oversight surveys: Standardized protocols were issued for observational surveys, and the number of comparative surveys was increased. HCFA now requires a minimum of one comparative survey in states having fewer than 200 nursing homes, two in states with 200 to 599 nursing homes, and three in states with 600 or more homes. Ninety percent of federal monitoring surveys will continue to be observational.
Projected completion date of summer 2001	OSCAR redesign: HCFA is in the process of redesigning its on-line management information system, OSCAR. While OSCAR currently provides extensive information about state surveys, including when surveys are conducted, the deficiencies cited, and the length of time between a home’s annual surveys, generating analytical reports from OSCAR is difficult, and most regions lack the expertise to do so. The new nursing home module in OSCAR will be more user-friendly because it will require less computer programming experience to conduct data analysis.

State Survey Findings for Periods Before and After the Administration's Nursing Home Initiatives

In order to compare trends in nursing home deficiency citations, we analyzed data from HCFA's OSCAR System. We compared results for two time periods—one before and one after implementation of the nursing home initiatives: (1) January 1, 1997 through June 30, 1998 (base) and (2) January 1, 1999 through July 10, 2000 (current). Because surveys are conducted at least every 15 months (with a required 12-month state average), it is possible that a facility was surveyed twice in either time period. To avoid double counting of facilities, we included only the most recent survey from each of the two time periods. Because some states do not enter survey results promptly, the current period did not include all surveyed facilities. The results of our analysis are presented in table 14.

Table 14: Percentage of Homes at Each Deficiency Level Before and After the Nursing Home Initiatives, by State

	Number of homes		Actual harm/ immediate jeopardy (percent)		Potential for more than minimal harm (percent)		Potential for minimal harm (percent)		Deficiency-free (percent)	
State	Before	After	Before	After	Before	After	Before	After	Before	After
Alabama	227	225	51.1	41.3	32.2	52.9	6.6	0.9	10.1	4.9
Alaska	16	15	37.5	33.3	43.8	46.7	0.0	6.7	18.8	13.3
Arizona	163	125	17.2	36.8	71.8	56.8	4.9	2.4	6.1	4.0
Arkansas	285	253	14.7	30.8	56.8	57.7	22.8	5.9	5.6	5.5
California	1,435	1,301	28.2	28.2	65.0	65.7	4.0	3.0	2.7	3.1
Colorado	234	229	11.1	16.6	38.5	49.8	5.1	3.9	45.3	29.7
Connecticut	263	260	52.9	53.5	19.4	30.8	0.4	0.4	27.4	15.4
Delaware	44	41	45.5	53.7	36.4	34.1	6.8	2.4	11.4	9.8
District of Columbia	24	18	12.5	5.6	37.5	61.1	41.7	33.3	8.3	0.0
Florida	730	746	36.3	21.7	51.1	62.5	1.6	1.7	11.0	14.1
Georgia	371	364	17.8	25.0	41.8	46.4	10.2	7.7	30.2	20.9
Hawaii	45	46	24.4	23.9	33.3	67.4	33.3	4.3	8.9	4.3
Idaho	86	83	55.8	54.2	36.0	37.3	1.2	0.0	7.0	8.4
Illinois	899	891	29.8	31.1	55.2	51.9	6.8	7.0	8.2	10.1
Indiana	602	581	40.5	48.2	46.2	40.1	4.8	2.4	8.5	9.3
Iowa	525	428	39.2	22.7	42.9	55.6	1.0	3.0	17.0	18.7
Kansas	445	404	47.0	36.9	32.6	45.8	1.8	0.0	18.7	17.3
Kentucky	318	306	28.6	25.2	37.1	61.4	7.9	3.9	26.4	9.5
Louisiana	433	365	12.7	20.3	31.6	50.4	27.5	6.3	28.2	23.0
Maine	135	124	7.4	10.5	62.2	64.5	7.4	5.6	23.0	19.4
Maryland	258	188	19.0	24.5	34.1	37.2	8.9	8.5	38.0	29.8
Massachusetts	576	541	24.0	32.9	24.0	34.2	3.3	4.4	48.8	28.5
Michigan	451	442	43.7	45.9	51.7	49.5	1.8	1.4	2.9	3.2
Minnesota	446	437	29.6	32.5	40.4	45.1	6.7	5.5	23.3	16.9
Mississippi	218	196	24.8	31.6	44.0	50.5	8.3	8.2	22.9	9.7
Missouri	595	565	21.0	25.7	43.7	55.8	6.2	3.0	29.1	15.6
Montana	106	105	38.7	39.0	39.6	50.5	5.7	1.9	16.0	8.6
Nebraska	263	241	32.3	26.6	24.7	48.5	3.0	3.7	39.9	21.2
Nevada	49	50	40.8	24.0	55.1	64.0	2.0	4.0	2.0	8.0
New Hampshire	86	82	30.2	35.4	25.6	32.9	14.0	4.9	30.2	26.8
New Jersey	377	336	13.0	23.8	24.4	38.1	15.4	11.0	47.2	27.1
New Mexico	88	82	11.4	30.5	44.3	45.1	11.4	1.2	33.0	23.2
New York	662	606	13.3	27.6	38.4	41.3	7.9	5.4	40.5	25.7

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	Number of homes		Actual harm/ immediate jeopardy (percent)		Potential for more than minimal harm (percent)		Potential for minimal harm (percent)		Deficiency-free (percent)	
State	**Before**	**After**	**Before**	**After**	**Before**	**After**	**Before**	**After**	**Before**	**After**
North Carolina	407	409	31.0	42.1	33.2	37.9	4.7	2.9	31.2	17.1
North Dakota	88	89	55.7	24.7	35.2	52.8	2.3	5.6	6.8	16.9
Ohio	1,043	995	31.2	28.6	41.3	50.3	4.9	3.3	22.6	17.8
Oklahoma	463	394	8.4	15.0	55.7	58.6	6.7	4.6	29.2	21.8
Oregon	171	157	43.9	53.5	26.3	27.4	2.9	0.0	26.9	19.1
Pennsylvania	811	774	29.3	30.7	44.4	47.7	3.6	3.2	22.7	18.3
Rhode Island	102	96	11.8	13.5	54.9	45.8	3.9	5.2	29.4	35.4
South Carolina	175	176	28.6	29.5	65.7	64.8	0.6	0.6	5.1	5.1
South Dakota	124	112	40.3	29.5	37.1	55.4	3.2	4.5	19.4	10.7
Tennessee	361	353	11.1	24.1	58.4	65.4	3.6	2.5	26.9	7.9
Texas	1,381	1,313	22.2	24.9	36.4	42.7	19.7	14.1	21.7	18.4
Utah	98	93	15.3	17.2	61.2	65.6	0.0	1.1	23.5	16.1
Vermont	45	45	20.0	13.3	35.6	48.9	11.1	2.2	33.3	35.6
Virginia	279	282	24.7	19.5	34.8	39.4	4.7	6.4	35.8	34.8
Washington	288	281	63.2	57.7	32.3	37.7	1.0	1.4	3.5	3.2
West Virginia	130	144	12.3	20.1	63.8	65.3	16.2	11.8	7.7	2.8
Wisconsin	438	424	17.1	14.6	53.7	50.5	5.3	3.3	24.0	31.6
Wyoming	38	41	28.9	34.1	55.3	46.3	2.6	2.4	13.2	17.1
Nation	**17,897**	**16,854**	**27.7**	**29.5**	**43.8**	**49.8**	**7.1**	**4.7**	**21.3**	**16.0**

State Efforts to Address Nursing Home Staffing Shortages

We identified 20 states that have enacted legislation that establish wage pass-throughs, wage supplements, or related programs to provide supplemental wages, fringe benefits, or funds for additional nursing home staff. Fourteen of these state programs were implemented since January 1998—3 in 1998; 9 in 1999; and 2 in 2000. Two other states—Michigan and Utah—enacted wage pass-throughs prior to 1998. The remaining four states only recently enacted legislation and have not yet implemented their programs. To identify these 20 states, we began with a September 1999 study based on a 50-state survey that identified seven state programs.[1] To update this study, we contacted the National Conference of State Legislatures, the Paraprofessional Healthcare Institute, and the Service Employees International Union and conducted an Internet search on "wage pass-through programs" during the summer of 2000. Because we did not survey all 50 states, there may be additional state programs. Table 15 provides a general description of each state's program.

Table 15: States With Programs to Address Nursing Home Staff Shortages

State	Time period	Amount appropriated	Program description
Arkansas	Program began July 1, 1999.	The wage pass-through appropriation was $25 million ($7 million state and $18 million federal dollars) for the nursing home staff wage enhancement.	The wage pass-through provided an increase of $4.93 on the facility's daily rate; requires participating facilities to maintain minimum staffing levels. Facilities will be required to submit quarterly staffing reports to the Arkansas Department of Human Services for review to determine compliance with the minimum staffing requirements. The Department may also perform periodic on-site reviews—which may be unannounced—to determine the correctness and completeness of the quarterly reports. Failure to meet minimum staffing requirements will result in the repayment by the facility of 100 percent of the enhancement payments received for services occurring in that quarter.

[1]North Carolina Division of Facility Services, *Comparing State Efforts to Address the Recruitment and Retention of Nurse Aide and Other Paraprofessional Aide Workers* (Sept. 1999).

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State	Time period	Amount appropriated	Program description
California	First wage pass-through implemented on August 1, 1999. A second wage pass-through was implemented August 1, 2000.	For the 1999 pass-through, the estimated annual total cost was $51.2 million ($25.6 million state and $25.6 million federal dollars); for the 2000 pass-through, the estimated annual total cost was $148.4 million ($74.2 million state and $74.2 million federal).	The 1999 wage pass-through provided funds for salary, wage and benefit increases for nursing facility direct care staff—registered nurses, licensed vocational nurses, and nurse assistants. The second wage pass-through in 2000 was expanded to include other staff such as housekeeping and dietary staff. The pass-through is calculated on a per-patient-day basis and added to the per diem rate paid to each facility. Compliance of facilities will be on a retrospective basis, with a sample of facilities being audited. Facilities that did not comply with the wage pass-through provisions will be subject to recoupment of the undistributed wage pass-through funds plus a 10 percent penalty.
Connecticut	State fiscal year 2000	The state legislature appropriated a wage enhancement for nursing homes of $75 million ($37.5 million state and $37.5 million federal) for state FY 2000. The state has appropriated $77 million ($38.5 million state and $38.5 million federal) for the state FY 2001 wage enhancement.	The facility's share of the enhancement program funds is based upon its percentage of total direct and indirect costs in relation to all facilities, adjusted for Medicaid days. Enhancement payments can be used for wage, benefit, and staffing increases for a nursing home. The Commissioner of the Connecticut Department of Social Services may require facilities to file cost reporting forms, in addition to the annual cost report, to verify the appropriate application of wage, benefit, and staffing enhancement rate adjustment payments.
Florida	Program began April 1, 2000.	Appropriated approximately $32 million ($13.9 million state and $18.1 million federal) annually for a "direct care staff adjustment."	The funds are to be used to reimburse nursing facilities for the costs of hiring additional certified nursing assistants and licensed nurses or for the cost of salary or benefit enhancements to retain such staff. All providers receiving the additional funds must provide documentation of direct care expenditures over that time period. The documentation is to be submitted to the Florida Agency for Health Care Administration in a format similar to the base data period documentation. Any amount deemed not to have been appropriately expended is to be reimbursed to the Agency. Cost report audits will be conducted.
Kansas	Program began in September 1999.	$4.3 million (approximately $1.7 million state and approximately $2.6 million federal) was awarded in total funds for state FY 2000 to establish a wage pass-through program for nursing facilities. Another $4.2 million (approximately $1.7 million state and approximately $2.5 million federal) was appropriated for FY 2001, but it is contingent upon HCFA's approval of a state plan amendment.	Funds are targeted for nursing facility front-line staff. Providers apply for a per diem add-on to the Medicaid rate and are responsible for documenting legitimate use of funds through quarterly reports. Statistics are being collected on turnover.

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State	Time period	Amount appropriated	Program description
Louisiana	Legislature passed a bill during the first special session of 2000; program has not yet been implemented.	Louisiana's wage pass-through is contingent upon HCFA's approval of a state plan amendment.	A portion of the earnings on the investment from the state's Medicaid Trust Fund for the Elderly are to be used for providing for a wage enhancement for direct care personnel working in Medicaid-certified nursing homes in accordance with a plan established by the Department of Health and Hospitals and representatives of the nursing facility industry. The plan will provide for a direct pass-through of the costs of such wage enhancements in a manner to ensure that the nursing home rate is adjusted to reflect the full costs of such wage enhancement.
Maine	Program began July 1, 1999.	$3.68 million ($1.25 million state and $2.43 million federal) was provided for a one-time nursing home supplement for the direct care rate.	The supplement is intended to address the problem of recruitment and retention of nonadministrative staff. Facilities had flexibility to use it for either new positions or increasing wages of direct care staff. State will audit through cost reports.
Maryland	Program not yet implemented.	Intention is to provide $10 million in general funds for FY 2002 and $10 million in general funds for FY 2003.	Intent of the General Assembly is that the Governor provide in the state budget for FY 2002 and FY 2003 additional funds to increase payments in the Nursing Service Cost Center of the Medicaid nursing home reimbursement. The funds are to be used to enable nursing homes to address recommendations of the state's Task Force on Quality of Care in Nursing Homes in order to (1) increase hours of direct care to residents; (2) increase nursing staff; and (3) increase wages, fringe benefits, and other forms of compensation provided to direct care personnel. Expenditures by nursing homes shall be subject to audit and cost settlement by the Maryland Department of Health and Mental Hygiene.
Massachusetts	Program began January 2000.	According to the state's fiscal year 2001 budget, appropriated $35 million ($17.5 million state and $17.5 million federal) for the exclusive purpose of funding increases in wages and related employee costs for certified nurse's aides at nursing facilities.	The Massachusetts Division of Medical Assistance and the Massachusetts Division of Health Care Finance and Policy were to establish criteria for the disbursement of the funds appropriated and report to the Senate and House Committees on Ways and Means on the criteria to be used by September 1, 2000. Criteria will mandate the degree to which such nursing facilities provide enhanced wages for certified nurse's aides and report to the two committees on the wage increases given at each facility by January 4, 2001.

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State	Time period	Amount appropriated	Program description
Michigan	The state established its first nursing home staff wage pass-through in state FY 1990 with limited participation. The state's most current wage pass-through is for state FY 2000.	In state FY 2000, approximately $33.6 million (approximately $15.08 million state and approximately $18.52 million federal) has been appropriated for a wage pass-through. For state FY 2001, the amount for the wage pass-through is not specifically identified. The FY 2001 appropriated inflationary allowance may be used to cover any allowable variable cost increases and is sufficient to provide a 50-cent-per-hour wage increase for nurse's aides at all facilities.	The current state FY 2000 wage pass-through provides a maximum increase of an additional 75 cents per hour and the reimbursement limit is to be applied on a per-employee basis. The provider must report actual wage pass-through cost data in the annual cost report for the wage pass-through year. In addition to a copy of the facility's written policy for internal administration of the wage pass-through, the provider must maintain, at the facility, information on individual employee wage increases and new benefits costs. The support schedule and associated payroll records must be available for Medicaid program audit verification. Failure to provide all supporting data for audit will result in disallowance of the wage pass-through reimbursement.
Minnesota	First wage adjustment bill passed in 1998 for state FY 1999. There have been two other separate wage adjustment bills for state FY 2000 and state FY 2001.	In state FY 2001, approximately $92.7 million (approximately $45.4 million state and approximately $47.3 million federal) was appropriated for a wage adjustment.	For the first two wage adjustment bills, the legislation left it to the nursing facility to decide which employees to give the money to. For the latest wage adjustment, they passed a bill that provides for everyone in the nursing facility (except the administrator, central office employees, and anyone paid through a management fee) to get an equal per-hour increase in wages. Each facility's per diem rate was increased $1.00 plus a portion of $3.13 depending on facilities' average operating rate. Facilities must file a distribution plan showing how they plan to give the money to their employees. The plans must then be approved by the Minnesota Department of Human Services before the rate adjustment is implemented. The plans are also subject to a look-behind audit.
Missouri	Program not yet implemented.	Appropriation formally approved for $22.7 million (approximately $8.9 million state and approximately $13.8 million federal) for quality-of-care wage enhancement for direct care staff of nursing facilities.	Proposed regulation currently drafted and receiving comments.
Montana	Program began July 1, 1999.	In state FY 2000, approximately $2.9 million (approximately $800,000 state and approximately $2.1 million federal) was appropriated for a nursing facility wage add-on for enhancing the wages of direct care staff in nursing homes. For state FY 2001, approximately $5.9 million (approximately $1.6 million state and $4.3 million federal) was appropriated for the nursing facility wage add-on.	For the state FY 2000 program, the nursing homes could receive up to a $2.14 per Medicaid day add-on to the rate for direct care staff wages. The nursing facility was given flexibility in deciding which full-time-equivalent classification would receive add-on (staff with patient contact and food service were possible groups). Providers were required to submit supporting documentation for approval that detailed how the funds would be used to provide for direct care staff wage increases.

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State	Time period	Amount appropriated	Program description
Oklahoma	First wage enhancement program was implemented May 1998. The state had a wage enhancement in state FY 1999 and FY 2000 and currently has one for state FY 2001.	The estimated cost for the state FY 2001 wage enhancement is approximately $19 million (approximately $5.6 million state and approximately $13.7 million federal).	The wage enhancement is an adjustment to the nursing facility's per diem rate equal to $3.15 per patient day. The amount of the rate increase for nursing facilities was calculated assuming that all nursing facilities would meet the state's minimum staffing requirements. Staffing ratios will be reviewed on a monthly basis for all nursing facilities. Those that demonstrate "willful" noncompliance with staffing ratios will be subject to a sizeable penalty.
South Carolina	First wage add-on began December 1, 1998. Second wage add-on was implemented October 1, 1999.	The appropriation for the state FY 2000 wage add-on was approximately $4.5 million (approximately $1.35 million state and approximately $3.15 million federal).	Effective December 1, 1998, a 75-cents per patient day add-on was included in each nursing facility's reimbursement rate. The add-on was provided to assist nursing facilities in retaining currently employed nurse's aide staff. If a nursing facility is cited during a survey for inadequate nurse aide staff during the time period in which the 75-cent add-on is provided, it will be required to submit financial and statistical information relating to the expenditure. If, as a result of the review, a payback is warranted, it may not exceed the total amount reimbursed through the add-on. Effective October 1, 1999, a certified nurse's aide vacancy add-on was included in each qualifying facility's reimbursement rate. The add-on will be provided in order that nursing facilities can address the industrywide nurse's aide staffing turnover problem that was enhanced by a change in the minimum staffing requirements.
Texas	Program began May 1, 2000.	The Texas Enhanced Direct Care Staff Rate program provided $41 million ($15.8 million in general revenue funds and $25.2 million in federal funds) during state FY 2000 for reimbursement increases for nursing homes and hospice room and board (in nursing homes) and is providing $40.9 million ($15.8 million state and $25.1 million federal) during state FY 2001.	There is no specified portion of the funds that are to be used for nursing homes versus hospice room and board. The funds provide additional funds for direct care staff of nursing homes—registered nurses, licensed vocational nurses, and certified nurse's aides. Participation in the program requires the facility to maintain certain direct care staffing levels. All contracted facilities will provide the Texas Department of Human Services an Annual Staffing and Compensation Report reflecting the activities of the facility while delivering contracted services over the rate year. This report will be used as the basis for determining compliance with the staffing requirements and recoupment amounts. Also, the Department requires a 6-month staffing report that will be used as the basis for determining compliance with the staffing requirements and recoupment amounts.

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State	Time period	Amount appropriated	Program description
Utah	State had previously implemented a pass-through program in 1990 and 1992 for nursing facilities. The most recent nursing facility pass-through program began July 1, 1998.	For the 1998 program, the state implemented a wage pass-through, which added $3.06 per day for nurse's aides—approximately $3.5 million (approximately $945,000 state and $2.56 million federal) was appropriated for the wage pass-through.	Hourly wages for nurse's aides were monitored to ensure funding was directed to the wage problem. In addition, the nursing facility Medicaid payment rate has a "nursing component" that is "provider specific." Payments are based on nursing costs reported for the prior year. Therefore, if nursing expenditures are reduced, future payment rates reflect that decrease.
Vermont	Program began July 1, 1999.	$4 million ($1.52 million state and $2.48 million federal) was appropriated for the wage pass-through.	The supplement is to be calculated as the prorated share of the net revenues based on the ratio of its nursing wages, salaries, and fringe benefits to the total of all nursing wages, salaries, and fringe benefits paid by Vermont nursing homes participating in the Medicaid program as reported on their 1997 Medicaid cost reports. The supplement is then added to the facility's total per diem rate. Within 60 days after the end of each state fiscal year during which wage supplement payments are made, each facility is to file on forms prescribed by the Vermont Division of Rate Setting a report of the wages, salaries, fringe benefits, and bonuses paid to employees during the state fiscal year.
Virginia	Program began July 1, 1999	$21.7 million (approximately $10.5 million state and approximately $11.2 million federal) was appropriated for the wage supplement.	The nursing home wage supplement was to compensate nursing facilities for increased costs of certified nurse's aides and other increases in direct care costs. The nursing homes are to report what was actually spent, and if the facility did not spend the money for the wage supplement, then it must be returned to the state.
Wisconsin	Program began October 1, 1999.	The statewide amount of the nursing home wage pass-through is not to exceed $8.3 million (approximately $3.42 million state and $4.88 million federal) in state FY 1999-2000 and $11.1 million (approximately $4.53 million state and $6.57 million federal) in state FY 2000-2001.	A nursing home wage pass-through is provided to facilities to increase wages and fringe benefits, or to increase staff hours equal to 5% of the total amount of wages reported in a facility's 1998 cost report.

Additional Information on Federal Oversight Activities

Federal Comparative Surveys

Because HCFA does not expect to implement a centralized database on comparative surveys until 2001, we manually compiled a summary of the 157 comparative surveys conducted between October 1998 and May 2000 by obtaining copies of the state and corresponding federal survey from each regional office. Table 16 presents the results of our analysis.

- Compared with the results of state surveys, 70 percent of federal comparative surveys found more serious care problems. On average, state surveyors identified 3 deficiencies per home, while federal surveyors found almost 10.
- Significant differences emerged among the 10 regions responsible for conducting comparative surveys. In August 1999, HCFA instructed regions to start their federal comparative surveys within 14 to 28 days after the state's survey was completed. Our analysis found that HCFA's New York and Philadelphia regions both had an average 39-day time period between the conclusion of the state survey and the beginning of the federal comparative survey. In contrast, the average interval for the Denver region was 23 days. Our analysis also found that of the 10 regions, only Chicago cited fewer deficiencies, on average, than state surveyors. Similarly, Boston was the only region to cite deficiencies at a lower scope and severity level than state surveyors.

Table 16: GAO Analysis of the Results of Federal Comparative Surveys Conducted Between October 1998 and May 2000

HCFA region	Number of surveys	Number of surveys where scope and severity of state deficiency was higher than that of federal deficiency	Number of surveys where scope and severity of federal deficiency was higher than that of state deficiency	Average number of days between surveys	Average number of state deficiencies	Average number of federal deficiencies
Boston	13	4	3	28.6	3.7	5.6
New York	7	0	6	38.9	4.1	12.0
Philadelphia	16	2	11	39.1	2.8	6.3
Atlanta	28	5	19	28.6	3.7	8.1
Chicago	22	4	13	33.1	2.9	2.1
Dallas	23	0	23	25.1	2.0	14.5
Kansas City	13	1	9	32.8	3.2	14.2
Denver	16	1	11	22.6	2.3	11.7
San Francisco	10	0	10	24.5	7.3	23.6
Seattle	9	4	5	27.2	5.8	9.3
Total	**157**	**21**	**110**	**29.6**	**3.4**	9.9

New Federal Nursing Home Performance Standards for States

Beginning October 2000, HCFA plans to track the states' compliance with an initial set of seven state performance standards. Based largely on standards established for the SAQIP program, the seven standards are scheduled to replace states' self-evaluation of compliance. HCFA is in the process of developing protocols to ensure that the regions consistently enforce the seven standards. Table 17 summarizes the standards, indicates whether the state or HCFA was previously responsible for assessing compliance, and lists the data HCFA expects the regions to use in evaluating performance.

Table 17: New State Performance Standards, Relationship to SAQIP, and Federal Evaluation Data Sources

State performance area	New state performance standard (effective October 1, 2000)	Source of new performance standard[a]	Data source
Conduct of the survey	Surveys are planned, scheduled, and conducted in a timely manner.	SAQIP (State)	OSCAR
Deficiency documentation	Survey findings are supportable.	SAQIP (State)	State survey statement of deficiencies
Consistency in survey performance	Certifications of homes' compliance with federal standards are fully documented and consistent with applicable law, regulations, and general instructions.	SAQIP (State)	Federal Monitoring Surveys
Enforcement actions	When certifying noncompliance, adverse action procedures set forth in regulations and general instructions are to be adhered to.	SAQIP (State)	Long-Term Care Enforcement Tracking System
Federal expenditure monitoring	All program expenditures and charges to be substantiated to HHS Secretary.	SAQIP (HCFA)	State Survey Agency Budget/Expenditure Report and Nursing Home Initiative Expenditure Report
Complaints investigation	Conducting and reporting of complaint investigations is timely and accurate and complies with general instructions for complaint handling.	SAQIP (State)	OSCAR
OSCAR data entry	Accurate and timely data entry into OSCAR.	SAQIP (HCFA)	OSCAR

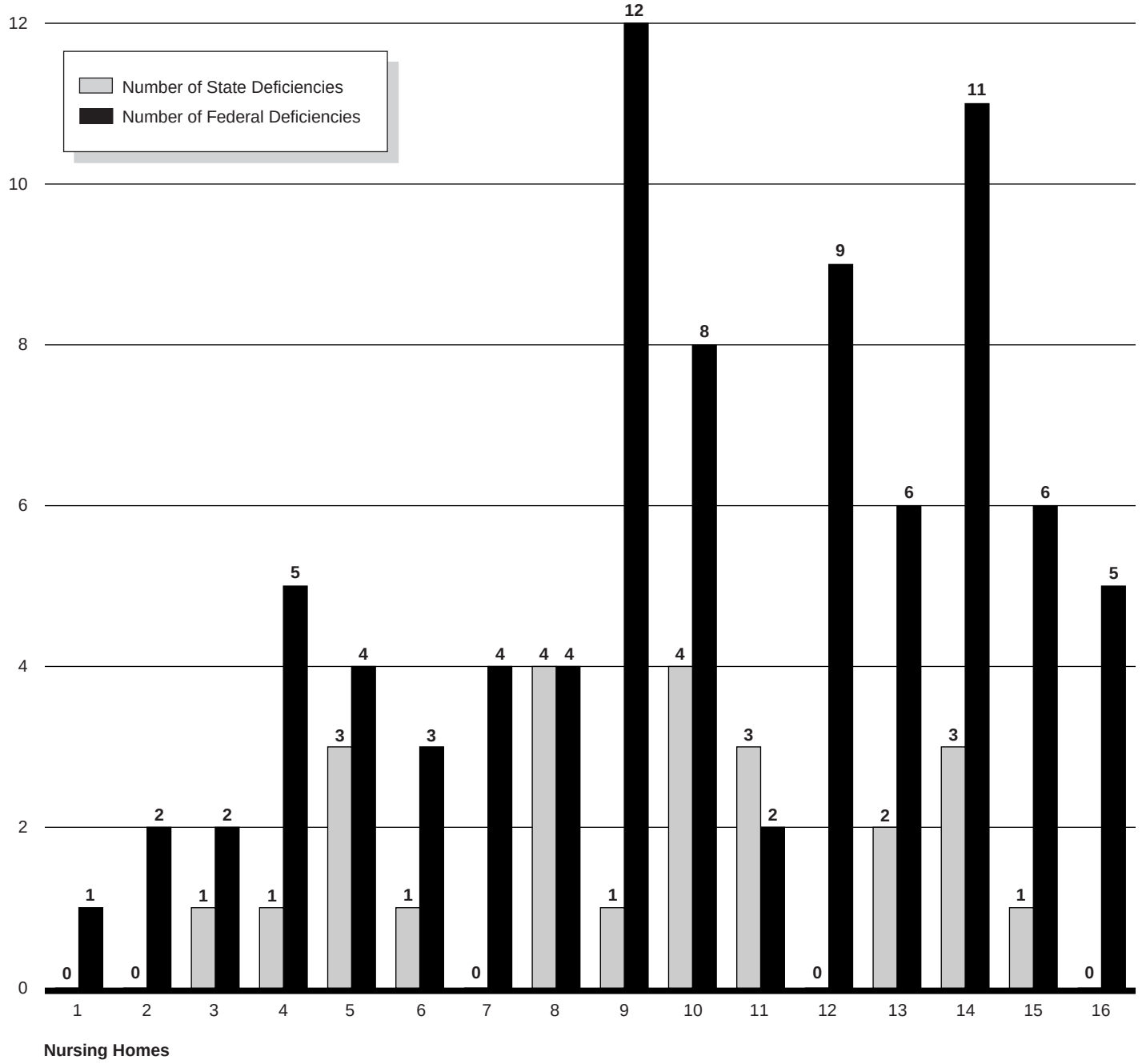
[a]The current SAQIP Nursing Home Performance Standards for State Agencies are divided into two sets of performance standards—one for states and one for HCFA regional offices. The states are responsible for self-assessing their ability to meet the seven state standards and reporting those results to their regional offices. The regional offices have an additional four performance standards they are responsible for ensuring their state survey agencies meet. The "source of new standard" column indicates whether it is a state or HCFA SAQIP standard.

Results of Recent Federal Surveys in Oklahoma

Between April and June 2000, HCFA conducted full federal surveys at the 16 nursing homes suspected of bribing the state survey agency director.[1] This number is significant because most states have only two full federal surveys each year. Figure 1 demonstrates that compared with the most recent state survey, federal surveyors found significantly more quality-of-care problems at these homes.

[1]Four of these 16 federal surveys would qualify as comparatives because 2 months or less had elapsed since the most recent state survey.

Figure 1: Comparison of State and Federal Quality-of-Care Deficiencies for 16 Nursing Homes in Oklahoma



Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: SEP 22 2000

TO: Kathryn G. Allen
Associate Director
Health Financing and Public Health Issues
General Accounting Office (GAO)

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: GAO Draft Report: "Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives" (GAO/HEHS-00-197)

Thank you for giving us the opportunity to review and comment on the draft report entitled Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives, (GAO/HEHS-00-197). We generally agree with the GAO's findings and conclusions.

Protecting the 1.6 million people who live in nursing homes is a priority for this Administration and for the Health Care Financing Agency (HCFA), and we remain committed to bringing consistency and accountability to the oversight of the nation's 17,000 nursing homes. In 1995, HCFA began enforcing the nation's toughest-ever nursing home regulations. These regulations brought about measurable improvement, as documented in our 1998 Report to Congress. However, both our report and the work done by the General Accounting Office (GAO) made clear that more needed to be done. Therefore, President Clinton, announced a major new initiative in July 1998 to increase protections for vulnerable nursing home residents and to crack down on problem providers.

Implementation of the President's Nursing Home Initiative (NHI) began in 1999 and is continuing at both Federal and State levels. Some NHI provisions have already been implemented successfully in most States, and current data indicate that:

- On a national level, we have reached the goal of conducting 10 percent of such surveys on nights and weekends.
- State surveyors are identifying more substandard quality of care, with the average number of deficiencies found per survey up from 6.3 in 1996 to 7.0 in 1999, and the number of facilities cited for failure to prevent or care for bed sores up from 16.4 percent in 1996 to 17.7 percent in 1999.
- They also are citing more nursing homes for abuse, with the total up from 6.7 percent in early 1996 to 14.1 percent in 1999.
- Over 90 percent of facilities with severe deficiencies were referred for immediate sanctions.

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- Only 10 of 33 nursing homes involuntarily terminated from the Medicare program in 1999 had been readmitted. Those that were readmitted had remained out of the program an average of 5 months while they made corrections to come back into compliance.

GAO raises a few concerns related to the predictability of surveys, the inter-State variability in citing serious deficiencies, staffing shortages in nursing homes, and the fact that some Regional Offices are not implementing the expedited notice provisions for denial of payment for new admissions. We agree with GAO about the importance of these issues and are taking steps to address them. Preliminary data show that we have reached the national 10% goal for staggered surveys as of July 2000. We have followed up with those States that have not met the 10% threshold on an individual basis to determine the reasons for the delay and their plans to achieve the goal. Nevertheless, we are concerned about GAO's findings that surveys are still too predictable in some states and want to discuss additional measures with GAO.

Regarding variability among the States in citing serious deficiencies, we expect that with greater emphasis on training and more consistent HCFA Central and Regional Office oversight, we will continue to see reduction in the variability. GAO notes HCFA's recent Report to Congress describing the relationship between low nursing home staffing levels and quality of care, and mentions the steps which some states are already taking to address this problem. In addition, the President recently announced a proposal to establish incentive grants to States that commit to raising staffing levels in nursing homes. These grants could be used for a number of purposes including enhancing facility staff recruitment and retention efforts. Having made a number of efforts to ensure that denial of payment sanctions are imposed timely, we are concerned that GAO found problems remaining and will follow up with the Regional Offices on this matter.

We recognize GAO's concern about apparent discrepancies between expenditure reports and statements by State officials regarding expenditures, and we will follow up with the States on this.

We also recognize GAO's concern about the need to monitor State performance and to ensure consistency in the survey process and in interactions between our Regional Offices and State survey agencies. HCFA is taking steps to develop and require continuing education for all surveyors and requiring periodic recertification of all surveyors. On October 1, 2000, new Standards of Performance for State survey agencies will go into effect, and the Regional Offices will begin using a uniform set of protocols to monitor State performance and identify variations and changes on an ongoing basis. The new standards include requirements to ensure: that surveys are planned, scheduled and conducted timely; that survey findings are supportable; that certifications are fully documented, and consistent with applicable regulations and instructions; that applicable procedures are adhered to in certifying non-compliance; and that the conduct of complaint investigations is timely and accurate, and complies with general instructions.

HCFA agrees with GAO that it is still too early to draw definitive conclusions about the impact of various NHI provisions from the preliminary data available to date. We also agree that sustained Federal and State attention will be needed to realize the full potential of the nursing home quality initiatives. In that context, we think it is important to

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emphasize that we are only now about to complete the first fiscal year, FY 2000, in which full funding for the initiative was available. Throughout this fiscal year, we have been phasing in activities as States have been able to get legislative budget approval and complete recruitment, hiring, and training of new surveyors. This lag in funding explains, in part, why there is variation across States in implementing and achieving goals on the same timeline. We will continue to monitor our own progress and that of the States in implementing these provisions, and will modify our processes as needed.

While a good deal of progress has been made, we recognize that more work and a sustained commitment are needed to ensure the success of NHI in improving quality of care. We agree with the GAO that this process will take time. In addition to implementing the remaining provisions, HCFA is committed to a number of specific actions that will help strengthen and build upon the NHI. These include: examining how to make optimal use of available remedies and the possible need for additional authorities; continuing to work with States not making progress in meeting the 10 percent goal for off-hour surveys and the timeliness requirements for complaint investigations; working with States to develop more streamlined methods for investigating serious complaints; and refining data systems to provide more timely, useful and customer-friendly information. We have developed and implemented protocols for monitoring quality of care in nursing homes owned and operated by chains that have filed for Chapter 11. We also will continue our efforts to address the link between staffing levels and quality of care.

We appreciate GAO's willingness to work with HCFA over the past year and to provide early feedback to us as we began implementation of these quality of care initiatives. We are committed to continuing to work with GAO in this collaborative and constructive manner for the good of the 1.6 million Americans who live in nursing homes.

Comments From California's Department of Health Services

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

GRAY DAVIS, *Governor*

DEPARTMENT OF HEALTH SERVICES
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Ms. Kathryn G. Allen
Associate Director
Health Financing and Public Health Issues
United States General Accounting Office
Health, Education and Human Services Division
Washington, D.C. 20548

Dear Ms. Allen:

We appreciate the opportunity to submit California's written response to the General Accounting Office's (GAO) draft report "Nursing Homes: Sustained Efforts are Essential to Realize Potential of the Quality Initiatives". I want to thank the GAO for recognizing California's long-standing and continued efforts to improve the quality of care and quality of life for residents in its over 1400 nursing homes.

Continued efforts to improve the quality of care and quality of life for residents

As stated in the draft report, California has, through its annual budget, supplemented nursing home staff wages ("wage-pass through") as well as added staff to the state agency to increase the nursing home focused enforcement program to 100 facilities. As noted in your report, this program was used as a model for HCFA's focused enforcement program. The annual budget also gave funding to the state agency for the following:

- Quality awards to nursing homes providing exemplary care and monetary awards to those nursing homes providing exemplary care to the highest number of Medicaid residents
- Financial grants for innovative programs leading to improved quality of care and quality of life in nursing homes
- Requirements for nursing homes to report certain indicators of financial problems that could lead to financial insolvency
- Established the Financial Solvency Advisory Board to make recommendations on additional state licensing requirements to improve financial stability in nursing homes
- Added additional staff for guaranteed rapid response to consumer complaints
- Increased staff to vary the cycle of nursing home surveys to decrease the predictability of surveys

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Governor Gray Davis also has signed legislation (Chapter 451, Statutes of 2000) which will implement the following to address continued efforts to improve elder care in California:

- Statewide training by the state agency on effective nursing home practices to improve quality of care and quality of life for residents
- Technical assistance by the state agency to nursing homes to help in the improvement of nursing home practices
- Improved consumer information systems
- Improved abuse reporting by nursing homes
- Management companies must provide application to the state agency and be approved by the state agency in order to enter into management agreements with nursing homes
- Management companies and their subsidiaries will be added to the state agency information systems
- Nursing home licenses can be rescinded and a provisional license issued for certain federal nursing home enforcement actions
- Nursing home licenses can also be revoked for any federal deficiency
- State agency can impose a temporary manager in lieu of recommending imposition of a temporary manager under federal requirements
- Any complaint involving serious threat of imminent death or serious bodily harm will have an onsite inspection within 24 hours of receipt of the complaint
- Centralizing complaint intake and upgrading complaint tracking systems
- Nursing homes must post a notice on all doors providing egress and ingress to the nursing home when certain federal remedies are imposed

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- Nursing homes must provide written notification to each resident, each resident's known family member and legal representative and all applicants for admission to the nursing homes when certain federal remedies are imposed
- The state agency will develop and perform standardized quality assurance reviews on all nursing home survey deficiencies that could lead to imposition of higher level federal remedies
- State civil monetary penalties have been increased for nursing home violations of the most serious nature
- The state agency will annually evaluate the nursing home enforcement process and provide the evaluation to the legislature and recommend additional legislation if needed to improve the process
- The state agency will determine need and make recommendations to the legislature regarding the minimum number of nursing hours per day needed to provide quality care in nursing homes
- The state agency will review and make recommendations to the legislature for changes to the state nursing home reimbursement methodology
- Improves the transfer and discharge appeal rights for nursing home residents

Points of clarification
(changes in bold and italicized)

Page 11: Addition to end of paragraph #1"...and entering the proper data into OSCAR***, including California which has completed 17% of its surveys as off-hour surveys, thus exceeding the HCFA standard of 10%.***

Page 13: Top of page "..., each office will report to one of ***four*** field coordinators (north, central, south ***and Los Angeles***)...

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Page 23: Middle of page"...but failed to account separately for initiatives expenditures as required by HCFA. ***HFCA initially stated the states would not be required to separately report the initiative expenditures and then later did require the states to do so and many of the states had not tracked the specific items requested by HCFA in the separate report.***

Page 28: End of page "...increase in the volume of nursing home appeals. ***An additional impact of appeals is that federal attorneys are requiring state surveyor and consultant staff to provide testimony to support HCFA's action. Preparation time and hearings can last 8-10 days and during this time survey and certification work that would be done by surveyor and consultant staff is not accomplished.***

California would like to once again acknowledge the courtesy and professionalism of the General Accounting Office staff and their ability to understand the very complex and intricate survey and enforcement processes.

We would also like to acknowledge the Health Care Financing Administration and its continued efforts to improve elder care.

California welcomes the continued review of the nursing home survey and enforcement process, and would recommend HCFA and Congress work with the states to determine the best method to coordinate these reviews.

Sincerely,

Diana M. Bontá, R.N., Dr. P.H.
Director

Comments From Michigan's Department of Consumer and Industry Services

State of Michigan
John Engler, Governor

Department of Consumer & Industry Services
Kathleen M. Wilbur, Director

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September 20, 2000

Kathryn G. Allen, Associate Director
Health Financing and Public Health Issues
United States General Accounting Office
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Dear Ms. Allen:

Thank you for the opportunity to respond to the draft report entitled Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives, (GAO/HEHS-00-197). Michigan supports the efforts of HCFA, the General Accounting Office and the Senate Special Committee on Aging to improve the oversight of nursing home services. In response to the 1999 GAO report, we took significant steps to assure compliance with federal standards for state activities. I am pleased to see that these actions have been acknowledged in the draft report. We have additional information in two areas which may assist in bringing the draft up to date with the current activities in our state.

1. **Page 11 and Table 2:** *"... 7 percent of Michigan surveys were late-- that is, conducted after the 16th month."*

   Michigan shares your concern for reducing the predictability of surveys and has taken steps to accomplish that goal.

   First, while the percentage of late surveys may be accurate for the period used for this assessment, we can assure you that since January 2000, no standard survey in our state has exceeded the federal requirement of no more than 16 months since the last survey. To accomplish this, we implemented a computer report this January that indicates facilities due for surveys in the coming months. The report aids in appropriate scheduling of standard surveys and will assure that we maintain compliance with federal requirements in the future.

   Second, Michigan also incorporated the federal standard of conducting surveys between 9 and 15 months, with an average of 12 months, into the new computer program and into our program performance measures. HCFA Region Office V has stated that an average of 12.9 or less meets the federal requirements. Michigan's average survey interval for fiscal year 2000 to date is 12.7 months and is steadily decreasing to 12 months.

   Third, to further reduce predictability, Michigan exceeds federal standards for off-hour standard surveys and conducts complaint visits in off hours where appropriate (although this is not a federal requirement).

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2. **Page 17-- Increasing the Priority Attached to Complaints**

In April 1999, the Department initiated an internal review of Michigan's long-term care and non-long term care complaint investigation processes. During this review, particular attention was paid to the following issues raised by the 1999 GAO report entitled Nursing Homes: Complaint Investigation Processes Inadequate to Protect Residents: 1) procedures that discourage the filing of complaints, 2) understatement of the seriousness of complaints, and 3) failure to investigate serious complaints quickly enough.

The internal review identified opportunities for improvement of complaint processes. A plan was developed to eliminate all 480 backlogged complaints that were then past the 30-day state required time frame by June 30, 1999.

To accomplish this, a project manager and a panel made up of Survey Team managers and Complaint Intake Unit staff developed a new procedure to govern the collection, screening, prioritization, assignment and investigation, entry of data into the database system, and the reporting of findings to complainants. Complaints assigned to surveyors prior to this project were investigated during regularly scheduled hours. Some surveyors also volunteered to investigate complaints on an overtime basis and a contractual retiree was hired to help investigate Southeast Michigan cases during regular hours. During the project, staff continued to meet HCFA's two-day time frame for investigating "immediate jeopardy" (IJ) complaints and the 30-day time frame for completing all other complaints that came in after May 25, 1999.

This action eliminated Michigan's complaint backlog. Four hundred seventy-five (475) of the 480 complaints in open status were investigated and completely processed by June 30, 1999. The other five were completed in early July 1999.

Since July 1999, Michigan has implemented a number of additional measures to improve the complaint process and to ensure timely investigation of complaints:

1. New complaint forms created to aid citizens of the State of Michigan in providing necessary information– facilitating the processing of complaints. The new complaint forms are now being added to the Department's web page.

2. An upgrade of the 1-800 Complaint Hotline telephone system was completed to facilitate the processing of complaints and to better accommodate after hours calls.

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3. A distinct Complaint Intake Unit was created with added staff dedicated to receive and prioritizing complaints and facility reported incidents to make complaint processes more accessible to the public and to better focus investigations.

4. The state Complaint Investigation Manual was revised and disseminated July 1, 1999 to all appropriate staff to ensure consistency of investigative procedures.

5. A Complaint Investigation Team was created as a separate unit to develop expertise in complaint investigation and to provide rapid response to serious injury and serious harm complaints.

6. Off-hours investigations were increased for complaint surveys and are conducted as needed.

7. Performance measures were established for the Complaint Investigation Team that require investigations within two days for serious injury complaints, ten days for actual harm as required by federal law, and a self-imposed 30 day deadline for non-priority complaints. Findings for each investigation must be reported within 30 days.

8. Caseload status reports have also been developed for use by management and leadership to evaluate the effectiveness and timeliness of the complaint investigation process.

The improvements made showed, and continue to show, success in Michigan. Data recently supplied to GAO for July to December 1999 show 100% (63) of serious injury cases completed within the 48 hour time frame, 100% (16) complaints completed within the ten day time frame for actual harm cases, and 95% of the 717 non-priority cases investigated within 30 days. Michigan's record in calendar year 2000 shows similar results.

3. **Table 5, Footnote d**

In the Michigan program, the term "investigate" means that both the on-site survey is performed and the report of results is delivered to the complainant within 30 days. Our program procedures now require that the actual onsite survey for the 818 "non-priority" complaints be conducted within 15 days of receipt, not 30 days as stated in the footnote. In other words, Michigan procedures require that all complaints which require an onsite are visited within 15 days. We think that this is a more stringent time frame than you will find in most states. While we do not meet this goal in every case, we are making steady progress toward this goal. Our average onsite visit interval for all complaints during October 1999 and February 2000 was 16.2 days.

I hope this information is of assistance to you.

Sincerely,

Kathleen M. Wilbur

Kathleen M. Wilbur
Director

Comments From Missouri's Department of Social Services

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GOVERNOR

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September 21, 2000

Ms. Kathryn G. Allen, Associate Director
U.S. General Accounting Office
Health, Education, and Human Services Division
Health Financing and Public Health Issues
Washington, DC 20548

Dear Ms. Allen:

I appreciate the opportunity to respond to your September 14, 2000 letter and the attached U.S. General Accounting Office's draft report to the Senate Special Committee on Aging and Senator Christopher Bond entitled Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives, (GAO/HEHS-00-197). Since becoming the Director of the Division of Aging (DA) on February 14, 2000, I have been working diligently with staff to ensure implementation of and compliance with Medicare and Medicaid regulations including the Nursing Home Initiatives (NHIs).

While generally in agreement with the findings and recommendations contained in the report regarding the NHIs, DA has the following comments and suggestions related to key areas within the report:

Survey Methodology

The Health Care Financing Administration's (HCFA's) major redesign of its nursing home survey methodology utilizing Quality Indicators (QIs) from the Minimum Data Set (MDS) is a first step in implementing needed modifications to the survey process. QIs allow survey staff to enter facilities with information in-hand specific to the general population, as well as identifying individual residents with specific care issues (i.e., pressure ulcers, weight loss, dehydration). DA agrees with GAO's concern that the QI reports are generated from information self-reported by the nursing facilities. With the September, 2000 addition of the requirement for facility staff to attest to the MDS

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information being collected in accordance with applicable Medicare and Medicaid requirements, HCFA has taken a step towards ensuring facilities understand the responsibility of accurately and timely completing these resident centered assessments. Resources have not been provided to the state survey agencies to allow for periodic reviews of MDS assessments and care plans outside the annual survey cycle. Periodic independent validation of the accuracy of the MDS data gathered by the facility would further strengthen the use of the data in ensuring the survey process addresses specific issues or concerns in each facility.

As the GAO report indicates, these initial survey modifications need to be in place a longer period of time prior to a final determination being made that they have resulted in the desired outcomes. However, continuing to modify and add to an already highly complex system, does not necessarily address the inflexibility and rigidity seen in the current process. We recommend HCFA, the state survey agencies, long-term care industry, consumers and other interested parties come together to perform a comprehensive review and evaluation of the existing survey process with a common goal of designing, developing and implementing the best possible system including the use of technology. HCFA and state survey agencies need this system to readily identify, document, track and report on the quality of care and quality of life in facilities including identification of "early warning" signs of developing problems and violations in nursing facilities. The current survey process remains "one size fits all". HCFA and the state survey agencies need to be able to accurately assess facilities quality care and services. Survey resource allocation should be managed to minimize resource expenditure for compliant homes enabling limited resources to be directed to facilities needing close scrutiny to ensure appropriate program decisions are made timely when facilities are unwilling or unable to successfully sustain compliance.

Survey Predictability

DA concurs with GAO's finding that the 10% staggered survey NHI, by itself, is too limited in scope to truly reduce survey predictability. DA is in compliance with the NHI related to staggered surveys; management reports for federal fiscal year (FFY) 2000 show that we met the minimum compliance requirement of 10% by the end of June with completion of 49 surveys (492 X 10% = 49) starting on weekends and/or off-routine hours. During the remaining months of FFY 2000, we have continued to begin surveys on weekends and/or off-hours to assist in further reducing the predictability of the recertification survey process. We have recommended to HCFA that they modify the practice of using the federal On-line Date Inquiry and Entry/On-line Survey, Certification and Reporting (ODIE/OSCAR) system as the **primary data source** for information related to this NHI. Currently, ODIE/OSCAR data entry requires all information to be entered only after completion of the survey process including Informal Dispute Resolution. The timing of data entry into the ODIE/OSCAR system results in state survey agencies appearing to be non-compliant. Data entry modifications have been recommended to HCFA by the state survey agencies to allow completion of initial entry of key survey data prior to completion of the IDR process. However, state agencies have

not yet received information regarding plans for any implementation of ODIE/OSCAR system changes allowing for more timely data entry. (We do understand HCFA has begun a major redesign project (QIES) that will eventually replace the existing system.)

While we concur with GAO's recommendation that annual surveys would be less predictable if the process was segmented to allow surveyors more than one review visit during a year, the manner in which this segmentation occurs -- along with the ability of state survey agencies to include a segment of the survey in another process, such as a complaint investigation -- would need to be taken into consideration given current resource limitations.

Resource Planning

We concur with GAO's finding that states were not able to fully expend federal fiscal year 1999 NHI funding due to late distribution. We cannot stress enough the importance of adequate planning for program implementation and communication at all levels within HCFA's central office, regional offices down to the state survey agencies. Even though additional federal funds may be made available during a fiscal period, states have budgetary policies that require state legislative action to allow the state agency to obtain required state shares and provide authority for utilization of federal funds. Further, when continuation of federal funds from period-to-period is questionable, states are not always successful in obtaining state appropriation authority for full time equivalent (FTE) employees to perform mandated functions.

Statements related to future funding appear to indicate that HCFA's funding methodologies will continue to be at odds with the objective of assuring quality oversight and monitoring of Medicare/Medicaid certified facilities. Use of OSCAR data for determining resource allocations to states is indicative of a continuing pattern of emphasizing survey productivity rather than quality of the surveys conducted. We understand that HCFA continues to work towards funding surveys based upon an "average survey" without consideration of survey quality or the need to direct resources towards problematic facilities. Currently, state survey agencies are not funded at a level that allows for determination of the number of hours to be spent in a facility based upon the conditions found or known to exist in the facility or to allow for monitoring of compliance in an adequate number of problem facilities.

Special Focus Facilities

While worthwhile, DA concurs with GAO that the special focus facility NHI is to narrow in scope excluding many homes that were providing poor care. Each state had two facilities that were identified as special focus facilities. We would recommend HCFA consider providing sufficient resources for expansion of this NHI requiring two full surveys rather than one annually in facilities providing poor care and that consideration be given to modifying the process to allow for monitoring or abbreviated surveys as an extension of this NHI.

Training Issues

A key area of concern for state agencies is training to ensure our staff are competent and qualified to perform survey functions. Much of our time is spent ensuring consistent application of federal survey guidelines across teams and regions. Another concern is the short time frames provided for implementation of new initiatives resulting in extremely limited training opportunities for staff prior to implementation of the federal guideline. During state fiscal year (SFY) 2001, DA will be implementing the new nationally developed Preceptor's Training Program. This program will assist DA in assuring that training of surveyors is managed in a uniform and consistent manner throughout our state.

HCFA needs to ensure that prior to conducting training sessions their guidelines are finalized and materials provided to trainers are consistent throughout their train-the-trainer sessions. Recent experience with NHI training sessions being conducted with draft materials is an example of state trainers not receiving the same training between sessions. Routinely, state agencies are allowed to send only two individuals to train-the-trainer sessions resulting in the need for additional state staff to be trained as trainers prior to conducting actual sessions for approximately 200 total staff. Additionally, when establishing time frames for implementation HCFA should consider that state agencies cannot discontinue responding to complaint investigations and completing ongoing processes to have all regional staff attend a single training session requiring repetition of sessions.

HCFA is responsible for providing basic surveyor training for all state survey staff prior to those staff sitting for the federal Surveyor Minimum Qualification Test (SMQT). We have noted over time that modifications are made to the training program, but information about the modifications is not always provided timely to the state training coordinator to ensure all existing survey staff remain up-to-date. We believe HCFA should consider remanding responsibility for training to the HCFA regional offices, so that a regional training coordinator can be assigned to assist in ensuring that training provided throughout the region is consistent. Frequently, HCFA has utilized various regional office staff for training sessions without consideration of the variances within their own regions. This results in confusion for state surveyors who return to teams where other team members may have heard different interpretations dependent upon which HCFA regional office conducted a specific session.

We noted reference to an OSCAR and other data tracking coordinator responsible for ensuring that HCFA regions have the necessary trained personnel and that regional administrators and the cental office are to be apprised of data analysis results. A need for a similar position exists in the state survey agency. Training on the ODIE/OSCAR system has been infrequent and system modifications have occurred without prior notice to state agencies. We anticipate as major system modifications are made and as QIES continues to develop, HCFA will assist states in ensuring state staff have access to a trained and qualified state data tracking coordinator.

Complaint Processes

Timely investigation of the growing number of complaints is essential in ensuring an accurate reporting of the events that resulted in the complaint being filed. However, to meet the federal program mandates and state inspection requirements (two inspections per year), as well as time frames for completion of complaint investigations, additional resources are needed to ensure all time frames are met. HCFA continues to prioritize the completion of the annual survey ahead of completion of complaint investigations. DA continues to request annually, through the state and federal budget processes, funds for additional survey staff. Historically, state survey agencies have not been consistently successful in obtaining sufficient resources to meet the increasing need for complaint processes, as well as all other federal and state mandates.

Table 11

This table uses as a comparison California with 3 percent of the nursing homes in the state found deficiency free on their most recent survey compared to about 16 percent in Missouri. Appendix II of this report identifies the national average percentage of deficiency free homes to be 16.0%.

In regard to the adequacy of complaint investigations, DA identified problems with our complaint process prior to the Missouri state auditor's review conducted in state fiscal year 1999 and therefore, we concurred with her recommendations for improvement. In SFY 1996, DA staff identified the need for sweeping revisions to the complaint system. Beginning in SFY 1997, DA conducted internal reviews and convened focus groups to clearly identify issues and to make recommendations for systemic revision. Requests for budget appropriation for additional staff were made in 1998, 1999, 2000 and 2001 to obtain sufficient numbers of staff to implement the recommended revisions. These requests were partially funded. In addition, plans were made to replace the antiquated Central Registry for Abuse, Neglect and Exploitation (CRANE) system, through which all complaint reports are reported, tracked and documented. Until the new system comes on-line, an interim tracking and monitoring system has been implemented. The new on-line system is currently in the preliminary testing phase.

In mid-SFY 1999, DA began phasing in region-by-region a new complaint investigation process including a case management approach to ensure that complaint investigations are initiated timely and, at a minimum, a call is placed to the reporter to determine the need for an immediate on-site visit. This process change resulted in increased community participation (family, friends, facility operators and other concerned individuals), bringing to positive resolution issues affecting the day-to-day lives of facility residents.

DA concurred with the state auditor that additional improvements are needed to the complaint system. DA took action following discussions with state audit staff to:

- Designate a central office complaint coordinator and monitor to ensure: complaint investigations are timely handled; reporters are called; required notices are mailed; and complaint investigation data is received and entered into a regional complaint tracking system with the regional data base forwarded to central office on a monthly basis for review and action, as applicable.
- Request additional DA staff to allow us to begin in September, 2000, to at least quarterly, monitor quality through a random selection of completed complaint reports. Comparisons of the selected reports to established quality assurance criteria will be completed; feedback will be provided to survey staff and training will be focused on areas needing improvement.
- Initiate a management and internal control review of complaint processing beginning with the Kansas City Regional Office.
- Provide investigative skills training for all staff at the SFY 2001 Annual Surveyor's Training and later in the fiscal year provide an advanced course for supervisors and complaint investigators.

Additionally, we have submitted to the HCFA regional office a detailed training plan for all staff within the region responsible for the facility where the federal comparative survey was conducted in February 2000. The plan contains required training elements on each task cited within the comparative survey as not meeting federal guidelines and requires the training be monitored by the central office state training coordinator. Further, the plan requires supervisors to continue monitoring after the training each team's surveys for these tasks and that each supervisor submit a sample of surveys completed by teams under their supervision to the central office quality assurance unit for review.

Comparative Surveys

DA believes the federal comparative survey process could be beneficial in determining state survey agency compliance, but requires refinement. In our review of the comparative surveys conducted in our state, we noted that these federal surveys are completed using different criteria and resources than those set forth by HCFA for use by state agencies. Differences include: utilization of different numbers and types of survey staff; use of different samples of residents; reviews of different areas of resident care; the periods of time surveyed are not the same and findings from the federal comparative survey are not required to be legally defensible.

Missouri looks forward to continued work with HCFA, the other state agencies, advocates, residents and their families in further implementing these and other NHIs to improve the quality of care and life for residents in our state's nursing facilities. Choosing a nursing facility for a family member or loved one is never an easy task. Our common goal must remain ensuring that facilities offering services to some of our most vulnerable citizens maintain the dignity of the individual; provide them with the respect, they so rightly deserve; and ensure their safety, security and comfort while receiving quality care and services appropriate to meet their individual needs.

Sincerely,

Richard C. Dunn
Director

RCD/pw

Comments From Washington's Department of Social and Health Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND ADULT SERVICES ADMINISTRATION
PO Box 45600 • Olympia, WA 98504-5600

September 20, 2000

William J. Scanlon, Director
Health Financing & Public Issues
General Accounting Office
441 "G" Street NW
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Dear Mr. Scanlon:

We appreciate the opportunity to provide comment on the report regarding implementation of the Nursing Home Quality Initiatives. While full implementation of the initiatives is ongoing, the information and data presented in the report is of interest.

The report recognizes many of the challenges related to Federal enforcement. Washington State has a proactive state enforcement system which has been in effect since 1989. State enforcement processes can serve to heighten the effectiveness of the Federal system. Should the GAO or Congress wish to review the components of the Washington State system that further protect nursing home residents, we stand ready to participate in that process.

Sincerely,

Patricia K. Lashway

Patricia K. Lashway, Director
Residential Care Services

GAO Contact and Staff Acknowledgments

GAO Contact

Walter Ochinko, (202) 512-7157

Staff Acknowledgments

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Related GAO Products

Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality (GAO/HEHS-00-6, Nov. 4, 1999).

Nursing Homes: HCFA Should Strengthen Its Oversight of State Agencies to Better Ensure Quality Care (GAO/T-HEHS-00-27, Nov. 4, 1999).

Nursing Home Oversight: Industry Examples Do Not Demonstrate That Regulatory Actions Were Unreasonable (GAO/HEHS-99-154R, Aug. 13, 1999).

Nursing Homes: HCFA Initiatives to Improve Care Are Under Way but Will Require Continued Commitment (GAO/T-HEHS-99-155, June 30, 1999).

Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit (GAO/HEHS-99-157, June 30, 1999).

Nursing Homes: Complaint Investigation Processes in Maryland (GAO/T-HEHS-99-146, June 15, 1999).

Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents (GAO/HEHS-99-80, Mar. 22, 1999).

Nursing Homes: Stronger Complaint and Enforcement Practices Needed to Better Ensure Adequate Care (GAO/T-HEHS-99-89, Mar. 22, 1999).

Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards (GAO/HEHS-99-46, Mar. 18, 1999).

California Nursing Homes: Federal and State Oversight Inadequate to Protect Residents in Homes With Serious Care Violations (GAO/T-HEHS-98-219, July 28, 1998).

California Nursing Homes: Care Problems Persist Despite Federal and State Oversight (GAO/HEHS-98-202, July 27, 1998).

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