BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

The Medicare Hospital Certification System Needs Reform

The Department of Health, Education, and Welfare is required by law to certify that all hospitals participating in the Medicare program are providing quality care to patients. Hospitals accredited by the Joint Commission on Accreditation of Hospitals are automatically certified except for two requirements.

However, the certification system has problems caused by (1) limited capacity to measure the quality of health care, (2) differences in standards used by HEW and the Commission, (3) differences in how States and the Commission conduct surveys and apply standards, and (4) ineffective monitoring of States' activities.

GAO recommends that the Secretary of HEW provide incentives for hospitals to promptly correct deficiencies. He should also improve the Department's policy guidance and monitoring activities and encourage other actions so that the number of surveys hospitals receive would be reduced.

HRD-79-37
MAY 14, 1979

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(4)

To the President of the Senate and the
Speaker of the House of Representatives CWD 00001

This report discusses the Medicare hospital certification system, which is administered by the Department of Health, Education, and Welfare pursuant to the Social Security Act, as amended. The report describes a number of problems with the certification system that are caused by (1) limitations of the surveys made by the States under contract with the Department and by the Joint Commission on Accreditation of Hospitals, (2) differences between Medicare conditions of participation and Commission standards, (3) differences in how the States and the Commission conduct surveys and apply their standards, and (4) ineffective Department monitoring of States' activities.

We made our review because the certification system plays an important role in ensuring that hospitals provide quality care to patients and because the system is unique in its substantial reliance on activities of a nongovernmental body--the Commission.

We are sending copies of this report to the Secretary of Health, Education, and Welfare; the Director, Office of Management and Budget; and the President, Joint Commission on Accreditation of Hospitals.

Elmer B. Staats

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

THE MEDICARE HOSPITAL CERTIFICATION SYSTEM NEEDS REFORM

D I G E S T

The Social Security Amendments of 1965 state that hospitals receiving Medicare funds be certified as meeting quality of care requirements called conditions of participation. The law states that hospitals accredited by the Joint Commission on Accreditation of Hospitals meet all but two conditions of participation. As a result, Commission-accredited hospitals are automatically certified, except for two conditions. The law also requires the Department of Health, Education, and Welfare (HEW) to validate the Commission's work by continuously surveying a statistical sample of accredited hospitals.

HEW contracts with State health agencies to (1) make the validation surveys of Commission-accredited hospitals and monitor those not complying with the conditions, (2) survey utilization review and institutional planning at accredited hospitals, and (3) survey unaccredited hospitals, make certification recommendations, and obtain corrective action.

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LIMITATIONS OF SURVEY PROCESS

HEW conditions and Commission standards are used to determine whether hospital procedures, policies, and environment establish a framework within which quality care can be provided. Survey findings may differ or deficiencies may go undetected because

--differences between desirable procedures and actual practices are difficult to observe or

--criteria underlying Commission standards and HEW conditions do not reflect current practices. (See ch. 2.)

LIMITATIONS OF VALIDATION PROCESS

Validations have shown that about 65 percent of accredited hospitals do not meet the conditions of participation. Results diverged because survey criteria, emphasis, and team characteristics differed. Comparisons of recent validation surveys with accreditation surveys show that the Commission reported nearly twice as many deficiencies as the States and more significant ones. Although both Commission and State surveys reported about the same number of deficiencies where HEW conditions of participation and Commission standards were the same, only 12 percent of these deficiencies were reported in both surveys.

The effect of the validation process is that 3 percent of the accredited hospitals must respond to a second set of requirements and an extra survey and 2 percent are transferred to State monitorship and receive more supervision. The other accredited hospitals--about 75 percent of all hospitals receiving Medicare funds--are affected indirectly through improvements made by the Commission that can be attributed to the validation process. According to HEW, the initial validation report to the Congress led to improvements in the Commission's fire safety standards and survey procedures. (See ch. 3.)

STATE CERTIFICATION PROCESS IS UNRELIABLE

Compared to Commission survey products, the State products are unreliable. Many significant deficiencies were not detected, and assessment criteria were not uniformly applied. As a result, States recertified hospitals that did not meet statutory and other essential requirements and reached varying compliance decisions when the same deficiencies were reported. They did not always encourage hospitals to correct deficiencies quickly--sometimes because they did not adequately follow them up; other times because the hospital may not have had sufficient incentive to act. (See ch. 4.)

HEW SURVEY GUIDANCE NEEDED

Unlike the Commission's program, HEW's is decentralized, making uniform guidance and effective monitoring particularly important to obtaining a consistent product at a reasonable cost. However, HEW guidance for survey team size and composition, surveyor qualifications and training, and survey duration are inadequate. These factors vary among and often within States, contributing to disparate survey results.

The lack of adequate program guidance is reflected in costs. In 1977, the average Commission survey cost $2,350, and individual surveys ranged from $1,500 to $4,500, depending on hospital size. Estimated survey costs for States in the HEW regions GAO visited ranged from $1,464 to $7,244. The average survey cost for each of the seven States GAO visited was about $2,500, according to HEW. These amounts are understated because they do not include HEW's cost for monitoring the States' activities. (See ch. 5.)

HEW MONITORING IS INEFFECTIVE

HEW has concentrated on monitoring State's management performance, such as how effectively they schedule surveys and process documents, rather than assessing how consistently or correctly the States applied Medicare regulations. Even when deficiencies were identified, the regions did not always follow up to make sure they were corrected. In fact, the regions have little recourse if the States ignore their recommendations. (See ch. 6.)

CONCLUSIONS AND RECOMMENDATIONS

The Congress should revitalize the Medicare certification system for hospitals by requiring HEW to

--contract with the Commission to conduct all certification surveys,

--use Federal suveyors to survey unaccredited hospitals and validate accredited hospitals, or

--significantly improve the existing process.

In any case, underlying problems must first be corrected. HEW must make improvements in its policy guidance and monitoring at all levels, including standardizing controls for discovering and correcting weaknesses in Commission, the regions, and if the last alternative is chosen, the States. GAO is making several recommendations to achieve this end and to improve incentives for hospitals to correct deficiencies promptly. Also, GAO is recommending measures to reduce the number of hospital surveys. (See ch. 7.)

HEW agreed with the thrust of GAO's conclusions and its recommendations directed to the Secretary of HEW, and identified actions taken or planned to address the recommendations. HEW, however, was not supportive of contracting with the Commission for all certification activities because of (1) anticipated strong resistance from the States and (2) the strong ties between licensure programs and certification in some States.

The Commission advised GAO that the report was fair and objective concerning the Commission's activity. Although recognizing that GAO found fault with HEW validation efforts, the Commission suggested that this was an essential program and good public policy. Regarding GAO's recommendation that the Congress consider the alternative of requiring HEW to contract with the Commission to conduct all certification surveys, the Commission stated that the absence of appropriate public debate and requisite legislation made it inappropriate for the Commission to comment at this time. (See ch. 8.)

Contents

ABBREVIATIONS

GAO	General Accounting Office
HCFA	Health Care Financing Administration
HEW	Department of Health, Education, and Welfare
JCAH	Joint Commission on Accreditation of Hospitals

CHAPTER 1

INTRODUCTION

How to guarantee acceptable quality health care without unduly interfering in the practice of medicine--this is a persistent problem confronting the health professions and government regulators. This concern was evident when the Social Security Amendments of 1965 (Public Law 89-97) instituted Medicare--a federally funded health insurance program for the aged. The law states that the Department of Health, Education, and Welfare (HEW) is to certify that hospitals comply with certain quality requirements, called conditions of participation, before receiving Medicare funds.

PROVISIONS FOR CERTIFYING HOSPITALS

The Office of Standards and Certification, within the Bureau of Health Standards and Quality, Health Care Financing Administration (HCFA), administers the Medicare certification program. HCFA was established in March 1977 to reduce duplication by consolidating responsibility for administering Medicare and Medicaid (a Federal/State health insurance assistance program for welfare recipients and other poor persons). The Bureau's creation placed responsibility for all Medicare certification functions in one unit. Its 10 regional directors are responsible for applying the conditions of participation to determine the initial certification and annual recertifications. In March 1978 a new director and deputy director of the Office of Standards and Certification were appointed.

The conditions of participation were modeled on Joint Commission on Accreditation of Hospitals (JCAH) standards. JCAH, a private, nonprofit organization, was established in 1951 to encourage hospitals to attain high standards of medical care. The founding organizations included the American College of Surgeons, the American Medical Association, the American Hospital Association, and the American College of Physicians. These organizations appoint a board of 20 commissioners, which governs JCAH. A committee of the board decides whether to accredit hospitals for 1 or 2 years or not to accredit, on the basis of information obtained during hospital surveys.

The 1965 Social Security Amendments state that hospitals surveyed and accredited by JCAH meet the conditions of participation. The amendments also gave the Secretary of HEW the option, which was exercised, to allow similar status to hospitals surveyed and accredited by the American Osteopathic Association. These hospitals are automatically certified except for utilization review 1/ and institutional planning 2/ activities, which must be certified separately. As of May 30, 1978, of the 6,674 general hospitals participating in Medicare, about 76 percent were automatically certified as a result of being accredited by JCAH and about 2 percent as a result of being accredited by the American Osteopathic Association.

Two suits by consumers against the Federal Government contended that the provision of the 1965 amendments allowing automatic certification of JCAH-accredited hospitals was unconstitutional because it delegated a congressionally charged function to a nongovernmental party. The cases were never brought to trial. Responding to this issue, however, the 1972 amendments to the Social Security Act required that a statistical sample of JCAH-accredited hospitals receive validation surveys to assure they comply with the conditions of participation. According to HEW, validations are performed to monitor the JCAH process and point to changes needed in its system. Under the 1972 amendments, HEW reports validation survey results to the Congress annually. No similar requirement was imposed on hospitals accredited by the American Osteopathic Association.

1/Utilization review requirements involve assessing a hospital's plan for assuring that admissions, durations of stays, and professional services furnished were necessary and promoted the most efficient use of health facilities and services.

2/Institutional planning requirements involve assessing the hospital's overall plan and budget. The plan, prepared under the direction of the governing body, includes (1) an annual operating budget covering anticipated income and expenses and (2) a 3-year capital expenditure plan identifying the objectives and proposed sources of financing for each anticipated expenditure over $100,000. JCAH was notified in July 1978 that HEW was preparing the necessary regulatory changes to include the institutional planning requirement under automatic certification status.

The law also empowers the Secretary of HEW to contract with appropriate State health agencies to (1) survey unaccredited facilities and make certification recommendations, (2) survey accredited facilities and make certification recommendations on utilization review and institutional planning, (3) make validation surveys for a statistical sample of JCAH-accredited hospitals, (4) investigate substantial complaints about patient health and safety at accredited and unaccredited certified institutions, and (5) follow up on noted deficiencies and obtain corrective action from unaccredited facilities and from accredited facilities turned over to State monitorship as a result of the validation process. Accredited hospitals not meeting one or more conditions of participation are monitored by the States until they meet the conditions.

In addition to hospital certification surveys, HEW contracts with the State agencies to certify other Medicare providers and suppliers, such as skilled nursing facilities, independent laboratories, and home health agencies. The State agencies are also responsible for licensure programs in States that have them. Hospitals obtain licenses in some States by merely completing an application and in others by meeting a number of requirements, including passing an onsite inspection. States may conduct the hospital's licensure survey with the Medicare certification survey in unaccredited facilities or with the utilization review and institutional planning survey in accredited facilities.

AN ILLUSTRATION RELATING LICENSURE, CERTIFICATION, AND ACCREDITATION

The following hypothetical example involving a new hospital illustrates how the licensure, certification, and accreditation processes operate.

A group of physicians and community leaders recognized the need for a new hospital. Complying with State law they applied for a permit from the State health agency, documenting (1) the qualifications, backgrounds, and character of the hospital's owners and managers and (2) the financial resources available for its construction, operation, and maintenance. Evidence that the facility would be operated in the public interest was also furnished. After reviewing the application the State issued a permit authorizing the holders to proceed with the project.

The hospital needed a license to operate. After receiving an application the State health agency made an onsite inspection and determined that the hospital met the standards,

rules, and regulations issued under the State licensing act. The agency was to return annually to assure continued compliance. The owners and managers received a license for 1 year. It was to be automatically renewed as long as the hospital continued to meet licensing requirements.

Since the hospital served the entire community, including the aged, its owners applied to HEW for Medicare certification. The State health agency, under contract with HEW, made the initial survey and was to make annual resurveys to assess the hospital's compliance with the conditions of participation. In the future, the annual Medicare survey and licensing inspection were to be made concurrently. Once certified for Medicare the hospital was automatically certified for Medicaid. Even if it had sought only Medicaid certification, the State would still have based eligibility on compliance with the Medicare conditions of participation.

After operating for 6 months the hospital was eligible for JCAH accreditation, and its governing body applied to JCAH for a survey. JCAH determined that the hospital's level of compliance with its standards warranted a 2-year accreditation. Because it was accredited, the State's annual resurvey was to be limited to assessing adherence to State licensing requirements and HEW utilization review and institutional planning requirements.

When it had been accredited for a year, the hospital was randomly selected for a validation survey. The State health agency made the survey and determined that the hospital did not comply with one of the conditions of participation. As a result, it was brought under State monitorship, but this did not affect its JCAH accreditation or HEW certification. Once the State determined that the hospital complied with the condition, it was no longer subject to State monitorship.

COST OF CERTIFYING HOSPITALS

Medicare inpatient hospital care cost about $14.2 billion in fiscal year 1977. HEW's cost for certification could not be determined, but the cost of the States' survey and certification activities for all Medicare providers was about $23.9 million. We estimate that about $6 million of this amount was related to hospital certification responsibilities. JCAH spent $6.5 million to accredit hospitals in calendar year 1977. Survey fees charged to the hospitals covered its expenses. Reasons underlying differences in JCAH and HEW survey costs are discussed in chapter 5.

The Government indirectly pays part of the hospital's cost for JCAH surveys through Medicare, Medicaid, and other health care reimbursement programs. For example, an HEW official estimated that Medicare reimburses hospitals for 30 to 32 percent of their general and administrative expenses, which include JCAH survey costs.

SCOPE OF REVIEW

We made our review at HEW headquarters, JCAH, four HEW regional offices, and seven State health agencies. We observed JCAH, HEW, and State agency surveys and reviewed JCAH and HEW files for selected hospitals in each HEW region, documents to support certification decisions, and other internal reports. Officials of HEW, JCAH, and other public and private agencies were interviewed. We did not evaluate the Medicare certification system for other providers, including those accredited by the American Osteopathic Association, nor did we review the Medicaid certification system.

Our fieldwork was done between May 1977 and June 1978.

CHAPTER 2

LIMITATIONS OF SURVEY PROCESS

HEW's hospital certification system, as provided for in the Social Security Act, has a limited capacity to determine whether patients receive quality health care. According to HEW and JCAH officials, the conditions of participation and the accreditation standards indirectly measure the quality of hospital care by assessing whether hospital procedures, policies, and environment provide a framework within which quality care can be provided. For example, neither JCAH nor HEW reviews the practice of medicine in a hospital by evaluating the reasonableness of diagnoses, the privileges of physicians, the need for surgery, or the outcome of treatment. Rather, they assess the adequacy of hospital systems to address such items. HEW and JCAH survey findings may differ or deficiencies may go undetected because

--differences between desirable procedures and actual practices are difficult to observe or

--criteria underlying JCAH standards and HEW conditions do not reflect current practices.

OBSERVING DIFFERENCES BETWEEN PROCEDURES AND PRACTICES

Many factors affect a surveyor's ability to detect deficiencies. An obvious one is the opportunity to observe actual hospital routine during the annual certification survey. Since hospital officials receive advance notice of the survey dates, the hospital will be at its best, making it especially difficult to detect poor or improper practices, as illustrated by the following case.

In 1977 a surgical technician and former employee lodged complaints against a hospital that had recently received a 2-year JCAH accreditation. The State surveyed the hospital and found it in compliance with the conditions of participation.

Because both survey processes emphasize hospital organization, policies, and procedures, none of the former employee's complaints were substantiated.

For example, JCAH and the State found no deficiencies in procedures and policies related to these allegations:

--Surgical consent was sometimes acquired after the patient was drugged for surgery.

--Unlicensed personnel commonly acted as first assistants in major surgery when the assisting surgeon was late.

--Surgery records were written with exaggerated start and finish times, and nonemergency cases were booked late in the day and charged as emergency procedures to produce more revenue.

--Evidence existed of unnecessary surgery to generate needed hospital funds.

Although surveyors may find deficiencies in procedures and policies that could result in poor patient care, they may be unable to detect improper practices because of the limited opportunity to observe hospital routine. Without evidence of improper practices, however, inadequacies in policies and procedures may not be sufficient for JCAH to withdraw or limit a hospital's accreditation or for HEW to defer or terminate its certification.

For example, JCAH noted that the hospital needed

--documentation that the clinical use of antibiotics was periodically reviewed and findings resolved,

--provisions for handling clean/sterile and dirty/contaminated items and supplies,

--written and enforced policies and procedures for infection control in the pharmacy, and

--orientation of employees toward infection control procedures.

Had the hospital corrected these deficiencies, it would have reduced the possibility that some or all of the following practices reported by the former employee would occur:

--Because of staff shortages, the circulating nurse regularly left contaminated surgical areas for supplies, transporting septic organisms in the process. She also used an unsterile room adjoining another operating room to use an autoclave and supplies.

--Employees commonly scrubbed for major surgery with open wounds on their hands.

--The hospital's low infection rate was accomplished by luck or paperwork and by administering high doses of antibiotics after surgery.

ASSURING THAT STANDARDS AND CONDITIONS REFLECT CURRENT PRACTICE

The importance of keeping requirements current is clear. Until a requirement is introduced, surveyors may not discover related deficiencies. Also, growth in knowledge changes professional agreement about what constitutes good practice, and revelations of deficiencies indicate the need for greater controls.

For example, the National Association of Blue Shield Plans is ending routine payments for 42 surgical and diagnostic procedures which it considers

--new and of unproven value,

--established and of dubious usefulness,

--duplicative of other procedures, or

--unlikely to yield additional information through repetition.

Because both JCAH and HEW assess the organization and process employed by the institution and not the judgments emanating therefrom, the Medicare conditions of participation and JCAH standards do not prohibit these procedures.

The conditions of participation have been revised only slightly since the Medicare program began. Revisions are now being considered, with some requirements to be dropped and others to be added. (See ch. 4.) In contrast, JCAH has a built-in mechanism for continually updating the standards based on input from the public, private, and professional organizations as well as from HEW. It has changed survey emphasis to reflect these improvements. For example, after it implemented its standards for medical evaluation studies, compliance with these standards became an essential requirement for continued accreditation.

Nonetheless, a time lag will always occur between the point that need for change is recognized and the point that new requirements are instituted. For example, Federal regulations raise laboratory requirements for certified hospitals to the same level as those Medicare applies to independent laboratories, effective November 24, 1978. Implementation of the regulations demonstrates the potential impact changes in survey requirements can have on the results of quality assessments. To retain automatic certification for accredited laboratories, JCAH is revising its standards. 1/ It is also considering requiring compliance with the revised standards an essential element of continued accreditation.

The Center for Disease Control began evaluating certified hospital laboratories for compliance with the new requirements in January 1978. Center officials believe the results will show that proficiency testing programs have not been adequate to assure that personnel are qualified, quality controls are sufficient, and performance is acceptable. JCAH has required participation in one or more proficiency testing programs, while HEW has had no proficiency testing requirement. The Center's evaluations have shown that some technicians could not correctly identify blood groups. Insufficient data are available to determine the extent of this and other problems, but inaccurate grouping could be fatal to a patient.

1/HEW granted JCAH automatic certification for accredited laboratories based on its revised standards effective January 1979.

CHAPTER 3

LIMITATIONS OF VALIDATION PROCESS

The existing validation process does not assure that JCAH accreditation is equivalent to HEW certification. Validation surveys have shown that accredited hospitals do not meet the conditions of participation, even though recent results show that JCAH reported nearly twice as many deficiencies as the States and more significant ones. Regarding equivalent requirements, JCAH and the States reported about the same number of deficiencies, but each overlooked many that the other found. Validation and accreditation results diverged because of differences between HEW and JCAH assessment criteria, survey emphasis, and program management. (See chs. 4 and 5.)

The only discernible effects of the validation process are that

--3 percent of the accredited hospitals must respond to a second set of requirements and an extra survey and

--2 percent (or two out of every three validated hospitals) are brought under State monitorship and receive another layer of supervision.

The other accredited hospitals--or about 75 percent of all hospitals receiving Medicare funds--are affected indirectly through improvements made by JCAH that can be attributed to the validation process. According to HEW, the initial validation report to the Congress led to improvements in JCAH fire safety standards and survey procedures.

Until recently HEW was unable to obtain JCAH survey results because in late 1974 HEW violated a confidentiality agreement by releasing the results of a JCAH survey. According to HEW officials, not having the JCAH survey findings hampered their validation activities. We were able to obtain access to JCAH survey records after receiving permission from individual hospitals.

RESULTS OF VALIDATIONS

Validation surveys assess accredited hospitals' compliance with the conditions of participation. Hospitals not meeting one or more of the conditions are monitored by the State until the conditions are met; however, they continue to receive Medicare funds unless terminated from the program.

The results of validations performed during three periods--January 1 to September 30, 1974; October 1, 1974, to October 31, 1975; and July 1, 1976, to December 31, 1977--are shown below.

In all three periods, two-thirds of the accredited hospitals in the validation sample were brought under State monitorship.

Validation Survey Results

	Validation period					
	1/1/74 to 9/30/74		10/1/74 to 10/31/75		7/1/76 to 12/31/77	
	Number	Percent	Number	Percent	Number	Percent
In compliance	37	35	57	37	53	34
Out of compliance	68	65	99	63	103	66
Total	105	100	156	100	156	100

No relationship existed between the number which the States brought under their monitorship and the number to which JCAH awarded a 1- or 2-year accreditation.

DIFFERENCES IN REQUIREMENTS

We found very little similarity between JCAH accreditation and State validation findings for 35 hospitals validated between July 1, 1976, and December 31, 1977. Although JCAH reported nearly twice as many deficiencies as the States, HEW had no equivalent requirement for 55 percent of them.

Deficiencies Reported

	JCAH		States	
	Number	Percent	Number	Percent
Nonequivalent requirements	1,255	55	194	16
Equivalent requirements	1,028	45	1,008	84
Total	2,283	100	1,202	100

Some nonequivalent requirements were similar. For example, HEW requires fire drills every month, while JCAH requires them once quarterly. If a hospital has fire drills every 2 months, the States would cite a deficiency, but JCAH would not.

Regarding equivalent requirements, JCAH and the States reported about the same number of deficiencies, but only 212 (or 12 percent) of these were alike. Thus, both JCAH and the States overlooked many deficiencies.

DIFFERENCES IN EMPHASIS ON FIRE SAFETY

Over 90 percent of all hospitals brought under State monitorship were cited for noncompliance with the fire safety condition.

Reasons for State Monitorship

Noncompliance with	Validation period 1/1/74 to 9/30/74 Number	Percent	10/1/74 to 10/31/75 Number	Percent	7/1/76 to 12/31/77 Number	Percent
Fire safety	36	53	56	57	91	88
Fire safety and other conditions	29	43	35	35	7	7
Other conditions only	3	4	8	8	5	5
Total	68	100	99	100	103	100

In its 1975 report to the Congress on the results of the first validation period, HEW recommended that JCAH be allowed to continue evaluating fire safety requirements, provided that it strengthen its capability to evaluate and enforce them. It made no recommendations related to differences in other survey areas, even though 47 percent of the validated hospitals did not comply with at least one other condition.

Between October 1975 and July 1976, HEW called a moratorium on validations so JCAH could revise its standards and survey procedures, particularly in the fire safety area. JCAH did so, implementing its new requirements in October 1976. In its 1976 report to the Congress, HEW noted that JCAH had acted to close the gap between its findings and the States'. Nonetheless, after validations were resumed, about the same

percentage of accredited hospitals failed to meet the fire safety condition, while only 12 percent failed to meet any other condition.

HEW bases its fire safety requirements on the 1967 edition of the National Fire Protection Association's Life Safety Code, whereas JCAH has used the 1973 code since validations were resumed. The major difference between the editions is that the 1973 code applies less stringent construction requirements if the building has an automatic fire extinguishing system and noncombustible construction. The HEW regions grant waivers on a case-by-case basis for compliance with the 1973 code. Waivers are usually granted only after the hospital is brought under State monitorship for failure to meet the fire safety condition, unless a plan of correction is not required for the cited deficiency.

The use of different life safety codes does not, however, explain the validation survey results in our sample of 35 hospitals. JCAH and the States reported nearly the same number of fire safety deficiencies, but only 15 percent were the same deficiencies. We found no difference in the degree of severity between the deficiencies each reported. The States' greater emphasis on fire safety appeared to best explain why most validated hospitals still did not meet at least this condition--47 percent of the deficiencies the States in our sample found related to fire safety, compared with 24 percent of the ones JCAH found.

DIFFERENCES IN ESSENTIAL REQUIREMENTS

JCAH and HEW have identified items considered essential to continued accreditation and certification. JCAH has nine such items; failure to comply with any one of six reduces a hospital's accreditation term from 2 years to 1 and could result in loss of accreditation, while failure to comply with any one of the other three results in loss of accreditation.

HEW divided the 16 conditions of participation into more than 100 standards. Of these, 43 are considered essential requirements that hospitals must meet to comply with the related conditions. Eight are statutory requirements. HEW's Medicare State Operations Manual provides that hospitals found out of compliance with one or more conditions should receive deferred certification until they either take corrective action or are terminated from the program.

JCAH has equivalencies for 39 of HEW's 43 essential requirements, and HEW has equivalencies for 7 of JCAH's 9. Only the requirements for fire safety, hospital licensure, 24-hour registered-nurse coverage, and medical records are considered essential by both.

JCAH cites more deficiencies in essential requirements

In the files we reviewed, JCAH reported more violations of essential requirements than did the States, but it did not report all that the States cited. It reported 33 violations of essential requirements that the States did not identify--6 of which were statutory requirements. The few violations of JCAH essential requirements found by the States were also found by JCAH. Even where the States found noncompliance with HEW essential requirements, they did not consistently cite the related condition or bring the hospital under State monitorship as required. In addition, JCAH was more successful in getting hospitals to correct deficiencies. (See ch. 4.)

EFFECT OF VALIDATIONS

Although each series of validations shows that many accredited hospitals do not meet the conditions of participation, HEW officials believe JCAH is doing a good job and continues making progress to improve its survey process. HEW has never terminated an accredited hospital or acted to end the equivalency between accreditation and certification. 1/

According to Department officials, HEW considers its oversight obligation fulfilled by annual reports to the Congress. It still has not submitted the 1977 or 1978 reports, but it expects to complete one in early 1979, covering validations from July 1976 through September 1977.

The net effect of the validation process is that 3 percent of the accredited hospitals must respond to an extra set of requirements and an extra survey and 2 percent to an extra

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1/HEW advised us that it had terminated one hospital--the Francis P. Memorial Hospital of New Bedford, Massachusetts. According to the American Hopsital Association's hospital directory, this institution is designated as a psychiatric hospital, not a general hospital.

regulator. The other accredited hospitals are affected indirectly through changes that may be made by JCAH as a result of the validation process. The process does not affect the hospital's ability to admit Medicare patients and receive Medicare funds.

CHAPTER 4

STATE CERTIFICATION PROCESS IS UNRELIABLE

Both JCAH and HEW attempt to determine whether hospitals meet certain quality requirements. JCAH is effective in determining whether hospitals meet its requirements, while HEW is not. State survey results are frequently inconsistent, and deficiencies sometimes remain uncorrected for lengthy periods. HEW has not enforced its criteria for assessing compliance or replaced them with more relevant requirements, nor has it given hospitals incentives to correct deficiencies quickly. When a new survey report form is introduced and proposed revisions to the conditions of participation are adopted, the situation is expected to deteriorate.

UNIFORMITY OF SURVEY RESULTS

Our review of accreditation files showed that JCAH has applied its assessment criteria uniformly to reach accreditation decisions. Besides complying with JCAH's essential requirements, a hospital must perform certain activities contributing to quality patient care to receive a 1-year accreditation. Several other variables are crucial to the accreditation decision, including the hospital's compliance with previous recommendations, its documentation of firm plans to correct serious deficiencies, and its pattern of deficiencies and their cumulative effect.

HEW files showed that its assessment criteria are not uniformly applied. According to Department guidelines, a hospital may be recertified even if it has a significant deficiency--one which influences the hospital's potential to provide adequate care--if the deficiency (1) is not an essential requirement, (2) is not a hazard to patients' health and safety, and (3) can be corrected in a reasonable period. The State must also evaluate the combined effect of all deficiencies and the facility's efforts to correct them.

The survey report form divides the 16 conditions of participation into standards, which are further subdivided into factors. Although the factors are designed to explain the standards and the standards to explain the conditions, HEW provides little guidance on how factors relate to standards and standards to conditions or how overall compliance is to be assessed. As a result, the States failed to consistently interpret factors, standards, and conditions, including essential requirements, when assessing compliance.

For example:

--In 1977 a State cited a hospital out of compliance with the physical environment condition, based on deficiencies in the essential requirement, building safety. Between 1974 and 1976 the same requirement and a second essential requirement were cited, but the condition was found in compliance. In 1975 the HEW regional office informed the State that deferred certification might be in order. When the State agency refused to change its decision, the region recertified the hospital, but one official wrote, "I hope that you never have to eat your words in the case of a flammable disaster."

--A State cited the statutory requirement that the hospital provide 24-hour nursing service rendered or supervised by a registered professional nurse out of compliance, but found the overall nursing condition in compliance.

--In 1974 and 1975 a State found the same factors out of compliance under the dietary facilities standard; however, the standard was reported in compliance in 1974 and out of compliance in 1975.

--In 1976 a State found the medical staff bylaws standard in compliance, but commented that the bylaws needed to be reviewed and revised.

HEW revised its survey report form in July 1977. The new form intensifies compliance assessment problems by grouping unrelated items and dropping other items. Evidence of these problems came from surveyors who still carried old survey forms to help them make assessments. Although obtaining an adequate description of deficiencies has been a persistent problem in establishing their significance, the new form is so general that it requires even more elaboration to clarify the nature of the deficiencies. Without clarification, followup on specific deficiencies will often be impossible. Also, HEW has not included several requirements that were previously considered to be essential in its revised survey report form and in its proposed revisions to the conditions of participation. As a result, it is unclear what items HEW now considers critical to compliance.

DETECTION AND CORRECTION OF DEFICIENCIES

Our review of certification files showed that significant deficiencies in unaccredited hospitals sometimes went undetected for years, suggesting that previous State surveyors had not done a thorough job. For example, for hospitals surveyed since 1966, the States first noted in 1976 or 1977 that

--one had hazardous areas unprotected by sprinklers or set off by firewalls,

--another had facilities not located for the safety and convenience of patients,

--a third lacked policies for issuing drugs to floor units, and

--a fourth lacked policies for controlling toxic and dangerous drugs.

File reviews showed that accredited hospitals apparently corrected most deficiencies before the next JCAH survey and carried few deficiencies beyond two surveys. Unaccredited State-surveyed hospitals also appeared to correct most deficiencies before the next survey but did not correct the remaining deficiencies quickly. For example:

--State surveyors noted dry and staple food stored on the ambulance garage floor in surveys from 1974 to 1977. A surveyor commented that the floor was very dirty and water had accumulated under many cases of canned items. Also, potatoes, bananas, apples, and lettuce were stored on the garage floor next to a wax stripper and an industrial cleaning solution.

--State surveyors cited inadequate space for handling contaminated linens from 1969 through 1977. The same facility did not have procedures for handling contaminated wastes or an incinerator for disposing of them. The State first reported this deficiency in 1968, but it still existed in 1977.

--State surveyors reported inadequate pathology staff in 1973, 1975, 1976, and 1977.

The status of deficiencies in unaccredited hospitals could not be accurately assessed because the States do not enforce the requirement that surveyors follow up on outstanding deficiencies and HEW has not cited them for failure

to do so. One State refused to track deficiencies below the condition level unless certification was deferred; however, it did not follow HEW guidelines for deferring certification. JCAH generally does not make followup visits to determine hospital progress in correcting deficiencies but does as a matter of procedure assess deficiency status during later accreditation surveys.

In many instances, deficiencies which, once corrected, could not immediately recur were reported in alternate years because the State surveyors did not follow up on or reidentify the deficiencies. For example:

--Hazardous areas at one hospital had inadequate fire protection in 1971, 1972, 1974, and 1975, but not in 1973.

--Another hospital lacked proper facilities for handling contaminated linen in 1969, 1970, 1972, 1974, 1976, and 1977, but not in 1973 and 1975.

--A third hospital had a kitchen that was too small and congested in all years between 1968 and 1977, except 1976.

JCAH's greater success in obtaining correction may occur because participation in the accreditation program is voluntary. A hospital receiving successive 1-year accreditations is cautioned that improvements are necessary to continue program affiliation. Generally, a hospital may receive three consecutive 1-year accreditations before losing its accreditation. JCAH withdrew the accreditation of 206 hospitals between 1975 and the end of 1977. An undetermined number voluntarily withdrew from the program when threatened with loss of accreditation. Although loss of accreditation may damage an institution's public image and affect its ability to obtain staff, it continues to receive Medicare funds unless the State determines it is not complying with the conditions of participation.

Unaccredited hospitals may have less incentive to correct deficiencies quickly. They can be certified despite deficiencies if they have an acceptable plan of correction. Although the plan includes target dates for corrective action, these may be unrealistic or the hospital may not meet them. When hospitals do not correct deficiencies, the States have only two recourses--they can recommend either deferred certification or termination from the program.

According to HEW's Medicare State Operations Manual, hospitals not meeting one or more conditions should receive deferred certification until the condition is met or the hospital is terminated. This often does not happen because the criteria for deferring certification are not always applied. Deferred certification does not affect the hospital's ability to collect Medicare funds or admit Medicare patients.

The threat of termination is useful only as a last resort, not as an incentive for correcting lesser deficiencies. Termination requires extensive documentation of deficiencies, because a hospital may appeal the decision through administrative channels and the courts. HEW officials said that health-related deficiencies are difficult to uphold in court, so they rely on fire safety hazards to justify termination. Even so, terminating a hospital can take years. HEW has terminated only 81 fully certified hospitals between the inception of Medicare in 1966 and the end of 1977, including 17 hospitals between 1975 and the end of 1977. The number of hospitals that voluntarily withdrew from the program when faced with termination was unavailable.

REVISIONS TO THE CONDITIONS OF PARTICIPATION

HEW has drafted revisions to the conditions of participation. The proposed requirements are even more general than the present ones. Some officials believe that it will be even more difficult to terminate substandard hospitals from Medicare participation because it will be more difficult to convince the courts that Federal requirements are not met.

CHAPTER 5

HEW SURVEY GUIDANCE IS NEEDED

Effective guidelines are necessary to ensure consistent implementation of accreditation and certification policies and procedures. Guidelines are particularly important in the HEW certification process, in which there are more than 50 decisionmaking centers. Although the 10 HEW regional offices are responsible for certification decisions, they generally follow the States' recommendations. In some States, district offices make the recommendation to the regional office. In contrast, the JCAH process achieves more consistent results because a single accreditation committee determines compliance based on the independent recommendations of surveyors, report reviewers, and senior program managers.

Compared to JCAH's guidance, HEW's is inadequate. As a result, survey team size and composition, surveyor qualifications and training, and survey duration vary among States. These variances may explain some of the differences between

--the findings of JCAH and the States,

--the findings and decisions of individual survey teams within States,

--the compliance decisions of States, and

--the costs of surveys made by JCAH and the States.

DIFFERENCES IN SURVEY CHARACTERISTICS

Although JCAH and HEW both rely on professional judgment to determine compliance, JCAH's program better assures that inconsistencies based on different backgrounds are minimized. JCAH survey team size, composition, and qualifications are uniform, and survey duration is defined. Teams consist of a physician, a hospital administrator, and a nurse. Physicians must be licensed and experienced in hospital medical functions. Nurses must be registered and have a bachelor's degree, and 10 years of experience as a nursing director or in a responsible administrative position is preferred. Hospital administrators must have a bachelor's degree and should have 5 years of experience as a hospital's chief executive officer.

In contrast, HEW has very general requirements for surveyor qualifications and no guidelines for survey team size and composition or survey duration. HEW requires surveyors to qualify as health professionals or be under the State's civil service system. State civil service requirements vary. For example, one State requires that health surveyors have at least a bachelor's degree and prior work experience, while another accepts "considerable" college education. Some States require that fire safety surveyors have a graduate engineering degree, while others require only a high school diploma.

State survey teams range in size from four to nine and include combinations of positions equivalent to a health facilities generalist, a hospital administrator, a registered nurse, a laboratory technician, a radiology specialist, a dietitian, a sanitarian, and a fire marshal. Any combination is acceptable. State survey teams generally do not include a physician, and one State we visited did not even include a nurse in surveys until late 1977.

The duration of JCAH surveys is based on hospital size and ranges from 1 to 3 calendar days, or 3 to 9 staff-days. Hospitals with under 100 beds are surveyed in 1 day, those with 100 to 500 beds in 2 days, and those with over 500 beds in 3 days. About 40 percent of the accredited hospitals have under 100 beds. According to JCAH, surveyors always visit the hospital as a team and complete their work on consecutive days. To minimize the effect of variances in team quality, different teams generally survey a given hospital in successive years.

State surveys also vary in duration, but not necessarily in relation to hospital size. HEW told us that the duration of the survey depends on the complexity of the problems identified. Also, according to HEW, unaccredited hospitals are characteristically smaller, less sophisticated, and less able to attract and retain trained professional and support staff, and therefore may require as much as or more survey effort than larger hospitals. About 75 percent of the unaccredited certified hospitals have under 100 beds. State surveyors do not always visit a hospital on the same days, surveys are not always conducted on consecutive days, and the same individuals are frequently sent to resurvey a hospital.

HEW guidelines specify that fire safety surveyors may visit a hospital up to 30 days before the rest of the team. Excluding this allowance, the time elapsed to complete surveys in our sample of unaccredited hospitals with under 100 beds ranged from 1 to 140 days in 1977. Staff-days expended ranged

from 4 to 13. These variations were not a function of hospital size. In one case, the staff-days expended to survey a particular hospital ranged from 6 to 13 between 1975 and 1977. In another, nine surveyors evaluated a 21-bed hospital.

COMPARISON OF TRAINING PROGRAMS

To compensate for differences in background and professional judgment and to better assure uniform application of the standards, prospective JCAH surveyors attend a 2-week orientation program and undergo a supervised field apprenticeship at six or seven hospitals before becoming full-fledged team members. They also receive continuing education at an annual surveyors' conference and usually receive an annual peer review.

The training for State surveyors has not been designed to offset differences in surveyor expertise or professional judgment. HEW offers various workshops and seminars for health and fire safety surveyors but relies on the States to orient new staff and provide inservice training. State orientation ranges from combinations of classroom training, directly supervised on-the-job training, and in-office training to no training at all. As a result, not all State surveyors receive Medicare-related training before making certification surveys.

States are required to provide regular inservice training, usually at weekly or monthly staff meetings. In one State some surveyors did not even know such training was available, while in other States there was no documentation to indicate that training was given or that it was Medicare related.

HEW requires that State health surveyors attend the 2-week Federal Surveyor Improvement Program. Many did not receive this training or received it long after they began surveying. For example, surveyors participating in six courses given between October 1976 and March 1977 had experience ranging from 2 months to 10-1/2 years. Until early 1978, officials in one State refused to send surveyors to the training because they believed it was a waste of time.

Both HEW and JCAH training courses last 2 weeks, but JCAH devotes about 55 hours to classroom instruction directly related to hospital survey topics. As a part of this, JCAH surveyors also receive, during their 2-week mandatory training course, special training tailored to their professions and survey responsibilities. HEW devotes about 40 hours to

classroom instruction but covers all Medicare providers and suppliers, including hospitals, nursing homes, independent laboratories, and end-stage renal disease treatment facilities. All State surveyors receive the same training during the basic course and may participate in additional special training programs offered by HEW.

The JCAH program addresses how to assess compliance with the standards, including what requirements a hospital must meet and why. The HEW training focuses on the interpretation of regulations necessary to complete the survey report form. It identifies what to look for when assessing compliance, but not the impact of deficiencies on the overall compliance decision. Finally, JCAH evaluates trainees' performance and determines whether they have mastered the concepts presented, need more training, or should be terminated. HEW has no surveyor evaluation system, but according to HEW officials, State surveyor performance is evaluated through quarterly comprehensive program reviews and regional office comparative validation surveys.

COMPARISON OF PROGRAM COSTS

JCAH spent $6.5 million in 1977 on hospital accreditations, including surveying 2,776 hospitals, upgrading and developing standards, and training staff. It charged hospitals $1,500 per survey day, or between $1,500 and $4,500 per survey, to cover expenses. Based on total program expenditures, the average survey cost $2,350. In 1978 an application fee increased survey charges by $150.

Changes in the accreditation program, including upgrading laboratory standards, adding a laboratory surveyor, employing hospital field representatives, and increasing salaries, are expected to raise program costs to about $8 million in 1978 and $10 million in 1979. These costs will be passed on to participating hospitals. Although the total amount has not been determined, JCAH estimates that just adding the laboratory surveyor will increase costs by $109 to $128 per survey day.

In fiscal year 1977, HEW spent an undetermined sum to administer the hospital certification program and paid the States about $6 million for all hospital certification activities, including conducting 1,590 surveys, making followup visits, and training staff. The difference between the numbers of JCAH and State surveys is less than the difference between the numbers of accredited and unaccredited hospitals because States do certification, validation, and complaint surveys and because some JCAH-accredited hospitals are surveyed only every 2 years.

While quarterly reports of Medicare activity and expenditures are filed by each State, survey costs for hospitals are not available. Although each regional office used different methods for estimating hospital survey costs, individual survey cost estimates for fiscal year 1977 furnished by the regional offices we visited ranged from $1,464 in region I to $7,244 in region V. Program officials advised us that, according to their data, the average survey cost for each of the seven States we visited was about $2,500.

CHAPTER 6

HEW MONITORING IS INEFFECTIVE

HEW relies on 10 regional offices to monitor the States' activities. These offices concentrate on States' management performance, such as how effectively they schedule surveys and process documents, rather than how consistently or appropriately they apply the Medicare regulations. HEW's computerized management information system should detect many of the problems we identified, but it is not used because HEW officials consider the data unreliable. Even when deficiencies were reported, the regions did not follow up to assure corrective action was taken. Ultimately, HEW has little recourse if the States resist making corrections. As a result, deficiencies in State operations affecting the quality and timeliness of the survey product persist.

HEW SYSTEM FOR MONITORING PROGRAM OPERATIONS

HEW headquarters monitors the regional offices through periodic evaluations of their activities. The regions monitor the States through intermittent comprehensive program reviews of their operations, Federal surveys of unaccredited providers, and desk reviews of survey documents. In addition, both HEW headquarters and the regional offices use a computerized management information system to assess the progress and performance of certification activities.

Headquarters reviews

HEW implemented a formal program for evaluating and improving regional office operations in 1973. A new program of ongoing evaluations is being developed to replace it. Under the former system all regional offices were reviewed once and some twice. There was no provision for followup between reviews to determine if recommendations were adopted.

The headquarters reviews we examined focused on how, in general, the regional offices managed the hospital certification program. For example, they determined whether surveys were scheduled as required and survey reports completed within established time frames. Less emphasis was placed on how regional offices assured that the States consistently and correctly applied the HEW conditions of participation.

Regional office reviews

The format and timing for regional office comprehensive program reviews of State activities are being revised. Instead of evaluating a broad range of topics every 18 to 24 months, the new program will include indepth evaluations of selected topics at each State agency in the region. These reviews should facilitate the identification and timely correction of problems common to all States. Such evaluations are expected to be done quarterly.

The regional offices' comprehensive program reviews had the same weakness as the headquarters reviews. They focused primarily on management performance rather than on the quality of the survey product and ways to improve it. Management deficiencies cited during comprehensive program reviews of State operations include

--improper complaint processing,

--improper handling of regional office information requests,

--inadequate controls over scheduling surveys and followup visits,

--late submission of survey materials,

--inadequate coordination between survey units within the State, and

--inadequate and/or untimely submission of providers' plans of correction.

Other deficiencies reported included incomplete documentation and descriptions of deficiencies, inadequate review of survey reports for accuracy and completeness, insufficient staffing of budgeted positions, and deficient inservice training.

Also, like the headquarters evaluation of regional operations and the States' monitorship of hospitals, the regional offices have not followed up and reported on all deficiencies identified in their reviews. Although the regions have stimulated improvement in State management, many problems persist. For example, the law requires that the certification recommendation be available to the public 90 days after the survey ends. The States are permitted 45 days to process survey documents. The regional office may use the remaining time in the 90-day period for its review. However, the States in our sample took 8 to 141 days, and the regional offices took 3 to 148 days.

Even when HEW has attempted to evaluate how effectively the States apply the conditions of participation, the results have been discouraging. The regional offices can assess the survey product through Federal surveys of unaccredited providers or desk reviews of survey documents. Although these methods were sometimes used to identify surveyor training needs, there was little evidence that formal training was provided to meet these needs.

Federal surveyors consistently found hospitals out of compliance with more standards and conditions than did State surveyors. For example:

--A Federal survey team found that a hospital did not meet the pharmacy condition of participation because it had (1) no pharmacist, (2) no policies for issuing drugs, and (3) conflicting policies regarding dangerous drugs. State surveyors failed to note any of these deficiencies. The Federal surveyors concluded that State surveyor training was needed.

--Federal surveyors found that a hospital did not meet the laboratory condition of participation because it had (1) inadequate maintenance of laboratory apparatus, (2) no emergency laboratory services, (3) no qualified physician to supervise laboratory services, (4) no clinical laboratory director, and (5) inadequate pathology services. The State found the hospital in compliance with the condition.

--Federal surveyors found that a hospital did not meet the medical staff condition of participation because the medical staff lacked (1) consultation policies, (2) staff evaluation and reappointment procedures, (3) staff privileges reviews, (4) a governing body liaison, and (5) a functioning credentials or medical records committee. Also lacking was evidence that the medical staff maintained quality of care. The State reported the condition met.

HEW officials recognize that not enough Federal surveys are made to adequately monitor the States' performance, but they have reduced the number made because of budgetary constraints. Regions I, V, and VIII surveyed only 0 to 4.7 percent of the certified unaccredited hospitals within their jurisdictions.

Before May 1977, when HEW began implementing reporting by exception, regional staff reviewed all survey reports and

related documents. When this approach is fully implemented, States will submit for regional office review survey reports and related documents only for hospitals for which the State recommended a waiver, deferred certification, or termination. Regional office staff will periodically visit the States and review a sample of files to monitor the States' performance. HEW officials advised us that surveyor comments remain on file at the State agency and are referred to by surveyors when assessing need for provider consultations. They said that all items not reported as deficient are assessed during quarterly comprehensive program reviews in each State agency.

The potential success of reporting by exception in improving State operations is questionable. Our file reviews indicated HEW has not uncovered many inconsistencies in the States' application of the conditions of participation. HEW's computerized management information system could help detect such inconsistencies.

The management information system was developed as a tool for assessing the progress and performance of certification activities at the State and regional levels. It offers basic data for managing the certification process and analyzing compliance findings, including tracking deficiencies across surveys. According to headquarters and regional officials, however, this information is of limited value because the computer reports are consistently inaccurate. Officials in one region said it will take at least a year to correct the data for their hospitals.

Ultimately, the effectiveness of HEW's monitoring is limited by its ability to compel States to take corrective action. If it notes major deficiencies in State operations, such as failure to perform surveys, it can seek correction from the Governor or even terminate the State contract. However, these actions are last resorts.

CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

HEW cannot ensure that certified hospitals provide quality care because neither the conditions of participation nor the JCAH standards directly assess the quality of care. JCAH and the States survey hospitals to determine whether their procedures, policies, and environment provide a framework within which quality care can be provided. The difficulty of observing differences between desirable procedures and actual practices and the degree to which the conditions or standards do not reflect current practice limit the effectiveness of the survey process.

Also, HEW cannot even assure that certified hospitals meet the conditions of participation because it lacks authority over JCAH and only loosely controls State activities. The validation process shows that most accredited hospitals in the validation sample do not satisfy the conditions. This occurs because of discrepancies between the conditions and JCAH standards and between State and JCAH program management.

Even though JCAH is identifying more deficiencies and more important deficiencies and stimulating faster correction, validation results create the appearance that it is less effective than the States. The only discernible effect of validations is to subject sampled hospitals to a second set of requirements and a second layer of monitoring. The other accredited hospitals are ignored, although if the statistical sample is valid, a proportionate number of them are also out of compliance with the conditions.

Further, the States are not assuring that unaccredited hospitals meet the conditions. State survey results are unreliable because many significant deficiencies are not detected and assessment criteria are not consistently applied. Contributing to these problems are inadequate Federal guidelines for compliance decisions and weak controls over survey team characteristics, surveyor training, and survey duration.

States also fail to adequately follow up on many deficiencies. This may be because hospitals have insufficient incentives to take corrective action. The ultimate incentive, the threat of termination, is a weak one because proving noncompliance in court is difficult. HEW is considering revised requirements which are so general that establishing noncompliance will be even harder.

Finally, HEW is not effectively monitoring the States. It has detected many deficiencies in the States' operations but has not obtained corrections. It has failed to identify the numerous inconsistencies in their application of the conditions. HEW could use Federal surveys and the computer system to more effectively identify problems, but the former receive low priority because of budgetary constraints and the latter is not used because the data are considered inaccurate. Even when inadequacies are cited, HEW has little recourse if the States resist correcting them.

ALTERNATIVES FOR REVITALIZING CERTIFICATION

Recommendation to the Congress

We recommend that the Congress revitalize the Medicare certification process for hospitals. To do so, the Congress should consider requiring HEW to either

1. contract with JCAH to conduct all certification surveys,

2. use Federal surveyors to survey unaccredited hospitals and validate accredited hospitals, or

3. significantly improve the existing process.

These alternatives have different implications.

Contracting with JCAH

Contracting with JCAH to conduct certification surveys would not eliminate the accreditation program or automatic certification for accredited hospitals. HEW would monitor JCAH's performance through federally conducted validation surveys and desk audits.

This arrangement would provide a better, more consistent evaluation of hospitals and eliminate the problems associated with having more than 50 independent decisionmakers. Also, JCAH's surveys are less costly than the States'. (See pp. 24 and 25.) Based on its 1978 budget estimates, JCAH could survey unaccredited hospitals for less than half what the States spend.

The net additional cost to the Federal Government of contracting with JCAH (it does not now directly pay for JCAH accreditations) would be less than $1.6 million, calculated as follows:

		Estimated costs
		(millions)
Estimated cost for JCAH to survey accredited and unaccredited hospitals		$10.0
Less:		
Estimated payments to States for surveying unaccredited hospitals and validating selected accredited hospitals	$6.0	
Estimated administrative cost reimbursed to hospitals under Medicare for accreditation surveys	2.4	8.4
Estimated net cost for JCAH to survey unaccredited hospitals		$ 1.6

The $1.6 million additional Federal cost could be reduced by the administrative costs reimbursed to hospitals under Medicaid for accreditation surveys. An estimate of these costs was not available.

Although JCAH may be amenable to contracting for certification surveys, there are some obstacles. States may view this step as an infringement on their authority. The relationship between HEW and the States might be damaged, and HEW's ability to effectively monitor and correct weaknesses in the States' other certification operations could be impaired. Also, an additional survey would be needed at some unaccredited hospitals because some States combine licensure and certification surveys. Other States, however, automatically license accredited hospitals.

Federalizing unaccredited hospital surveys

Federal surveys of unaccredited hospitals would promote survey uniformity by eliminating more than 50 decisionmaking centers. HEW would reduce its payments to the States, but savings might be offset by the cost of additional Federal surveyors. This alternative would also subject some hospitals to an additional survey and might strain HEW's relationship with the States. For this alternative to succeed, HEW would have to dramatically improve its monitoring of regional offices and JCAH.

Improving the present system

Improving the current system would disrupt the certification system least. Although the States would not lose authority, stronger HEW oversight might strain the Federal relationship in other ways. This alternative would be least costly because HEW would continue to benefit from JCAH certifying hospitals through its accreditation process at no cost. Only expenditures for developing and improving policies and procedures would be required. However, HEW still would not have sufficient control over the States to enforce needed change. Even with improvements, maintaining more than 50 decisionmaking centers would make achieving uniformity difficult.

PROBLEMS NEEDING ATTENTION

Recommendations to the Secretary of HEW

Regardless of how the Congress resolves the question of program organization, certain underlying problems must be corrected. HEW must improve its policy guidance and monitoring activities at all levels, including controls for discovering and correcting weaknesses in JCAH, the regional offices, and if alternative 3 is chosen, the States. We recommend that the Secretary of Health, Education, and Welfare

- --regularly review and update the conditions of participation, making sure they are specific enough to enable surveyors to establish compliance or noncompliance;
- --define the relationship between Medicare conditions and JCAH standards, establishing equivalencies or waivers where requirements differ;
- --determine what constitutes compliance with the conditions, clarifying (1) the relationship between factors, standards, and conditions and (2) the items that are essential to compliance; and
- --improve the accuracy of the computer system so it can be used to monitor certified and accredited hospitals.

If alternative 1 is not chosen, we recommend that the Secretary also

- --implement measures to assure prompt, uniform survey results, including more effective guidelines for survey team size and composition, surveyor qualifications and training, and survey duration;

--effectively evaluate the State agencies and regional offices and provide training or other guidance addressing the problems identified; and

--transfer only noncompliant accredited hospitals not correcting deficiencies within established time frames to State monitorship.

To reduce the number of surveys hospitals receive, we recommend that the Secretary encourage

--JCAH to alter its institutional planning and utilization review requirements so that accredited hospitals can be automatically certified in these areas and

--the States to grant licensure to certified hospitals or at least coordinate licensure surveys with certification and accreditation surveys.

Since HEW contracts with the States to certify all Medicare providers and since the Bureau of Health Quality and Standards monitors their activities, HEW may find that these recommendations also apply to its other certification programs.

To provide incentives for hospitals to promptly correct deficiencies, we recommend that the Secretary:

--Withhold Medicare reimbursement for new patients or limit the number of Medicare admissions.

--Require that hospitals be certified annually for participation in Medicare, thereby changing HEW's decision to one of granting certification rather than taking it away. The change from recertification to annual certification would eliminate the extensive documentation and time-consuming process currently necessary to terminate hospitals from Medicare participation. The Secretary could still waive compliance with conditions of participation as provided in program regulations.

--Authorize HEW to grant 2-year certifications to exemplary hospitals. This would save time and lessen the survey workload so HEW could concentrate its efforts on problem facilities.

CHAPTER 8

COMMENTS OF JCAH AND HEW

JCAH COMMENTS

JCAH chose not to comment on our recommendation to the Congress to consider the alternative of requiring HEW to contract with JCAH to conduct all certification surveys. JCAH stated that the absence of appropriate public debate and requisite enabling legislation made its comments on the recommendation inappropriate at this time.

Regarding our recommendation to the Secretary of HEW on reducing the number of surveys hospitals receive, JCAH discussed its progress in providing for automatic Medicare certification in accredited hospitals in the areas of institutional planning and utilization review. JCAH also noted that it is working with the States to curtail redundant hospital survey activities.

JCAH believed the statements in the report that (1) it has a mechanism for updating its standards and (2) its standards do not reflect current practice, were contradictory. We point out that there is always a lag between recognizing need for change and developing and instituting new requirements. JCAH experienced this situation when it upgraded its life safety code, clinical laboratory, utilization review, and institutional planning standards. Having a mechanism to update standards does not necessarily mean that current standards reflect current practice.

In its general comments, JCAH suggested that, although the Government must ensure that minimum standards are met, it should also encourage private voluntary initiatives to do more than the minimum essential. JCAH also noted that the validation of its surveys is an essential part of the certification system and good public policy.

HEW COMMENTS

HEW made three overview comments on the report. First HEW said that the report fails to present any evidence to show that the quality of care received by patients in JCAH-accredited hospitals exceeds that received by patients in unaccredited hospitals. HEW said that our statistics showing that JCAH surveys identify more deficiencies than State surveys do not necessarily mean that patients in JCAH-accredited hospitals are safer than patients in non-JCAH-accredited institutions.

HEW identifies an important point regarding the Medicare hospital certification system. It is correct in saying that we provide no evidence that JCAH-accredited hospitals provide better care than unaccredited hospitals. Such an undertaking would be difficult, if not impossible. Our objective was to evaluate HEW's system for determining if Medicare patients receive quality care. Our first conclusion regarding the system was that it doesn't measure quality of care patients receive but instead assesses whether hospital procedures, policies, and environment provide a framework within which quality care can be provided. Both JCAH and HEW officials agreed with this conclusion.

The only feasible way of comparing JCAH surveys with those performed by the various States was to compare the results of the two surveys as we did for 35 hospitals surveyed by JCAH and validated by State surveyors. The results of these comparisons as well as other factors discussed in the report provide substantial evidence supporting our conclusion regarding JCAH and State survey procedures and practices.

Secondly, HEW said that the report appeared to be critical of its procedures which permit facilities to develop deficiency corrective action plans. HEW said that its primary thrust is to obtain correction of identified deficiencies and not to terminate facilities immediately upon detection of deficiencies. The Department said that, in addition to assuring patients receive quality care, it is also concerned with assuring access to care of all beneficiaries.

The report does not contain any statements suggesting that hospitals be terminated when deficiencies are found. While HEW claims its primary thrust is to obtain correction of deficiencies, our work indicated it has not been successful. As described in chapter 4, significant deficiencies went unreported for years and some reported deficiencies were not corrected quickly in State-certified hospitals. JCAH-accredited hospitals usually corrected deficiencies before the next survey. We recognize the need to develop corrective action plans. We believe, however, that these plans must be implemented in a timely manner or the purpose of developing plans and the entire hospital certification system is pointless. Impact on beneficiaries should be a major consideration in any certification decision.

HEW was not receptive to the alternative of contracting with JCAH for all Medicare hospital certification activities. It said that strong resistance from the States would result and that some States' licensure programs are strongly tied to the certification program. HEW suggested that JCAH contracts could be effective in those States where certification workload is minimal.

We acknowledge the anticipated reaction of States regarding contracting with JCAH and believe that contracting with JCAH could have an important positive impact of causing more States to use certification as a basis for licensure. While State reaction is an important factor the Congress needs to consider in evaluating the three alternatives we propose, the advantages and disadvantages of each alternative need to be carefully considered.

HEW generally concurred in our recommendations and identified the following actions taken or planned.

--Revisions to the Medicare conditions of participation are in process. A Notice of Proposed Rulemaking is expected in early 1979.

--Proposed regulations are being developed addressing the issue of equivalencies of JCAH standards and HEW conditions of participation.

--The State Operations Manual is undergoing a major revision to give surveyors necessary guidance to make compliance decisions. The revised manual should be published in the fall of 1979.

--A contract will be awarded to develop measurement criteria for surveyors to use in applying the conditions to determine compliance.

--As a result of major initiatives undertaken in fiscal year 1978, the management information system has been, and will continue to be, improved.

--Guidelines addressing survey team size and composition, duration, and surveyor qualifications have been drafted and will be finalized and implemented by the end of 1979.

--Specialty training courses to address weaknesses in survey skills identified during program reviews will be developed.

--Regulations are being developed that recognize the JCAH institutional planning requirement as equivalent to the Medicare condition of participation. Similar recognition of JCAH's utilization review requirement is being considered.

HEW agreed with our recommendation about providing incentives for hospitals to promptly correct deficiencies. It suggested an additional financial initiative--an across-the-board reduction in interim Medicare payments to a hospital, with the amounts withheld kept in a special fund for release when the hospital corrects its deficiencies. HEW believed this sanction would be the most effective and least disruptive to beneficiary care. We believe that this approach would be a viable means of stimulating a hospital to take corrective action. As HEW noted, however, legislative action would be necessary before its proposal could be implemented.

HEW did not agree with our recommendation to make certification an annual procedure. It pointed out that beneficiaries depend on hospitals, who in turn depend on receiving Medicare and Medicaid reimbursement and manage accordingly. It believes that the procedure would create unnecessary hardships for hospitals and that removal of annual recertifications would prevent hospitals from making long-range plans to improve their operations.

We believe that the change in procedure would stimulate hospitals to develop plans of correction that are more realistic in addressing out-of-compliance conditions and the time frames needed for correction. This change would still permit HEW:

--To address the seriousness of a situation and the plan and time frame for corrective action.

--To grant certification with a waiver based on an acceptable plan of corrective action.

--To grant certification with a waiver of conditions that are not correctible, if there were extenuating circumstances, such as difficulties in recruitment because of a hospital's isolated location.

HEW concurred in our recommendation to grant 2-year certifications to exemplary hospitals and advised that several pilot projects are examining the issue.

Joint Commission on Accreditation of Hospitals
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John E. Affeldt M.D.
President

February 12, 1979

Gregory J. Ahart
Director
Human Resources Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

Please refer to your letter of December 21, 1978 seeking Joint Commission on Accreditation of Hospitals (JCAH) comment on your draft proposed report to Congress, "Reform Needed for the Medicare Hospital Certification System".

We have reviewed this draft report. Our comments are appropriately limited to JCAH matters and are organizad into two parts, the first addressed to selected Chapter 7 recommendations and the second directed toward other items contained in the report.

COMMENT ON RECOMMENDATION

GAO RECOMMENDATIONS (for ready reference we will repeat your recommendation(s) and follow each with our comment.)

Recommendation

Congress revitalize the Medicare certification process for hospitals. To achieve this objective the Congress should explore requiring HEW to either

1. contract with JCAH to conduct all certification surveys

2. ....

3. ....

APPENDIX I

Comment

The absence of appropriate public debate and requisite enabling legislation make JCAH comment on this recommendation inappropriate at this time.

Recommendation

To reduce the number of surveys hospitals receive, recommend that the Secretary encourage

- JCAH to alter its institutional planning and utilization review requirements so that accredited hospitals can be automatically certified in these areas, and

- the States to grant licensure to certified hospitals or at least coordinate licensure surveys with certification and accreditation surveys.

Comment

On July 11, 1978, the Health Care Financing Administration (HCFA) advised the JCAH that the institutional planning requirements in our Accreditation Manual for Hospitals are equivalent to similar Medicare/Medicaid requirements and that necessary regulatory changes were being prepared to provide for automatic Medicare certification in this area for accredited hospitals.

We have been informally advised by HCFA staff that the hospital "utilization review" requirements adopted by our Board of Commissioners on December 9, 1978 are equivalent to the Medicare requirements. We expect the Department will extend Medicare "deemed status" to JCAH accredited hospitals in this area at the appropriate time.

There are ongoing activities or initiatives in twenty states to coordinate State licensure and voluntary accreditation surveys. These activities include accreditation as a proxy for licensure, joint surveys and/or complementary surveys. Our Board of Commissioners has directed that we work with States in their efforts to curtail redundant hospital survey activity.

OTHER COMMENTS

Nonaccredited hospitals

The word "nonaccredited" is used throughout the report to identify hospitals

subject to State Agency surveys for certification purposes. The term "unaccredited" would better describe the institution. Since "nonaccreditation" is one of the possible findings of a JCAH survey, this term is widely perceived as denoting an institution which has failed a JCAH accreditation survey. The majority of hospitals subjected to State Agency certification have neither sought nor failed JCAH accreditation. In this connection, the description of possible JCAH survey decisions included in the INTRODUCTION is incomplete because it does not include the "nonaccreditation" decision.

Timely Standards

Chapter 2 of the report contains the observation, "...JCAH has a built-in mechanism for continually updating the standards based on input from the public, private and professional organizations as well as HEW." This fact would seem to contradict the conclusion expressed elsewhere in the report that, "JCAH standards...do not reflect current practices."

Hospital Clinical Laboratory Standards

Chapter 2 of the report refers to JCAH efforts to revise hospital clinical laboratory standards. In this connection the JCAH Board of Commissioners adopted new standards for hospital clinical laboratories in April 1978. In May 1978, HCFA found these standards equivalent to the revised Medicare standards in this area that were to be effective November 24, 1978. The JCAH expanded the hospital accreditation survey team to include a laboratory technologist and commenced surveying hospitals under these new standards in January 1979. The January 16, 1979 Federal Register announced the continuation of Medicare "deemed status" for clinical laboratories in JCAH accredited hospitals. The charge for a hospital accreditation survey has been increased by $550.00 per survey day to accommodate this new JCAH emphasis.

Surveyor Training

In the interest of comprehensiveness the report might also have observed that JCAH surveyors attend at least one refresher training course each year in addition to their initial training program.

OVERVIEW

We are persuaded that government can only impose minimum standards in any area. Higher standards will only be achieved through voluntary efforts of individuals committed to such an objective. We believe the government must insure that minimum standards are met but we suggest it is in the public interest for government to encourage private voluntary initiatives to do more than the minimum essential.

Joint Commission on Accreditation of Hospitals

We recognize that GAO found fault with the Department's efforts to validate the JCAH accreditation process. We suggest, however, that this is an essential program and that validation of our activity is good public policy. The solution lies in having the Department improve its validation program by following your direct and implicit recommendations. We submit that an underlying assumption of the present validation survey process is that State Agency certification of an unaccredited hospital means that the hospital meets all the Medicare conditions. The GAO report demonstrates the fallacy of that assumption.

We wish to take this opportunity to thank you for your fair and objective report concerning JCAH activity. We appreciate very much this opportunity to comment on it.

Sincerely,

John E. Affeldt, M.D.
President

PEM:JEA/bc

APPENDIX II

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D C 20201

APR 13 1979

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Reform Needed For the Medicare Hospital Certification System." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Thomas D. Morris
Inspector General

Enclosure

APPENDIX II

Comments of the Department of Health, Education, and Welfare on the General Accounting Office's Draft Report Entitled, "Reform Needed for the Medicare Hospital Certification System"

Overview

In this report, the GAO compares Medicare Hospital Certification Procedures with procedures of the Joint Commission on the Accreditation of Hospitals (JCAH), and concludes that JCAH policies and procedures are superior to those of HEW. Several issues should be addressed in regard to this conclusion. First, GAO fails to present any evidence to show that the quality of care received by patients in JCAH accredited hospitals exceeds that received by patients in non-accredited hospitals. For example, the fact that JCAH identifies more deficiencies than State surveyors does not necessarily mean that patients in particular JCAH institutions are safer than patients in non-JCAH institutions. The Department believes that the significance of a single deficiency must be determined as part of the overall review of an institution's ability to assure the health and safety of its patients.

Second, GAO appears critical of HEW procedures which permit facilities to develop corrective action plans to bring their operations up to par within specified time periods. It should be understood that HEW's primary thrust is to obtain correction for identified deficiencies, not to terminate facilities immediately upon detection of deficiencies. In addition to assuring quality of care in a given facility, HEW is also concerned with assuring access of care to all beneficiaries.

Third, on the issue of revitalizing the Medicare hospital certification process, it is our belief that any options which center on abolishing or diminishing the State role in the certification process will be strongly resisted by the States. Some states have strongly tied their licensure programs to the Federal certification program. Further, it is our experience that use of Federal surveyors is an expensive option, and not necessarily a cost effective one. However, the Department believes that a contract with JCAH to survey non-accredited hospitals could be an effective alternative in those States where this workload is minimal.

APPENDIX II

GAO RECOMMENDATION TO THE SECRETARY

The Secretary should regularly review and update the conditions of participation, making sure they are sufficiently specific to enable surveyors to establish compliance or noncompliance.

DEPARTMENT COMMENT

The Department concurs and is in the process of revising the Medicare Hospital Conditions of Participation. A Notice of Proposed Rulemaking is expected in early 1979. The Comments on the proposed rule will determine the degree of specificity incorporated in the final regulations.

GAO RECOMMENDATION TO THE SECRETARY

The Secretary should define the relationship between Medicare conditions and JCAH standards, establishing equivalencies or waivers where requirements differ.

DEPARTMENT COMMENT

The Department agrees. We are taking action in several areas to clarify the relationship between JCAH standards and the Medicare Hospital Conditions of Participation.

We are developing proposed regulations which will address the issue of equivalency by specifying that any time either Medicare Conditions of Participation or JCAH standards are changed, they must be reviewed by HEW to determine if they are equivalent. Even though these regulations have not been issued in final form, equivalency determinations have been made in the areas of life safety and clinical laboratories. For example, in February 1978, the Department published new regulations for hospital clinical labs. The preamble to these regulations explained that unless JCAH revised its standards to become "equivalent" to the new HEW Conditions of Participation, JCAH - accredited hospitals would no longer be deemed to meet them. In January 1979 JCAH made the required changes.

Further, the Department is currently conducting, on a pilot basis, simultaneous JCAH accreditation - HEW validation surveys. The pilot surveys will provide JCAH and State surveyors with an opportunity to resolve variances in deficiency findings on site, eliminating conflicting survey results which have sometimes plagued accredited hospitals. Federal participation on these surveys has been substantially increased to guarantee uniformity. We will analyze the results of these pilot studies to determine if the study should be extended.

Finally, we are developing a national policy for life safety code waivers, for which we have to solicit public comment by mid-1979.

including more effective guidelines for survey team size and composition, surveyor qualifications and training, and survey duration;

-- effectively evaluate the State agencies and regional offices and provide training or other guidance which addresses the problems identified;

-- transfer only those noncompliant accredited hospitals not correcting deficiencies within established time frames to State monitorship.

DEPARTMENT COMMENT

Guidelines for Survey Teams

The Department concurs. Guidelines have been developed to address survey team size and composition, duration, and surveyor qualifications, and have been issued to the Regional Offices. An evaluation of the impact of these guidelines on a sample of States will be conducted by the end of FY 79.

Assessment of State Agencies and Regional Offices

The Department concurs with GAO's recommendation to strengthen the evaluation process for both States and Regional Offices. As noted by GAO, the Department has developed new procedures which have been in use for approximately six months. The Department plans to evaluate the new procedures and make further revisions, if necessary, in the next six months.

· Further, the Department will continue to develop specialty training courses to address weaknesses in surveyor skills identified during program reviews. Approximately two specialty courses are developed per year.

Transfer of Noncompliant Accredited Hospitals

· Legislative changes which eliminate the requirement to transfer noncompliant accredited hospitals to State monitorship may be considered. The pilot study on simultaneous JCAH accreditation-HEW validation surveys calls for JCAH monitoring of deficiencies identified by both JCAH and State surveyors, thus reducing the number of follow-up visits by the States. We will consider results of this part of the study in making any proposals for legislative change.

GAO RECOMMENDATION TO THE SECRETARY

To reduce the number of surveys hospitals receive, we recommend that the

Secretary encourage:

--JCAH to alter its institutional planning and utilization review requirements so that accredited hospitals can be automatically certified in these areas, and

--the States to grant licensure to certified hospitals or at least coordinate licensure surveys with certification and accreditation surveys.

DEPARTMENT COMMENT

Institutional Planning and Utilization Review Requirements

The Department concurs and is currently promulgating regulations, to be published this summer, which recognize the JCAH institutional planning requirement as equivalent to the Medicare/Medicaid requirement. In addition, the Department is considering JCAH's request for similar recognition of their utilization review requirement. However, we would like to point out that an equivalent JCAH requirement on utilization review will have no effect on a hospital subject to PSRO review since PSRO review supersedes utilization review.

State Coordination of Licensure and Certification

The Department concurs with GAO's recommendation to encourage States to combine licensure and certification surveys and to use certification findings as a basis for state licensure, but we would like to emphasize that this is an area of action ultimately reserved for the States. It is worthwhile to note that as many as twenty States have already voluntarily taken steps to coordinate licensure and certification.

GAO RECOMMENDATION TO THE SECRETARY

To provide incentives for hospitals to promptly correct deficiencies we recommend that the Secretary:

--withhold Medicare reimbursement for new patients or limit the number of Medicare admissions;

--require that hospitals be certified annually for participation in Medicare. The change from recertification to annual certification would eliminate the extensive documentation and time-consuming process currently necessary to terminate hospitals from Medicare participation. The Secretary could still waive compliance with conditions of participation as provided in program regulations, and

--authorize HEW to grant 2-year certifications to exemplary hospitals.

This would save time and lessen the survey workload so HEW could concentrate its efforts on problem facilities.

DEPARTMENT COMMENT

Financial Incentives

The Department concurs with the development of financial incentives to enforce standards compliance. However, before any sanction is considered, we feel that an evaluation should be made in 3 areas: beneficiary access to care, legalities of sanction application, and impact on billing system procedures. We believe that a sanction which would permit us to make across-the-board reductions in interim payments made to the provider could be most effective and least disruptive to beneficiary care. The amounts withheld could be kept in a special fund for release when and if the hospital corrects its deficiency. The Department is interested in exploring the possibility of this type of approach.

This procedure would not require additional bill monitoring, which would be necessary if the GAO recommendation to withhold payments for new admissions is adopted. Further, this procedure would permit the hospital to continue operations, albeit at a reduced level of financial support. Thus, beneficiaries would not be denied access to necessary medical care.

Also, use of our suggestion would not change the interim rate of payment which is used to reduce charge to cost on a bill but would withhold 10 percent to 50 percent of the actual Health Insurance payments made to the hospital for interim billing. We will give serious consideration to a legislative proposal on this matter.

Annual Certification vs. Annual Recertification

The Department does not concur with GAO's recommendation to make certification an annual procedure, because we believe that it would create unnecessary hardships for facilities. Beneficiaries depend on facilities who in turn depend on receiving Medicare and Medicaid reimbursement and manage their operations accordingly. Removal of annual recertifications would prevent a facility from making long range plans to improve their operations.

Two Year Certifications

The Department concurs with the thrust of the recommendation to grant 2 year certifications to exemplary hospitals. The Department has underway several pilot projects which are examining this issue. A "triage" pilot in Wisconsin categorizes Long Term Care facilities as poor, average, or excellent, and allocates survey time accordingly. Findings in this LTC project should be generalizable to acute care facilities. We will review the study results to determine where applications may be made to hospitals. We expect to publish a policy on two year certifications within the next year.

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