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NURSING HOMES

Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards

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

The Honorable John D. Dingell
Ranking Minority Member
Committee on Commerce
House of Representatives

The Honorable Pete Stark
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

The Honorable Ron Wyden
United States Senate

The Honorable Nick Smith
House of Representatives

The 1.6 million elderly living in nursing homes are among the sickest and most vulnerable populations in the nation. The federal government, together with states, plays a key role in ensuring that nursing home residents receive adequate quality of care. In addition to paying a projected $39 billion for nursing home care in 1999, the federal government sets standards that homes must meet to participate in the Medicare and Medicaid programs and has authority to impose sanctions[1] if homes do not meet these standards. In recent years, the Congress has authorized additional sanctions, such as fines, to help ensure that homes maintain compliance with the standards. Since these new sanctions have taken effect, however, concerns about the quality of care some homes provide have persisted. For example, we previously reported on

[1]The term used in the law and regulations to describe a nursing home penalty for noncompliance is "remedy." Throughout this report, we use a more common term, "sanction," to refer to such penalties. Sanctions include actions such as fines, denial of payment for new admissions, and termination from the Medicare and Medicaid programs.

weaknesses in federal oversight of nursing home care in California and on inspection and enforcement weaknesses nationwide.[2]

This report responds to your request for information on the enforcement of federal nursing home standards. As agreed with your offices, it (1) provides national data on the existence of serious deficiencies in nursing home compliance with Medicare and Medicaid standards and (2) discusses the use of sanction authority for homes that failed to maintain compliance with the standards. Concurrent with our last report, the Health Care Financing Administration (HCFA)[3] announced several initiatives to correct problems it had found with its enforcement process. As part of our work for this report, and as agreed with your offices, we also evaluated the extent to which these actions would address any problems we identified.

Our information about the extent of serious deficiencies in compliance with standards came mainly from analyzing HCFA's nationwide database of periodic inspections (called surveys) of nursing homes. Our information about the use of sanctions came mainly from work conducted at 4 of HCFA's 10 regional offices and in four states that collectively account for about 23 percent of the nation's nursing homes.[4] Within these four states, we selected 74 homes for detailed analysis, choosing homes that had been referred to HCFA—often several times—for enforcement action. We were looking primarily to see how sanctions were working when homes had serious or sustained compliance problems. Because the sample was chosen deliberately from among the worst homes, it is not representative of all homes, either in these states or nationwide. We conducted our work between December 1997 and March 1999 in accordance with generally accepted government auditing standards. Appendix I contains a more detailed explanation of our scope and methodology.

Results in Brief

Overall, our work showed that while HCFA has taken steps to improve oversight of nursing home care, it has not yet realized a main goal of its enforcement process—to help ensure that homes maintain compliance with federal health care standards.

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

[3]HCFA administers Medicare and, in conjunction with the states, Medicaid.

[4]The HCFA regions were III, V, VI, and IX; the states were Pennsylvania, Michigan, Texas, and California, respectively.

Surveys conducted in the nation's 17,000-plus nursing homes in recent years showed that each year, more than one-fourth of the homes had deficiencies that caused actual harm to residents or placed them at risk of death or serious injury. The most frequent violations causing actual harm included inadequate prevention of pressure sores, failure to prevent accidents, and failure to assess residents' needs and provide appropriate care. Although most homes were found to have corrected the identified deficiencies, subsequent surveys showed that problems often returned. About 40 percent of the homes that had such problems in their first survey during the period we examined (July 1995 to October 1998) had them again in their last survey during the period.

Sanctions initiated by HCFA against noncompliant nursing homes were never implemented in a majority of cases and generally did not ensure that the homes maintained compliance with standards. Our review of HCFA's survey data combined with our analysis of 74 homes that had a history of problems showed a common pattern: HCFA would give notice to impose a sanction, the home would correct its deficiencies, HCFA would rescind the sanction, and a subsequent survey would find that problems had returned. The threat of sanctions appeared to have little effect on deterring homes from falling out of compliance again because homes could continue to avoid the sanctions' effect as long as they kept correcting their deficiencies. HCFA has some tools to address this cycle of repeated noncompliance but has not used them effectively. Fines, or civil monetary penalties, are potentially a strong deterrent because they can be applied even if a home comes back into compliance. However, the usefulness of civil monetary penalties is being hampered by a backlog of administrative appeals coupled with a legal provision that prohibits collection of the penalty until the appeal is resolved. In effect, the sanction is often delayed for several years. We also found problems with several aspects of HCFA's policies for ensuring that sufficient attention is placed on homes that have serious deficiencies or a history of recurring noncompliance as well as with policies for reinstating homes that have been terminated from the Medicare and Medicaid programs.

HCFA's recent actions to improve nursing home oversight are aimed mainly at resolving problems pointed out in earlier studies, such as staggering the survey schedule and prosecution of egregious violations, but have not resolved additional problems that we have identified. Issues that remain to be addressed include strengthening the use of civil monetary penalties, improving the referral process for sanctions, and increasing the deterrent effect of terminating homes from the Medicare and Medicaid programs. A

final area that will affect HCFA's ability to resolve its recognized oversight problems is the state of its management information system. The system in place is ineffective at providing comprehensive information needed to identify homes with recurring problems, homes owned by chains, and deficiencies identified as a result of complaint investigations rather than standard surveys.

We are making several specific recommendations to the Administrator of HCFA to strengthen HCFA's enforcement process and thereby increase the protection provided to nursing home residents. In a written response to our draft report, HCFA generally concurred with our recommendations and cited other efforts, planned and under way, to help ensure nursing home residents receive quality care.

Background

Nursing homes play an essential role in our health care system. They care for persons who are temporarily or permanently unable to care for themselves but who do not require the level of care provided in an acute care hospital. Titles XVIII and XIX of the Social Security Act establish minimum standards that all nursing homes must meet to participate in the Medicare and Medicaid programs.[5]

Oversight Is a Shared Federal and State Responsibility

The states and the federal government share responsibility for oversight of the quality of care in the nation's 17,000 nursing homes. Oversight includes routine and follow-up surveys to assess compliance with standards and enforcement activities to ensure that identified deficiencies are corrected and remain corrected. At the direction of the Congress, HCFA sets standards for nursing homes' participation in Medicare and Medicaid. HCFA also contracts with state agencies to check compliance with these standards through surveys at least every 15 months. States also enforce their own licensing requirements in all state-licensed nursing homes, including those with Medicare certification, and check for compliance with these licensure requirements during standard surveys. States also conduct surveys in response to complaints.

Enforcement of Medicare and Medicaid standards is likewise a shared responsibility. HCFA is responsible for enforcing standards in homes with Medicare certification—about 86 percent of all homes.[6] When homes are found to have deficiencies at the most severe level, or when homes fail to

[5]56 Fed. Reg. 48827.

[6]This percentage includes homes that have both Medicare and Medicaid certification.

correct deficiencies in a timely manner, HCFA policies call for states to refer these cases to HCFA, together with any recommendations for sanctions. HCFA normally accepts these recommendations but can modify them. States are responsible for enforcing standards in homes with only Medicaid certification—about 14 percent of all homes.

1987 Law Shifted Focus of Regulatory Standards and Added Sanctions

As part of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), the Congress changed the focus of standards that homes needed to meet to participate in Medicare and Medicaid. Prior to OBRA 87, the Medicare and Medicaid participation standards focused on a home's capability to provide care, not on the quality of care actually provided. Largely in response to a 1986 Institute of Medicine study,[7] which recommended more resident-oriented nursing home standards, OBRA 87 refocused standards on the actual delivery of care and the results of that care. For example, the focus of the standards moved to such matters as a home's performance in providing appropriate care for incontinence or for preventing pressure sores, and the performance would be evaluated by reviewing medical records and examining residents.

To ensure that facilities would achieve and maintain compliance with the new standards, OBRA 87 also greatly expanded the range of enforcement sanctions. Studies of nursing home regulation had shown that many homes tended to cycle in and out of compliance with standards that were important to protecting residents' health and safety, thereby placing nursing home residents in jeopardy. For example, in 1987 we reported that more than one-third of nursing homes reviewed failed to consistently meet one or more of the standards that were most likely to adversely affect residents' well-being.[8] These facilities were nevertheless able to remain in Medicare and Medicaid without incurring any penalties if the deficiencies were corrected in a timely manner. As such, there was no effective federal penalty to deter noncompliance. At that time, the only sanctions available were termination from the program or, under certain circumstances, denial of payments for new Medicare or Medicaid residents. OBRA 87 added several new alternatives, such as civil monetary penalties, and expanded the deficiencies that could result in denial of payments. (See table 1.)

[7]Improving the Quality of Care in Nursing Homes, Institute of Medicine (Washington, D.C., 1986). The purpose of the study was to recommend changes in regulatory policies and procedures to ensure nursing home residents receive satisfactory care.

[8]Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed (GAO/HRD-87-113, July 22, 1987).

Table 1: Sanctions Available to Enforce Compliance With Medicare and Medicaid Program Standards

Sanction	Description	In place before OBRA 87	Added or expanded under OBRA 87
Civil monetary penalties	Penalties ranging from $50 to $10,000 per day can be assessed.		X
Temporary management	The nursing home accepts a substitute manager appointed by the state with the authority to hire, terminate, and reassign staff; obligate funds; and alter facility procedures as appropriate.		X
Denial of payments	Medicare and/or Medicaid payments can be denied for all covered residents or for newly admitted residents.	X	X
Directed in-service training	The nursing home is required to provide training to staff on a specific issue identified as a problem in the survey.		X
Directed plan of correction	The facility would be required to take action within specified time frames according to a plan of correction developed by HCFA, the state, or the temporary manager.		X
State monitoring	An on-site state monitor can be placed in the nursing home to help ensure that the home achieves and maintains compliance.		X
Termination	The provider is no longer eligible to receive Medicare and Medicaid payments for beneficiaries residing in the facility.	X	

Particularly with regard to civil monetary penalties, the Congress intended that these sanctions create a strong incentive to maintain compliance with federal standards by penalizing homes for their deficiencies. To this end, the associated House Budget Committee Report stated

> the Committee amendment would expressly allow a State to impose civil money penalties for each day in which a facility was found out of compliance with one or more of the requirements of participation, even if the facility subsequently corrected its deficiencies and brought itself into full compliance. This, in the Committee's view, is essential to creating a financial incentive for facilities to maintain compliance with the requirements for participation (emphasis added).[9]

The Department of Health and Human Services (HHS) issued regulations implementing OBRA 87 in two stages. Regulations implementing standards

[9]H.R. 391, 100th Cong., p. 473. The Committee's provision establishing civil monetary penalties was adopted in conference.

were effective by October 1990, but enforcement regulations covering sanctions did not become effective until July 1995. According to a HCFA official, publication of enforcement regulations was delayed because of the controversial nature of the regulation and the workload associated with responding to the large volume of comments received in the rulemaking process.

Sanctions Are Matched to Severity of Deficiencies

OBRA 87 gave the HHS Secretary authority to specify criteria as to when and how each sanction should be applied. In developing the regulations implementing these sanctions, HCFA proceeded on the assumption that, while all standards must be met and enforced, failure to meet a standard takes on greater or lesser significance depending on the circumstances and the actual or potential effect on residents. Thus, the regulations established an approach for determining the relative seriousness of each instance of noncompliance with standards.

For each deficiency identified in the survey process, the approach places the deficiency in one of 12 categories, labeled "A" through "L" depending on the extent of patient harm (severity) and the number of patients adversely affected (scope). The most dangerous category (L) is for a widespread deficiency that causes actual or potential for death or serious injury to residents; the least dangerous category (A) is for an isolated deficiency that poses no actual harm and has potential only for minimum harm. Homes with deficiencies that do not exceed the C level are considered in "substantial compliance," and as such, providing an acceptable level of care.[10] The effect of HCFA's categorizing is that for a home to be out of compliance, it must have one or more deficiencies that subject a resident to at least the potential for more than minimal harm. Identifying the scope and severity of a deficiency also provides the basis for three groups of enforcement sanctions, which may be required or optional. (See table 2.)

[10]We use the term "compliance" throughout the remainder of the report to mean homes that meet HCFA's definition of "substantial compliance" with the standards.

Table 2: HCFA's Scope and Severity Grid for Medicare and Medicaid Compliance Deficiencies

	Scope			Sanction[a]	
Severity category	**Isolated**	**Pattern**	**Widespread**	**Required**	**Optional**
Actual or potential for death/serious injury[b]	J	K	L	Group 3	Group 1 or 2
Other actual harm	G	H	I	Group 2	Group 1[c]
Potential for more than minimal harm	D	E	F	Group 1 for categories D and E; group 2 for category F	Group 2 for categories D and E; group 1 for category F
Potential for minimal harm (substantial compliance)	A	B	C	None	None

[a]Group 1 sanctions are directed plan of correction, directed in-service training, and/or state monitoring. Group 2 sanctions are denial of payment for new admissions or all individuals and/or civil monetary penalties of $50 to $3,000 per day of noncompliance. Group 3 sanctions are temporary management, termination, and/or civil monetary penalties of $3,050 to $10,000 per day of noncompliance.

[b]This category is referred to in regulations as "immediate jeopardy."

[c]Sanctions for category I also include option for temporary management.

Homes in substantial compliance are not subject to sanctions. For noncompliant homes referred to HCFA for sanction, the severity of the sanction that must or can be imposed generally increases with the severity of the deficiency. For each category in the scope and severity grid, a sanction from a particular group must be imposed and sanctions from certain other groups can be added.[11] For example, a home with one or more deficiencies rated J or higher must receive a sanction from group 3, and HCFA has the option of levying additional sanctions from groups 1 or 2. HCFA regulations provide that the choice of sanctions is to take into account not only the severity and scope of the deficiency but also a consideration of prior performance, desired corrective and long-term compliance, and the number and severity of all the homes' deficiencies together.

Under their shared responsibility for Medicare-certified nursing homes, state agencies identify and categorize deficiencies and make referrals with proposed sanctions to HCFA. HCFA is responsible for imposing sanctions and collecting monetary penalties.

[11]Two conditions override the penalties in the scope and severity grid. If a home does not correct all its deficiencies within 3 months of the survey, a denial of payment for new admissions must be imposed. If a home fails to achieve compliance status within 6 months of the survey, it must be terminated from Medicare and Medicaid.

States May Grant Noncompliant Homes a Grace Period

Under HCFA's policies, most homes are given a grace period, usually 30 to 60 days, to correct deficiencies identified in the standard or complaint surveys. States do not refer these homes to HCFA for sanction unless they fail to correct their deficiencies within the grace period. Exceptions are provided for homes with deficiencies rated J, K, or L and for homes that meet HCFA's definition of a "poorly performing facility"—a special category of homes with repeat severe deficiencies. HCFA policies call for states to refer these homes immediately for sanction.

HCFA also requires a notice period before the sanction takes effect. When a HCFA regional office receives a referral from a state, it reviews the case and the state's recommendation, decides whether to impose a sanction, and notifies the home if a sanction is to be imposed. Under HCFA regulations, homes have 15 to 20 days to come into compliance, and if a home does so by the deadline, the sanction does not take effect. There are two major exceptions. One is a civil monetary penalty, which can be assessed retroactively even if a home corrects the problem. The other is when a nursing home is found to have a deficiency rated J, K, or L. In this circumstance, HCFA may put a sanction into effect after a 2-day notice period.

Many Nursing Homes Had Deficiencies That Harmed Residents

National data on nursing home surveys for July 1995 to October 1998 showed that the proportion of homes with the most severe deficiencies remained at uncomfortably high levels throughout this period. The total number of homes not in compliance, even for the most serious deficiency categories, remained relatively steady. Furthermore, about 40 percent of the homes found to have serious deficiencies in a survey early in the period were found to have deficiencies of equal or greater severity in a subsequent survey late in the period.[12]

One-Fourth of All Homes Had Deficiencies in the Highest Severity Categories

Compliance with nursing home standards of care continued to be a problem during the entire 3-year period we examined. Comparing the number of cited deficiencies per noncompliant nursing home during this period showed little overall change from the first, or base, survey (3.79) to

[12]HCFA categorizes surveys and takes enforcement action based on the deficiency's scope and severity ranking. We used this approach for comparing survey results from different periods.

the most recent survey (3.74).[13] In the earlier set of surveys, 28 percent of homes had at least one deficiency in the two highest severity categories (actual or potential for death or serious injury and other actual harm); in the most recent set of surveys, the figure was 27 percent (see table 3).

Table 3: Base Period and Ending Period Survey Deficiencies

	Base survey[a]		Most recent survey[b]	
HCFA severity category	**Number of homes**	**Percent**	**Number of homes**	**Percent**
Actual or potential death/serious injury	125	1	192	1
Other actual harm	4,690	27	4,521	26
Potential for more than minimal harm	6,527	38	7,535	43
No deficiencies or in substantial compliance (deficiencies with potential for minimal harm)	5,902	34	5,435	31
Total	**17,244**	**100**	**17,683**	**100[c]**

[a]First survey conducted between July 1, 1995, and December 31, 1996.

[b]Most recent survey conducted between January 1, 1997, and October 22, 1998.

[c]Does not add to 100 due to rounding.

In the two highest severity categories, common deficiencies included inadequate attention to prevent pressure sores, failure to provide supervision or assistance devices to prevent accidents, and failure to assess residents' needs or provide necessary care. Table 4 shows the most frequently cited violations in these severity groups for surveys conducted in the most recent survey period.

[13]We identified the most recent survey conducted between January 1, 1997, and October 22, 1998, and compared the results to the first survey conducted between July 1, 1995, and December 31, 1996. Interim surveys may have occurred but were excluded from this analysis. Data from prior periods are not comparable because severity classifications were not required for surveys conducted prior to July 1, 1995.

Table 4: Most Frequently Cited Deficiencies That Caused Actual Harm, January 1997 to October 1998

Number of homes cited[a]	Deficiency category	Health effect of deficiency
2,809	Inadequate attention to prevent pressure sores—the erosion of skin and underlying tissue that result from pressure, friction, or lack of blood supply	Without proper care, complications of pressure sores can occur and include pain, infection, increased debilitation, and skin loss with extensive destruction or damage to muscle and bone. The severity can range from skin redness to large wounds that can expose skin tissue and bone.
1,857	Failure to provide supervision or assistance devices to prevent accidents	Without appropriate supervision and accident prevention devices, such as alarm devices or external hip protectors, accidental injury may be more likely to occur, especially for bed-bound residents, who are at the highest risk for falls because they may try to get out of bed on their own and fall, which often results in serious injury, such as hip fracture.
2,158	Failure to provide comprehensive assessment of resident needs; poor development of care plans; failure to provide necessary care to attain the highest level of well-being[b]	The quality of care that residents receive is largely dependent on assessment of their needs and developing and following the plan of care developed to meet these needs. For example, resident assessments should identify individual needs, such as urinary or bowel continence, and these needs should be matched with a plan, such as "the resident will be assisted to the bathroom every 3 hours." At regular intervals, the health care team is supposed to develop objectives for the highest level of functioning and well-being a resident may be expected to attain, such as "the resident will remain continent at all times."
1,171	Failure to maintain acceptable nutritional status	Residents who receive insufficient nutrition to maintain body weight may be more susceptible to increased rates of infection, skin breakdown, cognitive impairment, and premature mortality.
555	Failure to provide appropriate treatment for incontinent resident	If left unattended, incontinence can lead to serious physical complications including infection, skin breakdown, and sepsis, as well as emotional damage to resident dignity.
510	Failure to maintain or enhance resident's dignity	HCFA regulations protect and promote the right of each resident to a dignified existence. Accordingly, HCFA policies stipulate that nursing homes must assist residents to be well-groomed, promote resident independence, respect resident privacy, and focus on residents as individuals. Such uncaring acts as physically exposing a resident to visitors and other residents or verbally abusing a resident are violations of a resident's dignity.
421	Improper use of physical restraints	Physical restraints, such as cotton vests that can be tied to a chair to prevent the resident from slipping, are devices to restrict freedom of movement and are used to protect residents from injury. Restraint devices cannot be easily removed by residents and improper use can cause decreased muscle tone, increase likelihood of falls or other accidents, incontinence, pressure ulcers, depression, confusion, and mental deterioration.
385	Failure to provide proper treatment and services for residents with limited range of motion, such as wheelchair- or bed-bound residents	Lack of physical exercise can lead to a loss of function or range of motion in the fingers, wrists, elbows, shoulders, hips, knees, and ankles. A decline in a resident's physical range of motion can result in arm and leg contractures and further pain, debilitation, and immobility.

(Table notes on next page)

[a]The total number of homes cited exceeds the total number of homes in the two severity categories because some homes were cited for more than one deficiency.

[b]We combined these three deficiencies because of their close link. Resident assessments provide the information necessary to set treatment objectives and care plans to achieve the highest level of functioning and well-being a resident may be expected to attain.

Forty Percent of Homes With Severe Deficiencies Were Repeat Violators

Although most noncompliant homes eventually returned to compliance, many did not maintain this status. Among those homes cited for deficiencies at the two highest levels of severity during the base survey, about 40 percent were cited for deficiencies at the same or higher level of severity during the most recent survey. In other words, during the 3-year period, 4 of 10 homes that were found by the base survey to have caused actual or potential death or serious injury or other actual harm to residents had deficiencies (possibly different deficiencies) that were just as severe—or worse—in the most recent inspection. Although we focused our analysis on deficiencies in the most severe categories, we noted that among those homes with deficiencies considered to hold potential for more than minimal harm in the first survey, about 77 percent were cited for deficiencies (again, possibly different ones) at the same or higher level of severity during the most recent survey.

Sanctions Do Not Ensure Nursing Homes Maintain Compliance

To determine the role sanctions play in bringing about a greater degree of compliance, we focused on a sample of 74 homes that had been referred for sanctions.[14] The case histories of these homes showed that sanctions helped bring the homes back into temporary compliance but provided little incentive to keep them from slipping back out of compliance. While several aspects of the sanction program, such as civil monetary penalties, have potential to provide the necessary incentive to better ensure continued compliance, certain HCFA policies or practices limited their effectiveness with these homes.

Most Sanctions Achieved Temporary Corrective Action

The 74 homes we reviewed had been referred by the states to HCFA for possible sanctions a total of 241 times—on average, about 3 times each. All 74 homes also had at least one deficiency that caused actual harm to residents or placed residents at risk of serious injury or death. Some referrals were accompanied by a recommendation for one sanction, while others were accompanied by recommendations for two or more. The most

[14]Based on HCFA regional data, we estimate that in a single year, 1997, about 12 percent of noncompliant homes in the four states we visited were referred to HCFA for possible sanction.

common sanction initiated by HCFA was denial of payments for new admissions—176 times. HCFA also initiated 115 civil monetary penalties and 44 terminations.

Many homes corrected their deficiencies after being notified that a sanction would be imposed. In these cases, HCFA rescinded the sanction. (See table 5.) For example, denial of payment never took effect in 97 of the 176 instances in which HCFA gave notice that a sanction would be imposed. Recision usually occurred because the facility corrected the deficiency before the effective date of the sanction.[15]

Table 5: Disposition of Referrals for the 74 Homes Reviewed

Sanction	HCFA notices to impose sanction	Sanctions that never took effect
Denial of payment for new admissions	176	97
Civil monetary penalties	115	78
Termination	44	31

The ability of sanctions to help bring about corrective action is reflected in the fact that, at the time of our study, only 7 of the homes in our sample that were sanctioned with termination remained terminated from the Medicare and Medicaid programs. However, sanctions—or the penalties they carry—only temporarily induced homes into taking action to correct identified deficiencies, as many were again out of compliance by the time the next survey or follow-up inspection was conducted. Of the 74 homes we reviewed, 69 were again referred for sanctions after being found out of compliance once more—some went through this process as many as six or seven times. Table 6 shows some of the cases in our sample where homes had been cited for serious deficiencies, referred to HCFA for sanctions, and subsequently cited for serious deficiencies again.

[15]Although civil monetary penalties show a similar pattern of having far fewer fines take effect than were imposed by HCFA, the relatively small number of penalties that have taken effect is a reflection of the large number of fines under appeal. As appeals are settled, a higher number of the 115 fines imposed may take effect.

Table 6: Examples of Nursing Homes With Patterns of Repeat Deficiencies and Repeat Referrals for Sanctions

State in which nursing home is located	Summary of deficiency history
Michigan	Twice in 1995, and again in 1996 and 1997, the state cited one home for causing actual harm to residents. Deficiencies included failure to prevent the development of pressure sores in several residents and failure to prevent accidents, which resulted in a broken arm for one resident and a broken leg for another.
Texas	State surveyors cited one nursing home for placing residents in immediate jeopardy and actual harm twice in 1995—including failure to prevent choking hazards, provide proper incontinent care, and prevent or heal pressure sores. On the next round of surveys, beginning in January 1997, surveyors again found quality of care deficiencies that caused harm to residents, including failure to provide adequate nutrition.
Pennsylvania	In 1995, 1996, and 1997, the state cited one nursing home for causing harm to residents. Problems included resident abuse and failure to provide services to several residents in accordance with a plan of care resulting in excessive weight loss.

This yo-yo pattern of compliance and noncompliance could be found even among homes that were terminated from Medicare, Medicaid, or both. Termination is usually thought of as the most severe sanction and is generally done only as a last resort.[16] Once a home is terminated, however, it can generally apply for reinstatement if it corrects its deficiencies. For three of the six reinstated homes in our group, the pattern of noncompliance returned. For example, a Texas nursing home was terminated from Medicare for a string of violations that included widespread deficiencies at the severity level of actual harm to residents. About 6 months after the home was terminated, it was readmitted under the same ownership. Within 5 months, state surveyors identified a series of deficiencies involving harm to residents, including failure to prevent avoidable pressure sores or ensure that residents received adequate nutrition.

Other sanctions authorized by OBRA 87—increased state monitoring, appointment of a temporary manager to oversee the home while it corrects its deficiencies, and state-directed plans of correction (see table 1)—have so far been applied infrequently. All three are receiving limited use, state officials said, because of various cost and administrative concerns. For example, officials in three of the four states said they lacked a pool of qualified administrators to act as temporary managers. Michigan

[16]When a home is terminated, it loses any income from Medicare and Medicaid payments, which for many homes represents a substantial part of operating revenues. Residents who receive support from Medicare or Medicaid must be moved to other facilities.

was an exception to this pattern. In the first quarter of 1998, Michigan entered into a contract with the Michigan Public Health Institute to provide oversight of facilities with significant compliance problems. Oversight activities focus on directed plans of correction and state monitoring.

Manner in Which Sanctions Are Implemented Hampers Their Effectiveness

Sanctions have been unable to ensure continued compliance because several procedures for implementing sanctions can minimize their effectiveness or invalidate them altogether. Civil monetary penalties, a sanction with strong potential deterrent effect, were hampered by a growing backlog of appeals. Imposing sanctions without a grace period was seldom used because of restrictive HCFA guidance. And termination, the ultimate sanction because it removes homes from the program, had little effect because many homes were able to reenter the program with little consequence for their past actions and were given a clean slate for the future.

Appeals Backlogs Hamper Deterrent Effect of Civil Monetary Penalties

Civil monetary penalties have an advantage in encouraging homes to remain in compliance—they can be applied retroactively to the date of initial noncompliance. In other words, they cannot be avoided simply by taking corrective action, and the longer the deficiency remains, the larger the penalty can be. HCFA initially planned to make wide use of the new sanctions when they were put in place but has since modified its policy by reserving civil monetary penalties for more serious deficiencies (G or higher in the scope and severity grid).

However, the use of civil monetary penalties for even this narrow range of deficiencies has resulted in a growing backlog of appeals. Nursing homes can appeal civil monetary penalties before HHS' Departmental Appeals Board. Appealed penalties are not collected until the case is closed, usually through the ruling of an administrative law judge or a negotiated settlement between HCFA and the nursing home. Nationwide, a lack of hearing examiners has created a backlog of about 620 cases awaiting decision as of August 1998, with some cases dating back to 1996. By February 1999, the backlog had grown to over 700 cases and is predicted to grow further. HHS budget documents estimated that each year at least twice as many appeals would be received as would be settled. This backlog creates a bottleneck for timely collections. For example, HCFA accounting records showed, as of September 1998, only 37 of the 115 monetary penalties imposed on the 74 homes we reviewed had been

collected. Unless penalties are actually collected they have minimal deterrent effect.

Large backlogs undermine the effectiveness of civil monetary penalties in two ways. First, they increase the pressure on HCFA to resolve the appeal by negotiating settlements—a strategy that helps somewhat in controlling the growth of the backlog but can also lower the size of the fine, potentially reducing the effect of the penalty.[17] Second, even if the appeal goes to a hearing and a penalty is upheld, considerable time may have elapsed without the home having to pay. As a result, it is not surprising that some nursing home owners routinely appeal imposed penalties. For example, regional enforcement logs showed one large Texas nursing home chain appealed 62 of the 76 civil monetary penalties imposed on its nursing homes (including chain-owned homes that were not in our sample) between July 1995 and April 1998. These 62 penalties totaled $4.1 million.

Some Procedures Limit Ability to Impose Immediate Sanctions

Under HCFA policy, HCFA can apply sanctions on an immediate basis (that is, without a grace period to correct deficiencies) to homes designated as poor performers and to homes that place residents in immediate jeopardy (actual death or serious injury or potential for such an outcome). Doing so can help encourage sustained compliance because eliminating the grace period means that homes are more likely to be affected by penalties.

However, HCFA's guidance for when to apply poor performer and immediate jeopardy designations has allowed severe and repeat violators to avoid immediate sanctions. Until September 1998, HCFA's definition of a poorly performing home was so narrow that it excluded many nursing homes that had repeated deficiencies causing actual harm to residents. In our earlier report on California nursing homes, we found that 73 percent of homes cited repeatedly for harming residents did not meet HCFA's definition of a poorly performing facility. In the other states we visited, we also found instances of severe and repeated deficiencies that were not designated as poor performers and thus avoided immediate sanctions.

HCFA has since revised its definition to broaden the circumstances under which a nursing home could be designated as a poorly performing facility. The new definition includes homes with any deficiencies rated H or higher in the scope and severity grid on its current survey and in its previous

[17]It was beyond the scope of our work to review negotiated settlements or adjudicated appeals in detail. However, because regulations provide for an automatic reduction of 35 percent in the penalty amount if a home waives its appeal rights, a home would have a financial incentive to appeal only if it expected to realize a greater reduction or other advantage, such as a lengthy delay.

standard survey or any intervening survey (including complaint investigations). HCFA said it would expand the definition in 1999 to include deficiencies rated G.

The revision, however, narrowed the definition in certain other respects, such as shortening the period during which deficiencies could be considered from the previous two surveys to the most recent one. The revised definition also excluded F-rated deficiencies (widespread potential for more than minimal harm) from consideration of poorly performing facility status. Because the changes are so recent, it is too early to tell what their effect will be on the number of homes designated as poor performers.

A second area—which HCFA has not addressed—involves referral of homes cited for deficiencies that contributed to the death of a resident. We found several examples where state surveyors cited the deficiency during a complaint investigation that took place some time after the incident and found that the deficient practice contributing to the death had ceased at the time of the investigation. Under HCFA policy, such deficiencies corrected at the time of the investigation are considered "past noncompliance" and are to be cited as isolated actual harm, level G in HCFA's scope and severity grid. HCFA does not require homes with level-G deficiencies to be referred for sanctions. As a result, homes cited for deficiencies so severe that they contributed to resident deaths may not be referred to HCFA for sanctions at all. By allowing these homes to escape immediate sanction, much of the ability to deter future noncompliance is lost. Table 7 shows examples of homes that were not referred for immediate sanction.

Table 7: Examples of Deficiencies Contributing to Resident Deaths Not Referred to HCFA for Immediate Sanction

State in which nursing home is located	Summary of deficiency
Michigan	The home failed to follow its written policies and procedures designed to protect residents. As a result, the home failed to prevent a confused resident from leaving unaccompanied and was unaware that the resident was absent for several days. During this period, the resident was stabbed to death. Facility staff noted that the resident's bed was empty during a midnight bed check, but no one verified the patient's whereabouts. Three days later, the resident's family returned from a holiday weekend and learned about the homicide from the police. The family notified the nursing home, which had not reported the missing resident to the police or the state survey agency.
Michigan	The home failed to follow a plan of care and physician's orders to monitor every 30 minutes a confused resident restrained in bed. As a result, the resident climbed out of bed, became entangled in the restraint, and died of asphyxia due to chest compression. The resident was found suspended from the vest restraint intended to keep her from leaving the bed.
California	The home failed to protect a resident from abuse by another resident. The assaulted resident suffered a head injury and later died. The home compounded the situation by not promptly notifying the resident's attending physician of his deteriorating condition and by failing to notify the state agency of the death as required by law.

After Readmission, Terminated Homes Receive a Clean Slate, but Some Continue Old Behaviors

Another group of homes that can largely avoid the threat of immediate sanction even though they exhibited a pattern of recurring and serious noncompliance are those that have been terminated from Medicare and subsequently readmitted. After a terminated home has been readmitted in Medicare, HCFA policy prevents state agencies from considering the home's prior record in determining if the home should be designated as a poorly performing facility, effectively giving the home a "clean slate." This policy produces the disturbing outcome that termination could actually be advantageous to a home with a poor history of compliance because this history would no longer be considered in making enforcement decisions after it was readmitted to Medicare. Given the continuing spotty performance we found among those homes in our sample that had been terminated and subsequently reinstated, this policy merits reexamination.

Two other aspects of HCFA's use of termination also limit its effectiveness. First, HCFA typically paid terminated homes in our sample for 30 days after termination regardless of whether transfers of patients were under way.[18]

[18]Medicaid regulations expressly condition this payment on reasonable efforts being made to transfer patients during this 30-day period. Continued Medicare funding during this period is discretionary with HCFA.

This policy in effect gives terminated homes 30 extra days of payment while they seek reinstatement. Second, HCFA generally used a short "reasonable assurance period"[19] to determine if homes seeking reinstatement to Medicare had corrected their problems and were otherwise complying with the standards. While HCFA can make this period last up to 180 days, the homes we examined were given reasonable assurance periods of 15 to 60 days—a shorter period that provides less assurance that homes can sustain long-term compliance.

Despite Recent HCFA Proposals to Make Sanctions More Effective, Additional Steps Are Needed

Recent actions taken or proposed by HCFA to improve nursing home oversight can help make sanctions more of a deterrent against continued noncompliance, but on their own they are not enough to fully address the problems we identified. HCFA began a series of actions in response to our earlier report on California nursing homes and its own July 1998 report to the Congress summarizing a 2-year study of nursing home regulation.[20] These actions address a number of problems we identified in our earlier report but do not resolve all of them or additional problems we have identified through our ongoing work. Further, weaknesses in HCFA's management information systems will continue to limit HCFA's ability to implement its initiatives and further strengthen its enforcement processes.

HCFA Initiatives Leave Problem Areas Unresolved

In July 1998, HHS announced several actions that HCFA would take to toughen enforcement of nursing home regulations, particularly focusing on homes with serious and repeat deficiencies. The actions include plans to expand the definition of "poorly performing facility" to include more homes with repeat deficiencies that harmed residents. HCFA also directed that the results of an intervening survey, such as complaint investigations, be considered in determining whether a home should be designated as "poorly performing." The actions also called for increased survey frequency for homes with the most chronic compliance problems and focusing enforcement efforts on nursing homes in chains that have a record of noncompliance with federal rules. With regard to the problems we have identified in this report, however, HCFA's actions leave several issues unresolved. HCFA may be able to resolve one of the issues (the

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

[20]HCFA, Report to Congress: Study of Private Accreditation (Deeming) of Nursing Homes, Regulatory Incentives and Non-Regulatory Initiatives, and Effectiveness of the Survey and Certification System (July 1998).

backlog of civil monetary appeals) if HHS' budget request for additional staff positions is adopted. However, there are no actions under way with regard to two other issues—referring homes for sanction in all cases where deficiencies contributed to the death of a resident and better using the deterrent effect of termination from the Medicare and Medicaid programs (see table 8).

Table 8: Sanction-Related Problems That Remain and Recent HCFA Initiatives

Sanction-related problems identified	Recent HCFA initiatives	GAO observations
Civil monetary penalties are hampered by a backlog of appeals	HHS' budget request for fiscal year 2000 includes additional funding to reduce the appeals backlog	The likelihood of obtaining additional funds is uncertain
Policies do not require states to refer all cases where deficiencies have resulted in a resident death to HCFA for sanction	None	Instances in which death resulted may not be referred to HCFA
Procedures for readmitting terminated homes limit the usefulness of terminating homes from the program	None	Expanded definition of "poorly performing facility" does not include homes that were terminated for poor performance and subsequently reinstated; other problems identified with these procedures still remain

HCFA initiatives also include a proposal to allow civil monetary penalties to be assessed on instances of noncompliance as an alternative to the number of days out of compliance. Since the proposed regulation had not been issued at the time we completed our review, we were not able to evaluate the extent, if any, that it could have on increasing use of civil monetary penalties.

Management Information Systems Have Limited Ability to Support Key HCFA Initiatives

HCFA's initiatives to focus more oversight on homes with serious and repeat noncompliance are likely to encounter obstacles due to three weaknesses in HCFA management information: the inability to centrally track enforcement actions, the lack of needed data on the results of complaint investigations, and the inability to identify nursing homes under common ownership.

HCFA Unable to Track Enforcement Actions

HCFA lacks a system that integrates federal and state enforcement information to help ensure that homes receive appropriate regulatory

attention. Such a system would track key information about steps taken by HCFA offices and the states, such as verification that deficiencies were corrected or sanctions imposed. Although HCFA's Online Survey, Certification, and Reporting (OSCAR) system was developed for this purpose, we learned that the system's information was incomplete and inaccurate because states and HCFA have not consistently entered data into OSCAR. We found that the HCFA regions and states that we visited maintain and use their own systems, not OSCAR, to monitor enforcement actions. At the time of our initial inquiry, HCFA's regional systems ranged from manual paper-based systems to complex computerized programs, and none of the four states' tracking systems was compatible with OSCAR or the regional systems.

This lack of management information makes it difficult for HCFA's central office to coordinate and oversee the actions of its 10 regional offices, which are responsible for working with the states to administer the enforcement system. For example, officials in HCFA's central office were not aware that regions were frequently late in imposing the sanction of denial of payment for new admissions on nursing homes out of compliance for 3 months—a sanction mandated under HCFA regulation. The four HCFA regional offices we visited often missed the time frame and sometimes did not impose the sanction at all. Of the 241 enforcement actions we reviewed, 85 involved situations where payment for new admissions was not stopped, even though homes had been out of compliance for more than 3 months. In 61 of the 85 cases, the regional office imposed denial of payment an average of 24 days after the deadline. In the remaining 24 cases, the region never denied payments at all, despite these homes being out of compliance for an average of 156 days. When we discussed this problem with responsible HCFA headquarters staff, they were unaware of the extent of this problem. If HCFA's central office lacks adequate management information on the activities of its regional offices, it will be unable to monitor whether they are properly carrying out HCFA's initiatives.

Data on Complaint Investigation Results Inadequate

A second area in which HCFA lacks adequate information is the results of complaint surveys. HCFA does not require states to cite violations of federal standards if the deficiencies were found during complaint surveys or to ensure that if such deficiencies are cited, they are reported to HCFA. One of the four states we reviewed based its decisions to refer homes to HCFA for sanctions solely on the results of the surveys.[21] California did not report

[21]HCFA officials told us that New York and Louisiana also do not report results of complaint investigations to HCFA.

the results of complaint investigations to HCFA; instead it chose to deal with the homes under the state's licensing authority. These practices leave HCFA without full information about nursing homes' compliance status with Medicare and Medicaid standards. In September 1998, HCFA modified its guidance to states to stipulate that any federal deficiencies cited during complaint investigations must be used in determining if a nursing home is a "poorly performing facility."

The situation in California exemplifies how this lack of information limited HCFA's ability to get a full picture of a home's compliance with Medicare and Medicaid standards. California surveyors usually do not cite federal deficiencies when they find violations in complaint investigations.[22] As a result, California does not recommend, and HCFA has no basis to impose, federal sanctions on deficient nursing homes resulting from complaint investigations.

In many instances, substantiated complaint investigations disclosed severe deficiencies that were not part of the record referred to HCFA. For example, one home had 61 complaints between September 1995 and July 1998. State investigators substantiated violations in 30 of these complaints, some of which resulted in actual harm and placed residents in immediate danger, such as abuse of a resident by a staff member and failure to prevent or treat pressure sores. The state agency levied fines totaling $80,000 under its licensing authority but did not cite any federal deficiencies although many of its findings clearly violated Medicare and Medicaid standards. The home's surveys did not document major problems. As a result, HCFA remained unaware of this home's compliance problems.

HCFA Unable to Identify Homes Under Common Ownership

The third weakness with HCFA's management information is the lack of data about homes with common ownership that are having severe compliance problems. Chain-owned nursing homes, a significant and growing segment of the nursing home industry, often cross state and regional boundaries. Effective oversight requires an information system that will be able to identify which chains have experienced severe compliance problems. However, HCFA tracks enforcement actions by individual facility provider number only. Consequently, regulators considering enforcement actions against a chain provider in one part of the state or country cannot easily determine the extent to which the problems they have identified are reflective of a broader pattern within the chain.

[22]California surveyors cite deficiencies and impose fines under state licensing requirements. In June 1998, California changed its procedures to cite federal deficiencies for substantiated complaints.

To illustrate the impact of this lack of ownership information, we identified a chain provider and linked the records on the provider by three available sources: HCFA, states, and fiscal intermediaries.[23] The linking showed that the chain provider had a disproportionate number of enforcement actions relative to other homes in the same states. In Texas, the provider owned about 11 percent of the nursing homes but accounted for over 18 percent of the state's enforcement actions, including 25 percent of the state's immediate jeopardy cases and 25 percent of the poorly performing facilities. In Michigan, where the chain owned eight facilities, six of the eight had a total of 27 separate enforcement actions. Despite multiple enforcement actions against these homes, Michigan and HCFA regional officials were unaware that the Michigan homes had a common owner or of the problem history of the owner's facilities in Texas. In discussing this finding with HCFA officials, they noted that this example clearly demonstrated the need for information on common ownership. The inability to identify and track homes by chain could pose an immediate limitation on HCFA's recent initiative to direct more enforcement efforts toward nursing home chains. To be successful in this initiative, HCFA needs to ensure that it can identify and track homes with common ownership.

Conclusions

Despite reforms to ensure that nursing homes maintain compliance with federal quality standards, one-fourth of all homes nationwide continue to be cited for deficiencies that either caused actual harm to residents or carried the potential for death or serious injury. This pattern has not changed since the July 1995 reforms were implemented. Although the reforms equipped federal and state regulators with many alternatives and tools to help promote sustained compliance with Medicare and Medicaid standards, the way in which states and HCFA have applied them appears to have resulted in little headway against the pattern of serious and repeated noncompliance. Such performance may do little to dispel concerns over the health and safety of frail and dependent nursing home residents.

The enforcement system we observed still sends signals to noncompliant nursing homes that a pattern of repeated noncompliance carries few consequences. HCFA's recent actions, such as broadening the definition of a "poorly performing facility," are a step in the right direction. However, four key problems we identified remain in need of attention. First, if the backlog of civil monetary penalties is not reduced, much of the deterrent effect of this sanction will continue to be lost. Second, weaknesses remain in the deterrent effect of termination, including the lack of a tie to "poorly

[23]Fiscal intermediaries are contractors who process Medicare claims for HCFA.

performing facility" status for reinstated homes and the limited "reasonable assurance period" for monitoring terminated homes before reinstating them. Third, under HCFA guidance, states are not required to refer for sanction all homes with deficiencies that contribute to resident deaths. And finally, the changes do not address the need for HCFA to improve its management information system. HCFA's ability to improve its oversight of nursing homes will depend heavily on whether it has the information to identify and monitor those homes that pose the greatest risk of harm.

Recommendations to the Administrator of HCFA

To strengthen its ability to ensure that nursing homes maintain compliance with Medicare and Medicaid quality-of-care standards, we recommend that the Administrator of HCFA take the following actions:

- Improve the effectiveness of civil monetary penalties. The Administrator should continue to take those steps necessary to shorten the delay in adjudicating appeals, including monitoring progress made in reducing the backlog of appeals.
- Strengthen the use and effect of termination. The Administrator should (1) continue Medicare and Medicaid payments beyond the termination date only if the home and state Medicaid agency are making reasonable efforts to transfer residents to other homes or alternate modes of care, (2) ensure that reasonable assurance periods associated with reinstating terminated homes are of sufficient duration to effectively demonstrate that the reason for termination has been resolved and will not recur, and (3) revise existing policies so that the pre-termination history of a home is considered in taking a subsequent enforcement action.
- Improve the referral process. The Administrator should revise HCFA guidance so that states refer homes to HCFA for possible sanction (such as civil monetary penalties) if they have been cited for a deficiency that contributed to a resident's death.
- Develop better management information systems. The Administrator should enhance OSCAR or develop some other information system that can be used both by the states and by HCFA to integrate the results of complaint investigations, track the status and history of deficiencies, and monitor enforcement actions.

Agency Comments and Our Response

We obtained comments on our draft report from HCFA and the four states that we visited. HCFA, California, Michigan, and Pennsylvania commented in writing (see app. II through app. V); Texas provided oral comments. In

general, HCFA and the states concurred with our findings and recommendations and cited steps being taken to strengthen enforcement of Medicare and Medicaid requirements. They also suggested technical changes, which we included in the report where appropriate.

HCFA commented that our findings underscore the need for the agency's recent initiatives and will help sharpen the focus on areas that still need to be addressed. In its response (see app. II), HCFA generally agreed with our four recommendations and cited specific steps that it was planning to address them. HCFA concurred with our recommendation to shorten the delay in adjudicating appeals but also noted that it does not oversee the department's appeals board. HCFA pointed out that the President's fiscal year 2000 budget includes funds to double the number of administrative law judges that hear appeals for the board. We recognize that HCFA does not have administrative oversight of appeals board activities, but it does have the key role in monitoring and evaluating the effectiveness of civil monetary penalties as a sanction. Our recommendation was made with this latter role in mind.

Regarding our recommendation for a better management information system, HCFA stated that a major system redesign is being undertaken. HCFA stated that the redesign was a long-term project but that it had plans for interim steps to make the existing system more useful to both state and HCFA offices. Also, concerning our recommendation to improve its referral process, HCFA indicated that it would reiterate to the states the need to use civil monetary penalties in serious cases of past noncompliance.

HCFA also concurred with two specific steps that we recommended to strengthen termination as a sanction but did not concur with the third—using a longer reasonable assurance period before reinstating the home. HCFA pointed out that a long reasonable assurance period would not be appropriate if the home were terminated because it ran out of time correcting a minor deficiency that was corrected shortly after termination. This recommendation was based on evidence that a short reasonable assurance period appears to be given without attention to a home's past performance. For example, four of the six reinstated homes in our sample were given reasonable assurance periods of 30 days or less. Most had repeated and serious deficiencies—those causing actual harm to patients. Our earlier work in California also showed that reinstated homes were often cited soon after reinstatement with new deficiencies that harmed residents. The intent of this recommendation is to help accomplish the stated purpose of the reasonable assurance provision—that there be some

assurance that the cause for termination has been removed and will not recur. In response to HCFA's comment, we revised the recommendation to clarify this intent.

While in agreement with our recommendations, California's comments recommended additional steps, such as enhanced funding to the states, that would help strengthen nursing home oversight (see app. III).

Michigan's comments largely focused on the implementation of initiatives taken in 1998 to correct problems that we discuss in the report. Michigan particularly highlighted its resident protection initiative, designed to monitor facility corrective action and performance both before and after the state determines the facility has achieved substantial compliance. It emphasizes such sanctions as directed plans of correction and state monitoring—steps the homes must pay for themselves. We were aware of this initiative, which had become operational shortly before our visit in June 1998, and have revised the report where appropriate to reflect this initiative. However, data on its effectiveness in creating incentives for homes to maintain compliance with the standards were not available at the time we conducted our work. The results of future surveys will be needed to assess the initiative's success.

We also provided a copy of the report for review by the American Health Care Association (AHCA) and the American Association of Homes and Services for the Aging (AAHSA). AHCA officials expressed agreement with the report's recommendations. They did express concern, however, about our sample size and methodology for selecting homes for detailed review. In selecting 74 homes that states had referred to HCFA for enforcement action, we focused on homes with serious and often repeat deficiencies. Our rationale in selecting these homes was if we found that such homes had been effectively dealt with, there might be some assurance that the system was at least addressing the worst problems. However, we did not find that the enforcement process was working as effectively as it should, even for these homes. Both AHCA and AAHSA also pointed out that deficiencies cited as actual harm (level G) on HCFA's scope and severity grid may represent broad variation in seriousness and, by definition, refer to isolated situations that affect one or a very limited number of residents, with some citations appearing to be less serious than others. We acknowledge that there may be variation in the seriousness of actual harm violations but also found in the course of our work that a G-level citation most often involved serious resident care issues and at times did affect more than one resident.

Copies of this report are also being sent to the Administrator of HCFA and other interested parties. If you or your staff have any questions about this report, please contact me or Kathryn Allen, Associate Director, at (202) 512-7114. This report was prepared by Margaret Buddeke, Peter Schmidt, Terry Saiki, Stan Stenersen, and Evan Stoll under the direction of Frank Pasquier.

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

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Tables

Abbreviations

AAHSA	American Association of Homes and Services for the Aging
AHCA	American Health Care Association
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OBRA	Omnibus Budget Reconciliation Act
OSCAR	Online Survey, Certification, and Reporting

Scope and Methodology

To determine the extent to which nursing homes maintain compliance with federal standards, we analyzed HCFA's nationwide database of nursing home inspections—the Online Survey, Certification, and Reporting (OSCAR) system. This data system records the results of states' recertification surveys in standard format. The format changed to recognize the deficiency scope and severity classifications made effective by the July 1995 final enforcement regulations. As a result, analysis of the scope and severity of nursing home deficiencies is inherently limited to periods after July 1995. Accordingly, the period of our analysis included surveys done from July 1995 through October 1998. We restricted our analysis to the 187 nursing home requirements for participation in Medicare and Medicaid categorized as related to patient care. Therefore, our analysis did not include data on compliance with safety code standards, such as fire protection and physical plant requirements.

In addition to using these data to analyze the extent to which homes comply with the standards, we used the data to determine the most frequently occurring deficiencies and their relative severity. In order to compare nursing homes' performance in achieving and maintaining compliance over time, we used OSCAR data to identify the earliest recertification survey performed after the regulations became effective compared to the homes' most current surveys. To do this, we used data from a facility's first survey during the period July 1, 1995, to December 31, 1996, which became part of the "base" period. Data from the latest survey since January 1, 1997, became part of the "current" period. For some nursing homes, there was an intervening survey, but we did not use data from these surveys.

Although we did not thoroughly assess the reliability of the OSCAR database, for purposes of analyzing findings of nursing home recertification surveys, HCFA officials as well as private researchers who work with the database generally recognize the data as reliable. Even though the data are considered reliable for recertification deficiencies reported by the states, the extent to which they provide a consistent measure of the quality of care across states is unknown. Nevertheless, OSCAR data contain omissions that likely understate the extent of deficiencies found during other surveys by state inspectors. For example, in California, serious violations found during complaint investigations conducted by state inspectors were not routinely shown in OSCAR and appear to be understated in national data as well.

To determine the extent to which the new sanctions contribute to nursing homes' sustained compliance, we were unable to use OSCAR to perform a similar nationwide analysis. We found that OSCAR does not contain complete or reliable data on enforcement actions, such as the extent to which sanctions are imposed, and no other system exists that provides such nationwide data. For this reason, we relied on enforcement monitoring databases from the four HCFA regional offices we visited.

Thus, to obtain information about the effectiveness of sanctions in deterring future noncompliance, we had to gather available data on enforcement actions from states and HCFA's regional offices. In general, we used a two-step process. First, we looked at the extent to which states were referring cases of noncompliance to HCFA for enforcement sanctions. Second, we reviewed a sample of cases where states had recommended to HCFA that sanctions be imposed. We selected 4 of HCFA's 10 regional offices—Philadelphia (region III), Chicago (region V), Dallas (region VI), and San Francisco (region IX)—for further review. We selected these four regions because they are geographically dispersed and contain about 55 percent of the nation's nursing homes. Within each region, we selected one state—Pennsylvania, Michigan, Texas, and California, respectively—in which to gather additional information on specific providers and chains. We selected these four states because they had substantial numbers of nursing homes that accounted for about 23 percent of the nation's nursing homes.

At the states, we reviewed procedures for referring cases to HCFA; discussed these procedures with each state's ombudsman; and where appropriate, reviewed selected case files to obtain a better understanding of procedures in place. At each of the four HCFA regional offices, we used HCFA regional enforcement records to identify nursing homes that had scope and severity designations of G or higher for which the state survey agencies had forwarded to HCFA survey files with recommendations for sanctions. From these records, we selected a sample of enforcement cases to review. The sample was not designed to be representative of the universe of enforcement actions. Rather, it was designed to give us a sufficient number of cases where different types of sanctions, including termination, were possible. We then reviewed these case files with an eye toward determining the implemented sanction's strength or weakness as a deterrent to future noncompliance. Accordingly, we focused the sample on nursing homes, including known chain providers that had multiple referrals by state agencies to HCFA for enforcement or had been terminated.

In all, we selected 74 separate nursing home providers. These providers accounted for 241 enforcement actions between July 1995 and October 1998 (see table I.1). These enforcement actions consisted of both recertification surveys and other abbreviated surveys (follow-up or complaint) where the state had referred cases to the HCFA regional office for sanctions.

Table I.1: Summary of Nursing Home Selection for GAO Review

HCFA region	Regional office location	State visited	Number of nursing homes reviewed	Number of HCFA enforcement actions
III	Philadelphia	Pennsylvania	17	44
V	Chicago	Michigan	18	81
VI	Dallas	Texas	27	96
IX	San Francisco	California	12	20

To determine the extent to which HHS' actions were sufficient to ensure sanctions were applied in a timely and effective manner, we reviewed the actions announced by HCFA from July through November 1998 that concerned enforcement of nursing home standards. As such, proposed changes to the nursing home survey and certification process were outside the scope of our review. We also reviewed the extent to which adequate management information systems existed to support and oversee HCFA's revised initiatives to strengthen its enforcement process. This included an examination of record formats in OSCAR, HCFA's regional office tracking system, and state nursing home compliance systems.

We also reviewed HCFA regulations, policies, and guidance; interviewed officials in HCFA's headquarters and regional offices; and interviewed state survey agency officials. We also interviewed representatives from industry groups and advocacy groups and academic researchers. Our Office of the General Counsel, in consultation with HCFA attorneys, provided legal guidance on our interpretation of relevant OBRA 87 provisions.

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

Office of the Administrator
Washington, D.C. 20201

MAR 1 1 1999

FROM: Nancy-Ann Min DeParle
Administrator, HCFA

SUBJECT: General Accounting Office (GAO) Draft Report, "Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards"

TO: William J. Scanlon, Director
Health Financing and Systems Issues, GAO

We appreciate the opportunity to review your draft report to Congress concerning enforcement of federal nursing home standards. We agree with most of the report's findings that HCFA should continue efforts to strengthen its ability to ensure that nursing homes maintain compliance with Medicare and Medicaid quality-of-care standards.

We are enclosing our comments to the specific recommendations. We look forward to working with GAO and the Congress as we further our commitment to protecting the health and safety of beneficiaries residing in nursing homes.

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

Comments of the Health Care Financing Administration (HCFA)
on the General Accounting Office (GAO) Draft Report,
"Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards"

In July 1998, the Clinton Administration announced a broad and aggressive new initiative to improve enforcement of nursing home regulations. This General Accounting Office (GAO) report, which examines conditions in nursing homes over a period from July 1995 to October 1998 (just after the new initiative was launched), underscores the need for this initiative and will help sharpen our focus on areas that need to be addressed. We generally concur with the report's four specific recommendations, and are already taking actions to address them.

There has been substantial improvement in nursing home quality since 1995, when the Clinton Administration began enforcing the nation's toughest-ever enforcement regulations. However, our July 1998 Report to Congress and a July 1998 GAO report made clear that more needed to be done. That is why, building on the earlier reforms, the President in July 1998 unveiled an aggressive initiative to further strengthen enforcement and assure quality care.

We are pleased that the current GAO report recognizes our efforts to address problems both we and the GAO identified last year. We agree that further refinements to our enforcement initiative are needed. And we remain committed to taking appropriate steps to ensure that nursing home residents are safe and receive quality care, and we will continue to work with the States, Congress, residents and their families, resident advocacy groups, and nursing home providers to advance this essential mission. We would like to note that, since the time period analyzed in the current GAO report, we have implemented many aspects of our new enforcement initiative:

Faster Remedies

As part of the President's nursing home initiative, and as mentioned in this report, HCFA has expanded its definition of the type of facility for which HCFA would take an immediate enforcement action without a grace period (i.e., an opportunity for the facility to correct before sanctions are imposed). We previously labeled these facilities as "poor performing facilities (PPFs)". However, we are now revising our guidance to remove this label, and provide, in its place, direction about when facilities will be given an

opportunity to correct. The guidance will make the assumption that unless a facility has no actual harm on the current survey it would not automatically be given an opportunity to correct before sanctions are imposed. Because facilities have no right to a period of correction prior to the imposition of sanctions, there could be other instances where facilities would not be given such an opportunity; for example, where a facility's pre-termination history indicated no commitment to achieve and maintain compliance with participation requirements, we believe it would be appropriate to impose sanctions immediately.

Enhanced Enforcement Training
HCFA has been vigorous in encouraging States to apply appropriate sanctions for the noncompliance identified in the President's initiative. We will be providing training and guidance to States beginning this Spring on the nursing home initiatives including enforcement, use of quality indicators in the survey process, survey tasks in the areas of medication review, pressures sores, dehydration, weight loss, and abuse prevention.

Enhanced Oversight of Selected Facilities
HCFA has identified facilities in each State for more frequent inspection and intense monitoring. In selecting these special focus facilities (SFFs), HCFA scored each nursing home based on the results of its most recent annual inspection and any substantiated complaints during the past 2 years. HCFA presented each State survey agency with the names of those homes that generated the highest scores. States selected two facilities and have begun to monitor them more frequently.

Baseline data has been collected on each facility and monthly status reports are required. The monthly status report includes any survey outcomes, complaint investigations, enforcement actions, or press attention for each facility. The purpose of more intense monitoring of these facilities is to determine whether or not closer scrutiny and imposition of immediate remedies will have a lasting effect on these homes, i.e., whether the "yo yo" compliance history is affected. HCFA will conduct systematic analysis to determine if more intense monitoring is effective and if there are innovations with monitoring these facilities which can be used in the overall program.

Stronger Federal Oversight
HCFA has initiated a national program for improving the accuracy and consistency of State survey results. In October 1998, a standardized system for evaluating State survey performance was implemented. The Federal Oversight and Support Survey (FOSS) is a structured protocol for HCFA staff to use onsite in assessing the State survey teams' adherence to Federally mandated procedures and policies. Where training needs or corrective actions are identified, HCFA staff works with the State to assure that the necessary changes are implemented. We expect that this more standardized and

aggressive approach to oversight will improve national consistency in the performance of nursing home surveys.

Quality of Care Enhancements
HCFA is in the process of implementing a wide range of initiatives to improve its ability to detect and prevent bed sores, dehydration, and malnutrition in nursing homes. In conjunction with national experts in nursing home care and quality indicator development, HCFA is developing a systematic data driven process for assessing quality problems in nursing homes. This data driven surveillance system will use indicators of potential care problems for facility residents to identify a sample for more in-depth on-site assessment including a larger sample to review for weight loss and pressure sores. National roll outs of this systematic approach are expected to be completed by the end of 2000 with an interim enhancement to the survey process implemented in 1999. In addition, HCFA staff are working with the American Dietetic Association, clinicians, consumers and nursing homes to share best practices for residents at risk for weight loss, dehydration, and pressure sore development. This includes better guidance and training for surveyors on standards of care practices. A national campaign to educate residents, families, other consumers, and nursing home staff about the risks of malnutrition and dehydration as well as nursing home residents' rights to quality care in nursing homes will begin this year.

Abuse Prevention Campaign
Over the past 8 months, HCFA has concentrated efforts on the reduction of abuse and neglect in facilities. A national abuse and neglect forum consisting of representatives from groups concerned with the frail elderly and disabled has been formed. A survey protocol developed through the forum workgroup for evaluating nursing homes' abuse and neglect prevention processes will be implemented nationally by July 1999. A national consumer education campaign on prevention and detection will also be inaugurated in 1999.

Management Information System
HCFA is in the process of a major redesign and enhancement of its information system for nursing home quality. The goal is to implement in stages a system that is both user friendly for HCFA, State survey agencies, providers and consumers, and includes information necessary for nursing home quality of care evaluation and improvement. In June 1998 the first segment of this information system began with the development of State and national repositories with resident-specific data on declines and improvement (Minimum Data Set (MDS) longitudinal data). In July 1999, HCFA will start using quality indicators developed by national experts to analyze MDS data and identify domains of potential care problems. These quality indicator reports will be available to HCFA and State survey agencies for enhancing the survey system as well as to providers

for internal quality improvement activities. In addition, in July 1999, an improved system for information collection, consolidation, and integration will be available to State survey agencies. State staff and managers will be able to generate, for individual facilities, tables that include relevant survey results as well as quality indicator information. This improved information system will enhance States' ability to assess the overall performance of an individual nursing home and to better manage survey resources. Future stages of the improved information system on facility quality will include: enhancement to the State systems on enforcement actions; major revisions to the current On-line Survey, Certification and Reporting (OSCAR) system to provide better and more integrated national information in a more user friendly environment; consumer information on quality indicators; updated quality indicators; and better national enforcement data. HCFA will proceed as quickly as possible with development of its improved information system for nursing home quality although there will be some delays attributable to Y2K priorities.

Consumer Information

HCFA is working to make survey results more accessible to the public. HCFA's new internet site -- Nursing Home Compare -- gives families and consumers direct Internet access to comparative information about nursing homes as well as provides incentives for nursing homes to improve the quality of care. Since the site was established last September, approximately 826,000 pages have been viewed and we are working with consumers, industry and others to make it more useful to consumers and their families. These and other such projects reflect HCFA's commitment to improving care in nursing homes through better information, education and enforcement.

Budget

In support of the nursing home initiatives, Congress appropriated $4 million to the $118.7 million in Medicare survey and certification funds requested for fiscal year (FY) 1999. And in order to ensure adequate funding of these efforts, the Clinton Administration intends to reprogram $4 million from other activities so that a total of $126.7 million will be directed to the nursing home related survey, certification and enforcement initiatives for FY99. These funds are being used primarily to support key improvements in state survey processes, including:

- staggering the beginning of at least 10% of the annual surveys during the morning and evening hours and on weekends;
- providing enhanced monitoring of those nursing homes who past compliance and complaint survey records indicate a poor history of compliance;
- revising the definition of and targeting nursing homes in which actual harm was found in the current survey and in either the last standard survey or an intervening complaint survey and;

- altering the survey protocol and resident sample selection in a way that identifies residents more susceptible to abuse and to having health problems associated with the lack of proper nutrition and hydration.

The Administration has proposed to expand its nursing home survey, certification and enforcement related funding in the FY2000 budget request to $135.9 million, an increase of $9.2 million over the FY 1999 funding. With the approval of this funding, HCFA envisions making significant gains in improving the care of beneficiaries and in providing the oversight necessary to assure that all are working toward this common goal.

GAO Recommendation

To strengthen its ability to ensure that nursing homes maintain compliance with Medicare and Medicaid quality-of-care standards, we recommend that the Administrator of HCFA take the following actions:

-- Improve the effectiveness of civil money penalties. The Administrator should continue to take those steps necessary to shorten the delay in adjudicating appeals, including monitoring progress made in reducing the backlog of appeals.

HCFA Comment

We concur. We should note, however, that the Health Care Financing Administration (HCFA) does not oversee the Departmental Appeals Board (DAB), which is housed in the Office of the Secretary of the Department of Health and Human Services. However, HCFA supports the Secretary's efforts to increase resources at the DAB in an attempt to improve the effectiveness of the civil money penalty (CMP) sanctioning process. The DAB operates independently from HCFA but its workload has increased substantially as a result of OBRA 1987 and we expect it to continue to increase in view of our new enforcement efforts. In the fiscal year (FY) 2000 budget, the President has proposed to double the number of Administrative Law Judges at the DAB. Since providers are entitled to a DAB hearing before CMPs can be collected, we are hopeful that doubling the number of judges will help with the processing of appeals, which may thereby improve the effectiveness of CMPs specifically, and our enforcement efforts overall.

As announced last July, we are developing a new regulation which will allow States to impose CMPs for each instance of a violation regardless of the amount of time the facility was out of compliance with requirements. This additional enforcement option will give States greater flexibility to assess penalties quickly.

5

Recommendation

-- Strengthen the use and effect of termination. The Administrator should (1) continue Medicare and Medicaid payments beyond the termination date only if the home and State Medicaid agency are making reasonable efforts to transfer residents to other homes or alternative modes of care, (2) use longer "reasonable assurance periods" before reinstating terminated homes, and (3) revise existing policies so that the pre-termination history of a home is considered in taking a subsequent enforcement action.

HCFA Comment

(1) Continue Medicare and Medicaid payments beyond the termination date only if the home and State Medicaid agency are making reasonable efforts to transfer residents to other homes or alternative modes of care.

We concur. As noted in the draft, existing Medicaid regulations provide that Federal Financial Participation (FFP) for institutional services may be continued for up to 30 days after the effective date of termination if the Medicaid residents were admitted to the facility before the effective date of termination ***and*** if the State is making reasonable efforts to transfer those residents to other facilities. Under current rules and procedures, Medicare also makes funds available but does not explicitly require a State's effort to transfer residents.

While HCFA's guidance to the States about resident transfers at §3008.2 of the State Operations Manual, reiterates the regulatory language and provides operational guidance about relocation considerations and activities, it does not currently include a Federal oversight component of States' transfer efforts. HCFA agrees that Medicaid facilities should not be automatically paid for 30 additional days of care for the residents after termination of the facility from the program unless reasonable efforts to transfer residents are being made.

Since the GAO findings indicate that there may be inconsistent and inappropriate application of this rule, HCFA will conduct a baseline study of the 30 involuntary terminations taken last fiscal year. In addition, we will assess whether procedures should be available for Medicare payment beyond termination if it is necessary. The study will determine what resident transfer procedures the States and the facilities put into place over the 30 days following termination, if any. HCFA will determine if oversight and payment practices and policies existed and if they were (and are) being applied appropriately and consistently. HCFA will also attempt to determine what happened subsequently to the facility, e.g., facility closed and ultimately transferred the residents;

facility stayed open and paid for care of the residents not transferred; facility sold to others, etc. Based on the findings, HCFA will take action as determined to be appropriate.

(2) Use longer "reasonable assurance periods" before reinstating terminated homes.

We do not concur. While we appreciate and agree with the GAO's concern that terminated homes are sometimes readmitted by States too quickly, we do not believe that arbitrarily requiring a longer "reasonable assurance" period for all facilities would give HCFA and the States the flexibility they need to administer the Medicare and Medicaid programs. We also question whether the scope of the problem is as significant as GAO suggests.

Currently, HCFA's State Operations Manual provides States with several examples to assist in determining the length of a reasonable assurance period. The reasonable assurance period can be anywhere from one to six months. This guidance recognizes that there may be situations where HCFA terminated a nursing home from the Medicare program for failure to correct its deficiencies within the statutorily required 6-month period, and for which a long reasonable assurance period would not necessarily be in the best interest of the nursing home residents or the State. For example, a facility had a physical environment deficiency which caused no actual harm, ran out of time to correct it, was involuntarily terminated, and then subsequently fixed the problem. In this case, HCFA may choose a short reasonable assurance period because of the type of deficiency which caused the involuntary termination. There also may be instances where the nursing home is in an underserved or rural area where there may be limited access to care.

We also note that under current law there is no parallel requirement for reasonable assurance for Medicaid facilities. That requirement was removed by OBRA 1987. To the extent that this is a problem in the majority of nursing homes, we are willing to discuss reasonable assurance in more detail if the Congress wants to examine this issue further.

(3) Revise existing policies so that the pre-termination history of a home is considered in taking subsequent enforcement action.

We concur. While current Federal regulations at §488.404(c) and operating instructions at §7400 of HCFA's State Operations Manual provide that a facility's prior history of noncompliance may be considered in remedy selection, HCFA has not emphasized this factor. Thus, it is correct that, under current application of HCFA's rules, previously terminated nursing homes are able to re-enter the Medicare or Medicaid programs with a "clean slate" relative to past performance and, as such, are treated less aggressively than

other facilities for which termination did not become necessary. In order to eliminate the enforcement-related advantages that previously terminated facilities currently enjoy upon re-entry, we agree with GAO that pre-termination performance ought to be a factor in how that facility is treated subsequently upon re-entry. We will make explicit in our manual that these facilities will automatically be subject to immediate sanctions upon subsequent findings of noncompliance. States and HCFA regional offices track termination information, and we will work to ensure that the information is used systematically when subsequent enforcement actions are considered. We will further consider applying this policy to previously terminated homes that re-enter under new ownership.

GAO Recommendation

Improve the referral process. The Administrator should revise HCFA guidance so that States refer homes to HCFA for possible sanction (such as CMPs) if they have been cited for a deficiency that contributed to a resident's death.

HCFA Comment

We concur. It should be noted that States have authority to make their own remedy determinations and, unless otherwise mandated, such determinations are at their discretion. However, current guidelines authorize referral and imposition of CMPs for egregious violations, such as those that contribute to a resident's death, even if the problem has been corrected. In addition, the new CMP regulation we announced last July will give States the additional option of recommending fines for specific incidents, such as an instance of abuse or neglect that contributed to a resident's death. This would be an additional tool to address situations such as those cited in the report where a resident suffers harm due to a serious violation that is then quickly corrected. The cases cited by the GAO where referrals were made are disturbing and we need to reiterate to States that, under current law, there is a remedy for cases of past noncompliance and they should use it in appropriate situations. As we develop more comprehensive information systems, we will request that States report to HCFA when deaths occur for which no CMP is being imposed.

GAO Recommendation

Develop better management information systems. The Administrator should enhance OSCAR or some other information system that can be used both by the States and by HCFA to integrate the results of complaint investigations, track the status and history of deficiencies, and monitor enforcement actions.

8

HCFA Comment

We concur. We are undertaking a major redesign of these systems. Because this is a long-term project and because we must prepare to meet the Y2K computer challenge, we will soon be making some interim improvements to the current enforcement data system that will make the system more useful to the States and our Regional Offices as well as allow us to better monitor the enforcement actions. Secondly, software being implemented in July, 1999 will provide for a more user-friendly environment for tracking the status and history of deficiencies at the State level. This software will also automate the current requirement for collection by States of ownership information.

Although our current system provides for collection of survey information based on complaints for failure to meet federal requirements, States do not consistently report complaint data through this system. We will redirect States to adhere to federal requirements for reporting this information. However, many States have complaint investigation systems that exceed federal requirements and we have no authority to require that these data are reported to HCFA.

As we redesign our management information system we will revise the complaint module to assure that these data are fully integrated with the other information on facility performance.

Comments From California's Department of Health Services

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, *Governor*

DEPARTMENT OF HEALTH SERVICES
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March 9, 1999

Ms. Kathryn Allen
Associate Director
Health Financing and Public Health Issues
United States General Accounting Office
Room 5A14
441 G Street, NW
Washington, DC 20548

Dear Ms. Allen:

We appreciate the opportunity to submit California's written response to the General Accounting Office (GAO) report, "Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards." As stated previously, California takes seriously the shared responsibility with the federal government to promote the quality of care in nursing homes and takes pride in the work we do on behalf of nursing home residents.

California supports the recommendations in the GAO report and is ready to work with the Health Care Financing Administration (HCFA), Congress and all interested parties to ensure the appropriate degree of nursing home oversight. However, Congress must be aware that implementation of these recommendations requires the provision of adequate funding to HCFA and to the states. Although some funding has been provided to the states for the implementation of the President's initiatives, it is not adequate. This insufficient funding may result in the inability of the states to perform other types of oversight activities for such providers of health care as general acute care hospitals, ambulatory surgical centers, clinics, hospice centers, and home health agencies.

1) Additional Recommendations

The Congress has it within its power and authority to strengthen the effectiveness of nursing home oversight and thus improve the quality of care and quality of life in nursing homes in all states. We would like to make the following additional recommendations to the Congress, some of which were previously made in our comments to the report "California Nursing Homes: Care Problems Persist despite State and Federal Oversight":

- Congress must give HCFA the authority to prohibit a provider from becoming re-certified for a specified period of time after being terminated from the program.

- Congress must give HCFA enough funding to fully fund quality surveys as well as fund the ability of states to meet the statutory requirement that annual surveys are completed for each nursing home within a 12-15 month period. We recommend HCFA devote resources to determining the cost of a quality survey, not the "average" survey. Increasing the number of residents reviewed will increase state costs for conducting federal surveys, but will also

increase identification of life-threatening deficiencies in care practices.

- Congress must allow HCFA the flexibility to work with the states to determine the best method to investigate nursing home complaints. California, in conjunction with HCFA, Region IX, has implemented a revised complaint investigation procedure that facilitates the use of both state and federal complaint investigation procedures. The investigation begins using the state investigation process. If substandard quality of care, actual harm or immediate jeopardy is identified, an abbreviated standard survey per the federal process is done. We have found this is the most appropriate and cost-effective method to investigate the over 6900 nursing home complaint investigations done annually in California. This is shown in our recent experience with both the focused enforcement process and revised complaint investigation process in which abbreviated standard surveys are taking an average of 100 hours to conduct. The only alternative to providing this type of flexibility is to fully fund abbreviated standard surveys for every complaint investigation. Under the current federal grant, California is funded 14 hours for complaint investigations.

- Congress must provide HCFA with the funding needed to enhance the Online Survey and Certification Reporting (OSCAR) system to allow the states and HCFA to integrate the results of complaint investigations, track the status and history of deficiencies, and monitor enforcement actions. California has seen marked results of centralizing and implementing a database for the license application function for nursing homes. The purpose of the centralization of license applications was to identify and develop a database of current and prospective licensees whose compliance histories would make them undesirable to be licensed in California. As a result, California has denied licenses to two nursing home chains. An additional four nursing home chains requested licenses for a number of facilities. Based on their compliance history, each chain was granted one facility license that is provisional and may be revoked within 6 months of issuance if the entire chain is unable to maintain compliance.

1) Acknowledgements

California would like to acknowledge the courtesy and professionalism of the General Accounting staff. The OBRA survey and enforcement processes are complex and we were favorably impressed by their grasp its intricacies.

In addition, California would like to acknowledge HCFA and its dedication to promote the highest quality of care and quality of life for the nation's nursing home residents. We also acknowledge the tremendous budget, time, and staff constraints under which HCFA must operate.

We would also like to acknowledge the vast majority of licensed and certified nursing homes that provide dependable and excellent care, attending to the emotional and physical well being of residents. Without these facilities, many individual Californians and their families would be in dire straits, indeed. There is no question that a regulator's number one job is to cull willfully negligent and otherwise non-compliant licensees from the health care marketplace. At the other end of that spectrum, however, we are often able to promote improvements in quality of care and quality of life for nursing home residents by communicating the best practices in one facility to administrators and nursing staff in others. This would not be possible if there were no reputable and competent nursing home administrators.

Finally, California would like to acknowledge the family and friends of residents. It is their diligence and presence that continually drives improvement in the quality of care.

3) Recommendations for Clarification and Correction

We have attached an addendum in which we request that certain clarifications and corrections are made to the report.

4) Summary and Conclusion.

California welcomes and encourages both HCFA and the Congress to address further reforms to the nursing home survey and enforcement process. We recommend they work with the states to determine the best method to achieve further reforms, taking into account each state's unique characteristics and financial needs, while assuring the nation's nursing home residents receive consistently high quality services.

Sincerely,

Joseph P. Munso
Chief Deputy Director

Comments From Michigan's Bureau of Health Systems

State of Michigan
John Engler, Governor

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

Bureau of Health Systems

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March 10, 1999

Peter Schmidt, Ph.D., Senior Evaluator
Health Services Quality and Public Health Issues
U.S. General Accounting Office
441 G. Street NW
Washington, DC 20548

Dear Dr. Schmidt:

Re: State Agency Comments - Draft Report: NURSING HOMES Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards (GAO Code 108342)

Attached are comments from the Michigan Department of Consumer and Industry Services, Bureau of Health Systems regarding the above-referenced report.

In Table 7 (page 25), you provide two Michigan examples of deficiencies contributing to death of nursing home residents. We wish to review the first example in which the resident eloped and was stabbed. We are unable to find a case of a resident being stabbed. Please provide us with information so that we may review the case.

If you have questions, please contact me at (517) 241-2637.

Sincerely,

Gladys M. Thomas

Gladys M. Thomas, Ph.D., Director
Health Facility Licensing and Certification

Attachment

Michigan Relay Center (Voice and TDD) 1-800-649-3777

Michigan's Comments on Enforcement of Federal Quality Standards

March 9, 1999

Page 4. "Overall, our work showed that while HCFA has taken steps to improve oversight of nursing home care, it has not yet realized a main goal of its enforcement process--to help ensure that homes maintain compliance with federal health care standards."

Michigan Comments:

We agree that the goal of enforcement is to help assure that homes achieve and maintain compliance with standards over time. The choice of remedies under OBRA should be made with this goal uppermost.

In 1998, Michigan implemented its "Resident Protection Initiative" (RPI). Under the RPI, homes subject to early remedies (no grace period) have been expanded **beyond** the federal definition of "poor performer" and the early intervention remedies (other than federally required fines) have immediate effect and are not delayed by appeals; RPI remedies (other than federally required fines) relate **directly** to the cause of the non-compliance--including in-service training, directed plans of correction, bans on admission, state designated clinical or administrative advisors, and temporary managers. The remedies also have immediate financial impact on homes because they are paid for by the homes themselves--thus providing deterrence. Most important, the oversight required by the state-law RPI remedies extends **beyond** the date of "substantial compliance" to assure that the corrective actions sustain ongoing compliance.

The RPI uses the resources of the Michigan Public Health Institute (MPHI) to monitor facility corrective action and performance both before and after substantial compliance is achieved. MPHI is a special corporation created under state law to promote public-private collaboration to improve public health. The long term care program of MPHI provides health care expertise at facility expense as part of the RPI.

Page 5. "The threat of sanctions appeared to have little effect on deterring homes from falling out of compliance again, because homes could continue to avoid the sanctions' effect as long as they kept correcting their deficiencies."

Michigan Comments:

It is our view that it is not just the **threat** of sanctions that is important to acheiving sustained compliance, but the **type** of sanction that is used. The favored enforcment options should be those which (1) promote deterrance (prevention) by having a financial impact on the home quickly after a deficiency is found; (2) compel a home to address and correct the reasons for noncompliance in a professionally sound manner; and (3) assure that the corrective steps are maintained even after the date that "substantial compliance" is declared.

Michigan has employed denial of payment for new admissions and bans on admission as a favored sanction for homes needing early intervention, as well as directed plans of correction, directed in service training, and placement of approved clinical advisors and temporary managers at facility expense. Oversight continues for periods up to six months **after** substantial compliance is achieved to assure that systemic changes have been made.

Page 5. "HCFA has some tools to address this cycle of repeated noncompliance but has not used them effectively. Fine, or 'civil monetary penalties,' are the sanction with potentially a strong deterrent effect, because they can be applied even if a home comes back into compliance. However, the usefulness of civil monetary penalties is being hampered by a backlog of administrative appeals coupled with a legal provision that prohibits collection of the penalty until the appeal is resolved. In effect, the sanction is delayed for several years."

Michigan Comments:

We agree. That is why Michigan uses alternative remedies to address poor performers. In the first two years of OBRA, Michigan imposed more civil monetary fines than any other state in our region (Attachment A). We continue to impose fines whenever federally required. However, as in other states, some homes continued to demonstrate "yo-yo" compliance records--failing to maintain compliance even after they achieve it. Civil monetary penalties are subject to lengthy administrative appeals and even when the administrative hearing backlog is corrected, there will be delays as appeals are made in the judicial system.

To achieve sustained compliance, a home must be compelled to address and correct the reasons for noncompliance in a professionally sound manner; and to assure that the corrective steps are maintained even after the date that substantial compliance is declared. Civil monetary fines do neither of these.

Our alternative remedies include temporary managers, directed plans of correction, in-service training and state approved clinical advisors. These services are provided by contract between the facility and the Michigan Public Health Institute. Our Department and MPHI have worked with HCFA to assure that MPHI remediators are properly trained in federal and state requirements. MPHI services are paid for by the facility and are placed in the home by state

order. We have found that this approach is much more effective than fines in correcting the cause of deficiencies and maintaining compliance over time. Fines are imposed whenever federally required. If a home is unwilling to cooperate in the program, other enforcement remedies are pursued, up to and including license revocation and termination.

Page 5. Issues that remain to be addressed include strengthening the use of civil monetary penalties, improving the referral process for sanctions, and increasing the deterrent effect of terminating homes from the Medicare and Medicaid programs."

Michigan Comments:

Michigan historical data shows that civil monetary penalties and termination do not achieve the goal of maintaining compliance over time. Michigan believes that the RPI, as described above, promotes systemic changes and avoids the trauma of having to move residents. However, we will take decisive action in closing a home which is unwilling or unable to cooperate in this approach. We have permanently closed 4 homes in the last year.

Pages 8-9. "To ensure that facilities would achieve and maintain compliance with the new standards, OBRA 87 also greatly expanded the range of enforcement sanctions... Particularly with regard to civil monetary penalties, Congress intended that these sanctions create a strong incentive to maintain compliance with federal standards by penalizing homes for their deficiencies."

Michigan Comments:

If the goal of sustained compliance is to be achieved, much more emphasis should be placed upon the early use of the alternative sanctions which are already authorized by OBRA. Michigan has worked closely with HCFA to implement these alternative sanctions in a manner consistent with OBRA under the Michigan Resident Protection Initiative (RPI).

Page 15. "In the two highest severity categories, common deficiencies included inadequate attention to prevent pressure sores...."

Michigan Comments:

Preventive measures, other than specific enforcement actions, are critical to reducing deficiencies. For example, Michigan held a state-wide surveyor/provider training conference on the prevention, recognition and treatment of pressure sores in the Spring of 1998. Since that conference, the citation rate for pressure sore deficiencies has been significantly reduced. It went from the second highest cited deficiency in 1997 to the sixth highest in 1998.

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Pages 18-19. The case histories of these [sampled] homes showed that sanctions helped bring the homes back into temporary compliance but provided little incentive to keep homes from slipping out of compliance once again.... When a sanction was imposed, the home generally corrected its deficiencies, and when it did, HCFA rescinded the sanction."

Michigan Comments:

The type of enforcement remedy is important to preventing repeat violations. While Michigan imposes civil monetary fines whenever required by OBRA, and has used them extensively in the past, the fines do not compel a home to address and correct the **reasons** for its noncompliance and do not assure that the corrective steps are maintained **after** the date that substantial compliance is declared. That is why we have implemented alternative sanctions and our own computer-based system for identification.

The computer program (which combines federal and state survey data) analyzes the current survey performance, the complaints substantiated since the last standard survey and the difficulty a facility had in achieving performance in the last survey cycle (including whether they were terminated). Facilities whose performance score is more than one standard deviation from the state-wide average are subject to early sanctions after their performance is reviewed. Attachment B is a description of the Michigan early review and intervention system.

Page 21. "Other sanctions authorized by OBRA 87-- increased state monitoring, appointment of a temporary manager to oversee the home while it corrects its deficiencies, and state-directed plans of correction... have so far been applied infrequently. All three are receiving limited use, state officials said, because of various cost and administrative concerns. For example, officials in three of the four states said they lacked a pool of qualified administrators to act as temporary managers."

Michigan Comments:

Michigan began using alternative remedies on a regular, organized basis in January 1998. In 1998 we imposed 65 directed plans of correction; 28 directed in-service trainings; 15 state appointed clinical advisors and 8 temporary managers. Attachment C shows the number of alternative sanctions imposed by Michigan in 1997 and 1998. State and federal remedies have been coordinated under Medicaid administrative rules. It is clear that the use of effective alternative remedies increased dramatically after implementation of the RPI in 1998.

Page 22. "Imposing sanctions without a grace period was seldom used because of restrictive HCFA guidance. And termination, the ultimate sanction because it removes homes from the program, had little effect because many homes were able to reenter the

program with little consequence for their past actions and a 'clean slate' for the future."

Michigan Comments:

Michigan has employed alternative remedies extensively under our Resident Protection Initiative. Under RPI, Michigan routinely imposes federally recognized alternative sanctions without a grace period, even where the facility is not a federal "poor performer." This is based on computer analysis of a facility's current and past performance (as described above) which is available immediately after the close of a survey.

Page 23. "Under HCFA policy, it can apply sanctions on an immediate basis (that is, without a grace period to correct deficiencies) to homes designated as poor performers and to homes that place residents in immediate jeopardy (actual death or serious injury, or potential for such an outcome). Doing so can help encourage sustained compliance because eliminating the grace period means that homes are more likely to be affected by penalties. However, HCFA's instructions about when to apply poor performer and immediate jeopardy designations have allowed severe and repeat violators to avoid immediate sanctions."

Michigan Comments:

With HCFA concurrence, Michigan has exercised its discretion to recommend that there be immediate imposition of sanctions (no "grace period") in the case of homes which meet the state criteria for early intervention.

Page 25. "Readmitted homes receive a 'clean slate' against mandatory sanctions in that, after a terminated home has been reinstated in Medicare, HCFA's policy prevents state agencies from considering the home's prior record in determining if the home should be designated as a poorly performing facility. This policy produces the disturbing outcome that termination could actually be advantageous to a home with a poor history of compliance, because this history would no longer be considered in making enforcement decisions after it was readmitted to Medicare."

Michigan Comments:

This is not the case in Michigan. Michigan's early review computer system tracks the fact of termination and assigns a point total for termination which makes it virtually certain that the home will receive early review in the next enforcement cycle--regardless of performance.

The 4 homes terminated in the last year in Michigan were permanently delicensed and have not been allowed to reenter either Medicare or Medicaid. The homes that were terminated before 1998 were allowed to reenter only with the continued oversight of a state appointed manager following reentry. These homes have experienced significant improvement in performance and

have not repeated their overall poor performance.

Page Pages 29-30. "HCFA lacks a system that integrates federal and state enforcement information to help ensure that homes receive appropriate regulatory attention.... A second area in which HCFA lacks adequate information is the results of complaint surveys."

Michigan Comments:

Michigan, as part of its RPI has integrated state and federal enforcement information into a single computer system called Carenet. This has allowed us to identify homes for early review and intervention on the basis of either federal or state poor performance. It also allows us to track key enforcement dates and requirements under both state and federal law.

Page 32. "Although reforms equipped federal and state regulators with many alternatives and tools to help promote sustained compliance with Medicare and Medicaid standards, the way in which states and HCFA have applied them appears to have resulted in little headway against the pattern of serious and repeated noncompliance. Such performance may do little to dispel concerns over the health and safety of frail and dependent nursing home residents"

Michigan Comments:

This is not true for Michigan. We have worked closely with HCFA and succeeded in coordinating federal and state remedies for violation of federal conditions of participation. These reforms have been implemented and go beyond federal OBRA requirements for early intervention, achievement of sustained compliance and oversight after substantial compliance is achieved.

Page 33. "The Administrator should ... continue Medicare and Medicaid payments beyond the termination date only if the home and state Medicaid agency are making reasonable efforts to transfer residents to other homes or alternate modes of care..."

Michigan Comments:

Accelerating termination only turns an unresolved problem back to the state and requires that residents be uprooted because the goal of sustained compliance could not be achieved through the chosen remedies. A better approach is to develop remedies that work to identify poor performers at an early stage of the enforcement cycle and to improve services without moving residents. Michigan is doing this through its Resident Protection Initiative.

GAORESP.WPD/ March 9, 1999

6

Comments From Pennsylvania's Department of Health

Commonwealth of Pennsylvania

DEPARTMENT OF HEALTH

March 10, 1999

DEPUTY SECRETARY FOR QUALITY ASSURANCE
(717) 783-1078

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

Dear Ms. Allen:

Pennsylvania Department of Health staff have reviewed the draft GAO report, "NURSING HOMES--Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards" and agrees with the conclusion of the report which states that "the enforcement system observed still sends signals to noncompliant nursing homes that a pattern of repeated noncompliance carries few consequences" and "HCFA needs to improve its management information system to obtain information to identify and monitor those homes that pose the greatest risk of harm."

Our experiences in Pennsylvania underscore the premise that as long as facilities with compliance problems are given opportunities to correct serious deficiencies, without timely consequences, they continue to cycle in and out of compliance. Additionally, the federal backlog of administrative appeals regarding civil monetary penalties, coupled with the legal provision that prohibits collection of the penalty until the appeal is resolved, sends the wrong message to providers; in that, the perception exists that the fines will never be collected, thus, they are not a deterrent to noncompliance.

The Health Care Financing Administration (HCFA) revised the definition of "poor performing" facility to include a facility that is found out of compliance with any deficiency with a scope and severity at the level of actual harm or higher on the current survey and the facility had a deficiency at the level of actual harm or higher at the previous standard survey or any intervening survey. Poor performing facilities are not given an opportunity to correct deficiencies prior to the imposition of remedies. HCFA's revised "poor performing" facility definition and policy is a first step in identifying and sanctioning facilities with repeated

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noncompliance. However, the effectiveness of implementing this new definition and policy will be lessened if the current system for adjudicating civil monetary penalties is not enhanced or improved.

The HCFA management information system will be invaluable in identifying trends related to noncompliance and identifying challenging issues we are confronting from a public health perspective relative to delivering care to nursing home residents.

Thank you for the opportunity to comment on the draft report.

Sincerely,

Lori A. Gerhard, Acting Deputy Secretary
for Quality Assurance

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