APPENDIX
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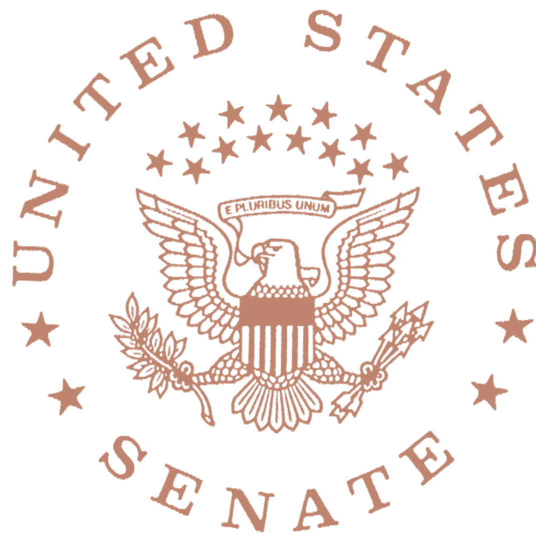
UNITED STATES
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Exhibit 1

Midwestern Consortium
Division of Survey and Certification
601 East 12th Street, Room #355
Kansas City, MO 64106

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

December 4, 2015

Dr. Susan Mosier
Secretary, Kansas Department of Health and Environment
1000 SW Jackson St, Suite 540
Topeka, KS 66612-1367

RE: KDHE State Agency Performance

Dear Secretary Mosier:

The Centers for Medicare & Medicaid Services (CMS) have chosen to bring an issue of grave concern directly to your attention regarding the ability of the Kansas Department of Health and Environment, Health Facilities Program, (KDHE) to adhere to the provisions of the 1864 Agreement, Title XVIII and Title XIX of the Social Security Act (https://www.ssa.gov/OP_Home/ssact/title18/1864.htm) and the State Operations Manual (SOM).

Our analysis of the available data and discussions with KDHE management and staff increasingly reflect the immediate need for improvement in KDHE's organization, management and oversight of all regulatory systems and functions. These improvements are crucial for KDHE to consistently implement Federal regulations governing the health, safety and well-being of people receiving care in Medicare and Medicaid certified facilities in the State of Kansas.

For the past year, CMS has worked with KDHE management to foster improvements in survey outcomes and administrative oversight of the Medicare program. CMS has had candid conversations with KDHE leadership about staffing, initial provider certifications, the quality of investigations, training, survey outcomes, enforcement issues and the apparent and admitted inability of KDHE to meet mandated workload requirements within established timeframes. Over the past year, we have not seen sustained improvements in any of these areas of concern. At this time, CMS has no confidence that KDHE has developed an actionable plan sufficient to address these significant failures.

The failures that CMS have identified and addressed with KDHE management include the following:

Staffing

Prior to 2012, KDHE reported they had 10.5 field surveyors, one quality performance surveyor, two office managers and a Director. In March of 2015, CMS was informed that KDHE had 2.5 field surveyors and one office manager. From our discussions with the State, it appears that KDHE has been unable to hire staff in sufficient numbers to complete the expected workload due to Administrative obstacles and non-competitive wages. It appears that KDHE is critically understaffed. According to our most recent information, KDHE has only two full-time Non-Long Term Care (NLTC) surveyors. As a result, these two staff persons are responsible for all survey and certification actions for the 151 hospitals, 53 dialysis centers, 165 rural health clinics, 62 ambulatory surgical centers, 22 outpatient physical therapy providers, and one outpatient rehabilitation center. The two surveyors available to KDHE are relatively new employees and lack investigative experience. The lack of available and experienced staff has led to a number of programmatic failures.

Hospitals

On October 27, 2015, at approximately 8:30 PM., a patient at Osawatomie State Hospital raped a female staff member of the hospital. KDHE was notified by the hospital the next day (October 28th) at 11am. KDHE did not notify CMS until more than 24 hours after receiving the information. State Agencies are required to investigate allegations that constitute a potential Immediate Jeopardy within two working days from receipt of the allegation. CMS was informed that KDHE surveyors do not work on Fridays and surveyors would be sent to Osawatomie to investigate the incident on Tuesday, November 3rd. CMS informed KDHE that the agency was expected to commence the investigation within the required timeframes. During the subsequent survey, KDHE determined that the hospital's non-compliance constituted an immediate jeopardy. This situation of Immediate Jeopardy had not been removed before completion of the survey on November 3rd. In such situations, survey agencies are required to submit written evidence of their findings to the facility within two days. KDHE failed to develop a written report until November 20th—more than two weeks after the conclusion of the survey. This delayed a more timely resolution of a dangerous situation that threatened the safety of all patients and staff at the hospital.

Emergency Medical Treatment and Labor Act (EMTALA)

In August 2015, KDHE conducted two EMTALA complaint investigations. Each of the investigations were incomplete, were not finished in a timely manner and lacked sufficient evidence to support the findings of non-compliance. In September of 2015, CMS outlined a number of concerns related to these surveys and with the documentation KDHE provided to support the findings and requested revisions to the survey report. In October, CMS had a conference call with KDHE as the survey findings had still not been revised. As of November 2015, KDHE staff have not completed these investigations.

In October of 2015, KDHE received a third EMTALA complaint but did not notify CMS of the case data entry as required. This failure resulted in significant delays in processing and investigating this allegation. On November 2, 2015, CMS authorized an EMTALA

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investigation. This investigation was required to be completed by November 9, 2015. As of this writing, this investigation has not been completed.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

In September 2015, CMS staff accompanied a KDHE ICF/IID surveyor during a recertification survey. Serious concerns regarding the quality of the investigation and adherence to survey protocol were identified, in addition to issues related to the timely completion of survey activities. KDHE staff continued survey activities after conducting the formal exit conference with the facility on September 17th. The survey report reflected a survey end date of October 2, 2015. Despite this unauthorized extension of the survey date, KDHE was still nine working days late in providing the facility with the survey report. CMS's review of the survey report revealed that KDHE failed to gather sufficient evidence to support the Condition-level finding of facility non-compliance that was evident during the survey.

Critical Access Hospitals (CAHs)

There are a total of 84 Critical Access Hospitals in Kansas. Given the critical staffing shortfalls, CMS is not assured that KDHE will have the resources necessary to complete the 20 CAH surveys KDHE plans to conduct in FY 2016.

End Stage Renal Dialysis Centers (ESRDs)

In Fiscal Year 2016, KDHE will be required to survey 10% of the 53 ESRD facilities in the state. On October 28, 2015, CMS received notification that two ESRD facilities were "severely overdue" for surveys and six ESRD facilities were "moderately overdue" for surveys. Our review of the KDHE certification workloads shows that Kansas has 14 ESRDs that have not been surveyed in 72 months and two of the 14 facilities have not been surveyed in 96 months. According the FY16 Mission and Priorities Document (MPD), States are expected to survey ESRDs no less than once every 42.9 months. Given these lengthy periods between surveys, CMS is concerned that KDHE may not complete its required workload.

State Performance review Standards and the Survey protocols (SPSS)

The SPSS is one of the primary means CMS uses to evaluate the effectiveness of State Agency performance. Each of the areas of concern identified above are reflected in the results from the standardized review of state performance conducted twice a year by CMS. In February of 2015, CMS notified KDHE of significant failures in their State Performance Measures. KDHE failed to achieve acceptable performance in the quality of documentation of their survey results, in properly prioritizing complaints, and in updating data systems in a timely manner. Upon receipt of these results, KDHE did not challenge the accuracy of the data, but suggested that the failures were the result of staffing shortages. Not only has KDHE failed to achieve acceptable results in several performance measures, KDHE has also failed to develop an acceptable Plan of Correction in a timely manner to address these failures. CMS has had

several discussions with KDHE to develop a sustainable solution to these concerns. Although KDHE developed a plan of correction that included submission of monthly status update reports, these reports have not been consistently submitted. Given the significant delays in survey activities documented in this letter, CMS is not confident in KDHE's ability to pass additional performance measures in the coming year.

This letter requests that you fully review and address the systemic conditions within KDHE that have resulted in these failures. Should KDHE be unable to correct these serious concerns, CMS could revoke the 1864 Agreement between CMS and KDHE. This would be an action of last resort, as our main priority is to continue the Agreement with KDHE in a manner that safeguards the health and safety of those seeking care in Medicare and Medicaid certified facilities. We ask that you review the circumstances that have led to these concerns and inform our office of the action you intend to take by January 4, 2016. If you have questions or concerns, please contact Capt. Victoria Vachon, Non-Long Term Care Branch Manager for the Kansas City Regional Office, at 816-426-6354.

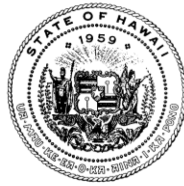
Sincerely,

Nadine Renbarger,
Associate Regional Administrator
Midwest Division of Survey and Certification

cc: Governor Sam Brownback, Kansas
Thomas Hamilton, Director, Survey and Certification Group
Renard Murray, Consortium Administrator, CQISCO
David Wright, Deputy Regional Administrator
Joyce Smith, Director, KDHE
Capt. Victoria Vachon, Non-Long Term Care Branch Manager
Gregg Brandush, Deputy Associate Regional Administrator
Nannette Foster Reilly, Consortium Administrator, CFMFFSO

Exhibit 2

DAVID Y. IGE
GOVERNOR OF HAWAII



VIRGINIA PRESSLER, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

In reply, please refer to:
File:

May 6, 2015

Steven Chickering
Western Division of Survey and Certification
Associate Regional Administrator
Department of Health and Human Services
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Dear Mr. Chickering:

Thank you for your letter dated March 27, 2015, reference WDSC-KF/DL, regarding CMS's concerns over the Hawaii State Survey Agency's (SA) performance and CMS's request for a plan of correction. I am also in receipt of your Benchmark letter dated April 3, 2015.

The purpose of this letter is to provide you with the state's plan of correction and a more detailed response to specific issues you raised in your March 27 letter as well as to your Benchmark letter dated April 3. Please refer to Attachment 1 Plan of Correction, Attachment 2 Detailed Response to Specific Issues, and to Attachment 3 Benchmark Update.

Let me assure you the Hawaii Department of Health (DOH) and the Office of Health Care Assurance (OHCA) share your concerns and have taken steps within their authority to improve upon the SA's performance to meet the contractual and statutory responsibilities in accordance with Section 1864 of the U.S. Social Security Act (1864 Agreement) to protect the health and safety of Hawaii's Medicare and Medicaid populations. I am confident that by continuing to work together we will arrive at an effective and shared solution to this problem.

As you acknowledged in your letter, the SA has been in near constant communication with your office on the difficulties experienced by the SA to fulfill its Medicare certification survey responsibilities. The SA has also kept me apprised of their performance and resource challenges and has done the same with my predecessors during the previous two state administrations.

The SA's suboptimal performance is primarily due to the lack of staff – both from the inability to hire qualified surveyor and administrative support staff and from the lack of approved and funded positions. Circumstances were also exacerbated by state funding and budgetary monitoring issues outside the immediate control of the DOH or of the SA. The department asks for CMS's help in obtaining additional surveyor and support positions by being more forthcoming with a letter of support that clearly states CMS's willingness to fund an additional two nurse surveyor positions and one administrative support position in federal FY 2016 and another two

nurse surveyor positions and one administrative support position in federal FY 2017. The department was unable to secure additional positions for federal FY 2015 due to the lateness in receiving CMS's letter of support and confirmation of federal funding.

I look forward to meeting you some day or talking with you by phone. If you have any questions or concerns about this letter or attachments, please contact Keith R. Ridley, Chief, Office of Health Care Assurance at [redacted] or at [redacted].

Sincerely,

VIRGINIA PRESSLER, M.D.
Director of Health

c: Danette Wong Tomiyasu, M.B.A.
Deputy Director, Health Resources Administration

Keith R. Ridley, Chief
Office of Health Care Assurance

Martha Drinan, Medicare Certification Officer
Office of Health Care Assurance, Medicare Section

Attachment 1

PLAN OF CORRECTION

OBJECTIVE 1: IMPROVE ON STAFF RESOURCES

1. A.: Hire Qualified Staff into Vacant Positions

Following up on the hiring successes experienced by the SA during the federal fiscal years (FFY) 2013 and 2014 when OHCA filled two (2) vacant RN surveyor positions, one (1) IT specialist position and one (1) administrative support position twice (an initial hire subsequently resigned to return to her former private sector position; the position was again recruited for and subsequently refilled), OHCA continued its aggressive recruitment activities throughout FFY 2014 and into FFY 2015. At the beginning of the FFY 2015, there were two (2) vacant RN surveyor positions and one (1) vacant secretary position. The vacant secretary position was problematic to fill since it had a short “not to exceed” date of December 1, 2014, due to other cascading factors beyond the control of the SA. Once the date could be extended, recruitment became easier.

Action Plan:

1. Internal Recruitment: submit recruitment paperwork on the two (2) vacant RN positions to DOH Human Resources Office (HRO) for internal recruitment within 2 weeks of vacancy;

2. External Recruitment: if internal recruitment efforts are unproductive, submit recruitment paperwork on the vacant RN position(s) to the state Department of Human Resource Development (DHRD) for external recruitment within 1 week of ending internal recruitment;

3. Begin interview(s) of applicant(s) within 1 week of obtaining applicant listing;

4. Select and hire qualified RN applicant(s) by the end of the federal 1st quarter (December 31, 2014);

5. Submit recruitment paperwork on the vacant secretary position to HRO for internal recruitment within 2 weeks of vacancy;

6. If internal recruitment efforts are unproductive, submit recruitment paperwork on the vacant secretary position to DHRD for external recruitment within 1 week of ending internal recruitment;

7. Begin interview(s) of applicant(s) within 1 week of obtaining applicant listing;

8. Select and hire by the end of the federal 2nd quarter (March 31, 2015).

Status: This objective has been MET.

1. 1 RN surveyor position filled on December 8, 2014. The recruitment effort for internal applicants began in March 2014 – 9 days following vacancy. Lacking qualified internal applicants, the external effort began May 2014. Another applicant list was provided in August 2014. Applicants were interviewed and selection was made on October 14, 2014, for the December 2014 start date.

2. 1 RN surveyor position filled on January 5, 2015. The recruitment effort for internal applicants began May 2013 – 1 week prior to vacancy. Lacking qualified internal applicants, a request for authorization to Recruit Above the Minimum (RAM) was submitted in April 2014 for external applicants. An applicant list was provided in August 2014. Applicants were interviewed and selection was made on October 14, 2014, for the January 2015 start date.

3. 1 Secretary position filled on April 1, 2015. The recruitment effort for internal applicants began February 2014 – 1 week prior to vacancy. Lacking qualified internal applicants, the external effort began April 2014. Subsequent applicant lists were required due to lack of applicants and/or qualified candidates and because the position had a short not-to-exceed date due to civil service rules which were beyond the department's or SA's control. Recruitment paperwork was resubmitted in January 2015 once the not-to-exceed date was extended to December 2018. Applicants were interviewed and selection was made on March 2, 2015, for the April 2015 start date.

1. B.: Add Staff Resources

The SA completed a staffing analysis by assessing the amount of time and effort work hours that are needed to complete the required state licensing and federal certification surveys and by determining the number of staff needed to meet those hours. The SA determined it would need an addition seven (7) surveyors and estimated the need for two (2) additional administrative support positions to support the current and additional surveyors. This staff analysis was shared with the RO and with DOH leadership beginning in 2013. The SA recommended a step-wise approach to adding staff by being realistic on the SA's ability to hire this number of staff at one time and in consideration of state and federal funding approval requirements, the time needed to establish, recruit and fill the new positions, the survey time taken away from current surveyors to train new surveyors, and other factors.

Action Plan:

1. CMS Letter of Support: request and obtain a letter of support from CMS, via the RO, for support of the SA's request for additional positions to be submitted to the 2014, 2015, and 2016 state legislature;

2. Step-Wise Approach: submit a state budget request through the DOH by August 2014 for the 2015 legislative session for 2 RN surveyor and 1 administrative support positions and appropriate levels of state general funds in each of the 2 years of the state's biennium budget for state fiscal years 2016 and 2017 (beginning July 1, 2015, through June 30, 2017);

3. Respond to questions from the governor's office, Budget and Finance (B&F), and legislative money committees to ensure passage of the budget request;

4. CMS Budget Request for FFY 2015: submit a federal budget request by December 31, 2014, or as directed by the RO for federal funding for the newly approved positions for the federal FY 2015 budget year;

5. Respond to questions from the RO and/or Central Office (CO) to ensure passage of the FFY 2015 budget request;

6. CMS Budget Request for FFYI 2016: submit a federal budget request to CMS by December 31, 2015, or as directed by the RO for federal funding for the newly approved positions for the federal FY 2016 budget year;

7. Respond to questions from the RO and/or Central Office (CO) to ensure passage of the FFY 2016 budget request;

8. Upon approval of the new positions and securing state and federal funding, complete the necessary paperwork to establish and begin to recruit for the positions within six (6) months of such approval;

9. Fill the positions within six (6) months of beginning recruitment.

Status: **Action Plan steps will continue until this objective is met.**

1. The SA's request to the RO in 2013 for a letter of support for the state's 2014 legislative session was unsuccessful when CMS and the SA were unable to agree on language for the letter of support;

2. The SA reiterated its request in 2014 for a support letter for the 2015 legislative session and a letter of support was received on March 27, 2015, more than 2 months after the 2015 Hawaii legislative session was convened;

3. The SA's budget requests were submitted to DOH and included in the DOH departmental budget and submitted to the governor's office for consideration to be included in the governor's budget package to be submitted to the 2015 legislature;

4. The SA's budget requests were not approved largely due to the lateness in receiving confirmation of federal funding for the positions;

5. Continue to follow the above action steps in preparation for the state's 2016 legislative session and for the federal FY2016 and for 2017.

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OBJECTIVE 2: IMPROVE STATE FUNDING

Each year for the past many years the SA submitted federal budget requests reflecting the shared survey costs between CMS and the state for the SA's operations. This included shared costs of its approved supervisor, surveyor, and administrative support positions. The shared costs reflected approximately 80% / 20% between CMS and the state, respectively. However, the approved positions were reflected in the state budget as 100% federally funded and the SA needed to continually seek sufficient state funding and to move moneys between expense categories to ensure the expected shared costs were realized. At no time were federal moneys used to cover state expenses and vice versa.

Action Plan:

1. Submit the SA's budget request through the DOH by August 2013 for the 2014 legislative session to reflect how the approved positions were actually funded, i.e., 80% federal 20% state, and for the shared state funds to be approved and available beginning July 1, 2014;

2. Obtain state funding to cover other state expenses associated with conducting integrated provider surveys.

Status: This objective has been MET.

The 2014 legislature approved the change in shared funding of the approved positions to reflect the 80% / 20% between CMS and the state, respectively. The approval became effective beginning July 1, 2014, and state general funds were available and released for SA use.

OBJECTIVE 3: IMPROVE TIMELINESS OF SKILLED NURSING FACILITIES' RECERTIFICATION SURVEYS

3. A.: Tier 1 Skilled Nursing Facilities (SNF)

During federal FY 2014 the SA concentrated its efforts on neighbor islands' facilities since many of these facilities were not surveyed during federal FY 2013. This left many of the Oahu facilities not surveyed. Refer to Attachment 3 CMS Benchmark Update and to the attached log and PDF copy of the monthly calendars October 2014 through September 2015.

Action Plan:

1. Schedule recertification surveys on all Medicare certified SNFs by September 11, 2015;

2. Provide monthly updates to the RO on the completion of the SNF recertification surveys;

3. Provide a fiscal year-end report to the RO by September 30, 2015, on the status of SNF recertification surveys;

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4. Adjust the recertification survey schedule for federal FY 2016 to decrease the interval between SNF surveys pursuant to the federal Mission and Priority Document (MPD).

Status: Action steps are in process.

3. B.: Non-Nursing Homes

Non-nursing home recertification surveys include surveys on deemed and non-deemed hospitals and critical access hospitals, hospital validation surveys, ESRD, ASC, home health agencies, and others. The SA must acquire staffing and other resources to accomplish this objective. Therefore, meeting this objective is contingent upon meeting Objective 1.B.

Action Plan: See Objective 1.B.

OBJECTIVE 4: UNDER-SPENDING OF FEDERAL GRANT

The historical under-spending during federal FYs 2010 and 2011 were based on remnants of hiring freezes and furloughs which began during federal FY 2009 and part of 2010. 2011 and 2012 were the peak years of under-spending and were largely attributed to staff vacancies including the vacant Medicare Certification Officer position.

Under-spending greatly decreased during federal FY 2013 and 2014 as federal sequestration decreased the amount of the federal award and as expenses increased due to filling of vacant staff positions including the Medicare Certification Officer. However, during the first year of federal sequestration (2013), the SA became overly concerned over the reduced amount of federal award and withheld travel moneys to ensure staff positions would not be endangered due to a lack of money. Learning from the lessons of 2013, expenses increased during 2014 as travel restrictions were lifted, some vacant positions were filled, and nurse surveyors' salaries were increased due to renegotiated bargaining unit agreements between the nurses' union and the State. As a result, the SA saw its lowest level of under-spending at $25,668 during 2014 and would have over-spent by approximately $23,000 if it weren't for the unanticipated resignation of a newly hired nurse surveyor.

Action Plan for FFY 2015:

1. Fill vacant positions: fill all vacant RN surveyor and administrative support positions by June 30, 2015;

2. Neighbor island surveys: schedule and conduct recertification surveys on neighbor island SNFs by September 15, 2015, and charge the appropriate cost of travel to Title XVIII and Title XIX;

3. Oahu surveys: schedule and conduct recertification surveys on Oahu SNFs by September 15, 2015, and charge the appropriate mileage and parking costs to Title XVIII and Title XIX;

4. Track and report expenditures to CMS to ensure the spend-down of the federal award;

5. Provide an update to the CMS RO leadership team on FFY 2015 spending at the next state agencies meeting in San Francisco in September 2015.

Status for FFY 2015: This Objective has been partially MET and the remainder is in process.

1. All vacant positions were filled. The RN surveyor positions were filled in December 2014 and January 2015, and the administrative support position was filled in April 2015;

2. Recertification surveys have been scheduled for all SNFs on the Oahu and the neighbor islands to be conducted by September 15, 2015.

Attachment 2

SPECIFIC RESPONSES

Below is the draft response to specific performance concerns identified in the CMS Fiscal Year 2014 State Agency Performance Evaluation Report on the Hawaii SA. The draft response was forwarded to the CMS RO on March 12, 2015. The SA is awaiting further discussion with the RO before finalizing the response.

SUMMARY OF THE SA OPERATIONS

During Federal Fiscal Year (FFY) 2014 the Hawaii State Agency (SA) continued to operate with retirement and turnover staffing shortages. The SA has continued to discuss staffing shortages and their direct impact on performance with the CMS Regional Office (RO) in San Francisco. The SA continues the pursuit of additional surveyor and administrative support positions needed to meet current and future workload priorities.

During FFY 2014, the SA lifted restrictions to in-state neighbor island travel to conduct facility surveys. The restrictions had resulted from the need to transfer funds in FFY 2013 from operations to cover salary expenses resulting from a reduced federal budget due to federal sequestration. A primary SA goal during FFY 2014 was to resume surveys on neighbor islands and to actively reduce the back log of significantly overdue facility surveys. Additionally, during FFY 2014 a Federal "Shut Down" caused by Congressional budget delays required that all SA's nationwide cease all federal surveys for a designated period of time. Resuming regular survey activity also required additional redirection and reassignments at both the front end and back end of the "Shut-Down." This created a gap in the completion and momentum for surveys as staff resources were intentionally diverted to State only tasks and responsibilities.

During FFY 2014, the SA was successful in obtaining state-share funding. The state-share funds were approved during the 2014 legislative session and became available beginning July 1, 2014.

The SA completed three (3) EMTALA investigations during FFY 2014. Two (2) of them were on the neighbor islands. A work analysis for total hours showed that the EMTALA investigation on Kauai involving Samuel Mahelona Memorial Hospital and Wilcox Memorial Hospital required two (2) surveyors for nine (9) days or eighteen (18) total staff-days. An EMTALA investigation on the Big Island at the North Hawaii Community Hospital and Hale Ho'ola Hamakua required two (2) surveyors for eight (8) days or sixteen (16) total staff-days. And an EMTALA investigation at The Queen's Medical Center on Oahu required two (2) surveyors for four (4) days or eight (8) total staff-days. This is a total of 42 staff-days or almost two (2) months. This created a critical staffing void in being able to conduct and complete skilled nursing facility and other surveys during those times.

OVERVIEW OF ACTION PLAN

Recruit and Hire Qualified Staff:

A primary objective towards meeting the CMS workload requirements of the Mission and Priority Document (MPD) is to fill vacant surveyor and administrative support positions. The SA had hired a RN surveyor from the private sector in late FFY 2013. Unfortunately, this person decided to return to the private sector on March 28, 2014, resulting in an unanticipated vacant surveyor position and causing an unexpected disruption in conducting re-certification surveys. In addition, an administrative support person was also hired in late FFY 2013 but resigned on February 14, 2014, to return to her former private sector position. Nevertheless, through aggressive recruitment efforts by the SA, the SA was able to fill three (3) critical positions during FFY 2014. The SA filled one (1) Registered Nurse V surveyor position on June 16, 2014, the IT Specialist position on February 10, 2014, and an Office Assistant position on March 17, 2014, to replace the one who resigned on February 14, 2014. This left the SA with two (2) vacant RN surveyor positions and one (1) Secretary II position. The RN positions were filled in FFY 2015 on December 8, 2014, and on January 5, 2015, and an offer was made to fill the Secretary II position in mid-March 2015.

Obtain State Share Funding and Monitor Budgets:

During FFY 2014, the SA was successful in obtaining state-share funding. The state-share funds were approved during the 2014 legislative session and became available beginning July 1, 2014.

Obtain Additional Staff Positions:

A staffing analysis conducted by the SA and shared with the RO found that the SA needs an additional seven (7) surveyor positions and two (2) administrative support staff in order to adequately meet the expected workload in the MPD. These positions are critically needed to address the immediate staffing demands brought to bear on the SA by EMTALA investigations, deemed hospital complaint investigations, as well as the current Tier I and Tier II priorities for which the SA is currently delinquent.

However, the SA will take a step-wise approach to these increased staffing needs and has requested two (2) surveyors and one (1) administrative support positions for FFY 2015. A decision from the Central Office and Regional Office is pending. The SA will also ask for another two (2) surveyors and another one (1) administrative support positions for FFY 2016.

RESPONSE TO SPECIFIC PERFORMANCE MEASURES

Below is the SA's response to specific performance measures during FFY 2014.

Frequency Dimension

F1: Off Hour Surveys
Threshold: 10% or 5 facilities.
Actual Score: 0%

Overview of the Problem:

This performance measure was not met for two primary reasons. The first was that approximately half or 50% of the twenty-nine (29) nursing facilities surveyed in FFY 2014 or fourteen (14) nursing facilities are on neighbor islands. Neighbor island surveys were a top priority for the SA in 2014 and air travel also requires car rentals to drive to and from rural survey sites, including hotel sites. This results in surveyors arriving at neighbor island facility sites usually by mid to late morning instead of prior to 8:00 am. The second reason was an administrative oversight. Some surveyors continued to use an outdated SA form that did not record data for staggered surveys. Thus, critical data entry into the ACO system did not occur for any of those surveys including surveys that may have been completed as Off Hour Surveys during FFY 2014.

Corrective Action:

1. The SA on March 3,2015, deleted the outdated form from the SA files;

2. The MCO issued a memo to staff on March 13, 2015, to formally instruct surveyors to use the correct Post Survey Team Evaluation (PSTE) form (dated January 15, 2013) and to instruct office assistants to immediately return incomplete PSTE forms to the MCO to ensure accurate data entry for each selected staggered survey;

3. The MCO beginning April 2015 will assign at least one (1) "Staggered Survey" each month until five (5) facilities have been completed as staggered surveys by August 31, 2015;

4. The Medicare Certification Officer (MCO) will sign off on all future completed PSTE forms to ensure that this information is recorded accurately on the correct PSTE form and subsequently entered into ACO correctly; and

5. As an additional "check and balance" the Office Assistants who perform the data entry functions have been instructed to immediately return PSTE forms to the MCO when they encounter incomplete/missing off-hours data or when the obsolete PSTE form is used. The MCO will closely monitor this performance measure to ensure meeting this requirement in 2015.

F2: Frequency of Nursing Home Surveys

Tier 1 Requirement: 100% of nursing homes surveyed; no more than 15.9 months elapse between surveys for any particular nursing home; statewide average interval of no more than 12.9 months.

Threshold: 96%
Actual Score: 63%

Overview of the Problem:

The SA has forty-six (46) nursing home facilities statewide and twenty-nine (29) were surveyed in FFY 2014 with seventeen (17) facilities not surveyed. This is a score of 63% nursing facilities. Only twelve (12) of these surveys met the 15.9 months elapse time requirement. The remaining facilities were the overdue facilities that the SA focused its attention on, mostly on the neighbor islands. The statewide average interval was 19.1 months in FFY 2014. This is directly related to the staffing shortages and on delayed neighbor island surveys from FFY 2013 as described above.

Corrective Action:

1. During FFY 2015, the SA acquired two (2) newly hired surveyors. They are currently receiving the required training to conduct surveys in nursing homes. While all experienced surveyors are assisting with this training task, each new surveyor was assigned a dedicated preceptor to provide direct guidance to the new surveyors. The newly hired surveyors are expected to complete the SMQT by June 30, 2015.

2. Initial training activities for the newly hired surveyors will require more dedicated surveyor time than would otherwise be expended during surveys, as can be expected. The SA performance for the F2 measurement should gradually improve as the new staff complete the required core training and acquire the necessary skills to survey nursing home facilities as a key priority for the SA. However, as stated above, additional resources will be required over an extended period of time in order for the SA to significantly improve on this measurement.

3. A Registered Nurse V surveyor position was filled on June 16, 2014, to participate in nursing home surveys and other survey assignments according to the established workload priorities, upon completion of the required core training.

4. The IT Specialist position was filled on February 10, 2014, to provide IT support and assistance to the surveyors as they encounter hardware or software problems both in the office and while on survey.

5. An Office Assistant position was filled on March 17, 2014, to provide administrative support to the MCO and surveyors.

6. A Registered Nurse V Position was filled on December 8, 2014, to participate in nursing home surveys and other survey assignments according to the established workload priorities, upon completion of the required core training including SMQT.

7. A Registered Nurse V position was filled on January 5, 2015, to participate in nursing home surveys and other survey assignments according to the established workload priorities, upon completion of the required core training including SMQT.

8. Recruitment and hiring for a Secretary II position to provide administrative support for the MCO is nearly complete. An offer has been extended and accepted and the start date will be determined by mid-March 2015.

9. The OHCA Chief will continue to collaborate with the RO to secure funding and approval for two (2) surveyor positions and one (1) administrative support position in FFY 2015.

10. As overdue surveys are completed, the elapsed months between surveys will decrease.

F3.1 Frequency of Non-Nursing Home Surveys – Tier I

Home Health Agencies:
Threshold: 100%
Actual: MET 100%

The SA has met this performance measure for two (2) consecutive years in FFY 2013 and FFY 2014. This performance measure was not met in FFY 2012.

ICF/IID's:
Threshold: 100%
Actual: 81.3%

Corrective Action:

The SA has sixteen (16) ICF/IID facilities statewide and thirteen (13) ICF/IID facilities were surveyed in FFY 2014. Three (3) ICF/IID facilities were not surveyed in FFY 2014. Four (4) ICF/IID facilities exceeded the 15.9 months survey frequency, resulting in nine (9) or 81.3% of the surveyed ICF/IID facilities that met the measure. The corrective action for this measure remains essentially the same as that stated above for the measure for Nursing Home Surveys (F3.1) in that ICF/IID facilities will be surveyed within the guidelines of the established priorities including maximizing on the addition of the three (3) new surveyors (one in 2014 and two in 2015). Additionally, the three (3) new surveyors will be assigned to partner with the SA designated ICF/IID Lead Surveyors to ensure that the SA attains improvement for this performance measure in FFY 2015.

By May 1, 2015 the MCO will issue a memo to the designated ICF/IID Lead Surveyors to require the identification of the ICF/IID facility surveys with the proposed dates of completion for at least four (4) ICF/IID facilities, including how the new surveyors will be individually assigned to partner with the designated ICF/IID Lead Surveyors in performing and completing the prioritized ICF/IID surveys.

F3.2: Frequency of Non-Nursing Home Surveys – Tier 2

Hospice Tier 2:
Threshold: 5%
Actual: 0%

Overview of the Problem:

The SA has seven (7) non-deemed hospice facilities statewide and on February 6, 2015, the SA completed one (1) neighbor island hospice survey. As previously stated, during FFY 2014 all surveyor resources were intentionally directed toward completing LTC facility surveys, especially on the neighbor islands.

Corrective Action:

1. On February 10, 2015 the SA proposed to the RO that during FFY 2015 Federal contractors should be asked to survey four (4) non-deemed hospices including one provider with a hospice site on Oahu and another hospice site on Molokai. This will ensure that all non-deemed hospice providers are surveyed on a timely basis for FFY 2015.

2. On March 6, 2015 the MCO provided additional information requested by the RO in order to initiate the federal contractor process to survey the four (4) selected hospice providers in the state.

Ambulatory Surgical Centers:
Threshold: 25%
Actual: 0%

Overview of the Problem:

The SA has thirteen (13) ASC facilities statewide. The SA should have completed three (3) ASC surveys during FFY 2014. As previously stated, the SA was primarily focused on completing the backlog of nursing home surveys, which was intentionally identified as the SA's first priority, especially for neighbor island facilities, during FFY 2014.

Corrective Action:

1. During FFY 2015, the three (3) new surveyors will be assigned to partner with the SA designated ASC Lead Surveyor to ensure that the SA attains this performance measure in 2015.

2. By May 1, 2015, the MCO will issue a memo to the designated ASC Lead Surveyor to require the identification of the ASC facility surveys with proposed

dates of completion for at least three (3) ASC facilities, including how the new staff will be individually assigned to partner with the designated ASC Lead Surveyor in performing and completing the prioritized ASC surveys.

End Stage Renal Disease:
Threshold: 10%
Actual: 0%

Overview of the Problem:

The SA has twenty-three (23) ESRD facilities statewide and none were surveyed in FFY 2014 as a result of the SA directing all surveyor resources to completing LTC facility surveys.

Corrective Action:

1. During 2015, the three (3) new surveyors will be assigned to partner with the SA designated ESRD Lead Surveyor to ensure that the SA significantly improves performance for this performance measure in 2015.

2. By May 1, 2015, the MCO will issue a memo to the designated ESRD Lead Surveyor to require the identification of the ESRD facility surveys with proposed dates of completion for at least three (3) ESRD facilities, including how the new staff will be individually assigned to partner with the designated ESRD Lead Surveyor in performing and completing the prioritized ESRD surveys.

Hospitals:
Threshold: Maximum number of years between surveys non-accredited Hospitals = 5 Years.
Actual: No. exceeding maximum: 1

Overview of the Problem:

The SA had scheduled and intended to survey both the Lanai Community Hospital SNF and CAH in FFY 2014. The necessary surveyor resources had been assigned to complete both the SNF and CAH. However, immediately prior to the team traveling to this neighbor island site, an EMTALA investigation was authorized by the RO. As a result, the surveyor resources had to be diverted to the EMTALA investigation. The remaining surveyor resources were assigned to conduct the overdue recertification survey on the Lanai Community Hospital SNF only, leaving the CAH as the lesser workload priority.

Corrective Action:

1. The SA will continue to pursue the securing of two (2) additional surveyor positions to address the need for rapid response situations, including EMTALA investigations, deemed hospital complaints, IJ's, and other designated high priorities (i.e. PSI Surveys, QIS Comparative Surveys, AO Validation Surveys).

2. Assign additional surveyors to complete the EMTALA training. See Corrective Action, F2 above.

F3.3: Frequency of Non-Nursing Home Surveys – Tier 3

Non-Deemed Hospices:
Threshold/Actual: NOT MET

ESRD's:
Threshold/Actual: NOT MET

Non-Deemed Hospitals & CAH's:
Threshold/Actual: NOT MET

Corrective Action:

1. Fill vacant positions. This was accomplished as discussed above.

2. Create additional surveyor positions and administrative support positions and obtain federal and state funding to help to begin to address the established Tier 3 workload priorities. Until such a time, the SA will continue to focus on Tier I and Tier II priorities to accomplish the set and prioritized performance measures with available staffing resources.

F4: Frequency of Data Entry of Standard Surveys for Non-Deemed Hospitals and Nursing Homes

Threshold: 70 Calendar Days
Actual: MET NH Mean # of Days = 51 and Non-NH Mean # of Days = 67.7.

F5: Frequency of Data Entry of Complaint Surveys for Non-Deemed Hospitals and Nursing Homes

Threshold: 95%
Actual: 55.6%

Overview of the Problem:

The SA uploaded a total of nine (9) nursing home complaint surveys of which five (5) or 55.6% were uploaded on time. The remaining four (4) complaint surveys were shown as not completed/not closed timely. The ability to complete complaint surveys is a function of staffing resources and the number of staff assigned to specific complaints as well as the complexity of the complaint. In one case, this occurred due to legal complexities in which an attorney had filed the complaint on behalf of a complainant (father) concerning an adult patient/resident (son). The remaining surveys were entered late due to late completion of the complaint survey documents and/or required documentation.

Corrective Action:

By May 29, 2015, the MCO will identify training opportunities for survey staff through CMS training courses or through the RO that will assist surveyors in the timely completion of complaint surveys, using the required protocols and managing difficult complaint cases.

Quality Dimension

Q1: Documentation of Deficiencies

Threshold: 1 – 7 NH 85%
Actual: MET 94%, 97%, 91%, 100%, 100%, 97%, 100%

Threshold: 1 – 6 Non-NH 85%
Actual: MET 100%, 100%, 96%, 100%, 96%, 86%

Q2: N/A

Q3: N/A

Q4: N/A

Q5: N/A

Q6: Prioritizing Complaints and Incidents

Threshold: NH 90%
Actual: 0%

Threshold: Non-NH 90%
Actual: 60%

Overview of the Problem:

Triaging complaints according to best clinical judgment remains a priority for the SA. The SA and RO are not always consistently in agreement concerning retrospective review findings by the RO.

Corrective Action:

The SA will continue to obtain technical assistance and guidance from the RO and discusses cases to arrive at mutually agreeable decisions on the best courses of actions, especially in cases where the complaint information conflicts with established criteria or where the complaint presents conflicting information.

1. Beginning July 2015 and semi-annually thereafter, the SA will request the RO to participate in a conference call as part of the SA's staff meeting to review pre-identified complaints or incidents where the SA and RO disagreed on the prioritization with the goal of obtaining training on why the RO determined the different prioritization.

2. The MCO will identify complaints for discussion and will forward the documentation to the RO at least one (1) month prior to the scheduled conference call.

3. At the ROSA meeting in San Francisco during the week of March 16, 2015, the MCO will ask the RO to identify an appropriate RO liaison staff person for technical assistance and guidance on these future training opportunities.

Q7: N/A

Criteria 2 and 3 N/A; Criteria 4 MET 100%

Q8: Quality of EMTALA Investigations

Threshold: 1 – 5; 90%
Actual: MET - 100%, 100%, 100%, 100%, and 100%

Q9: Quality of Complaint/Incident Investigations

Threshold: 1 – 5; 85%
Actual: 17%, 83% 17%, 17%, 100%

Overview of the Problem:

There were six (6) facilities reviewed against five (5) criteria items pertaining to quality of the investigation. The three (3) items that received a score of 17% were: 1. Was a sufficient sample chosen to evaluate the complaint/incident; 2. Does the SA documentation include observations, interviews, and/or record reviews of each allegation in order to evaluate sufficiently whether the facility is in compliance; and, 3. Does the RO agree with the SA's determination of whether current noncompliance exists based on the evidence collected for each quality of care allegation. The one (1) item that received a score of 83% was: 1. If the complaint/incident concerns conditions on a certain day or on a certain shift, did the SA conduct the survey at the relevant time?

The discordant findings show that there are differences from the surveyor methods and determinations as compared with those identified by the RO during their retrospective review of documentation concerning complaint investigations. However, it should be noted that the review sample was a small sample and would have required a perfect performance to pass the threshold.

Corrective Action:

1. Beginning July 2015 and semi-annually thereafter, the SA will request the RO to participate in a conference call as part of the SA's staff meeting to review pre-identified complaints or incidents where the SA and RO disagreed on the quality of the investigation with the goal of obtaining training on how the RO arrived at their decision.

2. The MCO will identify complaints for discussion and will forward the documentation to the RO at least one (1) month prior to the scheduled conference call.

3. At the ROSA meeting in San Francisco during the week of March 16, 2015, the MCO will ask the RO to identify an appropriate RO liaison staff person for technical assistance and guidance on these future training opportunities.

Attachment 3

CMS BENCHMARK UPDATE

The below is provided as an update to the CMS benchmark requirements on the Hawaii SA for federal fiscal year 2015 as noted in Mr. Steve Chickering's letter dated April 3, 2015.

Management Structure and Personnel Stabilization

a. Hire 2 RN surveyors by June 30, 2015:

Status: **MET:** 1 RN surveyor was hired beginning December 8, 2014, and the 2nd RN surveyor was hired beginning January 5, 2015. Surveyors are being trained, have completed their in-house QIS training, and are scheduled to attend the CMS Basic LTC Training in Baltimore in June 2015. Meanwhile, both RN surveyors are included as survey team members on recertification surveys. These hires mean the SA has filled all its vacant surveyor positions.

b. Hire 1 support staff position by June 30, 2015:

Status: **MET:** 1 secretary position was hired beginning April 1, 2015. This hire means the SA has filled all its vacant administrative support positions.

Tier 1 SNF Workload

The Hawaii SA has scheduled to conduct all Medicare certified SNFs for recertification surveys during the current federal FY2015 by September 11, 2015. See the attached log (Excel spreadsheet) and PDF copy of the monthly calendars. In addition, the log will be used as a statewide tracking tool and for reporting the completion of surveys on a monthly basis as required by the RO.

Status: **being MET**

The SNF recertification survey schedule is very tight and for the remainder of the FFY2015, no or virtually no other recertification or other CMS surveys are scheduled due to the lack of surveyor positions. If any other surveys are required by CMS, i.e., EMTALA, hospital validation surveys, etc., the SA will likely be unable to conduct those surveys unless the RO agrees to recognize the need to conduct those surveys at the cost of not conducting a SNF recertification survey, and that if the RO requires the SA to complete a different survey instead of a SNF recertification survey, that the RO will "credit" the SA for the SNF survey for benchmark funding purposes.

Final Note

As a result of the SA meeting the requirements of CMS's benchmarks as noted above, the SA trusts the RO will release the benchmark funds for the Personnel Stabilization requirement in its entirety by June 30, 2015, or earlier if possible, and that the RO will be prepared to release the funds for the Tier 1 SNF workload on a monthly basis as the SA demonstrates the completion of work.

Exhibit 3

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Consortium for Quality Improvement and
Survey Certification Operations
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

Refer to: WDSC-KF/DL

October 14, 2015

Virginia Pressler, M.D., Director
Hawaii Department of Health
Director's Office
P.O. Box 3378
Honolulu, HI 96801

Dear Dr. Pressler:

I am writing in response to our meeting with the Region IX Survey and Certification management team at the CMS Regional Office in San Francisco on August 31, 2015 and to your letter, dated May 6, 2015, addressed to Steven Chickering, on our shared concern about the apparent staffing inadequacies at the Hawaii Department of Health, Office of Health Care Assurance (OHCA) and to offer our support for improving the number of staff for OHCA.

OHCA is the State's quality assurance arm to conduct certification surveys on behalf of the U.S. Department of Health and Human Services (DHHS), Centers for Medicare & Medicaid Services (CMS) pursuant to Section 1864 of the Social Security Act (1864 Agreement). Certification surveys are performed at health care facilities in an effort to protect the health and safety of Medicare and Medicaid beneficiaries when beneficiaries receive care at certified facilities. The surveyors who conduct these surveys are required to possess a high level of professionalism, knowledge, skill, and ability. However, without sufficient numbers of highly qualified and stable staff, Hawaii will not be able to meet the survey workload expectations as outlined in the CMS Mission and Priority Document (MPD) and the 1864 Agreement.

Historically, Hawaii has experienced challenges with completing statutorily mandated nursing home, home health agency and non-nursing home surveys. For example, the Social Security Act requires that nursing homes be surveyed, on average, no less frequently than every year. Additionally, each individual nursing home should be surveyed at least once every 15 months[1]. During federal fiscal year 2014, Hawaii surveyed only 29 of 46 nursing homes, and the statewide average interval was 19.1 months. Under section 1864 of the Social Security Act, the State has an obligation to conduct onsite review of providers' compliance with public health and safety requirements; ensure that serious complaints will be effectively investigated; and, to conduct such surveys in accordance with federal law and CMS policy.

[1] See the Social Security Act at 1819(g)(2)(iii) and 1919(g)(2)(iii), and 42 CFR 488.308

The CMS Western Division of Survey and Certification - San Francisco has regularly met and worked with OHCA's management team to assist them with efficiencies in survey process and to increase productivity. While CMS acknowledges that the management team has taken measures to address staffing shortfalls, OHCA has been limited by the challenges related to the adequacy of the number of qualified staff and to the recruitment and retention of staff. These challenges have not been within OHCA's direct control. This lack of qualified staff appears to have negatively impacted prior years' performances and, if left unaddressed will likely contribute to Hawaii's continued inability to meet federal survey workload expectations.

OHCA estimates that a total of seven (7) additional surveyors are required in order to complete the current CMS workload, but they are willing to establish the positions gradually while continuously assessing the impact of the initial new staff on their ability to complete the CMS workload. In addition, the funding level currently provided by CMS is 80% for surveyors and 60% for administrative support staff while the remaining 20% and 40%, respectively, is the responsibility of the state. This funding level has been historically accepted by CMS but is subject to adjustment should workload time and effort change.

CMS supports you in obtaining additional staff for OHCA by providing benchmarked grant funding support for six (6) permanent full-time positions at the funding level currently provided by CMS. The positions are for an additional two (2) surveyors and one (1) administrative support staff each year over a two (2) year period of time.

CMS provided benchmarked funding for FY15 for two surveyors and one administrative support staff with the hopes the state legislature would approve the additional positions. The benchmarked funding means that CMS will fund these positions once the State approves and hires these new OHCA positions. Although these positions were not approved by the State in 2015, CMS will continue to offer benchmarked funding for federal fiscal year 2016 (October 1, 2015, to September 30, 2016) for the two surveyors and one administrative support staff at 80% of costs, and, for federal fiscal year 2017 (October 1, 2016, to September 30, 2017) to fund another two surveyors and one administrative support staff. We hope the State will approve and fund these positions.

CMS also recognizes there is a difference between the state and federal fiscal years and that the timing of CMS's funding won't always coincide with the state's timing to approve these additional positions. However, the State must begin to demonstrate its good will and shared concern for OHCA's staffing inadequacies and at least begin to authorize an increase in staff complement and the necessary state funding by June 1, 2016. Without this demonstration of good will this CMS funding offer will be rescinded.

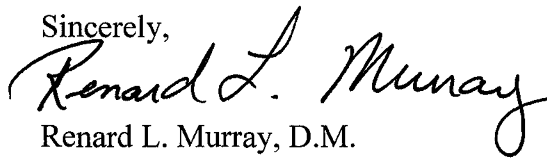
While it is not normally CMS's intent to intervene in a state's internal personnel matters, CMS recognizes that the situation in Hawaii is serious and merits prompt attention and, therefore, is willing to take this extraordinary step to assist you and OHCA obtain an adequate number of staff necessary to perform certification surveys aimed at protecting Medicare and Medicaid beneficiaries from poor quality of health care or threats to safety.

Finally, CMS requests that you reply to this letter, within 30 days of receipt, with a plan of action to obtain approval of additional staff resources as outlined above. Please response to me directly and to Mr. Steven Chickering.

HHSOIG - 0348

Thank you for your continued work in protecting the well-being of the Medicare and Medicaid beneficiaries in your State, and your continued efforts to address the local barriers that make such work a continuing challenge.

Sincerely,



Renard L. Murray, D.M.
Consortium Administrator

cc: Keith R. Ridley, Chief
Office of Health Care Assurance
Hawaii State Department of Health
601 Kamokila Blvd., Room 337
Kapolei, HI 96707

Thomas E. Hamilton,
Director, Survey and Certification Group

Steven Chickering
Associate Regional Administrator
Western Division of Survey and Certification

David R. Wright
Deputy Consortium Administrator
Consortium for Quality Improvement and Survey Certification Operations

HHSOIG - 0349

Exhibit 4

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Room 714
Dallas, Texas 75202

CONSORTIUM FOR QUALITY IMPROVEMENT AND SURVEY & CERTIFICATION OPERATIONS

August 1, 2014

Clyde L. Reese III, Esq.
Commissioner
Georgia Department of Community Health
2 Peachtree Street
Atlanta, GA 30303

RE: Georgia State Survey Agency Performance

Dear Mr. Reese:

The Centers for Medicare & Medicaid Services (CMS) has grave concerns regarding the ability and willingness of the Georgia State Survey Agency (Survey Agency) to adhere to the provisions of the 1864 Agreement, Title XVIII and Title XIX of the Social Security Act, the State Operations Manual (SOM) and the CMS budget call letter. Analyses of data and discussions with Survey Agency management and staff increasingly reflect the immediate need for improvement in the Survey Agency's organization, management and oversight of all regulatory systems and functions. These improvements are crucial for the Survey Agency to consistently implement Federal regulations governing the health, safety and well-being of people with Medicare and Medicaid in the State of Georgia.

For the past three years, CMS has worked actively with the management teams of the Survey Agency to foster improvements in survey outcomes.[1] The CMS has had candid conversations with Survey Agency management about staffing levels, training, initial provider/supplier certifications, survey outcomes, long-term care (LTC) re-certification and enforcement issues and the apparent and admitted inability of the Survey Agency to meet mandated workload requirements. We are extremely concerned that regulatory oversight of health care facilities and clinical laboratories in Georgia has progressively declined. The Survey Agency lacks a quality assurance program to ensure that deficient practices are properly identified in a timely manner. Recent complaint cases at Tara at Thunderbolt Nursing & Rehabilitation, A. G. Rhodes Home, Inc., Pruitt Health – Lilburn, Golden Living Center – Glenwood, Riverside Health Care Center and Quinton Memorial Healthcare & Rehabilitation Center indicate that triaging of LTC complaints lacks the necessary level of competence and managerial oversight and review. Based on the 2013 edition of the Nursing Home Data Compendium, there are 34,067 residents living in nursing homes in Georgia; therefore, the implications for health, safety and well-being are very significant.

[1] The CMS conducts quarterly meetings with State Survey Agency Directors.

HHSOIG - 0372

The Survey Agency has not initiated actions to ensure the effectiveness of annual surveys and complaint investigations.[2] Re-certification surveys are not completed timely. Complaint surveys are not completed timely. A recent complaint/re-certification case at Joe-Anne Burgin Nursing Home demonstrates this ineffectiveness, lack of coordination and poor planning, if not lack of planning. This provider's last recertification survey was September 13, 2012. The Survey Agency began a complaint survey on March 25, 2014; the Survey Agency completed the complaint survey on May 14, 2014, 49 days after the complaint survey start date. The Survey Agency's exit date for the re-certification survey was June 27, 2014. No less than 21 months have elapsed since the last re-certification survey and the current re-certification survey is yet to be finalized. On numerous occasions, CMS has emphasized the fact that complaint surveys and re-certification surveys should be conducted concurrently, where possible. As you will note in the data reports included with this letter, **92.3%** of the LTC surveys conducted by the Survey Agency for the current Federal fiscal year (FY 2014) exceeded the required 15.9 month timeframe. Additionally, we are in the tenth month of the current fiscal year and only **51.3%** of the LTC providers have been surveyed. For the past fiscal year (FY 2013), **14.6%** of the LTC providers were not surveyed at all during the required timeframe. These actions and results are unacceptable.

Our national data system, ASPEN Complaints/incidents Tracking System (ACTS),[3] developed to promote consistency, uniformity and meaningful comparisons and evaluations, is not being utilized by the Survey Agency to the fullest extent. During the most recent State Performance Standards System (SPSS) review of May 2014, CMS determined that, in some cases for LTC providers, the ACTS data system lacked sufficient information for supervisory personnel to adequately triage pending complaints.[4] For hospital providers, it has been observed that hospital records have been requested prior to entering a facility for complaint investigations and administrative reviews (off-site investigations) have been conducted after the complaints were triaged. This is not an acceptable practice or option available to the Survey Agency after hospital complaints have been triaged.[5]

The Survey Agency has not conducted the clinical laboratory surveys in a timely manner. As of June 30, 2014, 102 clinical laboratories had expired certificates; an additional 110 clinical laboratories' certificates are set to expire by September 17, 2014; therefore, no less than 212 clinical laboratories' certificates will have expired in Federal fiscal year 2014. These laboratories have paid all necessary fees associated with the clinical laboratory program; their clinical laboratory certificates have expired; and they are unable to bill for services. This results in revenue losses for the providers and threatens the ability of some clinical laboratories to remain open.

Based upon a review by CMS, the Survey Agency has not consistently or timely uploaded new hospice providers' initial certification information to the national ASPEN system.[6] CMS found 7 initial certification kits that had not been uploaded to the national system. This prevented some hospice providers from registering with CMS so that they could begin transmitting patients' admission and

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[2] Every nursing home receiving Medicaid or Medicaid payments must undergo a standard survey not less than once every 15.9 months and the statewide average survey interval for these surveys must not exceed 12.9 months. Complaint investigations provide an opportunity for State surveyors to intervene promptly if problems arise between standard surveys.

[3] As of January 2004, CMS requires that States use ACTS, a national electronic tracking system that monitors the processing and investigation of complaints.

[4] Prompt and appropriate response to consumer and public complaints regarding services received in a nursing home is a vital protection offered by the nation's survey and certification system.

[5] The value of the survey program comes from completing surveys, the quality of the surveys themselves, proper identification of deficiencies and appropriate enforcement actions and remedies of identified problems, preferably through systemic change.

[6] Monitoring and management of the hospice certification process are delegated to the States in the Atlanta Region.

HHSOIG - 0373

discharge records beginning July 1, 2014. To avoid a two (2) percentage point reduction in their FY 2016 annual payment update, all Medicare-certified hospice providers must report admission and discharge data to CMS.

Please find enclosures which demonstrate some of the most serious concerns regarding the Survey Agency's performance. They include results of fiscal years 2012, 2013 and mid-year 2014 SPSS reviews, summaries of data reviews and data reports run from CMS national systems.

This letter requests that you fully investigate the aforementioned concerns, such that immediate and lasting changes will be effectuated to improve quality outcomes for people with Medicare and Medicaid. Additionally, please provide a detailed action plan with specific timeframes to address the listed concerns by September 1, 2014.

Thank you for your efforts to improve health outcomes for people with Medicare and Medicaid in Georgia and for your responses to the above-listed requests. If you have questions or concerns, please feel free to contact me at [redacted] or Sandra Pace, Associate Regional Administrator, at [redacted].

Sincerely,

James Randolph Farris, M.D.
Consortium Administrator

Enclosures

cc: Thomas Hamilton – S&C Group, Baltimore
Jan Tarantino – S&C Group, Baltimore
Mary Scruggs – GA State Survey Agency
Avery Flower – GA State Survey Agency

HHSOIG - 0374

ATTACHMENT 3: SURVEY UNTIMELINESS

SUMMARY OF GA SSA STATE PERFORMANCE STANDARDS SYSTEM PERFORMANCE			
FY 2014			
MEASURE DESCRIPTION		**MET**	**NOT MET**
	FREQUENCY		
F1	Off-hour surveys for nursing homes	X	
F2	Frequency of nursing home surveys		X
F3.1	Frequency of non-nursing home surveys - Tier 1		X
F3.2	Frequency of non-nursing home surveys - Tier 2	X	
F3.3	Frequency of non-nursing home surveys - Tier 3	X	
F4	Timeliness of upload into CASPER of standard surveys for non-deemed hospitals and nursing homes	X	
	QUALITY		
Q1	Documentation of deficiencies for nursing homes, ESRD facilities, ICFs/IID, and non-deemed HHAs and hospitals	X	
Q2	Conduct of nursing home health surveys in accordance with federal standards as measured by federal oversight support surveys (FOSS)	N/A	
Q3	Documentation of noncompliance in accordance with federal standards for nursing home health FOSS surveys	N/A	
Q4	Identification of health and life safety code (LSC) deficiencies on nursing home surveys as measured by federal comparative survey results	N/A	
Q5	Implementation of the nursing home quality indicator survey	HOLD	
Q6	Prioritizing complaints and facility self-reported incidents		X
Q7	Timeliness of complaint and facility self-reported incident investigation		X
Q8	Quality of EMTALA investigations	X	
Q9	Triaging of deemed facility complaints	X	
	ENFORCEMENT		
E1	Timeliness of processing immediate jeopardy	X	
E2	Timeliness of mandatory denial of payments for new admissions (DPNA) notification for nursing homes	X	
E3	Processing of termination cases for non-nursing home providers/suppliers	X	
E4	Special focus facilities (SFF) for nursing homes	X	

SUMMARY OF GA SSA SPSS PERFORMANCE			
FIRST HALF OF FY 2015			
MEASURE DESCRIPTION		MET	NOT MET
	FREQUENCY		
F1	Off-hour surveys for nursing homes		X
F2	Frequency of nursing home surveys		X
F3.1	Frequency of non-nursing home surveys - Tier 1		X
F3.2	Frequency of non-nursing home surveys - Tier 2		X
F3.3	Frequency of non-nursing home surveys - Tier 3	X	
F4	Timeliness of upload into CASPER of standard surveys for non-deemed hospitals and nursing homes	X	
	QUALITY		
Q1	Documentation of deficiencies for nursing homes, ESRD facilities, ICFs/IID, and non-deemed HHAs and hospitals	X	
Q2	Conduct of nursing home health surveys in accordance with federal standards as measured by federal oversight support surveys (FOSS)		
Q3	Documentation of noncompliance in accordance with federal standards for nursing home health FOSS surveys		
Q4	Identification of health and life safety code (LSC) deficiencies on nursing home surveys as measured by federal comparative survey results		
Q5	Implementation of the nursing home quality indicator survey		
Q6	Prioritizing complaints and facility self-reported incidents		X
Q7	Timeliness of complaint and facility self-reported incident investigation		X
Q8	Quality of EMTALA investigations		
Q9	Triaging of deemed facility complaints		
	ENFORCEMENT		
E1	Timeliness of processing immediate jeopardy	X	
E2	Timeliness of mandatory denial of payments for new admissions (DPNA) notification for nursing homes		
E3	Processing of termination cases for non-nursing home providers/suppliers		X
E4	Special focus facilities (SFF) for nursing homes		

ATTACHMENT 4: CLINICAL LABORATORY PROBLEMS

PERSPECTIVE	OBJECTIVE	MEASURE	OUTCOME
CLIA APPLICATIONS	TO PROCESS NEW APPLICATIONS	THE APPLICATIONS ARE TO BE PROCESSED WITHIN 2 WEEKS	CURRENT PROCESSING TIME FOR APPLICATIONS IS 2 MONTHS; IT WAS PREVIOUSLY 9-12 MONTHS (The Atlanta RO has processed over 100 applications for the SA). If application are not processed the laboratory cannot billed.
CLIA UPDATES	TO PROCESS UPDATES TO EXISTING CLIA APPLICATIONS	TO PROCESS UPDATES WITHIN 72 HOURS	THE CURRENT PROCESSING TIME IS 1-3 MONTHS; IT WAS PREVIOULSY 6-8 MONTHS
PHONE INQUIRIES AND EMAILS	TO ANSWER PHONE INQUIRIES AND EMAILS FROM LABORATORIES INQUIRING ABOUT CLIA CERTIFICATES, BILLING, etc.	TO RETURN PHONE CALLS WITHIN 24HRS	THE GA STATE AGENCY HAS NOT RETURNED CALLS WITHIN 24 HOURS; THE VOICE MAIL MESSAGE IS CONSISTENTLY FULL (The RO averages 8-10 calls a day about the Georgia SA)
COMPLAINT PROCESS	To perform surveys and complete documentation within 55 days.	The State Agency is responsible for completing these timeframes and before the survey expiration dates.	Doing FY14, the State of GA had to contract out survey work due to the fact that they had high volume of laboratory certificates expired. Doing FY15, the state agency continue to have expired certificates and not uploading laboratory information in the systems in a timely manner.

PROFICIENCY TESTING	To perform review of laboratory PT every 30 to 45 days.	The surveyor supposed to perform every 30 to 45 days and initiate enforcement actions when necessary.	The State of GA has failed to perform PT Desk Review on a consistent basis. Also, laboratories that should have had enforcement actions, but the State failed to identified. Approximately, 10 enforcement actions that were sent to Regional Office in November and December 2015 should have been sent in October and September 2015.

PERFORMANCE MEASURES – CLINICAL LABORATORIES FY2014	Results	Comments
C6: Survey Timeframes		
One or more initial surveys completed after registration period expired?	Yes	
One or more recertification surveys completed after compliance certificate expired?	Yes	
SA has implemented a tracking system	No	
Written corrective action plan required?	Yes	
Quantified Performance Results less than 85%	Yes	Scored 40%
C8: Proficiency Testing Desk Review		
SA has implemented a mechanism to track PT scores every 30-45 days?	No	
Quantified Performance Results less than 85%	No	Scored 93%
C9: Outcome-oriented Survey Process (OSP)		
Surveyors have implemented the policy of "mandatory citations"?	Yes	
Quantified Performance Results less than 85%	No	Scored 100%
C10: Principles of Documentation (PoD)		
Quantified Performance Results less than 85%	Yes	Scored 50%
Written corrective action plan required?	Yes	
C11: Acceptable Plan of Correction (PoC)		
Quantified Performance Results less than 85%	Yes	Scored 33%
Written corrective action plan required?	Yes	
C13: Complaints		
SA utilizes ACTS for all complaints?	No	
Quantified Performance Results less than 85%	Yes	Scored 78%
Written corrective action plan required?	Yes	

Exhibit 5

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

CONSORTIUM FOR QUALITY IMPROVEMENT AND SURVEY & CERTIFICATION OPERATIONS

The Honorable Nathan Deal
Governor of Georgia
206 Washington Street
Suite 203, State Capitol
Atlanta, Georgia 30334

March 11, 2016

Dear Governor Deal:

The Secretary of the U.S. Department of Health and Human Services (Secretary) has an agreement under Section 1864 of the Social Security Act (1864 Agreement) with the Georgia Department of Community Health (DCH), Health Facilities Regulation Divisions (HFRD) to operate as the State Survey Agency (SSA) responsible for certifying that Medicare health care providers and suppliers in Georgia meet the minimum federal health and safety requirements in the care and provision of services to the residents of Georgia. Article II of the 1864 Agreement specifies the functions to be performed by the SSA. Further, Chapter 8 of the Centers for Medicare and Medicaid Services (CMS) State Operations Manual (SOM), Internet Only Manual Pub. 100-7 lists the performance standards as required under the agreement, provides the definition of "inadequate survey performance," and explains the evaluation process for determining whether or not performance standards have been met.[1] Additionally, Article VIII of the 1864 Agreement addresses the termination of the agreement.

Since 2011, HFRD has had significant survey and certification performance issues which are described below and in the Attachments. Many of these result from ongoing staff vacancies (two regional director positions and over twenty surveyor positions), frequent leadership turnover, insufficient staff training, inadequate orientation processes and limited ability to track and provide oversight of core survey and certification functions performed by staff. HFRD's organizational challenges, steep knowledge gap in program operations, insufficient staffing and lack of tangible progress on a corrective action plan have resulted in the SSA's inadequate performance under its 1864 Agreement.

These performance impairments hamper HFRD's ability to appropriately oversee the quality of care provided patients and residents in Medicare certified facilities. We are currently conducting a formal review of the 1864 Agreement that CMS has with the State of Georgia in light of the state's performance issues to evaluate the extent to which performance improves. As part of that review, we are requesting assurances from the Office of the Governor to address the unacceptable performance with immediate, effective and lasting corrective actions. CMS has

[1] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c08.pdf

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already established remedies and alternative sanctions outlined in the SOM including (training, technical assistance, and a plan of correction). We have also imposed sanctions through communications with responsible State Officials. Without substantive corrective actions, CMS will recommend that the Secretary initiate action to terminate the 1864 Agreement with the State of Georgia sixty (60) days from the date of this correspondence. CMS would provide a separate letter in the event of the need to terminate the Agreement as a whole or in part.

The operational challenges have a significant impact on the ability of HFRD to adequately monitor and safeguard the care received by Georgia nursing home residents. Examples of such impact are described in **Attachment 1.**

This notification follows ongoing and focused assistance and intervention by CMS to the staff and management teams as described in **Attachment 2**. The DCH Commissioner signed off on a strategic corrective action plan on August 29, 2014. The deliverables from the corrective action plan have not occurred, been untimely or incomplete.

Despite ongoing CMS guidance, assistance and coaching, the HFRD's performance has not improved and continues to decline. As part of follow up with your office, an outline of the specific criteria and thresholds related to performance are reflected below. Some of the core outcomes that must be achieved by all SSAs across the country under the 1864 Agreement and specific comments regarding the performance of the Georgia SSA are as follows:

1. **Outcome Requirements: Surveys** – Comprehensive identification of deficiencies; accurate categorization of deficiency seriousness; documentation of deficiencies so as to support correction/enforcement; and conduct of surveys in accordance with laws, regulations and CMS instructions (e.g., timeliness, correct number and type, survey teams include surveyors with required qualifications, appropriate internal SSA operating policies and procedures).

   Areas of Unacceptable SSA Performance:

   - ***Survey Timeliness:*** Nursing home and hospital providers have not been surveyed within the required survey frequency timeframes. See **Attachment 3.**
   - Some nursing home complaints alleging abuse, neglect and substandard quality of care conditions that have been triaged as necessitating two (2) day investigations have not been timely completed or not completed at all.
   - Providers are not receiving notifications of deficiencies in a timely way, nor feedback on their plans of correction submissions to the State in a timely manner so that issues can be resolved.
   - ***Survey Quality:*** There has been a substantial increase in the number of deficiency-free nursing home surveys, including when potential or actual harm was observed by surveyors and did exist. See **Attachment 1**.
   - After CMS has reviewed and discussed specific surveys with SSA management, state surveyors have been unable or unwilling to accurately categorize the scope and severity of deficiencies on subsequent revisit surveys.

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- ***Post Survey Quality Review and Processing:*** Documentation of deficiencies have supported enforcement actions but enforcement actions have not been recommended/taken due to untimely processing and/or lack of transfer of cases to the CMS Atlanta Regional Office.
- ***Staffing, Training and Competency:*** Surveys are conducted by surveyors and reviewed by individuals lacking the skill sets of critical thinking, organization, data analysis, decision making, prioritization, and investigative techniques. The Exhibits discuss numerous cases in which these deficits lead to inadequate performance of the survey and certification functions.
- None or very limited processes are in place to track and provide oversight of core survey and certification functions.
- There is continued poor performance of recently hired staff, contracted surveyors from other states and retired surveyors from Georgia due to the HFRD's ineffective training program based on CMS' review of cases conducted by these individuals.
- ***Oversight and Processing of Clinical Laboratory Certifications:***
  Clinical laboratory data entry is not being performed in a timely manner and uploaded into the national system so that clinical laboratories receive their certificates before the expiration dates. Neither new nor current clinical laboratory applications are being processed within the required 30-day timeframe. The SSA is not responding to phone calls or e-mails from clinical laboratories attempting to check the status of their applications. The CMS RO receives ten to twenty calls each day from clinical laboratories asking for help getting their applications processed. Some clinical laboratories have been trying for more than a year to get their applications processed. See **Attachment 4.**

2. **Outcome Requirements: Complaint Processing** – Correct triaging; correct deficiency determination; accurate categorization of deficiency seriousness; documentation deficiencies so as to support correction/enforcement; and conduct of surveys in accordance with laws, regulations and CMS instructions (e.g., timeliness, correct number and type, survey teams include surveyors with required qualifications, appropriate internal SSA operating policies and procedures).

   Areas of Unacceptable SSA Performance:

   - Complaints and provider self-reported incidents have not been triaged correctly nor investigated in a timely manner resulting in delays in addressing concerns reported by individuals.
   - Individuals who are unfamiliar with the SOM, specifically with Chapters 5 (Complaint Procedures) and 7 (Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities), have been triaging many provider/supplier self-reported incidents. This results in incidents that are not investigated at all or where there are delays in investigating concerns.
   - Quality of care concerns are not being identified and addressed timely, thus, compromising the health and safety of residents.

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- Providers are not receiving notifications of deficiencies within 10 working days as directed in Section 2728 of the State Operations Manual (SOM), nor information on the extent to which their proposed corrections are accepted so that they can address deficiencies adequately in accordance with Sections 7304 and 7600.4 of the SOM.
- Enforcement timelines are not being met. See **Attachment 1.**
- SSA complaint processing problems continue and have become more serious over time prompting increased interventions by CMS.
- Clinical laboratory complaints are not closed out and/or letters are not sent to the clinical laboratories. Consequently, some laboratories have not received their certification certificates; certificates have expired; and this prevents clinical laboratories from being allowed to bill the Medicare and Medicaid programs.
- Clinical laboratories require proficiency testing desk review within 30 to 45 days, this has not been done.

3. **Outcome Requirements: Deficiency Correction/Enforcement** – Appropriate decisions are rendered regarding plans of correction; recommended sanctions are appropriate for the deficiencies; and conduct of surveys in accordance with laws, regulations and CMS instructions (e.g., timeliness, correct number and type, survey teams include surveyors with required qualifications, appropriate internal SSA operating policies and procedures).

   Areas of Unacceptable SSA Performance:

   For nursing homes, CMS requires that a facility must be in substantial compliance with participation requirements within three months of a finding of noncompliance, otherwise a denial of payment for new admissions (DPNA) is imposed, and at six months of noncompliance, the facility's participation is terminated from the Medicare and Medicaid programs. HFRD does not review facility allegations of compliance or conduct revisit surveys in a timely manner, which makes it difficult for providers to correct deficiencies before approaching the three and six month mandatory remedies timeframes.

4. **Outcome Requirement: State Personnel** – Provide qualified personnel needed to carry out the SSA's responsibilities.

   Areas of Unacceptable SSA Performance:

   - SSA staff is being assigned to conduct survey and certification program oversight without required training on essential survey and certification tasks, such as essential certification database systems, principles of documentation, investigative skills, enforcement processes, quality assurance reviews and knowledge of current clinical practices.
   - Not retaining or implementing guidance and instructions given by the CMS Atlanta Regional Office over the past eighteen months related to deficiency determination, scope and severity assignment, requirements for acceptable plans of correction and mandatory processing timeframes.

- The HFRD's projected hiring date of March 15, 2015, noted in its corrective action plan on August 29, 2014, for staff and management positions has not been met. Two regional director positions in the SSA's Long Term Care Program are vacant and have been vacant for months, along with 22 current surveyor vacancies. Filling these positions is critical to establishing effective leadership for HFRD.
- There are twenty or more vacant surveyor positions. The SSA is not taking sufficient measures to fill these vacancies.
- The SSA leadership is often unwilling or unable to respond to direct questions regarding survey, certification or enforcement issues in a timely manner.
- Inefficient use of resources: There have been reported instances where the SSA management team has sent surveyors onsite to nursing homes without conducting the survey of a reported complaint, but only to indicate that complaint investigation surveys will be conducted at some future dates. Intended surveys must be unannounced and not be used as perceived threats to providers.
- The HFRD's Long Term Care Program is not receiving the timely support from the DCH Commissioner's Office regarding hiring and recommended strategic operational changes.

These performance issues have substantive impacts on the health and safety of those receiving care in 10,608 Medicare and Medicaid certified facilities in the State of Georgia.

As described above, without assurances from the Office of the Governor to address the unacceptable performance with immediate, effective and lasting corrective actions, CMS will recommend that the Secretary initiate action to terminate the 1864 Agreement with the State of Georgia sixty (60) days from the date of this correspondence. CMS would provide a separate letter in the event of the need to terminate the Agreement as a whole, or in part.

Thank you for your assistance in protecting the health, safety and well-being of citizens with Medicare and Medicaid in Georgia. If you have questions, please contact me at [redacted] or Sandra M. Pace, Associate Regional Administrator at [redacted].

Sincerely,

Renard L. Murray, D.M.
Consortium Administrator

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Enclosures (4)

cc:
Thomas Hamilton – S&C Group, Baltimore
Jan Tarantino – S&C Group, Baltimore
David Wright, CQISCO, Dallas
Sandra Pace –CQISCO, Atlanta
Clyde Reese, Esq., Georgia DCH Commissioner

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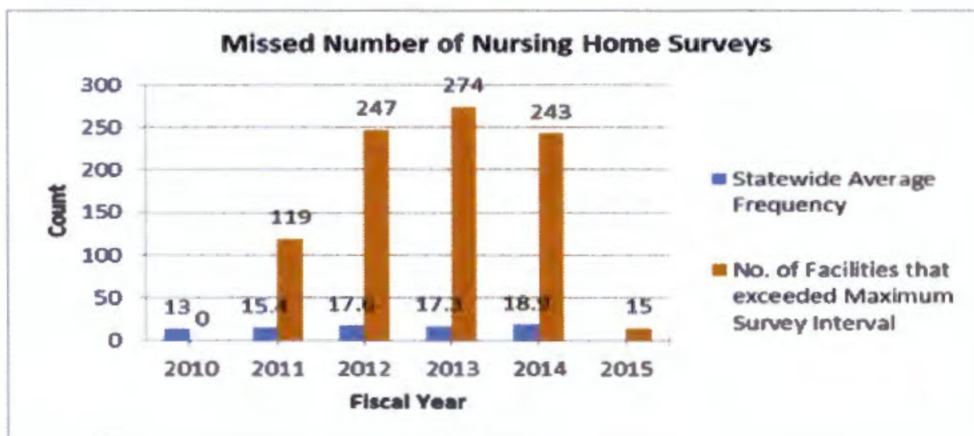
ATTACHMENTS

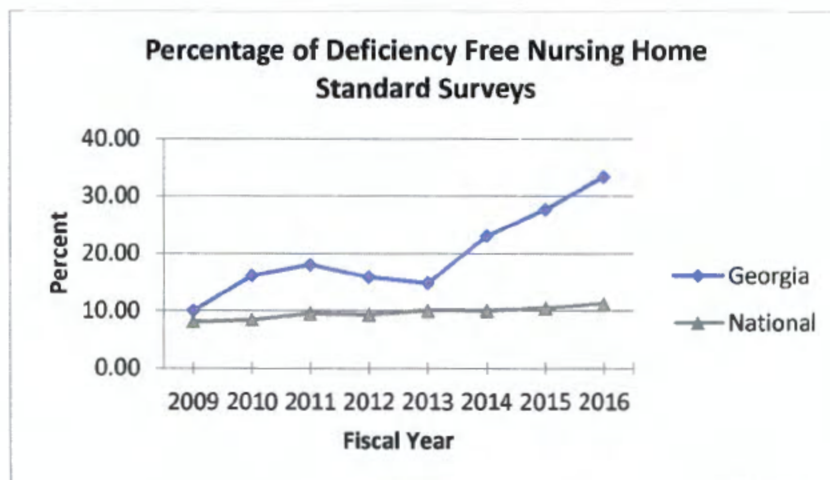
ATTACHMENT 1: IMPACT OF STATE'S UNACCEPTABLE PERFROMANCE

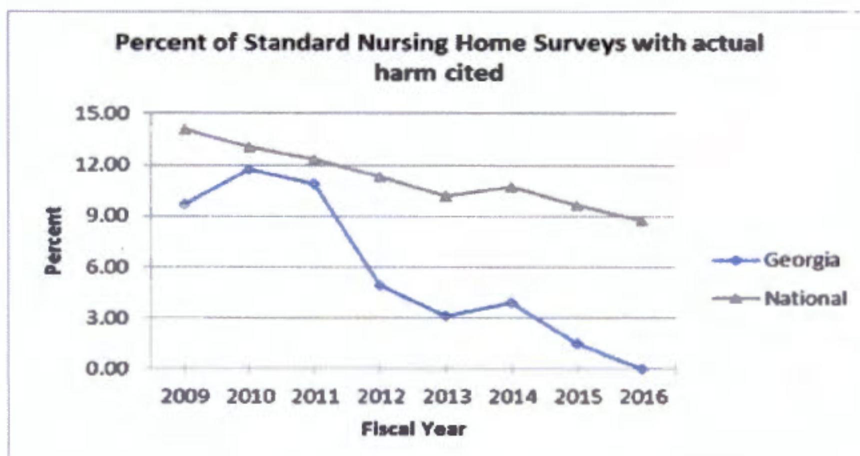
Performance of Georgia State Survey Agency

The Georgia State Survey Agency has had prolonged performance issues. Despite significant intervention by the CMS Regional Office and Central Office, performance has not improved and it is affecting CMS' oversight of quality and provision of proper provider notice.

The tables below indicate that while the frequency of the standard surveys may have improved, the surveyor identification of deficiencies onsite have dropped substantially. We have concerns that the State is not properly reviewing the quality of care onsite nor the allegations of facility compliance, and is not conducting revisits timely nor properly to ensure compliance.







Performance of Georgia State Survey Agency

With the national average at 5.71, Georgia ranks 52nd among states and territories for the average number of total health deficiencies cited per survey at 2.98 per survey. Georgia also has the 7th highest rate of deficiency free surveys at 22.7 percent compared to a national average of 10.1 percent.

Georgia has had no H or I level citations since FY2010.

From FY2010 to FY2015, Georgia cut its number of J and K level citations in half, approximately. For FY 2010, J and K level citations per 100 surveys were 5.73 per 100. For FY2015, J and K level citations per 100 surveys were 2.76 per 100.

Negative Impacts

CMS' primary concern is the health, safety and welfare of Medicare beneficiaries in Georgia. Residents, family members, the general public and other stakeholders rely upon CMS and our contractors to ensure that surveys conducted in our nation's nursing homes are complete, accurate, reliable, reflective of the facts, and supportable in accordance with applicable laws and regulations. When immediate jeopardy, substandard quality of care or harm are identified in a nursing home it is vitally important that the survey reflect the deficient practice. Moreover, survey findings also impact the Special Focus Facility (SFF) status and the Nursing Home Star Rating.

In accordance with Title 18 and 19 of the Social Security Act, the 1864 Agreement, the Mission and Priority Document and 42 C.F.R. § 488.318 the Georgia Department of Community Health hereafter referred to as the State Survey Agency (SSA) had failed to perform to protect the citizens of Georgia. In Section 42 C.F.R § 488.318 inadequate survey performance is "a pattern of failure to:

- Identify deficiencies and the failure cannot be explained by changed conditions in the facility or other specific case factors;
- Cite only valid deficiencies;
- Conduct surveys in accordance with the Federal Requirements, including Chapter 7 of the State Operations Manual (SOM);
- Use Federal standards, protocols, and the forms, methods and procedures specified by CMS in manual instructions;
- Failure to identify immediate jeopardy situation;"
- Failure to identify immediate jeopardy situation;"

Citizens of Georgia have been adversely impacted by the crisis management leadership of the State Survey Agency. CMS has observed that communication is ineffective and occurs in silos. Few, if any, consensus-building strategies are utilized. The management team is often unwilling or unable to respond to direct questions regarding survey, certification and enforcement issues. . Moreover, the SSA does not effectively carry out federal participation requirements and accept responsibility for compliance, nor accept responsibility for all actions, decisions and tasks delegated to subordinates. Enforcement data reports have been provided to the SSA quarterly. The reports are one of many tools available to assist the SSA in monitoring their performance. The enforcement reports are not thoroughly reviewed. Quality assurance (QA) tools submitted with enforcement cases are signed and dated in advance, without the completing the individual components of the QA tool.

In the last 17 months, an increasing number of providers and stakeholders have contacted CMS to report that telephone lines often go unanswered and messages may not be left for staff as mail boxes are full. Moreover, there is instability in the management team, a virtual revolving door; consequently, enforcement systems learned are lost. Historically, the SSA has failed to assure a survey interval of not more than 12.9 months for all certified providers. Benchmarks were established to improve the survey interval, which the SSA accomplished, but at the expense of sacrificing quality. There has been a substantial increase in the number of deficiency free surveys. Self-reported incidents have been closed without thorough review and/or onsite investigation. Allegations of abuse, neglect, and substandard quality of care conditions triaged as necessitating a

2-day onsite investigation have not been completed. In some instances, the management team elected to send surveyors onsite to a nursing home only to announce that a complaint investigation survey would be conducted at some future date. Thereby undermining the state's ability to assess whether residents are provided with proper medical and physical care and their environment is safe. CMS has repeatedly informed the SSA that providing advanced notice of an inspection is detrimental to the survey process, and potentially places residents' lives in immediate danger.

Inadequate State Performance in Long-Term Care Enforcement

Rockmart Health & Rehabilitation, CCN# 11-5530

The SSA concluded a recertification survey and complaint investigation on October 29, 2015. The findings reflected misappropriation of resident property, failure to assure the implementation of abuse policies and procedures; failure to provide sliding scale insulin in accordance with physician orders; failure to provide timely and adequate care for a resident with a colostomy bag; failure to develop and implement an infection control program; and substandard environmental conditions. Moreover, the administration and governing body had failed to assure effective management of resources. Vendor payments were past due, and in some instances had resulted in interruption of services. Payroll checks had been returned for insufficient funds. The local police had attempted to serve staff with warrants for attempting to cash bad checks due to insufficient funds. Employee insurance premiums had been deducted, however, the payments had not been made, resulting in cancellation of benefits, and employee's incurring debts due to lack of coverage. The survey findings indicated that the Rockmart Chief of Police had notified corporate officials, the Ombudsman, the City Manager, the Emergency Management System, the Emergency Management Agency, and the Rockmart Fire Department to be on alert and ready to assist with resident care and relocation if utilities were not operational or staff did not come to work. The highest scope and severity identified by the SSA was an "F" indicative of "no actual harm with potential for more than minimal harm that is not immediate jeopardy. The SSA submitted this enforcement case to CMS on December 9, 2015.

CMS questioned the scope and severity of the egregious survey findings. The SSA read the statement of deficiencies and concurred with CMS that more investigation was needed. The SSA identified immediate jeopardy and completed an extended survey on December 16, 2015, which resulted in the involuntary termination of the provider agreement on January 8, 2016.

Goodwill Health & Rehabilitation, CCN# 11-5486

The enforcement cycle for this nursing home began on June 11, 2015 with health and Life Safety Code surveys. Revisit surveys were conducted on July 21, 2015 by LSC staff and on August 18, 2015 and October 15, 2015 by health surveyors. Based on the October 15, 2015 survey, noncompliance continued with the federal participation requirements. The six month mandatory termination date was December 11, 2015. The SSA totally forgot about conducting a revisit survey until the issue was mentioned twice by CMS. On December 7, 2015, the SSA initiated an abbreviated survey to determine if the nursing home had achieved compliance, and to investigate six self-reported incidents with allegation of abuse and inappropriate resident behavior and facility practices. The survey concluded on December 11, 2015 with the identification of immediate jeopardy, substandard quality of care, and actual harm to residents; health and safety. The immediate jeopardy identified during the survey was ongoing.

The SSA failed to meet established deadlines for mandatory termination of the provider agreement. Federal law requires that providers be given notice of involuntary termination and CMS is required to publish notice of the involuntary termination in a local newspaper in advance of termination. CMS had to publish notice twice because the SSA failed to submit documents for completion of the survey timely. This nursing home received $4,775,073.36 in Medicaid payments in 2014 and $4,355,310.59 in Medicaid payments in 2015 for the provision of quality care to residents in Georgia.

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Crossview Care Center, CCN# 11-5541

The survey of Crossview Care Center has been a debacle from the outset. The survey cycle started on March 19, 2015 with a LSC recertification survey. Noncompliance was identified; however, the investigation was incomplete. The SSA missed citation of immediate jeopardy related to abuse and the care of residents requiring sliding scale insulin for the effective management of diabetes. On May 22, 2015, a health recertification survey was completed. This survey identified immediate jeopardy that existed from January 22, 2015 and was removed on May 21, 2015. The SSA delayed in sending the provider the statement of deficiencies (Form CMS-2567). Legal counsel for the provider sent letters and numerous e-mails seeking feedback on the survey, and requesting communication on the survey outcomes. Months went by, and no one at the SSA responded to the provider.

Since the SSA was unresponsive, the provider requested an informal dispute resolution (IDR) of the survey and also a hearing before the Departmental Appeals Board which is currently listed as Docket number C-15-4175. CMS also sent numerous requests to the SSA seeking an update on this enforcement case, to no avail. CMS was unable to implement any enforcement remedies due to the inefficient management of this enforcement case. As of January 13, 2016, the SSA has still not determined the effective compliance date for this nursing home, nor provided CMS with an enforcement kit that may be utilized to resolve the survey cycle. The maximum period of time a provider may be out of substantial compliance is 180 days before CMS issues notice of mandatory termination of the provider agreement.

Grace Healthcare Center of Tucker, CCN#11-5596

The enforcement cycle for this nursing home started on September 24, 2015. A complaint investigation survey conducted on October 22, 2015 identified actual harm at the scope and severity of "G." The findings indicate that the facility failed to implement a resident's plan of care. The resident fell out of bed, sustained a closed head injury (i.e. subdural hematoma) and died at the hospital. Despite the serious findings, the SSA failed to issue the provider the statement of deficiencies until December 23, 2015. The administrator requested a meeting with SSA to express their concerns regarding the SSA's handling of this case.

The enforcement kit was not submitted to CMS until December 30, 2015, past the 90 day timeframe for the implementation of mandatory denial of payment for new admissions (DPNA). Upon submission of the enforcement kit to CMS, a determination was made that the investigation was incomplete. The SSA failed to identify immediate jeopardy. Immediate jeopardy is defined as "a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."

Vulnerable Citizens in the Media

Family members, the police, and the Department of Justice have expressed concerns regarding incidents that have occurred in Georgia nursing homes wherein frail and/or vulnerable residents have experienced neglect, physical or sexual abuse necessitating medical treatment; and facility personnel have failed to provide quality health care services with dignity and respect for each resident. In each instance, the SSA has waited for the nursing home's investigation of the incident, failed to implement survey protocols and complete a thorough investigation. The SSA has not taken the initiative to be proactive with any investigation. CMS has explained the importance of transparency in operations, and in responding timely to media events and inquires. However, obtaining feedback on serious incidents and investigations is difficult. CMS has received a number of inquiries from the media related to the following cases; nonetheless, the SSA's lack of

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proficiency and competency has resulted in delays in providing feedback to the Office of Legislation and the CMS press officer.

New London Health Center, CCN# 11-5771

In April 2015, a resident was transferred to the hospital in extremely poor, with a gash on their head and ingrown toenails. Pictures of the resident showed the development of pressure sores down to the resident's bones. The DOJ interviewed the state surveyor regarding the lack of survey outcomes. The SSA cited pressure sores at the scope and severity of "D" which is isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. The SSA did not cite noncompliance related to the resident with multiple wounds and exposed bone tissue.

Oceanside Health & Rehabilitation, CCN# 11-5459

In February 2015, a resident was allegedly raped by another resident. In April 2015, the media broadcasted the story. CMS immediately contacted the SSA for an update on the sexual abuse investigation. In addition to allegations of sexual abuse, the complainant reported observing residents with feces, and strong fetid body odors, in part due to lack of daily care and lack of appropriate wound care, and inaccessible call lights. The victim of sexual abuse identified the perpetrator to nursing home personnel. The perpetrator had a known history of inappropriate behaviors. The SSA did not identify the deficient practice associated with the noncompliance, and no deficiencies were cited.

Northeast Atlanta Health & Rehabilitation Center, CCN# 11-5504

The family of a vulnerable adult installed a "nanny cam" video in the resident's room to be assured that the resident was receiving assistance with activities of daily living in a dignified manner. The video revealed that their loved one may have been the victim of abuse and neglect. The SSA initiated the investigation, and only with repeated inquiries from CMS did we receive any updates on the investigation of the serious allegations.

Pruitthealth Lilburn CCN#11-5516

Media reports in early January 2016 reflected that a resident had experienced physical abuse. The media pictures showed a female resident with extensive facial bruises around the eyes. The media reported that an employee of the nursing home, a Certified Nursing Assistant, had been arrested by the police. The SSA initiated an investigation. Preliminary reports to date, indicate that the SSA has not identified deficient practice, nor determined what actions were taken by the nursing home.

Special Focus Facilities (SFFs):

Special focus facilities are nursing homes with a poor history of compliance with the federal participation requirements. SFFs generally have a cyclic pattern of noncompliance and difficulty sustaining quality resident outcomes. SFFs are surveyed twice as often as other nursing homes. Georgia has two nursing homes enrolled in the SFF program. On a monthly basis the SSA is required to provide an update on the status of both SFF nursing homes. Monthly, for eight consecutive months, the SFF report submitted by the SSA was late, incomplete or inaccurate. Moreover, the SSA failed to utilize the SFF guidance to determine if a nursing home had met the graduation criteria.

Protection of Residents:

In accordance with the State Operations Manual and Appendix Q, the Guidelines for Determining Immediate Jeopardy, intakes triaged this priority require immediate corrective action, which necessitates the SSA conducting an onsite investigation in two days. The regulations at 42 C.F.R 489.3 define immediate jeopardy as, "A situation in which the provider's noncompliance with one

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or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident." **The Georgia SSA has 42 intakes without scheduled surveys**. There are an additional 80 intakes assigned for closure via a desk review. Delaying the investigation of immediate jeopardy intakes is a serious breach of trust. The reputation of the SSA has been damaged. Moreover, the failure to protect Georgia's most vulnerable citizens from fraud and abuse concerns and protections pervades every aspect of the delivery of services in long term care facilities. Furthermore, the SSA must assume a measure of culpability for leaving Georgia citizens in dangerous, compromising situations.

Complaints & Self-Reported Incidents:

In calendar year 2015, the SSA received 35 facility self-reported incidents and 1404 complaints. Analysis of the data reveals that 14 of 35 self-reported incidents were closed without an onsite survey. Twenty-two (22) self-reported incidents included allegations of resident to resident or staff to resident abuse, neglect and exploitation. The SSA substantiated 227 complaints (15.77%) and 1177 complaints (81.79%) were unsubstantiated. CMS evaluates the SSA's ability to accurately prioritize and triage complaints as part of Q6 of the State Performance Standard System (SPSS) review. A score of 80 percent is required to meet the Q6 requirement. In fiscal year 2015, the Georgia SSA failed to prioritize and triage 13 of 40 cases accurately, resulting in a low score of 67.5 percent. CMS has observed that SSA surveyors lack knowledge of the Federal participation requirements; often failed to utilize sound clinical judgment in determining survey outcomes; and failed to utilize CMS guidance and protocols to accurately determine scope and severity. The active recruitment of retired surveyors has only exacerbated the problem. Some contract staff lack current knowledge of the federal requirements, and the SSA has not validated the knowledge, skills and abilities of newly recruited staff, nor assigned newly hired personnel with seasoned mentors. Newly hired staff is floundering with the survey process and have left facility after facility after having conducted an inadequate investigation.

Enforcement State Performance Measures:

CMS is required to impose mandatory Denial of Payment for New Admissions (DPNA) when the provider has failed to achieve compliance with the federal participation requirements within 90 days of the enforcement cycle start date. In order to assure the timely implementation of DPNA, the SSA is required to submit enforcement cases to CMS not later than the 70th day. In fiscal year 2015, 14 of 38 enforcement cases were received after the 70th day. The SSA is considered to meet this performance requirement if 80 percent of the cases are received by the 70th day. Georgia's score is 63.2 percent.

Revisit Surveys:

The SSA has failed to conduct revisit surveys timely and in accordance with Section 7317.2 of the State Operations Manual. "One revisit will normally be conducted after a survey which found noncompliance and another before the expiration of the 6-month period by which a facility must be in substantial compliance to avoid termination of its provider agreement. Authorization must be obtained from the CMS Regional Office for more than two onsite revisits for Medicare-only and dually participating facilities." Examples of poor state agency performance include, but are not limited to:

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Eastman Healthcare & Rehabilitation, CCN# 11-5622

The enforcement cycle for this facility began on July 16, 2015. Noncompliance was identified during an abbreviated survey. On October 15, 2015, the SSA conducted a recertification survey that identified continuing noncompliance with the federal participation requirements. The SSA did not forward this enforcement case to CMS until January 5, 2016, eleven days before the six-month mandatory termination date. CMS was unable to publish notice of involuntary termination within 15 days as required by statute and law.

On January 13, 2016, CMS was informed that 18 additional enforcement cases will be received by the RO where DPNA has not been implemented, and each provider is facing a six-month mandatory termination of the provider agreement since revisits have not been monitored and conducted as required.

Scepter Health & Rehabilitation of Snellville, CCN# 11-5643

The enforcement cycle for this nursing home began on May 15, 2015. Following two revisits wherein noncompliance continued, CMS staff reviewed and discussed this case with the SSA management team, informing them that authorization would be required for a third revisit. On October 23, 2015, the SSA conducted a third revisit without CMS authorization.

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Non Long Term Care Concerns

EMTALA CASES:

- Atlanta Medical Center – Complaint #: GA [redacted]. The complaint investigation was completed on7/8/2015. The Georgia State survey Agency did not notify the Regional Office that the complaint investigation was completed. The Regional Office (RO) notified the Georgia State survey Agency on 1/16/2016 that the complaint information to include medical records were not loaded up in the database (ACTS). The information related to complaint was loaded up in ACTS after the RO office notified the Georgia State survey agency.
- Floyd Medical Center – Complaint # GA [redacted] was approved for an EMTALA investigation on 5/8/2015. The packet was not sent to the Regional Office until 9/6/2015.
- Houston Medical Center – Compliant # GA [redacted]. The investigation was completed on 8/5/2015. The packet was not loaded up into ACTS until 11/23/2015.
- DeKalb Medical Center – Complaint # GA [redacted]. The investigation was completed on 9/1/2015. The RO did not receive the packet until 12/3/2015. During this survey a RO CMS representative assisted with this complaint survey investigation. The Georgia State Surveyor refused to do the Exit conference and at that time the survey investigation was taken over by the RO CMS representative.
- Redmond Medical Center – Complaint # GA [redacted]. The complaint investigation was completed on 9/2/2015. The packet was received by the RO on 11/8/2015.

CLIA APPLICATIONS and PHONE SYSTEM:

- On several occasions, we have reminded GA State Agency that the Regional Office are receiving high volumes of calls from providers because the GA State Agency mail box is full. Hulio Griffin met with Melanie Simon (GA HFRD Executive Director) on December 22, 2015 to discuss the concern of the phone and tracking system and the CLIA workload.
- The provider sent in a new CLIA application, approximately 6 months ago, and it still has not been processed. Applications should be processed in a 30 day timeframe.
- Several providers are unable to bill, because CLIA certificate expired, because no recent survey was conducted and has been unable to contact the GA State CLIA agency.
- One provider predicted that he has lost $25,000 in revenue, because the survey has not been done and they have not been able to contact the Georgia State Agency. The provider's certificate expired, due to no fault of the facility and wanted to know if the Georgia SA will reimburse them.
- Provider had survey conducted, but is still unable to bill. He tried to contact Georgia SA, and left a message. After a week and no one returned phone call, he contacted Region IV office.

Non Long Term Care Concerns

Other Concerns:

Oconee Regional Medical Center, (CMS Certification Number: 11-0150), is an accredited, deemed certified, 140-bed, acute care hospital, located in Milledgeville, Georgia. On July 7, 2015, the Georgia State Survey Agency concluded a complaint investigation at Oconee Regional Medical Center. The survey revealed that condition-level deficiencies existed to include an Immediate Jeopardy situation.

This was an IJ, based on the SOM the GA SA is required to certify its findings in ACTS within 2 working days after the completion of the survey. The GA SA did not submit the final 2567 until July 27, 2015, and the survey concluded July 7, 2015. This was an IJ.

ATTACHMENT 2: CMS ASSISTANCE AND INTERVENTIONS

CMS Assistance and Interventions

CMS provided funding for a former SSA director to make four (4) onsite visits to the Georgia SSA within the latter part of calendar year 2015 to provide technical assistance.

CMS RO management has had four (4) face-to-face meetings with the DCH Commissioner and his leadership team to discuss the performance and concerns at the Georgia SSA. The last two meetings occurred on August 14, 2014 and on July 28. 2015.

The DCH Commissioner signed off on a strategic correction action plan on August 29, 2014. The deliverables from the corrective action plan have not occurred, been untimely or incomplete.

CMS Survey Branch Training

The Region IV ICF/IID Lead and Survey manager conducted training on all ICF/IID requirements on February 20, 2013 for all Georgia SSA ICF/IID staff and new management.

The RO staff provided extensive guidance and additional training to the Georgia SSA ICF/IID team and management related to a complaint survey at Gracewood ICF/IID facility when the team experienced significant issues with the investigation of this complaint. The investigation was initiated on March 4, 2014. The team failed to obtain the needed information to support citations regarding the facility's inability to safe guard clients from harm and missed determination of immediate jeopardy. The RO ICF/IID lead guided the team in their investigation during a meeting on June 24, 2014. There were multiple communications with the team from June until the facility achieved substantial compliance on August 2, 2014.

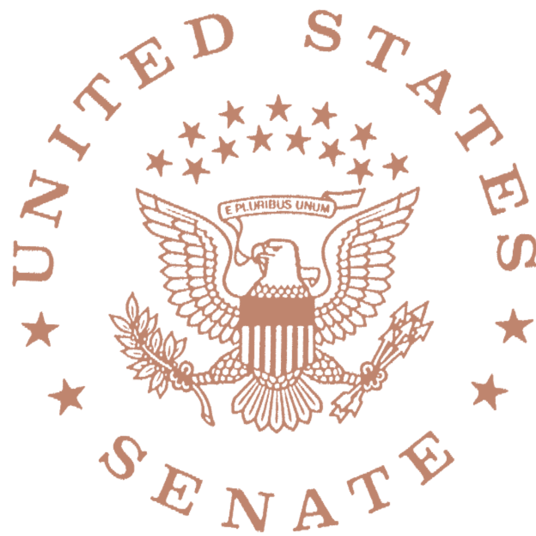
The RO provided additional assistance to the Georgia SSA in principles of documentation and findings to complete the final survey report of August 2, 2014.

CMS Long Term Care Branch Training Subjects

- Regulatory issues.
- The importance of offsite preparation.
- Information gathering.
- Utilizing investigative protocols.
- Quality assessment and assurance review at the nursing home and following completion of the survey.
- Credible allegations removal.
- Determination of the enforcement cycle.
- How to count revisit surveys.
- How to complete the special focus facility report.
- State Operations Manual (SOM), Chapter 7.
- State Performance Standards Review process.

CMS Non-Long Term Care Branch Training

- Clinical labs training on the following dates: April 14 – April 18, 2014, June 2 & June 3, 2015, September 9, 2015, October 27, 2015 and November 16, 2015.
- Principles of documentation – October 23, 2015.
- EMTALA training – October 26, 2015.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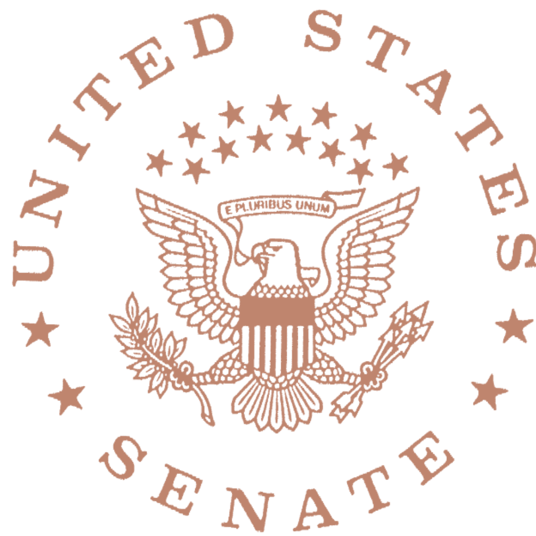
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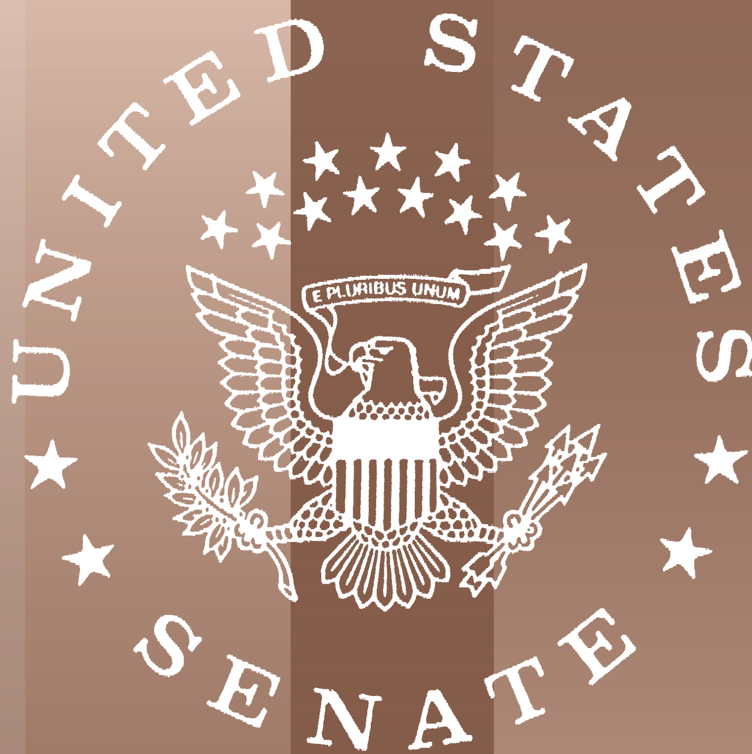

A REPORT BY THE
MAJORITY STAFF OF THE
U.S. SENATE SPECIAL
COMMITTEE ON AGING