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NURSING HOME REFORM

Continued Attention Is Needed to Improve Quality of Care in Small but Significant Share of Homes

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Highlights

Highlights of GAO-07-794T, a testimony before the Special Committee on Aging, U.S. Senate

May 2, 2007

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Why GAO Did This Study

With the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), Congress responded to growing concerns about the quality of care that nursing home residents received by requiring reforms in the federal certification and oversight of nursing homes. These reforms included revising care requirements that homes must meet to participate in the Medicare or Medicaid programs, modifying the survey process for certifying a home's compliance with federal standards, and introducing additional sanctions and decertification procedures for noncompliant homes.

GAO's testimony addresses its work in evaluating the quality of nursing home care and the enforcement and oversight functions intended to ensure high-quality care, the progress made in each of these areas since the passage of OBRA '87, and the challenges that remain.

GAO's testimony is based on its prior work; analysis of data from the Centers for Medicare & Medicaid Services' (CMS) On-Line Survey, Certification, and Reporting system (OSCAR), which compiles the results of state nursing home surveys; and evaluation of federal comparative surveys for selected states (2005-2007). Federal comparative surveys are conducted at nursing homes recently surveyed by each state to assess the adequacy of the state's surveys.

www.gao.gov/cgi-bin/getrpt?GAO-07-794T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118 or allenk@gao.gov.

What GAO Found

The reforms of OBRA '87 and subsequent efforts by CMS and the nursing home industry to improve the quality of nursing home care have focused on resident outcomes, yet a small but significant share of nursing homes nationwide continue to experience quality-of-care problems. In fiscal year 2006, almost one in five nursing homes was cited for serious deficiencies, those that caused actual harm or placed residents in immediate jeopardy. While this rate has fluctuated over the last 7 years, GAO has found persistent variation in the proportion of homes with serious deficiencies across states. In addition, although the understatement of serious deficiencies—that is, when federal surveyors identified deficiencies that were missed by state surveyors—has declined since 2004 in states GAO reviewed, it has continued at varying levels.

CMS has strengthened its enforcement capabilities since OBRA '87 in order to better ensure that nursing homes achieve and maintain high-quality care, but several key initiatives require refinement. CMS has implemented additional sanctions authorized in the legislation, established an immediate sanctions policy for homes found to repeatedly harm residents, and developed a new enforcement management data system. However, the immediate sanctions policy is complex and appears to have induced only temporary compliance in some homes with a history of repeated noncompliance. Furthermore, CMS's new data system's components are not integrated and national reporting capabilities are incomplete, which hamper CMS's ability to track and monitor enforcement.

CMS oversight of nursing home quality has increased significantly, but CMS initiatives continue to compete for staff and financial resources. Attention to oversight has led to greater demand on limited resources, and to queues and delays in certain key initiatives. For example, a new survey methodology has been in development for over 8 years and resource constraints threaten the planned expansion of this methodology beyond the initial demonstration states.

Significant attention from the Special Committee on Aging, the Institute of Medicine, and others served as a catalyst to focus national attention on nursing home quality issues, culminating in the nursing home reform provisions of OBRA '87. In response to many GAO recommendations and at its own initiative, CMS has taken many important steps; however, the task of ensuring high-quality nursing home care for all residents is not complete. In order to guarantee that all nursing home residents receive high-quality care, it is important to maintain the momentum begun by the reforms of OBRA '87 and continue to focus national attention on those homes that cause actual harm to vulnerable residents.

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you acknowledge the 20th anniversary of the passage of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), which contained nursing home reform provisions. In March 1986, the National Academy of Sciences' Institute of Medicine (IOM) released a report concluding that quality of care and quality of life in many nursing homes were not satisfactory, despite the existence of government regulation, and that more effective government regulation could substantially improve nursing home quality.[1] In July 1987, we issued a report recommending that Congress pass legislation that would strengthen enforcement of federal nursing home requirements, consistent with the IOM's recommendations.[2] Largely in response to these reports, Congress passed the nursing home reform provisions of OBRA '87, which was significant in that it changed the focus of quality standards from a home's capability to provide care to its actual delivery of care and resident outcomes. OBRA '87 directed the Health Care Financing Administration, now known as the Centers for Medicare & Medicaid Services (CMS), to reform its certification and oversight of nursing homes for Medicare and Medicaid, which includes surveys to ensure the quality of resident care, complaint investigations, and remedies and penalties for nursing homes not in compliance with federal standards.[3]

The nation's 1.5 million nursing home residents are a highly vulnerable population of elderly and disabled individuals for whom remaining at home is no longer feasible. With the aging of the baby boom generation, the number of individuals needing nursing home care and the associated costs are expected to increase dramatically. Combined Medicare and Medicaid payments for nursing home services were about $72.7 billion in 2005, including a federal share of about $49 billion. The federal

[1]See Institute of Medicine, National Academy of Sciences, *Improving the Quality of Care in Nursing Homes* (Washington, D.C.: March 1986).

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

[3]Prior to July 2001, CMS was known as the Health Care Financing Administration. Throughout this testimony, we refer to the agency as CMS, even when describing initiatives taken prior to its name change. Medicare is the federal health care program for elderly and disabled people. Medicare may cover up to 100 days of skilled nursing home care following a hospital stay. Medicaid is the joint federal-state health care financing program for certain categories of low-income individuals. Medicaid also pays for long-term care services, including nursing home care.

government plays a key role in ensuring that nursing home residents receive appropriate care by setting quality-of-care, quality-of-life, and life safety requirements that nursing homes must meet to participate in the Medicare and Medicaid programs and by contracting with states to routinely inspect homes and conduct complaint investigations.[4] To encourage compliance with these requirements, Congress has authorized certain enforcement actions.

Since this Committee requested us to investigate California nursing homes in 1997, we have reported to Congress and testified numerous times on the quality of resident care, identified significant weaknesses in federal and state activities designed to detect and correct quality problems in nursing homes, and made many recommendations to improve the survey process and federal oversight of nursing home quality.[5] In response to our recommendations as well as needed improvements CMS identified in its own self-assessment in 1998, CMS announced a set of initiatives intended to address many of these weaknesses. Over time, CMS has refined and expanded these initiatives in order to continue to improve nursing home quality.

My remarks today will focus on GAO's work in evaluating the quality of nursing home care and the enforcement and oversight functions intended to ensure high-quality care.[6] I will address the progress made in these three areas since OBRA '87, as well as the challenges that remain. This statement is based primarily on prior GAO work. In addition, we interviewed CMS officials; analyzed data from CMS's On-Line Survey, Certification, and Reporting system (OSCAR), which compiles the results of state nursing home surveys; and evaluated the results of federal comparative surveys for selected states for the period January 2005 through March 2007. Federal comparative surveys are conducted at nursing homes recently surveyed by each state to assess the adequacy of the state's surveys. We considered these data sufficiently reliable for our purposes. We discussed the highlights of this statement including our new

[4]In this report, we use the term states to include the 50 states and the District of Columbia.

[5]Related GAO products are included at the end of this statement. See appendix I for recommendations GAO has made, related CMS initiatives, and the implementation status of these initiatives.

[6]OBRA '87 included other requirements pertaining to nursing homes, such as staffing, services, and specific rights of residents, including privacy, restricted use of physical or chemical restraints, and voicing of grievances, but GAO has not examined these issues.

analyses with CMS officials, and they provided us additional information, which we incorporated as appropriate. We conducted our work from March through April 2007 in accordance with generally accepted government auditing standards.

In summary, despite the reforms of OBRA '87 and subsequent efforts by CMS and the nursing home industry to improve the quality of nursing home care, a small but significant share of nursing homes nationwide continues to experience quality-of-care problems. In 2006, one in five nursing homes nationwide was cited for serious deficiencies—those deficiencies that cause actual harm or place residents in immediate jeopardy. While this rate has fluctuated over the last 7 years, we have regularly found (1) significant variation across states in their citation of serious deficiencies, indicating inconsistencies in states' assessments of quality of care and (2) understatement of these deficiencies—when deficiencies are found on federal comparative surveys but not cited on corresponding state surveys. Among the five large states we reviewed—California, Florida, New York, Ohio, and Texas—understatement of serious deficiencies has declined from 18 percent prior to December 2004 to 11 percent for the most recent time period ending in March 2007, but understatement has continued at varying levels.

Since the passage of OBRA '87, CMS has strengthened its enforcement capabilities—for example, by implementing sanctions authorized in the legislation, establishing an immediate sanctions policy for nursing homes found to repeatedly harm residents, and developing a new enforcement management data system—but several key initiatives require refinement. The immediate sanctions policy is complex and appears to have induced only temporary compliance in certain nursing homes with histories of repeated noncompliance. In addition, the term "immediate sanctions" policy is misleading because it requires only that homes be notified immediately of CMS's intent to implement sanctions, not that sanctions be implemented immediately. Furthermore, when a sanction, such as a denial of payment for new admissions (DPNA), is implemented, there is a lag time between when the deficiency citation occurs and the effective date of the sanction. Finally, although CMS has developed a new data system, the system's components are not integrated and the national reporting capabilities are incomplete, hampering the agency's ability to track and monitor enforcement.

CMS oversight of nursing home quality and state surveys has increased since OBRA '87, but certain key initiatives continue to compete for resources. To increase its oversight of quality of care in nursing homes,

CMS has focused its resources and attention in areas such as prompt investigation of complaints and allegations of abuse, more frequent federal comparative surveys, stronger fire safety standards, and upgrades to data systems. However, this increased emphasis on nursing home oversight coupled with growth in the number of Medicare and Medicaid providers has caused greater demand on limited resources, which, in turn, has led to queues and delays in certain key initiatives. For example, the implementation of a new survey methodology, the Quality Indicator Survey (QIS), has been in development for over 8 years and resource constraints threaten the planned expansion of this methodology beyond the initial five demonstration states.

Significant attention from the Special Committee on Aging, the Institute of Medicine, and others served as a catalyst to focus national attention on nursing home quality issues, culminating in the nursing home reform provisions of OBRA '87. Since then, in response to many GAO recommendations and at its own initiative, CMS has taken many important steps to respond in a timelier, more rigorous, more consistent manner to identified problems. Nevertheless, the task of ensuring high-quality nursing home care is still not complete. To guarantee that all nursing home residents receive high-quality care, it is important to maintain the momentum begun by the reforms of OBRA '87 and continue to focus national attention on those homes that cause actual harm to vulnerable residents.

Background

Titles XVIII and XIX of the Social Security Act establish minimum requirements that all nursing homes must meet to participate in the Medicare and Medicaid programs, respectively. With the passage of OBRA '87, Congress responded to growing concerns about the quality of care that nursing home residents received by requiring major reforms in the federal regulation of nursing homes. Among other things, these reforms revised care requirements that facilities must meet to participate in the Medicare or Medicaid programs, modified the survey process for certifying a home's compliance with federal standards, and introduced additional sanctions and decertification procedures for homes that fail to meet federal standards. Following OBRA '87, CMS published a series of regulations and transmittals to implement the changes. Key implementation actions have included the following: In October 1990, CMS implemented new survey standards; in July 1995, it established enforcement actions for nursing homes found to be out of compliance; and it enhanced oversight through more rigorous federal monitoring surveys beginning in October 1998 and annual state performance reviews in fiscal year 2001. CMS has continued

to revise and refine many of these actions since their initial implementation.

Survey Process

Every nursing home receiving Medicare or Medicaid payment must undergo a standard survey not less than once every 15 months, and the statewide average interval for these surveys must not exceed 12 months.[7] During a standard survey, separate teams of surveyors conduct a comprehensive assessment of federal quality-of-care and life safety requirements. In contrast, complaint investigations, also conducted by surveyors, generally focus on a specific allegation regarding resident care or safety.[8]

The quality-of-care component of a survey focuses on determining whether (1) the care and services provided meet the assessed needs of the residents and (2) the home is providing adequate quality care, including preventing avoidable pressure sores, weight loss, and accidents. Nursing homes that participate in Medicare and Medicaid are required to periodically assess residents' care needs in 17 areas, such as mood and behavior, physical functioning, and skin conditions, in order to develop an appropriate plan of care. Such resident assessment data are known as the minimum data set (MDS). To assess the care provided by a nursing home, surveyors select a sample of residents and (1) review data derived from the residents' MDS assessments and medical records; (2) interview nursing home staff, residents, and family members; and (3) observe care provided to residents during the course of the survey. CMS establishes specific investigative protocols for state survey teams—generally consisting of registered nurses, social workers, dieticians, and other specialists—to use in conducting surveys. These procedural instructions are intended to make the on-site surveys thorough and consistent across states.

[7]CMS generally interprets these requirements to permit a statewide average interval of 12.9 months and a maximum interval of 15.9 months for each home. In addition to nursing homes, CMS and state survey agencies are responsible for oversight of other Medicare and Medicaid providers such as home health agencies, intermediate care facilities for the mentally retarded, accredited and nonaccredited hospitals, end-stage renal dialysis facilities, ambulatory surgical centers, rural health clinics, outpatient physical therapy centers, hospices, portable x-ray suppliers, comprehensive outpatient rehabilitation facilities, and Community Mental Health Centers.

[8]CMS contracts with state survey agencies to conduct surveys and complaint investigations.

The life safety component of a survey focuses on a home's compliance with federal fire safety requirements for health care facilities.[9] The fire safety requirements cover 18 categories, ranging from building construction to furnishings. Most states use fire safety specialists within the same department as the state survey agency to conduct fire safety inspections, but some states contract with their state fire marshal's office.

Complaint investigations provide an opportunity for state surveyors to intervene promptly if problems arise between standard surveys. Complaints may be filed against a home by a resident, the resident's family, or a nursing home employee either verbally, via a complaint hotline, or in writing. Surveyors generally follow state procedures when investigating complaints but must comply with certain federal guidelines and time frames. In cases involving resident abuse, such as pushing, slapping, beating, or otherwise assaulting a resident by individuals to whom their care has been entrusted, state survey agencies may notify state or local law enforcement agencies that can initiate criminal investigations. States must maintain a registry of qualified nurse aides, the primary caregivers in nursing homes, that includes any findings that an aide has been responsible for abuse, neglect, or theft of a resident's property. The inclusion of such a finding constitutes a ban on nursing home employment.

Effective July 1995, CMS established a classification system for deficiencies identified during either standard surveys or complaint investigations. Deficiencies are classified in 1 of 12 categories according to their scope (i.e., the number of residents potentially or actually affected) and their severity. An A-level deficiency is the least serious and is isolated in scope, while an L-level deficiency is the most serious and is considered to be widespread in the nursing home (see table 1). States are required to enter information about surveys and complaint investigations, including the scope and severity of deficiencies identified, in CMS's OSCAR database.

[9]CMS requires nursing homes to meet applicable provisions of the fire safety standards developed by the National Fire Protection Association (NFPA), of which CMS is a member. NFPA is a nonprofit membership organization that develops and advocates scientifically based consensus standards on fire, building, and electrical safety.

Table 1: Scope and Severity of Deficiencies Identified during Nursing Home Surveys

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

Source: CMS.

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

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

Enforcement

In an effort to better ensure that nursing homes achieve and maintain compliance with the new survey standards, OBRA '87 expanded the range of enforcement sanctions. Prior to OBRA '87, the only sanctions available were terminations from Medicare or Medicaid or, under certain circumstances, DPNAs. OBRA '87 added several new alternative sanctions, such as civil money penalties (CMP) and requiring training for staff providing care to residents, and expanded the types of deficiencies that could result in DPNAs. To implement OBRA '87, CMS published enforcement regulations, effective July 1995. According to these regulations, the scope and severity of a deficiency determine the applicable sanctions. CMS imposes sanctions on homes with Medicare or dual Medicare and Medicaid certification on the basis of state referrals.[10] CMS normally accepts a state's recommendation for sanctions but can modify it.

Effective January 2000, CMS required states to refer for immediate sanction homes found to have harmed one or a small number of residents or to have a pattern of harming or exposing residents to actual harm or potential death or serious injury (G-level or higher deficiencies on the agency's scope and severity grid) on successive surveys. This is known as the double G immediate sanctions policy. Additionally, in January 1999,

[10]Ensuring that documented deficiencies are corrected is a shared federal-state responsibility. States are responsible for enforcing standards in homes with Medicaid-only certification—about 14 percent of homes. They may use the federal sanctions or rely on their own state licensure authority and nursing home sanctions.

CMS launched the Special Focus Facility program. This initiative was intended to increase the oversight of homes with a history of providing poor care. When CMS established this program, it instructed each state to select two homes for enhanced monitoring. For these homes, states are to conduct surveys at 6-month intervals rather than annually. In December 2004, CMS expanded this program to require immediate sanctions for those homes that fail to significantly improve their performance from one survey to the next and termination for homes with no significant improvement after three surveys over an 18-month period.[11]

Unlike other sanctions, CMPs do not require a notification period before they go into effect. However, if a nursing home appeals the deficiency, by statute, payment of the CMP—whether received directly from the home or withheld from the home's Medicare and Medicaid payments—is deferred until the appeal is resolved.[12] In contrast to CMPs, other sanctions, including DPNAs, cannot go into effect until homes have been provided a notice period of at least 15 days, according to CMS regulations; the notice period is shortened to 2 days in the case of immediate jeopardy. Although nursing homes can be terminated involuntarily from participation in Medicare and Medicaid, which can result in a home's closure, termination is used infrequently.[13]

Oversight

CMS is responsible for overseeing each state survey agency's performance in ensuring quality of care in nursing homes participating in Medicare or Medicaid. Its primary oversight tools are (1) statutorily required federal monitoring surveys and (2) annual state performance reviews. Pursuant to OBRA '87, CMS is required to conduct annual monitoring surveys in at least 5 percent of the state-surveyed Medicare and Medicaid nursing homes in each state, with a minimum of five facilities in each state. These federal monitoring surveys can be either comparative or observational. A

[11]As of December 2004, Alaska is not required to select Special Focus Facilities, because there were fewer than 21 nursing homes in the state at that time.

[12]If efforts to collect the CMP directly from the home fail, Medicare and Medicaid payments are withheld.

[13]Homes also can choose to close voluntarily, but we do not consider voluntary closure to be a sanction. When a home is terminated, it loses any income from Medicare and Medicaid, which accounted for about 40 percent of nursing home payments in 2004. Residents who receive support through Medicare or Medicaid must be moved to other facilities. However, a terminated home generally can apply for reinstatement if it corrects its deficiencies.

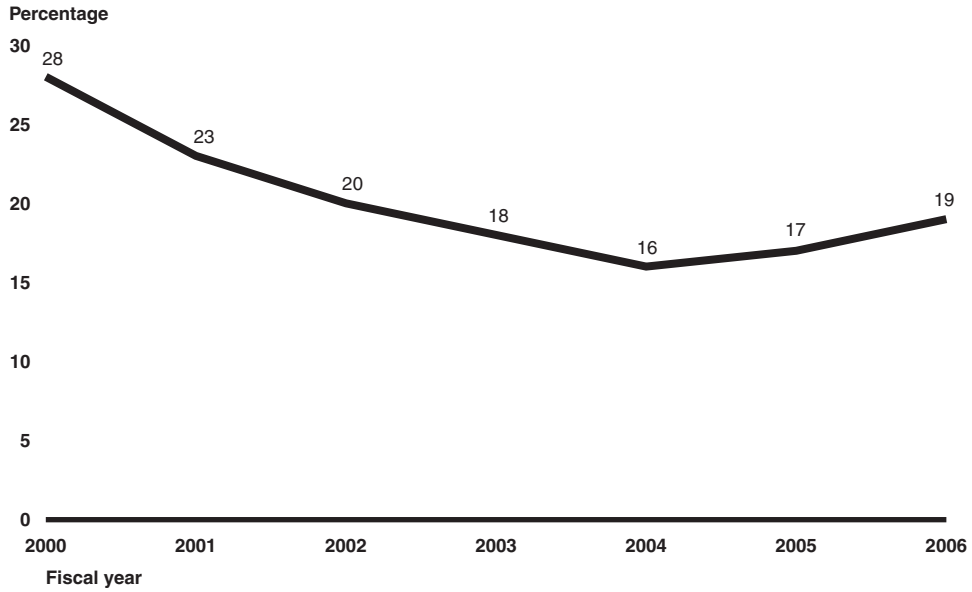
comparative survey involves a federal survey team conducting a complete, independent survey of a home within 2 months of the completion of a state's survey in order to compare and contrast the findings. In an observational survey, one or more federal surveyors accompany a state survey team to a nursing home to observe the team's performance. State performance reviews measure state survey agency compliance with seven standards: timeliness of the survey, documentation of survey results, quality of state agency investigations and decision making, timeliness of enforcement actions, budget analysis, timeliness and quality of complaint investigations, and timeliness and accuracy of data entry. These reviews replaced state self-reporting of their compliance with federal requirements.

Quality of Care Remains a Problem for a Small but Significant Proportion of Nursing Homes Nationwide

A small but significant proportion of nursing homes nationwide continue to experience quality-of-care problems—as evidenced by the almost 1 in 5 nursing homes nationwide that were cited for serious deficiencies in 2006—despite the reforms of OBRA '87 and subsequent efforts by CMS and the nursing home industry to improve the quality of nursing home care. Although there has been an overall decline in the numbers of nursing homes found to have serious deficiencies since fiscal year 2000, variation among states in the proportion of homes with serious deficiencies indicates state survey agencies are not consistently conducting surveys. Challenges associated with the recruitment and retention of state surveyors, combined with increased surveyor workloads, can affect survey consistency. In addition, federal comparative surveys conducted after state surveys found more serious quality-of-care problems than were cited by state surveyors. Although understatement of serious deficiencies identified by federal surveyors in five states has declined since 2004, understatement continues at varying levels across these states.

CMS data indicate an overall decline in reported serious deficiencies from fiscal year 2000 through 2006. The proportion of nursing homes nationwide cited with serious deficiencies declined from 28 percent in fiscal year 2000 to a low of 16 percent in 2004, and then increased to 19 percent in fiscal year 2006 (see fig. 1).

Figure 1: Percentage of Nursing Homes Nationwide with Serious Deficiencies, Fiscal Years 2000-2006



Source: GAO analysis of OSCAR data.

Despite this national trend, significant interstate variation in the proportion of homes with serious deficiencies indicates that states conduct surveys inconsistently. (App. II shows the percentage of homes, by state, cited for serious deficiencies in standard surveys across a 7-year period.). In fiscal year 2006, 6 states identified serious deficiencies in 30 percent or more of homes surveyed, 16 states found such deficiencies in 20 to 30 percent of homes, 22 found these deficiencies in 10 to 19 percent of homes, and 7 found these deficiencies in less than 10 percent of homes. For example, in fiscal year 2006, the percentage of nursing homes cited for serious deficiencies ranged from a low of approximately 2 percent in one state to a high of almost 51 percent in another state.

The inconsistency of state survey findings may reflect challenges in recruiting and retaining state surveyors and increasing state surveyor workloads. We reported in 2005 that, according to state survey agency officials, it is difficult to retain surveyors and fill vacancies because state

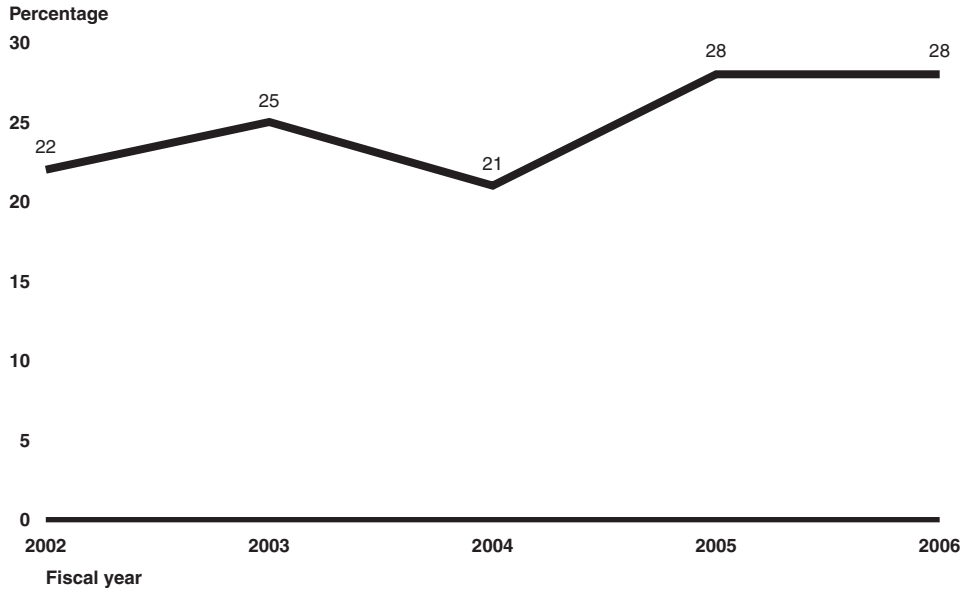
survey agency salaries are rarely competitive with the private sector.[14] Moreover, the first year for a new surveyor is essentially a training period with low productivity. It can take as long as 3 years for a surveyor to gain sufficient knowledge, experience, and confidence to perform the job well. We also reported that limited experience levels of state surveyors resulting from high turnover rates was a contributing factor to (1) variability in citing actual harm or higher-level deficiencies and (2) understatement of such deficiencies. In addition, the implementation of CMS's nursing home initiatives has increased state survey agencies' workload. States are now required to conduct on-site revisits to ensure serious deficiencies have been corrected, promptly investigate complaints alleging actual harm on-site, and initiate off-hour standard surveys in addition to quality-of-care surveys. As a result, surveyor presence in nursing homes has increased and surveyor work hours have effectively been expanded to weekends, evenings, and early mornings.

In addition, data from federal comparative surveys indicate that quality-of-care problems remain for a significant proportion of nursing homes. In fiscal year 2006, 28 percent of federal comparative surveys found more serious deficiencies than did state quality-of-care surveys. Since 2002, federal surveyors have found serious deficiencies in 21 percent or more of comparative surveys that were not cited in corresponding state quality-of-care surveys (see fig. 2). However, some serious deficiencies found by federal, but not state surveyors, may not have existed at the time the state survey occurred.[15]

[14]GAO, *Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety*, GAO-06-117 (Washington, D.C.: Dec. 28, 2005).

[15]For example, a deficiency noted in a federal survey could involve a resident who was not in the nursing home at the time of the state survey.

Figure 2: Percentage of Federal Comparative Surveys That Noted Serious Deficiencies Not Identified in State Surveys



Source: GAO analysis of OSCAR data.

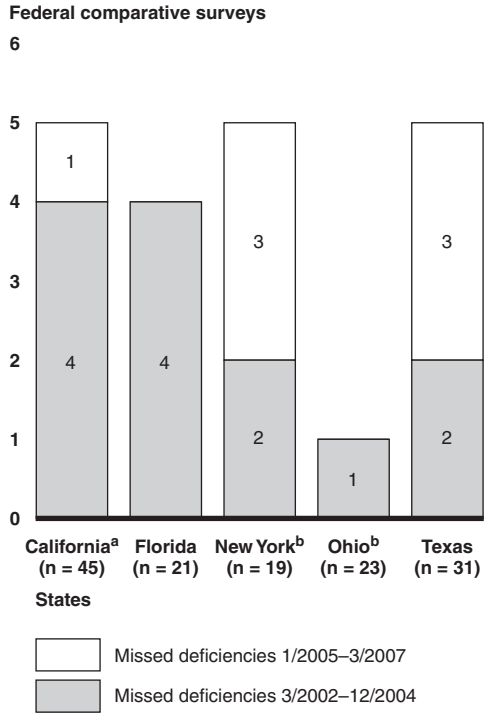
In December 2005, we reported on understatement of serious deficiencies in five states—California, Florida, New York, Ohio, and Texas—from March 2002 through December 2004.[16] We selected these states for our analysis because the percentage of their state surveys that cited serious deficiencies decreased significantly from January 1999 through January 2005.[17] Our analysis of more recent data from these states showed that understatement of serious deficiencies continues at varying levels. Altogether, we examined 139 federal comparative surveys conducted from March 2002 through March 2007 in the five states. Understatement of serious deficiencies decreased from 18 percent for federal comparative surveys during the original time period to 11 percent for federal comparative surveys during the period January 2005 through March 2007.

[16]GAO-06-117. CMS requires its federal surveyors to specifically identify which deficiencies state surveyors missed during the state survey.

[17]These declines in serious deficiencies were 14.3 percentage points for Texas, 15.4 percentage points for Florida, 17.4 percentage points for Ohio, 22.8 percentage points for California, and 23.0 percentage points for New York.

Federal comparative surveys for Florida and Ohio for this most recent time period found that state surveys had not missed any serious deficiencies; however, since 2004 all five states experienced increases in the percentage of homes cited with serious deficiencies on state surveys (see app. II). Understatement of serious deficiencies varied across these five states, as the percentage of serious missed deficiencies ranged from a low of 4 percent in Ohio to a high of 26 percent in New York during the 5-year period March 2002 to March 2007. Figure 3 summarizes our analysis by state, from March 2002 through March 2007.

Figure 3: Federal Comparative Surveys in Five States That Identified Serious Deficiencies Missed by State Surveys, March 2002-March 2007



Source: GAO analysis of federal comparative surveys for five years.

Notes: The total number of federal comparative surveys conducted in each state for the 5-year period, March 2002 to March 2007, is listed in parentheses following the name of the state. The percentage of federal comparative surveys that noted serious deficiencies missed by state surveyors in each state was California, 11 percent; Florida, 19 percent; New York, 26 percent; Ohio, 4 percent; and Texas, 16 percent.

[a]On two comparative surveys, federal surveyors did not provide information on whether any of the deficiencies they identified existed at the time of the state survey; therefore, this number may be understated.

[b]On one comparative survey, federal surveyors did not provide information on whether any of the deficiencies they identified existed at the time of the state survey; therefore, this number may be understated.

CMS Has Strengthened Its Enforcement Capabilities, although Key Initiatives Still Need Refinement

CMS has strengthened its enforcement capabilities since OBRA '87 by, for example, implementing additional sanctions and an immediate sanctions policy for nursing homes found to repeatedly harm residents and developing a new enforcement management data system; however, several key initiatives require refinement. The immediate sanctions policy is complex and appears to have induced only temporary compliance in certain nursing homes with histories of repeated noncompliance. The term "immediate sanctions" is misleading because the policy requires only that homes be notified immediately of CMS's intent to implement sanctions, not that sanctions must be implemented immediately. Furthermore, when a sanction is implemented, there is a lag time between when the deficiency citation occurs and the sanction's effective date. In addition to the immediate sanctions policy, CMS has taken other steps that are intended to address enforcement weaknesses, but their effectiveness remains unclear. Finally, although CMS has developed a new data system, the system's components are not integrated and the national reporting capabilities are incomplete, hampering the agency's ability to track and monitor enforcement.

Despite Changes in Federal Enforcement Policy, Immediate Sanctions Do Not Always Deter Noncompliance and Often Are Not Immediate

Despite CMS's efforts to strengthen federal enforcement policy, it has not deterred some homes from repeatedly harming residents. Effective January 2000, CMS implemented its double G immediate sanctions policy. The policy is complex and does not always appear to deter noncompliance, nor are the sanctions always implemented immediately. We recently reported that the immediate sanctions policy's complex rules, and the exceptions they include, allowed homes to escape immediate sanctions even if they repeatedly harmed residents.[18] CMS acknowledged that the complexity of the policy may be an inherent limitation and indicated that it intends to either strengthen the policy or replace it with a policy that achieves similar goals through alternative methods.

In addition to the complexity of the policy, it does not appear to always deter noncompliance. We recently reported that our review of 63 homes with prior serious quality problems in four states indicated that sanctions may have induced only temporary compliance in these homes because surveyors found that many of the homes with implemented sanctions were

[18]GAO, *Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents*, GAO-07-241 (Washington, D.C.: Mar. 26, 2007).

again out of compliance on subsequent surveys.[19] From fiscal year 2000 through 2005, 31 of these 63 homes cycled in and out of compliance more than once, harming residents, even after sanctions had been implemented, including 8 homes that did so seven times or more. During this same time period, 27 of the 63 homes were cited 69 times for deficiencies that warranted immediate sanctions, but 15 of these cases did not result in immediate sanctions.[20]

We also recently reported that the term "immediate sanctions" is misleading because the policy is silent on how quickly sanctions should be implemented and there is a lag time between the state's identification of deficiencies during the survey and when the sanction (i.e., a CMP or DPNA) is implemented (i.e., when it goes into effect). The immediate sanctions policy requires that sanctions be imposed immediately. A sanction is considered imposed when a home is notified of CMS's intent to implement a sanction—15 days from the date of the notice. If during the 15-day notice period the nursing home corrects the deficiencies, no sanction is implemented. Thus, nursing homes have a de facto grace period. In addition, there is a lag time between the state's identification of deficiencies and the implementation of a sanction. CMS implemented about 68 percent of the DPNAs for double Gs among the homes we reviewed during fiscal year 2000 through 2005 more than 30 days after the survey.[21] In contrast, CMPs can go into effect as early as the first day the home was out of compliance, even if that date is prior to the survey date because, unlike DPNAs, CMPs do not require a notice period. About 98 percent of CMPs imposed for double Gs took effect on or before the survey date. However, the deterrent effect of CMPs was diluted because CMS imposed CMPs at the lower end of the allowable range for the homes we reviewed. For example, the median per day CMP amount imposed for

[19]GAO-07-241. In this report, we analyzed federal sanctions from fiscal year 2000 through 2005 against 63 nursing homes with a history of harming residents and whose prior compliance and enforcement histories formed the basis for the conclusions in our March 1999 report. The homes were located in California, Michigan, Pennsylvania, and Texas.

[20]In 2003, we reported that we found over 700 cases that should have been referred for immediate sanctions but were not, from January 2000 through March 2002. See GAO, *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*, GAO-03-561 (Washington, D.C.: July 15, 2003).

[21]CMPs and DPNAs accounted for 80 percent of federal sanctions from fiscal year 2000 through 2005. The majority of federal sanctions implemented during this time period—about 54 percent—were CMPs. During this time period, DPNAs and terminations accounted for about 26 percent and less than 1 percent of federal sanctions, respectively.

deficiencies that do not cause immediate jeopardy to residents was $500 in fiscal year 2000 through 2002 and $350 in fiscal year 2003 through 2005; the allowable range is $50 to $3,000 per day.

Although CMPs can be implemented closer to the date of survey than DPNAs, the immediacy and the effect of CMPs may be diminished by (1) the significant time that can pass between the citation of deficiencies on a survey and the home's payment of the CMP and (2) the low amounts imposed, as described earlier. By statute, payment of CMPs is delayed until appeals are exhausted. For example, one home we reviewed did not pay its CMP of $21,600 until more than 2 years after a February 2003 survey had cited a G-level deficiency. This citation was a repeat deficiency: less than a month earlier, the home had received another G-level deficiency in the same quality-of-care area. This finding is consistent with a 2005 report from the Department of Health and Human Services' (HHS) Office of Inspector General that found that the collection of CMPs in appealed cases takes an average of 420 days—a 110 percent increase in time over nonappealed cases—and "consequently, nursing homes are insulated from the repercussions of enforcement by well over a year."[22]

CMS has taken additional steps intended to improve enforcement of nursing home quality requirements; however, the extent to which—or when—these initiatives will address enforcement weaknesses remains unclear. First, to ensure greater consistency in CMP amounts proposed by states and imposed by regions, CMS, in conjunction with state survey agencies, developed a grid that provides guidance for states and regions. The CMP grid lists ranges for minimum CMP amounts while allowing for flexibility to adjust the penalties for factors such as the deficiency's scope and severity, the care areas where the deficiency was cited, and a home's past history of noncompliance. In August 2006, CMS completed the regional office pilot of its CMP grid but had not completed its analysis of the pilot as of April 2007. CMS plans to disseminate the final grid to states soon.[23] Second, in December 2004, CMS expanded the Special Focus Facility program from about 100 homes to include about 135 homes. CMS also modified the program by requiring immediate sanctions for those homes that failed to significantly improve their performance from one

[22]See HHS, Office of Inspector General, *Nursing Home Enforcement: The Use of Civil Money Penalties*, OEI-06-02-00720 (April 2005).

[23]Use of the CMP grid would be optional to provide states flexibility to tailor sanctions to specific circumstances.

survey to the next and by requiring termination for homes with no significant improvement after three surveys over an 18-month period. According to CMS, 11 Special Focus Facilities were terminated in fiscal year 2005 and 7 were terminated in fiscal year 2006. Despite the expansion of the program, many homes that could benefit from enhanced oversight and enforcement are still excluded from the program. For example, of the 63 homes with prior serious quality problems that we recently reviewed, only 2 were designated Special Focus Facilities in 2005, and the number increased to 4 in 2006.

While CMS Collects Valuable Enforcement Data, Its Enforcement Monitoring Data Systems Need Improvement

In March 1999, we reported that CMS lacked a system for effectively integrating enforcement data nationwide and that the lack of such a system weakened oversight. Since 1999, CMS has made progress developing such a system—ASPEN Enforcement Manager (AEM)—and, since October 1, 2004, CMS has used AEM to collect state and regional data on sanctions and improve communications between state survey agencies and CMS regional offices. CMS expects that the data collected in AEM will enable states, CMS regional offices, and the CMS central office to more easily track and evaluate sanctions against nursing homes as well as respond to emerging issues. Developed by CMS's central office primarily for use by states and regions, AEM is one of many modules of a broader data collection system called ASPEN. However, the ASPEN modules—and other data systems related to enforcement such as the financial management system for tracking CMP collections—are fragmented and lack automated interfaces with each other. As a result, enforcement officials must pull discrete bits of data from the various systems and manually combine the data to develop a full enforcement picture.

Furthermore, CMS has not defined a plan for using the AEM data to inform the tracking and monitoring of enforcement through national enforcement reports. While CMS is developing a few such reports, it has not developed a concrete plan and timeline for producing a full set of reports that use the AEM data to help assess the effectiveness of sanctions and its enforcement policies. In addition, while the full complement of enforcement data being recorded by the states and regional offices in AEM is now being uploaded to CMS's national system, CMS does not intend to upload any historical data, which could greatly enhance enforcement monitoring efforts. Finally, AEM has quality control weaknesses, such as the lack of systematic quality control mechanisms to ensure accuracy of data entry.

CMS officials told us they will continue to develop and implement enhancements to AEM to expand its capabilities over the next several years. However, until CMS develops a plan for integrating the fragmented systems and for using AEM data—along with other data the agency collects—efficient and effective tracking and monitoring of enforcement will continue to be hampered. As a result, CMS will have difficulty assessing the effectiveness of sanctions and its enforcement policies.[24]

CMS Has Strengthened Oversight, although Competing Priorities Impede Certain Key Initiatives

CMS oversight of nursing home quality and state surveys has increased significantly through several efforts, but CMS initiatives for nursing home quality oversight continue to compete with each other, as well as with other CMS programs, for staff and financial resources. Since OBRA '87 required CMS to annually conduct federal monitoring surveys for a sample of nursing homes to test the adequacy of state surveys, CMS has developed a number of initiatives to strengthen its oversight. These initiatives have increased federal surveyors' workload and the demand for resources. Greater demand on limited resources has led to queues and delays in certain key initiatives. In particular, the implementation of three key initiatives—the new Quality Indicator Survey (QIS), investigative protocols for quality-of-care problems, and an increase in the number of federal quality-of-care comparative surveys—was delayed because they compete for priority with other CMS projects.

Intensity of Federal Efforts Has Increased Significantly

CMS has used both federal monitoring surveys and annual state performance reviews to increase its oversight of quality of care in nursing homes. Through these two mechanisms it has focused its resources and attention on (1) prompt investigation of complaints and allegations of abuse, (2) more frequent and timely federal comparative surveys, (3) stronger fire safety standards, and (4) upgrades to data systems.

Complaint Investigations

To ensure that complaints and allegations of abuse are investigated and addressed in accordance with OBRA '87, CMS has issued guidance and taken other steps. CMS guidance issued since 1999 has helped strengthen state procedures for investigating complaints. For example, CMS instructed states to investigate complaints alleging harm to a resident

[24]We recently recommended that the Administrator of CMS undertake a number of steps to strengthen enforcement capabilities. CMS generally concurred with our recommendations, although it pointed out some resource constraints to implementing certain ones. See GAO-07-241.

within 10 workdays; previously states could establish their own time frames for complaints at this level of severity. In addition, CMS guidance to states in 2002 and 2004 clarified policies on reporting abuse, including requiring notification of local law enforcement and Medicaid Fraud Control Units, establishing time frames, and citing abuse on surveys.

CMS has taken three additional steps to improve its oversight of state complaint investigations, including allegations of abuse. First, in its annual state performance reviews implemented in 2002, it required that federal surveyors review a sample of complaints in each state.[25] These reviews were done to determine whether states (1) properly categorized complaints in terms of how quickly they should be investigated, (2) investigated complaints within the time specified, and (3) properly included the results of the investigations in CMS's database. Second, in January 2004, CMS implemented a new national automated complaint tracking system, the ASPEN Complaints and Incidents Tracking System. The lack of a national complaint reporting system had hindered CMS's and states' ability to adequately track the status of complaint investigations and CMS's ability to maintain a full compliance history on each nursing home. Third, in November 2004, CMS requested state survey agency directors to self-assess their states' compliance with federal requirements for maintaining and operating nurse aide registries. CMS has not issued a formal report of findings from these assessments, but in 2005 we reported that CMS officials noted that resource constraints have impeded states' compliance with certain federal requirements.[26] As a part of this effort, CMS is also conducting a Background Check Pilot Program. The pilot program will test the effectiveness of state and national fingerprint-based background checks on employees of long-term care facilities, including nursing homes.[27]

Federal Comparative Surveys

CMS has increased the number of federal comparative surveys for both quality of care and fire safety and decreased the time between the end of the state survey and the start of the federal comparative surveys. These improvements allow CMS to better distinguish between serious problems

[25]Annual state performance reviews were established in fiscal year 2001 and fully implemented in fiscal year 2002.

[26]GAO-06-117.

[27]Pilot programs have been phased in from fall 2005 through September 2007 in seven states—Alaska, Idaho, Illinois, Michigan, Nevada, New Mexico, and Wisconsin. An independent evaluation is expected in spring 2008.

missed by state surveyors and changes in the home that occurred after the state survey. The number of comparative quality-of-care surveys nationwide per year increased from about 10 surveys a year during the 24-month period prior to October 1998 to about 160 per year for fiscal years 2005 and 2006.[28] The number of fire safety comparative surveys increased as well from 40 in fiscal year 2003 to 536 in fiscal year 2006. In addition, the average elapsed time between state and comparative quality-of-care surveys has decreased from 33 calendar days for the 64 comparative surveys we reviewed in 1999 to 26 days for all federal comparative surveys completed through fiscal year 2006.

Fire Safety Standards

In addition to conducting more frequent federal comparative surveys for fire safety, CMS has strengthened fire safety standards. In response to a recommendation in our July 2004 report to strengthen fire safety standards,[29] CMS issued a final rule in September 2006 requiring nonsprinklered nursing homes to install battery-powered smoke detectors in resident rooms and common areas.[30] In addition, CMS has issued a proposed rule that would require all nursing homes to be equipped with sprinkler systems and, after reviewing public comment, intends to publish a final version of the rule and stipulate an effective date for all homes to comply.[31]

Upgrades to Data Systems

CMS has pursued important upgrades to data systems, expanded dissemination of data and information, and addressed accuracy issues in the MDS in addition to implementing complaint and enforcement systems. One such upgrade increased state and federal surveyors' access to OSCAR data. CMS now uses OSCAR data to produce periodic reports to monitor both state and federal survey performance. Some reports, such as survey timeliness, are used during state performance reviews, while others are intended to help identify problems or inconsistencies in state survey

[28]As of fiscal year 2006, there were about 16,000 nursing homes which would require over 800 federal monitoring surveys. Since 1992 when all federal monitoring surveys were comparative, CMS has begun to rely more heavily on observational surveys, which require a smaller number of federal surveyors. In fiscal year 2006, roughly 77 percent of federal monitoring surveys were observational.

[29]GAO, *Nursing Home Fire Safety: Recent Fires Highlight Weaknesses in Federal Standards and Oversight*, GAO-04-660 (Washington D.C.: July 16, 2004).

[30]71 Fed. Reg. 55326 (Sept. 22, 2006) (codified in pertinent part at 42 C.F.R. §483.70). CMS began surveying nursing homes' compliance with the new requirement in May 2006.

[31]71 Fed. Reg. 62957 (Oct. 27, 2006) (to be codified at 42 C.F.R. §483.70).

activities and the need for intervention. In addition, CMS created a Web-accessible software program called Providing Data Quickly (PDQ) that allows regional offices and state survey agencies easier access to standard OSCAR reports, including one that identifies the homes that have repeatedly harmed residents and meet the criteria for imposition of immediate sanctions.

Since launching its Nursing Home Compare Web site in 1998, CMS has expanded its dissemination of information to the public on individual nursing homes participating in Medicare or Medicaid.[32] In addition to data on any deficiencies identified during standard surveys, the Web site now includes data on the results of complaint investigations, information on nursing home staffing levels, and quality measures, such as the percentage of residents with pressure sores. On the basis of our recommendations, CMS is now reporting fire safety deficiencies on the Web site, including information on whether a home has automatic sprinklers to suppress a fire, and may include information on impending sanctions in the future. However, CMS continues to address ongoing problems with the accuracy and reliability of some of the underlying data. For example, CMS has evaluated the validity of quality measures and staffing information it makes available on the Web, and it has removed or excluded questionable data.

In addition to building the quality measures reported on Nursing Home Compare, the MDS data are the basis for patient care plans, adjusting Medicare nursing home payments as well as Medicaid payments in some states, and assisting with quality oversight. Thus the accuracy of the MDS has implications for the identification of quality problems and the level of nursing home payments. OBRA '87 required nursing homes that participate in the Medicare and Medicaid programs to perform periodic resident assessments; these resident assessments are known as the MDS. In February 2002, we assessed federal government efforts to ensure the accuracy of the MDS data.[33] We reported that on-site reviews of MDS data that compared the MDS to supporting documentation were a very effective method of assessing the accuracy of the data. However, CMS's efforts to ensure the accuracy of the underlying MDS data were too reliant on off-site reviews, which were limited to documentation reviews or data

[32]http://www.medicare.gov/NHCompare/home.asp.

[33]GAO, *Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities*, GAO-02-279 (Washington, D.C.: Feb. 15, 2002).

analysis. To ensure the accuracy of the MDS, CMS signed a new contract for on-site reviews in September 2005; these reviews are ongoing.

Competing Priorities Impede Certain Key CMS Initiatives

CMS initiatives for nursing home quality oversight continue to compete with each other, as well as with other CMS programs, for staff and financial resources. Greater nursing home oversight and growth in the number of Medicare and Medicaid providers has created increased demand for staff and financial resources. Greater demand on limited resources has led to queues and delays in key initiatives. Three key initiatives—the new Quality Indicator Survey (QIS), investigative protocols for quality-of-care problems, and an increase in the number of federal quality-of-care comparative surveys—were delayed because they compete for priority with other CMS projects.

The implementation of the QIS, in process for over 8 years, continues to encounter delays because of a lack of resources. The QIS is a two-stage, data-driven, structured survey process intended to systematically target potential problems at nursing homes by using an expanded sample and structured interviews to help surveyors better assess the scope of any identified deficiencies. CMS is currently concluding a five-state demonstration of the QIS system. A preliminary evaluation by CMS indicates that surveyors have spent less time in homes that are performing well, deficiency citations were linked to more defensible documentation, and serious deficiencies were more frequently cited in some demonstration states. However, CMS officials recently reported that resource constraints in fiscal year 2007 threaten the planned expansion of this process beyond the five demonstration states. Although 13 states applied to transition to QIS, resource limitations may prevent this expansion. In addition, at least $2 million is needed over 2 years to develop a production quality software package for the QIS.

Since hiring a contractor in 2001 to facilitate convening expert panels for the development and review of new investigative protocols, CMS has implemented eight sets of investigative protocols. In December 2005, we reported that these investigative protocols provided surveyors with detailed interpretive guidance and ensured greater rigor in on-site investigations of specific quality-of-care areas, such as pressure sores, incontinence, and medical director qualifications. However, the issuance of additional protocols was slowed because of lengthy consultation with experts and prolonged delays related to internal disagreement over the structure of the process. Instead, it has returned to the traditional revision process even though agency staff believes that the expert panel process

produced a high-quality product. Since issuing several protocols in 2006, CMS has plans to issue two additional protocols.

Although CMS hired a contractor in 2003 to further increase the number of federal quality-of-care comparative surveys, it stopped funding this initiative in fiscal year 2006. The agency reallocated the funds to help state survey agencies meet the increased workload resulting from growth in the number of other Medicare providers.

Concluding Observations

About 20 years ago, significant attention from the Special Committee on Aging, the Institute of Medicine, and others served as a catalyst to focus national attention on nursing home quality issues, culminating in the nursing home reform provisions of OBRA '87. Beginning in 1998, the Committee again served as a catalyst to focus national attention on the fact that the task was not complete; through a series of hearings, it held the various stakeholders publicly accountable for the substandard care reported in a small but significant share of nursing homes nationwide. Since then, in response to many GAO recommendations and on its own initiative, CMS has taken many important steps and invested resources to respond in a timelier, more rigorous, and more consistent manner to identified problems and improve its oversight process for the care of vulnerable nursing home residents. This is admittedly no small undertaking, given the large number and diversity of stakeholders and caregivers involved at the federal, state, and provider levels. Nevertheless, despite the passage of time and the level of investment and effort, the work begun after OBRA '87 is still not complete. It is important to continue to focus national attention on and ensure public accountability for homes that harm residents. With these ongoing efforts, the momentum of earlier initiatives can be sustained and perhaps even enhanced and the quality of care for nursing home residents can be secured, as intended by Congress when it passed this legislation.

Mr. Chairman, this concludes my prepared remarks. I would be pleased to respond to any questions that you or other Members of the Committee may have.

GAO Contact and Acknowledgments

For future contacts regarding this testimony, please contact Kathryn G. Allen at (202) 512-7118 or at allenk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Walter Ochinko, Assistant Director; Kaycee M. Glavich; Leslie V. Gordon; K. Nicole Haeberle; Daniel Lee; and Elizabeth T. Morrison made key contributions to this statement.

Appendix I: Prior GAO Recommendations, Related CMS Initiatives, and Implementation Status

Table 2 summarizes our recommendations from 11 reports on nursing home quality and safety, issued from July 1998 through March 2007; CMS's actions to address weaknesses we identified; and the implementation status of CMS's initiatives as of April 2007. The recommendations are grouped into four categories—surveys, complaints, enforcement, and oversight. If a report contained recommendations related to more than one category, the report appears more than once in the table. For each report, the first two numbers identify the fiscal year in which the report was issued. For example, HEHS-98-202 was released in 1998. The Related GAO Products section at the end of this statement contains the full citation for each report. Of our 42 recommendations, CMS has fully implemented 18, implemented only parts of 7, is taking steps to implement 10, and declined to implement 7.

Table 2: Implementation Status of CMS's Initiatives Responding to GAO's Nursing Home Quality and Safety Recommendations, July 1998 through April 2007

GAO report number	GAO recommendation	CMS initiative	Implementation status
Surveys			
GAO/HEHS-98-202	1. Stagger or otherwise vary the scheduling of standard surveys to effectively reduce the predictability of surveyors' visits. The variation could include segmenting the standard survey into more than one review throughout the 12- to 15-month period, which would provide more opportunities for surveyors to observe problematic homes and initiate broader reviews when warranted.	CMS took several steps to reduce survey predictability, but some state surveys remain predictable. • In 1999, CMS instructed state survey agencies to (1) conduct 10 percent of surveys on evenings and weekends, (2) vary the sequencing of surveys in a geographical area to avoid alerting other homes that the surveyors are in the area, (3) vary the scheduling of surveys by day of the week, and (4) avoid scheduling surveys for the same month as a home's prior survey. • In 2004, CMS provided states with an automated scheduling and tracking system (AST) to assist in scheduling surveys. CMS officials told us that AST can be used to address survey predictability. States appeared to be unaware of this feature and use of AST is optional. • CMS disagreed with and did not implement the recommendation to segment the standard survey into more than one review throughout the 12- to 15-month period.	◑

GAO report number	GAO recommendation	CMS initiative	Implementation status
	2. Revise federal survey procedures to instruct surveyors to take stratified random samples of resident cases and review sufficient numbers and types of resident cases so that surveyors can better detect problems and assess their prevalence.	CMS has been developing a revised survey methodology since 1998. A pilot test of the new methodology began in the fall of 2005. Implementation could begin in mid-2007.	◐
GAO-03-561	3. Finalize the development, testing, and implementation of a more rigorous survey methodology, including investigative protocols that provide guidance to surveyors in documenting deficiencies at the appropriate scope and severity level.	See CMS action in response to recommendation to revise federal survey procedures (recommendation #2 above). CMS began revising surveyors' investigative protocols in October 2000. Eight protocols have been issued, and two additional protocols are under development. Due to issues with interpretation, CMS is no longer planning to issue definitions of actual harm and immediate jeopardy outside of the regulations.	◐
	4. Require states to have a quality assurance process that includes, at a minimum, a review of a sample of survey reports below the level of actual harm to assess the appropriateness of the scope and severity cited and to help reduce instances of understated quality-of-care problems.	CMS has no plans to implement this recommendation, indicating that regular workload and priorities take precedence over it.	⊗
GAO-05-78	5. Hold homes accountable for all past noncompliance resulting in harm to residents, not just care problems deemed to be egregious, and develop an approach for citing such past noncompliance in a manner that clearly identifies the specific nature of the care problem both in the OSCAR database and on CMS's Nursing Home Compare Web site.	CMS revised its definition of past noncompliance. While CMS has not ruled out placing enforcement information on its Nursing Home Compare Web site in the future, CMS officials told us that resource constraints limit the agency's ability to do so at the current time.	◐
Complaints			
GAO/HEHS-99-80	6. Develop additional standards for the prompt investigation of serious complaints alleging situations that may harm residents but are categorized as less than immediate jeopardy. These standards should include maximum allowable time frames for investigating serious complaints and for complaints that may be deferred until the next scheduled annual survey. States may continue to set priority levels and time frames that are more stringent than these federal standards.	In October 1999, CMS issued a policy letter stating that complaints alleging harm must be investigated within 10 days. In January 2004, CMS provided detailed direction and guidance to states for managing complaint investigations for numerous types of providers, including nursing homes. In June 2004, CMS made available updated guidance on the Internet that consolidates complaint investigation procedures for numerous types of providers.	●

GAO report number	GAO recommendation	CMS initiative	Implementation status
	7. Strengthen federal oversight of state complaint investigations, including monitoring states' practices regarding priority-setting, on-site investigation, and timely reporting of serious health and safety complaints.	In 2000, CMS began requiring its regional offices to perform yearly assessments of states' complaint investigations as part of annual state performance reviews.	●
GAO-03-561	8. Finalize the development of guidance to states for their complaint investigation processes and ensure that it addresses key weaknesses, including the prioritization of complaints for investigation, particularly those alleging harm to residents; the handling of facility self-reported incidents; and the use of appropriate complaint investigation practices.	In January 2004, CMS provided detailed direction and guidance to states for managing complaint investigations for numerous types of providers, including nursing homes. In June 2004, CMS made available updated guidance on the Internet that consolidates complaint investigation procedures for numerous types of providers.	●
GAO-02-312	9. Ensure that state survey agencies immediately notify local law enforcement agencies or Medicaid Fraud Control Units when nursing homes report allegations of resident physical or sexual abuse or when the survey agency has confirmed complaints of alleged abuse.	In 2002, CMS issued a memorandum to the regional offices and state survey agencies emphasizing its policy for preventing abuse in nursing homes and for promptly reporting it to the appropriate agencies when it occurs. CMS determined it does not have the legal authority to require state survey agencies to report suspected physical and sexual abuse of nursing home residents.	◑
	10. Accelerate the agency's education campaign on reporting nursing home abuse by (1) distributing its new poster with clearly displayed complaint telephone numbers and (2) requiring state survey agencies to ensure that these numbers are prominently listed in local telephone directories.	In 2002, CMS released a memorandum to regional offices and state agencies that addresses displaying complaint telephone numbers. CMS asked all state agencies to review how their telephone number is listed in the local directory and asked them to ensure that their complaint telephone numbers are prominently listed. In 2007, CMS officials told us that it has not and is not likely to release the poster.	◑
	11. Systematically assess state policies and practices for complying with the federal requirement to prohibit employment of individuals convicted of abusing nursing home residents and, if necessary, develop more specific guidance to ensure compliance.	CMS is conducting a Background Check Pilot Program in several states, as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The pilot is expected to run through September 2007 and will be followed by an independent evaluation. The final study is targeted for submission by spring of 2008.	○

GAO report number	GAO recommendation	CMS initiative	Implementation status
	12. Clarify the definition of abuse and otherwise ensure that states apply that definition consistently and appropriately.	In 2002, CMS released a memorandum to its regional offices and state survey agency directors clarifying its definition of abuse and instructing them to report suspected abuse to law enforcement authorities and, if appropriate, to the state's Medicaid Fraud Control Unit.[a]	●
	13. Shorten the state survey agencies' time frames for determining whether to include findings of abuse in nurse aide registry files.	CMS informed GAO that federal regulations specify that if an investigation finds an individual has neglected or abused a resident or misappropriated resident property, the state must report the findings in writing within 10 working days to the nurse aide registry. However, CMS stated it does not specify a time frame for completion of such investigations due to concerns that a time limit could compromise complaint investigations in some instances.	◑
Enforcement			
GAO/HEHS-98-202	14. Require that for problem homes with recurring serious violations, state surveyors substantiate, by means of an on-site revisit, every report to CMS of a home's resumed compliance status.	In 1998, CMS issued guidance to regional offices and state survey agencies strengthening its revisit policy by requiring on-site revisits until all serious deficiencies are corrected. Homes are no longer permitted to self-report resumed compliance.	●
	15. Eliminate the grace period for homes cited for repeated serious violations and impose sanctions promptly, as permitted under existing regulations.	CMS phased in implementation of its double G policy from September 1998 through January 2000.	●
GAO/HEHS-99-46	16. Improve the effectiveness of civil monetary penalties: The Administrator should continue to take those steps necessary to shorten the delay in adjudicating appeals, including monitoring progress made in reducing the backlog of appeals.	As requested by HHS, Congress approved increased funding and staffing levels for the Departmental Appeals Board in fiscal years 1999 and 2000.	●
	17. Strengthen the use and effect of termination: • Continue Medicare and Medicaid payments beyond the termination date only if the home and state Medicaid agency are making reasonable efforts to transfer residents to other homes or alternative modes of care.	CMS conducted a study and concluded that it was not practical to establish rules to address this problem.	◑

GAO report number	GAO recommendation	CMS initiative	Implementation status
	• Ensure that reasonable assurance periods associated with reinstating terminated homes are of sufficient duration to effectively demonstrate that the reason for termination has been resolved and will not recur.	CMS added examples to the reasonable assurance guidance in 2000, but declined to lengthen the reasonable assurance period.	
	• Strengthen the use and effect of termination: Revise existing policies so that the pretermination history of a home is considered in taking a subsequent enforcement action.	In 2000, CMS revised its guidance so that pretermination history of a home is considered in taking subsequent enforcement actions.	
	18. Improve the referral process: The Administrator should revise CMS guidance so that states refer homes to CMS for possible sanction (such as civil monetary penalties) if they have been cited for a deficiency that contributed to a resident's death.	In 2000, CMS revised its guidance to require states to refer homes for possible sanction if they had been cited for a deficiency that contributed to a resident's death.	●
GAO-07-241	19. Reassess and revise the immediate sanctions policy to ensure that it accomplishes the following:	CMS acknowledged that the complexity of its immediate sanctions policy may be an inherent limitation and indicated that it intends to either strengthen the policy or replace it with a policy that achieves similar goals through alternative methods.	○
	• Reduce the lag time between citation of a double G and the implementation of a sanction.	CMS agreed to reduce the lag time between citation and implementation of a double G immediate sanction by limiting the prospective effective date for DPNAs to no more than 30 to 60 days.	
	• Prevent nursing homes that repeatedly harm residents or place them in immediate jeopardy from escaping sanctions.	CMS indicated it will remove the limitation in the double G policy on applying an additional sanction simply because a nursing home has not completed corrections to a deficiency that gave rise to a previous sanction.	
	• Hold states accountable for reporting in federal data systems serious deficiencies identified during complaint investigations so that all complaint findings are considered in determining when immediate sanctions are warranted.	CMS agreed to collect additional information on complaints for which data are not reported in federal data systems.	
	20. Strengthen the deterrent effect of available sanctions and ensure that sanctions are used to their fullest potential:		○
	• Ensure the consistency of CMPs by issuing guidance, such as the standardized CMP grid piloted during 2006.	CMS agreed to issue a CMP analytic tool, or grid, and to provide states with further guidance on discretionary DPNAs and terminations.	

GAO report number	GAO recommendation	CMS initiative	Implementation status
	• Increase use of discretionary DPNAs to help ensure the speedier implementation of appropriate sanctions.	CMS indicated it will issue further guidance for states on factors to be considered in determining whether a discretionary DPNA is imposed or a termination date is set earlier than the time periods required by law	
	• Strengthen the criteria for terminating homes with a history of serious, repeated noncompliance by limiting the extension of termination dates, increasing the use of discretionary terminations, and exploring alternative thresholds for termination, such as the cumulative duration of noncompliance.	CMS stated it will work with states, consumer organizations, stakeholders, and others to design proposals for a better combination of enforcement actions for homes with repeated quality-of-care deficiencies.	
	21. Develop an administrative process under which CMPs would be paid—or Medicare and Medicaid payments in equivalent amounts would be withheld—prior to exhaustion of appeals and seek legislation for the implementation of this process, as appropriate.	CMS agreed to seek legislative authority to collect CMPs prior to the exhaustion of appeals.	○
	22. Further expand the Special Focus Facility program with enhanced enforcement requirements to include all homes that meet a threshold to qualify as poorly performing homes.	CMS agreed with the concept of expanding the Special Focus Facility program to include all homes that meet a threshold qualifying them as poorly performing homes, but said it lacks the resources needed for this expansion. CMS also identified other initiatives it will implement to improve the program.	○
	23. Improve the effectiveness of the new enforcement data system:		○
	• Develop the enforcement-related data systems' abilities to interface with each other in order to improve the tracking and monitoring of enforcement.	CMS agreed to study the feasibility of linking the separate data systems used for enforcement; however, it indicated that available resources may limit further action.	
	• Expedite the development of national enforcement reports and a concrete plan for using the reports.	CMS agreed to study the feasibility of developing national standard enforcement reports, but stated that further action on these reports may be limited by resource availability.	
	• Develop and institute a system of quality checks to ensure the accuracy and integrity of AEM data.	CMS agreed to develop and implement a system of quality checks to ensure the accuracy of its data systems, including AEM.	
	24. Expand CMS's Nursing Home Compare Web site to include implemented sanctions and homes subjected to immediate sanctions.	CMS proposed reporting implemented sanctions only for poorly performing homes that meet an undefined threshold—this is not fully responsive to our recommendation.	◑

GAO report number	GAO recommendation	CMS initiative	Implementation status
Oversight			
GAO/HEHS-99-46	25. Develop better management information systems. The Administrator should enhance OSCAR or develop some other information system that can be used by both by the states and CMS to integrate the results of complaint investigations, track the status and history of deficiencies, and monitor enforcement actions.	CMS has implemented new national enforcement and complaint tracking systems but has delayed its replacement of the OSCAR data system until 2009 as a result of funding cuts and CMS focus on other initiatives.	○
GAO/HEHS-99-80	26. Require that the substantiated results of complaint investigations be included in federal data systems or be accessible by federal officials.	In January 2004, CMS's new ASPEN Complaint Tracking system was implemented nationwide.	●
GAO/HEHS-00-6	27. Improve the scope and rigor of CMS's oversight process:		●
	• Increase the proportion of federal monitoring surveys conducted as comparative surveys to ensure that a sufficient number are completed in each state to assess whether the state appropriately identifies serious deficiencies.	CMS has significantly increased the number of quality-of-care comparative surveys. In fiscal year 2006, however, the agency will no longer contract for additional quality-of-care comparative surveys because of funding constraints.	
	• Ensure that comparative surveys are initiated closer to the time the state agency completes the home's annual standard survey.	To better ensure that conditions in a nursing home have not changed since the state survey, CMS regional offices reduced the average time between the state survey and the initiation of a federal comparative survey from 33 days in 1999 to 26 days by 2004.	
	• Require regions to provide more timely written feedback to the states after the completion of federal monitoring surveys.	CMS instructed the regions to report the results of federal monitoring surveys to states on a monthly basis.	
	• Improve the data system for observational surveys so that it is an effective management tool for CMS to properly assess the findings of observational surveys.	CMS developed a separate database accessible to all regional offices that includes the results of observational surveys. Beginning in fiscal year 2002, CMS added data on the results of comparative surveys.	
	28. Improve the consistency in how CMS holds state survey agencies accountable by standardizing procedures for selecting state surveys and conducting federal monitoring surveys:		◑
	• Ensure that the regions target surveys for review that will provide a comprehensive assessment of state surveyor performance.	CMS did not implement our recommendation to select individual state surveys for federal review in a manner that ensures its regional offices observe as many state surveyors as possible.	

GAO report number	GAO recommendation	CMS initiative	Implementation status
	• Require federal surveyors to include as many of the same residents as possible in their comparative survey sample as the state included in its sample (where CMS surveyors have determined that the state sample selection process was appropriate).	In October 2002, CMS instructed federal surveyors to select at least half of those residents selected by the state surveyors for their resident sample.	
	29. Further explore the feasibility of appropriate alternative remedies or sanctions for those states that prove unable or unwilling to meet CMS's performance standards.	In December 1999, CMS adopted new state sanctions. In fiscal year 2005, CMS began to tie survey agency funding increases to the timely conduct of standard surveys, a step that we believe offers a strong incentive for improved compliance.	●
GAO/HEHS-02-279	30. Review the adequacy of current state efforts to ensure the accuracy of minimum data set (MDS) data, and provide, where necessary, additional guidance, training, and technical assistance.	CMS disagreed with and did not implement this recommendation.	⊗
	31. Monitor the adequacy of state MDS accuracy activities on an ongoing basis, such as through the use of the established federal comparative survey process.	CMS disagreed with and did not implement this recommendation.	⊗
	32. Provide guidance to state agencies and nursing homes that sufficient evidentiary documentation to support the full MDS assessment be included in residents' medical records.	CMS disagreed with and did not implement this recommendation.	⊗
GAO-03-187	33. Delay the implementation of nationwide reporting of quality indicators until there is greater assurance that the quality indicators are appropriate for public reporting—including the validity of the indicators selected and the use of an appropriate risk-adjustment methodology—based on input from the National Quality Forum and other experts and, if necessary, additional analysis and testing.	CMS disagreed with and did not implement this recommendation.	⊗
	34. Delay the implementation of nationwide reporting of quality indicators until a more thorough evaluation of the pilot is completed to help improve the initiative's effectiveness, including an assessment of the presentation of information on the Web site and the resources needed to assist consumers' use of the information.	CMS disagreed with and did not implement this recommendation.	⊗

GAO report number	GAO recommendation	CMS initiative	Implementation status
GAO-03-561	35. Further refine annual state performance reviews so that they (1) consistently distinguish between systemic problems and less serious issues regarding state performance, (2) analyze trends in the proportion of homes that harm residents, (3) assess state compliance with the immediate sanctions policy for homes with a pattern of harming residents, and (4) analyze the predictability of state surveys.	CMS did not implement this recommendation because it believes that the state performance standards take into account statutory and nonstatutory performance standards.	⊗
GAO-04-660	36. Ensure that CMS regional offices fully comply with the statutory requirement to conduct annual federal monitoring surveys by including an assessment of the fire safety component of states' standard surveys, with an emphasis on unsprinklered homes.	CMS's evaluation of state surveyors' performance now routinely includes fire safety as part of the statutory requirement to annually conduct federal monitoring surveys in at least 5 percent of surveyed nursing homes in each state.	●
	37. Ensure that data on sprinkler coverage in nursing homes are consistently obtained and reflected in the CMS database.	CMS now obtains the sprinkler status of over 99 percent of nursing homes during routine surveys and inputs this information into OSCAR.	●
	38. Until sprinkler coverage data are routinely available in CMS's database, work with state survey agencies to identify the extent to which each nursing home is sprinklered or not sprinklered.	See CMS action in response to recommendation for ensuring that data on sprinkler coverage in nursing homes are consistently obtained (recommendation #37 above).	●
	39. On an expedited basis, review all waivers and Fire Safety Evaluation System (FSES) assessments for homes that are not fully sprinklered to determine their appropriateness.[b]	CMS has completed reviews of all waiver requests and FSES assessments and noted that the number of homes using FSES dropped significantly as a result of the review.	●
	40. Make information on fire safety deficiencies available to the public via the Nursing Home Compare Web site, including information on whether a home has automatic sprinklers.	This information was made available on the Nursing Home Compare Web site as of October 2006.	●
	41. Work with the National Fire Protection Association to strengthen fire safety standards for unsprinklered nursing homes, such as requiring smoke detectors in resident rooms, exploring the feasibility of requiring sprinklers in all nursing homes, and developing a strategy for financing such requirements.	CMS issued regulations effective May 24, 2005, requiring nursing facilities to install smoke detectors in resident rooms and public areas if they do not have a sprinkler system installed throughout the facility or a hard-wired smoke detection system in those areas. Facilities were given 1 year, until May 24, 2006, to comply with this requirement. In addition, the National Fire Protection Association approved a revision to the 2006 Life Safety Code which requires the installation of automatic sprinkler systems in all existing facilities.	●

GAO report number	GAO recommendation	CMS initiative	Implementation status
	42. Ensure that thorough investigations are conducted following multiple-death nursing home fires so that fire safety standards can be reevaluated and modified where appropriate.	CMS developed and issued a standardized procedure to ensure that both state survey agencies and its own staff take appropriate action to investigate fires that result in serious injury or death.	●

(●) Fully implemented our recommendation

(◑) Implemented only part of our recommendation and no further steps are planned

(○) Taking steps to implement our recommendation

(⊗) Did not implement our recommendation

Source: GAO analysis of CMS's responses to our recommendations.

[a]In 1999, CMS had required the use of an investigative protocol on abuse prohibition during every standard survey. The protocol's objective is to determine if the facility has developed and operationalized policies and procedures that prohibit abuse, neglect, involuntary seclusion, and misappropriation of resident property.

[b]As an alternative to correcting or receiving a waiver for deficiencies identified on a standard survey, a home may undergo an assessment using the Fire Safety Evaluation System. The system provides a means for nursing homes to meet the fire safety objectives of CMS's standards without necessarily being in full compliance with every standard.

Appendix II: Percentage of Nursing Homes Cited for Actual Harm or Immediate Jeopardy during Standard Surveys

In order to identify trends in the percentage of nursing homes cited with actual harm or immediate jeopardy deficiencies, we analyzed data from CMS's OSCAR database for fiscal years 2000 through 2006 (see table 3). Because surveys are conducted at least every 15 months (with a required 12-month statewide average), it is possible that a home was surveyed twice in any time period. To avoid double counting of homes, we included only homes' most recent survey from each period.

Table 3: Percentage of Nursing Homes Cited for Actual Harm or Immediate Jeopardy, by State, Fiscal Years 2000-2006

		Fiscal year						
State	Number of homes 2006	2000	2001	2002	2003	2004	2005	2006
Alabama	231	35.5	23.0	12.7	18.1	15.6	23.1	24.2
Alaska	15	28.6	26.7	26.7	0.0	0.0	0.0	26.7
Arizona	135	24.2	12.6	7.3	6.6	9.4	9.9	24.8
Arkansas	245	38.1	27.7	22.3	24.7	19.5	15.9	14.5
California	1,304	24.1	10.9	5.1	3.7	6.1	8.0	14.1
Colorado	215	20.4	26.4	32.7	20.9	25.9	40.4	44.8
Connecticut	245	41.9	51.6	45.8	43.1	54.4	44.2	50.8
Delaware	44	47.5	14.6	10.8	5.3	15.0	35.7	36.8
District of Columbia	20	17.7	28.6	30.0	41.2	40.0	30.0	25.0
Florida	688	22.8	20.2	14.9	10.2	7.8	4.2	9.1
Georgia	371	19.5	21.0	23.7	24.6	16.6	18.0	15.9
Hawaii	48	23.8	14.3	21.2	12.1	22.9	2.8	2.1
Idaho	80	51.4	29.7	39.2	31.9	27.3	38.4	47.8
Illinois	816	28.4	19.2	15.3	18.3	15.1	15.7	21.7
Indiana	526	45.0	29.4	23.2	19.7	24.1	28.3	33.4
Iowa	466	14.7	12.0	8.0	9.1	11.8	11.2	11.7
Kansas	361	37.9	30.7	32.9	26.5	30.3	34.9	38.3
Kentucky	298	26.8	29.1	23.2	26.1	14.6	7.7	11.4
Louisiana	307	21.8	29.9	21.7	16.2	12.0	15.4	15.8
Maine	114	11.1	13.9	6.6	11.1	12.8	7.0	9.8
Maryland	235	22.4	16.5	26.1	15.4	17.8	7.6	7.6
Massachusetts	456	29.1	24.4	24.6	25.9	16.7	22.6	20.9
Michigan	429	42.8	24.5	29.7	26.9	22.9	22.9	29.7
Minnesota	404	30.4	17.3	22.3	18.3	14.3	14.4	18.8
Mississippi	207	33.0	19.8	18.7	16.0	18.9	18.1	9.4
Missouri	526	19.8	13.0	15.6	12.5	11.7	15.4	15.6

Montana	97	33.3	29.7	12.0	20.0	18.0	17.9	16.7
Nebraska	229	19.2	21.1	20.1	14.8	15.3	14.4	25.7
Nevada	47	34.8	14.6	11.9	9.1	17.5	19.6	21.3
New Hampshire	83	37.8	31.1	29.4	24.1	25.6	26.3	22.9
New Jersey	363	25.5	27.8	18.8	10.5	13.5	18.2	15.5
New Mexico	75	23.7	16.9	14.9	21.3	24.3	29.4	25.0
New York	658	33.8	37.1	34.2	15.2	11.0	14.0	18.5
North Carolina	424	43.6	35.8	25.6	29.0	21.1	18.5	17.2
North Dakota	83	25.9	28.7	17.9	12.4	13.6	17.7	21.7
Ohio	980	26.6	27.3	25.4	19.1	11.4	13.8	14.6
Oklahoma	359	19.3	21.3	22.0	26.3	13.9	23.2	20.1
Oregon	142	45.5	32.6	23.7	20.3	15.9	19.8	18.6
Pennsylvania	724	30.3	19.2	13.5	17.2	19.5	15.2	13.6
Rhode Island	90	14.3	12.9	5.6	6.7	9.3	9.5	4.5
South Carolina	178	26.4	17.2	19.8	29.6	32.7	24.8	17.1
South Dakota	111	27.1	26.7	26.8	32.1	21.6	12.8	21.7
Tennessee	332	28.2	20.2	20.7	21.8	22.9	17.3	12.5
Texas	1,175	29.7	30.5	22.4	18.0	12.0	16.2	18.3
Utah	93	19.5	14.1	25.6	19.0	11.1	8.4	17.9
Vermont	41	22.5	18.2	15.0	10.0	19.5	23.7	13.5
Virginia	281	19.2	14.3	11.6	13.7	10.2	15.5	15.8
Washington	247	46.9	38.3	37.0	30.9	28.1	27.2	24.1
West Virginia	132	12.1	17.7	20.4	12.7	9.8	15.0	9.7
Wisconsin	403	15.8	15.6	11.2	10.9	13.1	18.2	23.0
Wyoming	39	52.8	32.4	25.0	22.9	17.1	11.8	16.2
Nation	**16,172**	**28.4**	**23.3**	**20.2**	**17.8**	**15.7**	**16.8**	**18.9**

Source: GAO analysis of OSCAR and PDQ data.

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